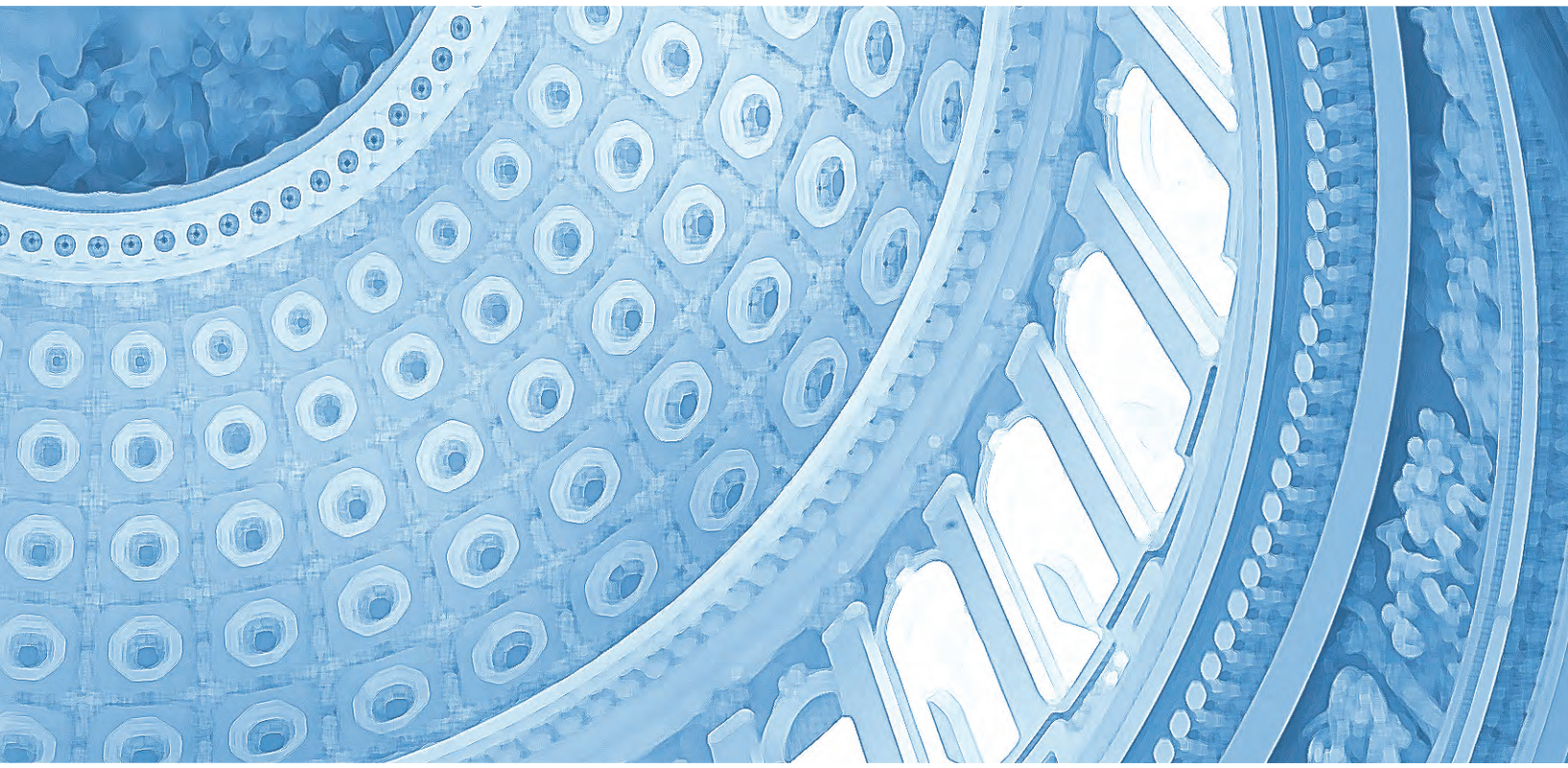
MACPAC

Medicaid and CHIP Payment and Access Commission



Report to the Congress on Medicaid and CHIP

March 2012

MACPAC

Medicaid and CHIP Payment and Access Commission

The Medicaid and CHIP Payment and Access Commission (MACPAC) was established in the Children's Health Insurance Program Reauthorization Act of 2009, and its charge was later revised in the Patient Protection and Affordable Care Act of 2010. Appointed by the U.S. Comptroller General, the 17 Commissioners have diverse backgrounds, offer broad perspectives on Medicaid and CHIP, and represent different regions across the United States.

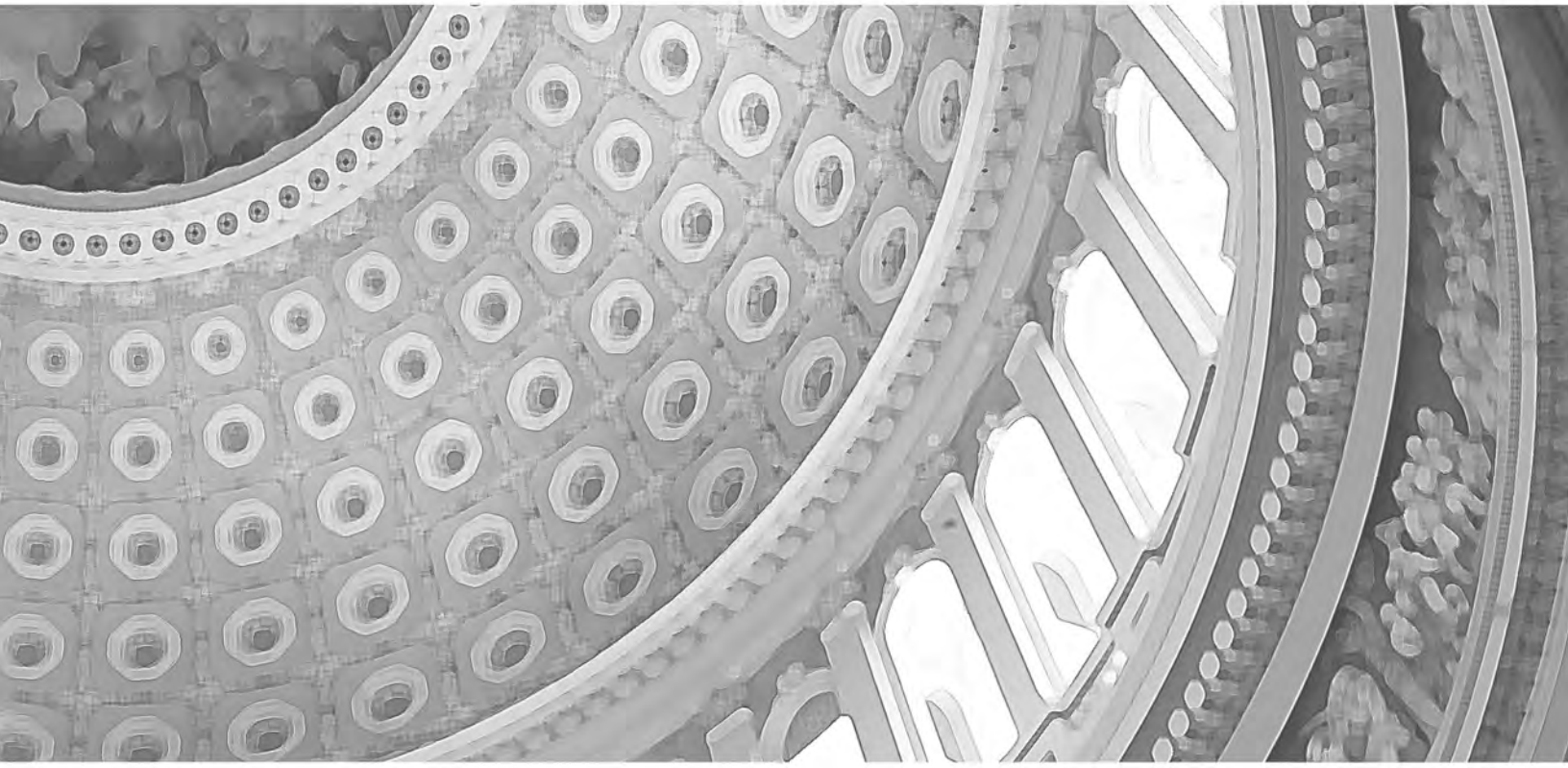
The Commission is a non-partisan, federal, analytic resource for the Congress on Medicaid and CHIP. MACPAC is the first federal agency charged with providing policy and data analysis to the Congress on Medicaid and CHIP, and for making recommendations to the Congress and the Secretary of the U.S. Department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

- Eligibility, enrollment, and benefits;
- Payment;
- Access to care;
- Quality of care;
- Interactions between Medicaid and Medicare; and
- Data development to support policy analysis and program accountability.

As required in its statutory charge, the Commission will submit reports to the Congress on March 15 and June 15 of each year. As applicable, each member of the Commission will vote on recommendations contained in the reports. The Commission's reports provide the Congress with a better understanding of the Medicaid and CHIP programs, their roles in the U.S. health care system, and the key policy and data issues outlined in the Commission's statutory charge.

MACPAC

Medicaid and CHIP Payment and Access Commission



Report to the Congress on Medicaid and CHIP

March 2012

MACPAC

Medicaid and CHIP Payment and Access Commission

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March 15, 2012

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

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

Dear Mr. Vice President and Mr. Speaker:

I am pleased, on behalf of the Commission, to submit the Medicaid and CHIP Payment and Access Commission's (MACPAC's) March 2012 *Report to the Congress on Medicaid and CHIP*. As outlined in our statutory charge, MACPAC is a nonpartisan Commission dedicated to conducting objective policy and data analysis to assist the Congress in overseeing and improving these programs.

Using the analytic foundation established in our 2011 inaugural Reports to the Congress, our March 2012 Report focuses on several Congressional priority issues: Medicaid and persons with disabilities, access to care for children in Medicaid or CHIP, state Medicaid financing approaches and implications for provider payment, an update on CHIP financing issues, and program integrity efforts in Medicaid. The 2012 Report also includes the Medicaid and CHIP Program Statistics (MACStats) supplement. Additionally, we make recommendations to the Secretary of Health and Human Services on two key issues: the advancement of approaches to improve care and control costs for the over 9 million persons with disabilities covered by Medicaid, and the coordination and implementation of Medicaid program integrity activities.

In our chapter on persons with disabilities in Medicaid, our analysis shows that of the 58.8 million people enrolled in FY 2008, more than 9 million persons qualify for Medicaid due to a disability. Of those enrollees, 5.6 million generally rely only on Medicaid for their coverage, while 3.5 million also have coverage through Medicare. Persons with disabilities accounted for only 15 percent of the Medicaid population, but 42 percent of total Medicaid spending due to their substantial, complex health needs and spending for both acute care and long-term services and supports. Our recommendations in this chapter are based on a review of Medicaid eligibility, population characteristics, benefits, spending, and approaches to quality measurement for persons with disabilities. First, we recommend the accelerated advancement of targeted, efficient, and innovative approaches to providing high-quality care for persons with disabilities, especially those with Medicaid-only coverage. Second, we recommend updating and improving quality measurement for persons with disabilities for use in both the current program and new program

innovations. The Commission intends to continue to examine both access to and quality of care for the high-need, high-cost populations—both Medicaid-only and those who are dually enrolled in Medicaid and Medicare—in the current delivery system as well as in new care arrangements and managed care.

In our chapter reviewing access to care for children in Medicaid or CHIP, the Commission analyzed survey data to compare access to care measures for children in Medicaid or CHIP to that of children who have employer-sponsored insurance (ESI) or are uninsured. Results show that after controlling for income, health status, and other socioeconomic factors, children enrolled in Medicaid or CHIP were reported to have better access to care than children who are uninsured, and on most measures have comparable access to care to children with ESI. Future work of the Commission will address access to care for the adult Medicaid population and the impact of provider participation on access.

In our work on Medicaid and CHIP financing, the Commission reviews the range of non-federal financing approaches used in the Medicaid program, including their history and statutory and regulatory basis. Using information presented in this chapter as a foundation, the Commission will continue to examine states' approaches to financing their share of the Medicaid program and the implications for payment policies, as well as the relationship between payment policies and access to appropriate services. This chapter also reviews the status of federal financing for CHIP.

For Medicaid and program integrity, we review initiatives to deter and detect fraud and abuse at the federal and state levels and assess the interaction of the multiple agencies involved in these efforts. The Commission's first recommendation on this issue addresses the importance of improving coordination and removing program redundancies across federal and state program integrity initiatives. The second recommendation focuses on improving analytic tools and accelerating and broadening the dissemination of best practices for deterring and detecting fraud and abuse.

In MACStats—a standing supplement in all MACPAC Reports to the Congress—national and state-specific program data are compiled to facilitate Medicaid and CHIP policy analysis. Pulling together data from multiple sources, the 2012 MACStats provides updated data on eligibility, benefits, and spending.

The Commission provides nonpartisan, data-driven information to the Congress about the Medicaid and CHIP programs to assist federal and state policymakers in identifying potential ways to improve access, quality, payment, and program accountability. We hope that this Report and the work of the Commission will serve to inform and assist the Congress in its deliberations.

Sincerely,

Diane Rowland, ScD
Chair

Enclosure

Acknowledgements

The Commission would like to thank the following people who contributed to the March 2012 *Report to the Congress on Medicaid and CHIP*.

The Commission was fortunate to receive indispensible feedback from several state Medicaid and CHIP officials, including Andrew Allison, Tom Betlach, Heidi Robbins Brown, Kathleen Dunn, Lloyd Early, Mike Fogarty, Darin Gordon, Bruce Greenstein, Valerie Harr, William Hazel, Patti Killingsworth, Chuck Milligan, Billy Millwee, Elena Nicolella, Jeff Schiff, and Julie Weinberg.

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Report Summary

Medicaid and the State Children's Health Insurance Program (CHIP) play significant roles in our health care system. In fiscal year (FY) 2011, Medicaid financed care for an estimated 70 million people, over a fifth of the U.S. population, at a cost of $432 billion.[1] CHIP served 8 million children in FY 2011 with spending of $12 billion.

As part of its statutory charge, each March the Commission reports on the results of its review of policies affecting the Medicaid and CHIP programs. Using the analytic foundation established in our 2011 inaugural Reports to the Congress, the Commission's March 2012 *Report to the Congress on Medicaid and CHIP* focuses on several key Congressional priorities including Medicaid enrollees with disabilities, access to care for children, state approaches for financing Medicaid, federal CHIP financing, and Medicaid program integrity.

The report is divided into four chapters and a statistical supplement.

- Chapter 1: Medicaid and Persons with Disabilities focuses on Medicaid enrollees who qualify for Medicaid on the basis of a disability and examines eligibility, enrollment, population characteristics, services, spending, and quality measurement efforts for this population.
- Chapter 2: Access to Care for Children Enrolled in Medicaid or CHIP presents new research assessing access to care for children, by comparing children in Medicaid or CHIP with children having employer-sponsored insurance (ESI) and those who are uninsured.
- Chapter 3: State Approaches for Financing Medicaid and Update on Federal Financing of CHIP explores issues related to the interaction of Medicaid state financing and provider payment and provides an update on federal CHIP financing.
- Chapter 4: Program Integrity in Medicaid describes initiatives that federal and state governments have in place to safeguard against fraud and abuse in Medicaid.
- Medicaid and CHIP Program Statistics (MACStats) presents updated data on Medicaid and CHIP enrollment, eligibility, and spending.

The Commission is charged with making recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services (the Secretary), and

[1] In the review of Medicaid for persons with disabilities in Chapter 1 of this Report, a Medicaid enrollment figure of 58.8 million is used; this figure reflects FY 2008 data and excludes the U.S. territories. The 70 million figure shown here, provided by the Office of the Actuary at the Centers for Medicare & Medicaid Services, reflects the estimated number of individuals ever enrolled in FY 2011 and includes the U.S. territories.

the states on a wide range of issues affecting Medicaid and CHIP. This report includes four recommendations to improve these programs. Two recommendations address the Commission's work on Medicaid enrollees with disabilities and the need for program innovations that promote high-quality, cost-effective care and appropriate quality measurement tools for this population. Two other recommendations are designed to improve federal and state program integrity efforts in Medicaid. These recommendations are intended to foster higher-quality and cost-effective care for program enrollees and generate greater efficiency and administrative simplification in Medicaid program management. Consistent with its statutory charge, MACPAC consulted with the appropriate federal and state-focused organizations to examine the federal and state budget consequences of its recommendations.

Chapter 1: Medicaid and Persons with Disabilities

This chapter reviews Medicaid's role for persons with disabilities. As indicated in the Commission's June 2011 Report to the Congress, individuals qualifying for Medicaid on the basis of a disability accounted for half of the real (inflation-adjusted) growth in Medicaid spending between FY 1975 and FY 2008. In this chapter, the focus is on persons who are under age 65, qualify for Medicaid on the basis of disability, and generally rely only on Medicaid for their coverage. The Commission chose to focus on this group because Medicaid spends more on them than on any other Medicaid population and not enough is known about the quality of care they receive. Finally, there are opportunities for innovation in the delivery of services to this population that do not require coordination with the Medicare program, which adds a layer of complexity in serving persons dually eligible for Medicaid and Medicare.

Chapter 1 explores population characteristics, services, spending, and quality measurement for Medicaid enrollees under age 65 who qualify on the basis of a disability. Chapter 1a reviews key Medicaid eligibility policies and examines enrollment and population characteristics of persons with disabilities. Chapter 1b describes services and spending for this population and explores opportunities for innovation in service delivery. Chapter 1c highlights federal and state initiatives as well as those under way by other organizations to strengthen quality measurement for persons with disabilities.

The Commission plans to examine issues related to individuals dually eligible for Medicaid and Medicare in the future, including eligibility, population characteristics, service use, spending patterns, and quality measurement.

Eligibility and population characteristics. More than 9 million persons under age 65 were enrolled in Medicaid on the basis of a disability in FY 2008.[2] These enrollees—both individuals who generally rely on Medicaid as their only source of coverage (5.6 million people in FY 2008)[3] and individuals who are dually enrolled in both Medicaid and Medicare (3.5 million people in FY 2008)—are a highly diverse group with a variety

[2] In the Medicaid Statistical Information System (MSIS) data that are used throughout this chapter to describe FY 2008 Medicaid enrollment and spending, about 670,000 enrollees age 65 and older are identified in the data as qualifying on the basis of a disability. Given that disability is not a Medicaid eligibility pathway for individuals age 65 and older, MACPAC recodes these 670,000 enrollees to have a basis of eligibility as "aged" throughout this report.

[3] Some Medicaid enrollees also have private insurance coverage. MACStats Tables 3A and 4A in the Commission's June 2011 Report to the Congress indicate that 11.5 percent of Medicaid/CHIP children with disabilities who receive Supplemental Security Income (SSI) report having private coverage, as do 3.8 percent of Medicaid adults with disabilities receiving SSI who are not dually eligible for Medicaid and Medicare. However, for ease in terminology, we refer to Medicaid enrollees who are not dually enrolled in Medicare as "Medicaid-only enrollees."

of physical and behavioral health conditions. Medicaid enrollees who qualify for Medicaid on the basis of a disability include persons with physical, intellectual, developmental, behavioral, or mental conditions. While some people have had lifelong disabilities since birth, others have acquired disabling conditions through disease, chronic illness, or trauma. Many of these enrollees have multiple chronic conditions, particularly mental illness, as well as co-occurring behavioral health and physical health conditions.

Services and spending. Because of their extensive and complex health needs, Medicaid enrollees with disabilities may use a broad range of long-term services and supports (LTSS) that complement their routine medical care and help them maintain function and independence. These include personal care and other support services provided in home and community-based settings. Owing to their high need for health services, individuals under age 65 who qualify for Medicaid on the basis of a disability represent a disproportionate share of Medicaid spending, accounting for 42 percent of total Medicaid spending, but only 15 percent of the Medicaid population in FY 2008.

Medicaid spends more in total and per person on Medicaid-only enrollees under age 65 who qualify on the basis of a disability than on any other Medicaid population. For example, in FY 2008, Medicaid spent $19,682 per full-year equivalent Medicaid-only enrollee under age 65 who qualified on the basis of a disability, while it spent $3,025 for children and $4,651 for adults who were enrolled in Medicaid through non-disability pathways. Medicaid's spending for individuals under age 65 who qualified for Medicaid on the basis of disability and were dually enrolled in Medicaid and Medicare was $13,835 in FY 2008. The difference in spending between Medicaid-only and dually eligible enrollees who qualify on the basis of disability is driven by Medicare being the primary payer for acute care services for dually eligible enrollees.

Among Medicaid-only enrollees under age 65 who qualify for Medicaid on the basis of a disability, nearly 75 percent of their Medicaid spending was for acute care in FY 2008 and the remainder was for LTSS. LTSS spending accounts for the majority (63 percent in FY 2008) of Medicaid spending for individuals dually eligible for Medicaid and Medicare since Medicare is the primary payer of acute care services for these individuals.

Opportunities for innovation and improving quality. A number of state and federal initiatives are currently under way that promote opportunities for developing, implementing, and sharing innovative approaches to manage spending and improve service delivery for persons with disabilities. These programmatic improvements should help foster higher quality care for persons with disabilities. The Commission encourages the acceleration of promising approaches to promote high-quality, cost-effective, and coordinated care for persons with disabilities, particularly those with Medicaid-only coverage. This is an area in which states have policy control over program development without the complex issues related to coordination with Medicare that are present for the population enrolled in both Medicaid and Medicare. The Commission recommends:

Recommendation 1.1: The Secretary and the states should accelerate the development of program innovations that support high-quality, cost-effective care for persons with disabilities, particularly those with Medicaid-only coverage. Priority should be given to innovations that promote coordination of physical, behavioral, and community support services and the development of payment approaches that foster cost-effective service delivery. Best practices regarding these programs should be actively disseminated.

At present, little is known about the quality of care received by Medicaid enrollees with disabilities. There have been recent efforts at the federal and state levels, as well as by other organizations, to identify and develop quality measures applicable to persons with disabilities and to evaluate how quality measures should be incorporated into quality assessment efforts. While these initiatives provide an important and much needed foundation for measuring and improving quality of care for this population, the Commission encourages the development of new initiatives to provide improved quality measures for Medicaid enrollees with disabilities and recommends:

Recommendation 1.2: The Secretary, in partnership with the states, should update and improve quality assessment for Medicaid enrollees with disabilities. Quality measures should be specific, robust, and relevant for this population. Priority should be given to quality measures that assess the impact of current programs and new service delivery innovations on Medicaid enrollees with disabilities.

Chapter 2: Access to Care for Children Enrolled in Medicaid or CHIP

More than 40 million children are estimated to have had Medicaid or CHIP coverage at some point during FY 2011, representing approximately half of the U.S. child population. Drawing on the Commission's access framework presented in the March 2011 Report to the Congress, Chapter 2 presents an overview of how access to care and service use are affected by the health insurance status of children. The analysis assesses differences in children's access to care attributable to the specific source of coverage, adjusting for various health, demographic, and socioeconomic characteristics.

The Commission's analysis of data from the National Health Interview Survey and the Medical Expenditure Panel Survey shows that children enrolled in Medicaid or CHIP are reported to have better access to care than similarly situated uninsured children and, in most cases, comparable access to similarly situated children with ESI.

Children enrolled in Medicaid or CHIP compared to uninsured children. Survey results show that, in comparison with similarly situated uninsured children, children enrolled in Medicaid or CHIP have substantially better access to care for almost every measure analyzed, as reported by a parent or another knowledgeable adult in the household. Compared to uninsured children, children enrolled in Medicaid or CHIP are reported to be:

- more likely to have a usual source of care;
- more likely to have had a well-child visit in the past year;
- more likely to have had a specialist visit in the past year; and

- less likely to have delayed medical care in the past year.

Children enrolled in Medicaid or CHIP compared to children with ESI. Comparisons between children with Medicaid or CHIP and similarly situated children with ESI yield a more mixed picture. Many of the survey measures of health care access and use show comparable results for the two subgroups of children, such as having a usual source of care and having had a visit to a specialist or mental health professional in the past year. According to the survey results, children with Medicaid or CHIP are more likely than children with ESI to have a clinic or health center as their usual source of care while children with ESI are more likely to have a doctor's office as their usual source of care.

After accounting for differing enrollee characteristics, children with Medicaid or CHIP and those with ESI reported similar rates of delaying medical care in the past year. However, the reasons for delaying care vary with insurance status. Children with Medicaid or CHIP are less likely to delay care because of worries about out-of-pocket costs, but more likely to delay care because of challenges with provider office hours and office waiting times. In contrast, for uninsured children, out-of-pocket costs present a major barrier to obtaining or receiving care.

Chapter 3: State Approaches for Financing Medicaid and Update on Federal Financing of CHIP

Chapter 3 outlines the approaches that states use to finance their non-federal share of Medicaid expenditures and begins to explore the interaction of Medicaid financing and provider payment, including the use of supplemental payments by some states to certain providers. The chapter concludes with an update on CHIP financing, including the calculation of federal CHIP allotments to states and the contingency fund available for states that exhaust their federal CHIP funding.

Sources of non-federal financing. While the majority of non-federal spending is state general revenue, there is considerable variability in other sources of revenue that states may use. For example, local government sources such as counties and municipalities contribute to the non-federal share of Medicaid spending in many states. These units of local government either transfer local government funds to the state through an intergovernmental transfer (IGT) or certify an incurred expenditure eligible for federal matching to support the cost of providing the Medicaid-covered service or program administrative activity (certified public expenditures).

Nearly every state uses statutorily permissible health care related taxes to generate revenue for the non-federal share of Medicaid payments. The taxes are commonly used by states to: establish supplemental Medicaid payments for the classes of providers that pay the tax, increase or avert reductions in Medicaid rates, and/or finance other areas of the Medicaid program.

Supplemental payments to providers. In many cases, states use local government contributions and health care related taxes to finance lump-sum "supplemental payments" based on federal upper payment limit (UPL) requirements as well as disproportionate share hospital (DSH) payments. In FY 2011, supplemental payments accounted for 41 percent of the $91.9 billion in total fee-for-service Medicaid payments to hospitals.

In its future work, the Commission will continue its analysis of states' approaches to financing their share of the Medicaid program and the effect different approaches have on payment methods and rates; the effect of variable federal matching rates and incentives on state financing and payment policies; the potential interaction among financing, payment, and access to services; and the role that UPL supplemental payment policies play in states moving toward managed care.

Chapter 4: Program Integrity in Medicaid

Program integrity in both public and private insurance programs consists of efforts to deter and detect fraud, waste, and abuse and to improve program management, monitoring, and oversight. Chapter 4 discusses anti-fraud and abuse programs and examines key features of program integrity initiatives in Medicaid. The chapter provides information about federal and state oversight efforts, describes coordination and collaboration between and within federal and state agencies, discusses challenges in quantifying program integrity activities and provides an overview of program integrity in Medicaid managed care.

In Medicaid, effective approaches in program integrity help to ensure that federal and state dollars are spent appropriately and that enrollees receive necessary care. Program integrity activities also work toward ensuring that eligibility decisions are made correctly, prospective and enrolled providers meet federal and state participation requirements, services provided to enrollees are medically necessary and appropriate, and provider payments are made in the correct amount and for appropriate services.

In its review, the Commission found that there are a variety of statutory provisions and administration initiatives in place that address program integrity, and more than a dozen agencies at the federal and state levels are involved. Success depends on effective coordination and collaboration among the various agencies as well as initiatives that strike the right balance between effective oversight and administrative burden. In addition, the lack of available, timely, and accurate data for program integrity may make it difficult to quantify and compare the effectiveness of such activities.

The potential for overlap and duplication among the various agencies and programs makes effective administration and management of these initiatives essential. Administrative simplification, the identification and sharing of successful practices, and elimination of redundant and ineffective activities are actions that can be taken to improve program integrity. To this end, the Commission makes the following recommendation:

> **Recommendation 4.1:** The Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:
>
> - Create feedback loops to simplify and streamline regulatory requirements;
> - Determine which current federal program integrity activities are most effective; and
> - Take steps to eliminate programs that are redundant, outdated, or not cost-effective.

It is also important that states have adequate resources and staff who are knowledgeable about the most current analytic tools and best practices for detecting potential problems, monitoring trends, and assessing the impact of program integrity initiatives. Therefore, the Commission recommends:

> **Recommendation 4.2:** To enhance the states' abilities to detect and deter fraud and abuse, the Secretary should:
>
> - Develop methods for better quantifying the effectiveness of program integrity activities;
> - Assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective;
> - Improve dissemination of best practices in program integrity; and
> - Enhance program integrity training programs to provide additional distance learning opportunities and additional courses that address program integrity in managed care.

In its future work, the Commission intends to examine coordination of program integrity activities across Medicaid and Medicare, options for reducing waste in the Medicaid program, and approaches to program management that will improve program integrity.

Medicaid and CHIP Program Statistics: MACStats

MACStats is a standing section in all Commission Reports to the Congress. In this Report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, optional Medicaid benefits covered, and federal medical assistance percentages (FMAPs), as well as an overview of cost sharing permitted under Medicaid, and the dollar amounts of common federal poverty levels (FPLs) used to determine eligibility for Medicaid and CHIP.

CHAPTER 1

Medicaid and Persons with Disabilities

Recommendations

Medicaid and Persons with Disabilities

1.1 The Secretary and the states should accelerate the development of program innovations that support high-quality, cost-effective care for persons with disabilities, particularly those with Medicaid-only coverage. Priority should be given to innovations that promote coordination of physical, behavioral, and community support services and the development of payment approaches that foster cost-effective service delivery. Best practices regarding these programs should be actively disseminated.

1.2 The Secretary, in partnership with the states, should update and improve quality assessment for Medicaid enrollees with disabilities. Quality measures should be specific, robust, and relevant for this population. Priority should be given to quality measures that assess the impact of current programs and new service delivery innovations on Medicaid enrollees with disabilities.

CHAPTER 1

Medicaid and Persons with Disabilities

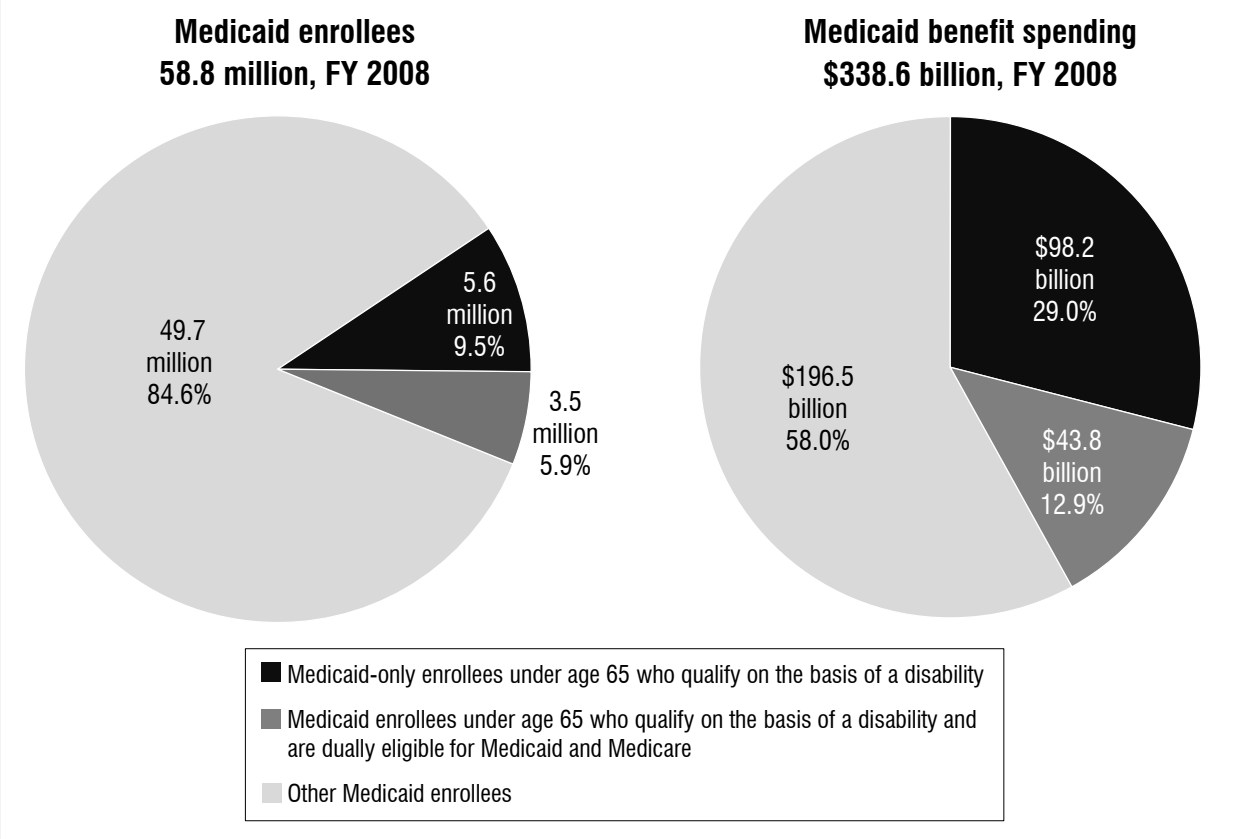
Medicaid financed health care and related services for 58.8 million individuals in fiscal year (FY) 2008, including over 9 million low-income persons under age 65 who qualified for the program on the basis of a disability.[1] Most of these Medicaid enrollees—62 percent or 5.6 million people—relied on Medicaid as their only source of coverage,[2] while 38 percent or 3.5 million people were dually enrolled in both Medicaid and Medicare. These figures do not include the many individuals with disabilities who qualify for Medicaid through an eligibility pathway other than based on a disability (e.g., as a low-income child, parent, or individual age 65 and older).

With budget constraints at the federal and state levels, policymakers are exploring ways to manage spending while encouraging the provision of high-quality services to high-need, high-cost enrollees. Addressing the needs of persons with disabilities presents challenges for Medicaid programs—not only because of the high spending associated with the population, but also because of their clinical diversity and resulting service delivery issues. Persons under age 65 qualifying for Medicaid on the basis of a disability include adults and children with lifelong disabilities that they have had since birth and others who have disabling conditions acquired through disease, chronic illness, or trauma. Medicaid enrollees who qualify on the basis of disability include persons with:

[1] In the Medicaid Statistical Information System (MSIS) data that are used throughout this chapter to describe FY 2008 Medicaid enrollment and spending, about 670,000 enrollees age 65 and older are identified as qualifying on the basis of a disability. Given that disability is not a Medicaid eligibility pathway for individuals age 65 and older, MACPAC recodes these 670,000 enrollees to have a basis of eligibility as "aged" throughout this report.

[2] Some Medicaid enrollees with disabilities also have private coverage. MACStats Tables 3A and 4A in the Commission's June 2011 Report to the Congress indicate that 11.5 percent of Medicaid/CHIP children with disabilities who receive Supplemental Security Income (SSI) report having private coverage, as do 3.8 percent of Medicaid adults with disabilities receiving SSI who are not dually eligible for Medicaid and Medicare. However, for ease in terminology, we refer to Medicaid enrollees who are not dually enrolled in Medicare as "Medicaid-only enrollees" in this chapter.

FIGURE 1-1. Medicaid Enrollment and Benefit Spending, FY 2008



Notes: Other Medicaid enrollees include low-income children and adults under age 65 who qualify through non-disability eligibility pathways and low-income individuals age 65 and older. Enrollees qualifying on the basis of a disability are children and adults under age 65. Medicaid-only enrollees under age 65 who qualify on the basis of disability are individuals who generally rely only on Medicaid as their source of coverage (a relatively small share of Medicaid-only enrollees report having private insurance coverage in addition to Medicaid). Dual eligibles are enrolled in both Medicaid and Medicare; however, all dollar amounts presented in this chart are limited to Medicaid spending. Figures for dual eligibles include "partial" duals for whom Medicaid coverage is limited to payment of Medicare premiums and cost sharing; they also include "full" duals for whom Medicaid also covers additional benefits not available under Medicare (e.g., long-term services and supports). Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC's June 2011 Report to the Congress for methodology. Excludes Medicaid-expansion CHIP enrollees and the U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

- physical conditions (e.g., quadriplegia, amputation);
- intellectual or developmental disabilities (e.g., cerebral palsy, autism, Down syndrome); and
- severe behavioral or mental illnesses (e.g., schizophrenia, bipolar disorder).

This chapter examines eligibility, enrollment, population characteristics, services, spending, and the use of quality measures for persons with disabilities. It lays the groundwork for a more in-depth exploration of the potential for managing spending while improving the quality of care for persons with disabilities. This analysis focuses on the 5.6 million Medicaid enrollees under age 65 who qualify on the basis of a disability and who generally rely only on Medicaid for their coverage. The Commission chose to focus on Medicaid-only enrollees who qualify on the basis of a disability because Medicaid spends more on them than on any other Medicaid eligibility group and not enough is known about the quality of care they receive. In addition, there are opportunities

for innovation in the delivery of services to this population that do not require coordination with the Medicare program, which adds a layer of complexity in serving persons dually eligible for Medicaid and Medicare. The Commission plans to examine issues related to individuals dually eligible for Medicaid and Medicare in future reports to the Congress, including the quality of care they receive.

Recommendations. The Commission makes two recommendations in this chapter. First, it recommends the accelerated advancement of innovative approaches to providing high-quality and cost-effective care for persons with disabilities, especially those with Medicaid-only coverage. Second, the Commission recommends updating and improving quality measurement for persons with disabilities for use in both the current program and new program innovations.

Several key points informed the Commission's recommendations:

- **Over 9 million persons qualify for Medicaid based on a disability, and most—5.6 million—rely on Medicaid coverage alone.** Most of the 9.1 million Medicaid enrollees under age 65 who qualified for Medicaid coverage based on a disability in FY 2008 generally relied only on Medicaid for their coverage (Figure 1-1 and Table 1-1). Persons with disabilities tend to have more stability in their Medicaid eligibility status over time and are more likely to have longer periods of continuous enrollment in Medicaid than other Medicaid enrollees.[3]

TABLE 1-1. Medicaid Enrollment and Benefit Spending by Eligibility Group, FY 2008

Eligibility Group	Number of Enrollees (millions)	Total Medicaid Benefit Spending (billions)	Medicaid Spending per Full-year Equivalent Enrollee
Children	28.3	$68.1	$3,025
Adults	15.4	49.5	4,651
Aged	6.0	78.9	14,945
Disabled	9.1	142.0	17,412
Medicaid-only coverage	*5.6*	*98.2*	*19,682*
Dually enrolled in Medicaid and Medicare	*3.5*	*43.8*	*13,835*
All enrollees	**58.8**	**$338.6**	**$7,267**

Notes: Enrollees qualifying on the basis of a disability are children and adults under age 65. Dual eligibles are enrolled in both Medicaid and Medicare; however, all dollar amounts presented in this chapter are limited to Medicaid spending. Figures for dual eligibles include "partial" duals for whom Medicaid coverage is limited to payment of Medicare premiums and cost sharing; they also include "full" duals for whom Medicaid also covers additional benefits not available under Medicare (e.g., long-term services and supports). Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC's June 2011 Report to the Congress for methodology. Excludes Medicaid-expansion CHIP enrollees and the U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

[3] Medicaid enrollees qualifying on the basis of a disability had the longest average number of months enrolled in FY 2008 (10.8 months) compared to non-disabled adults (8.3 months), non-disabled children (9.5 months), and aged enrollees (10.5 months) (MACPAC analysis of MSIS Annual Person Summary (APS) data from CMS).

- **Medicaid spends more in total and per person on Medicaid-only enrollees qualifying on the basis of a disability than on any other population in Medicaid.** In FY 2008, Medicaid spent $19,682 per full-year equivalent Medicaid-only enrollee under age 65 who qualified on the basis of a disability, while it spent $3,025 for children and $4,651 for adults who were enrolled in Medicaid through non-disability pathways. Medicaid's spending for individuals under age 65 who qualified for Medicaid on the basis of a disability and were dually enrolled in Medicaid and Medicare was $13,835 in FY 2008. The difference in spending between Medicaid-only and dually eligible enrollees who qualify on the basis of a disability is driven by Medicare being the primary payer for acute care services for dually eligible enrollees. Additionally, some dually eligible individuals receive limited Medicaid coverage that only includes payment of their Medicare premiums and cost-sharing, rather than full Medicaid benefits.

  Further, as indicated in the Commission's June 2011 Report to the Congress, individuals qualifying for Medicaid on the basis of a disability accounted for half of the real (inflation-adjusted) growth in Medicaid spending between FY 1975 and FY 2008. Much of the growth for this group was driven by increased enrollment while the remainder was attributable to growth in per capita spending.

- **Quality measurement for Medicaid enrollees with disabilities would benefit from updating and improvement.** Medicaid-only enrollees with disabilities are among the highest users of health services because of their poor health. They report poorer health status and a greater presence of health conditions and functional impairments than other Medicaid enrollees. Comorbidities are common among Medicaid enrollees who qualify on the basis of a disability, particularly mental illness. More needs to be known about the quality of care delivered to persons with disabilities. Little is known about whether or not existing quality measures adequately assess quality of care for persons with disabilities, or if the adjustment of existing measures or development of new ones is warranted for this population.

- **Opportunities exist for the federal government and states to develop, implement, and share innovations that promote service coordination and the development of payment approaches that foster cost-effective service delivery for this population.** Persons with disabilities use a broad range and mix of services. Many Medicaid enrollees with disabilities use long-term services and supports (LTSS) that complement their medical care and help them maintain function and independence. The need for supportive services, which may be lifelong for some individuals, adds a dimension of complexity in providing coverage for persons with disabilities that is not shared by most other Medicaid enrollees.

  Opportunities exist, including through the Center for Medicare & Medicaid Innovation within the Centers for Medicare & Medicaid Services, for states and the federal government to promote innovations for persons with disabilities. Innovations that foster more coordination of physical, behavioral, and community support services, and the development of cost-effective service delivery and payment approaches, would benefit this population.

This chapter explores eligibility, enrollment, population characteristics, services, spending, quality measurement, and the potential for service delivery innovation for Medicaid enrollees with disabilities in the following sections:

- **Chapter 1a: Eligibility and Population Characteristics.** Key Medicaid eligibility policies for persons with disabilities are reviewed. In addition, this section provides an overview of enrollment and population characteristics of persons under age 65 enrolled in Medicaid qualifying on the basis of a disability, including comorbidities, qualifying diagnoses, health status, and socioeconomic and demographic characteristics.

- **Chapter 1b: Services and Spending.** Services used by Medicaid enrollees with disabilities are examined, including services that may be limited or not covered under Medicare or private health insurance, such as LTSS. This section also explores Medicaid spending patterns of persons under age 65 qualifying on the basis of a disability. State and federal initiatives currently under way that promote opportunities for developing, implementing, and sharing innovative approaches for managing spending and improving care provided to Medicaid-only enrollees with disabilities are also reviewed.

  This section highlights the Commission's recommendation to the Secretary of the U.S. Department of Health and Human Services and the states on the need for accelerated program innovations that foster high-quality and cost-effective care for persons with disabilities, particularly those with Medicaid-only coverage.

- **Chapter 1c: Quality Measurement.** Quality measurement for Medicaid enrollees with disabilities is examined, highlighting the efforts of federal, state, and private organizations to develop quality measures that may be relevant to this population.

  This section also includes the Commission's recommendation supporting the evaluation of current quality measures for Medicaid enrollees with disabilities and updating and improving quality assessment as necessary. The recommendation addresses the importance of quality measurement as an integral part of service delivery innovations for this population.

Looking Forward

The Commission plans to examine issues related to individuals dually eligible for Medicaid and Medicare in future reports to the Congress. The Commission will further explore eligibility, population characteristics, service use, spending patterns, and quality measurement for this population.

CHAPTER 1a

Eligibility and Population Characteristics

More than 9 million individuals under age 65 are enrolled in Medicaid on the basis of a disability. These enrollees are a highly diverse group that includes, for example, infants with birth defects, adults with traumatic brain injuries, children with autism, and young adults with schizophrenia. Many of the Medicaid enrollees who are eligible based on disability have multiple disabling conditions and chronic illnesses. Some people have lifelong disabilities they have had since birth, while others have disabling conditions acquired through disease, chronic illness, or trauma (Box 1a-1).

This section summarizes the Medicaid eligibility pathways and population characteristics of individuals who qualify for Medicaid on the basis of a disability. These individuals are all under age 65 because individuals 65 and older cannot be eligible for Medicaid on the basis of a disability; nearly all Medicaid enrollees age 65 and older are eligible based on being "aged." Key points of this section include:

- About two-thirds of Medicaid enrollees who qualify on the basis of a disability do so through one particular pathway: by receiving payments from Supplemental Security Income (SSI), the federal program for persons with disabilities (and aged individuals) who have low levels of income and assets. The remaining one-third are enrolled through one of the many other Medicaid eligibility pathways referred to in this chapter as non-SSI disability pathways.
- The population eligible for Medicaid on the basis of a disability is large and growing. Between 1975 and 2008, these enrollees were the fastest growing eligibility group and accounted for half of real (inflation-adjusted) Medicaid spending growth.
- The disabling conditions that may cause an individual to qualify for Medicaid are varied and may be physical, mental, developmental, or intellectual.
- Most individuals qualifying for Medicaid on the basis of a disability have comorbid conditions in addition to their qualifying diagnoses. Nearly half of the Medicaid-only enrollees eligible on the basis of a disability have a mental illness such as depression,

schizophrenia, or bipolar disorder.[1] The presence of mental illness can pose complex challenges to Medicaid both in terms of care management and controlling spending for these enrollees.

- Among children with disabilities who receive both Medicaid and SSI, 63 percent are male, 62 percent receive special education or early intervention services, and most are in a household in which a family member works. Among Medicaid-only adults under age 65 with SSI, 61 percent are female, half receive food stamps, and nearly 15 percent are in the two-year waiting period for Medicare.

The following topics are described in this section:

Medicaid eligibility pathways for persons with disabilities. There are multiple ways for individuals to qualify for Medicaid on the basis of a disability. While receipt of SSI is the primary eligibility pathway for persons with disabilities, others exist as well. These other pathways generally still use the SSI definition of disability, but income and asset criteria vary by state.

Enrollment and population characteristics. Enrollment data for fiscal year (FY) 2008 are presented in this section. About two-thirds of individuals who qualify for Medicaid on the basis of a disability do so through the SSI pathway; the other one-third qualify through non-SSI disability pathways. Further, the majority of individuals under age 65 qualifying on the basis of a disability are Medicaid-only enrollees (62 percent in FY 2008), while the remaining 38 percent are dually enrolled in Medicaid and Medicare.

- **Qualifying diagnoses and comorbidities.** As summarized in this section, numerous diagnoses and conditions qualify persons with disabilities for Medicaid, if they are severe enough. Research findings are also included that illustrate the prevalence of comorbidities among Medicaid-only enrollees who qualify based on disability. In addition, data from the Social Security Administration (SSA) on SSI recipients' qualifying diagnoses are used to provide information not available from federal Medicaid data.
- **Other characteristics.** Survey data are used in this part to describe other characteristics of individuals under age 65 enrolled in Medicaid and SSI. The data presented include demographic and socioeconomic characteristics.

Medicaid Eligibility for Persons with Disabilities

SSI disability pathway. SSI is a federal program that provides cash assistance to low-income persons with disabilities (under age 65) and aged individuals (age 65 and older). In most states, SSI beneficiaries are a mandatory population for state Medicaid programs and are automatically eligible for Medicaid.[2]

[1] Some Medicaid enrollees with disabilities also have private coverage. MACStats Tables 3A and 4A in the Commission's June 2011 Report to the Congress indicate that 11.5 percent of Medicaid/CHIP children with disabilities who receive SSI report having private coverage, as do 3.8 percent of Medicaid adults with disabilities receiving SSI who are not dually eligible for Medicaid and Medicare. However, for ease in terminology, we refer to Medicaid enrollees who are not dually enrolled in Medicare as "Medicaid-only enrollees" in this chapter.

[2] In all but 11 states, receipt of SSI automatically entitles a person to Medicaid. Those 11 states—known as "209(b)" states—are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. In these states, receipt of SSI benefits does not confer automatic Medicaid eligibility because they are permitted to have more restrictive financial (e.g., income as a percent of the federal poverty level, assets) and non-financial (e.g., definition of disability) criteria for determining eligibility than the SSI program. However, these criteria may not be more restrictive than those in effect in the state on January 1, 1972, and must provide for deducting incurred medical expenses from income through Medicaid "spend down" so that individuals may reduce their countable income to the 209(b) income eligibility level. Most 209(b) states use the SSI definition of disability.

BOX 1a-1. Examples of Medicaid Enrollees with Disabilities

Claire: born with a genetic syndrome that is the only known case of its kind	It took doctors a long time to identify her disorder, but Claire had symptoms at birth that indicated multiple and severe physical, developmental, and intellectual disabilities. At almost five years of age, Claire is only as big as an 18- to 24-month-old child, and developmentally and intellectually, she is about 9 months old. She is semi-mobile with a wheelchair but cannot direct where she wants to go or walk independently. She does not understand language and cannot communicate, and she may be losing her hearing (KCMU 2011).
Tina: suffered a ruptured arteriovenous malformation of the brain, similar to a massive stroke, the result of a congenital defect	Tina was in critical care treatment in the months immediately following her brain trauma. She underwent multiple surgeries, followed by intensive rehabilitation and further surgeries. Once stabilized enough to leave the hospital, Tina moved to a rehabilitation center, but still with breathing and feeding tubes. After about 10 months, she was able to come home. At age 20, Tina receives physical therapy at home to help her learn to walk again. She also receives cognitive therapy and occupational therapy to help her with daily activities that maximize her independence (KCMU 2011).
John: suffered a severe spinal-cord injury in an automobile accident, leaving him paralyzed from the neck down	John, age 41, has a number of secondary conditions as a result of his injury and paralysis. He is prone to urinary tract infections, irregular bowel and bladder function, ulcers, breathing problems, hypothermia, and osteoporosis. In addition, he occasionally experiences skin breakdowns and low blood pressure. John has a personal care attendant (PCA) and lives on his own. He receives PCA services 78 hours each week (Brodsky et al. 2000).
Karla: born with microcephaly, cerebral palsy, and spastic quadriplegia	Karla's disabilities are severe enough that she needs constant help and supervision. With assistance, Karla performs many of the basic daily hygiene activities previously done for her by a home health aide. At age 22, she reads at a first-grade level and uses a portable picture-based computer system to communicate (NRCPDS 2012).
Greg: has bipolar disorder	Greg has an extensive record of mental illness, including brief episodes of psychosis and a misdiagnosis of paranoid schizophrenia. He has been relatively medically stable and currently takes a combination of four prescription drugs to manage his bipolar disorder (KCMU 2003).

SSI disability definition. The definition of disability used for SSI—which is also the definition used for adults in the Social Security Disability Insurance (SSDI) program, through which qualifying individuals may obtain Medicare after a 24-month waiting period—is used for nearly all Medicaid disability pathways. This definition was designed to grant eligibility for federal income support when an individual's ability to work is significantly impaired, rather than when broad criteria concerning functional or health status are met. As a result, there are many individuals who have multiple chronic conditions but who may not be eligible for Medicaid on the basis of a disability. In addition, there are enrollees who could meet the criteria to be considered disabled but who have already obtained Medicaid through a non-disability pathway (e.g., as a low-income child or parent) and therefore have not sought a disability determination.

Conditions that may cause an individual to qualify for Medicaid on the basis of disability include:

- physical conditions (e.g., quadriplegia, amputation);
- intellectual or developmental disabilities (e.g., cerebral palsy, autism, Down syndrome); and
- severe behavioral or mental illnesses (e.g., schizophrenia, bipolar disorder).

However, having a particular condition is generally not sufficient to qualify a person for Medicaid on the basis of a disability. As discussed in Annex 1 to this section, the definition of disability requires that the condition be severe— taking into account the ability to work (for adults) and the presence of functional limitations (for children)—and last at least 12 months or result in death. (Detailed information on SSI enrollees' qualifying diagnoses is presented later in this section.)

Besides meeting disability criteria, SSI recipients must also have low levels of income and assets (resources). In 2012, an individual qualifying for SSI cannot have countable income of more than $698 per month—about 75 percent of the federal poverty level (FPL)[3]—or countable assets of more than $2,000 (see Annex 1 for more information on SSI).

Non-SSI disability pathways. The Congress has added a variety of other eligibility pathways over the years with varying policy purposes, such as lessening work disincentives and emphasizing home and community-based alternatives to institutionalization. Generally, individuals still must meet the SSI definition of disability, but their countable income or assets may be above SSI levels. The following are a few of the key Medicaid eligibility pathways for persons with disabilities who do not qualify for SSI:[4]

- **Poverty level.** States have the option to cover persons with disabilities with income or assets above the level permitted for SSI eligibility.
- **Medically needy.** Under this option, persons with disabilities who have higher incomes can "spend down" to a state-specified medically needy income level by incurring medical expenses.
- **Special income level.** Under this option, states can cover institutionalized individuals with incomes up to 300 percent of the SSI benefit rate (approximately $2,100 per month for an individual, or 224 percent of the FPL); states may also extend this eligibility to individuals who receive home and community-

[3] See Table 19 in MACStats for dollar amounts that correspond to the FPL for various family sizes.

[4] See Table 11 in MACStats for information on states' income eligibility levels for some of these pathways.

TABLE 1a-1. Persons Eligible for Medicaid on the Basis of a Disability by Eligibility and Age Groups, FY 2008

	Enrollment of Persons Eligible for Medicaid on the Basis of a Disability (millions)	Medicaid Eligibility Group		Age Group	
		SSI	Non-SSI	Under 19	19 to 64
Total persons under age 65 eligible for Medicaid on the basis of a disability	**9.1**	**65.8%**	**34.2%**	**15.7%**	**84.3%**
Medicaid-only coverage	5.6	79.9	20.1	25.4	74.6
Dually enrolled in Medicaid and Medicare	3.5	43.2	56.8	0.1	99.9

Note: Enrollees qualifying on the basis of a disability are children and adults under age 65. The Supplemental Security Income (SSI) category includes persons with disabilities with incomes above SSI levels who receive state supplementary payments. The non-SSI category includes persons with disabilities who qualify for Medicaid through pathways such as poverty level, medically needy, special income level, and other non-SSI pathways. Individuals with disabilities in 11 "209(b)" states that may use more restrictive eligibility criteria than SSI to determine Medicaid eligibility may be reported in either the SSI or non-SSI category. Excludes the U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data from CMS

based waiver services as an alternative to institutionalization.

- **Working persons with disabilities.** States must cover certain qualified, severely impaired individuals whose earnings would otherwise disqualify them from Medicaid; states can allow certain other working persons with disabilities to buy into Medicaid (see Annex Box 1a-A1).
- **Home and community-based services (HCBS).** States may extend eligibility to individuals who receive certain HCBS and require an institutional level of care or meet other needs-based criteria that assess functional status.

Enrollment and Population Characteristics

The population eligible for Medicaid on the basis of a disability is large and growing. Between 1975 and 2008, enrollees with disabilities were the fastest growing eligibility group in Medicaid and accounted for half of real (inflation-adjusted) Medicaid spending growth (MACPAC 2011b). Survey and administrative data presented below provide a picture of these enrollees with disabilities, focusing on the Medicaid-only population.

Enrollment

In FY 2008, there were 9.1 million persons under age 65 enrolled in Medicaid on the basis of a disability.[5] About two-thirds of all persons who

[5] For purposes of federal program enrollment and spending data, the classification of "disabled" generally refers to Medicaid enrollees under age 65 who qualify for Medicaid on the basis of a disability. In the Medicaid Statistical Information System (MSIS) data that are used throughout this chapter to describe FY 2008 Medicaid enrollment and spending, about 670,000 enrollees age 65 and older are identified in the data as qualifying on the basis of a disability. Given that disability is not a Medicaid eligibility pathway for individuals age 65 and older, MACPAC recodes these 670,000 enrollees to have a basis of eligibility as "aged" throughout this report.

qualify for Medicaid on the basis of a disability do so because they receive SSI benefits; the remainder are eligible through non-SSI pathways (Table 1a-1).

Persons dually eligible for Medicaid and Medicare. As noted throughout this chapter, some individuals enrolled in Medicaid on the basis of a disability (through SSI or non-SSI pathways) are dually eligible for both Medicaid and Medicare. In general, these dually eligible individuals under age 65 are SSDI beneficiaries (see Annex 1) who receive Medicare after a 24-month waiting period (SSA 2011c).[6] One analysis estimated that there were approximately 500,000 adults enrolled in Medicaid who were receiving SSDI but were in the 24-month waiting period prior to enrollment in Medicare (Dale and Verdier 2003).

Among individuals eligible for Medicaid on the basis of a disability, 38 percent were dual eligibles; the remainder (62 percent) were covered only by Medicaid (Table 1a-1).[7] (As noted in Chapter 1b, Medicaid-only enrollees also account for the majority of Medicaid spending on persons qualifying based on disability.)

The share of enrollees qualifying through receipt of SSI is smaller among dual eligibles with disabilities (43 percent) than among Medicaid-only enrollees with disabilities (80 percent).[8]

There is no automatic eligibility link between SSDI and Medicaid. Individuals found eligible for SSDI generally meet the Medicaid definition of disability, but they must also qualify for SSI or meet the requirements for another eligibility pathway to qualify for Medicaid.[9]

Population characteristics

In addition to its size and growth over time, another notable feature about the population of Medicaid enrollees with disabilities is its heterogeneity. A wide range of disabilities, clinical characteristics, health care and other supportive service needs, and socioeconomic and demographic characteristics are represented in this population. The discussion below emphasizes the range of disability diagnoses prevalent in the Medicaid population (focusing on SSI beneficiaries), the extent of multiple chronic conditions (comorbidities), and other population characteristics such as the socioeconomic characteristics of Medicaid enrollees with disabilities.

SSA data on qualifying diagnoses. The most readily available source of data on the disability diagnoses of Medicaid enrollees comes from SSA administrative records. Medicaid administrative data, unfortunately, provide little or no information about the diagnosis that was the original basis for an individual's disability determination. While the SSA data cannot identify all individuals enrolled in Medicaid on the basis of a disability, they permit analyses of individuals under age 65 who receive SSI, who represent a majority of those qualifying for Medicaid based on disability.

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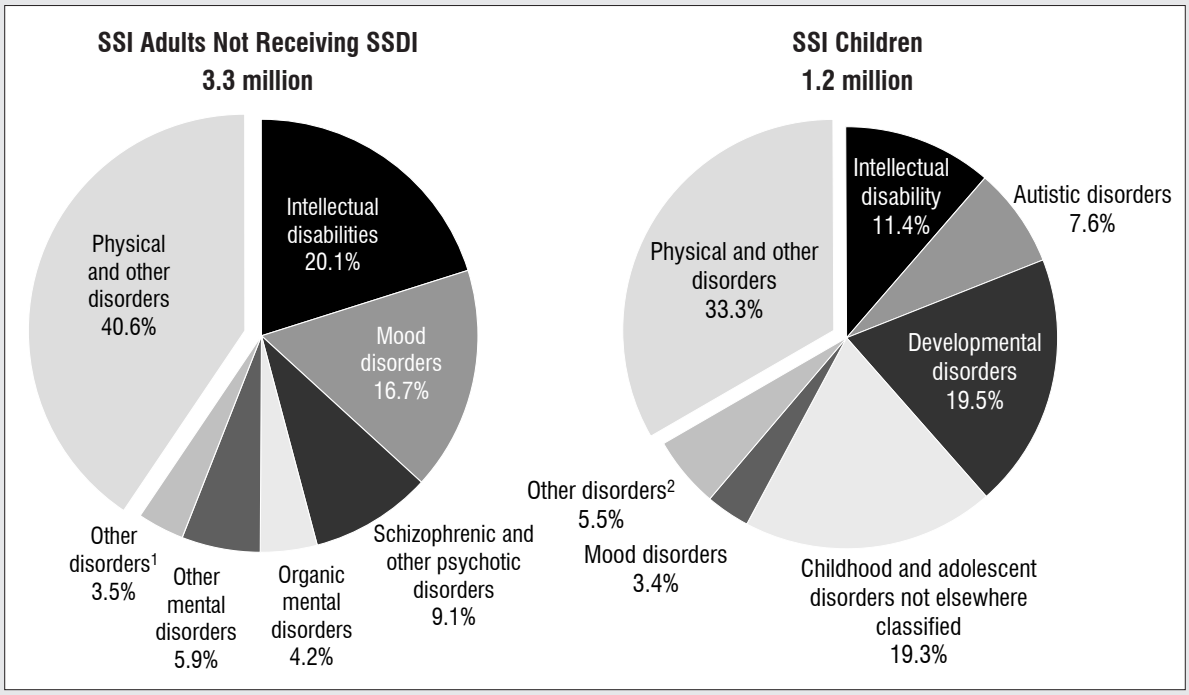
[6] Some dual eligibles under age 65 may receive Social Security's Old-Age and Survivors Insurance (OASI) benefits. As noted in Annex 1, although SSDI and OASI can both make payments based on the disability of the insured worker, spouse, and/or child in varying circumstances, Medicare eligibility is available only for individuals receiving these Social Security benefits based on their own disability (i.e., disabled worker, disabled widow(er), disabled adult child).

[7] As noted earlier, a relatively small share of Medicaid enrollees report having private insurance coverage in addition to Medicaid.

[8] One reason for this difference is that nearly all persons with disabilities dually eligible for Medicaid and Medicare have SSDI income, which in some cases is high enough to disqualify them from receiving cash assistance under SSI. As a result, they must qualify for Medicaid through a non-SSI eligibility pathway.

[9] For Medicare enrollees who have incomes below specified FPL percentages, Medicaid provides limited coverage of certain Medicare premium and cost-sharing amounts. These limited-benefit pathways under Medicaid for dual eligibles are referred to as Medicare savings programs (MSPs). Individuals enrolled in MSPs receive full Medicaid benefits only if they are also eligible under another Medicaid eligibility pathway (e.g., SSI or poverty level).

FIGURE 1a-1. SSI Adults Not Receiving SSDI (Age 18 to 64) and SSI Children (Under Age 18) by Qualifying Diagnosis, 2010



Note: This figure includes adults who received federal SSI and/or federally administered state supplementation but not SSDI, as well as children who received federal SSI and/or federally administered state supplementation. The diagnostic groupings used by the Social Security Administration (SSA) closely parallel the major ICD-9 classifications commonly used by the medical community to categorize conditions. Physical and other disorders include non-mental disorder conditions such as congenital anomalies; infectious and parasitic diseases; endocrine, nutritional, and metabolic diseases; injuries; neoplasms; and diseases of the blood and blood-forming organs, circulatory system, digestive system, genitourinary system, musculoskeletal system and connective tissue, nervous system and sense organs, respiratory system, and skin and subcutaneous tissues.

1 Includes autistic disorders (1%), developmental disorders (1%), and childhood and adolescent disorders not elsewhere classified (1%).

2 Includes other mental disorders (3%), organic mental disorders (2%), and schizophrenic and other psychotic disorders (<1%).

Source: SSA 2011e

Based on data from SSA, Figure 1a-1 illustrates the qualifying diagnoses of certain SSI recipients—children under 18 as well as adults age 18-64 whose only federal disability income benefit was SSI. Because these individuals do not qualify for SSDI and thus are generally not eligible for Medicare, they reflect the Medicaid-only enrollees who make up the majority of those qualifying for Medicaid on the basis of a disability.

According to SSA data, 3.3 million adults under age 65 qualified for SSI in 2010 on the basis of a disability[10] and did not receive other federal disability income benefits. As categorized by SSA, mental and intellectual disabilities made up 59 percent of these adults' qualifying diagnoses. A mental disorder includes, for example, schizophrenia, bipolar disorder, psychosis, or depression. Forty-one percent qualified due to a physical or other non-mental disorder—for example, injuries, birth defects, or disease of organs or systems (Figure 1a-1).

[10] By definition, persons eligible on the basis of a disability are under age 65. Those who are eligible for SSI who are age 65 or older are eligible on the basis of being aged.

An even larger proportion of children receiving SSI qualified on the basis of mental or intellectual disabilities. Among the 1.2 million children receiving SSI due to a disability in 2010, 67 percent qualified on the basis of a mental or intellectual disability (Figure 1a-1). While severe mental illness such as schizophrenia represented less than 1 percent of the qualifying diagnoses among children, 20 percent had developmental disorders and 8 percent had autistic disorders. Another 19 percent of children qualified for SSI based on childhood and other adolescent disorders, including attention deficit hyperactivity disorder (ADHD). Only 33 percent of children receiving SSI had qualifying diagnoses of physical or other non-mental disorders.

Comorbidities. A relatively comprehensive picture of the chronic health conditions that affect people with disabilities in Medicaid can be found in Medicaid claims and other sources of data. These data show that comorbidities are common among Medicaid enrollees qualifying on the basis of a disability, including those with Medicaid only as well as those dually eligible for Medicaid and Medicare; many have multiple chronic conditions and co-occurring behavioral health and physical health conditions (Patchias 2011, Kronick 2007). Recent research on chronic conditions among Medicaid-only enrollees qualifying on the basis of a disability (Kronick et al. 2009) found:[11]

- There is a high prevalence of mental illness (47 percent), cardiovascular disease (38 percent), and central nervous system diseases (28 percent).
- Nearly half (45 percent) were diagnosed with three or more chronic conditions; these individuals accounted for 75 percent of the spending for Medicaid-only enrollees with disabilities.
- Within the highest-cost 1 percent of these enrollees, 87 percent had three or more chronic conditions, and 67 percent had five or more chronic conditions.

Mental illness. Behavioral health conditions are widespread among Medicaid-only enrollees qualifying on the basis of a disability. The presence of mental illness can pose complex challenges to Medicaid both in terms of care coordination and high spending for these enrollees.

As noted earlier, one study found that 47 percent of Medicaid-only enrollees qualifying on the basis of a disability had a mental illness such as depression, psychosis, or bipolar disorder. This was based on data combining medical claims and prescription drug utilization. The analysis of claims data showed that 29 percent received services for a mental health condition. Another 18 percent had used a prescription drug for mental health treatment (Kronick et al. 2009).

Mental illnesses are common co-occurring conditions among the most expensive enrollees. When looking at the pairs of chronic conditions affecting the highest-cost 5 percent of Medicaid-only enrollees qualifying on the basis of a disability, mental illnesses are in three of the top five (Kronick et al. 2009).

Among Medicaid-only enrollees qualifying on the basis of a disability who have one of the five most common chronic physical conditions,[12] approximately two-thirds also have a mental illness (Boyd 2010). Up to 20 percent of Medicaid-only enrollees qualifying on the basis of a disability with one of these five chronic physical conditions also have mental illness *and* a drug or alcohol disorder.[13]

[11] The findings in Kronick et al. (2009) exclude Arizona, Delaware, Hawaii, Maryland, Michigan, New Mexico, Oregon, Pennsylvania, and Tennessee because of those states' widespread use of managed care in Medicaid, for which adequate data are not available.

[12] Asthma/chronic obstructive pulmonary disease, congestive heart failure, coronary heart disease, diabetes, and hypertension.

[13] These numbers are likely too low because of underreported drug and alcohol use.

For those with common chronic physical conditions, health care spending is 60 to 75 percent higher for those with mental illness than for those without; the addition of a substance abuse disorder doubles to triples their health care spending, depending on their conditions.

Although limited to the state of New York, one recent study found that adult Medicaid enrollees with mental health or substance abuse conditions—including persons eligible through non-disability pathways and those dually eligible for Medicaid and Medicare—are sicker, use more services, and are more costly to Medicaid than similar enrollees without these conditions (Coughlin and Shang 2011). The study also found that Medicaid enrollees with substance abuse conditions were less likely to qualify for Medicaid due to a disability, which likely reflects the fact that drug addiction and alcoholism are not health conditions qualifying as a disability under SSI or Medicaid (§1614(a)(3)(J) of the Social Security Act (the Act)). However, the study found a strong correlation between mental health and substance abuse conditions; 22 percent of adult Medicaid enrollees in New York with mental health conditions had substance abuse problems, while 56 percent of Medicaid enrollees with substance abuse problems also had mental health conditions.

Other characteristics. Self-reported health status, income, education, family structure, and work status can provide valuable context for understanding the medical and social needs of low-income persons with disabilities. Administrative data do not contain all of the relevant information needed to create a comprehensive profile of Medicaid enrollees qualifying on the basis of a disability. Survey data such as the National Health Interview Survey (NHIS) can provide information that is useful in understanding characteristics, in addition to the qualifying diagnoses, of Medicaid-only enrollees under age 65 who are receiving SSI. It should be noted that, especially for children and certain adults, survey responses are often provided by a knowledgeable adult in the family, rather than by individuals with disabilities themselves.

The findings that follow are for non-institutionalized Medicaid-only enrollees under age 65 receiving SSI, based on previously published MACPAC analyses (MACPAC 2011b) as well as new analyses from the same data.[14] The results are presented separately for adults age 19 to 64 and for children under 19, because those age groups reflect most enrollees' pathways to Medicaid.[15]

Demographic and socioeconomic characteristics of Medicaid enrollees receiving SSI include:

Adults age 19 to 64

- Females accounted for 61.4 percent of adults in this age group who have Medicaid-only coverage and SSI. This is significantly lower than the female share of non-elderly Medicaid adults overall (66.3 percent), but higher than that among adults who were privately insured (50.9 percent) or uninsured (44.9 percent).
- Half of non-elderly Medicaid-only adults with SSI were also receiving food stamps.
- 14.5 percent of non-elderly Medicaid-only adults with SSI were receiving SSDI. These individuals were most likely in the 24-month waiting period that SSDI recipients face before Medicare coverage begins.

[14] The NHIS is a survey of non-institutionalized individuals. The results exclude individuals residing in nursing homes, for example. The NHIS data in this section are from 2007-2009.

[15] As noted in MACPAC 2011b, many of the measures for children were obtained only for those age 0 to 17 or 2 to 17, rather than 0 to 18. For example, survey responses for ADHD are sought only for children age 2 to 17.

Children

- Males accounted for the majority (62.9 percent) of children with disabilities who receive both Medicaid and SSI—a significantly higher proportion than among children with Medicaid or CHIP overall (51.4 percent) or privately insured and uninsured children (50.9 percent for both groups).
- Among children with both Medicaid and SSI, 62.2 percent received special education or early intervention services, compared to 9.8 percent of children with Medicaid or CHIP overall, 5.7 percent of privately insured children, and 6.0 percent of uninsured children.
- For 61 percent of children with both Medicaid and SSI, the family also received some other form of government assistance. Nearly half (47.6 percent) of children with Medicaid and SSI received food stamps.
- Among children with both Medicaid and SSI, the majority (54.7 percent) had a family member who worked—42.4 percent had at least one full-time worker and 12.3 percent had only a part-time worker(s).

For health status, the data indicate:

Adults age 19 to 64

- 57.9 percent of non-elderly Medicaid-only adults with SSI reported being in fair or poor health, compared to 32.2 percent of non-elderly Medicaid adults overall, 6.4 percent of adults with private coverage, and 12.5 percent of uninsured adults.
- Compared to non-elderly Medicaid adults overall as well as non-elderly adults with private coverage or who are uninsured, non-elderly Medicaid-only adults with SSI were more likely to have chronic conditions (e.g., hypertension, depression, arthritis, bronchitis, coronary heart disease), restrictions in activities of daily living (ADLs), functional limitations, provider visits, emergency room visits, and at-home care visits.

Children

- Children with disabilities who receive both Medicaid and SSI were more likely to report fair or poor health, the presence of impairments requiring special equipment (e.g., braces, wheelchair), and limitations in their ability to crawl, walk, run, or play than were children enrolled in Medicaid or CHIP overall, as well as privately insured and uninsured children.
- Compared to children enrolled in Medicaid or CHIP overall, as well as to privately insured and uninsured children, children with both Medicaid and SSI were more likely to report the presence of ADHD, asthma, autism, cerebral palsy, congenital heart disease, Down syndrome, and other developmental delays.

In its future work, the Commission will continue to examine issues related to persons with disabilities, including persons dually eligible for Medicaid and Medicare.

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Chapter 1a Annex 1

SSI, SSDI, and the Definition of Disability

The Social Security Administration (SSA) administers two separate federal programs that are primarily designed to provide payments to individuals based on disability—Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). Individuals are eligible for SSDI based on minimum work history requirements and having made certain contributions through payroll taxes. SSI does not have minimum work or contribution requirements; instead, it is limited to persons under age 65 with disabilities (and individuals age 65 and older) who have low levels of income and assets. Both SSI and SSDI use a similar definition of disability, which most states are required to follow for their Medicaid programs.[1]

Definition of Disability

For adults applying for SSI or SSDI, the law defines disability as the inability to engage in any substantial gainful activity (SGA) because of one or more medically determinable physical or mental impairments that can be expected to result in death or last for at least 12 months (§§223(d)(1)(A) and 1614(a)(3)(A) of the Social Security Act (the Act)).[2] Considering their age, education, and work experience, individuals must not be able to engage in any kind of SGA that exists in the national economy, regardless of whether such work actually exists in the immediate area or whether a specific job vacancy exists (§§223(d)(2)(A) and 1614(a)(3)(B) of the Act). Individuals are generally considered to be engaging in SGA if their earnings (net of impairment-related expenses) exceed a specified monthly amount (§§223(d)(1)(A) and 1614(a)(3) of the Act). For 2012, the monthly SGA amount for an individual is $1,010 in earnings (SSA 2011a).

For children under age 18, the SSI definition of disability is slightly different. Rather than considering work limitations, it is based on whether the child has any medically determinable physical or mental impairment(s) that cause marked and severe functional limitations, and that can be expected to cause death or last at least 12 months (§1614(a)(3)(C)(i) of the Act).

Individuals apply for SSI and SSDI at local SSA offices. If applicants meet certain basic eligibility criteria (for example, earnings below the SGA amount), the application is

[1] As noted in Section 1a, 11 "209(b)" states may use a more restrictive definition of disability, although most do not.

[2] Individuals may also qualify because of blindness, which relies on a slightly different definition (§§216(i)(1)(B) and 1614(a)(2) of the Act).

forwarded for a medical disability determination. Federally funded state disability determination service (DDS) agencies—often within what many states call their department of human services or department of vocational rehabilitation—are responsible for developing medical evidence and rendering the determination of whether individuals have disabilities or are blind under the law.

Supplemental Security Income

SSI, which is authorized under Title XVI of the Act, is a means-tested program that provides cash assistance payments to people who are aged, blind, or disabled. In 2012, the monthly federal benefit rate—that is, the maximum monthly amount of SSI payments, which defines the upper income limit for SSI eligibility—is $698 for an individual (about 75 percent of the FPL)[3] and $1,048 for a couple.[4] The SSI limits on countable assets are $2,000 for an individual and $3,000 for a couple.

Although individuals are not precluded from working while they receive SSI benefits, their earnings generally must remain below the SGA amount in order to continue meeting the program's definition of disability (§1614(a)(3)(E) of the Act). In addition, their countable income (both earned and unearned) must remain below the monthly federal benefit rate.[5]

The monthly benefit rate may be reduced if individuals have other income. For the two basic categories of individuals under age 65 who can receive SSI, the average SSI payments (as of January 2012) were as follows:

- Adults (age 18-64) with a disability received an average monthly benefit of $533.50.
- Children under age 18 with a disability received an average monthly benefit of $620.20.

In January 2012, approximately 4.8 million adults and 1.3 million children received SSI payments on the basis of a disability (SSA 2012a).

As previously noted, receipt of SSI benefits automatically entitles a person to Medicaid in all but 11 "209(b)" states, which are permitted to have more restrictive financial (e.g., income as a percent of FPL, assets) and non-financial (e.g., definition of disability) criteria for determining Medicaid eligibility than the SSI program.

Social Security Disability Insurance

SSDI, which is authorized under Title II of the Act, provides benefits to persons with disabilities or blindness who are insured by workers' contributions to the Social Security Trust Fund. These contributions are based on earnings as required by the Federal Insurance Contributions Act. Certain dependents (spouses and children) of insured individuals may also qualify for benefits.

Eligibility for SSDI requires a work history (on the part of the claimant, a parent, or a spouse). As with SSI, SSDI generally requires beneficiaries' earnings remain below the SGA (§221(m)(2)(B) of the Act).

There are three basic categories of individuals who can qualify for SSDI benefits based on disability (their own disability or that of a family member):

- disabled workers—insured workers under Social Security's full retirement age with a disability (average monthly benefit in January 2012 of $1,110.60);

[3] See Table 19 in MACStats for dollar amounts that correspond to the FPL for various family sizes.

[4] Many states pay a supplemental benefit to persons in addition to their federal benefits.

[5] Certain amounts and types of income are not counted for SSI purposes. For example, there is a general income disregard of $20 per month; in addition, the first $65 of monthly earnings and half of all earnings above $65 are excluded (§1612(b) of the Social Security Act). Thus individuals can have gross income in excess of 75 percent FPL and still qualify for SSI because their countable income is below that level.

BOX 1a-A1. The Ticket to Work and Work Incentives Improvement Act of 1999

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA, P.L. 106-170) revised several aspects of the SSDI and SSI programs as a means of promoting employment for persons with severe disabilities. Because access to health care and health insurance was cited as critical to supporting the employment of persons with disabilities, TWWIIA also gave states additional options to expand Medicaid coverage to employed persons with disabilities.

TWWIIA added two optional Medicaid pathways for states to provide to persons with disabilities. In both cases, the state has full discretion to set financial eligibility criteria (income and assets). These pathways are generally referred to as Medicaid "buy-ins" because enrollees can be charged income-related premiums at levels that are not generally permitted under Medicaid. States may also impose cost sharing such as copayments and deductibles. The two TWWIIA pathways are as follows:

- States may extend Medicaid eligibility to working-age individuals who would be eligible for SSI if not for their earnings. To be eligible under this pathway, individuals must be employed persons age 16 to 64 who meet the SSI disability definition.
- States may continue Medicaid coverage for working enrollees whose medical conditions remain severe, but who would otherwise lose SSI eligibility due to medical improvement as determined at a regularly scheduled disability review. States can only offer coverage under this pathway if they also extend eligibility under the previous pathway.

The level of services covered under the buy-in programs is the same as for other Medicaid enrollees.

- children of disabled workers—children of a parent entitled to SSDI (average monthly benefit in January 2012 of $330.60), where the child must be under age 18, a full-time student age 18, or a disabled adult child age 18 or older; and
- spouses of disabled workers—spouses of a worker entitled to SSDI, where the spouse must be age 62 or older or care for an entitled child who is under age 16 or is disabled (average monthly benefit in January 2012 of $298.70).

In January 2012, 8.6 million disabled workers, 1.9 million children (including a small number of disabled adult children), and 162,000 spouses received SSDI benefits (SSA 2012a).

Besides SSDI, payments for persons with disabilities may also be made under Social Security's Old-Age and Survivors Insurance (OASI). These payments are for disabled adult children of retired or deceased workers and for certain disabled widows and widowers. About 1.1 million disabled individuals (852,000 disabled adult children and 245,000 disabled widows and widowers) received OASI benefits in December 2010 (SSA 2011e).

For individuals who receive SSDI or OASI benefits on the basis of their own disability (i.e., disabled worker, disabled widow(er), disabled adult child), Medicare coverage is generally available after a 24-month waiting period. Non-disabled children and spouses do not qualify for Medicare by virtue of receiving SSDI benefits through a disabled worker.

Chapter 1a Annex 2

BOX 1a-A2. Major Legislative Milestones and Key Provisions in the Evolution of Medicaid's Role for Persons with Disabilities

1965 The Medicaid program was enacted as Title XIX of the Social Security Act (P.L. 89-97).

- Required states to cover populations receiving cash assistance, including adults receiving Aid to the Permanently and Totally Disabled or Old Age Assistance, and families receiving Aid to Families with Dependent Children.
- Permitted states to offer Medicaid coverage to the medically needy, which included those individuals who would meet the eligibility requirements for cash assistance if their medical expenses were deducted from their incomes.

1972 The Social Security Amendments of 1972 (P.L. 92-603):

- Established the Supplemental Security Income (SSI) program, which replaced the state-based Aid to the Permanently and Totally Disabled and Old Age Assistance programs.
  - Generally set national income and assets standards for SSI and a uniform definition of disability.
  - Required states to provide Medicaid coverage to all their federally qualified SSI recipients or to all individuals with disabilities using their state's eligibility standard for disabilities in effect in 1972 (known as 209(b) states).
- Expanded Medicare to cover individuals with disabilities who have received Social Security Disability Insurance (SSDI) for 24 months.

1981 The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) established the Section 1915(c) home and community-based services (HCBS) waiver program to allow states to provide long-term services and supports in the community to individuals who, but for such services, would require an institutional level of care.

- Permited states to target specific groups, limit the geographic area in which services are available, and cap the number of enrollees eligible for services under HCBS waivers.
- Required that waiver programs demonstrate cost neutrality.

BOX 1a-A2, Continued

1982 The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) established the "Katie Beckett" option, which allowed states to provide Medicaid to children with disabilities at home rather than in institutions:

- The child must be under 19 years of age, meet the SSI definition of disability, and meet the medical-necessity requirement for institutional care.
- Permitted Medicaid coverage of home care benefits so long as the estimated cost to Medicaid is no higher than it would be if the child were institutionalized.

1986 The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) established several new Medicaid eligibility categories:

- Gave states the option to provide full Medicaid benefits to individuals age 65 and older and individuals qualifying on the basis of a disability with income below a state-established level that does not exceed 100 percent of the federal poverty level (FPL).
- Required states to provide full Medicaid benefits to "qualified severely impaired individuals" under age 65 who are working despite severe mental or physical impairments, as long as those individuals received SSI disability or blindness benefits, state supplementary payments, or payments under Section 1619(a) of the Social Security Act and were otherwise eligible for Medicaid.
- Gave states the option to pay the Medicare premiums and cost sharing for low-income qualified Medicare beneficiaries (QMBs) with incomes at or below 100 percent FPL.

1988 The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360):

- Required states to pay the Medicare premiums and cost sharing for QMBs.
- Created a minimum level of asset and income protection for the spouses of individuals living in a nursing home in order to prevent spousal impoverishment.

Most of the MCCA was repealed in 1989, but the Medicaid provisions of the bill remained in law.

1990 The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) required states to pay Medicare premiums for beneficiaries with incomes between 100 and 120 percent FPL (specified low-income Medicare beneficiaries or SLMBs).

The Supreme Court ruling, *Sullivan v. Zebley*, mandated that, if children seeking SSI benefits do not qualify on the basis of medical standards alone, the SSA must perform an individualized functional assessment of how each child's impairment limits his or her ability to act and behave in age-appropriate ways.

BOX 1a-A2, Continued

1997 The Balanced Budget Act of 1997 (P.L. 105-33):

- Allowed states to provide Medicaid coverage to working individuals with disabilities with net family income up to 250 percent FPL, as long as their resources do not exceed the SSI resource standard.
  - States that use this option can charge premiums and impose cost sharing on a sliding scale based on income.
- Required states to pay Medicare premiums for Medicare beneficiaries with incomes between 120 and 135 percent FPL (qualifying individuals or QIs).

1999 The U.S. Supreme Court ruled in *Olmstead v. L.C.* (119 S. Ct. 2176) that persons with disabilities who are capable of living in the community should have the option to reside in the most integrated setting appropriate to their needs; subsequent federal guidance to states discussed the role of Medicaid in meeting this goal.

The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) gave states the option to extend eligibility to certain working persons, subject to premium payments ("buy-in"), who had been eligible for Medicaid on the basis of a disability, but who would otherwise lose eligibility because their earnings were too high or because they were no longer considered disabled due to medical improvement.

2003 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) established for people on Medicare a voluntary outpatient prescription drug benefit, known as Part D, which went into effect on January 1, 2006.

- Individuals dually eligible for Medicare and Medicaid who had previously received their prescription drugs through Medicaid switched to drug coverage through a private Medicare Part D plan.

2005 The Deficit Reduction Act of 2005 (P.L. 109-171):

- Included the Family Opportunity Act, which gave states the option to extend Medicaid coverage to children with disabilities with family incomes up to 300 percent FPL.
  - Permitted states to charge income-related premiums:
    - Under 200 percent FPL, premiums and cost sharing limited to 5 percent of family income;
    - Between 200 and 300 percent FPL, premiums and cost sharing limited to 7.5 percent of family income.
  - Parents must participate in ESI if the employer covers at least 50 percent of the premium.
- Added Section 1915(i) to the Social Security Act, to permit states to provide HCBS waiver services to persons with disabilities with incomes up to 150 percent FPL as a state plan option:
  - Permitted states to provide HCBS to individuals who do not require an institutional level of care.
  - Permitted states to establish enrollment caps and maintain waiting lists, and to provide services under this option only in certain parts of a state.

BOX 1a-A2, Continued

2010 The Patient Protection and Affordable Care Act (P.L. 111-148):

- Created the Community First Choice Option in Medicaid to allow states, through a state plan option, to provide statewide home and community-based attendant supports and services to individuals who, but for these services, would require institutional care.
  - Allows states to receive a six percentage point increase in federal matching payments for expenditures related to this option.
- Modified the Section 1915(i) HCBS state plan option:
  - Expanded the scope of services to include "other services requested by the state as the Secretary may approve."
  - Removed states' ability to limit the number of eligible individuals who can receive HCBS state plan option services.
  - Required statewide coverage, but provided states the ability to target specific populations (e.g., individuals with specific conditions).
  - Provided an option for states to provide HCBS to an additional group of individuals with incomes up to 300 percent of the SSI benefit rate who must be eligible for HCBS waivers (i.e., by meeting an institutional level of care requirement).

Note: States may be able to provide coverage for individuals at higher eligibility levels than indicated in this table through the use of income and asset disregards.

CHAPTER 1b

Services and Spending

Medicaid enrollees under 65 who qualify on the basis of a disability have extensive health needs that arise from a variety of physical and behavioral health conditions. In addition to acute care services, many Medicaid enrollees with disabilities use long-term services and supports (LTSS) that complement their medical care and help them maintain function and independence. The need for a broad range of services, which may be lifelong for some individuals, adds a dimension of complexity to providing coverage for persons with disabilities that is not shared by most other Medicaid enrollees.

As discussed in Chapter la, Medicaid enrollees who qualify on the basis of a disability are individuals under age 65 who meet a definition of disability that generally follows the one that is used for the federal Supplemental Security Income program. The majority of these individuals are Medicaid-only enrollees for whom Medicaid covers both acute and long-term services and supports. For dual eligibles, Medicare is the primary payer of their acute care services, meaning that Medicaid reflects only a portion of their total spending picture.[1] As a result of this difference in coverage, it is important to note that all dollar amounts presented in this chapter are limited to Medicaid spending. Future Commission work will present a more complete picture of total spending, both Medicaid *and* Medicare, for dual eligibles using linked Medicaid and Medicare data.

Owing to the range of health conditions they have, individuals under age 65 who qualify for Medicaid on the basis of a disability represent a disproportionate share of Medicaid spending. Furthermore, different subgroups within the population—for example, individuals who live in a nursing home or other institution—have different service use and spending patterns. In particular, this section of the chapter presents information on Medicaid spending for the overall population of individuals under age 65 who qualify on the basis of a disability and then highlights differences between those who are Medicaid-

[1] The total population of persons dually eligible for Medicaid and Medicare includes both non-elderly individuals and those age 65 and older; however, this chapter focuses on individuals under age 65 who qualify for Medicaid on the basis of a disability.

only enrollees and those who are dually eligible for Medicaid and Medicare.[2]

Given that individuals enrolled in Medicaid on the basis of a disability are a complex, high-cost population, policymakers are exploring ways to manage their spending while encouraging the provision of high-quality services. For example, a majority of states currently use or are actively considering some form of managed care as an option for persons with disabilities. These arrangements may have the potential to better coordinate the physical, behavioral, and LTSS needs of Medicaid enrollees with disabilities, but much depends on the specifics of how a given state's program is designed. As discussed in this section, additional federal and state efforts are under way to encourage program improvements for Medicaid enrollees with disabilities.

Key points include:

- In addition to covering basic medical services, Medicaid provides long-term services and supports and other important benefits for persons with disabilities that may be limited or not covered under Medicare or private health insurance.
- Individuals under age 65 enrolled in Medicaid on the basis of a disability accounted for only 15 percent of the Medicaid population in fiscal year (FY) 2008, but 42 percent of total Medicaid spending.
- Among individuals under age 65 qualifying on the basis of a disability, most Medicaid enrollment (62 percent in FY 2008) and Medicaid spending (69 percent) is for Medicaid-only enrollees, rather than dual eligibles who are enrolled in both Medicaid and Medicare.
- Among Medicaid-only enrollees who make up the majority of Medicaid spending for individuals under age 65 qualifying on the basis of a disability, nearly 75 percent of their Medicaid spending was for acute care in FY 2008 and the remainder was for LTSS.
- Among individuals enrolled on the basis of a disability, Medicaid spending on LTSS for an average Medicaid-only enrollee ($5,040 in FY 2008) is lower than for an average dual eligible ($8,784), indicating less use or intensity of these services for Medicaid-only enrollees.
- Opportunities exist for states and the federal government to develop, implement, and share innovative approaches to service delivery for persons with disabilities.

In light of these issues, the Commission recommends the accelerated advancement of targeted, efficient, and innovative approaches to providing high-quality care for persons with disabilities, especially those with Medicaid-only coverage.

Services Available under Medicaid

In addition to covering basic medical services, Medicaid provides important benefits for persons with disabilities that may be limited or not covered under Medicare or private health insurance. For some enrollees, particularly children, the depth of a particular Medicaid benefit may also exceed that of other payers.

[2] In the Medicaid Statistical Information System (MSIS) data that are used throughout this chapter to describe FY 2008 Medicaid enrollment and spending, about 670,000 enrollees age 65 and older are identified in the data as qualifying on the basis of a disability. Given that disability is not a Medicaid eligibility pathway for individuals age 65 and older, MACPAC recodes these 670,000 enrollees to have a basis of eligibility as "aged" throughout this report.

Breadth of benefits

As described in the Annex to this section, Medicaid allows states the option of covering a variety of LTSS that may help enrollees with disabilities maintain function and independence. These LTSS range from nursing and related care in specialized facilities to personal care and other support services that enable individuals to remain in their own homes.

When Medicaid was first enacted, mandatory coverage for LTSS was limited to nursing facility services for individuals age 21 and older. In 1970, coverage of home health was made mandatory for individuals entitled to nursing facility services. Since that time, the Congress has amended the Medicaid statute numerous times to provide options for covering a wide range of LTSS that allow persons with disabilities to live independently in home and community settings. Judicial decisions have played a role as well. For example, the Supreme Court ruled in *Olmstead v. L.C.* (119 U.S. 2176 (1999)) that persons with disabilities who are capable of living in the community should have the option to reside in the most integrated setting appropriate to their needs. Subsequent federal guidance to states discussed the role of Medicaid in meeting this goal (CMS 2000). Over time, Medicaid spending on non-institutional LTSS as a share of total LTSS has grown substantially. In FY 1995, 18 percent of Medicaid LTSS spending occurred in a non-institutional setting; by FY 2009, the figure had risen to 44 percent (Eiken et al. 2011).

For persons with disabilities and other individuals who would otherwise require care in an institution such as a nursing home, the establishment of home and community-based services (HCBS) waiver authority in 1981 was a key development. For most Medicaid-covered services, states may set limits based on criteria such as medical necessity but generally must offer the services to all enrollees on a statewide basis. Under HCBS waivers, states may provide a wide range of services (including those not otherwise covered for their general Medicaid populations) to individuals who would otherwise require institutionalization. States may exercise control over those services by targeting specific groups of enrollees, limiting the geographic area in which services are available, and capping enrollment. HCBS waivers are required to be cost neutral, meaning that the estimated Medicaid cost of providing services to individuals enrolled in an HCBS waiver cannot be more than the estimated Medicaid cost of providing services to those individuals in an institution.

In addition, although they are not a specifically defined category of benefits in federal Medicaid law, state Medicaid programs typically cover a broader range of behavioral health services than Medicare or private insurance. Examples include intensive case management, residential care for mental health and substance abuse disorders, and services provided in home and community settings rather than in hospitals or professional settings such as clinicians' offices (Garfield et al. 2010, Shirk 2008). Given that a large percentage of Medicaid enrollees who are eligible on the basis of a disability have behavioral health conditions and that mental illness is a common co-occurring condition among the most expensive enrollees, there is an increasing federal and state focus on developing programs to better coordinate physical and behavioral health care, which may include both acute services and LTSS.[3]

[3] For example, the Integrated Care Resource Center is a technical assistance project established by the Centers for Medicare & Medicaid Services that is designed to help inform states about innovative solutions for delivering coordinated health care for Medicaid's high-need, high-cost enrollees, with the goal of improving the quality and reducing the costs of care (ICRC 2012).

Depth of benefits

Even when a particular benefit is not unique to Medicaid, the program may differ from private insurance and other payers—and from state to state—in the amount, duration, and scope of the covered benefit. For example, under the Blue Cross and Blue Shield private insurance plans offered to federal employees, there are annual caps on the number of physical, occupational, speech, and cognitive therapy visits that are covered (OPM 2012). In general, states may also vary the extent to which a covered benefit is available to Medicaid enrollees by defining both medical necessity and the amount, duration, and scope of covered services.

For children in Medicaid, however, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provide an exception to benefit limits that might otherwise apply. Under EPSDT requirements for children under age 21, states must cover any necessary service named in the Medicaid statute (including optional services not otherwise covered by the state) "to correct or ameliorate defects and physical and mental illnesses and conditions" that are discovered when a child receives an EPSDT screening service (§1905(r) of the Social Security Act (the Act)). For example, dental benefits, which are of particular importance for children with disabilities who are at increased risk for oral health problems (CMS 2004), are available for children under EPSDT but may be limited or not available for adults with Medicaid. Whereas caps or other limits unrelated to medical necessity may apply to children with private insurance, EPSDT precludes states from placing similar limits on services for children in Medicaid (Rosenbaum et al. 2008).

Interaction with other programs

Although a detailed discussion is beyond the scope of this chapter, Medicaid coverage may interact with a variety of other programs that serve persons with disabilities. For example:

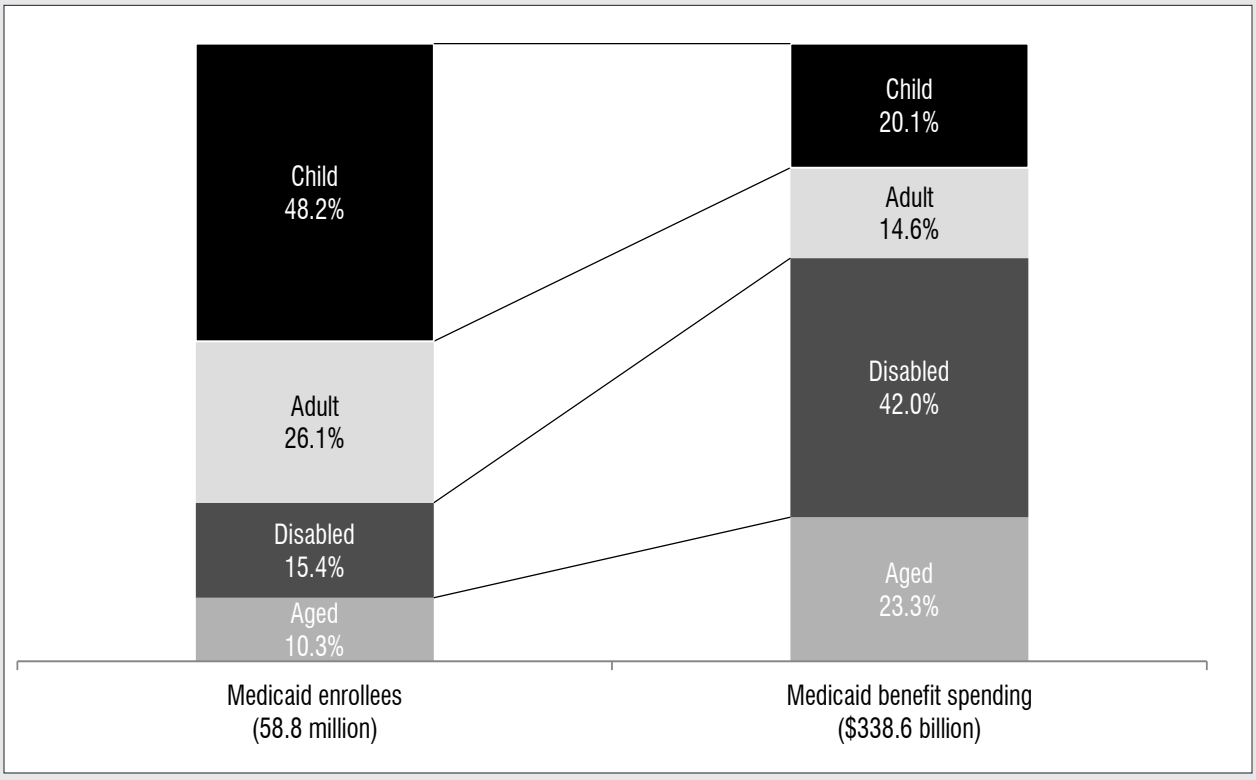
- Under the Individuals with Disabilities Education Act, public schools must provide special education and related services necessary for children with disabilities. For children enrolled in Medicaid, these related services (e.g., physical, occupational, and speech therapies) may be financed by Medicaid if they are otherwise covered by Medicaid and if the school-based providers meet the same requirements (e.g., state licensure) as other Medicaid providers (Herz 2009).
- Medicaid's optional targeted case management benefit can be used to aid enrollees in gaining access to needed medical, social, educational, and other services. For example, a case manager might help enrollees with intellectual or developmental disabilities schedule and obtain their Medicaid services, but also assist them in applying for food stamps or other non-Medicaid assistance.
- Although Medicaid can provide a variety of home and community-based services, the program cannot pay for room and board outside of institutions, and the availability of affordable, accessible housing for persons with disabilities may affect their ability to live in a community setting. A recent initiative of the U.S. Department of Housing and Urban Development provided funding to support rental assistance vouchers for non-elderly persons with disabilities, including nearly 1,000 individuals who live in nursing homes or other institutional settings—often financed by Medicaid—but who could move into the community with assistance (Lipson and Williams 2011).

Medicaid Spending for Individuals Under Age 65 Enrolled on the Basis of a Disability

In FY 2008, Medicaid benefit spending (including both state and federal funds) on all Medicaid enrollees totaled $339 billion. Owing to the range and complexity of health conditions they have, children and adults under age 65 who qualify for Medicaid on the basis of a disability represent a disproportionate share of this spending. As shown in Figure 1b-1, individuals under age 65 enrolled on the basis of a disability accounted for 15 percent of the Medicaid population in FY 2008 (9.1 million enrollees), but 42 percent of Medicaid spending ($142 billion). In contrast, non-disabled children and non-disabled adults under age 65 accounted for about three-quarters of enrollees but only about one-third of Medicaid spending.

The large share of total Medicaid spending for persons under age 65 enrolled on the basis of a disability reflects their high per person spending, which averaged $17,412 for a full-year equivalent enrollee in FY 2008 (Table 1b-1). This amount far exceeds average Medicaid spending among children ($3,025) or adults under age 65 ($4,651) enrolled in Medicaid through non-disability pathways.

FIGURE 1b-1. Medicaid Enrollment and Benefit Spending by Eligibility Group, FY 2008



Notes: Enrollees qualifying on the basis of a disability are children and adults under age 65. Includes dual eligibles enrolled in both Medicaid and Medicare (nearly all of whom are in the aged and disabled eligibility groups); however, all dollar amounts presented in this chapter are limited to Medicaid spending. Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC 2011b for methodology. Excludes Medicaid-expansion CHIP enrollees and the U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

TABLE 1b-1. Medicaid Enrollment and Benefit Spending by Eligibility Group, FY 2008

Eligibility Group	Number of Enrollees (millions)	Total Medicaid Benefit Spending (billions)	Medicaid Spending per Full-year Equivalent Enrollee
Children	28.3	$68.1	$3,025
Adults	15.4	49.5	4,651
Aged	6.0	78.9	14,945
Disabled	9.1	142.0	17,412
Medicaid-only coverage	*5.6*	*98.2*	*19,682*
Dually enrolled in Medicaid and Medicare	*3.5*	*43.8*	*13,835*
All enrollees	**58.8**	**$338.6**	**$7,267**

Notes: Enrollees qualifying on the basis of a disability are children and adults under age 65. Dual eligibles are enrolled in both Medicaid and Medicare; however, all dollar amounts presented in this chapter are limited to Medicaid spending. Figures for dual eligibles include "partial" duals for whom Medicaid coverage is limited to payment of Medicare premiums and cost sharing; they also include "full" duals for whom Medicaid also covers additional benefits not available under Medicare (e.g., LTSS). Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC 2011b for methodology. Excludes Medicaid-expansion CHIP enrollees and the U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

As is typical of health care spending for any group, Medicaid spending for enrollees with disabilities is highly concentrated among a small number of individuals. In FY 2008, Medicaid spending per full-year equivalent enrollee under age 65 qualifying on the basis of a disability averaged more than $100,000 for the top 5 percent of spenders. These individuals accounted for nearly half of total Medicaid spending among persons enrolled in the program on the basis of a disability.[4]

Medicaid spending for Medicaid-only enrollees and dual eligibles

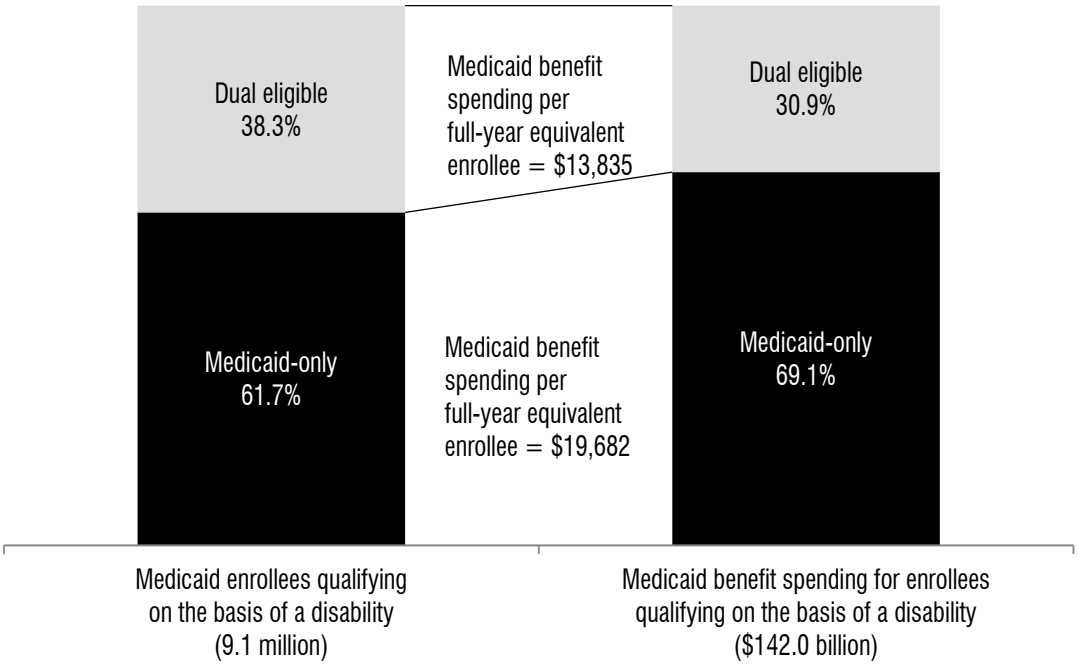
Most individuals under age 65 enrolled in Medicaid on the basis of a disability (62 percent in FY 2008) are Medicaid-only enrollees (Figure 1b-2). Similarly, the majority of Medicaid spending on individuals under age 65 qualifying on the basis of a disability (69 percent in FY 2008) is for Medicaid-only enrollees.

As shown in Figure 1b-2, among individuals under age 65 enrolled in Medicaid on the basis of a disability, Medicaid spending per enrollee is higher for Medicaid-only enrollees than for individuals dually eligible for Medicaid and Medicare. However, this finding does not necessarily indicate that the Medicaid-only population has higher overall spending. Instead, the differences in Medicaid spending between Medicaid-only enrollees and dual eligibles shown in this section are driven in large part by two factors:

- For all individuals dually eligible for Medicaid and Medicare, Medicare finances a significant portion of their acute care spending (e.g., hospital and physician services, prescription drugs). Because the figures in this chapter are limited to Medicaid, they do not reflect the full range of health care spending for dual eligibles. In comparison, Medicaid finances the full range of health care spending

[4] Data not shown; MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS.

FIGURE 1b-2. Medicaid Enrollment and Benefit Spending among Medicaid-only and Dual Eligible Enrollees Under Age 65 Qualifying on the Basis of a Disability, FY 2008



Notes: Enrollees qualifying on the basis of a disability are children and adults under age 65. Dual eligibles are enrolled in both Medicaid and Medicare; however, all dollar amounts presented in this chapter are limited to Medicaid spending. Figures for dual eligibles include "partial" duals for whom Medicaid coverage is limited to payment of Medicare premiums and cost sharing; they also include "full" duals for whom Medicaid also covers additional benefits not available under Medicare (e.g., LTSS). Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC 2011b for methodology.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data

for most Medicaid-only enrollees qualifying on the basis of a disability.[5]

- Figures in this chapter reflect Medicaid spending for both "partial" and "full" dual eligibles. For partial dual eligibles, Medicaid coverage is limited to payment of Medicare premiums and, in some cases, cost sharing. For full dual eligibles, Medicaid pays Medicare premiums and cost sharing, but also covers additional benefits not available under Medicare (e.g., LTSS). Again, in comparison, Medicaid finances the full range of health care spending for most Medicaid-only enrollees qualifying on the basis of a disability.

Future Commission work will provide a more comprehensive picture of total spending, both Medicaid and Medicare, for dual eligibles using linked Medicaid and Medicare data. In this chapter, all dollar amounts are limited to Medicaid spending.

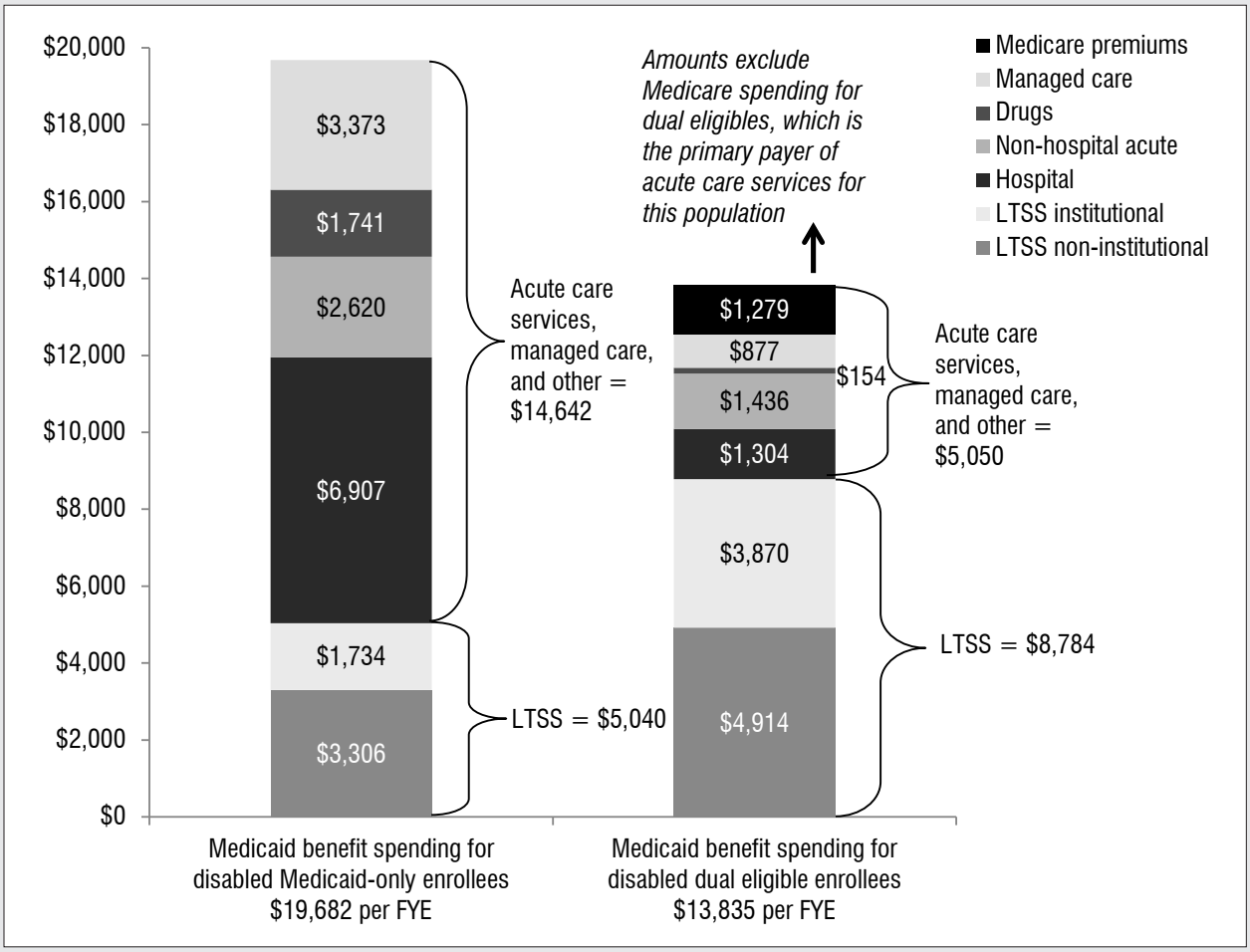
Composition of Medicaid spending on Medicaid-only enrollees and dual eligibles

Looking at the overall population of individuals under age 65 enrolled in Medicaid on the basis of a disability, 37 percent of their Medicaid spending was for LTSS in FY 2008.[6] The remaining

[5] As noted in Chapter la, a relatively small share of Medicaid-only enrollees report having private insurance coverage in addition to Medicaid.

[6] Data not shown; MACPAC analysis of MSIS APS data and CMS-64 FMR net expenditure data from CMS.

FIGURE 1b-3. Composition of Medicaid Benefit Spending Per Full-Year Equivalent Enrollee among Medicaid-only and Dual Eligible Enrollees Under Age 65 Qualifying on the Basis of a Disability, FY 2008



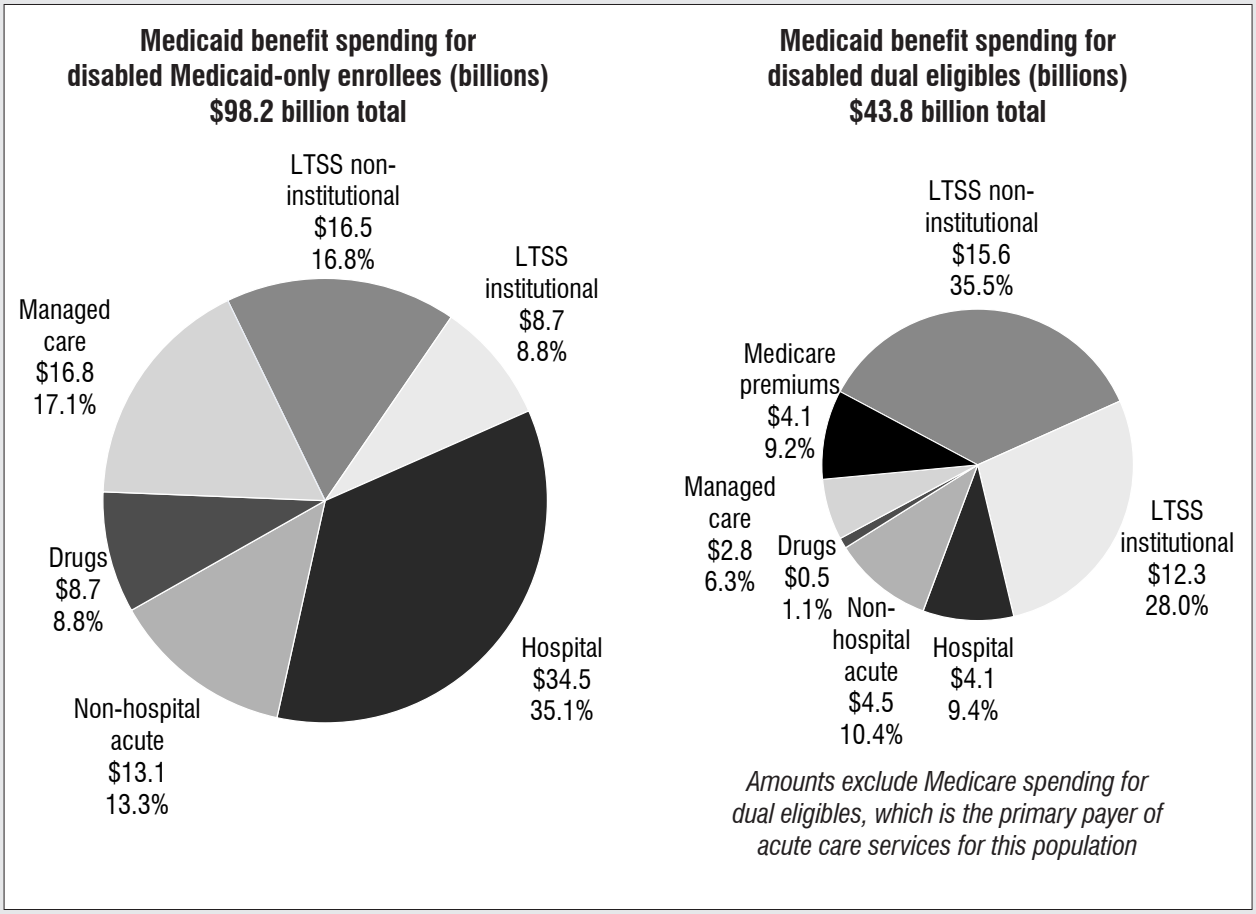
Notes: FYE is full-year equivalent. Enrollees qualifying on the basis of a disability are children and adults under age 65. Dual eligibles are enrolled in both Medicaid and Medicare; however, all dollar amounts presented in this chapter are limited to Medicaid spending. Figures for dual eligibles include "partial" duals for whom Medicaid coverage is limited to payment of Medicare premiums and cost sharing; they also include "full" duals for whom Medicaid also covers additional benefits not available under Medicare (e.g., LTSS). Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC 2011b for methodology. "Managed care" category may include a variety of acute care services and, in some cases, LTSS. "Hospital" includes inpatient, outpatient, and mental health facility. "LTSS non-institutional" includes HCBS waiver, personal care, home health, rehabilitation, private duty nursing, hospice, and targeted case management. "LTSS institutional" includes nursing facility and intermediate care facility for persons with intellectual disabilities. Excludes the U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

63 percent was for hospital and other acute care, prescription drugs, managed care, and Medicare premiums. However, these figures for the overall population mask substantial differences in the composition of Medicaid spending for those who have Medicaid-only coverage and those who are dually eligible for Medicaid and Medicare.

For example, among individuals under age 65 enrolled in Medicaid on the basis of a disability, Medicaid spending on LTSS for an average Medicaid-only enrollee is lower ($5,040 in FY 2008, Figure 1b-3) than for an average dual eligible with disabilities ($8,784), indicating less use or intensity of these services for Medicaid-only enrollees. In addition, Medicaid spending on LTSS is more

FIGURE 1b-4. Composition of Total Medicaid Benefit Spending among Medicaid-only and Dual Eligible Enrollees Under Age 65 Qualifying on the Basis of a Disability, FY 2008



Notes: Enrollees qualifying on the basis of a disability are children and adults under age 65. Dual eligibles are enrolled in both Medicaid and Medicare; however, all dollar amounts presented in this chapter are limited to Medicaid spending. Figures for dual eligibles include "partial" duals for whom Medicaid coverage is limited to payment of Medicare premiums and cost sharing; they also include "full" duals for whom Medicaid also covers additional benefits not available under Medicare (e.g., LTSS). Medicaid benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see MACStats section of MACPAC 2011b for methodology. "Managed care" category may include a variety of acute care services and, in some cases, LTSS. "Hospital" includes inpatient, outpatient, and mental health facility. "LTSS non-institutional" includes HCBS waiver, personal care, home health, rehabilitation, private duty nursing, hospice, and targeted case management. "LTSS institutional" includes nursing facility and intermediate care facility for persons with intellectual disabilities. Excludes U.S. territories.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

heavily skewed toward home and community-based services among Medicaid-only enrollees qualifying on the basis of a disability (Figure 1b-3).

Among Medicaid-only enrollees under age 65 qualifying on the basis of a disability, most Medicaid spending is for acute care services (74 percent in FY 2008, Figure 1b-4). The following discusses spending for this population in more detail.

Hospital services. Focusing on the Medicaid-only enrollees in Figure 1b-4—who account for the bulk of Medicaid spending on individuals under age 65 qualifying on the basis of a disability—hospital services (inpatient, outpatient, and mental health facility) exceed LTSS as a share of Medicaid spending (35 percent for hospital services in FY 2008, compared to 26 percent for LTSS).

Among Medicaid-only enrollees qualifying on the basis of a disability, those with the highest hospitalization rates have multiple physical and behavioral health conditions. In particular, mental illness is common among the highest-cost, most frequently hospitalized enrollees, and the presence of mental illness and drug and alcohol disorders is associated with substantially higher per capita costs and hospitalization rates (Boyd et al. 2010). The prevention of unnecessary hospital readmissions presents one opportunity to improve the quality of care provided to this population while also reducing costs (Gilmer and Hamblin 2010).

Other acute services and managed care. Again focusing on the Medicaid-only enrollees under age 65 who qualify on the basis of a disability in Figure 1b-4, other major sources of spending include non-hospital acute care (13 percent in FY 2008), prescription drugs (9 percent), and managed care (17 percent).

Historically, many persons with disabilities have been excluded or exempted from mandatory enrollment in Medicaid managed care plans. As noted in MACPAC's June 2011 Report to the Congress, more could be known about which program features might work best for different populations. For example, individuals with complex medical needs may benefit from particular methods of care management and may require the inclusion of additional providers in plan networks. In addition, to ensure continuity of services and coordination of benefits, mandatory enrollment and auto-assignment processes for enrollees with disabilities may differ from those typically used for non-disabled children and adults. Risk adjustment of payments to managed care plans is also an important consideration, given the diversity of health needs and high costs among persons with disabilities (MACPAC 2011b).

Today, a majority of states currently use or are actively considering some form of managed care as an option for persons with disabilities in Medicaid (Gifford et al. 2011, Smith et al. 2011). However, the extent to which some or all of the services frequently used by this population (e.g., prescription drugs, behavioral health services, LTSS) are included in a Medicaid managed care contract varies, as does the inclusion of certain populations. In addition, the term "managed care" may refer to several different arrangements, including comprehensive risk-based plans and limited-benefit plans that provide a contracted set of services in exchange for a capitated (per member per month) payment, as well as primary care case management (PCCM) programs that typically pay primary care providers a small monthly fee to coordinate enrollees' care (MACPAC 2011b). Although more than half of individuals under age 65 qualifying for Medicaid on the basis of a disability were enrolled in some form of managed care in FY 2008, they were more likely to be enrolled in limited-benefit plans (which typically cover only behavioral health, transportation, or dental services) than in comprehensive risk-based plans or PCCM programs (Table 1b-2).

LTSS. As shown in Figure 1b-4, among individuals under age 65 enrolled in Medicaid on the basis of a disability, LTSS account for a much smaller share of Medicaid spending for Medicaid-only enrollees (26 percent in FY 2008) than for dual eligibles (63 percent). As noted earlier, this difference is driven in large part by the fact that Medicare is the primary payer of acute care services for dual eligibles.

In addition, 16 percent of Medicaid-only enrollees under age 65 qualifying on the basis of a disability were LTSS users, and they accounted for about half of Medicaid spending on that group in FY 2008. Among dual eligibles under age 65 qualifying for Medicaid on the basis of a disability, 22 percent were LTSS users, and they accounted

TABLE 1b-2. Percentage of Medicaid Enrollees in Managed Care by Type of Arrangement, FY 2008

Type of Arrangement	Children	Adults	Disabled	Aged
Any managed care	**84.6%**	**57.1%**	**58.8%**	**35.2%**
Comprehensive risk-based plans	60.0	43.8	28.5	11.7
Limited-benefit plans	36.6	23.6	36.4	27.4
Primary care case management	19.0	8.9	13.3	2.3

Notes: Enrollees qualifying on the basis of a disability are children and adults under age 65. Managed care types do not sum to total because individuals are counted in every category for which a payment was made on their behalf during the year. Enrollees are counted as participating in managed care if at least one managed care payment was made on their behalf during the fiscal year; this method underestimates participation somewhat because it misses enrollees who entered managed care late in the year but for whom a payment was not made until the following fiscal year.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data from CMS

for about three-quarters of Medicaid spending on that group.[7] For dual eligibles, one long-standing barrier to high-quality, cost-effective care has been a lack of coordination between acute care services (covered primarily by Medicare), with LTSS and other services covered by Medicaid (Bella 2011, MedPAC 2010). However, even among Medicaid-only enrollees for whom Medicaid covers both acute care services and LTSS, only a small number of states have implemented or are considering policies to coordinate these benefits—for example, through managed care models under which a single entity assumes responsibility for arranging the full range of acute care services and LTSS covered by a state's Medicaid program in exchange for a fixed payment (Gifford et al. 2011, Bella and Palmer-Barnette 2010, Edwards et al. 2009).

Medicaid Innovations for Persons with Disabilities

Given the complex health care needs of and high spending for persons with disabilities, opportunities exist for states and the federal government to develop, implement, and share innovative approaches to service delivery for this population. Enrollees with Medicaid-only coverage present a particular opportunity for states, given that innovations for this population do not require coordination with the Medicare program—an issue that adds a layer of complexity in serving persons dually enrolled in Medicaid and Medicare. While efforts are under way to encourage innovative program improvements for Medicaid enrollees, the Commission supports the development of additional programmatic improvements designed to address the cost-effectiveness and quality of services provided to Medicaid enrollees with disabilities.

[7] Data not shown; LTSS user figures are based on MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS. The analysis reflects a method for identifying LTSS users that differs from the one that was used to develop Figures 5-7 in the MACStats section of MACPAC 2011b. The new method identifies a much smaller share of the Medicaid population as LTSS users and results in higher spending per LTSS user.

Opportunities for innovation. With budget constraints at both the federal and state levels, policymakers are exploring ways to manage spending while encouraging the provision of high-quality services for persons with disabilities. For example, the development of programs to better coordinate physical and behavioral health care present an opportunity to reduce unnecessary hospital readmissions. States are increasingly looking to managed care as one way to achieve this coordination—as well as obtain greater spending predictability, and potentially savings, in their Medicaid programs. In developing managed care options, states may make use of a variety of arrangements that address the need for behavioral health and other specialty services among persons with disabilities. With regard to LTSS, states have a number of state plan and waiver options available for serving enrollees in home and community-based settings. Some of these options, including HCBS waivers and the HCBS state plan option, allow states to target specific groups of enrollees in need of specialized services, such as persons with intellectual and developmental disabilities.

CMS Innovation Center activities. Federal statute provides the Secretary of the U.S. Department of Health and Human Services (the Secretary) with the authority to test and evaluate Medicaid program and policy innovations through the Center for Medicare & Medicaid Innovation (the Innovation Center) within the Centers for Medicare & Medicaid Services (§1115A of the Act). The Innovation Center has introduced 16 initiatives that focus on improving patient safety, promoting care that is coordinated across health care settings, investing in primary care transformation, creating new bundled payments for care episodes, and meeting the complex needs of dual eligibles (CMS 2012b).

Among Innovation Center initiatives, the potential exists to advance service delivery options that include innovations in payment and quality measurement for persons with disabilities, including those with Medicaid-only coverage. For example, the Health Care Innovation Challenge will award up to $1 billion in grants to applicants who put into practice new ideas for achieving better health, improved care and lower costs for persons enrolled in Medicare, Medicaid, and CHIP, particularly those with the greatest health care needs. Other Innovation Center initiatives, such as the Partnership for Patients, examine ways to reduce hospital-acquired conditions and preventable hospital readmissions, an effort relevant to Medicaid enrollees with disabilities for whom hospital services account for a large share of Medicaid spending. In order to encourage the timely dissemination of information, all Innovation Center initiatives include a "diffusion" element to provide best practices, lessons learned, and improved care strategies so that the innovation is not limited to a single demonstration site or particular community (CMS 2012b).

In addition to the support provided through the Innovation Center, the Integrated Care Resource Center—a technical assistance project established by CMS—provides states with help in coordinating health care for Medicaid enrollees with high-cost, chronic needs as well as dual eligibles (ICRC 2012). Many states are also taking advantage of recently enacted options for persons with disabilities that are outlined in Box 1b-1.

BOX 1b-1. Recently Enacted Statutory Provisions Providing States with Options to Serve Persons with Disabilities

Several recently enacted statutory provisions in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) provide tools for Medicaid to improve the delivery of services for persons with disabilities. While these tools provide states more options to address the needs of this population, many of the options have limitations in their scope as they are primarily targeted at increasing access to LTSS in home and community-based settings (Edwards 2011). They include:

- **Modification of HCBS.** The modification of the HCBS state plan option, which was first created by the Deficit Reduction Act of 2005 (P. L. 109-171), increases the scope of benefits covered in the option, removes states' ability to cap enrollment, requires statewide coverage, provides states with the ability to offer the benefit to additional individuals, and provides states with the ability to target the option to specific populations (e.g., individuals with specific conditions). Seven states (Idaho, Iowa, Colorado, Louisiana, Nevada, Oregon, and Wisconsin) have taken up the option as of March 2012 (CMS 2012a).
- **Money Follows the Person.** The extension for five years (through 2016) of the Money Follows the Person (MFP) rebalancing demonstration, which was originally established in the Deficit Reduction Act of 2005. This demonstration program provides states with an enhanced federal medical assistance percentage (FMAP) for 12 months for each Medicaid enrollee transitioned from an institution to the community during the demonstration period. Forty-three states and the District of Columbia have implemented MFP programs, with over 15,000 individuals transitioned back into the community as of June 2011 (Denny-Brown et al. 2011).
- **Community First Choice Option.** The establishment of the Community First Choice Option in Medicaid to allow states, through a state plan option, to provide statewide home and community-based attendant supports and services to individuals who require an institutional level of care with incomes up to 150 percent FPL, or greater if the state has a higher income level for an individual who has been determined to require an institutional level of care under the state plan. This option, which became available October 1, 2011, allows states to receive a six percentage point increase in federal matching payments for spending related to this option.
- **State Balancing Incentive Payments Program.** The establishment of the State Balancing Incentive Payments Program to provide enhanced federal matching payments to states in order to increase the proportion of Medicaid LTSS dollars that go toward HCBS and decrease the proportion that go toward institutional services. Total funding over four years (from October 2011 to September 2015) cannot exceed $3 billion in federal enhanced matching payments. New Hampshire will be the first state to receive grant funds under the program to run from April 1, 2012 through September 2015 (CMS 2012c).
- **Health Homes for Individuals with Chronic Conditions.** The establishment of the state option to receive enhanced federal support for the provision of health home services to eligible children and adults with chronic conditions. This provision became effective on January 1, 2011. States can have more than one health home model operating at once and can adapt existing models. Eligible individuals for whom a state may choose to offer a health home include those with chronic conditions—defined as a mental health condition, a substance use disorder, asthma, diabetes, heart disease, or being overweight (body mass index over 25) or other conditions as defined by the Secretary. Enrollees must select among state-designated health home providers. The health home population the state covers must consist of individuals who have at least two of the previously listed chronic conditions, one chronic condition and be at risk for another, or one serious and persistent mental health condition. As of March 2012, five state plan amendments (SPAs) have been approved (two in Missouri, two in Rhode Island, one in New York), three SPAs are under review (North Carolina, Oregon, Washington), CMS is providing technical assistance for six draft SPAs, and CMS has issued 15 planning grants to states (CMS 2012a).

Commission Recommendation

Despite federal and state efforts, a more targeted focus on persons with disabilities, particularly Medicaid-only enrollees with disabilities, should be a priority for the CMS Innovation Center and other federal and state efforts. The development of innovative programs for persons with disabilities would help promote high-quality and cost-effective care for this population.

Recommendation 1.1

The Secretary and the states should accelerate the development of program innovations that support high-quality, cost-effective care for persons with disabilities, particularly those with Medicaid-only coverage. Priority should be given to innovations that promote coordination of physical, behavioral, and community support services and the development of payment approaches that foster cost-effective service delivery. Best practices regarding these programs should be actively disseminated.

Rationale

Enrollees who qualify for Medicaid on the basis of a disability have extensive service needs and represent the largest share of Medicaid spending compared to all other Medicaid enrollee groups. This presents unique challenges to addressing the delivery of services and payment options for this population. This recommendation encourages the acceleration of innovative efforts to provide high-quality and cost-effective care to this population.

Medicaid-only enrollees with disabilities present key opportunities for innovation. Given the complex health care needs of and high spending for persons with disabilities, particularly those with Medicaid-only coverage, key opportunities exist for states and the federal government to develop, implement, and share innovative approaches to providing cost-effective, high-quality service delivery options for this population. Enrollees with Medicaid-only coverage present a particular opportunity for states, given that innovation for this population does not require coordination with the Medicare program—an issue that adds a layer of complexity in serving persons dually enrolled in Medicaid and Medicare.

Innovation should focus on Medicaid-only persons with disabilities. Ensuring that persons with disabilities with Medicaid-only coverage are a primary focus of these innovative efforts may lead to approaches that better provide cost-effective and high-quality care for this population. Most of the enrollees under age 65 who qualify for Medicaid based on a disability—62 percent (5.6 million people)—rely on Medicaid as their only source of coverage, while 38 percent (3.5 million people) are enrolled in both Medicaid and Medicare. Medicaid spends a substantial amount in total and on a per capita basis on Medicaid-only enrollees under age 65 who qualify for Medicaid based on a disability. Medicaid spent $98.2 billion in total in FY 2008 ($19,682 per full-year equivalent enrollee) on Medicaid-only enrollees qualifying on the basis of a disability and $43.8 billion in total in FY 2008 ($13,835 per full-year equivalent enrollee) on persons with disabilities enrolled in both Medicaid and Medicare.[8] Further, Medicaid-only enrollees report poorer health status and a greater presence of health conditions and functional impairments compared to all Medicaid enrollees.

[8] This difference in Medicaid spending is due in large part to the fact that: (1) Medicare covers a significant portion of acute care costs for dual eligibles, and (2) some dual eligibles receive limited Medicaid coverage that only includes payment of their Medicare premiums and cost sharing, rather than full Medicaid benefits.

Coordination of care is a priority for innovation. Physical health services, including oral health services, are often disconnected from behavioral health and community support services needed by persons with disabilities. The lack of coordination among the diverse services used by persons with disabilities may lead to fragmented and inefficient delivery of services to a population that often has extensive and complex health care needs. Innovative efforts that focus on care coordination and better management of service use can provide approaches that promote more cost-effective and higher quality service delivery for persons with disabilities.

Payment approaches should support cost-effective care. Innovative payment approaches that foster cost-effective care should support coordination of physical, behavioral, and community support services rather than act as a disincentive to such coordination. Accurate risk adjustment of payments to providers is important to account for the high costs and high needs of persons with disabilities.

Current innovation efforts present opportunities to focus on persons with disabilities. While the CMS Innovation Center has introduced many initiatives that are relevant to high-need, high-cost populations in Medicaid, it has the potential to foster innovation specifically for persons with disabilities, and the Commission encourages the Innovation Center to take this opportunity. For example, the Health Care Innovation Challenge presents a prime opportunity to support new care coordination and payment approaches for delivering high-quality, cost-effective care for persons with disabilities as well as to play a role in disseminating best practices and lessons learned from these initiatives.

Timely dissemination of best practices is helpful to states. States are moving forward with different approaches to address the challenges of providing care for this population with extensive service needs and high spending. As innovative, cost-effective programs serving persons with disabilities are being developed and implemented, states would benefit from timely dissemination of information about these programs to help them model their own innovative and effective approaches to improving services for this population.

Implications

Federal spending: There is no immediate and direct impact on the federal budget.

State spending: There is no immediate and direct impact on state budgets.

Beneficiaries: Enrollees with disabilities would benefit from the continued development and support of program innovations that will potentially provide higher quality and more coordinated care.

Providers: Innovations that support better coordination of care for the extensive and complex needs of persons with disabilities would allow providers to deliver more cost-effective and high-quality care to persons with disabilities.

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Chapter 1b Annex 1

Medicaid Long-Term Services and Supports

There is no universal definition of Medicaid long-term services and supports (LTSS). In fact, the definitions used by analysts vary, making it difficult to compare service use and spending figures across studies. In addition, the actual services provided under a given benefit may vary by state. The following briefly describes a range of mandatory and optional[1] Medicaid benefits provided under regular state plan rules that might be considered LTSS, drawing from language in federal statute, regulations, and guidance. If a state covers these services under its state plan, it may set limits by defining medical necessity criteria and the amount, duration, and scope of services provided, but it generally must offer the services to all enrollees on a statewide basis. As noted at the end of this Annex, there are additional options for states wishing to provide targeted LTSS for particular groups of enrollees.

State plan services

Nursing facility. Mandatory for most enrollees age 21 or older.[2] Includes services furnished in a facility that provides skilled nursing, rehabilitation, or health-related services for individuals who do not require hospital care, but whose mental or physical condition requires services that go beyond the level of room and board.

Intermediate care facility for persons with intellectual disabilities (ICF-ID).[3] Optional. Includes items and services furnished in a facility whose primary purpose is to furnish health or rehabilitative services to persons with intellectual disabilities or related conditions, and which provides services above the level of room and board.

Mental health facility for individuals under age 21 or age 65 and older. Optional. For individuals under age 21, includes services provided by a psychiatric hospital, an inpatient psychiatric program in a hospital, or by an accredited psychiatric facility. For individuals age 65 and older, includes inpatient hospital and nursing facility services

[1] As discussed earlier, EPSDT requires states to cover any medically necessary service (including LTSS) for children under age 21, regardless of its mandatory or optional status.

[2] As with other mandatory services, states are not required to cover nursing facility services for Medicaid enrollees who qualify under medically needy eligibility rules, which are generally used to allow individuals with incomes above regular Medicaid eligibility levels to "spend down" to a medically needy income level by incurring medical expenses.

[3] Although the statute refers to ICF services for persons with "mental retardation," a proposed rule from CMS published in the Federal Register on October 24, 2011, would replace this statutory term with "intellectually disabled" throughout federal Medicaid regulations.

provided in institutions for mental diseases (IMD). Federal Medicaid funds are not available for services provided to individuals age 21 to 64 who reside in an IMD.

Home health. Mandatory for enrollees who are entitled to nursing facility services.[4] Includes nursing services, home health aide services, and medical supplies, equipment, and appliances suitable for use in the home; may include physical therapy, occupational therapy, or speech pathology and audiology services.

Personal care. Optional. May include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks—such as bathing, dressing, doing household chores, and performing other routine activities—that they would normally do for themselves if they did not have disabilities. States have the option of offering a self-directed model that allows targeted groups of enrollees to use Medicaid funds for the purchase of personal assistance and related services under an approved plan and budget, and to manage the individuals who provide their services.

Rehabilitation. Optional. Includes any medical or remedial services recommended by a physician or other licensed practitioner for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. The specific services covered, providers rendering the services, and the settings in which the services are delivered vary by state.

Targeted case management. Optional. Includes services furnished to assist state-specified groups of enrollees who reside in, or are transitioning to, a community setting in gaining access to needed medical, social, educational, and other services. Targeted case management services include assessments, development of care plans, referral and related activities, and monitoring and follow-up activities; they exclude the direct delivery of underlying medical, educational, social, and other services.

Private duty nursing. Optional. Includes nursing services for enrollees who require more individual and continuous care than is available from a visiting nurse or routinely provided by the staff of a hospital or nursing facility.

Hospice. Optional. Includes services covered by the Medicare definition of hospice, which consists of a range of services (e.g., nursing care, home health aide and homemaker services, counseling) provided under a written plan by a hospice program to a terminally ill individual.

Home and community-based attendant services and supports (Community First Choice). Optional. For individuals who require an institutional level of care, includes home and community-based services related to accomplishing activities of daily living (ADLs) such as bathing and dressing, instrumental ADLs such as performing household chores, and health-related tasks. A variety of additional requirements apply. The Community First Choice option differs from other HCBS state plan and waiver options in that states cannot provide a targeted package of services or limit coverage to targeted groups. States receive a six percentage point increase in federal matching funds for services provided under this option.

Options for targeting Medicaid LTSS

Home and community-based services (HCBS) waivers and the HCBS state plan option offer states two ways of providing targeted LTSS

[4] Individuals not entitled to nursing facility services may include medically needy enrollees and enrollees under age 21 in states electing not to cover the services for those individuals.

without meeting certain benefit requirements that would otherwise apply. Waiver authority under Section 1115 of the Social Security Act may also be used to provide HCBS and other LTSS, sometimes as a part of broader changes to a state's Medicaid program.

HCBS waivers. Optional. Under HCBS waivers, states may offer individuals requiring an institutional level of care a wide range of services that enable them to remain in the community, including services not necessarily covered for the rest of the state's Medicaid population. These may include case management, home health aide, homemaker, personal care, adult day, habilitation, respite, and such other services requested by the state as the Secretary of Health and Human Services may approve. Day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services may also be included for individuals with chronic mental illness. States may target specific groups, limit the geographic area in which services are available, and cap the number of enrollees eligible for services under HCBS waivers. HCBS waivers are required to be cost neutral, meaning that the estimated Medicaid cost of providing services to individuals enrolled in an HCBS waiver cannot be more than the estimated Medicaid cost of providing services to those individuals in an institution.

These waivers most frequently target individuals age 65 or older and individuals with disabilities under age 65 (nearly half of all participants are in aged or aged/disabled HCBS waivers) and persons with intellectual and developmental disabilities (about 40 percent). The remainder (which account for about 10 percent of total enrollment in HCBS waivers) serve children with special needs and persons with physical disabilities, traumatic brain and spinal cord injuries, HIV/AIDS, and mental health needs (KCMU 2011).

States may use a variety of waiver authorities in order to tailor the delivery of medical and support services for their Medicaid enrollees, including persons with disabilities, but managing these waivers can be administratively burdensome. For example, although HCBS waivers are authorized under Section 1915(c) of the Social Security Act, states wishing to provide HCBS waiver and other state-covered services through a managed care delivery system must also obtain a 1915(b) waiver. Enrollees and states may benefit from the coordination of care achieved under these waiver authorities, but their separate application, reporting, and renewal requirements may also complicate the administration of a state's Medicaid program (Weinberg 2011).[5]

HCBS state plan option. Optional. The HCBS state plan option is similar to HCBS waivers in terms of the range of services that may be offered and the ability to target specific groups, but differs in that individuals with incomes up to 150 percent FPL are not required to need an institutional level of care in order to be eligible; they must instead meet needs-based criteria specified by the state that assess functional status and are less stringent than the institutional level of care criteria.[6] In addition, eligibility for targeted groups must be statewide and enrollment cannot be capped. States can, however, modify their needs-based criteria if actual enrollment exceeds projections.

[5] For 1915(b)/(c) combination waivers that serve dual eligibles, states may request an approval period of five years that would result in an aligned renewal period for the waivers (CMS 2010).

[6] States may also provide HCBS state plan option services to individuals with incomes up to 300 percent of the federal Supplemental Security Income (SSI) benefit rate (about 224 percent of the FPL) who are eligible for HCBS services under a waiver and therefore would generally require an institutional level of care.

CHAPTER 1C

Quality Measurement

Medicaid enrollees with disabilities tend to have service-intensive health care needs that may render them vulnerable to quality problems. More likely than other enrollees to be in poor health, Medicaid enrollees with disabilities often have multiple chronic conditions and functional impairments that require complex treatment plans and coordination across a number of providers, as well as with social support systems. While only 15 percent of Medicaid enrollees under age 65 were enrolled in Medicaid on the basis of a disability in fiscal year 2008, these individuals accounted for 42 percent of total Medicaid spending, creating both challenges and opportunities in terms of providing high-quality, cost-effective care. Shortcomings in the quality of care obtained by Medicaid enrollees with disabilities stand to have a negative impact on health outcomes, as well as add to the costs of caring for this relatively high-need, high-cost population.

At present, little is known about the quality of care received by Medicaid enrollees with disabilities. Due to data limitations, it is not always possible to identify enrollees with disabilities for purposes of quality assessment, making it difficult to evaluate how well they are served and whether there are quality problems particular to this population. Furthermore, there is no consensus on whether the measures commonly used to assess quality of care for Medicaid enrollees—such as hospital readmissions, preventable hospitalizations, and emergency department visits—are sufficient for assessing the care provided to persons with disabilities. Existing quality measures may need adjustments to accurately gauge the experiences of persons with disabilities, and additional research and measure improvement may be needed to more completely assess the quality of their care. However, addressing these quality measurement issues will require further research and investment in the scientific evidence base (Iezzoni 2010).

There have been recent efforts at the federal and state levels, as well as by private organizations, to identify and develop quality measures applicable to Medicaid enrollees with disabilities and to incorporate such measures into quality assessment. Some of these activities are highlighted below.[1] These initiatives provide a foundation for a needed acceleration of work to assess and ensure quality of care for Medicaid enrollees with disabilities.

This chapter includes a recommendation to support the improvement of quality measures for Medicaid enrollees with disabilities. The Commission recommends that the Secretary of the U.S. Department of Health and Human Services (the Secretary), in partnership with the states, update and improve quality assessment for Medicaid enrollees with disabilities. As the federal government and states develop new programs and service delivery innovations, the Secretary should prioritize quality measures for Medicaid enrollees with disabilities to monitor the impact of service delivery innovations on this population.

Selected Federal Quality Measurement Development Activities

Recent federal initiatives to strengthen quality measurement have included components relating to the development of quality of care measures for persons with disabilities.

Agency for Healthcare Research and Quality (AHRQ) initiatives. As part of an effort to track disparities in quality and access to care for persons with disabilities, AHRQ convened a meeting of experts in April 2010 to explore the development of quality measures for this population (Iezzoni 2010).[2] The panel addressed alternative definitions of disability and their implications for quality measurement, the scientific evidence base for quality measure development, data issues for measuring quality, and research priorities for developing quality measures for persons with disabilities. Key findings from this meeting include:

- Quality measures for common health conditions that can be severely disabling (e.g., asthma, diabetes, heart failure) are in widespread use, but generally do not address special considerations for persons with disabilities.
- Few quality measures specifically address disability-related issues, and there is a particular dearth of measures relating to patient functioning, wellness, and quality of life.
- Because people with disabilities are often excluded from clinical trials, little scientific evidence is available to guide development of quality measures for this population.[3]

To help develop AHRQ's research agenda, meeting participants identified issues for future investigation, including:

- the potential impact of varying approaches to disability determination on quality measurement for persons with disabilities;
- the potential need for special consideration of persons with disabilities when developing quality measures for large populations; and
- the selection of critical outcomes that should be tracked in disability-related quality research.

While the experts at the meeting were not asked to reach consensus regarding priorities or next

[1] The quality activities highlighted do not include long-term services and supports (LTSS) quality measurement efforts.

[2] The meeting was organized by AHRQ's Division of Priority Populations Research within the Office of Extramural Research, Education, and Priority Populations.

[3] Exceptions include certain well-studied disabling conditions such as spinal cord injuries and multiple sclerosis.

steps, the suggestions they offered included the development of both a specific set of quality measures for persons with disabilities and methods for collecting information on experiences obtaining care among persons with disabilities.

As a first step in implementing recommendations from the April 2010 meeting, AHRQ recently commissioned a report as part of its *Closing the Quality Gap: Revisiting the State of the Science* series, which focuses on gathering evidence about effective methods for closing the quality gap. One of the eight reports in the series, *QI Measurement of Outcomes for People with Disabilities*, addresses how health care outcomes are assessed for persons with disabilities. The main objective of the report is to analyze how health outcomes for general medical care have been evaluated for this population, particularly in the areas of care coordination and quality improvement. The analysis in the report poses three key research questions:

- How are outcomes related to basic medical needs assessed for persons with disabilities living in the community?
- What measures have been used to examine coordination among health providers for persons with disabilities living in the community?
- In evaluating coordination between health providers and community organizations, what measures have been used to examine effectiveness of care for persons with disabilities living in the community? (AHRQ n.d.)

To address these questions, researchers screened more than 15,000 articles to examine available outcomes for medical care and care coordination for persons with disabilities. While this report is not final,[4] initial conclusions indicate that there is little research examining health outcomes from the perspective of disability as a comorbidity. More research is needed on care coordination and quality improvement for persons with disabilities, and future research may benefit from an organized database collection of "critically assessed outcome measures." The collection of information on health outcomes for persons with disabilities is "essential for evaluating quality of care" (AHRQ n.d.).

Core quality measures for adults and children. The Centers for Medicare & Medicaid Services (CMS) released a core set of quality measures for children enrolled in Medicaid and CHIP in December 2009 and for adults enrolled in Medicaid in January 2012.[5] These core measure sets were developed based on a review of existing quality measures already in use by states, quality entities, associations, and others, and focused on a broad array of health care services, settings, and providers. While the pediatric and adult core measure sets are voluntary, states are encouraged to report to CMS on as many of the measures as feasible. If used by states, both sets of measures should be reported across an entire state and across all delivery systems, including fee-for-service, primary care case management, and risk-based managed care. Refinements to the measures will take place over the next several years. Annexes 1 and 2 to this chapter present the pediatric and adult core measure sets.

The 24 pediatric core measures address the following areas:

- prevention and health promotion;
- management of acute conditions;
- management of chronic conditions; and
- family experiences of care.

[4] Public comments closed on February 6, 2012.

[5] The Children's Health Insurance Program Reauthorization Act (P.L. 111-3) and the Patient Protection and Affordable Care Act (P.L. 111-148), respectively, required the development of these measure sets.

These core measures are intended to be used for the pediatric Medicaid and CHIP enrollee populations as a whole, but are not specific to children with disabilities beyond the inclusion of behavioral health measures.

The 26 core quality measures for adult Medicaid enrollees cover the same four areas mentioned above and include the additional areas of care coordination and service availability. The measures are intended to apply to all Medicaid adults. There are several measures targeting behavioral health conditions, but no other measures are specific to adults with disabilities.

Both the pediatric and adult measure sets address care for certain chronic conditions (such as asthma and diabetes) that are not necessarily disabling, but that are often present as comorbidities in persons with disabilities, and that may develop into disabling conditions.

Expert workgroups played a significant role in reviewing and evaluating the proposed quality measures for inclusion in the final core sets. In reviewing proposed pediatric measures, workgroup members determined that few or no valid and/or feasible measures existed for several areas including: specialty care, care for substance abuse, and mental health treatment (Mangione-Smith 2010). The adult measures workgroup concluded that the measures not recommended for inclusion in the core set addressed very narrow clinical conditions, excluded key populations (e.g., persons dually eligible for Medicaid and Medicare and persons with LTSS needs), presented potential data-collection challenges for states, or duplicated other, more highly rated measures included in the set (DHHS 2012).

Quality measurement for health homes. States may receive federal matching funds to provide coordinated care through a health home for eligible Medicaid enrollees with chronic conditions.[6] Providers serving as health homes must report certain quality measures to the state in order to receive payment (§1945(g) of the Social Security Act).

CMS recently selected a draft core set of quality measures (Table 1c-1) for CMS-approved health homes that states must ultimately report to the federal government. As with the core measure sets for Medicaid generally, the draft core set for health homes includes several behavioral health measures, but no other measures pertaining specifically to persons with disabilities.

Selected State Quality Measurement Activities

Several states are moving forward with new approaches for serving persons with disabilities. As states implement these new programs, they face decisions about how to measure and assess the quality of care furnished to persons with disabilities. One question is whether to employ existing quality measurement tools—such as the Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys (both explained in more detail below)—adapt these instruments, or develop additional measurement tools.

To help determine the extent to which states are engaged in the development of quality measures for persons with disabilities, MACPAC reviewed findings from a recent 50-state Medicaid managed care survey. MACPAC identified clinical quality

[6] Section 1945(h) of the Social Security Act defines a health home as a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

TABLE 1c-1. Draft Required Measures for CMS-approved Health Homes, 2011

Draft Measure	Measure Source(s)
Adult body mass index (BMI) assessment	HEDIS
Ambulatory care-sensitive condition admission	National Quality Measures Clearinghouse (NQMC); Rosenthal 2010
Care transition – transition record transmitted to health care professional	NQMC; National Quality Forum (NQF)
Follow-up after hospitalization for mental illness	HEDIS
Plan all-cause readmission	HEDIS
Screening for clinical depression and follow-up plan	NQF
Initiation and engagement of alcohol and other drug dependence treatment	HEDIS

Source: MACPAC communication with CMS staff, March 2012

and access measures that have been developed by states (i.e., not adapted from HEDIS) for quality assessment and that may be relevant for monitoring the quality of care provided to Medicaid enrollees with disabilities and to persons dually eligible for Medicaid and Medicare. These measures fall into the following categories: hospitalizations/emergency room (ER) visits; mental health/substance abuse; chronic care; access, utilization, and costs; care coordination; satisfaction and quality of life; and additional measures. Annex 3 provides additional detail on these state-developed measures.

Several states have also started designing strategies for measuring quality of care specifically for Medicaid enrollees with disabilities and other high-need, high-cost populations. Examples of these state efforts include the following:

- California, in implementing a new Section 1115 demonstration waiver to require enrollment in managed care of persons with disabilities and persons dually eligible for Medicaid and Medicare, is considering a dashboard to monitor the performance of all Medi-Cal managed care plans. The California Department of Health Care Services and the California HealthCare Foundation are developing a framework and specific measures for the dashboard. The state is determining what portion of the dashboard measures should be applicable to persons with disabilities and persons dually eligible for Medicaid and Medicare. State officials expect to use and report on a single set of measures, stratified by population, by 2013. Thirteen proposed measures address adult Medicaid enrollees with disabilities (Table 1c-2).
- Missouri's recently approved state plan amendment (SPA) for health homes includes quality measures that target persons with behavioral health conditions. The quality measurement goals outlined in the SPA include: improving health outcomes for persons with mental illness, reducing substance abuse, increasing patient empowerment and self-management, improving coordination of care, improving preventive care, improving

TABLE 1c-2. Selected Recommended Measures for California Medi-Cal Dashboard, 2011

Measure	Source	Population
Cervical cancer screening	HEDIS	Adults with disabilities
Comprehensive diabetes care	HEDIS	Adults with disabilities
Risk-adjusted average length of hospital stay	NQF	Adults with disabilities
Medication possession ratio	Other	Adults with disabilities
Antidepressant medication management	HEDIS	Adults with disabilities
Follow-up after hospitalization for mental illness	HEDIS	Adults with disabilities
Initiation and engagement of alcohol and other drug dependence treatment	HEDIS	Adults with disabilities
Waiver waiting lists	Other	Adults with disabilities; seniors
Services in community vs. institution	Other	Adults with disabilities; seniors
Getting care quickly	CAHPS	Adults with disabilities
Getting needed care	CAHPS	Adults with disabilities
Percentage of long-term stays with pressure sores	Other	Adults with disabilities; seniors
Percentage of residents who lose too much weight	Other	Adults with disabilities; seniors

Source: *Monitoring Medi-Cal: Recommendations for measuring the performance of California's Medicaid program*. California HealthCare Foundation, January 2011

diabetes care, improving asthma care, and improving cardiovascular care. Specific behavioral health measures that the state will use include: medication adherence to antipsychotics, antidepressants, and mood stabilizers; care coordination (e.g., percent of hospital-discharged members with whom the care manager made telephonic or face-to-face contact within two days of discharge and performed medication reconciliation with input from the primary care provider (PCP)); reduction in the proportion of adults (18 and older) reporting use of any illicit drug during the past 12 months; and reduction in the proportion of adults (18 and older) who drank excessively in the previous 12 months.

- Michigan received a design contract from CMS to develop new approaches to better coordinate care for persons dually eligible for Medicaid and Medicare. As part of the planning process, stakeholders representing behavioral health, managed care plans, academic researchers, LTSS providers, and other interested parties were convened to consider performance measures and quality monitoring in an integrated, capitated system. The stakeholder group determined that an integrated system should report metrics more often than annually, and by population and geographic region. They recommended considering development of population-specific dashboards that combine a few selected measures applicable to the whole population and a few selected measures that apply to a subpopulation (e.g., persons with developmental disabilities or nursing home residents). Population-specific measures would be selected from among those currently used by the state's LTSS providers, managed care

plans, habilitation supports waiver, serious and persistent mental illness program, and developmental disability services program.

- Wisconsin developed a survey called the Personal Experience Outcomes Integrated Interview and Evaluation System for enrollees with developmental and physical disabilities and enrollees who utilize LTSS. The survey collects their perspectives on choice, personal experiences, and health and safety. Its goal is to help care managers and enrollees evaluate whether available services are supporting enrollees' most important needs.

Other Quality Measurement Initiatives

In addition to federal and state efforts in quality measurement for persons with disabilities, there are also initiatives being led by private organizations or in collaboration with government agencies that may be applicable to Medicaid enrollees with disabilities.

HEDIS measure development. HEDIS is a set of quality, access, and effectiveness-of-care measures for selected conditions that is often used by states to monitor the care delivered by managed care organizations to Medicaid enrollees.[7] Many states require their participating plans to collect and report data on HEDIS measures. Measures address multiple areas such as effectiveness of care, access to and availability of care, experience of care, and utilization and relative resource use. Certain HEDIS disease-specific measures may be applicable to persons with complex health conditions, such as behavioral health measures and measures pertaining to adults age 65 and over. Efforts are currently underway to implement seven new HEDIS measures focused on schizophrenia and bipolar disorder. The National Committee for Quality Assurance (NCQA) recently sought public comment on these measures for inclusion in the 2013 HEDIS measurement set (NCQA 2012). NCQA is also working to set quality measurement priorities for persons dually eligible for Medicaid and Medicare and to develop, evaluate, and test measures for this population (O'Kane 2011).

CAHPS. CAHPS is a set of consumer surveys designed for children and adults that addresses a range of topics, including enrollees' satisfaction with care, perceptions of access to care, and use of services.[8] State Medicaid programs and managed care organizations use CAHPS to measure plan performance, determine where to focus improvement efforts, track performance improvement over time, and gauge member satisfaction. In addition to survey questions that are applicable to all Medicaid enrollees, there are supplemental question sets that gather the experiences and perceptions of subpopulations, such as children with chronic conditions.

The CAHPS survey for children with chronic conditions has 24 questions that inquire about the health care experiences of children and cover areas such as:

- access to prescription medications;
- access to specialized services;
- family-centered care; and
- coordination of care and services.

This survey identifies children with chronic conditions based on the use of or need for prescription medications; above-average use of or need for medical, mental health, or education services; functional limitations compared with other children of the same age; use of or need for specialized therapies; and treatment or counseling

[7] HEDIS measures are maintained and updated annually by the National Committee for Quality Assurance.

[8] AHRQ oversees the CAHPS program and surveys.

for emotional, behavioral, or developmental problems (AHRQ 2008).

An additional CAHPS survey tool collects data on persons with lower-limb mobility impairments. This 21-question set covers topics such as use of mobility equipment, ability to walk and/or difficulty in walking a quarter of a mile, obtaining a range of therapies (i.e., physical, occupational, and speech), and obtaining or replacing mobility equipment, among other issues. There are also three questions that can be used to identify adults with mobility impairments.[9]

Measure Applications Partnership (MAP). MAP is a public-private partnership, led by the National Quality Forum (NQF), that advises the U.S. Department of Health and Human Services (HHS) on choosing performance measures for public reporting and performance-based payment programs. Four advisory workgroups, including one focused on persons dually eligible for Medicaid and Medicare, will provide input on performance measurement across various areas. While the Dual Eligible Beneficiaries workgroup is focused primarily on quality measurement for persons who are dually eligible, its work is applicable to Medicaid enrollees with disabilities as well, given that almost 38 percent of Medicaid enrollees under age 65 qualifying on the basis of a disability are dually eligible for Medicaid and Medicare. The workgroup also includes members representing persons with disabilities.[10] The workgroup's initial report:

- highlights the unique characteristics of this population and deficits in quality measurement that address the complex problems faced by persons dually eligible for Medicaid and Medicare;
- outlines an approach to quality measurement that includes an overview of characteristics of persons dually eligible for Medicaid and Medicare (including high-need subgroups), goals for high-quality care, guiding measurement principles, and quality improvement opportunities; and
- characterizes appropriate measures for this population.

The group's final report, scheduled for submission to HHS in June 2012, will address gaps in available measures for persons dually eligible for Medicaid and Medicare and examine potential modifications to existing quality measures, as well as the need for new measures (NQF 2012).

[9] During the AHRQ expert meeting in April 2010 on quality measures for persons with disabilities, some participants expressed concern about the lower-limb mobility impairments CAHPS survey. In developing the survey questions, researchers found they could not use the word "barrier" when asking about physical impediments that individuals encounter, and they were unable to find an alternative phrasing. Given this, AHRQ meeting participants thought this major area of concern for persons with disabilities was overlooked in this particular survey.

[10] A list of workgroup members can be found in Appendix C of the Dual Eligible Beneficiaries workgroup's interim report (NQF 2011).

Commission Recommendation

Despite efforts at the federal and state levels and by other organizations to develop quality measures and improve quality of care for Medicaid enrollees, little is known about whether or not quality measures commonly used for the Medicaid population are sufficient for assessing the care provided to Medicaid enrollees with disabilities. More research is needed to determine if existing measures of quality are appropriate for this population, if adjustments to current measures are needed, or whether new measures should be developed to measure quality of care for enrollees with disabilities.

Recommendation 1.2

The Secretary, in partnership with the states, should update and improve quality assessment for Medicaid enrollees with disabilities. Quality measures should be specific, robust, and relevant for this population. Priority should be given to quality measures that assess the impact of current programs and new service delivery innovations on Medicaid enrollees with disabilities.

Rationale

Medicaid enrollees with disabilities are particularly vulnerable to poor quality care, yet little is known about the quality of care Medicaid enrollees with disabilities receive. Medicaid enrollees with disabilities have more complex health conditions and greater functional needs, and use many more medical and other health-related services than do other Medicaid enrollees. Despite this greater need and vulnerability, however, there are limitations in research and a lack of quality assessment specifically designed to identify the particular needs of these individuals.

It is not clear whether or not commonly used quality measures can adequately assess the quality of care provided to Medicaid enrollees with disabilities. There are some standard measures for a limited number of common and potentially disabling conditions such as asthma, diabetes, and heart failure. However, new measures may be required or adjustments to the current measures may be needed to consider enrollee health conditions (e.g., dental measures adjusted to target enrollees with disabilities) and functional status.

Research and scientific evidence needed to inform the development of quality measures to address disability-related issues is limited. The Commission encourages the development of new research to guide the development of new measures, and/or refinement of existing measures, applicable to these individuals. The improvement of quality measures for Medicaid enrollees with disabilities would provide federal and state governments with additional data and measurement tools to determine whether or not these individuals receive quality care.

Development of quality measures for Medicaid enrollees with disabilities provides states with measurement options to determine whether or not services provided are of high quality. The development of additional research to support outcomes data specific to Medicaid enrollees with disabilities is critical for supporting quality measures that are specific, robust, and appropriate for this population. This recommendation would provide federal and state governments with the additional measurement tools and data they need to help determine whether or not individuals receive quality care that is appropriate and cost-effective.

If new quality measures are developed for Medicaid enrollees with disabilities, other measures should be phased out. Phasing out some measures will be necessary to prevent data collection redundancies that impose unnecessary administrative burdens without improving the quality of care.

As the federal government and states develop innovative programs for this population, quality measurement should be continuously updated. The Commission recommends that research and evidence development on quality measurement should be sufficiently robust to fully assess the impact of these innovative programs on the coordination of physical, behavioral, and community support services. This would allow policymakers to assess health plan and provider performance and align payment approaches with quality improvement.

Implications

Federal spending: There is no immediate and direct impact on the federal budget.

State spending: There is no immediate and direct impact on state budgets.

Beneficiaries: Development of measures to monitor the quality of care delivered to Medicaid enrollees with disabilities may assist with improving enrollees' overall health outcomes and the quality of care they receive.

Providers: There is no anticipated provider impact given that the development of new quality measures for Medicaid enrollees with disabilities should allow for the phasing out of existing measures which may become redundant.

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Chapter 1c Annex 1

TABLE 1c-A1. HHS Initial Core Set of Children's Quality Measures for Medicaid and CHIP

	Measure
1	Frequency of ongoing prenatal care
2	Timeliness of prenatal care – the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization
3	Percent of live births weighing less than 2,500 grams
4	Cesarean rate for low-risk first birth women [NQF #0471]
5	Childhood immunization status [NQF #0038]
6	Immunizations for adolescents
7	BMI documentation for ages 2 to 18 [NQF #0024]
8	Screening using standardized screening tools for potential delays in social and emotional development – Assuring Better Child Health and Development (ABCD) initiative measures
9	Chlamydia screening for women [NQF #0033]
10	Well-child visits in the first 15 months of life
11	Well-child visits in the third, fourth, fifth, and sixth years of life
12	Well-child visits for 12 to 21 years of age – with PCP or OB-GYN
13	Total eligibles receiving preventive dental services (EPSDT measure, Line 12B)
14	Appropriate testing for children with pharyngitis [NQF #0002]
15	Otitis media with effusion – avoidance of inappropriate use of systemic antimicrobials – ages 2 to 12
16	Total EPSDT eligibles who received dental treatment services (EPSDT CMS Form 416, line 12C)
17	Emergency department (ED) utilization – average number of ED visits per member per reporting period
18	Pediatric catheter-associated blood stream infection rates (PICU and NICU) [NQF #0139]
19	Annual number of asthma patients (≥ 1 year-old) with ≥ 1 asthma-related ER visit (S/AL Medicaid Program)
20	Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase) [NQF #108]
21	Follow-up after hospitalization for mental illness
22	Annual hemoglobin A1c testing (all children and adolescents diagnosed with diabetes)
23	CAHPS® Health Plan Survey 4.0, Child Version including Medicaid and Children with Chronic Conditions supplemental items
24	Children's and adolescents' access to primary care practitioners (PCPs), by age and total

Note: Measures that have received National Quality Forum (NQF) endorsement are indicated with the relevant number.

Source: Department of Health and Human Services. 2009. Medicaid and CHIP programs: Initial core set of children's health care quality measures for voluntary use by Medicaid and CHIP programs. Notice with comment period. *Federal Register* 74, no. 248 (December 29): 68846–6884

Chapter 1c Annex 2

TABLE 1c-A2. HHS Initial Core Set of Adult Quality Measures for Medicaid

	Measure
1	Flu shots for adults ages 50 to 64 (collected as part of HEDIS CAHPS Supplemental Survey)
2	Adult BMI assessment
3	Breast cancer screening
4	Cervical cancer screening
5	Medical assistance with smoking and tobacco use cessation (collected as part of HEDIS CAHPS Supplemental Survey)
6	Screening for clinical depression and follow-up plan
7	Plan all-cause readmission
8	Diabetes, short-term complications admission rate
9	Chronic obstructive pulmonary disease (COPD) admission rate
10	Congestive heart failure admission rate
11	Adult asthma admission rate
12	Chlamydia screening in women ages 21 to 24 (same as CHIPRA core measure, however, the State would report on the adult age group)
13	Follow-up after hospitalization for mental illness
14	Elective delivery
15	Antenatal steroids
16	Annual HIV/AIDS medical visit
17	Controlling high blood pressure
18	Comprehensive diabetes care: LDL-C screening
19	Comprehensive diabetes care: Hemoglobin A1c testing
20	Antidepressant medication management
21	Adherence to antipsychotics for individuals with schizophrenia
22	Annual monitoring for patients on persistent medications
23	CAHPS Health Plan Survey v 4.0 – Adult Questionnaire with CAHPS Health Plan Survey v. 4.0H – NCQA Supplemental
24	Care transition – transition record transmitted to health care professional
25	Initiation and engagement of alcohol and other drug dependence treatment
26	Prenatal and postpartum care: postpartum care rate (second component to CHIPRA core measure "timeliness of prenatal care;" State would now report 2/2 components instead of 1)

Source: Department of Health and Human Services. 2012. Medicaid program: Initial core set of health care quality measures for Medicaid-eligible adults. Final notice. *Federal Register* 77, no. 2 (January 4): 286–290

Chapter 1c Annex 3

Quality Measures Relevant to High-Need, High-Cost Populations, Reported by State Medicaid Programs, 2010

Several states have initiated efforts to develop measures to monitor and evaluate high-need, high-cost enrollees' care and experiences accessing the health care system. MACPAC identified quality measures that are being used by at least one state, are not existing HEDIS measures, and may be relevant to Medicaid enrollees with disabilities and persons dually eligible for Medicaid and Medicare. The clinical quality and access measures were self-reported by states as part of the 50-state survey of Medicaid managed care programs conducted by Health Management Associates for the Kaiser Commission on Medicaid and the Uninsured. These measures fall into the following categories: hospitalizations/emergency room (ER) visits; mental health/substance abuse; chronic care; access, utilization, and costs; care coordination; satisfaction and quality of life; and additional measures.

TABLE 1c-A3. Quality Measures Reported by State Medicaid Programs, 2010

Measure	Total States Reporting	State/Program
Hospitalizations/ER Visits		
Inpatient visit for ambulatory care-sensitive conditions	2	IL (PCCM); TX (PCCM)
Avoidable hospitalization rate	2	ME (PCCM); MO (MCO for children only)
Emergency department diversion	1	OH (MCO)
Hospital readmission (within 72 hours with same complaint)	1	NE (PCCM)
Follow-up within 30 days of hospital discharge	1	PA (PCCM)
Mental Health/Substance Abuse		
Coordination of behavioral health and medical care	1	AZ (PHP)
Timeliness of first service for children with special health care needs (CSHCN) through the Children's Rehabilitative Services Program	1	AZ (PHP)
Access to care/appointment availability for routine behavioral health services	1	AZ (PHP)
Mental health admission to inpatient hospitals	1	CA (reported by one specialty plan)

TABLE 1c-A3, Continued

Measure	Total States Reporting	State/Program
Discharges to out-of-home placements	1	CA (reported by one specialty plan)
Mental health readmission rate	5	FL (MCO); IA (PHP); NC (PHP); PA (PHP for inpatient psychiatric admissions); TX (PCCM)
Average time between mental health hospitalizations	1	IA (PHP)
Follow-up after hospitalization for substance abuse treatment	2	IA (PHP); PA (PHP)
Follow-up after hospitalization for the dually diagnosed (mental health and substance abuse)	1	IA (PHP)
Implementation of mental health inpatient discharge plans	1	IA (PHP)
Outcome measurement for Medicaid children and adolescents, improvement in the psychosocial domain	1	IA (PHP)
Documentation of mental health discharge plan	1	IA (PHP)
Rate of discharge to homeless or emergency shelter	1	IA (PHP)
Inpatient concordance rate – percentage of requests for mental health inpatient treatment that the plan authorizes for a 24-hour level of care	1	IA (PHP)
Percent of involuntary hospitalizations	1	IA (PHP)
Readmission for non-inpatient services	1	IA (PHP)
Frequency with which network providers communicate with PCPs	1	IA (PHP)
Number of adult and child enrollees receiving integrated services, rehabilitation, or support services	1	IA (PHP)
Documentation of substance abuse treatment discharge plans	1	IA (PHP)
Rate of substance abuse treatment readmission	1	IA (PHP)
Psychotropic medication screening	1	IA (PHP)
Return to the community for children in psychiatric medical institutes	1	IA (PHP)
Improvement in emotional health – Medicaid adults and older adolescents	1	IA (PHP)
Percentage of enrollees receiving services annually	1	IA (PHP)
Expenditures for integrated services and supports	1	IA (PHP)
Substance abuse days and discharges, partial hospitalization days and discharges, and alternative services	1	MO (MCO)

TABLE 1c-A3, Continued

Measure	Total States Reporting	State/Program
Percentage of adults receiving services who have serious mental illness and no co-occurring substance abuse diagnosis	1	PA (PHP)
Percentage of adults receiving mental health services; substance abuse services	1	PA (PHP)
Chronic Care		
Asthma-related ER visits	4	AL (PCCM, FFS); GA (MCO, FFS); MO (MCO for children); PA (MCO for children)
Asthma admission rate	1	GA (MCO, FFS); TX (PCCM, PHP, FFS)
Preventable asthma-related ER visits	1	MO (MCO for children)
Appropriate asthma medication: three or more controller dispensing events	1	NY (MCO)
Frequency of HIV disease monitoring lab tests	1	FL (MCO)
Highly active anti-retroviral treatment	1	FL (MCO)
HIV-related outpatient medical visits	1	FL (MCO)
HIV/AIDS comprehensive care: engaged in care, viral load monitoring, syphilis testing	1	NY (MCO)
Cervical cancer screenings in women who are HIV-positive	1	PA (MCO)
Admission rates – diabetes short- and long-term complications, uncontrolled diabetes, COPD, HTN, CHF, dehydration	1	TX (PCCM, PHP, FFS)
Diabetes – rate of lower extremity amputation	1	TX (PCCM)
Managing sickle cell anemia	1	AK (PCCM)
Hepatitis C treatment effectiveness	1	AK (PCCM, FFS)
Inpatient discharges for chronic conditions	1	OH (MCO)
Inpatient readmissions for chronic conditions	1	OH (MCO)
ER visits for chronic conditions	1	OH (MCO)
Access, Utilization, and Costs		
24/7 access to PCP coverage	1	AK (PCCM)
Outpatient drug utilization – average cost and number of prescriptions per member per month (PMPM)	1	GA (MCO, FFS)
Access – unduplicated Medicaid members served	1	ME (PCCM)
Medicaid costs[1]	1	ME (PCCM)

[1] No additional details on specific Medicaid costs were provided by Maine in the survey.

TABLE 1c-A3, Continued

Measure	Total States Reporting	State/Program
Care Coordination		
Care management rate of all members	1	OH (MCO)
Care management rate of high-risk members	1	OH (MCO)
Satisfaction and Quality of Life		
Days of work or school lost due to patient's health condition	1	NE (PCCM)
Self-reported health status	1	NE (PCCM)
SF-12 and SF-10 functional status surveys	1	TX (PCCM, PHP, FFS)
Disease Management Association of America (DMAA) client satisfaction survey	1	TX (PCCM, PHP, FFS)
Additional Measures		
Inpatient preoperative antibiotics	1	AK (PCCM, FFS)
Prevalence of pressure ulcers	1	AZ (elderly and disabled long term care population)
Transport timeliness	1	FL (MCO)
Transport availability	1	FL (MCO)
Generic medications as a percent of all prescription fills	1	NC (PCCM for Medicaid non-duals only)
Adolescent preventive care measures – assessment or counseling for risk behaviors, depression, tobacco use, and alcohol/substance use	1	NY (MCO)
Annual dental visits for members with developmental disabilities	1	PA (MCO)

Note: Several measures in the table could apply to the general population, but given service use patterns for Medicaid enrollees with disabilities and persons dually eligible for Medicaid and Medicare, certain overall population measures such as avoidable hospitalization rate, hospital readmissions, ER diversion, etc., may be particularly relevant for these more complex populations. PCCM is primary care case management; PHP is non-comprehensive prepaid health plan (a prepaid plan that provides, arranges for, or otherwise has responsibility for a defined set of services, such as only behavioral health or dental services); MCO is managed care organization.

Source: Gifford et al. 2011

Medicaid and CHIP Program Statistics: March 2012 MACStats

MACStats Table of Contents

Overview of MACStats

MACStats is a standing section in all Commission Reports to the Congress. It was created because data and information on the Medicaid and CHIP programs can be difficult to find and are spread across a variety of sources. In this Report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, optional Medicaid benefits covered, and federal medical assistance percentages (FMAPs), as well as an overview of cost sharing permitted under Medicaid, and the dollar amounts of common federal poverty levels (FPLs) used to determine eligibility for Medicaid and CHIP. It also provides information that places these programs in the broader context of state budgets and national health expenditures. In addition, it supplements Chapter 3 (State Approaches for Financing Medicaid and Update on Federal Financing of CHIP) of this Report with relevant state-level data.

TABLE 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2011

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

Medicaid and CHIP Enrollment	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	69.3 million	54.6 million	Not available
CHIP	8.2 million	5.6 million	Not available
Totals for Medicaid and CHIP	77.5 million	60.2 million	49.7 million
U.S. Population	**Census Bureau**		**Survey Data (NHIS)**
	312.6 million	311.5 million	305.2 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	24.8% (77.5/312.6)	19.3% (60.2/311.5)	16.3% (49.7/305.2)

Notes: Excludes U.S. territories. Medicaid and CHIP enrollment numbers obtained from administrative data include individuals who received limited benefits (e.g., emergency services only). Administrative data are estimates for fiscal year 2011 (October 2010 through September 2011). By combining administrative totals from Medicaid and CHIP, some individuals may be double-counted if they were enrolled in both programs during the year. Overcounting of enrollees in the administrative data may occur for other reasons—for example, individuals may move and be enrolled in two states' Medicaid programs during the year. NHIS data are based on interviews conducted between January and June 2011. NHIS excludes individuals in institutions, such as nursing homes, and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage and respondents are known to underreport Medicaid and CHIP coverage. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of December 2011 (the month with the largest count); a number of residents ever living in the U.S. during the year is not available. The Census Bureau point-in-time number is the average estimated monthly number of U.S. residents for 2011.

Sources: MACPAC analysis based on the following: MACPAC communication with CMS Office of the Actuary; analysis of National Health Interview Survey (NHIS) by the National Center for Health Statistics for MACPAC; Department of Health and Human Services (HHS), *Fiscal year 2013 budget in brief*, 2012, http://www.hhs.gov/budget/budget-brief-fy2013.pdf; HHS, *Connecting kids to coverage: Steady growth, new innovation—2011 CHIPRA annual report*, http://www.insurekidsnow.gov/chipraannualreport.pdf; and Bureau of the Census, Population estimates, national totals: Vintage 2011, http://www.census.gov/popest/data/national/totals/2011/index.html

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

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

Sources of Data

The sources for Medicaid and CHIP enrollment numbers can be categorized as either administrative data or survey data. Administrative data are compiled by states and the federal government in the course of administering the Medicaid and CHIP programs. The administrative totals shown in Table 1 were estimated by CMS in part based on information submitted by state Medicaid and CHIP programs.

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

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

Enrollment Period Examined

Another key consideration that affects Medicaid and CHIP enrollment numbers, even when they are derived from the same data source, is the enrollment period examined. For example, as shown in Table 1, administrative data found that an estimated 69.3 million individuals were ever enrolled in Medicaid during the year, even if for a single month. But if looking at the number enrolled at a single point in time during the year, the estimated number of Medicaid enrollees is much smaller—54.6 million.[1] The number enrolled at a point in time will always be smaller than the number ever enrolled over a period of time.

Individuals Included in Data

In spite of examining the same enrollment period—point in time—large differences still exist between the Medicaid and CHIP enrollment reported from the administrative data (60.2 million) and the survey data (49.7 million). Not only is there a difference in how surveys and administrative data count Medicaid and CHIP enrollment, but different individuals are included in each data source.

Surveys like the NHIS generally interview the non-institutionalized U.S. civilian population. Active-duty members of the military are excluded, as are individuals living in institutions like nursing homes. This causes survey data to produce lower Medicaid and CHIP enrollment numbers.

The administrative data totals also include several million individuals who are receiving only limited Medicaid benefits. For example, for some low-income Medicare enrollees, Medicaid helps to pay for their Medicare out-of-pocket expenses.

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

Other limited-benefit Medicaid enrollees include those who receive only family planning services; Medicaid can also pay for limited coverage of emergency services for low-income individuals who are ineligible for Medicaid solely because they are not U.S. citizens, nationals, or qualified aliens. Surveys generally do not count single-benefit plans as health insurance coverage. This is another reason why enrollment numbers from administrative data can be higher than from surveys.

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

Conclusion

Medicaid and CHIP enrollment numbers are available from a variety of sources. Each may produce unique insights into the programs and their enrollees' characteristics; however, the total number of enrollees can vary substantially across the different sources. Much of this is attributable to differences resulting from the sources of data, the individuals included in the data, and the enrollment period examined.

TABLE 2. Medicaid Enrollment by State and Selected Characteristics, FY 2009 (thousands)

State	Total Medicaid Enrollment	Basis of Eligibility				Eligible on the Basis of Disability[1]		
		Child	Adult	Disabled[1]	Aged	Disabled total	Medicaid-only[2]	Dual eligible[2]
Total	**62,126**	**29,993**	**16,580**	**9,445**	**6,107**	**9,445**	**5,822**	**3,623**
Alabama	**955**	468	160	206	121	**206**	119	86
Alaska	**117**	66	28	15	8	**15**	9	6
Arizona	**1,721**	769	711	139	102	**139**	85	54
Arkansas	**680**	356	116	138	70	**138**	85	53
California	**10,941**	4,225	4,722	999	995	**999**	654	345
Colorado	**632**	375	113	88	57	**88**	54	34
Connecticut	**587**	304	145	69	69	**69**	31	38
Delaware	**207**	87	83	24	14	**24**	13	11
District of Columbia	**168**	75	41	36	16	**36**	28	9
Florida	**3,420**	1,730	680	565	445	**565**	345	220
Georgia	**1,819**	1,054	305	289	171	**289**	179	110
Hawaii	**243**	99	93	26	24	**26**	16	10
Idaho	**223**	137	30	39	17	**39**	23	16
Illinois	**2,660**	1,429	718	304	208	**304**	173	132
Indiana	**1,113**	619	251	158	85	**158**	80	78
Iowa	**514**	240	155	77	43	**77**	37	40
Kansas	**373**	209	55	73	36	**73**	41	31
Kentucky	**876**	411	141	229	96	**229**	143	86
Louisiana	**1,113**	577	211	212	113	**212**	137	76
Maine	**352**	124	105	62	61	**62**	28	33
Maryland	**841**	411	226	131	73	**131**	86	44
Massachusetts[3]	**1,489**	432	394	500	162	**500**	385	116
Michigan	**2,006**	1,104	437	328	138	**328**	197	131
Minnesota	**880**	417	242	124	96	**124**	65	60
Mississippi	**754**	380	124	161	89	**161**	97	64
Missouri	**1,062**	575	190	203	94	**203**	113	90
Montana	**115**	63	21	20	11	**20**	13	7
Nebraska	**242**	136	45	37	24	**37**	17	19

TABLE 2, Continued

State	Total Medicaid Enrollment	Basis of Eligibility				Eligible on the Basis of Disability[1]		
		Child	Adult	Disabled[1]	Aged	Disabled total	Medicaid-only[2]	Dual eligible[2]
Nevada	**291**	168	56	41	26	**41**	24	16
New Hampshire	**159**	95	22	27	15	**27**	12	15
New Jersey	**986**	534	134	169	149	**169**	101	68
New Mexico	**540**	332	110	62	36	**62**	39	23
New York	**5,208**	2,001	1,961	655	591	**655**	429	226
North Carolina	**1,795**	937	368	308	182	**308**	171	137
North Dakota	**75**	39	16	11	9	**11**	5	6
Ohio	**2,114**	1,036	529	373	176	**373**	225	147
Oklahoma	**771**	431	159	115	67	**115**	63	52
Oregon	**564**	287	132	91	55	**91**	50	41
Pennsylvania	**2,304**	1,037	467	562	237	**562**	387	176
Rhode Island	**196**	89	47	39	21	**39**	24	14
South Carolina	**875**	443	202	147	83	**147**	82	66
South Dakota	**124**	73	21	18	13	**18**	9	8
Tennessee	**1,496**	752	290	304	149	**304**	166	138
Texas	**4,488**	2,833	617	598	440	**598**	384	214
Utah[3]	**295**	161	82	37	15	**37**	21	16
Vermont	**182**	67	72	23	20	**23**	10	13
Virginia	**927**	502	153	166	106	**166**	92	74
Washington	**1,159**	654	235	182	88	**182**	114	68
West Virginia	**417**	198	62	115	42	**115**	75	40
Wisconsin[3]	**974**	399	287	142	146	**142**	80	62
Wyoming	**82**	54	12	11	6	**11**	6	5

Notes: Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month; however, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories.

Although state-level information is not yet available, the estimated number of individuals ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 66.7 million for FY 2010; 69.3 million for FY 2011; 70.7 million for FY 2012; and 71.0 million for FY 2013. These FY 2010–FY 2013 figures exclude about one million enrollees in the territories (MACPAC communication with CMS Office of the Actuary, February 2012).

1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged."

2 Dual eligibles are enrolled in both Medicaid and Medicare; includes those who only receive Medicaid assistance with Medicare premiums and cost sharing and those who also receive full Medicaid benefits. Medicaid-only enrollees are individuals who are not dual eligibles.

3 FY 2009 data unavailable for Massachusetts, Utah, and Wisconsin; FY 2008 values shown instead.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data from CMS as of February 2012

TABLE 3. CHIP Enrollment by State, FY 2011

State	Program Type[1] (as of January 1, 2012)	Children			Adults			Total CHIP Enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Parents	Pregnant women	Total adults enrolled	
Total	–	**2,272,496**	**5,696,103**	**7,968,599**	**217,056**	**9,141**	**226,197**	**8,194,796**
Alabama	Separate	–	109,255	**109,255**	–	–	–	**109,255**
Alaska	Medicaid Expansion	12,787	–	**12,787**	–	–	–	**12,787**
Arizona	Separate	–	20,043	**20,043**	–	–	–	**20,043**
Arkansas	Combination	100,324	3,369	**103,693**	9,098	–	**9,098**	**112,791**
California	Combination	411,834	1,351,997	**1,763,831**	–	–	–	**1,763,831**
Colorado	Separate	–	105,255	**105,255**	–	4,299	**4,299**	**109,554**
Connecticut	Separate	–	20,072	**20,072**	–	–	–	**20,072**
Delaware	Combination	2,697	12,651	**15,348**	–	–	–	**15,348**
District of Columbia	Medicaid Expansion	8,675	–	**8,675**	–	–	–	**8,675**
Florida	Combination	915	430,802	**431,717**	–	–	–	**431,717**
Georgia	Separate	–	248,536	**248,536**	–	–	–	**248,536**
Hawaii	Medicaid Expansion	30,584	–	**30,584**	–	–	–	**30,584**
Idaho	Combination	19,693	22,911	**42,604**	443	–	**443**	**43,047**
Illinois	Combination	165,395	171,490	**336,885**	–	–	–	**336,885**
Indiana	Combination	111,099	47,039	**158,138**	–	–	–	**158,138**
Iowa	Combination	21,019	54,114	**75,133**	–	–	–	**75,133**
Kansas	Separate	–	60,431	**60,431**	–	–	–	**60,431**
Kentucky	Combination	51,773	32,778	**84,551**	–	–	–	**84,551**
Louisiana	Combination	142,558	9,846	**152,404**	–	–	–	**152,404**
Maine	Combination	22,430	10,564	**32,994**	–	–	–	**32,994**
Maryland	Medicaid Expansion	119,906	–	**119,906**	–	–	–	**119,906**
Massachusetts	Combination	66,349	78,418	**144,767**	–	–	–	**144,767**
Michigan	Combination	13,549	69,455	**83,004**	–	–	–	**83,004**
Minnesota	Combination	150	4,311	**4,461**	–	–	–	**4,461**
Mississippi	Separate	–	91,470	**91,470**	–	–	–	**91,470**
Missouri	Combination	56,008	37,726	**93,734**	–	–	–	**93,734**
Montana	Combination	–	24,365	**24,365**	–	–	–	**24,365**

TABLE 3, Continued

State	Program Type[1] (as of January 1, 2012)	Children			Adults			Total CHIP Enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Parents	Pregnant women	Total adults enrolled	
Nebraska	Medicaid Expansion	52,852	–	**52,852**	–	–	–	**52,852**
Nevada	Separate	–	29,760	**29,760**	9	409	**418**	**30,178**
New Hampshire	Combination	584	10,217	**10,801**	–	–	–	**10,801**
New Jersey	Combination	80,386	117,897	**198,283**	190,956	332	**191,288**	**389,571**
New Mexico	Medicaid Expansion	9,635	–	**9,635**	16,550	–	**16,550**	**26,185**
New York	Separate	–	552,068	**552,068**	–	–	–	**552,068**
North Carolina	Combination	57,330	197,130	**254,460**	–	–	–	**254,460**
North Dakota	Combination	2,147	4,965	**7,112**	–	–	–	**7,112**
Ohio	Medicaid Expansion	280,650	–	**280,650**	–	–	–	**280,650**
Oklahoma	Combination	114,597	5,904	**120,501**	–	–	–	**120,501**
Oregon	Separate	–	112,165	**112,165**	–	–	–	**112,165**
Pennsylvania	Separate	–	272,492	**272,492**	–	–	–	**272,492**
Rhode Island	Combination	23,185	1,630	**24,815**	–	283	**283**	**25,098**
South Carolina	Medicaid Expansion	72,084	–	**72,084**	–	–	–	**72,084**
South Dakota	Combination	12,630	3,993	**16,623**	–	–	–	**16,623**
Tennessee	Combination	30,242	65,786	**96,028**	–	–	–	**96,028**
Texas	Separate	–	972,715	**972,715**	–	–	–	**972,715**
Utah	Separate	–	59,698	**59,698**	–	–	–	**59,698**
Vermont	Separate	–	7,054	**7,054**	–	–	–	**7,054**
Virginia	Combination	86,782	95,346	**182,128**	–	3,818	**3,818**	**185,946**
Washington	Separate	–	43,364	**43,364**	–	–	–	**43,364**
West Virginia	Separate	–	37,631	**37,631**	–	–	–	**37,631**
Wisconsin	Combination	91,647	80,804	**172,451**	–	–	–	**172,451**
Wyoming	Separate	–	8,586	**8,586**	–	–	–	**8,586**

Notes: 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 a separate CHIP program for the second half), the individual would only be counted in the most recent category. CHIP-funded coverage of childless adults was prohibited after December 31, 2009. New Jersey and Rhode Island cover targeted low-income pregnant women under a CHIP state plan option; all other CHIP-funded coverage of adults in FY 2011 was permitted through waivers.

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

Sources: For numbers of children: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) from CMS as of February 9, 2012, as reported by states; for numbers of adults: CMS analysis for MACPAC of SEDS as of February 1, 2012, as reported by states; for CHIP program type: CMS, "Children's Health Insurance Program Plan Activity as of January 1, 2012"

TABLE 4. Child Enrollment in Medicaid-financed Coverage by State, and CHIP-financed Coverage by State and Family Income, FY 2011

State	Medicaid-financed Children[1]	CHIP-financed Children (Medicaid-expansion and Separate CHIP Coverage)						
		At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		CHIP-financed children
	All incomes	Number	Percentage	Number	Percentage	Number	Percentage	
Total	**35,571,506**	**6,995,095**	**87.8%**	**800,950**	**10.1%**	**172,554**	**2.2%**	**7,968,599**
Alabama	**866,094**	90,666	83.0	13,218	12.1	5,371	4.9	**109,255**
Alaska	**79,286**	12,787	100.0	–	–	–	–	**12,787**
Arizona	**946,977**	20,043	100.0	–	–	–	–	**20,043**
Arkansas	**410,602**	103,693	100.0	–	–	–	–	**103,693**
California	**4,565,016**	1,494,349	84.7	257,795	14.6	11,687	0.7	**1,763,831**
Colorado	**453,719**	93,986	89.3	11,269	10.7	–	–	**105,255**
Connecticut	**301,545**	11,737	58.5	2,452	12.2	5,883	29.3	**20,072**
Delaware[2]	**93,598**	15,348	100.0	–	–	–	–	**15,348**
District of Columbia	**106,500**	–	–	8,675	100.0	–	–	**8,675**
Florida	**2,019,075**	431,717	100.0	–	–	–	–	**431,717**
Georgia	**1,168,338**	125,014	50.3	121,703	49.0	1,819	0.7	**248,536**
Hawaii	**140,150**	26,505	86.7	3,033	9.9	1,046	3.4	**30,584**
Idaho	**178,249**	42,604	100.0	–	–	–	–	**42,604**
Illinois	**2,178,950**	336,885	100.0	–	–	–	–	**336,885**
Indiana	**698,383**	144,059	91.1	14,079	8.9	–	–	**158,138**
Iowa	**306,158**	64,119	85.3	1,818	2.4	9,196	12.2	**75,133**
Kansas	**215,703**	57,155	94.6	3,175	5.3	101	0.2	**60,431**
Kentucky	**478,670**	84,551	100.0	–	–	–	–	**84,551**
Louisiana	**671,651**	146,787	96.3	5,617	3.7	–	–	**152,404**
Maine[3]	**142,931**	32,994	100.0	–	–	–	–	**32,994**
Maryland	**465,409**	54,746	45.7	60,127	50.1	5,033	4.2	**119,906**
Massachusetts	**500,534**	115,156	79.5	19,332	13.4	10,279	7.1	**144,767**
Michigan	**1,205,449**	83,004	100.0	–	–	–	–	**83,004**
Minnesota	**495,509**	4,238	95.0	54	1.2	169	3.8	**4,461**
Mississippi	**468,183**	91,470	100.0	–	–	–	–	**91,470**
Missouri	**566,293**	80,381	85.8	9,281	9.9	4,072	4.3	**93,734**
Montana	**76,514**	24,365	100.0	–	–	–	–	**24,365**
Nebraska	**166,277**	52,852	100.0	–	–	–	–	**52,852**

TABLE 4, Continued

State	Medicaid-financed Children[1]	CHIP-financed Children (Medicaid-expansion and Separate CHIP Coverage)						
		At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		CHIP-financed children
	All incomes	Number	Percentage	Number	Percentage	Number	Percentage	
Nevada	**236,360**	28,334	95.2%	1,121	3.8%	305	1.0%	**29,760**
New Hampshire	**96,625**	2,235	20.7	5,584	51.7	2,982	27.6	**10,801**
New Jersey	**639,764**	150,800	76.1	27,372	13.8	20,111	10.1	**198,283**
New Mexico	**380,373**	3,608	37.4	6,027	62.6	–	–	**9,635**
New York	**2,124,322**	401,561	72.7	87,279	15.8	63,228	11.5	**552,068**
North Carolina	**1,194,999**	246,228	96.8	3,419	1.3	4,813	1.9	**254,460**
North Dakota	**48,486**	7,112	100.0	–	–	–	–	**7,112**
Ohio	**1,214,287**	280,650	100.0	–	–	–	–	**280,650**
Oklahoma	**507,378**	83,642	69.4	36,859	30.6	–	–	**120,501**
Oregon	**385,131**	104,824	93.5	5,310	4.7	2,031	1.8	**112,165**
Pennsylvania	**1,300,042**	234,969	86.2	27,031	9.9	10,492	3.9	**272,492**
Rhode Island	**110,208**	21,744	87.6	3,071	12.4	–	–	**24,815**
South Carolina	**501,025**	69,941	97.0	1,696	2.4	447	0.6	**72,084**
South Dakota[2]	**47,469**	16,623	100.0	–	–	–	–	**16,623**
Tennessee	**792,302**	56,486	58.8	39,542	41.2	–	–	**96,028**
Texas	**3,471,310**	972,715	100.0	–	–	–	–	**972,715**
Utah	**247,298**	59,698	100.0	–	–	–	–	**59,698**
Vermont	**72,826**	–	–	3,329	47.2	3,725	52.8	**7,054**
Virginia	**625,438**	182,128	100.0	–	–	–	–	**182,128**
Washington	**764,662**	14,139	32.6	19,461	44.9	9,764	22.5	**43,364**
West Virginia	**249,203**	35,497	94.3	2,134	5.7	–	–	**37,631**
Wisconsin	**537,093**	172,364	99.9	87	0.1	–	–	**172,451**
Wyoming	**59,142**	8,586	100.0	–	–	–	–	**8,586**

Notes: The definition in this table for Medicaid-financed children may differ from that used elsewhere in this report. This table includes children with and without disabilities; in tables using Medicaid eligibility categories, children qualifying on the basis of a disability are counted in the "disabled" category, not the "child" category.

In 2012, 200 percent of the federal poverty level (FPL) is $22,340 for an individual and $7,920 for each additional family member in the lower 48 states and the District of Columbia. For additional information, see MACStats Table 19.

Enrollment numbers generally include children ever enrolled during the year, even if for a single month; however, in the event children were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half), the child would only be counted in the most recent category.

1 MACPAC analysis of Statistical Enrollment Data System (SEDS), as reported by states, found that 99.5 percent of Medicaid-financed children were at or below 200 percent FPL.

2 In SEDS, Delaware and South Dakota reported several thousand CHIP enrollees above 200 percent FPL, even though their CHIP programs are reported to only cover individuals up to 200 percent FPL; the numbers here were altered to put all of these enrollees at or below 200 percent FPL.

3 Maine data are from FY 2010.

Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from CMS as of February 9, 2012, as reported by states

TABLE 5. Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2011

		Managed Care		Fee for Service		Primary Care Case Management	
State	Total[1]	Number	Percentage	Number	Percentage	Number	Percentage
Total	**5,696,103**	**4,655,970**	**81.7%**	**763,166**	**13.4%**	**276,967**	**4.9%**
Alabama	**109,255**	–	–	109,255	100.0	–	–
Alaska	–	–	–	–	–	–	–
Arizona	**20,043**	19,168	95.6	875	4.4	–	–
Arkansas	**3,369**	–	–	3,369	100.0	–	–
California	**1,351,997**	1,194,841	88.4	157,156	11.6	–	–
Colorado	**105,255**	105,255	100.0	–	–	–	–
Connecticut	**20,072**	20,072	100.0	–	–	–	–
Delaware	**12,651**	11,930	94.3	–	–	721	5.7
District of Columbia	–	–	–	–	–	–	–
Florida	**430,802**	412,936	95.9	10,044	2.3	7,822	1.8
Georgia	**248,536**	235,944	94.9	12,592	5.1	–	–
Hawaii	–	–	–	–	–	–	–
Idaho	**22,911**	–	–	167	0.7	22,744	99.3
Illinois	**171,490**	4,592	2.7	51,629	30.1	115,269	67.2
Indiana	**47,039**	41,301	87.8	5,738	12.2	–	–
Iowa	**54,114**	54,114	100.0	–	–	–	–
Kansas	**60,431**	60,365	99.9	66	0.1	–	–
Kentucky	**32,778**	8,516	26.0	2,730	8.3	21,532	65.7
Louisiana	**9,846**	–	–	9,771	99.2	75	0.8
Maine[2]	**10,564**	–	–	2,126	20.1	8,438	79.9
Maryland	–	–	–	–	–	–	–
Massachusetts	**78,418**	30,218	38.5	30,286	38.6	17,914	22.8
Michigan	**69,455**	62,459	89.9	6,996	10.1	–	–
Minnesota	**4,311**	3,713	86.1	598	13.9	–	–
Mississippi	**91,470**	91,470	100.0	–	–	–	–
Missouri	**37,726**	14,887	39.5	22,839	60.5	–	–
Montana	**24,365**	–	–	24,365	100.0	–	–
Nebraska	–	–	–	–	–	–	–

TABLE 5, Continued

State	Total[1]	Managed Care		Fee for Service		Primary Care Case Management	
		Number	Percentage	Number	Percentage	Number	Percentage
Nevada	**29,760**	25,768	86.6%	3,992	13.4%	–	–
New Hampshire	**10,217**	10,217	100.0	–	–	–	–
New Jersey	**117,897**	114,901	97.5	2,996	2.5	–	–
New Mexico	–	–	–	–	–	–	–
New York	**552,068**	551,110	99.8	958	0.2	–	–
North Carolina	**197,130**	–	–	197,130	100.0	–	–
North Dakota	**4,965**	–	–	–	–	4,965	100.0%
Ohio	–	–	–	–	–	–	–
Oklahoma	**5,904**	–	–	5,904	100.0	–	–
Oregon	**112,165**	98,975	88.2	12,748	11.4	442	0.4
Pennsylvania	**272,492**	272,492	100.0	–	–	–	–
Rhode Island	**1,630**	1,630	100.0	–	–	–	–
South Carolina	–	–	–	–	–	–	–
South Dakota	**3,993**	–	–	1,257	31.5	2,736	68.5
Tennessee	**65,786**	–	–	–	–	65,786	100.0
Texas	**972,715**	972,715	100.0	–	–	–	–
Utah	**59,698**	59,698	100.0	–	–	–	–
Vermont	**7,054**	–	–	625	8.9	6,429	91.1
Virginia	**95,346**	78,802	82.6	14,641	15.4	1,903	2.0
Washington	**43,364**	25,343	58.4	17,830	41.1	191	0.4
West Virginia	**37,631**	–	–	37,631	100.0	–	–
Wisconsin	**80,804**	63,952	79.1	16,852	20.9	–	–
Wyoming	**8,586**	8,586	100.0	–	–	–	–

Notes: Enrollment numbers generally include children ever enrolled during the year, even if for a single month; however, in the event children were in multiple categories during the year the child would only be counted in the most recent category.

Categorizations of the types of delivery system are based on states' definitions and Statistical Enrollment Data System (SEDS) instructions to states. According to SEDS instructions, "managed care" includes arrangements under which the state contracts with a health maintenance or health insuring organization to provide a comprehensive set of services; enrollees choose a plan and a primary care provider (PCP) who will be responsible for managing their care. Under fee for service, providers submit claims to the state and are paid a specific amount for each service performed. Under primary care case management, providers are paid generally on a fee-for-service basis, but PCPs are paid an additional flat monthly fee for each patient assigned to them for case management.

1 Because this table shows enrollment only in separate CHIP programs, these totals do not include child enrollment in Medicaid-expansion CHIP programs.

2 Maine data are from FY 2010.

Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from CMS as of February 9, 2012, as reported by states

TABLE 6. Medicaid Spending by State, Category, and Source of Funds, FY 2011 (millions)

State	Benefits			State Program Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$4,793**	$3,535	$1,258	**$221**	$137	$84	**$5,014**	$3,672	$1,342
Alaska	**1,290**	837	453	**105**	59	46	**1,396**	896	499
Arizona	**8,988**	6,548	2,441	**156**	84	72	**9,144**	6,632	2,513
Arkansas	**3,952**	3,036	916	**201**	118	83	**4,153**	3,154	999
California	**54,065**	31,533	22,531	**4,488**	2,402	2,086	**58,553**	33,935	24,617
Colorado	**4,349**	2,457	1,892	**186**	99	86	**4,535**	2,556	1,978
Connecticut	**5,812**	3,253	2,560	**187**	101	86	**6,000**	3,354	2,646
Delaware	**1,392**	834	558	**77**	46	32	**1,469**	880	590
District of Columbia	**2,129**	1,581	548	**107**	56	51	**2,236**	1,637	599
Florida	**18,128**	11,375	6,753	**637**	346	291	**18,765**	11,721	7,044
Georgia	**8,065**	5,694	2,371	**400**	216	185	**8,465**	5,909	2,556
Hawaii	**1,524**	942	582	**71**	41	30	**1,595**	982	613
Idaho	**1,515**	1,132	383	**82**	48	35	**1,597**	1,180	417
Illinois	**12,836**	7,386	5,450	**679**	365	313	**13,515**	7,751	5,764
Indiana	**6,566**	4,717	1,849	**358**	195	162	**6,924**	4,913	2,012
Iowa	**3,317**	2,257	1,060	**130**	86	44	**3,447**	2,343	1,104
Kansas	**2,669**	1,734	935	**149**	84	65	**2,818**	1,818	1,000
Kentucky	**5,652**	4,322	1,330	**201**	142	59	**5,853**	4,464	1,389
Louisiana	**6,298**	4,722	1,576	**291**	194	96	**6,588**	4,916	1,672
Maine	**2,356**	1,656	700	**111**	62	50	**2,467**	1,718	749
Maryland	**7,320**	4,141	3,179	**286**	154	132	**7,606**	4,294	3,311
Massachusetts	**13,007**	7,409	5,599	**556**	312	244	**13,563**	7,721	5,842
Michigan	**12,063**	8,600	3,463	**515**	302	214	**12,578**	8,901	3,677
Minnesota	**8,271**	4,662	3,609	**409**	215	194	**8,680**	4,877	3,803
Mississippi	**4,411**	3,547	863	**140**	83	58	**4,551**	3,630	921
Missouri	**8,011**	5,540	2,472	**286**	168	119	**8,297**	5,707	2,590
Montana	**954**	710	245	**52**	30	22	**1,007**	740	267
Nebraska	**1,637**	1,050	587	**109**	62	47	**1,746**	1,112	635
Nevada	**1,563**	921	642	**95**	57	38	**1,658**	978	680
New Hampshire	**1,348**	761	587	**72**	42	31	**1,420**	803	617
New Jersey	**10,501**	5,866	4,635	**571**	312	260	**11,073**	6,177	4,895
New Mexico	**3,318**	2,551	766	**112**	65	47	**3,429**	2,616	813
New York	**51,712**	29,499	22,213	**1,296**	699	597	**53,008**	30,198	22,810
North Carolina	**10,297**	7,254	3,043	**649**	374	275	**10,946**	7,628	3,318
North Dakota	**702**	464	238	**44**	26	18	**746**	490	256

TABLE 6, Continued

State	Benefits			State Program Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Ohio	**$15,533**	$10,761	$4,772	**$522**	$297	$225	**$16,055**	$11,058	$4,997
Oklahoma	**4,008**	2,914	1,095	**273**	181	92	**4,282**	3,095	1,187
Oregon	**4,386**	3,023	1,364	**294**	153	141	**4,680**	3,175	1,505
Pennsylvania	**20,395**	12,680	7,715	**960**	548	412	**21,355**	13,228	8,128
Rhode Island	**2,099**	1,246	853	**80**	47	33	**2,178**	1,293	885
South Carolina	**4,931**	3,695	1,236	**156**	94	62	**5,086**	3,789	1,297
South Dakota	**750**	522	228	**36**	19	17	**786**	542	245
Tennessee	**7,970**	5,693	2,277	**414**	231	183	**8,384**	5,924	2,460
Texas	**27,847**	18,507	9,341	**1,248**	757	490	**29,095**	19,264	9,831
Utah	**1,733**	1,330	404	**121**	65	56	**1,854**	1,395	459
Vermont	**1,282**	834	448	**14**	11	4	**1,296**	845	452
Virginia	**6,894**	3,923	2,971	**235**	130	105	**7,129**	4,053	3,076
Washington	**7,335**	4,244	3,091	**552**	300	251	**7,887**	4,544	3,343
West Virginia	**2,740**	2,154	586	**124**	77	47	**2,864**	2,232	632
Wisconsin	**6,878**	4,538	2,341	**341**	198	143	**7,220**	4,736	2,483
Wyoming	**527**	304	223	**38**	22	16	**565**	326	239
Subtotal (States)	**$406,122**	**$258,890**	**$147,232**	**$19,437**	**$10,910**	**$8,527**	**$425,559**	**$269,800**	**$155,759**
American Samoa	**26**	13	13	**0**	0	0	**26**	13	13
Guam	**31**	16	15	**2**	1	1	**33**	17	16
Northern Mariana Islands	**27**	14	12	**0**	0	0	**27**	14	13
Puerto Rico	**1,667**	847	820	**49**	25	25	**1,717**	872	845
Virgin Islands	**35**	18	17	**4**	2	2	**38**	20	19
Subtotal (States & Territories)	**$407,907**	**$259,799**	**$148,109**	**$19,493**	**$10,938**	**$8,555**	**$427,400**	**$270,737**	**$156,663**
State Medicaid Fraud Control Units (MFCUs)	–	–	–	**287**	215	72	**287**	215	72
Medicaid survey and certification of nursing and intermediate care facilities	–	–	–	**288**	216	72	**288**	216	72
Vaccines for Children (VFC) program	–	–	–	–	–	–	**3,953**	3,953	–
Total	**$407,907**	**$259,799**	**$148,109**	**$20,068**	**$11,369**	**$8,698**	**$431,928**[1]	**$275,121**[1]	**$156,807**

Notes: Total federal spending shown here ($275.121 billion) differs from total federal outlays shown in FY 2013 federal budget documents ($274.964 billion) due to slight differences in the timing of data for the states and the treatment of certain adjustments. Federal spending in the territories is capped; however, territories report their total spending regardless of whether they have reached their caps. As a result, federal spending shown here may exceed the amounts actually paid to the territories. The federal share of total Medicaid spending nationally is generally 57 percent; the federal share was higher in FY 2011 due to a temporary increase in states' federal medical assistance percentages (FMAPs) under PL. 111-5 and PL. 111-226. State shares for MFCUs and survey and certification are MACPAC estimates based on 75 percent federal match; state-level estimates for these items are available but are not shown here. VFC is authorized in the Medicaid statute but is operated as a separate program; 100 percent federal funding finances the purchase of vaccines for children who are enrolled in Medicaid, uninsured, or privately insured without vaccine coverage. Spending on administration is only for state programs; spending for federal program administration is not included.

1 Amount exceeds the sum of Benefits and State Program Administration columns due to the inclusion of VFC.

Sources: For state and territory spending: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2012; for all other (MFCUs, survey and certification, VFC): CMS, *Fiscal Year 2013 justification of estimates for Appropriations Committees*, Baltimore, MD: CMS, 2012, https://www.cms.gov/PerformanceBudget/Downloads/CMSFY13CJ.pdf

TABLE 7. Total Medicaid Benefit Spending by State and Category, FY 2011 (millions)

State	Total Spending on Benefits	Fee for Service									Managed Care and Premium Assistance	Medicare Premiums and Coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Nursing facility and ICF-ID	Home and community-based LTSS			
Alabama	**$4,793**	$1,798	$325	$85	$36	$82	$200	$289	$935	$747	$102	$268	$-72
Alaska	**1,290**	340	101	53	18	206	88	33	126	319	0	23	-15
Arizona	**8,988**	885	41	4	5	98	244	-263	35	13	7,711	216	-1
Arkansas	**3,952**	1,107	284	65	17	177	329	159	784	774	15	296	-54
California	**54,065**	17,352	1,372	544	41	2,511	5,126	1,443	5,094	8,217	10,869	2,338	-842
Colorado	**4,349**	1,465	284	104	–	116	179	150	621	854	509	100	-32
Connecticut	**5,812**	1,055	99	158	90	275	104	279	1,502	1,332	843	310	-233
Delaware	**1,392**	76	22	32	1	44	52	75	209	154	709	34	-15
District of Columbia	**2,129**	449	53	20	3	109	78	55	330	397	614	34	-11
Florida	**18,128**	5,149	1,251	139	43	231	879	637	3,200	2,208	3,254	1,289	-152
Georgia	**8,065**	1,787	363	42	32	169	197	129	1,174	1,027	2,829	360	-46
Hawaii	**1,524**	128	5	28	2	28	7	3	10	104	1,251	56	-96
Idaho	**1,515**	515	153	3	25	124	79	41	267	224	65	40	-20
Illinois	**12,836**	5,446	878	174	106	335	679	481	2,279	1,868	359	393	-161
Indiana	**6,566**	1,675	204	152	10	307	270	320	1,492	871	1,135	170	-40
Iowa	**3,317**	792	181	59	87	68	231	132	855	681	159	140	-67
Kansas	**2,669**	497	101	36	5	28	63	75	515	650	635	88	-24
Kentucky	**5,652**	1,576	364	86	1	264	506	253	992	663	768	247	-68
Louisiana	**6,298**	2,462	523	123	–	199	319	573	1,337	844	14	270	-366
Maine	**2,356**	697	95	30	43	167	357	82	263	428	5	210	-21
Maryland	**7,320**	1,218	85	115	16	52	335	89	1,077	1,340	2,912	229	-148
Massachusetts	**13,007**	2,721	307	148	33	337	1,493	188	1,753	1,954	3,885	414	-226
Michigan	**12,063**	1,710	329	67	7	201	342	139	1,730	1,077	6,150	393	-83
Minnesota	**8,271**	823	219	31	193	43	150	163	948	2,424	3,247	181	-152
Mississippi	**4,411**	1,708	311	9	28	75	258	170	1,018	414	259	208	-46
Missouri	**8,011**	2,943	27	15	11	431	272	602	1,227	1,157	1,097	310	-80
Montana	**954**	276	51	22	15	14	100	33	176	234	7	33	-6
Nebraska	**1,637**	301	73	31	15	73	67	101	337	332	243	106	-42
Nevada	**1,563**	415	90	23	11	15	72	53	189	265	342	100	-12
New Hampshire	**1,348**	374	57	23	15	154	80	40	316	277	–	29	-17
New Jersey	**10,501**	2,427	62	25	47	385	817	294	2,628	1,281	2,274	340	-78
New Mexico	**3,318**	457	50	13	39	34	53	16	29	317	2,304	84	-78
New York	**51,712**	12,217	380	284	236	1,510	1,588	2,394	11,564	11,034	11,376	1,300	-2,171
North Carolina	**10,297**	3,018	950	329	34	232	653	621	1,709	2,203	356	441	-250

TABLE 7, Continued

State	Total Spending on Benefits	Fee for Service									Managed Care and Premium Assistance	Medicare Premiums and Coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Nursing facility and ICF-ID	Home and community-based LTSS			
North Dakota	**$702**	$120	$48	$11	$6	$11	$18	$22	$285	$171	$5	$12	$-6
Ohio	**15,533**	2,734	314	42	25	108	320	885	3,361	2,567	4,932	422	-176
Oklahoma	**4,008**	1,337	433	127	31	333	256	260	623	556	171	141	-261
Oregon	**4,386**	315	28	0	25	56	151	78	343	1,221	2,072	143	-46
Pennsylvania	**20,395**	2,474	214	87	9	128	387	-236	4,485	2,776	9,616	593	-138
Rhode Island	**2,099**	371	12	13	1	25	359	8	319	247	713	43	-13
South Carolina	**4,931**	1,460	244	97	26	250	223	40	668	585	1,355	181	-198
South Dakota	**750**	173	60	15	2	73	73	30	163	138	2	29	-9
Tennessee	**7,970**	974	26	183	1	39	81	352	355	708	4,959	349	-56
Texas	**27,847**	7,742	1,336	1,428	822	128	2,033	1,457	3,348	3,466	5,760	1,045	-718
Utah	**1,733**	574	119	36	4	15	87	102	228	212	366	22	-32
Vermont	**1,282**	44	2	0	0	1	855	-2	111	7	273	7	-16
Virginia	**6,894**	1,156	202	135	32	59	756	125	1,120	1,276	1,890	259	-115
Washington	**7,335**	1,583	272	137	23	403	295	249	739	1,541	1,890	317	-112
West Virginia	**2,740**	620	148	58	13	31	126	162	568	570	343	120	-18
Wisconsin	**6,878**	657	43	43	21	301	438	277	1,024	772	3,086	304	-87
Wyoming	**527**	139	50	13	8	33	23	21	106	133	0	10	-7
Subtotal	**$406,122**	**$98,329**	**$13,237**	**$5,495**	**$2,318**	**$11,086**	**$22,747**	**$13,676**	**$64,566**	**$63,627**	**$103,731**	**$15,045**	**$-7,736**
American Samoa	**26**	–	–	–	–	–	25	1	–	–	–	–	–
Guam	**31**	9	4	0	0	0	10	7	0	0	–	1	–
N. Mariana Islands	**27**	9	–	4	–	5	4	4	–	1	–	0	–
Puerto Rico	**1,667**	–	–	–	–	–	207	20	–	–	1,441	–	–
Virgin Islands	**35**	20	1	0	–	3	1	6	3	–	–	1	–
Total	**$407,907**	**$98,367**	**$13,242**	**$5,500**	**2,318**	**$11,094**	**$22,994**	**$13,713**	**$64,569**	**$63,628**	**$105,172**	**$15,047**	**$-7,736**
Percent of Total, Exclusive of Collections	–	**23.7%**	**3.2%**	**1.3%**	**0.6%**	**2.7%**	**5.5%**	**3.3%**	**15.5%**	**15.3%**	**25.3%**	**3.6%**	–

Notes: Service category definitions and spending amounts shown here may differ from other CMS data sources, such as the Medicaid Statistical Information System (MSIS). Includes federal and state funds. All amounts are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; they include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported for any given category sometimes show substantial annual fluctuations. ICF-ID is intermediate care facility for the intellectually disabled; LTSS is long-term services and supports. Hospital includes inpatient, outpatient, mental health facility, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments. Other practitioner includes nurse midwife, nurse practitioner, and other. Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center, and freestanding birth center. Other acute includes labs and X-rays; sterilizations; abortions; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; diagnostic screening and preventive services; school-based services; health home for persons with chronic conditions; tobacco cessation for pregnant women; and other care not otherwise categorized. Drugs are net of rebates. Home and community-based (HCB) includes home health, HCB waiver and state plan services, personal care, private duty nursing, case management (excluding primary care case management), rehabilitative services, and hospice. Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management (PCCM) fees, employer-sponsored premium assistance programs, and Programs of All-inclusive Care for the Elderly (PACE); comprehensive managed care plans account for the majority of spending in this category (22.3 percent of total benefits, exclusive of collections) followed by limited-benefit plans (2.5 percent) and PCCM, PACE, and premium assistance (which together were 0.5 percent). Collections include third-party liability, estate, and other recoveries.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2012

TABLE 8. CHIP Spending by State, FY 2011 (millions)

	Total CHIP[1]			Benefits						State Program Administration			2105(g) Spending[1]
				Medicaid-expansion CHIP programs			Separate CHIP programs and adult coverage waivers						
State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
Alabama	$185.4	$144.6	$40.8	–	–	–	$177.2	$138.2	$39.0	$8.2	$6.4	$1.8	–
Alaska	30.8	20.0	10.8	$29.5	$19.2	$10.3	–	–	–	1.3	0.8	0.5	–
Arizona	44.2	33.7	10.5	–	–	–	41.7	31.7	9.9	2.5	1.9	0.6	–
Arkansas	113.9	91.1	22.8	87.8	70.2	17.6	21.0	16.8	4.2	5.1	4.1	1.0	–
California	2,119.2	1,377.5	741.7	445.6	289.7	156.0	1,569.0	1,019.8	549.1	104.5	68.0	36.6	–
Colorado	164.7	107.1	57.7	–	–	–	162.1	105.4	56.7	2.6	1.7	0.9	–
Connecticut	34.3	35.5	-1.2	–	–	–	32.9	21.4	11.5	1.4	0.9	0.5	$13.2
Delaware	21.0	14.1	6.9	0.8	0.5	0.3	18.6	12.5	6.1	1.6	1.1	0.5	–
District of Columbia	15.9	12.6	3.3	15.6	12.3	3.3	–	–	–	0.4	0.3	0.1	–
Florida	486.1	334.2	151.9	2.6	1.8	0.8	445.8	306.5	139.3	37.8	26.0	11.8	–
Georgia	325.9	246.8	79.0	–	–	–	300.0	227.2	72.8	25.8	19.6	6.3	–
Hawaii	44.8	29.7	15.1	41.8	27.7	14.1	0.2	0.1	0.1	2.7	1.8	0.9	–
Idaho	49.1	38.4	10.7	21.7	17.0	4.7	26.1	20.4	5.7	1.3	1.0	0.3	–
Illinois	361.1	235.2	125.9	110.6	72.1	38.6	234.6	152.8	81.8	15.9	10.4	5.5	–
Indiana	117.9	90.2	27.6	76.2	58.4	17.9	38.5	29.4	9.0	3.2	2.4	0.7	–
Iowa	109.8	81.1	28.7	23.1	17.1	6.1	79.5	58.7	20.8	7.2	5.3	1.9	–
Kansas	76.7	54.7	22.0	–	–	–	70.4	50.2	20.2	6.3	4.5	1.8	–
Kentucky	169.3	135.5	33.8	105.9	84.8	21.1	59.8	47.9	11.9	3.5	2.8	0.7	–
Louisiana	219.8	163.8	56.0	184.7	137.6	47.0	19.6	14.6	5.0	15.5	11.6	3.9	–
Maine	41.5	31.0	10.5	23.7	17.7	6.0	13.7	10.2	3.5	4.2	3.1	1.1	–
Maryland	218.4	142.0	76.5	209.3	136.1	73.3	–	–	–	9.1	5.9	3.2	–
Massachusetts	534.1	347.1	187.0	237.4	154.3	83.2	243.3	158.1	85.2	53.3	34.7	18.7	–
Michigan	100.5	76.2	24.3	12.7	9.7	3.0	82.4	62.4	20.0	5.4	4.1	1.3	–
Minnesota	19.3	23.6	-4.4	0.1	0.1	0.0	18.9	12.3	6.6	0.3	0.2	0.1	11.1
Mississippi	195.2	160.7	34.5	–	–	–	194.9	160.4	34.5	0.3	0.2	0.0	–
Missouri	145.4	108.0	37.4	99.3	73.8	25.5	42.3	31.5	10.9	3.8	2.8	1.0	–
Montana	61.6	47.3	14.3	15.1	11.6	3.5	40.3	31.0	9.3	6.1	4.7	1.4	–
Nebraska	57.3	40.6	16.7	54.2	38.4	15.8	–	–	–	3.1	2.2	0.9	–
Nevada	36.3	24.0	12.3	1.3	0.8	0.5	33.1	21.9	11.2	1.9	1.3	0.6	–
New Hampshire	19.7	15.3	4.4	0.6	0.4	0.2	18.4	11.9	6.4	0.7	0.5	0.2	2.5
New Jersey	954.3	620.5	333.8	164.4	106.9	57.5	694.5	451.6	242.9	95.4	62.0	33.4	–
New Mexico	187.3	147.7	39.6	72.9	57.5	15.4	114.0	89.9	24.1	0.4	0.3	0.1	–

TABLE 8, Continued

State	Total CHIP[1]			Benefits						State Program Administration			2105(g) Spending[1]
				Medicaid-expansion CHIP programs			Separate CHIP programs and adult coverage waivers						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
New York	$820.4	$533.3	$287.1	$165.7	$107.7	$58.0	$650.4	$422.8	$227.6	$4.3	$2.8	$1.5	–
North Carolina	381.4	287.2	94.2	62.5	47.0	15.4	291.1	219.2	71.9	27.9	21.0	6.9	–
North Dakota	21.9	15.8	6.1	10.0	7.2	2.8	10.8	7.8	3.0	1.1	0.8	0.3	–
Ohio	353.3	263.5	89.8	348.0	259.5	88.5	–	–	–	5.4	4.0	1.4	–
Oklahoma	125.7	94.9	30.8	115.3	87.0	28.3	7.7	5.8	1.9	2.8	2.1	0.7	–
Oregon	159.1	117.7	41.4	–	–	–	149.4	110.5	38.8	9.7	7.2	2.5	–
Pennsylvania	410.5	283.1	127.5	–	–	–	403.9	278.5	125.4	6.6	4.6	2.1	–
Rhode Island	33.7	22.6	11.1	21.8	14.7	7.2	11.1	7.4	3.7	0.8	0.5	0.2	–
South Carolina	121.2	95.9	25.4	111.4	88.0	23.4	0.6	0.5	0.1	9.3	7.4	1.9	–
South Dakota	24.4	17.7	6.6	18.0	13.1	4.9	5.9	4.3	1.6	0.5	0.3	0.1	–
Tennessee	209.0	158.4	50.6	54.1	40.5	13.7	149.6	113.9	35.7	5.3	4.0	1.3	–
Texas	1,178.2	852.8	325.4	28.8	20.9	8.0	1,093.6	791.6	302.0	55.8	40.4	15.4	–
Utah	64.0	51.0	12.9	–	–	–	57.6	45.9	11.6	6.4	5.1	1.3	–
Vermont	7.6	8.1	-0.5	–	–	–	7.0	4.9	2.0	0.7	0.5	0.2	$2.7
Virginia	266.6	173.3	93.3	119.8	77.9	41.9	138.4	89.9	48.4	8.4	5.5	2.9	–
Washington	97.4	74.6	22.8	12.3	8.0	4.3	84.6	55.0	29.6	0.5	0.3	0.2	11.3
West Virginia	51.0	41.5	9.6	–	–	–	47.8	38.8	9.0	3.2	2.6	0.6	–
Wisconsin	143.3	106.7	36.6	55.7	40.0	15.7	74.2	53.5	20.7	13.5	9.7	3.8	3.5
Wyoming	15.7	10.2	5.5	–	–	–	14.9	9.7	5.2	0.8	0.5	0.3	–
Subtotal	**$11,745.2**	**$8,238.2**	**$3,507.0**	**$3,160.4**	**$2,226.7**	**$933.6**	**$7,991.0**	**$5,555.2**	**$2,435.8**	**$593.9**	**$412.0**	**$181.9**	**$44.4**
American Samoa	1.4	0.9	0.5	1.4	0.9	0.5	–	–	–	–	–	–	–
Guam	6.1	4.2	1.9	6.1	4.2	1.9	–	–	–	–	–	–	–
N. Mariana Islands	1.0	0.9	0.2	1.0	0.9	0.2	–	–	–	–	–	–	–
Puerto Rico	201.5	132.6	69.0	201.5	132.6	69.0	–	–	–	–	–	–	–
Virgin Islands	3.5	2.4	1.1	3.5	2.4	1.1	–	–	–	–	–	–	–
Total	**$11,958.8**	**$8,379.2**	**$3,579.7**	**$3,374.0**	**$2,367.7**	**$1,006.3**	**$7,991.0**	**$5,555.2**	**$2,435.8**	**$593.9**	**$412.0**	**$181.9**	**$44.4**

Notes: As shown in Table 3, some states have waivers under Section 1115 of the Social Security Act that use CHIP funds to provide coverage for adults (pregnant women and parents). Federal CHIP spending on administration is generally limited to 10 percent of a state's total federal CHIP spending for the year. States with a Medicaid-expansion CHIP program may elect to receive reimbursement for administrative spending from Medicaid rather than CHIP funds; Medicaid funds are not shown in this table.

1 Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level. Since there is no state share of CHIP spending for these children (because their state share is financed entirely under Medicaid), some states (Connecticut, Minnesota, and Vermont) are shown in this table as having negative state CHIP spending.

Source: MACPAC analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data from CMS as of February 2012

TABLE 9. Medicaid and CHIP Income Eligibility Levels as a Percentage of the Federal Poverty Level for Children and Pregnant Women by State, February 2012

As described in Chapter 3 of the Commission's March 2011 Report to the Congress, states' Medicaid eligibility levels for children under age 19 in effect as of March 31, 1997 continue to be financed by Medicaid. Any expansion above those levels—through expansions of Medicaid or through separate CHIP programs—are generally financed by CHIP. Adult pregnant women can receive Medicaid- or CHIP-funded services through regular state plan eligibility pathways or Section 1115 waivers; in addition, the unborn children of pregnant women may receive CHIP-funded coverage under a state plan option. Deemed newborns are infants up to age 1 who are deemed eligible for Medicaid or CHIP—with no separate application or eligibility determination required—if their mother was enrolled at the time of their birth.

	Medicaid Coverage							Separate CHIP Coverage		Medicaid/CHIP Coverage
	Infants under age 1		Age 1 through 5		Age 6 through 18					
State	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2012)	Birth through age 18	Unborn children	Pregnant women and deemed newborns[3]
Alabama	133%	–	133%	–	100%	–	Separate	300%	–	133%
Alaska	133	175%	133	175%	100	175%	Medicaid Expansion	–	–	175
Arizona	140	–	133	–	100	–	Separate	200[4]	–	150
Arkansas[5]	133	200	133	200	100	200	Combination	200	200%	200
California[6]	200	250	133	250	100	250	Combination	250/300[7]	300	200
Colorado	133	–	133	–	100	–	Separate	250	–	133/200[8]
Connecticut	185	–	185	–	185	–	Separate	300	–	250
Delaware	133	200	133	–	100	–	Combination	200	–	200
District of Columbia	185	300	133	300	100	300	Medicaid Expansion	–	–	300
Florida	185	200	133	–	100	–	Combination	200	–	185
Georgia	185	–	133	–	100	–	Separate	235	–	200
Hawaii	185	300	133	300	100	300	Medicaid Expansion	–	–	185
Idaho	133	–	133	–	100	133	Combination	185	–	133
Illinois	133	–	133	–	100	133	Combination	200	200	200
Indiana	150	–	133	150	100	150	Combination	250[9]	–	200
Iowa	185	300	133	–	100	133	Combination	300	–	300
Kansas	150	–	133	–	100	–	Separate	241	–	150
Kentucky	185	–	133	150	100	150	Combination	200	–	185
Louisiana	133	200	133	200	100	200	Combination	250	200	200
Maine	185	–	133	150	125	150	Combination	200	–	200
Maryland	185	300	185	300	185	300	Medicaid Expansion	–	–	250

TABLE 9, Continued

State	Medicaid Coverage: Infants under age 1 Medicaid funded[1]	Infants under age 1 CHIP funded[1]	Age 1 through 5 Medicaid funded[1]	Age 1 through 5 CHIP funded[1]	Age 6 through 18 Medicaid funded[1]	Age 6 through 18 CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2012)	Separate CHIP Coverage: Birth through age 18	Separate CHIP Coverage: Unborn children	Medicaid/CHIP Coverage: Pregnant women and deemed newborns[3]
Massachusetts	185%	200%	133%	150%	114%	150%	Combination	300%	200%[10]	185%
Michigan	185	–	133	150	100	150	Combination	200	185	185
Minnesota	275	280[11]	275	–	275	–	Combination	–	275	275
Mississippi	185	–	133	–	100	–	Separate	200	–	185
Missouri	185	–	133	150	100	150	Combination	300	–	185
Montana	133	–	133	–	100	133	Combination	250	–	150
Nebraska	150	200	133	200	100	200	Medicaid Expansion	–	–	185
Nevada	133	–	133	–	100	–	Separate	200	–	133/185[12]
New Hampshire	185	300	185	–	185	–	Combination	300	–	185
New Jersey	185	–	133	–	100	133	Combination	350	–	185/200[13]
New Mexico	185	235	185	235	185	235	Medicaid Expansion	–	–	235
New York	185	–	133	–	100	–	Separate	400	–	200
North Carolina	185	200	133	200	100	–	Combination	200	–	185
North Dakota[14]	133	133	133	133	100	100	Combination	160	–	133
Ohio[15]	133	200	133	200	100	200	Medicaid Expansion	–	–	200
Oklahoma[16]	150	185	133	185	100	185	Combination	200	185	185
Oregon	133	–	133	–	100	–	Separate	300	185	185
Pennsylvania	185	–	133	–	100	–	Separate	300	–	185
Rhode Island[17]	250	–	250	–	100	250	Combination	–	250	185/250[18]
South Carolina	185	200	133	200	100	200	Medicaid Expansion	–	–	185
South Dakota	133	140	133	140	100	140	Combination	200	–	133
Tennessee[19]	185	200	133	200	100	200	Combination	250	250	185
Texas	185	–	133	–	100	–	Separate	200	200	185
Utah	133	–	133	–	100	–	Separate	200	–	133
Vermont[20]	225	–	225	–	225	–	Separate	300	–	200
Virginia	133	–	133	–	100	133	Combination	200	–	133/200[21]
Washington	200	–	200	–	200	–	Separate	300	185	185
West Virginia	150	–	133	–	100	–	Separate	300	–	150
Wisconsin	185	–	185	–	100	150	Combination	300	300	300
Wyoming	133	–	133	–	100	–	Separate	200	–	133

TABLE 9, Continued

Notes: In 2012, the federal poverty level (100 percent FPL) in the lower 48 states and the District of Columbia is $11,170 for an individual and $3,960 for each additional family member. For additional information, see MACStats Table 19. Eligibility levels shown here apply to countable income; for some eligibility pathways, states may use various income disregards that result in different amounts of countable income. Some states achieve the eligibility levels listed by applying block disregards. Some numbers may differ in practice because of the operation of an income disregard that has not been taken into account.

1 The eligibility levels listed under 'Medicaid funded' are generally the Medicaid eligibility thresholds as of March 31, 1997. The eligibility levels listed under 'CHIP funded' are the income levels to which Medicaid has expanded with CHIP funding since its creation in 1997. In 1997 many states had different eligibility levels for children aged 6 through 13 and 14 through 18; in such cases, this table shows the 1997 levels for children from age 6 through 13.

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

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

4 Arizona's CHIP program has been closed to new enrollment since January 1, 2010.

5 Arkansas was approved to expand its separate CHIP program to 250 percent FPL effective January 1, 2011, but this has not been implemented.

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

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

8 Colorado covers pregnant women up to 133 percent FPL under Medicaid and from 134 percent through 200 percent FPL under CHIP through a Section 1115 waiver.

9 Indiana's increase of the income threshold from 250 to 300 percent FPL was approved November 18, 2009, but the state has not yet implemented the expansion.

10 Massachusetts has been approved to provide coverage of unborn children up to 225 percent FPL, but the state has only implemented up to 200 percent FPL.

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

12 Nevada covers pregnant women up to 133 percent FPL under Medicaid and from 134 percent through 185 percent FPL under CHIP through a Section 1115 waiver.

13 New Jersey covers pregnant women up to 185 percent FPL under Medicaid and from 186 percent through 200 percent FPL under CHIP through a state plan option for targeted low-income pregnant women.

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

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

16 Oklahoma covers TEFRA (also referred to as Katie Beckett) children from 0 percent through 200 percent FPL as a Medicaid expansion in all age groups. Oklahoma has been approved to increase the income threshold of its separate CHIP program to 300 percent FPL, but has implemented the expansion up to 200 percent FPL.

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

18 Rhode Island covers pregnant women up to 185 percent FPL under Medicaid and from 186 percent through 250 percent FPL under CHIP through a state plan option for targeted low-income pregnant women.

19 Tennessee covers children as a Medicaid expansion group with CHIP funding, called TennCare Standard, but this Section 1115 waiver is currently capped except for children who "rollover" from traditional Medicaid. This includes children with a family income above Medicaid income levels but at or below 200 percent FPL who are losing TennCare Medicaid eligibility.

20 Vermont's separate CHIP program covers children between 225 percent and 300 percent FPL.

21 Virginia covers pregnant women up to 133 percent FPL under Medicaid and from 134 percent through 200 percent FPL under CHIP through a Section 1115 wavier.

Source: MACPAC communication with CMS

TABLE 10. Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-aged, Non-disabled, Non-pregnant Adults by State, January 2012

States are required to provide Medicaid coverage for parents (and their dependent children), at a minimum, at their 1996 Aid to Families with Dependent Children eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents (via Section 1931 of the Social Security Act) and other adults under age 65 who are not pregnant, not eligible for Medicare, and have incomes below 133 percent FPL (via Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, which is an optional eligibility pathway through 2013 and mandatory thereafter). States may also provide coverage under Section 1115 waivers, which allow them to operate their Medicaid programs without regard to certain statutory requirements. As noted throughout this table, the covered benefits under these waivers may be more limited than those provided under regular state plan rules and may not be available to all individuals at the income levels shown. In addition, regardless of whether coverage is provided under a waiver, jobless and working individuals may qualify at different income levels due to disregards of certain amounts of earned income. States may use additional disregards (such as child care expenses) that are not accounted for here.

	Parents of Dependent Children					Other Adults	
		Jobless		Working		Jobless	Working
State	Minimum	1931 eligibility	1115 waiver	1931 eligibility	1115 waiver	1115 waiver unless noted otherwise	
Alabama	11%	11%	–	24%	–	–	–
Alaska	54	76	–	81	–	–	–
Arizona	23	100	–	106	–	100% (closed)	110% (closed)
Arkansas[2]	13	13	–	17	200%	–	200
California[3]	40	100	200%	106	200	200	200
Colorado	28	100	–	106	–	–	–
Connecticut	57	185	–	191	–	56[1]	72[1]
Delaware	22	75	100	119	106	100	110
District of Columbia	28	200	–	206	–	133[1]/200	144[1]/211
Florida	20	20	–	58	–	–	–
Georgia	28	27	–	49	–	–	–
Hawaii[4]	41	100	200	100	200	200	200
Idaho[5]	21	21	–	39	185	–	185
Illinois	25	185	–	191	–	–	–
Indiana[6]	19	19	200	24	206	200 (closed)	210 (closed)
Iowa[7]	28	28	200	82	250	200	250
Kansas	26	26	–	32	–	–	–
Kentucky	34	34	–	59	–	–	–
Louisiana	11	11	–	25	–	–	–

TABLE 10, Continued

State	Parents of Dependent Children					Other Adults	
		Jobless		Working		Jobless	Working
	Minimum	1931 eligibility	1115 waiver	1931 eligibility	1115 waiver	1115 waiver unless noted otherwise	
Maine[8]	36%	200%	–	200%	–	100% (closed)	100% (closed)
Maryland[9]	24	116	–	116	–	116	128
Massachusetts[10]	37	133	300%	133	300%	300	300
Michigan[11]	32	37	–	63	–	35 (closed)	45 (closed)
Minnesota[12]	35	100	275	120	275	75[1]/250	75[1]/250
Mississippi	24	24	–	44	–	–	–
Missouri	19	19	–	36	–	–	–
Montana	28	32	–	55	–	–	–
Nebraska	24	46	–	57	–	–	–
Nevada	23	25	–	87	–	–	–
New Hampshire	36	39	–	49	–	–	–
New Jersey[13]	28	29	200 (closed)	133	200 (closed)	23	23
New Mexico[14]	25	29	200 (closed)	85	408 (closed)	200 (closed)	414 (closed)
New York	46	68	150	74	150	100	100
North Carolina	36	35	–	49	–	–	–
North Dakota	28	34	–	59	–	–	–
Ohio	22	90	–	90	–	–	–
Oklahoma[15]	20	37	200	53	200	200	200
Oregon[16]	30	31	201	40	201	201	201
Pennsylvania	26	26	–	46	–	–	–
Rhode Island	36	110	175	116	181	–	–
South Carolina	13	50	–	91	–	–	–
South Dakota	33	52	–	52	–	–	–
Tennessee	38	69	–	126	–	–	–
Texas	12	12	–	26	–	–	–
Utah[17]	37	38	150 (closed)	44	150	150 (closed)	150
Vermont[18]	43	77	300	82	300	300	300
Virginia	23	25	–	31	–	–	–
Washington	36	36	133	73	133	133	133
West Virginia	17	16	–	32	–	–	–
Wisconsin[19]	34	200	–	200	–	200 (closed)	200 (closed)
Wyoming	24	38	–	51	–	–	–

TABLE 10, Continued

Notes: In 2012, the federal poverty level (100 percent FPL) is $11,170 for an individual and $3,960 for each additional family member in the lower 48 states and the District of Columbia. For additional information, see MACStats Table 19. Reflects income eligibility levels at time of application. The table takes earning disregards, which allow working individuals to qualify at higher income levels than jobless individuals, into account when determining income thresholds for working adults: for parents, computations are based on a family of three with one earner; for other adults, computations are based on an individual. In some cases, earnings disregards may only apply for the first few months of coverage; in these cases, eligibility limits for most enrollees would be lower than the levels that appear in this table. In some states, the income eligibility guidelines vary by region; in this situation, the income guideline in the most populous region is used.

"Closed" indicates that the state was not enrolling new adults eligible for coverage into a program at some point between January 1, 2011, and January 1, 2012.

1 Not funded under a Section 1115 waiver, but through the Medicaid state plan option that permits coverage of individuals under age 65 who are not pregnant, not eligible for Medicare, and have incomes below 133 percent FPL.

2 In Arkansas, adults up to 200 percent FPL are eligible for more limited subsidized coverage under the ARHealthNetworks waiver program; individuals must have income below the eligibility threshold and work for a qualifying, participating employer. In 2011, the state opened up the program to those who are also self-employed.

3 California covers adults through two programs: the Medicaid Coverage Expansion (MCE) up to 133 percent FPL and the Health Care Coverage Initiative between 133 percent and 200 percent FPL. While both coverage options offer more limited benefits than full Medicaid, the MCE benefit package is more comprehensive.

4 Hawaii covers adults up to 100 percent FPL under its QUEST Medicaid managed care waiver program; enrollment in QUEST is closed except for certain groups including individuals receiving Section 1931 Medicaid coverage or General Assistance or those below the old Aid to Families with Dependent Children standards. Adults up to 200 percent FPL are eligible for more limited coverage under the QUEST-ACE waiver program. Further, adults previously enrolled in Medicaid with incomes from 200 to 300 percent FPL can purchase more limited QUEST-NET waiver coverage by paying a monthly premium. Hawaii is awaiting CMS approval to reduce eligibility from 200 percent to 133 percent FPL in QUEST ACE and from 300 percent to 133 percent FPL in QUEST NET.

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

6 In Indiana, adults up to 200 percent FPL are eligible for more limited coverage under the Healthy Indiana waiver program. Enrollment is closed for childless adults. During 2011, the state opened the waiting list in an effort to add members up to the cap.

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

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

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

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

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

12 In Minnesota, parents up to 275 percent FPL and childless adults up to 250 percent FPL are eligible for coverage under the MinnesotaCare waiver program; parents above 215 percent FPL and childless adults in the waiver program receive more limited coverage.

13 In New Jersey, parents up to 200 percent FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard. In April 2011, New Jersey obtained a waiver to expand coverage to childless adults who had previously been covered through the state's General Assistance program. The eligibility levels shown apply to individuals who are "employable"; those considered "unemployable" have a lower threshold.

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

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

16 In Oregon, adults up to 100 percent FPL are eligible for more limited coverage under the Oregon Health Plan (OHP) Standard waiver program; enrollment in OHP Standard is closed. The state provides premium assistance to adults up to 201 percent FPL under its Family Health Insurance Assistance Program (FHIAP) waiver program. FHIAP is open for both individual and employer sponsored insurance, however, the state is only enrolling individuals from the reservation list.

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

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

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

Source: M. Heberlein, T. Brooks, J. Guyer, et al., *Performing under pressure: Annual findings of a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP, 2011-2012*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2012, http://www.kff.org/medicaid/upload/8272.pdf

TABLE 11. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Individuals Age 65 and Older and Persons with Disabilities by State, 2010

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

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
Alabama	1634	75%	–	–	–	224%
Alaska[5]	SSI Criteria	60	–	–	–	147
Arizona	1634	75	–	100%	–	224
Arkansas	1634	75	–	80 Aged only	12%	224
California	1634	75	–	100	66	100
Colorado	1634	75	–	–	–	224
Connecticut	209(b)	–	63%	–	68	224
Delaware	1634	75	–	–	–	187
District of Columbia	1634	75	–	100	64	224
Florida	1634	75	–	88	20	224
Georgia	1634	75	–	–	35	224
Hawaii	209(b)	–	100	100	45	–
Idaho	SSI Criteria	75	–	–	–	224
Illinois	209(b)	–	100	100	100	–
Indiana	209(b)	–	75	–	–	224
Iowa	1634	75	–	–	54	224
Kansas	SSI Criteria	75	–	–	53	224
Kentucky	1634	75	–	–	24	224
Louisiana	1634	75	–	75	11	224
Maine	1634	75	–	100	58	224
Maryland	1634	75	–	–	39	224
Massachusetts	1634	75	–	100	58	224
Michigan	1634	75	–	100	45	224
Minnesota	209(b)	–	53	100	75	224
Mississippi	1634	75	–	–	–	224
Missouri	209(b)	–	85	85	–	131
Montana	1634	75	–	–	69	–

TABLE 11, Continued

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
Nebraska	SSI Criteria	75%	–	100%	44%	–
Nevada	SSI Criteria	75	–	–	–	224%
New Hampshire	209(b)	–	76%	–	65	224
New Jersey	1634	75	–	100	41	224
New Mexico	1634	75	–	–	–	224
New York	1634	75	–	–	85	–
North Carolina	1634	75	–	100	27	–
North Dakota	209(b)	–	83	–	83	–
Ohio	209(b)	–	65	–	–	224
Oklahoma	209(b)	–	79	100	–	224
Oregon	SSI Criteria	75	–	–	–	224
Pennsylvania	1634	75	–	100	47	224
Rhode Island	1634	75	–	100	89	224
South Carolina	1634	75	–	100	–	224
South Dakota	1634	75	–	–	–	224
Tennessee	1634	75	–	–	–	224
Texas	1634	75	–	–	–	224
Utah	SSI Criteria	75	–	100	100	224
Vermont	1634	75	–	–	110	224
Virginia	209(b)	–	80	80	47	224
Washington	1634	75	–	–	75	224
West Virginia	1634	75	–	–	22	224
Wisconsin	1634	75	–	–	66	224
Wyoming	1634	75	–	–	–	224

Notes: In 2012, the federal poverty level (100 percent FPL) is $11,170 for an individual and $3,960 for each additional family member in the lower 48 states and the District of Columbia. For additional information, see MACStats Table 19. Eligibility levels shown here apply to countable income; for some eligibility pathways, states may use various income disregards that result in different amounts of countable income. The eligibility levels listed in this table are for individuals; the eligibility levels for couples differ for certain categories.

1 Both Section 1634 and SSI-criteria states use SSI criteria for Medicaid eligibility. In Section 1634 states, the federal eligibility determination process for SSI automatically qualifies an individual for Medicaid; in SSI-criteria states, individuals must submit information to the state for a separate eligibility determination. Section 209(b) states may use eligibility criteria more restrictive than the SSI program, but may not use more restrictive criteria than those in effect in the state on January 1, 1972; they must also allow individuals with higher incomes to "spend down" to the 209(b) income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes.

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

3 Under the medically needy option, individuals with higher incomes can "spend down" to the medically needy income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes. Five states (Connecticut, Louisiana, Michigan, Vermont, and Virginia) have a medically needy income standard that varies by location. In these instances, the highest income standard is listed.

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

5 The dollar amount that equals the upper income eligibility level for SSI does not vary by state; however, the dollar amount that equals the FPL is higher in Alaska (see MACStats Table 19), resulting in a lower percentage.

Sources: MACPAC analysis of eligibility information from CMS as of July 2010 and state websites

TABLE 12. Optional Medicaid Benefits by State, December 2010 and January 2011

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

Medicaid mandatory benefits are the following:

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

The table on the following pages is based on information from CMS. CMS notes that healthcare.gov was used as the primary source of information, with state Medicaid websites used as secondary sources.

Source: CMS, State Medicaid benefits matrix, December 2010 and January 2011, https://www.cms.gov/SpecialNeedsPlans/05_StateResourceCenter.asp

TABLE 12. Optional Medicaid Benefits by State, December 2010 and January 2011

Benefit	Number of States Providing Benefit	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS
Intermediate Care Facility Services for the Intellectually Disabled	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management for Mental Health	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nursing Facility Services (under age 21)	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Occupational Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Optometry Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
Physical Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribed Drugs	50[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management	50	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinic Services	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Speech and Language Therapy	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental Services	48	✓	✓	✓	✓	✓	–	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eyeglasses/Vision Care	48	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓
Hospice Care Services	48	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Psychiatric Services (under age 21)	48	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Podiatry Services	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Prosthetic Devices	48	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Speech, Hearing, and Language Therapy	45	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audiology Services	44	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓
Inpatient Services in an Institution for Mental Disease (age 65+)	42	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–
Psychologist Services	42	✓	✓	✓	✓	✓	✓	✓	–	–	✓	✓	✓	✓	–	✓	✓	✓	–	–	✓	✓	✓	–	✓	✓
Emergency Hospital Services	41	–	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	–	✓	✓	✓	✓	✓
Preventive Services	40	✓	✓	✓	–	✓	–	✓	–	✓	✓	✓	✓	✓	✓	✓	–	–	✓	–	✓	–	✓	✓	✓	✓
Dentures	37	✓	✓	–	✓	✓	–	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓
Personal Care Services	35	✓	✓	–	✓	✓	–	–	–	✓	✓	–	–	✓	–	–	–	–	✓	✓	✓	✓	✓	✓	✓	–
Home and Community Based Program/Services	34	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓
Rehabilitation Services	34	–	✓	✓	–	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	–	–	✓	✓	✓	✓	✓	✓	✓
Chiropractic Services	33	✓	–	–	✓	✓	–	✓	–	–	✓	–	–	✓	✓	✓	✓	–	✓	–	✓	–	✓	–	✓	✓
Private Duty Nursing Services	33	✓	–	✓	✓	–	✓	–	✓	✓	✓	✓	–	✓	–	✓	–	–	✓	–	✓	✓	✓	–	✓	✓
Diagnostic Services	32	✓	✓	✓	–	–	–	✓	✓	✓	✓	✓	✓	–	✓	✓	–	–	✓	–	✓	✓	✓	✓	✓	✓
Nurse Anesthetist Services	32	✓	✓	✓	✓	✓	✓	–	–	–	✓	✓	–	–	–	✓	✓	✓	✓	✓	–	✓	–	✓	✓	✓

TABLE 12, Continued

Benefit	Number of States Providing Benefit	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS
Targeted Case Management for Developmental Disabilities	32	✓	–	✓	✓	✓	✓	–	–	–	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓	–	✓	✓	–
Program of All-Inclusive Care for the Elderly (PACE)	31	–	–	–	✓	✓	✓	–	–	–	✓	–	✓	–	✓	–	✓	✓	–	✓	–	✓	✓	✓	–	–
Durable Medical Equipment/Medical Supplies	30	✓	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	–	–	✓	✓	–	✓	–	✓	✓	✓
Screening Services	30	✓	✓	✓	–	–	–	✓	–	✓	✓	✓	✓	✓	✓	✓	–	–	✓	–	✓	–	✓	–	✓	✓
Critical Access Hospital Services	23	–	✓	✓	✓	–	–	–	–	–	–	✓	✓	–	–	✓	✓	–	–	–	✓	–	–	–	✓	–
Respiratory Care (Ventilator) Services	22	✓	✓	✓	✓	–	–	–	–	✓	✓	✓	✓	–	✓	–	–	–	✓	–	–	✓	–	✓	–	–
Targeted Case Management for the Intellectually Disabled	18	✓	–	–	–	–	–	✓	–	–	✓	✓	–	–	–	–	–	✓	–	✓	–	–	✓	–	✓	–
Primary Care Case Management	15	–	–	–	–	–	✓	–	–	–	–	✓	–	✓	–	–	✓	–	–	–	–	–	✓	–	–	–
Hearing Aids	14	✓	–	–	✓	–	–	–	–	–	✓	✓	–	–	–	–	–	–	–	✓	–	✓	–	✓	✓	–
Services Related to Tuberculosis	14	–	–	–	–	✓	–	–	–	✓	–	✓	–	–	–	–	–	✓	–	✓	–	✓	–	–	✓	–
Targeted Case Management for HIV/AIDS	14	✓	–	–	–	–	–	–	–	–	–	✓	–	–	–	✓	–	–	–	✓	✓	✓	✓	–	–	–
Services from Religious Non-Medical Institutions	13	✓	–	✓	–	–	–	–	–	–	–	–	–	–	✓	✓	–	–	–	–	–	–	–	✓	✓	–
Targeted Case Management for Physical Disabilities	12	✓	–	–	–	✓	–	–	–	–	✓	✓	–	–	–	–	✓	✓	–	–	–	–	✓	✓	–	–
Substance Abuse Treatment Services	9	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	✓	✓	–	–
Targeted Case Management for the Medically Fragile	9	–	–	–	–	–	–	–	–	–	✓	✓	✓	–	–	–	–	–	✓	✓	–	–	–	–	–	–
Transplants	9	✓	–	–	–	–	–	–	✓	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
HIV Testing	8	–	–	✓	–	–	–	✓	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	✓	✓	–
Diabetes Education	4	–	–	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
Dialysis Services	4	✓	✓	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓
Targeted Case Management for Traumatic Brain Injury	4	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	✓	–	–	–	–	–	–	–	–
Nutritional Services	3	–	–	✓	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–
Prosthetic Services	3	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–
School Based Health-Related Services	3	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–
Targeted Case Management for Autism	3	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	✓	–	–	–	–
Sickle Cell Disease Services	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Acquired Brain Injury	2	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Genetic Counseling	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Medical Foster Care Services	1	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for the Technology Dependent	1	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 12. Optional Medicaid Benefits by State, December 2010 and January 2011

Benefit	Number of States Providing Benefit	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Intermediate Care Facility Services for the Intellectually Disabled	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management for Mental Health	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nursing Facility Services (under age 21)	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Occupational Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Optometry Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribed Drugs	50[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–[1]	✓	✓	✓	✓	✓
Targeted Case Management	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinic Services	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Speech and Language Therapy	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓
Dental Services	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Eyeglasses/Vision Care	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Hospice Care Services	48	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Psychiatric Services (under age 21)	48	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–
Podiatry Services	48	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–
Prosthetic Devices	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Speech, Hearing, and Language Therapy	45	–	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	–	–	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Audiology Services	44	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	–	✓	✓	✓	✓	–	✓	✓	✓	✓	–
Inpatient Services in an Institution for Mental Disease (age 65+)	42	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	–	–	✓	✓	✓	✓	✓	✓	–	✓	✓
Psychologist Services	42	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	–	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Emergency Hospital Services	41	–	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Preventive Services	40	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓	–
Dentures	37	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	–	✓	–	–	✓	–	–	✓	✓	✓	–
Personal Care Services	35	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	–	✓	✓	–	–	✓	✓	✓	–
Home and Community Based Program/Services	34	–	✓	✓	✓	✓	✓	✓	–	–	–	✓	–	–	✓	–	✓	–	✓	✓	–	–	✓	✓	–	–	–
Rehabilitation Services	34	✓	–	–	–	✓	✓	✓	✓	✓	–	✓	–	–	–	–	✓	–	–	✓	–	✓	✓	✓	✓	✓	✓
Chiropractic Services	33	–	✓	✓	–	✓	✓	–	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	–
Private Duty Nursing Services	33	–	✓	✓	✓	✓	–	–	✓	✓	✓	✓	–	✓	✓	–	✓	–	–	✓	✓	✓	–	✓	✓	✓	–
Diagnostic Services	32	–	✓	✓	✓	✓	✓	–	✓	✓	✓	–	–	–	✓	✓	–	–	–	–	✓	✓	✓	–	–	✓	–
Nurse Anesthetist Services	32	–	✓	✓	–	✓	–	✓	–	✓	✓	✓	✓	✓	–	–	✓	–	✓	✓	–	–	✓	✓	–	–	✓

TABLE 12, Continued

Benefit	Number of States Providing Benefit	MO	MT	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Targeted Case Management for Developmental Disabilities	32	✓	✓	✓	–	✓	–	✓	✓	–	–	✓	✓	✓	–	✓	–	–	–	✓	–	✓	✓	–	✓	✓	–
Program of All-Inclusive Care for the Elderly (PACE)	31	✓	✓	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	–	✓	–
Durable Medical Equipment/Medical Supplies	30	–	✓	✓	–	✓	✓	–	–	–	✓	✓	✓	–	–	✓	✓	✓	✓	–	✓	–	–	✓	–	✓	✓
Screening Services	30	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓	–	–	–	–	–	✓	–	✓	–	–	✓	–
Critical Access Hospital Services	23	–	✓	✓	✓	–	–	–	✓	–	✓	–	✓	✓	✓	–	–	✓	–	–	✓	–	–	✓	✓	✓	✓
Respiratory Care (Ventilator) Services	22	–	–	✓	✓	–	–	–	–	✓	–	✓	–	–	✓	–	–	–	✓	✓	–	–	–	✓	✓	✓	–
Targeted Case Management for Intellectually Disabled	18	–	–	–	✓	–	–	–	✓	–	–	✓	✓	–	✓	–	✓	–	–	✓	–	✓	✓	–	✓	–	–
Primary Care Case Management	15	–	–	–	✓	–	–	–	✓	✓	–	–	–	✓	✓	✓	✓	✓	–	✓	–	–	✓	–	–	–	–
Hearing Aids	14	✓	✓	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	✓	–	–	✓
Services Related to Tuberculosis	14	–	–	–	–	–	–	–	✓	✓	–	–	✓	–	–	–	–	–	–	✓	✓	–	–	–	–	✓	✓
Targeted Case Management for HIV/AIDS	14	–	–	–	–	–	–	–	✓	✓	–	–	–	✓	✓	✓	–	–	–	–	–	–	–	✓	–	✓	–
Services from Religious Non-Medical Institutions	13	–	–	–	–	–	✓	–	–	–	–	–	–	✓	✓	–	–	–	✓	✓	–	–	✓	–	–	✓	–
Targeted Case Management for Physical Disabilities	12	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	✓	–	–	–	–	–	–	–	✓	✓	–
Substance Abuse Treatment Services	9	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	✓	–	–	✓	–	✓	✓
Targeted Case Management for the Medically Fragile	9	–	–	–	–	✓	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	✓	–
Transplants	9	✓	✓	–	–	–	–	–	–	–	–	–	✓	–	–	✓	–	–	–	–	–	–	–	✓	–	–	✓
HIV Testing	8	–	–	–	✓	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–
Diabetes Education	4	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	✓	–	–	–	–	–	✓	–	–	–
Dialysis Services	4	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Traumatic Brain Injury	4	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–
Nutritional Services	3	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Prosthetic Services	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓
School Based Health-Related Services	3	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Autism	3	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–
Sickle Cell Disease Services	2	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Acquired Brain Injury	2	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Genetic Counseling	1	–	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Medical Foster Care Services	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for the Technology Dependent	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

1 Although not noted in the CMS source for this table, information from the State of Vermont website for Medicaid indicates that this is a covered benefit, which would increase the number of states providing it to 51.

TABLE 13. Maximum Allowable Medicaid Premiums and Cost Sharing, FY 2012

	At or Below 100% FPL	From 100% Through 150% FPL	Above 150% FPL
Exempt Populations	Exempt populations for most types of cost sharing include children under age 18, pregnant women, beneficiaries receiving hospice care, beneficiaries in nursing facilities and intermediate care facilities for the intellectually disabled, certain enrollees in hospitals and other medical institutions, and American Indians who are furnished a Medicaid item or service through an Indian provider or through a contract health service referral.		
Exempt Services	Emergency services and family planning services and supplies are excluded from cost sharing.		
Cap for Alternative Cost Sharing	Alternative cost sharing not permitted. Nominal amounts always apply.	When a state imposes alternative cost sharing above nominal amounts, the total amount of premiums and cost sharing may not exceed 5% of a family's monthly or quarterly income.	
Premium	Not permitted	Not permitted	Up to $19 a month for some populations, no limit for others (subject to 5% cap).
Non-Institutional Services	Deductible: Up to $2.55 Copayment: Up to $3.80	Deductible: Up to $2.55 Copayment: Up to 10% of the payment made by the Medicaid agency for the service	Deductible: Up to $2.55 Copayment: Up to 20% of the payment made by the Medicaid agency for the service
Institutional Services	Per admission, the deductible, coinsurance, or copayment may not exceed 50% of the payment made by the Medicaid agency for the first day of care.	Per admission, the deductible, coinsurance, or copayment may not exceed 50% of the payment made by the Medicaid agency for the first day of care or 10% of the cost of the item or service.	Per admission, the deductible, coinsurance, or copayment may not exceed 50% of the payment made by the Medicaid agency for the first day of care or 20% of the cost of the item or service.
Non-Emergency Care Provided in ER	Up to $3.80	Up to $7.60	No limit (subject to 5% cap)
Prescribed Drugs	Preferred and non-preferred copayment: Up to $3.80	Preferred and non-preferred copayment: Up to $3.80	Preferred copayment: Up to $3.80 Non-preferred: Up to 20% of the cost of the drug

Notes: In 2012, the federal poverty level (100 percent FPL) is $11,170 for an individual and $3,960 for each individual family member in the lower 48 states and the District of Columbia. For additional information, see MACStats Table 19.

This table contains FY 2012 numbers, where "nominal" is defined as being $2.55 for a monthly deductible or up to $3.80 for a copayment. The table does not reflect amounts that states may have implemented under a Section 1115 waiver.

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

Sources: Sections 1916 and 1916A of the Social Security Act; 42 CFR 447; CMS, Center for Medicaid, CHIP and Survey & Certification (CMCS), "Medicaid cost sharing – FY 2012 update to nominal cost sharing," *CMCS Informational Bulletin*, September 30, 2011, https://www.cms.gov/CMCSBulletins/downloads/CIB-9-30-2011.pdf

TABLE 14. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, Selected Periods in FY 2008–FY 2013

	FMAPs for Medicaid					E-FMAPs for CHIP	
State	FY 2008	First quarter of FY 2011 (includes temporary increase)[1]	Fourth quarter of FY 2011 (regular formula level)	FY 2012	FY 2013	FY 2012	FY 2013
Alabama	67.62%	78.00%	68.54%	68.62%	68.53%	78.03%	77.97%
Alaska	52.48	62.46	50.00	50.00	50.00	65.00	65.00
Arizona	66.20	75.93	65.85	67.30	65.68	77.11	75.98
Arkansas	72.94	81.18	71.37	70.71	70.17	79.50	79.12
California	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Colorado	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Connecticut	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Delaware	50.00	64.38	53.15	54.17	55.67	67.92	68.97
District of Columbia	70.00	79.29	70.00	70.00	70.00	79.00	79.00
Florida	56.83	67.64	55.45	56.04	58.08	69.23	70.66
Georgia	63.10	75.16	65.33	66.16	65.56	76.31	75.89
Hawaii	56.50	67.35	51.79	50.48	51.86	65.34	66.30
Idaho	69.87	79.18	68.85	70.23	71.00	79.16	79.70
Illinois	50.00	61.88	50.20	50.00	50.00	65.00	65.00
Indiana	62.69	76.21	66.52	66.96	67.16	76.87	77.01
Iowa	61.73	72.55	62.63	60.71	59.59	72.50	71.71
Kansas	59.43	69.68	59.05	56.91	56.51	69.84	69.56
Kentucky	69.78	80.61	71.49	71.18	70.55	79.83	79.39
Louisiana[2]	72.47	81.48	68.04	69.78	71.92	72.76	72.87
Maine	63.31	74.86	63.80	63.27	62.57	74.29	73.80
Maryland	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Massachusetts	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Michigan	58.10	75.57	65.79	66.14	66.39	76.30	76.47
Minnesota	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Mississippi	76.29	84.86	74.73	74.18	73.43	81.93	81.40
Missouri	62.42	74.43	63.29	63.45	61.37	74.42	72.96
Montana	68.53	77.99	66.81	66.11	66.00	76.28	76.20
Nebraska	58.02	68.76	58.44	56.64	55.76	69.65	69.03
Nevada	52.64	63.93	51.61	56.20	59.74	69.34	71.82
New Hampshire	50.00	61.59	50.00	50.00	50.00	65.00	65.00
New Jersey	50.00	61.59	50.00	50.00	50.00	65.00	65.00
New Mexico	71.04	80.49	69.78	69.36	69.07	78.55	78.35
New York	50.00	61.59	50.00	50.00	50.00	65.00	65.00

TABLE 14, Continued

State	FMAPs for Medicaid					E-FMAPs for CHIP	
	FY 2008	First quarter of FY 2011 (includes temporary increase)[1]	Fourth quarter of FY 2011 (regular formula level)	FY 2012	FY 2013	FY 2012	FY 2013
North Carolina	64.05%	74.98%	64.71%	65.28%	65.51%	75.70%	75.86%
North Dakota	63.75	69.95	60.35	55.40	52.27	68.78	66.59
Ohio	60.79	73.71	63.69	64.15	63.58	74.91	74.51
Oklahoma	67.10	76.73	64.94	63.88	64.00	74.72	74.80
Oregon	60.86	72.97	62.85	62.91	62.44	74.04	73.71
Pennsylvania	54.08	66.58	55.64	55.07	54.28	68.55	68.00
Rhode Island	52.51	64.22	52.97	52.12	51.26	66.48	65.88
South Carolina	69.79	79.58	70.04	70.24	70.43	79.17	79.30
South Dakota	60.03	70.80	61.25	59.13	56.19	71.39	69.33
Tennessee	63.71	75.62	65.85	66.36	66.13	76.45	76.29
Texas[3]	60.56	70.94	60.56	58.22	59.30	70.75	71.51
Utah	71.63	80.78	71.13	70.99	69.61	79.69	78.73
Vermont	59.03	69.96	58.71	57.58	56.04	70.31	69.23
Virginia	50.00	61.59	50.00	50.00	50.00	65.00	65.00
Washington	51.52	62.94	50.00	50.00	50.00	65.00	65.00
West Virginia	74.25	83.05	73.24	72.62	72.04	80.83	80.43
Wisconsin	57.62	70.63	60.16	60.53	59.74	72.37	71.82
Wyoming	50.00	61.59	50.00	50.00	50.00	65.00	65.00
American Samoa	50.00	50.00	55.00	55.00	55.00	68.50	68.50
Guam	50.00	50.00	55.00	55.00	55.00	68.50	68.50
N. Mariana Islands	50.00	50.00	55.00	55.00	55.00	68.50	68.50
Puerto Rico	50.00	50.00	55.00	55.00	55.00	68.50	68.50
Virgin Islands	50.00	50.00	55.00	55.00	55.00	68.50	68.50

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

FMAPs for Medicaid are generally calculated based on a formula that compares each state's per capita income relative to U.S. per capita income and provides a higher federal match for states with lower per capita incomes, subject to a statutory minimum (50 percent) and maximum (83 percent). The formula for a given state is: FMAP = 1 – ((State per capita income squared / U.S. per capita income squared) × 0.45)

Medicaid exceptions to this formula include the District of Columbia (set in statue at 70 percent) and the territories (currently set in statute at 55 percent). Other Medicaid exceptions apply to certain services, providers, or situations (e.g., services provided through an Indian Health Service facility receive an FMAP of 100 percent). Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent.

1 From the first quarter of FY 2009 through the third quarter of FY 2011, subject to certain requirements, states received a temporary FMAP increase (P.L. 111-5 and P.L. 111-226). Under the formula used to calculate the temporary increase, states reached their highest FMAPs by the first quarter of FY 2011 (shown here). The temporary increase then phased down in the second and third quarters of FY 2011. FMAPs returned to their regular formula levels in the fourth quarter of FY 2011. The temporary increase did not apply to CHIP.

2 Louisiana receives a disaster-recovery state FMAP adjustment for the fourth quarter of FY 2011 and FY 2012–FY 2013 (§1905(aa) of the Social Security Act).

3 Texas received a Hurricane Katrina-related FMAP adjustment for FY 2008 (§6053(b) of P.L. 109-171).

Sources: Federal Register notices from the Department of Health and Human Services

TABLE 15. Medicaid as a Share of States' Total Budgets and State-funded Budgets, State FY 2010 (millions)

State	Total Budget (Including State and Federal Funds)				State-funded Budget			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
All states	**$1,621,370**	**22.3%**	**20.5%**	**10.2%**	**$1,068,715**	**12.0%**	**24.5%**	**13.3%**
Alabama	20,584	25.8	24.3	21.4	11,892	11.4	31.6	27.0
Alaska	9,759	12.0	14.6	8.6	6,834	5.1	17.9	10.0
Arizona	27,680	27.7	22.0	12.6	17,025	12.1	26.0	17.4
Arkansas	19,922	20.0	17.2	15.3	13,028	6.0	20.9	23.2
California	206,089	18.9	19.6	8.1	117,001	9.5	27.9	8.9
Colorado	31,064	15.3	24.7	14.2	21,841	10.2	32.3	15.1
Connecticut	19,694	25.4	20.1	13.9	17,127	29.2[1]	18.1	14.0
Delaware	8,720	14.4	23.8	4.2	7,113	6.8	25.8	4.4
District of Columbia	–	–	–	–	–	–	–	–
Florida	62,049	30.0	20.5	7.7	39,286	16.9	24.0	11.1
Georgia	40,441	19.5	24.6	17.1	25,794	8.0	26.8	25.2
Hawaii	10,948	13.3	15.6	8.8	8,557	5.8	16.3	10.8
Idaho	6,393	23.0	27.4	7.7	3,820	10.4	38.3	12.8
Illinois	60,653	23.6	18.2	4.5	44,603	13.2	16.5	5.3
Indiana	26,662	23.1	32.4	7.1	16,329	9.9	44.5	11.6
Iowa	17,637	18.6	17.3	24.4	11,463	9.8	22.0	32.9
Kansas	14,045	18.8	25.5	16.1	8,857	8.8	32.2	19.9
Kentucky	25,941	21.9	19.4	22.4	15,464	7.7	24.9	32.7
Louisiana	29,134	23.7	18.1	8.0	17,275	7.4	23.5	12.7
Maine	8,257	28.6	17.6	3.3	5,106	10.9	23.1	5.2
Maryland	33,104	20.4	21.0	14.4	23,279	11.0	23.0	18.9
Massachusetts	50,424	18.8	12.9	7.9	46,492	20.4[1]	10.8	8.5
Michigan	47,758	24.2	28.4	4.5	28,217	11.1	37.9	7.0
Minnesota	30,133	25.1	21.7	10.7	20,744	13.6	25.9	15.2
Mississippi	18,283	22.9	17.1	15.3	9,552	10.3	25.0	27.2
Missouri	25,526	34.4	21.3	5.2	14,607	17.7	26.3	8.0
Montana	6,049	15.4	15.1	9.6	3,764	5.4	18.7	13.3
Nebraska	9,606	17.2	15.7	22.4	6,633	8.4	17.0	29.3

TABLE 15, Continued

State	Total Budget (Including State and Federal Funds)				State-funded Budget			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
Nevada	$8,284	18.3%	21.5%	10.8%	$5,492	10.4%	25.9%	12.8%
New Hampshire	5,466	24.9	19.0	5.0	3,394	16.6	24.9	7.4
New Jersey	47,764	21.3	24.6	7.9	34,077	11.9	28.1	10.7
New Mexico	15,246	22.1	21.1	18.0	9,817	6.9	26.0	22.6
New York	128,937	28.7	20.4	7.5	88,103	12.4	25.1	10.5
North Carolina	48,745	24.2	19.3	12.4	31,583	11.7	25.1	19.1
North Dakota	4,845	13.7	16.6	20.7	2,993	6.5	19.1	28.6
Ohio	57,640	21.3	20.2	4.9	43,404	21.4	22.0	6.5
Oklahoma	21,607	17.1	13.5	19.5	11,245	9.8	18.4	33.3
Oregon	32,554	13.1	11.6	7.1	24,176	5.0	12.6	8.8
Pennsylvania	68,108	29.6	19.8	3.3	40,439	18.5	24.1	5.4
Rhode Island	7,810	25.0	14.1	11.8	4,997	14.4	16.8	18.4
South Carolina	20,302	22.6	17.1	20.9	12,611	8.5	20.1	28.4
South Dakota	3,820	21.7	15.4	17.3	2,091	10.8	18.7	26.7
Tennessee	28,449	28.8	17.7	13.1	15,498	12.6	23.8	21.6
Texas	93,121	24.6	29.3	10.0	56,449	12.0	35.9	12.7
Utah	14,991	11.9	18.9	9.5	11,384	3.6	20.5	11.9
Vermont	4,667	25.9	33.0	2.2	2,802	13.4	48.5	3.7
Virginia	40,773	16.1	16.7	15.6	31,446	8.2	17.5	17.0
Washington	33,587	23.0	24.4	13.2	24,349	15.9	28.7	17.5
West Virginia	20,356	12.6	10.6	11.9	15,881	2.9	11.1	13.5
Wisconsin	40,086	17.1	18.1	12.3	28,554	7.4	21.5	13.5
Wyoming	7,657	7.3	11.7	5.3	6,227	3.1	12.9	6.3

Notes: Information for the District of Columbia was not collected by the National Association of State Budget Officers (NASBO). Total budget includes federal and all other funds. State-funded budget includes state general funds, other state funds, and bonds. Medicaid, elementary and secondary education, and higher education represent the largest total budget shares among functions broken out separately by NASBO. Functions not shown here are transportation, corrections, public assistance, and all other. Medicaid spending amounts exclude state program administration but include Medicare Part D "clawback" payments; they also reflect a temporary increase in federal matching funds for Medicaid (see MACStats Table 14 for information).

1 Total and state-funded budget shares should be viewed with caution because they reflect varying state practices, some of which are noted by NASBO. For example, Connecticut and Massachusetts report all of their Medicaid spending as state-funded spending; in Connecticut this is due to the direct deposit of federal funds into the State Treasury. In addition, states differ in the extent to which some functions—particularly elementary and secondary education—are funded outside of the state budget by local governments.

Source: National Association of State Budget Officers (NASBO), *2010 State expenditure report: Examining fiscal 2009-2011 state spending*, Washington, DC: NASBO, 2011, http://www.nasbo.org/sites/default/files/2010%20State%20Expenditure%20Report.pdf

TABLE 16. National Health Expenditures by Type and Payer, 2010

	Dollars (billions)							
Type of Expenditure	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
National health expenditures	**$2,593.6**	**$401.4**	**$11.7**	**$524.6**	**$848.7**	**$84.5**	**$423.2**	**$299.7**
Hospital	**814.0**	152.5	3.2	226.5	285.8	46.4	73.7	25.9
Physician and clinical	**515.5**	43.0	3.1	114.6	239.4	18.6	47.6	49.3
Dental	**104.8**	7.4	1.1	0.2	51.0	1.2	0.5	43.3
Other professional	**68.4**	4.9	0.2	14.4	24.8	–	6.4	17.7
Home health	**70.2**	26.2	0.0	31.5	4.5	0.8	2.2	5.0
Other non-durable medical products	**44.8**	–	–	3.0	–	–	0.0	41.8
Prescription drugs	**259.1**	20.2	1.6	59.5	117.0	8.6	3.4	48.8
Durable medical equipment	**37.7**	4.6	0.1	7.5	4.4	–	0.6	20.6
Nursing care facilities and continuing care retirement communities	**143.1**	45.1	0.0	31.9	12.7	4.0	8.9	40.4
Other health, residential, and personal care	**128.5**	67.7	0.8	4.7	6.3	1.9	40.0	7.1
Administration	**176.1**	29.8	1.7	30.7	102.7	2.8	8.3	–
Public health activity	**82.5**	–	–	–	–	–	82.5	–
Investment	**149.0**	–	–	–	–	–	149.0	–

TABLE 16, Continued

Type of Expenditure	Total	Share of Total						
		Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
National health expenditures	**100%**	**15.5%**	**0.4%**	**20.2%**	**32.7%**	**3.3%**	**16.3%**	**11.6%**
Hospital	**100**	18.7	0.4	27.8	35.1	5.7	9.1	3.2
Physician and clinical	**100**	8.3	0.6	22.2	46.4	3.6	9.2	9.6
Dental	**100**	7.1	1.0	0.2	48.7	1.2	0.5	41.3
Other professional	**100**	7.1	0.2	21.1	36.4	–	9.3	25.9
Home health	**100**	37.3	0.0	44.9	6.4	1.2	3.1	7.1
Other non-durable medical products	**100**	–	–	6.7	–	–	0.0	93.3
Prescription drugs	**100**	7.8	0.6	23.0	45.2	3.3	1.3	18.8
Durable medical equipment	**100**	12.2	0.2	19.9	11.6	–	1.5	54.5
Nursing care facilities and continuing care retirement communities	**100**	31.5	0.0	22.3	8.9	2.8	6.3	28.3
Other health, residential, and personal care	**100**	52.7	0.6	3.7	4.9	1.5	31.1	5.5
Administration	**100**	16.9	1.0	17.4	58.3	1.6	4.7	–
Public health activity	**100**	–	–	–	–	–	100.0	–
Investment	**100**	–	–	–	–	–	100.0	–

Notes: Figures for nursing care facilities and continuing retirement communities and other health, residential, and personal care reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40 percent of nursing home expenditures and about three-quarters of other personal health care expenditures.

Other professional includes services provided in establishments operated by health practitioners other than physicians and dentists, including those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational, and speech therapists, among others. Other non-durable medical products includes the retail sales of non-prescription drugs and medical sundries. Durable medical equipment includes retail sales of items such as contact lenses, eyeglasses, and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals. Nursing care facilities and continuing care retirement communities includes nursing and rehabilitative services provided in freestanding nursing home facilities that are generally provided for an extended period of time by registered or licensed practical nurses and other staff. Other health, residential, and personal care includes spending for Medicaid home and community-based waivers, care provided in residential facilities for people with intellectual disabilities or mental health and substance abuse disorders, ambulance services, school health, and worksite health care. Administration category includes the administrative cost of health care programs (e.g. Medicare and Medicaid) and the net cost of private health insurance (administrative costs, as well as additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses).

1 Department of Defense and Department of Veterans' Affairs.

2 Includes all other public and private programs and expenditures.

Sources: Office of the Actuary (OACT), CMS, *National health expenditures by type of service and source of funds*, January 2012, https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp; and OACT, *National Health expenditure accounts: Methodology paper, 2010,* 2012, http://www.cms.gov/NationalHealthExpendData/downloads/dsm-10.pdf

TABLE 17. Historical and Projected National Health Expenditures by Payer for Selected Years, 1970–2020

	Dollars (billions)						
	Total	Medicaid and CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Historical							
1970	**$75**	$5	$8	$15	$3	$18	$25
1975	**134**	13	16	30	6	30	37
1980	**256**	26	37	69	10	55	58
1985	**445**	41	72	131	15	89	96
1990	**724**	74	110	234	21	146	139
1995	**1,027**	145	184	327	27	198	146
2000	**1,377**	203	224	460	33	255	202
2001	**1,494**	228	247	503	37	270	209
2002	**1,636**	254	265	560	42	294	222
2003	**1,774**	275	282	614	49	317	237
2004	**1,900**	298	310	659	53	331	249
2005	**2,029**	317	339	703	57	351	263
2006	**2,162**	315	403	740	62	370	272
2007	**2,297**	335	432	776	66	400	287
2008	**2,404**	354	467	808	72	409	294
2009	**2,496**	386	500	829	79	408	294
2010	**2,594**	413	525	849	84	423	300
Projected							
2011	**2,708**	441	556	850	95	453	312
2012	**2,824**	471	566	884	103	478	322
2013	**2,980**	503	600	927	110	506	335
2014	**3,227**	603	637	1,014	118	526	330
2015	**3,418**	648	668	1,077	125	559	341
2016	**3,632**	701	707	1,141	133	597	353
2017	**3,850**	741	751	1,200	142	640	375
2018	**4,080**	790	801	1,251	151	686	400
2019	**4,346**	848	857	1,325	162	733	421
2020	**4,638**	914	922	1,402	173	783	444

TABLE 17, Continued

	Total	Share of Total					
		Medicaid and CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Historical							
1970	**100%**	7.1%	10.3%	20.6%	4.4%	24.2%	33.4%
1975	**100**	10.1	12.2	22.8	4.5	22.5	28.0
1980	**100**	10.2	14.6	27.0	3.8	21.6	22.8
1985	**100**	9.2	16.2	29.5	3.4	20.1	21.6
1990	**100**	10.2	15.2	32.3	3.0	20.2	19.1
1995	**100**	14.1	17.9	31.8	2.6	19.3	14.2
2000	**100**	14.8	16.3	33.4	2.4	18.5	14.7
2001	**100**	15.3	16.5	33.7	2.4	18.1	14.0
2002	**100**	15.5	16.2	34.2	2.6	17.9	13.6
2003	**100**	15.5	15.9	34.6	2.8	17.8	13.3
2004	**100**	15.7	16.3	34.7	2.8	17.4	13.1
2005	**100**	15.6	16.7	34.6	2.8	17.3	13.0
2006	**100**	14.6	18.6	34.2	2.9	17.1	12.6
2007	**100**	14.6	18.8	33.8	2.9	17.4	12.5
2008	**100**	14.7	19.4	33.6	3.0	17.0	12.2
2009	**100**	15.4	20.0	33.2	3.2	16.4	11.8
2010	**100**	15.9	20.2	32.7	3.3	16.3	11.6
Projected							
2011	**100**	16.3	20.5	31.4	3.5	16.7	11.5
2012	**100**	16.7	20.0	31.3	3.6	16.9	11.4
2013	**100**	16.9	20.1	31.1	3.7	17.0	11.2
2014	**100**	18.7	19.7	31.4	3.6	16.3	10.2
2015	**100**	19.0	19.5	31.5	3.7	16.3	10.0
2016	**100**	19.3	19.5	31.4	3.7	16.4	9.7
2017	**100**	19.2	19.5	31.2	3.7	16.6	9.8
2018	**100**	19.4	19.6	30.7	3.7	16.8	9.8
2019	**100**	19.5	19.7	30.5	3.7	16.9	9.7
2020	**100**	19.7	19.9	30.2	3.7	16.9	9.6

Note: Data reflect changes in methods, definitions, and source data that were made in a comprehensive revision in 2011. As part of the revision, CMS changed the classification structure of payers and no longer provides detail on the amount of spending by public and private source of funds in the NHE projection data, aside from what is shown here.

1 Department of Defense and Department of Veterans' Affairs.

2 Includes all other public and private programs and expenditures.

Sources: For historical data: Office of the Actuary (OACT), CMS, *National health expenditures by type of service and source of funds*, January 2012, https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp; for projections: OACT, *National health expenditure projections 2010-2020*, July 2011, https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf; and MACPAC communication with OACT, February 2012

TABLE 18. Characteristics of Non-institutionalized Individuals by Source of Health Insurance, 2011 (millions)

	All Ages					Age 0-18				
	Total all ages	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 0-18	Private	Medicaid/ CHIP	Medicare	Uninsured
Health Insurance Coverage[1]	**305.2 million**	60.5%*	16.3%	14.3%*	15.3%	**78.7 million**	54.4%*	36.2%	0.4%*	7.6%*
Gender (%)										
Male	**49.1***	48.9*	45.0	44.1	55.0*	**51.2**	51.0	51.0	49.2	53.2
Female	**50.9***	51.1*	55.0	55.9	45.0*	**48.8**	49.0	49.0	50.8	46.8
Family Income (%)[2]										
<100% of Poverty	**15.2***	4.5*	46.6	12.3*	25.6*	**21.2***	4.0*	47.1	47.2	23.8*
100 – 199% of Poverty	**18.9***	10.6*	33.3	23.0*	34.0	**22.8***	12.5*	36.2	†	39.3
200+% of Poverty	**65.8***	84.9*	20.1	64.7*	40.4*	**56.0***	83.4*	16.6	41.4*	36.9*
Race/Ethnicity (%)										
Hispanic	**16.4***	9.7*	28.4	7.4*	31.3	**23.2***	12.7*	34.7	44.6	39.8
White, Non-Hispanic	**64.4***	74.3*	42.9	78.0*	47.5*	**54.4***	69.6*	36.8	23.9	37.5
Black, Non-Hispanic	**12.1***	9.2*	20.9	10.0*	13.3*	**13.8***	9.1*	20.9	21.0	11.3*
Other races and multiple races	**7.2**	6.8	7.8	4.6*	7.8	**8.6**	8.6	7.5	†	11.5*
Health Status (%)										
Excellent/Very good	**65.1***	71.9*	58.9	37.5*	57.4	**82.1***	88.9*	73.3	78.3	75.4
Good	**24.4**	21.5*	25.6	33.2*	31.0*	**15.8***	10.2*	23.0	†	21.6
Fair/Poor	**10.5***	6.7*	15.4	29.2*	11.6*	**2.1***	0.9*	3.7	†	3.1
Place of Residence (%)[3]										
Large MSA	**53.9**	54.9	50.9	46.9	54.2	**54.5**	56.9*	50.6	68.6	54.9
Small MSA	**29.8**	30.2	29.6	30.7	27.9	**29.8**	30.0	30.1	†	24.8
Not in MSA	**16.3***	14.9*	19.5	22.4	17.9	**15.7***	13.1*	19.3	†	20.2

TABLE 18, Continued

	Age 19-64					Age 65 and Over				
	Total age 19-64	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 65 and over	Private	Medicaid/ CHIP	Medicare	Uninsured
Health Insurance Coverage[1]	**187.0 million**	64.4%*	9.7%	3.3%*	21.5%*	**39.4 million**	54.7%*	8.0%	93.8%*	1.0%*
Gender (%)										
Male	**49.3***	49.0*	36.9	46.9*	55.3*	**43.9***	44.8*	36.7	43.6*	51.1*
Female	**50.7***	51.0*	63.1	53.1*	44.7*	**56.1***	55.2*	63.3	56.4*	48.9*
Family Income (%)[2]										
<100% of Poverty	**14.0***	4.8*	46.9	28.1*	25.9*	**9.4***	3.1*	40.6	9.1*	18.3*
100 – 199% of Poverty	**16.9***	9.1*	29.2	33.6*	33.4*	**20.8***	15.7*	30.4	21.3*	20.3
200+% of Poverty	**69.1***	86.1*	23.9	38.3*	40.7*	**69.8***	81.2*	28.9	69.6*	61.4*
Race/Ethnicity (%)										
Hispanic	**15.4***	9.7*	20.2	10.4*	30.1*	**7.3***	3.7*	18.4	6.6*	31.2
White, Non-Hispanic	**65.4***	73.8*	50.4	63.8*	49.1	**79.3***	86.9*	54.7	80.8*	36.5*
Black, Non-Hispanic	**12.2***	9.7*	21.3	20.5	13.7*	**8.4***	6.2*	17.9	8.1*	12.2
Other races and multiple races	**7.0**	6.8	8.1	5.3*	7.2	**5.0***	3.2*	9.0	4.5*	20.1
Health Status (%)										
Excellent/Very good	**62.9***	70.4*	42.4	14.2*	54.8*	**41.5***	46.4*	23.0	41.1*	41.7*
Good	**26.1***	23.2*	28.7	27.9	32.4*	**34.1**	34.0	31.9	34.3	30.0
Fair/Poor	**11.1***	6.4*	28.9	57.9*	12.7*	**24.4***	19.6*	45.1	24.6*	28.3*
Place of Residence (%)[3]										
Large MSA	**54.8**	56.0	51.1	43.9*	53.9	**48.2**	44.8	51.6	47.2	65.7
Small MSA	**29.6**	29.9	29.4	30.2	28.4	**30.6**	32.1	26.8	30.9	23.7
Not in MSA	**15.6***	14.1*	19.4	25.9*	17.7	**21.2**	23.1	21.6	21.9	†

Notes:

1 Totals of health insurance coverage may add to more than 100 percent because individuals may have multiple sources of coverage. Not all types of coverage (e.g., military) are displayed. Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care. Medicaid/CHIP health insurance coverage also includes persons covered by other public programs, excluding Medicare (e.g., other state-sponsored health plans). A person was defined as uninsured if he or she did not have any private health insurance, Medicare, Medicaid/CHIP, state-sponsored or other government-sponsored health plans, or a military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

2 Poverty status is based on family size and 2010 family income. In 2010, 100 percent of poverty using Census' poverty threshold was $17,374 for a family of three. The family income results exclude the 12 percent of respondents with unknown poverty status.

3 MSA is a metropolitan statistical area with a population size of 50,000 or more persons. Large MSAs have a population size of 1,000,000 or more; small MSAs have a population size between 50,000 and 1,000,000.

† Sample size is not sufficient to support published estimates.

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

Source: Analysis of National Health Interview Survey (NHIS) data by the National Center for Health Statistics (NCHS) for MACPAC, January 2012; the estimates for 2011 are based on data collected from January through June, based on household interviews of a sample of the civilian non-institutionalized population

TABLE 19. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2012

States		Annual Family size 1	2	3	4	Amount for each additional family member	States		Monthly Family size 1	2	3	4	Amount for each additional family member
Lower 48 states and DC	100% FPL	$11,170	$15,130	$19,090	$23,050	$3,960	Lower 48 states and DC	100% FPL	$931	$1,261	$1,591	$1,921	$330
	133% FPL	14,856	20,123	25,390	30,657	5,267		133% FPL	1,238	1,677	2,116	2,555	439
	150% FPL	16,755	22,695	28,635	34,575	5,940		150% FPL	1,396	1,891	2,386	2,881	495
	185% FPL	20,665	27,991	35,317	42,643	7,326		185% FPL	1,722	2,333	2,943	3,554	611
	200% FPL	22,340	30,260	38,180	46,100	7,920		200% FPL	1,862	2,522	3,182	3,842	660
	250% FPL	27,925	37,825	47,725	57,625	9,900		250% FPL	2,327	3,152	3,977	4,802	825
	300% FPL	33,510	45,390	57,270	69,150	11,880		300% FPL	2,793	3,783	4,773	5,763	990
	400% FPL	44,680	60,520	76,360	92,200	15,840		400% FPL	3,723	5,043	6,363	7,683	1,320
Alaska	100% FPL	$13,970	$18,920	$23,870	$28,820	$4,950	Alaska	100% FPL	$1,164	$1,577	$1,989	$2,402	$413
	133% FPL	18,580	25,164	31,747	38,331	6,584		133% FPL	1,548	2,097	2,646	3,194	549
	150% FPL	20,955	28,380	35,805	43,230	7,425		150% FPL	1,746	2,365	2,984	3,603	619
	185% FPL	25,845	35,002	44,160	53,317	9,158		185% FPL	2,154	2,917	3,680	4,443	763
	200% FPL	27,940	37,840	47,740	57,640	9,900		200% FPL	2,328	3,153	3,978	4,803	825
	250% FPL	34,925	47,300	59,675	72,050	12,375		250% FPL	2,910	3,942	4,973	6,004	1,031
	300% FPL	41,910	56,760	71,610	86,460	14,850		300% FPL	3,493	4,730	5,968	7,205	1,238
	400% FPL	55,880	75,680	95,480	115,280	19,800		400% FPL	4,657	6,307	7,957	9,607	1,650
Hawaii	100% FPL	$12,860	$17,410	$21,960	$26,510	$4,550	Hawaii	100% FPL	$1,072	$1,451	$1,830	$2,209	$379
	133% FPL	17,104	23,155	29,207	35,258	6,052		133% FPL	1,425	1,930	2,434	2,938	504
	150% FPL	19,290	26,115	32,940	39,765	6,825		150% FPL	1,608	2,176	2,745	3,314	569
	185% FPL	23,791	32,209	40,626	49,044	8,418		185% FPL	1,983	2,684	3,386	4,087	701
	200% FPL	25,720	34,820	43,920	53,020	9,100		200% FPL	2,143	2,902	3,660	4,418	758
	250% FPL	32,150	43,525	54,900	66,275	11,375		250% FPL	2,679	3,627	4,575	5,523	948
	300% FPL	38,580	52,230	65,880	79,530	13,650		300% FPL	3,215	4,353	5,490	6,628	1,138
	400% FPL	51,440	69,640	87,840	106,040	18,200		400% FPL	4,287	5,803	7,320	8,837	1,517

Note: The federal poverty levels (FPLs) shown here are based on the Department of Health and Human Services 2012 federal poverty *guidelines*, which differ slightly from the Census Bureau's federal poverty *thresholds*, which are used mainly for statistical purposes. The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period.

Source: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, *2012 HHS federal poverty guidelines*, February 2012, http://aspe.hhs.gov/poverty/12poverty.shtml

TABLE 20. Medicaid Supplemental Payments by State and Category, FY 2011 (millions)

See Chapter 3 of this report for a discussion of supplemental payments in the Medicaid program. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; they include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. These amounts exclude payments made under managed care arrangements. Amounts reported by states for any given category (e.g., inpatient hospital) sometimes show substantial annual fluctuations. **Data limitations:** CMS only began to require separate reporting of non-DSH supplemental payments in FY 2010 and is continuing to work with states to standardize this reporting. As a result, the information presented below may not reflect a consistent classification of supplemental payment spending across states. Reporting is expected to improve over time.

	Inpatient and Outpatient Hospital[1]				Mental Health Facility[2]		
State	DSH payments	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	DSH payments	Total Medicaid payments	Supplemental payments as % of total
Total	**$14,349.6**	**$23,239.6**	**$91,894.9**	**40.9%**	**$2,941.7**	**$6,434.2**	**45.7%**
Alabama	445.8	218.2	1,725.2	38.5	3.3	72.6	4.5
Alaska	2.6	–	308.9	0.9	12.6	30.9	40.6
Arizona	137.3	176.8	854.4	36.8	28.5	30.2	94.2
Arkansas	61.2	308.1	952.0	38.8	0.8	154.9	0.5
California	2,274.9	8,206.7	16,958.8	61.8	0.3	393.0	0.1
Colorado	185.0	686.9	1,458.9	59.8	–	5.7	–
Connecticut	98.1	0.0	873.8	11.2	103.3	180.9	57.1
Delaware	–	–	69.2	–	5.6	6.6	85.9
District of Columbia	66.2	–	428.3	15.5	7.1	20.9	34.0
Florida	241.2	981.8	4,981.2	24.6	108.9	168.1	64.8
Georgia	410.1	124.8	1,769.2	30.2	–	18.1	–
Hawaii	20.0	57.1	128.0	60.2	–	0.0	–
Idaho	24.7	20.7	514.6	8.8	–	0.3	–
Illinois	334.2	1,703.0	5,276.4	38.6	75.7	169.5	44.6
Indiana	223.9	773.8	1,518.1	65.7	102.8	156.5	65.7
Iowa	81.9	35.0	754.7	15.5	–	36.9	–
Kansas	46.8	55.7	416.9	24.6	23.1	80.0	28.8
Kentucky	165.4	190.3	1,483.8	24.0	37.4	92.1	40.7
Louisiana	501.0	568.7	2,374.7	45.0	99.2	87.6	113.3[5]
Maine	–	4.5	588.6	0.8	51.5	107.9	47.7
Maryland	38.0	44.1	1,021.9	8.0	50.4	195.8	25.7

TABLE 20, Continued

State	Inpatient and Outpatient Hospital[1]				Mental Health Facility[2]		
	DSH payments	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	DSH payments	Total Medicaid payments	Supplemental payments as % of total
Massachusetts	–	$956.0	$2,586.1	37.0%	–	$134.4	–
Michigan	$326.8	626.9	1,628.9	58.5	$61.1	81.2	75.2%
Minnesota	89.3	126.0	758.3	28.4	0.1	64.8	0.1
Mississippi	204.1	411.5	1,637.4	37.6	–	70.8	–
Missouri	528.2	–	2,725.0	19.4	171.4	218.1	78.6
Montana	17.0	–	261.1	6.5	–	14.9	–
Nebraska	38.5	3.2	276.7	15.1	–	24.5	–
Nevada	88.4	36.9	370.7	33.8	–	44.4	–
New Hampshire	121.1	89.6	342.2	61.6	27.5	31.9	86.5
New Jersey	912.5	65.1	1,949.9	50.1	357.4	476.8	75.0
New Mexico	28.9	116.2	452.3	32.1	0.3	4.8	5.3
New York	2,606.7	1,531.8	11,172.8	37.0	551.5	1,044.5	52.8
North Carolina	258.5	287.7	2,775.4	19.7	150.5	243.0	61.9
North Dakota	0.8	1.1	111.1	1.8	1.0	8.9	11.1
Ohio	569.5	138.1	2,105.1	33.6	93.4	628.8	14.9
Oklahoma	40.7	16.2	1,269.5	4.5	3.3	67.4	4.9
Oregon	32.9	44.9	292.4	26.6	20.0	22.5	88.7
Pennsylvania	571.4	336.1	2,098.2	43.3	297.9	375.7	79.3
Rhode Island	122.7	78.9	365.6	55.2	–	5.6	–
South Carolina	474.6	102.5	1,358.8	42.5	56.1	101.6	55.2
South Dakota	–	–	195.3	–	0.5	-21.8	-2.5[7]
Tennessee	139.2	792.9	949.9	98.1	–	23.9	–
Texas	1,286.6	2,901.5	7,421.0	56.4	292.5	321.1	91.1
Utah	24.0	48.0	559.0	12.9	–	15.2	–
Vermont	37.4	–	43.8	85.4	–	–	–
Virginia	189.4	161.5	1,034.6	33.9	5.9	121.8	4.8
Washington	226.7	–	1,431.5	15.8	122.1	151.0	80.9
West Virginia	54.4	156.6	516.6	40.8	18.9	102.9	18.3
Wisconsin	0.1	23.1	622.6	3.7	–	34.2	–
Wyoming	0.8	31.1	125.5	25.4	–	13.1	–

TABLE 20, Continued

State	Nursing Facility and ICF-ID[3]			Physician and Other Practitioner[4]		
	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total
Total	**$1,560.6**	**$64,566.5**	**2.4%**	**$1,125.3**	**$15,420.8**	**7.3%**
Alabama	–	934.6	–	–	346.4	–
Alaska	–	125.8	–	–	118.7	–
Arizona	–	35.5	–	–	43.5	–
Arkansas	–	783.8	–	28.1	299.9	9.4
California	78.1	5,093.9	1.5	271.0	1,408.7	19.2
Colorado	83.2	620.7	13.4	3.1	284.1	1.1
Connecticut	–	1,502.0	–	–	189.2	–
Delaware	–	209.0	–	–	22.9	–
District of Columbia	–	330.2	–	–	54.3	–
Florida	4.6	3,199.8	0.1	253.3	1,288.0	19.7
Georgia	–	1,173.9	–	–	395.0	–
Hawaii	–	9.5	–	–	6.7	–
Idaho	42.0	266.5	15.7	–	178.2	–
Illinois	–	2,278.6	–	–	956.8	–
Indiana	77.6	1,492.2	5.2	66.1	213.7	30.9
Iowa	–	854.7	–	–	262.9	–
Kansas	9.0	515.4	1.7	15.0	105.3	14.2
Kentucky	0.4	992.5	0.0	–	391.7	–
Louisiana	–	1,336.7	–	25.8	522.6	4.9
Maine	–	263.3	–	1.1	122.1	0.9
Maryland	30.2	1,076.6	2.8	–	98.0	–
Massachusetts	–	1,752.8	–	3.8	340.4	1.1
Michigan	313.0	1,730.1	18.1	167.5	333.4	50.2
Minnesota	–	947.9	–	20.0	388.4	5.2
Mississippi	14.8	1,018.1	1.5	–	314.9	–
Missouri	–	1,226.6	–	–	37.5	–
Montana	–	176.1	–	–	65.2	–
Nebraska	–	337.5	–	–	85.8	–
Nevada	–	189.4	–	3.2	99.6	3.2
New Hampshire	–	316.3	–	–	71.9	–
New Jersey	–	2,628.5	–	–	109.1	–

TABLE 20, Continued

State	Nursing Facility and ICF-ID[3]			Physician and Other Practitioner[4]		
	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total
New Mexico	–	$28.5	–	$13.4	$87.8	15.3%
New York	$295.8	11,564.4	2.6%	–	615.3	–
North Carolina	–	1,708.7	–	–	979.1	–
North Dakota	–0.5	284.9	-0.2[6]	–	51.4	–
Ohio	–	3,361.3	–	–	339.0	–
Oklahoma	–	623.3	–	0.0	458.0	0.0
Oregon	–	343.2	–	–	51.8	–
Pennsylvania	557.2	4,484.8	12.4	–	222.1	–
Rhode Island	–	319.2	–	–	13.2	–
South Carolina	–	668.1	–	50.4	267.5	18.8
South Dakota	–	163.3	–	–	62.0	–
Tennessee	–	355.1	–	–	27.1	–
Texas	–	3,348.2	–	85.3	2,158.1	4.0
Utah	–	227.9	–	25.4	122.7	20.7
Vermont	0.1	111.2	0.1	–	1.8	–
Virginia	–	1,119.5	–	21.2	233.7	9.1
Washington	5.2	739.3	0.7	43.0	295.3	14.6
West Virginia	–	567.6	–	28.5	159.0	17.9
Wisconsin	37.9	1,024.2	3.7	–	62.4	–
Wyoming	12.0	105.6	11.4	–	58.6	–

Notes: Includes federal and state funds. Excludes payments made under managed care arrangements.

1 Includes inpatient, outpatient, critical access hospital, and emergency hospital categories in the CMS-64 data. The CMS-64 instructions to states note that disproportionate share hospital (DSH) payments are those made in accordance with Section 1923 of the Social Security Act. Non-DSH supplemental payments are described in the CMS-64 instructions as those made in addition to the standard fee schedule or other standard payment for a given service. They include payments made under institutional upper payment limit rules and payments to hospitals for graduate medical education.

2 Includes inpatient psychiatric services for individuals under age 21 and inpatient hospital or nursing facility services for individuals age 65 or older in an institution for mental diseases. The CMS-64 instructions to states note that disproportionate share hospital (DSH) payments are those made in accordance with Section 1923 of the Social Security Act. States are not instructed to break out non-DSH supplemental payments for mental health facilities.

3 Only two states (North Dakota and Wisconsin) reported supplemental payments to intermediate care facilities for persons with intellectual disabilities (ICFs-ID). The CMS-64 instructions to states describe non-DSH supplemental payments as those are made in addition to the standard fee schedule or other standard payment for a given service, including payments made under institutional upper payment limit rules.

4 Includes the physician and other practitioner categories in CMS-64 data; excludes additional categories (e.g., dental, nurse midwife, nurse practitioner) for which states are not instructed to break out supplemental payments. The CMS-64 instructions to states describe supplemental payments as those that are made in addition to the standard fee schedule payment. Unlike for institutional providers, there is not a regulatory upper payment limit for physicians and other practitioners.

5 Louisiana reported negative regular (i.e., non-DSH) mental health facility payments that led total Medicaid payments for this category to be less than the amount of DSH payments, creating a percentage over 100 percent.

6 North Dakota reported negative non-DSH supplemental payments for ICFs-ID, creating a negative percentage.

7 South Dakota reported negative regular (i.e., non-DSH) mental health facility payments that led total Medicaid payments for this category to be negative, creating a negative percentage.

Sources: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2012, and MACPAC communication with CMS, February 2012

TABLE 21. Federal CHIP Allotments, FY 2011 and FY 2012 (millions)

For even-numbered years (e.g., FY 2012), federal CHIP allotments are calculated as the sum of last year's allotment and any shortfall payments (e.g., contingency funds), increased by a state-specific growth factor. For even-numbered years, a state can also have its allotment increased to reflect a CHIP eligibility or benefits expansion; some states have applied for these allotment increases, but CMS has not named them nor finalized their additional allotment amounts, if any.

State	FY 2011 CHIP Allotments	FY 2011 Contingency Fund Payments	Total	FY 2012 Allotment Increase Factor	FY 2012 Federal CHIP Allotments
A	B	C	D = B + C	E	F = D x E
Alabama	$135.4	–	$135.4	1.0436	$141.4
Alaska	19.8	–	19.8	1.0593	21.0
Arizona	61.5	–	61.5	1.0516	64.6
Arkansas	90.9	–	90.9	1.0497	95.4
California	1,254.9	–	1,254.9	1.0473	1,314.3
Colorado	123.5	–	123.5	1.0560	130.4
Connecticut	31.3	–	31.3	1.0436	32.7
Delaware	13.6	–	13.6	1.0436	14.2
District of Columbia	12.0	–	12.0	1.0519	12.6
Florida	324.9	–	324.9	1.0460	339.8
Georgia	239.4	–	239.4	1.0481	250.9
Hawaii	33.3	–	33.3	1.0465	34.8
Idaho	36.2	–	36.2	1.0480	37.9
Illinois	273.2	–	273.2	1.0436	285.1
Indiana	94.5	–	94.5	1.0436	98.7
Iowa	75.5	$28.9	104.4	1.0442	109.0
Kansas	55.9	–	55.9	1.0520	58.8
Kentucky	129.6	–	129.6	1.0453	135.5
Louisiana	186.0	–	186.0	1.0493	195.2
Maine	35.5	–	35.5	1.0436	37.0
Maryland	168.8	–	168.8	1.0445	176.3
Massachusetts	317.0	–	317.0	1.0436	330.8
Michigan	121.0	–	121.0	1.0436	126.2
Minnesota	20.5	–	20.5	1.0436	21.4
Mississippi	160.6	–	160.6	1.0436	167.7
Missouri	112.7	–	112.7	1.0436	117.6
Montana	38.5	–	38.5	1.0436	40.1
Nebraska	38.9	–	38.9	1.0518	41.0
Nevada	24.1	–	24.1	1.0436	25.1
New Hampshire	12.8	–	12.8	1.0436	13.4
New Jersey	592.2	–	592.2	1.0436	618.0
New Mexico	245.5	–	245.5	1.0536	258.7
New York	525.8	–	525.8	1.0436	548.8

TABLE 21, Continued

State	FY 2011 CHIP Allotments	FY 2011 Contingency Fund Payments	Total	FY 2012 Allotment Increase Factor	FY 2012 Federal CHIP Allotments
A	B	C	D = B + C	E	F = D x E
North Carolina	$382.3	–	$382.3	1.0494	$401.2
North Dakota	15.3	–	15.3	1.0528	16.1
Ohio	278.0	–	278.0	1.0436	290.1
Oklahoma	120.4	–	120.4	1.0538	126.9
Oregon	91.1	–	91.1	1.0467	95.4
Pennsylvania	321.8	–	321.8	1.0436	335.9
Rhode Island	30.3	–	30.3	1.0436	31.7
South Carolina	98.0	–	98.0	1.0453	102.5
South Dakota	20.1	–	20.1	1.0524	21.1
Tennessee	134.2	–	134.2	1.0440	140.1
Texas	832.7	–	832.7	1.0599	882.6
Utah	63.9	–	63.9	1.0611	67.8
Vermont	5.8	–	5.8	1.0436	6.0
Virginia	175.2	–	175.2	1.0500	184.0
Washington	45.4	–	45.4	1.0497	47.6
West Virginia	41.3	–	41.3	1.0436	43.1
Wisconsin	102.7	–	102.7	1.0436	107.2
Wyoming	10.0	–	10.0	1.0455	10.4
Subtotal	**$8,373.7**	**$28.9**	**$8,402.6**	–	**$8,804.0**
American Samoa	0.9	–	0.9	1.0436	1.0
Guam	4.2	–	4.2	1.0436	4.4
N. Mariana Islands	0.9	–	0.9	1.0436	0.9
Puerto Rico	99.6	–	99.6	1.0436	103.9
Virgin Islands	0.0	–	0.0	1.0436	0.0
Total	**$8,479.3**	**$28.9**	**$8,508.2**	–	**$8,914.1**

Source: MACPAC Communication with Centers for Medicare & Medicaid Services, October 2011

TABLE 22. Federal CHIPRA Bonus Payments (millions)

State	FY 2009 CHIPRA bonus payments	FY 2010 CHIPRA bonus payments	Preliminary FY 2011 CHIPRA bonus payments	FY 2011 Outreach and Enrollment Efforts Among States Receiving CHIPRA Bonus Payments							
				12 Months of continuous eligibility	Liberalization of asset requirements	Elimination of in-person interview	Joint application and renewal form	Automatic, administrative renewal	Presumptive eligibility	Express lane	Premium assistance
AL[1]	$1.5	$5.7	$19.8	✓	✓	✓	✓	✓	–	–	–
AK	0.7	4.9	5.7	✓	✓	✓	✓	✓	–	–	–
CO	–	18.2	26.1	–	✓	✓	✓	–	✓	–	✓
CT	–	–	5.2	–	✓	✓	✓	✓	✓	–	–
GA	–	–	5.0	–	✓	✓	✓	–	–	✓	✓
ID	–	0.9	1.3	✓	✓	✓	✓	✓	–	–	–
IL	9.5	15.3	15.1	✓	✓	✓	✓	✓	✓	–	–
IA	–	7.7	9.6	✓	✓	✓	✓	–	✓	✓	–
KS	1.2	5.5	5.9	✓	✓	✓	✓	–	✓	–	–
LA	1.5	3.7	1.9	✓	✓	✓	✓	✓	–	–	–
MD	–	11.4	28.3	–	✓	✓	✓	✓	–	✓	–
MI	4.7	8.4	5.9	✓	✓	✓	✓	–	✓	–	–
MT	–	–	6.5	✓	✓	✓	✓	–	✓	–	–
NJ	3.1	8.8	16.8	–	✓	✓	✓	✓	✓	✓	–
NM	5.4	9.0	5.0	✓	✓	✓	✓	✓	✓	–	–
NC	–	–	21.1	✓	✓	✓	✓	✓	–	–	–
ND	–	–	3.2	✓	✓	✓	✓	✓	–	–	–
OH	–	13.1	21.0	✓	✓	✓	✓	–	✓	–	–
OR	1.6	10.6	22.5	✓	✓	✓	✓	✓	–	✓	–
SC	–	–	2.4	✓	✓	✓	✓	–	–	✓	–
VA	–	–	26.7	–	✓	✓	✓	✓	–	–	✓
WA	7.9	20.7	17.0	✓	✓	✓	✓	–	–	–	✓
WI	–	23.4	24.5	–	✓	✓	✓	✓	–	–	✓
Total	**$37.1**	**$167.2**	**$296.5**	**16**	**23**	**23**	**23**	**14**	**10**	**6**	**5**

Note: Each of these outreach and enrollment efforts are described in the Commission's March 2011 Report to the Congress (pp. 68–69). Some FY 2009 and FY 2010 bonus payments have been revised based on final enrollment figures.

1 Originally, Alabama's bonus payments were $40 million for FY 2009 and $55 million for FY 2010. A preliminary audit conducted by CMS and the state revealed an error in the state's calculation of qualifying children. The FY 2009 and FY 2010 amounts in the table reflect the adjusted results from that preliminary audit.

Sources: Department of Health and Human Services (HHS), *Connecting kids to coverage: Steady growth, new innovation—2011 CHIPRA annual report*, Appendix 3, http://www.insurekidsnow.gov/chipraannualreport.pdf; and HHS, *FY 2011 CHIPRA performance bonus awards*, December 2011, http://www.insurekidsnow.gov/professionals/eligibility/pb-2011-chart.pdf

CHAPTER 2

Access to Care for Children Enrolled in Medicaid or CHIP

CHAPTER 2

Access to Care for Children Enrolled in Medicaid or CHIP

This chapter presents findings on access to care for children enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) compared to uninsured children and children with employer-sponsored insurance (ESI). Medicaid and CHIP are critical sources of coverage for millions of low-income children. More than 40 million children had Medicaid or CHIP coverage at some point during fiscal year 2011, representing approximately half of the U.S. child population.

A key question is whether or not this coverage provides these children with timely access to appropriate health care services. To provide insights on this question, the Commission analyzed national household survey data to examine children's access to and utilization of care. Like much prior research, these analyses compare children with Medicaid or CHIP to children who were uninsured or covered by ESI while controlling for health, demographic, and socioeconomic characteristics. The key findings include the following:

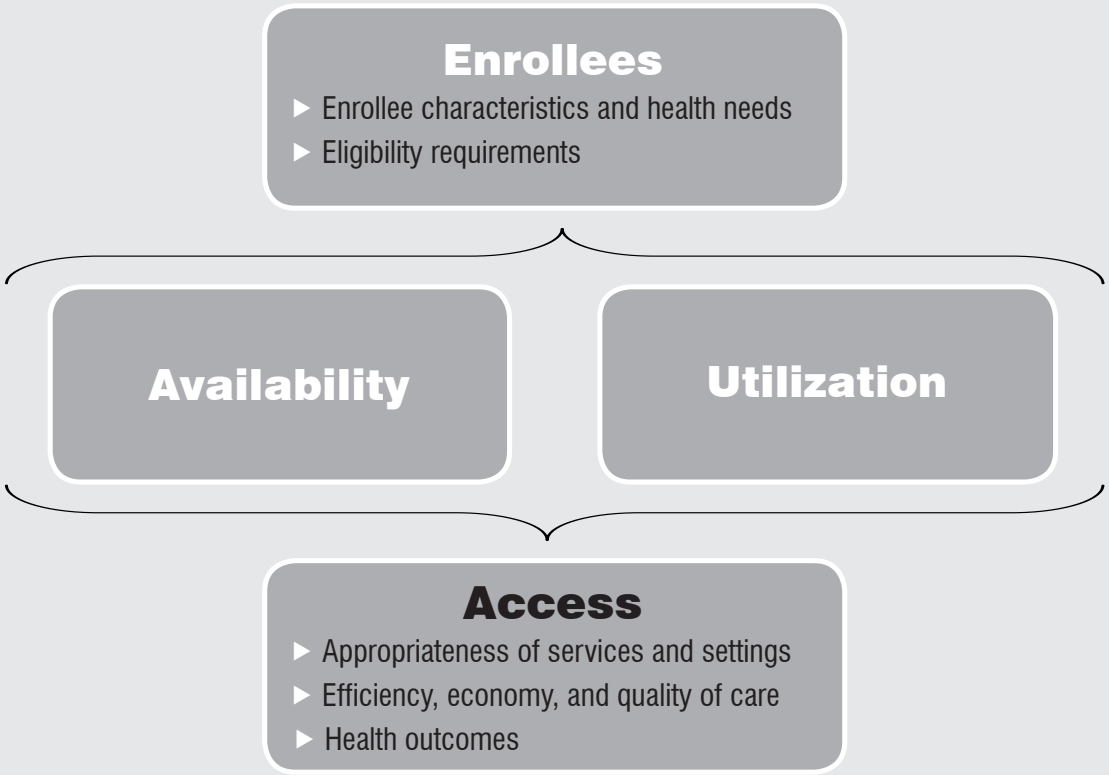
- For almost every measure of access to health care analyzed, the survey data indicate that children enrolled in Medicaid or CHIP have substantially better access to care than similarly situated uninsured children, as reported by a parent or other knowledgeable adult in the household. Compared to uninsured children, children enrolled in Medicaid or CHIP were:
  - more likely to have a usual source of care;
  - more likely to have had a well-child visit in the past year;
  - more likely to have had a specialist visit in the past year; and
  - less likely to have delayed medical care in the past year.
- While comparisons between children with Medicaid or CHIP and similarly situated children with ESI yield a more complex picture, their health care access and use are comparable for many of the survey measures, such as having a usual source of care and having had a specialist visit in the past year.

- This chapter focuses mainly on how access to care and service use are affected by the source of health insurance of similarly situated children, controlling for differences in the underlying health, demographic, and socioeconomic characteristics of children with Medicaid or CHIP as compared to uninsured children and children with ESI. While these adjustments had a substantial impact on only a few measures, the more detailed analyses suggest that factors beyond health insurance—for example, health status, race or ethnicity, and family income—can also be associated with differences in access to care, regardless of health insurance status.

For decades, the federal Medicaid statute has required state Medicaid programs to ensure adequate access to covered services. One of MACPAC's statutory requirements is to assess Medicaid and CHIP enrollees' access to care and the factors that affect access. In its March 2011 Report to the Congress, the Commission presented its initial framework for examining access (Figure 2-1). Drawing upon over 30 years of research on defining and measuring access to care, the framework focuses on three main elements: enrollees and their unique characteristics, provider availability, and utilization. These three elements serve as the structure for the quantitative findings presented here on children's access to care. These three elements also address both the supply and demand sides of health care.

The remainder of this chapter briefly describes the sources of data and methodology used and presents the MACPAC findings on children's access to care.[1]

FIGURE 2-1. The Commission's Access Framework



[1] Additionally, more detailed information is presented in the chapter's Annex and in the MACPAC Contractor Report (Kenney and Coyer 2012), which was the basis of the findings presented in this chapter. The MACPAC Contractor Report is available at www.macpac.gov.

Methodology Overview

As described in greater detail in this chapter's Annex, the findings in this chapter are based on two national household surveys—the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS). In comparing children enrolled in Medicaid or CHIP[2] to uninsured children and children with ESI,[3] factors controlled for include:

- Health-related characteristics, such as age, gender, health status, presence of certain chronic conditions (e.g., asthma), and disability;
- Additional demographic characteristics, such as race and ethnicity; and
- Socioeconomic characteristics, such as income, education, and citizenship.

The goal of controlling for these factors was to determine how access varies for children with different or no health insurance who are similarly situated in terms of certain health, demographic, and socioeconomic characteristics. However, there may be other relevant variables that could not be controlled for in this analysis.

For the findings on children's access to care, survey respondents were generally parents. By providing families' perspectives on children's access and health care experiences, parental reports complement the information on access to care that can be derived from other sources, such as provider surveys and administrative data.

However, these different types of data have both unique strengths and weaknesses as sources of information on access to care. Particular weaknesses associated with these household survey data include:

- They rely on parent recall, which may not be accurate.
- Parents may feel pressure to provide certain socially acceptable answers (for example, by indicating that their children received well-child visits even if they did not).
- They are based on subjective perceptions that might not align with objective criteria (for example, parents may not be aware that their child needs a particular type of care and may thus underreport "unmet health care needs").

Moreover, such weaknesses may vary systematically according to individuals' sources of health insurance, potentially biasing the results. As a result, developing a more complete assessment of access to care for children enrolled in Medicaid or CHIP will require placing the information provided by parents in the context of information from other sources.

Children with part-year health insurance coverage not included. The surveys used to produce the findings in this chapter capture children's source of health insurance coverage at the time of the survey. However, if children were uninsured at the time of the survey but were enrolled in ESI, Medicaid, or CHIP for several of the preceding months, their annual health care use and other measures of access may not accurately reflect their uninsured status. To address this concern, the findings in this chapter are limited to

[2] The NHIS asks separately about Medicaid and CHIP while the MEPS has a single question about whether the individual is covered by Medicaid or CHIP. However, Medicaid and CHIP estimates are not produced separately from the NHIS for several reasons; for example, many states' CHIP and Medicaid programs use the same name, so respondents would not necessarily know whether their child's coverage was funded by Medicaid or CHIP. The separate survey questions are used to reduce surveys' undercount of Medicaid and CHIP enrollees, not to produce valid estimates separately for each program. Thus, survey estimates generally combine Medicaid and CHIP into a single category, as is done in this chapter.

[3] In the NHIS, ESI coverage is defined as coverage through an employer (including self-employed), union, or the military (TRICARE/CHAMPVA). In the MEPS, ESI is defined as private group coverage through an employer or union, self-employed coverage, or TRICARE/CHAMPVA.

children who were either uninsured or insured for the entire year. This helps ensure that reports about access to care for insured children, for example, do not actually include parts of the year when the children did not have coverage.[4] The movement of children in and out of coverage and across sources of coverage has been widely recognized as an important policy issue and may be explored in future MACPAC analyses.[5]

Access to certain services not included. The findings in this chapter do not include results for certain specific services such as dental care. Dental services are delivered by a unique set of providers and are often financed differently from other types of care. MACPAC plans to produce focused analyses on oral care and other services in the context of Medicaid and CHIP in the future.

Enrollees and Their Unique Characteristics

Medicaid and CHIP enrollees differ from the general population in terms of their health, demographic, and socioeconomic characteristics, as shown in prior MACPAC reports.[6] These differences in individual and family characteristics can influence how and where children with Medicaid or CHIP obtain health care services. As described below, the findings on access to care presented in this chapter take into account the unique characteristics of enrollees with Medicaid or CHIP.

Health characteristics. Children with Medicaid or CHIP are more likely than children with ESI or uninsured children to be in fair or poor health and are more likely to have asthma[7] or to be limited because of physical, mental, or emotional problems (Figure 2-2). The fact that children with Medicaid or CHIP tend to be in poorer health suggests that they would be expected to use more health care services. As a result, children with Medicaid or CHIP could show higher utilization of health care services, not necessarily because Medicaid and CHIP provide greater access, but simply because children with Medicaid or CHIP are sicker. The findings in this chapter attempt to control for health-related characteristics that make children with ESI and no insurance differ from children with Medicaid or CHIP.[8]

Demographic and socioeconomic characteristics. Children with Medicaid or CHIP also differ from other children in terms of their demographic and socioeconomic characteristics. For example, children with Medicaid or CHIP are more likely to be in a family with income below the federal poverty level than are children with ESI and uninsured children.[9] Children with Medicaid or CHIP are *more* likely to be Hispanic than children with ESI, but *less* likely to be Hispanic than uninsured children (Figure 2-3).

[4] The coverage categories used in this report are as follows: a) full-year uninsured; b) full-year insured with Medicaid or CHIP at the time of the survey (and not with ESI or Medicare at the time of the survey); and c) full-year insured with ESI at the time of the survey. While the full-year insurance variables are defined over a 12-month period, some of the children in the ESI category may have had Medicaid or CHIP or other types of coverage over the course of the year; likewise, some of the children in the Medicaid/CHIP category may have had ESI coverage over the course of the year.

[5] For a discussion of the characteristics of children insured for only part of the year and the complexities involved with measuring their access to care, see Buchmueller et al. 2011 and Olson et al. 2005.

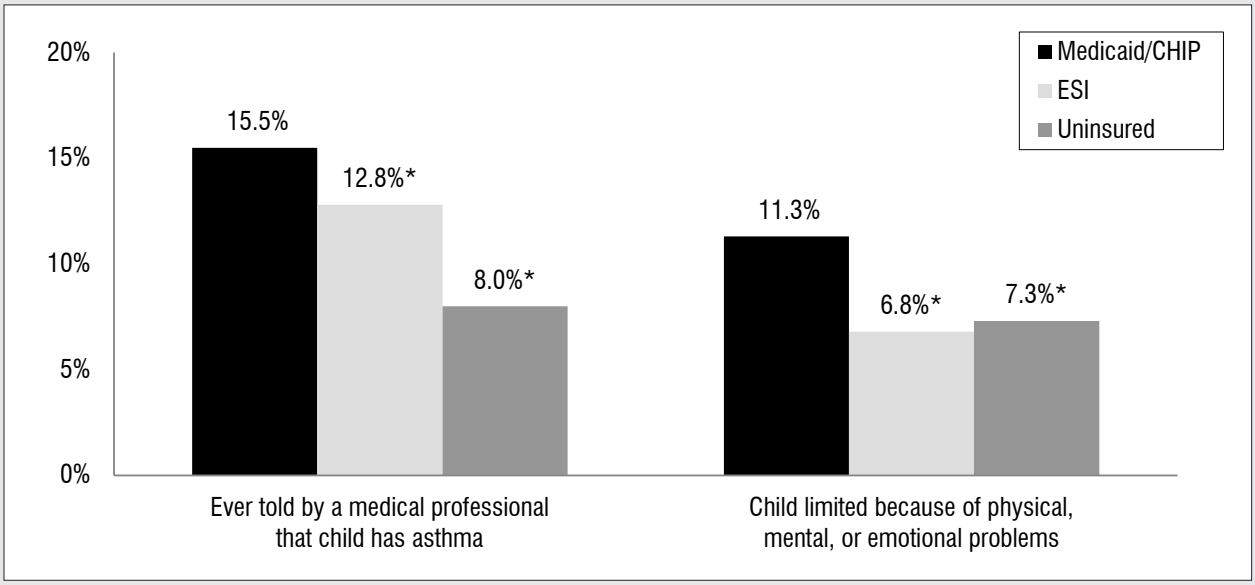
[6] See, for example, MACPAC 2011b, pp. 125-142.

[7] Report of asthma is based on whether the parent was ever told by a medical professional that the child had asthma. Uninsured children may be more likely to have undiagnosed health problems because they do not see health care providers as regularly.

[8] The MACPAC Contractor Report describes in detail the adjustments used, which are based on an approach developed by the Institute of Medicine. The MACPAC Contractor Report also shows the findings without the adjustments for these health-related characteristics.

[9] Income is measured at the health insurance unit (HIU). An HIU includes the members of a nuclear family who generally can be covered under one health insurance policy. This includes an individual, spouse, all unmarried children 18 and younger, and children 24 and younger who are full-time students.

FIGURE 2-2. Personal Health Characteristics of Children (0–18) by Insurance Status, 2009

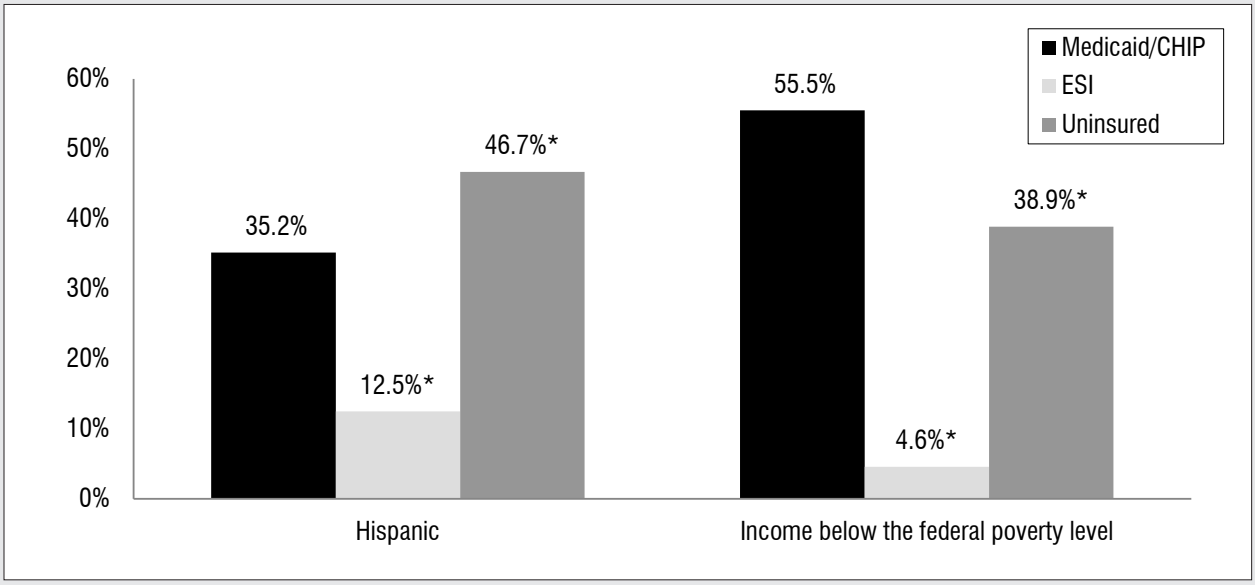


Notes: ESI is employer-sponsored insurance. To show how Medicaid/CHIP children differ from children with ESI or no coverage, these numbers are not adjusted as elsewhere for the groups' differing health, demographic or socioeconomic characteristics. Uninsured children may be more likely to have undiagnosed health problems because they do not see health care providers as regularly.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

FIGURE 2-3. Demographic and Socioeconomic Characteristics of Children (0–18) by Insurance Status, 2009



Notes: ESI is employer-sponsored insurance. Income is measured at the health insurance unit (HIU). The federal poverty level (FPL) is measured using the 2009 U.S. Department of Health and Human Services (HHS) poverty guidelines. To show how Medicaid/CHIP children differ from children with ESI or no coverage, these numbers are not adjusted for the groups' differing health, demographic or socioeconomic characteristics.

***** Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

As a result of these demographic and socioeconomic differences, children with Medicaid or CHIP could show different levels of health care utilization and access to care, not because of the source of coverage, but because of their underlying demographic and socioeconomic characteristics. For example, because significantly more children with Medicaid or CHIP live below the poverty line than do children with ESI or with no insurance, this analysis attempts to control for income to account for differences in levels of access due to income status. The findings in this chapter are based on controlling for demographic and socioeconomic characteristics that make children with ESI and no insurance differ from children with Medicaid or CHIP.[10]

Provider Availability

Availability focuses on whether health care providers are accessible to Medicaid and CHIP enrollees. There are two key factors that influence the availability of providers in a given area:

- provider supply—for example, the ratio of providers to the population; and
- provider participation—for example, the proportion of providers in an area that accepts Medicaid and CHIP.

Physicians and other health care providers are disproportionately located in areas where incomes are high and health care is financed predominantly by private insurance; they are less willing to locate in the more rural or low-income areas where many children with Medicaid and CHIP reside (Brasure et al. 1999, Fossett and Perloff 1999). Research has also found that communities with high proportions of black and Hispanic residents were much more likely than others to have a shortage of physicians, regardless of the average income in the community (Komaromy et al. 1996). Although overall provider supply may not be affected by federal or state Medicaid and CHIP policies, providers' willingness to participate in these programs may be affected by a number of factors under states' control, including payment rates and administrative burden for providers.

Because the data used here are from interviews of *users* of care, rather than *providers*, they do not directly measure the number of providers available to Medicaid and CHIP enrollees. Other sources of data such as provider surveys can produce more information on access as measured by provider availability and are being used in analyses MACPAC is currently conducting. However, there are several measures available in household survey data that indirectly measure whether providers are available to the consumers being surveyed. For example, whether an enrollee reports having a usual source of care may be the result of multiple influences, but one important factor is whether the enrollee is able to find a provider to serve as a usual source of care.

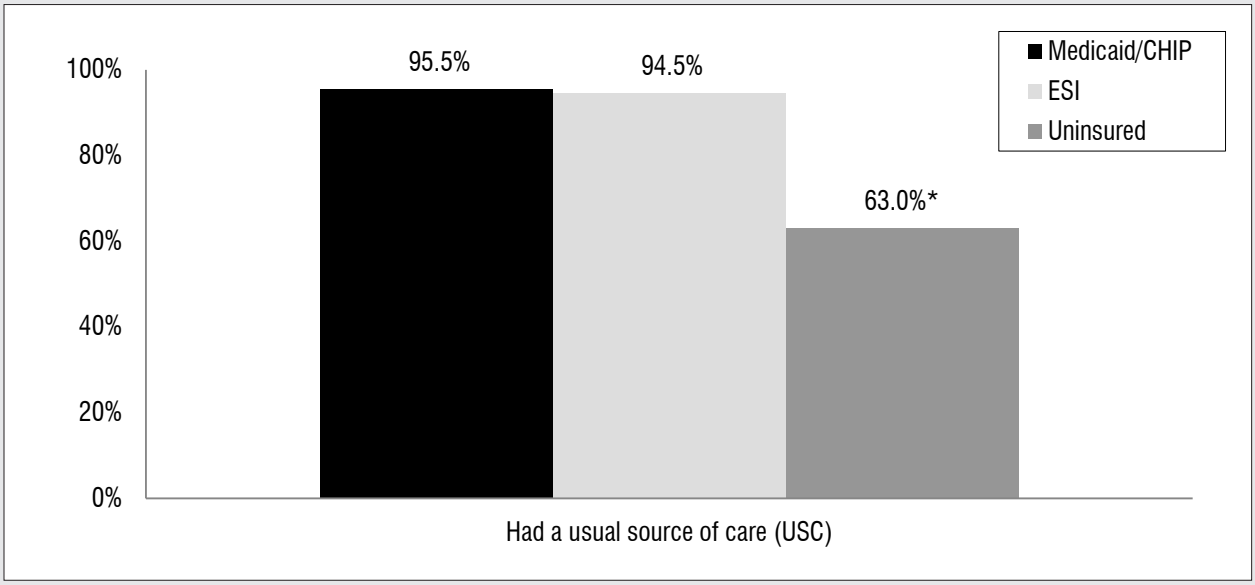
Nearly all children with Medicaid or CHIP have a usual source of care. Almost all children with Medicaid or CHIP (95.5 percent) and similarly situated children with ESI (94.5 percent) were reported to have had a usual source of care, compared to 63.0 percent of similarly situated uninsured children (Figure 2-4).[11]

Children with Medicaid or CHIP are more likely than children with ESI to have a clinic or health center as their usual source of care. A usual source of care is defined as the place that a person

[10] The MACPAC Contractor Report also shows the findings without these adjustments.

[11] The results in the remainder of this chapter compare children with Medicaid or CHIP to "similarly situated" children with ESI or without insurance unless otherwise specified. This means that numerous characteristics were controlled for using regression models, as described in this chapter's Annex and the MACPAC Contractor Report.

FIGURE 2-4. Usual Source of Care among Similarly Situated Children (0–18) by Insurance Status, 2009



Notes: ESI is employer-sponsored insurance. Usual source of care (USC) is defined as the place that the person usually goes to when sick or in need of health-related advice; the emergency department is not considered a USC. The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

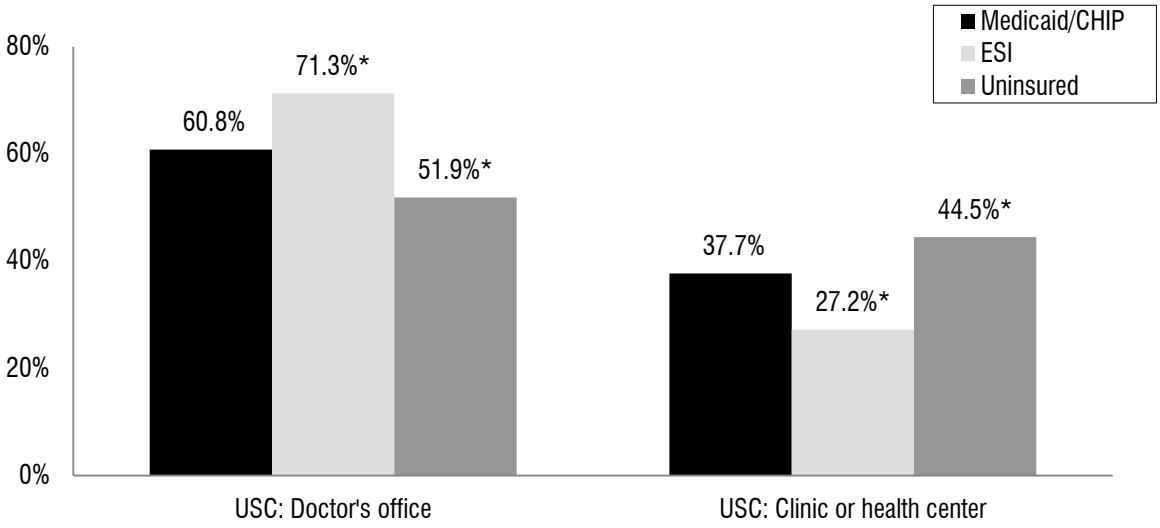
typically goes to when sick or in need of health-related advice. For the analyses in this chapter, the emergency department is not considered a usual source of care. Among children with a usual source of care (USC), most have a doctor's office as their USC, regardless of their source of health insurance. Previous research has found that Medicaid and CHIP enrollees disproportionately rely on providers at community health centers for primary care services (Hing and Uddin 2008). This is consistent with the findings in Figure 2-5, which show that, even after accounting for differences in the health, demographic, and socioeconomic status of children with a USC, children with Medicaid or CHIP are more likely to have a clinic or health center as their USC, compared to children with ESI.[12] Uninsured children are even more likely than children with Medicaid or CHIP to rely on clinics and health centers as their USC.

Reasons for delaying needed care vary with insurance status. After accounting for differing enrollee characteristics, children with Medicaid or CHIP and those with ESI reported similar rates of delayed medical care (Table 2-1).

The findings in this chapter rely on comparisons of children with Medicaid or CHIP to *similarly situated* children with ESI. When comparing the two groups *without* controlling for their differing characteristics, children with ESI were less likely to have delayed care (9.4 percent) compared to children with Medicaid or CHIP (17.0 percent)—a difference of 7.6 percentage points. When controlling only for the populations' differing health characteristics, the difference between the two groups decreases; if children with ESI had as many health needs as children with Medicaid or CHIP, they would be more likely to have delayed

[12] "Clinic or health center" does not include hospital outpatient departments.

FIGURE 2-5. Type of Usual Source of Care (USC) among Similarly Situated Children (0–18) with a USC by Insurance Status, 2009



Notes: ESI is employer-sponsored insurance. Usual source of care (USC) is defined as the place that the person usually goes to when sick or in need of health-related advice; the emergency department is not considered a USC. See Figure 2-4 for overall rates of children having a USC. Doctor's office includes an HMO. Clinic or health center does not include hospital outpatient departments. The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

care (a smaller difference, 5.7 percentage points, as shown in Table 3 of the MACPAC Contractor Report's technical appendix). After also controlling for demographic and socioeconomic characteristics, in addition to health characteristics, the significant difference in reported delayed medical care between children with Medicaid or CHIP and ESI disappears. This may indicate that delaying needed medical care is a challenge for children with lower incomes and other related characteristics, regardless of their health insurance status.

Children with Medicaid or CHIP are less likely than other groups to delay care because of worries about out-of-pocket costs. In terms of the reasons why care was delayed, however, children with Medicaid or CHIP reported lower levels of delaying care because of worries about out-of-pocket costs compared to similarly situated children with ESI and uninsured children (Table 2-1). This is likely related to the requirement that children enrolled in Medicaid generally not have cost sharing such as copayments (42 CFR 447.53(b)(1)).

Provider office hours and office waiting times present some challenges for children with Medicaid or CHIP. For children with Medicaid or CHIP and with ESI, similar rates were reported for delaying care because of difficulty in obtaining an appointment or getting through on the phone. Delays in care because families could not make appointments during office hours were uncommon, but were more often reported for children with Medicaid or CHIP than for those with ESI (Table 2-1). This may be influenced by the fact that 42.9 percent of children with Medicaid or CHIP had a usual source of care available at night or during weekend hours, which is significantly lower than for children with ESI

TABLE 2-1. Delayed Medical Care among Similarly Situated Children (0–18) by Insurance Status, 2009

	Medicaid/CHIP	ESI	Uninsured
Delayed medical care (any reason below)	**17.0%**	**16.1%**	**29.8%***
Because once at the site, wait too long to see the doctor	8.2	5.9*	4.0*
Because could not get an appointment soon enough	6.9	5.6	5.0
Because did not have transportation	4.6	3.4*	4.0
Because could not go when open (office hours)	3.7	2.5*	3.9
Because could not get through on the phone	2.9	2.2	2.5
Because of worries about out-of-pocket costs	1.6	4.9*	21.6*

Notes: ESI is employer-sponsored insurance. Usual source of care (USC) is defined as the place that the person usually goes to when sick or in need of health-related advice; the emergency department is not considered a USC. The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

(51.4 percent). Children enrolled in Medicaid or CHIP were also more likely to have care delayed because the wait for the health care provider in the office was too long.

There were no significant differences reported among children with Medicaid or CHIP and similarly situated children with ESI for the following four access measures:

- **Timeliness of needed care.** Among children who had a condition that needed care right away, 91.5 percent of the children with Medicaid or CHIP were reported to have received care as soon as needed.
- **Appointments for routine care.** Among children who had appointments for routine care, an appointment was reported to be available as soon as was needed for 93.3 percent of the children with Medicaid or CHIP.
- **Ease of obtaining care and tests.** Among children who needed care, tests, or treatments, households reported it was easy for 94.8 percent of the children with Medicaid or CHIP to get such care.
- **Ease of obtaining specialty care.** Among children who needed to see a specialist, it was reported to be easy for 82.6 percent of the children with Medicaid or CHIP to see the necessary specialist.

Indeed, even for uninsured children who obtained care, there was no significant difference in most of these measures compared to children with Medicaid or CHIP, with the exception of specialty care: 58.6 percent of uninsured children needing specialty care found it easy to see a specialist.

Utilization of Health Care Services

By itself, insurance coverage does not guarantee the receipt of necessary or appropriate services. Thus utilization, the third component of the Commission's framework on access, assesses enrollees' use of services and how they perceive their experiences with obtaining care and interacting with their providers. Utilization is "realized access," or how services are actually used by individuals. This section presents findings on utilization of care by children enrolled in Medicaid or CHIP, compared to similarly situated children with ESI or no coverage.[13]

Use of primary and preventive care among children with Medicaid or CHIP equals or exceeds that among other children. As shown in Figure 2-6, parents of children with Medicaid or CHIP reported rates of well-child visits that exceeded those of similarly situated children with ESI or no coverage. This was also true for children having any office visit to a health care provider.

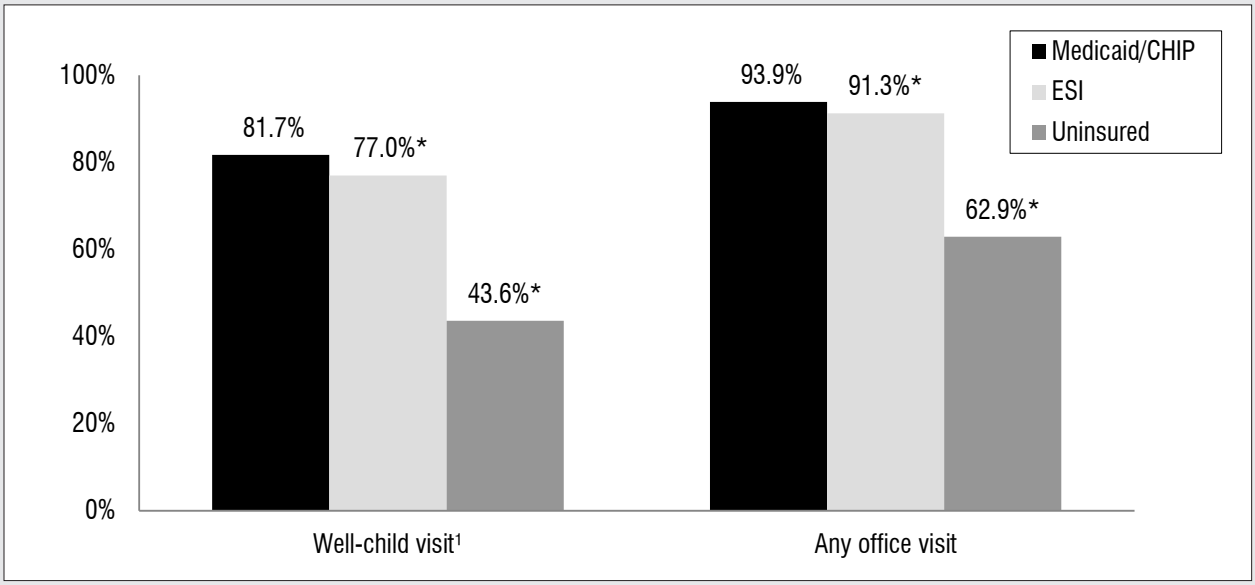
While children with Medicaid or CHIP were reported to receive flu vaccines at rates similar to those covered by ESI (34.2 percent vs. 32.3 percent), the receipt of flu vaccines among all children is very low given that the Centers for Disease Control and Prevention (CDC) recommends that all children over six months of age be inoculated. Consistent with their less-frequent contact with the health care system, uninsured children are less likely to have flu shots, screenings such as blood pressure checks, and encounters that include advice on topics such as the benefits of regular dental check-ups and exercise.

Use of specialists is comparable among children with Medicaid or CHIP and similarly situated children with ESI. The survey results show that children with Medicaid or CHIP have rates of visits to specialists and mental-health professionals that are not significantly different from those among similarly situated children with ESI (Figure 2-7). The utilization rates among uninsured children are significantly lower for specialists in general and mental-health professionals in particular, compared to children with Medicaid or CHIP.

Again, the findings in this chapter rely on comparisons of children with Medicaid or CHIP to *similarly situated* children with ESI. When comparing the two groups without controlling for their differing characteristics, children with ESI are *more* likely to have a specialist visit (18.6 percent) compared to children with Medicaid or CHIP (14.4 percent)—a difference of 4.2 percentage points. When controlling *only* for the populations' differing health characteristics, the difference between the two groups is even larger; if children with ESI had as many health needs as children with Medicaid or CHIP, they would be even more likely to have visited a specialist (5.8 percentage point difference, as shown in Table 3 of the MACPAC Contractor Report's technical appendix). However, after controlling for demographic and socioeconomic characteristics, in addition to differing health characteristics, the significant differences between children with Medicaid or CHIP and ESI disappear with respect to a specialist visit, as shown in Figure 2-7. This may indicate that accessing specialty care is a challenge for low-income children, regardless of their health insurance status.

[13] Additional detail is available in the MACPAC Contractor Report.

FIGURE 2-6. Ambulatory Care among Similarly Situated Children (0–18) by Insurance Status, 2009



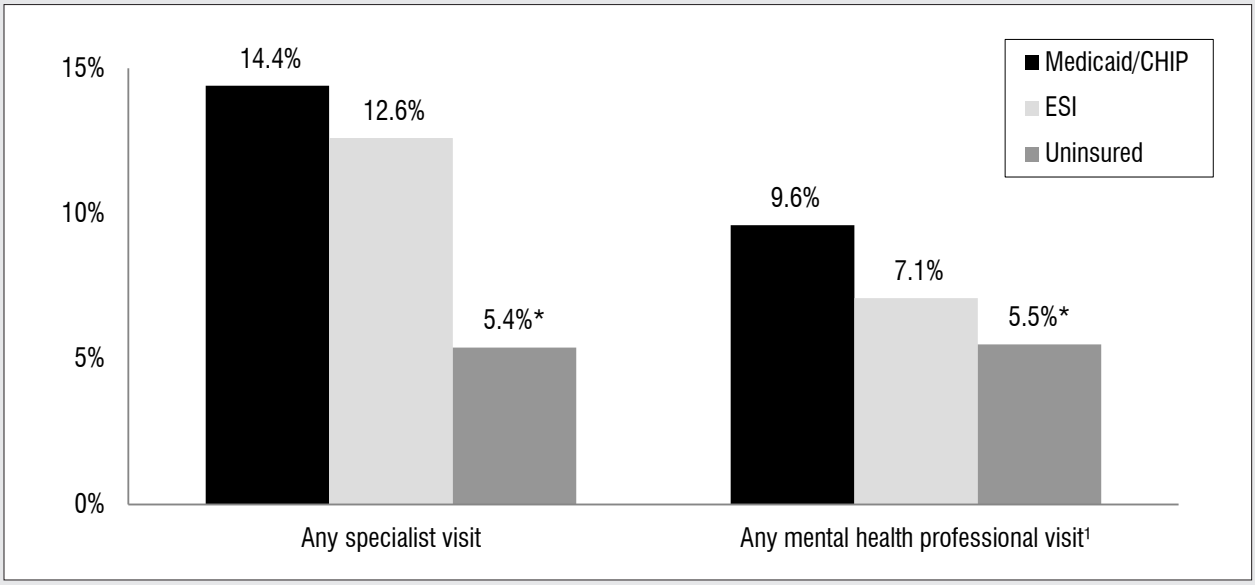
Notes: ESI is employer-sponsored insurance. The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

[1] Question only asked of children age 0 to 17.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

FIGURE 2-7. Specialty Care among Similarly Situated Children (0–18) by Insurance Status, 2009



Notes: ESI is employer-sponsored insurance. Specialists include medical doctors who specialize in a particular medical disease or problem (other than psychiatrists or ophthalmologists). The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

[1] Question only asked of children age 2 to 18.

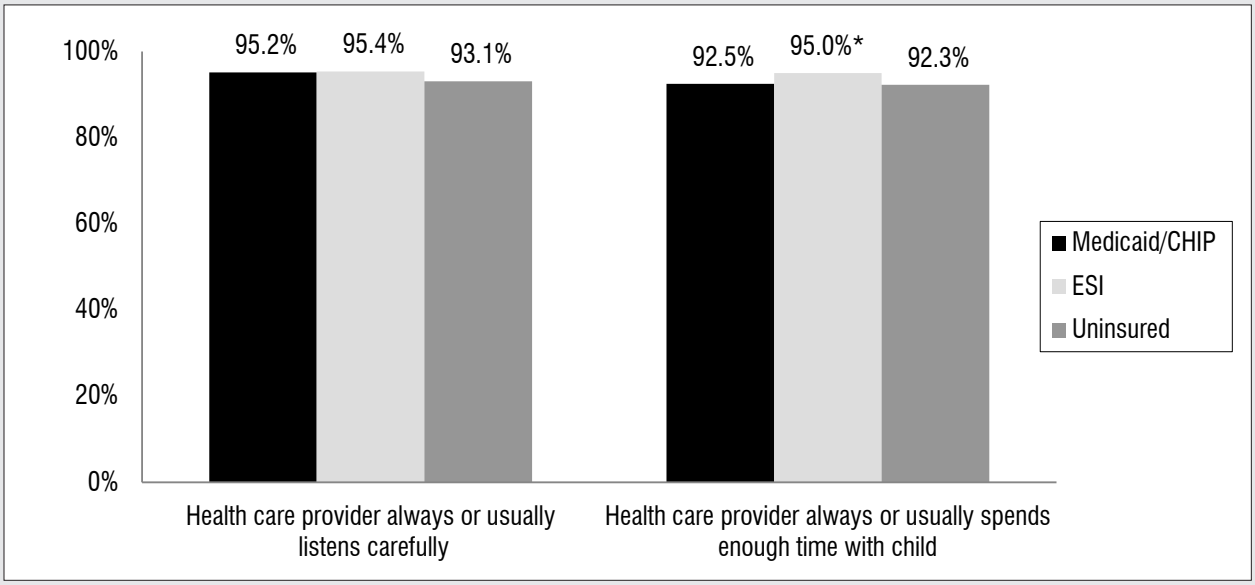
Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

In addition, this measure does not assess the extent to which specialty care was needed, nor whether children received all necessary specialty care. Rather, it is a simple measure of whether a visit to a specialist occurred. This sole measure cannot be used to indicate whether or not children with Medicaid or CHIP face challenges in obtaining access to needed specialty care, but must also be placed in the context of information from other sources, such as provider surveys and claims data.

Regardless of the source of health insurance, health care providers were reported to listen carefully and spend enough time with their child patients. The vast majority of children who had at least one visit to a health care provider's office or clinic in the past 12 months were reported to have had positive interactions with the provider. For all three insurance groups, over 90 percent indicated that the provider usually or always listened carefully, explained things in a way that was easy to understand, showed respect, and spent enough time with the child. The differences between uninsured and children with Medicaid or CHIP were not statistically significant. Only in one case—whether the doctors or health care professionals spend enough time with the child—was the difference between ESI and Medicaid or CHIP significant. And, although the difference was statistically significant, both numbers were above 90 percent (Figure 2-8).

As previously noted, these measures are based on the perceptions of respondents on behalf of children who obtained care. The surveys do not identify, for example, the amount of time the provider actually spent with the children, only whether respondents considered it to be "enough." Respondents with children who have no coverage or with different sources of coverage may have different expectations for how much time with

FIGURE 2-8. Patient-centered Measures among Similarly Situated Children (0–17) by Insurance Status, 2008



Notes: ESI is employer-sponsored insurance. Questions only asked of children who had at least one doctor or health care professional visit in the past 12 months. The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2008 Medical Expenditure Panel Survey (MEPS)

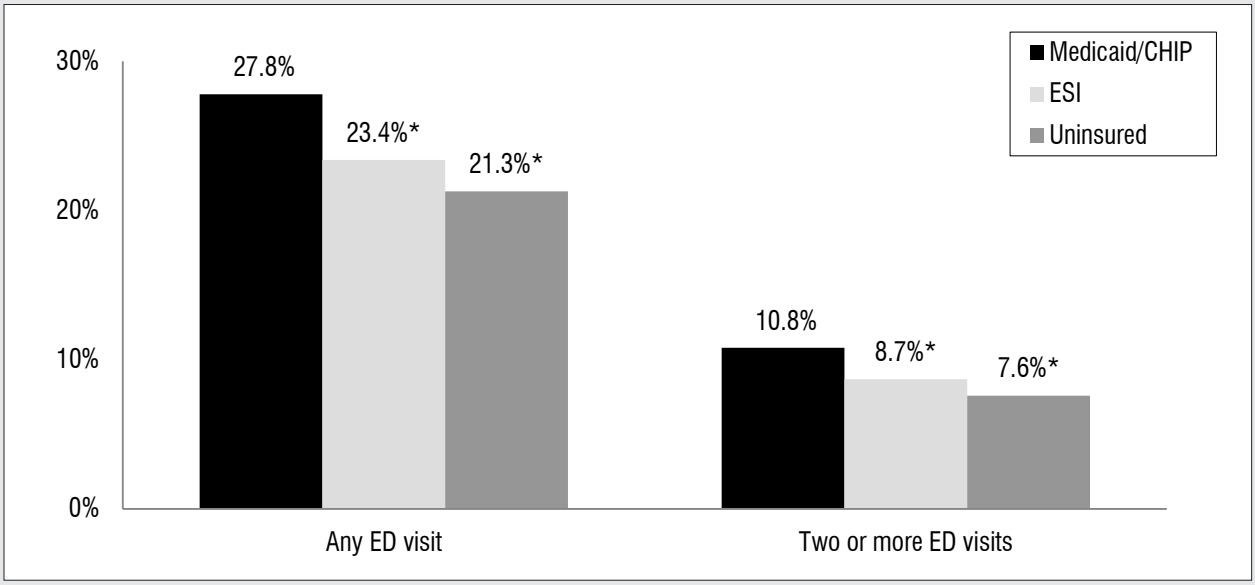
the child is "enough," which could affect their responses.

Children with Medicaid or CHIP have the highest rates of emergency department visits. Although emergency department (ED) care is necessary for some conditions, utilizing EDs for non-emergent care is generally more costly and provides fewer opportunities for follow-up than if the underlying condition were treated by a primary care provider (GAO 2011). A high rate of ED use may indicate that children are not receiving care in the optimal setting.

The survey results show that children with Medicaid or CHIP are much more likely than uninsured children and children with ESI to have had an ED visit and to have had multiple ED visits in the past 12 months (Figure 2-9).[14] While these results are adjusted for differences in children's health, demographic, and socioeconomic characteristics, they do not adjust for the availability of health care providers after hours or for whether the children live in medically underserved areas, for example. The higher rates of ED visits among children with Medicaid or CHIP is well documented in the research literature and confirmed in this analysis. This may be due in part to their having less access to nighttime and weekend care through their usual source of care, and longer wait times in the office to see their providers (Table 2-1) (IOM 2007).

More analysis is needed to understand what may be causing higher rates of ED use among children with Medicaid or CHIP, whether or not such ED use is appropriate, and whether or not the higher rates are a reflection of problems with access to primary or specialty care.

FIGURE 2-9. Emergency Department Visits among Similarly Situated Children (0–18) by Insurance Status, 2009



Notes: ESI is employer-sponsored insurance. The means reported for children with ESI coverage and for uninsured children are regression-adjusted, using the health, demographic, and socioeconomic characteristics of the children with Medicaid/CHIP coverage.

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

Source: Urban Institute analysis for MACPAC of the 2009 National Health Interview Survey (NHIS)

[14] Using the unadjusted ESI numbers, the differences are even larger, as shown in Table 3 of the MACPAC Contractor Report's technical appendix.

Looking Forward

Prior studies have shown that insurance coverage—Medicaid and CHIP for children in particular—improves access to care compared to being uninsured, and the findings in this chapter are consistent with that earlier research (IOM 2009, Hargraves and Hadley 2003). Other studies have examined the impact of Medicaid and CHIP relative to ESI on access to care (Dubay and Kenney 2001, Long et al. 2005, Selden and Hudson 2006).

The findings presented in this chapter show that children enrolled in Medicaid or CHIP have substantially better access to care than similarly situated uninsured children and, in most cases, experience comparable access as similarly situated children with ESI. The comparisons between similarly situated children help ensure that any differences in access were attributable to the specific source of coverage, not underlying enrollee characteristics. In the relatively few cases where the results differed when controlling for underlying characteristics such as family income, race, or ethnicity, the findings show that these factors tend to be associated with reduced access to care, regardless of whether children are enrolled in ESI, Medicaid, or CHIP. Because Medicaid and CHIP serve a disproportionate share of children from certain racial and ethnic minority groups with lower incomes and worse health status, the programs have an important but challenging role to ensure timely access to appropriate care.

Using its framework for examining access to care, the Commission will continue to explore access in Medicaid and CHIP. The Commission intends to extend this analysis to other populations such as non-elderly adults. The Commission also plans to explore in greater depth particular issues pertaining to children's access, including oral health, geographic variation by state and by rural/urban status, and the relationship between payment policy and access.

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Chapter 2 Annex

Summary of Data Sources and Methods for the Analysis of Children's Access to Care

This Annex gives a brief overview of the data sources and the analytic approach used to produce the statistical analysis presented in this chapter.[1]

Sources of Data

The results presented in this chapter are from publicly available data from two national household surveys that are administered annually by the federal government—the NHIS and the MEPS. The survey responses regarding children were provided by a knowledgeable adult in the household.

Although state-specific estimates may be available for some of the largest states, neither the NHIS nor the MEPS permits state-level estimates for all 50 states. Thus, these estimates do not provide information on state-level differences in access to care or on the factors that drive differences across states.

NHIS. The NHIS (2009) was the primary source of data used in this chapter because it provides great detail on individuals' health while also providing some of the most reliable estimates of individuals' sources of health insurance coverage (Plewes 2010). The NHIS is an annual face-to-face household survey of civilian non-institutionalized individuals and is designed to monitor the health of the U.S. population through the collection of information on a broad range of health topics. Administered by the National Center for Health Statistics within the CDC, the NHIS consists of a nationally representative sample from approximately 35,000 households with about 87,500 people (CDC 2010).

The NHIS is fielded continuously throughout the year, with data collected through an in-person household interview using computer-assisted personal interviewing (CAPI) technology. The NHIS employs a complex, multistage sample design and includes an oversample of minority populations, including African American, Hispanic, and Asian American respondents.

[1] Additionally, more detailed information is presented in the MACPAC Contractor Report (Kenney and Coyer 2012), which was the basis of the findings presented in this chapter. The MACPAC Contractor Report is available at www.macpac.gov.

The NHIS Basic Module remains relatively constant over time and consists of the Family, Sample Adult, and Sample Child Core components. For the Family Core component, information is collected for each member of the household. One sample child (if any children under age 18 are present) and one sample adult are randomly selected from each household to collect more detailed information for the Sample Child Core and the Sample Adult Core components. Responses to the Sample Child Core questionnaire are obtained from a knowledgeable adult residing in the household. The Sample Adult and Sample Child questionnaires differ on some items, but both collect basic information on health status, health care service use, and health-related behaviors.

MEPS. The MEPS (specifically, its household component) was used in this chapter to provide estimates not available from the NHIS. The sample frame for the MEPS is drawn from a subsample of households participating in the previous year's NHIS. Like the NHIS, the MEPS is a face-to-face household survey of civilian non-institutionalized individuals. Administered by the Agency for Healthcare Research and Quality (AHRQ), the MEPS consisted of a nationally representative sample of about 31,000 people in 2008 (AHRQ 2010). The full-year consolidated MEPS data file for 2008 was used in this chapter.

The MEPS collects data through an overlapping panel design. A new panel of sample households is selected each year, and data for each panel are collected for two calendar years. The two years of data for each panel are collected in five rounds of interviews that take place over a two-and-a-half year period. A single household respondent reports information for the entire household through in-person household interviews using CAPI technology. The survey collects detailed information on health care use, expenditures, sources of payment, and health insurance coverage for all household members. The MEPS also provides estimates of health status, demographic and socioeconomic characteristics, and access to health care.

Analytic Approach

The findings in this chapter are based on the standard research approach of controlling for factors other than health insurance status. In this case, the goal was to determine how reported measures of access to and use of health care differ based on children's insurance coverage, controlling for numerous other characteristics using regression models. Those characteristics include:

- health-related characteristics, such as age, gender, health status, presence of certain chronic conditions (e.g., asthma), and disability;
- additional demographic characteristics, such as race and ethnicity; and
- socioeconomic characteristics, such as income, education, and citizenship.

Additional analyses in the MACPAC Contractor Report show unadjusted as well as regression-adjusted differences in access and use among children with Medicaid or CHIP, ESI, and no coverage. Two multivariate regression model specifications were used to capture differences related to two types of factors. For the first set of models, based on Institute of Medicine (IOM) recommendations (IOM 2002), the analyses controlled for differences in health status. For children, these factors were age, gender, self-reported health status, chronic conditions, and disability status. The second set of factors also included variables that capture demographic and socioeconomic characteristics. The additional variables were race, ethnicity, citizenship, parent composition, and—at the health insurance unit level—highest educational attainment, employment, income, homeownership, citizenship,

health status, and disability status. These are the results used in this chapter.

Even with these adjustments, the differences in access that persist may not necessarily be wholly attributable to insurance status. There may be other relevant variables that could not be controlled for in this analysis. For example, whether or not a person lived in a Metropolitan Statistical Area is not available on the publicly available NHIS data, even though it is collected through the survey. There may be additional unobserved factors related to health status, health-seeking behavior, and socioeconomic status that influence both insurance status and access to care.

CHAPTER 3

State Approaches for Financing Medicaid and Update on Federal Financing of CHIP

CHAPTER 3a

State Financing of Medicaid: Context, Scope, and Relationship to Provider Payment

This section begins the Commission's work on the interaction between state Medicaid financing and provider payment. It outlines the primary approaches that states take to finance their share of Medicaid expenditures, including the use of state general revenue, local government contributions, and health care related taxes, and describes supplemental payments made by states to certain providers. These issues are important to Medicaid policy because:

- State financing approaches affect Medicaid payment methodologies and payment amounts, which in turn may affect enrollees' access to services.
- A better understanding of both state financing and provider payment can help policymakers to identify and implement policies that are efficient and effective and promote access to appropriate services.

This section describes:

- **State flexibility in financing Medicaid.** The law provides states with flexibility in financing the non-federal share of the Medicaid program. While the majority of non-federal spending is state general revenue, states vary in their use of contributions from local governments, including providers operated by local governments. Federal statute allows these contributions in recognition of the historical role of local governments in financing health care for low-income individuals.
- **Health care related taxes.** These taxes are authorized by federal statute and have been implemented by nearly every state. Information regarding these taxes, including tax rates and the amount of revenue generated, is not readily available, limiting policymakers' understanding of the role of such taxes in total provider payment amounts and making it difficult to assess the potential impact of changes to health care related tax provisions.

- **Supplemental provider payments.** In many cases, states use local government contributions and health care related taxes to finance lump-sum "supplemental payments" for Medicaid services (most commonly to hospitals) based on fee-for-service (FFS) federal upper payment limit (UPL) requirements, as well as disproportionate share hospital (DSH) payments for uncompensated care costs in hospitals. Such supplemental payments may be a particularly important source of revenue for certain providers such as safety-net hospitals. In fiscal year (FY) 2011, supplemental payments accounted for 41 percent of total FFS Medicaid payments to hospitals.[1]
- **Data limitations regarding UPL supplemental payments.** The amount of lump-sum supplemental payments based on UPLs and the providers that receive them cannot be readily discerned from federal data sources. Thus, it is not possible to compare payment levels across providers and states or to determine the total amount of Medicaid spending on specific services and populations, making it difficult to evaluate the impact of Medicaid payment policies.
- **UPL supplemental payments and managed care.** Some states have indicated that UPL supplemental payment policies have influenced state decisions regarding the expansion of Medicaid managed care programs for high-cost enrollees.

The Commission's March 2011 *Report to the Congress on Medicaid and CHIP* provided an overview of Medicaid fee-for-service payment policy, including the statutory and regulatory history and resulting variation in state payment methods. The Commission's June 2011 report, *The Evolution of Managed Care in Medicaid,* provided an overview of Medicaid managed care payment policy. In November, the Commission released a MACBasic outlining the process by which Medicaid providers are paid. In the section that follows, the Commission examines the manner in which payment is financed, and the impact of financing on payment policy, particularly payments to certain classes of providers that treat high numbers of Medicaid enrollees. This section includes a description of:

- Context and History
- Federal and Non-federal Medicaid Financing
- Supplemental Provider Payments
- Looking Forward

Context and History

Financing the Medicaid program is a shared responsibility of the federal and state governments. States are required to cover certain populations and benefits as a condition of participation in the Medicaid program, and may cover others at state option (§1902(a)(10) of the Social Security Act (the Act)). As long as a state operates its program within federal requirements, it is entitled to receive federal matching funds toward allowable state expenditures. As described below, federal contributions for Medicaid provider payments are provided in accordance with a formula that calculates a federal matching rate for each state, while contributions toward administrative costs vary by the type of activity, as specified in the statute.

Federal policy regarding both the permissible sources of non-federal Medicaid expenditures and federal contributions toward those expenditures dates to Medicaid's 1965 enactment. Prior to 1965, health care services for low-income individuals were provided primarily through a patchwork

[1] MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data, February 2012.

BOX 3a-1. Glossary of Key Terms

Certified Public Expenditure (CPE) – An expenditure made by a governmental entity, including a provider operated by state or local government, under the state's approved Medicaid state plan, making the expenditure eligible for federal match.

Disproportionate Share Hospital (DSH) Payments – Supplemental payments to hospitals that serve a disproportionate share of low-income patients. Payments to each hospital are limited to the actual cost of uncompensated care to Medicaid enrollees and uninsured individuals for hospital services.

Federal Financial Participation (FFP) – Federal matching funds provided to a state for Medicaid expenses.

Federal Medical Assistance Percentage (FMAP) – The rate at which the federal government matches each states' spending on Medicaid services.

Health Care Related Tax – A licensing fee, assessment, or other mandatory payment that is related to health care items or services; the provision of, or the authority to provide, the health care items or services; or the payment for the health care items or services. A tax is considered to be related to health care items or services if at least 85 percent of the burden of the tax revenue falls on health care providers.

Intergovernmental Transfer (IGT) – A transfer of funds from another governmental entity (e.g., counties, other state agencies), including a provider operated by state or local government, to the Medicaid agency.

Supplemental Payment – A Medicaid payment to a provider, typically in a lump sum, that is made in addition to the standard payment rates for services. Includes both UPL payments and DSH payments for uncompensated care.

Upper Payment Limit (UPL) – The maximum aggregate amount of Medicaid payments that a state may make to a class of institutional providers.

UPL Payment – A supplemental payment to a Medicaid provider based on the difference between the amount paid in standard payment rates and the UPL.

of programs sponsored by state and local governments, charities, and community hospitals (HCFA 2000). Payments were often in the form of direct investments in hospitals and clinics for low-income individuals. Medicaid's financing approach was designed to build upon these existing programs by providing federal matching funds for state and local spending on approved health care services provided to certain populations.

Section 1902(a)(2) of the Act, included in the original statute, recognized the role of these local programs, requiring that a state plan for medical assistance must "provide for financial participation by the state equal to not less than 40 per centum of the non-federal share of the expenditures under the plan with respect to which payments under Section 1903 are authorized under this title." While the administration of each state's Medicaid program was required to be centralized at the state level, this provision allowed the pre-existing patchwork of programs to maintain primary responsibility for service delivery and non-federal financing of services that now qualified for federal payments. As a result, states that traditionally relied on local governments to provide health care services to low-income individuals were able to continue to do so under the Medicaid program. In addition, pre-existing programs continued to provide services to low-income populations that were not covered by Medicaid.

Federal and Non-federal Medicaid Financing

In FY 2011, the Medicaid program accounted for $432 billion in total spending. Generally, the federal share of Medicaid is about 57 percent. From FY 2009–2011, however, the federal share of Medicaid spending was higher due to a temporary increase in states' federal medical assistance percentages (FMAPs) to provide broader federal assistance over this period (Figure 3a-1). The Congressional Budget Office estimates that the federal share of Medicaid will return to about 57 percent in FY 2012 and 2013, and increase to between 60 and 62 percent in FY 2014 when provisions of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) become effective (CBO 2011).

Medicaid now accounts for more than 15 percent of national health care spending (Martin et al. 2012). The non-federal share of Medicaid spending is estimated to account for 17 percent of states' general revenue and about 14 percent of total non-federal funds spent by states for all purposes in state fiscal year (SFY) 2011 (NASBO 2011). Because Medicaid is such a significant component of state budgets, states are continually seeking more efficient ways to finance and pay for services.

Federal Medicaid financing

The federal share of Medicaid expenditures is often referred to as the federal match, or federal financial participation (FFP). Federal Medicaid funds are authorized through Congressional appropriation and funds are withdrawn from the general fund of the U.S. Treasury as needed to reimburse states for the federal share of their Medicaid expenditures (OACT 2010).

Each quarter, states submit the CMS-64 Quarterly Medicaid Statement of Expenditures (CMS-64)[2] to the Centers for Medicare & Medicaid Services (CMS), reporting the actual amount of expenditures that are eligible for the federal match in the following two broad categories:

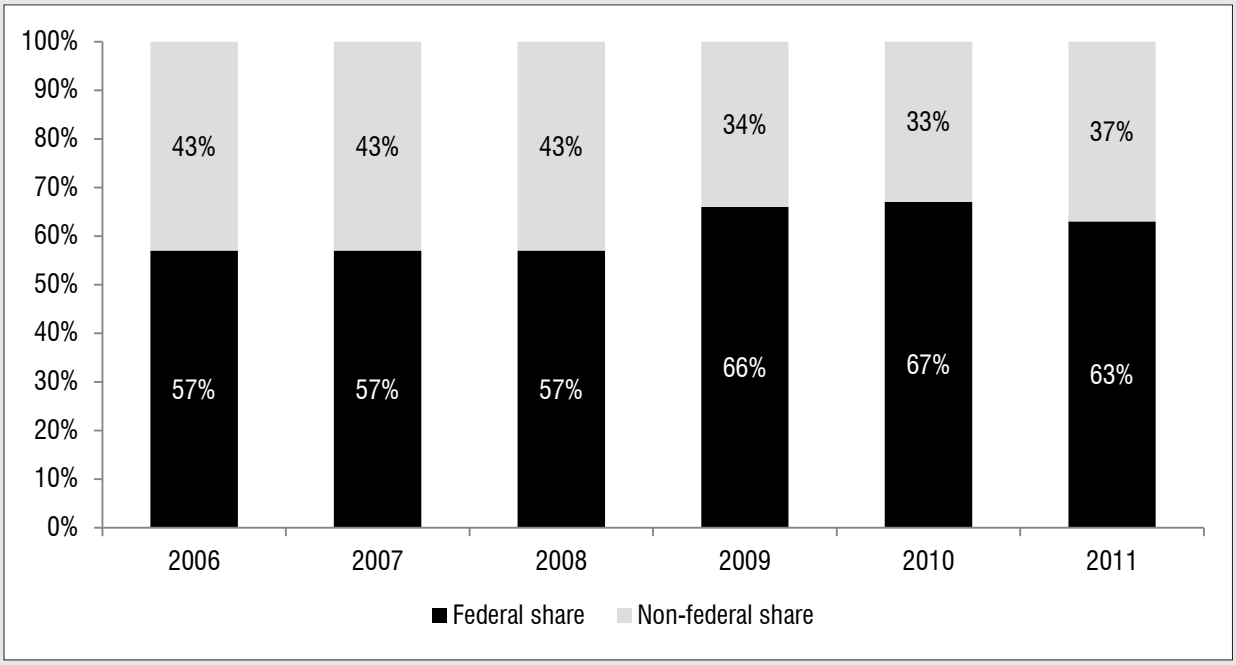
- **Medical assistance.** The federal share of most health care service costs, including payments to providers and managed care entities, is determined by a state's FMAP. The U.S. Department of Health and Human Services (HHS) calculates each state's FMAP annually based on a statutory formula that takes into account per capita income and other factors. (See Table 14 of MACStats for additional information regarding states' FMAPs.)
- **Program administration.** The federal share for Medicaid administration (e.g., staff, information technology systems, auditing activities) does not vary by state and is generally 50 percent.[3]

At times, the Congress has used enhanced matching rates to promote certain policy goals. For example, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provided a temporary increase in each state's FMAP from October 2008 through December 2010. The increase was later extended at lower levels through June 2011. The ARRA also provided 100 percent FFP to states for incentives to eligible Medicaid providers to purchase, implement, and operate certified electronic health records (EHR) technology and established 90 percent FFP for state administrative expenses related to carrying out

[2] CMS-64 Quarterly Expenditure Report form available at: https://www.cms.gov/MedicaidBudgetExpendSystem/Downloads/CMS64Forms.pdf.

[3] While most administrative activities garner the standard 50 percent federal match, some are eligible for higher rates such as 90 percent for the design, development, and installation of Medicaid Management Information Systems (MMIS) and 75 percent for skilled professional medical personnel, translation services, utilization review, and MMIS operation (§1903(a)(2) of the Act).

FIGURE 3a-1. Federal and Non-federal Share of Medicaid Expenditures, FY 2006–2011



Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data, February 2012

this provision. For additional discussion of federal financing, see the Commission's March 2011 *Report to the Congress on Medicaid and CHIP*.

Non-federal financing

The non-federal share of Medicaid expenditures is commonly referred to as the "state share." States generate their share through multiple sources, including state general revenue, contributions from local governments including providers operated by local governments,[4] and specialized revenue sources such as health care related taxes. As noted, although 40 percent of non-federal financing must come from the state, up to 60 percent may be derived from local sources (§1902(a)(2) of the Act).[5,6]

Each state makes its own decisions, within federal requirements, regarding how to finance its share of the Medicaid program. As a result, the extent to which states rely on funding sources other than general revenue varies considerably and may be influenced by states' traditional sources of general revenue and approaches to financing health care for low-income individuals. The following are the most common sources of non-federal Medicaid financing:

- state general revenue;

[4] Federal statute permits the use of funds transferred from or certified by units of government within a state as the non-federal share of Medicaid expenditures regardless of whether the unit of government is also a health care provider (§1903(w)(6)(A) of the Act). "Unit of local government" is defined as "a city, county, special purpose district, or other governmental unit in the state" (§1903(w)(7)(G) of the Act).

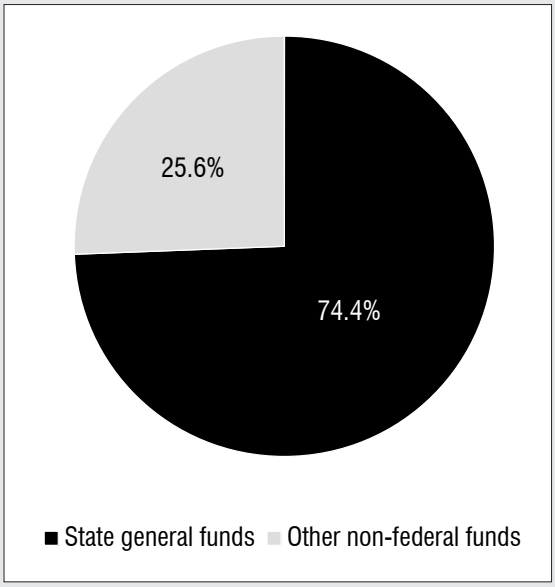
[5] While individual state policies dictate the sources and amounts of each state's financing, the Act refers to the "non-federal share" in acknowledgement of local government contributions.

[6] As a condition of receiving increased FMAP under both PPACA and ARRA, Section 1905(cc) of the Act, added by PPACA, requires that states do not increase the percentage of non-federal share that they require political subdivisions to contribute beyond what was required as of December 31, 2009.

- local contributions (through intergovernmental transfers and certified public expenditures); and
- health care related taxes.

Since the program's inception in 1965, flexibility in financing the non-federal share has allowed states to maintain local sources of health care financing while making these local funds eligible for federal match. At various points, particularly beginning in the early 1990s, this multi-source approach to financing has been the subject of federal scrutiny, sometimes because of evidence of state excesses (GAO 2004b, GAO 1994), and sometimes in an effort to control federal spending by limiting states' ability to make expenditures that qualify for federal contributions. At the same time, the fact that Medicaid enrollment increases and state revenues decrease during economic downturns, coupled with the fact that most states operate within one- or two-year budget periods, may increase pressure on states to find ways to finance their share of the Medicaid program during such times.

FIGURE 3a-2. State Medicaid Financing, SFY 2011



Source: National Association of State Budget Officers, 2010 State Expenditure Report

State general revenue

Nearly three-quarters of state financing for Medicaid nationally is through states' general revenue collected through income taxes, sales taxes, and other sources. As Figure 3a-2 demonstrates, for FY 2011, an estimated 74 percent of all non-federal Medicaid funds were from states' general revenue (down from 80 percent in 2009 and 76 percent in 2010) (NASBO 2011).[7] In most cases, general revenue is appropriated directly to the state Medicaid agency. At times, however, general revenue may be appropriated to other state government entities (e.g., a department of mental health) to be used for Medicaid purposes. In these cases, the other state government entities either transfer the funds to the Medicaid agency or spend the funds directly on Medicaid services and administration and provide certification that this spending has occurred for the purposes of claiming FFP.

Local sources of non-federal share

Counties, municipalities, and other units of local government, including providers operated by local governments, contribute to the non-federal share of Medicaid spending in many states. As discussed previously, this local-level Medicaid spending is rooted in the history of the program and varies by state. As with state government entities that are outside of the Medicaid agency, these units of local government, which may also be Medicaid providers (e.g., a county hospital or school district), either transfer local government funds in the

[7] According to the National Association of State Budget Officers (NASBO), a small number of state budget offices were unable to report non-federal Medicaid funding by source. In these cases, the entire amount was reported as general revenue. Therefore, the total percentage of general revenue may be slightly overstated. For the purposes of the NASBO survey, health care related tax revenue is counted as "other state funds" and not general revenue.

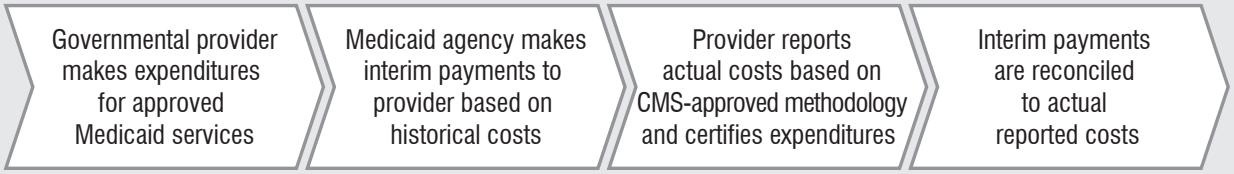
amount of the non-federal share of Medicaid payments to the state Medicaid agency through an intergovernmental transfer, or certify the total expenditure incurred to provide Medicaid services or Medicaid program administration, known as a certified public expenditure.

- **Intergovernmental transfers (IGTs).** An IGT is a transfer of funds from another governmental entity (e.g., a county or other state agency) to the Medicaid agency before a Medicaid payment is made. When these funds are used as the non-federal share of a Medicaid expenditure, they are eligible for FFP. IGTs are commonly used by counties to contribute the non-federal share for certain governmental providers (e.g., community mental health centers, hospitals) located in those counties. IGTs may also be contributed directly by governmental providers themselves, such as hospitals operated by state or local government. The ability of states to use IGTs to finance their Medicaid programs is recognized in both federal statute and regulation (§1903(w)(6) of the Act; 42 Code of Federal Regulations (CFR) 433.51).
- **Certified public expenditures (CPEs).** A CPE is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider (e.g., county hospital, local education agency), incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (§1903(w)(6) of the Act; 42 CFR 433.51). The governmental entity certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims FFP.

CPE-based financing must recognize actual costs incurred. As a result, CMS requires cost reimbursement methodologies for providers using CPEs to document the actual cost of providing the services, typically determined through a statistically valid time study, periodic cost reporting, and reconciliation of any interim payments, as outlined in Figure 3a-3 below.

CPEs are most commonly used by local education agencies (LEAs) for Medicaid school-based health care and related administrative services. The amount of time that school staff members spend on Medicaid-related activities is typically determined based on time studies; LEAs then certify to the state that the full cost of these activities is "spent" by the schools on Medicaid services. Based on this certification, the state is able to claim the federal share of these costs, which may then be paid to the LEAs. While CPEs are most common among LEAs, they are also used by other provider types (e.g., hospitals operated by state or local government or local health departments) in some states.

FIGURE 3a-3. Basic Certified Public Expenditure Process for Medicaid Services



Health care related taxes

Health care related taxes (sometimes referred to as provider taxes, fees, or assessments) are defined by federal statute as taxes of which at least 85 percent of the tax burden falls on health care providers (§1903(w)(3)(A) of the Act).[8] These taxes are commonly used by states to:

- establish supplemental Medicaid payments for the classes of providers that pay the tax;
- increase or avert reductions in Medicaid rates; and/or
- finance other areas of the Medicaid program.

Federal regulations specify 18 separate provider classes as eligible for health care related taxes (42 CFR 433.56). According to a recent survey, 47 states have at least one provider tax in place as of SFY 2011 (Table 3a-1),[9] and they are most commonly assessed on nursing facilities (39 states), hospitals (34 states), intermediate care facilities for the intellectually disabled (ICFs-ID)[10] (32 states), and managed care organizations (MCOs)(9 states). The full amount of revenue generated through health care related taxes is unknown. In FY 2011, states reported $18 billion in revenue from health care related taxes, although only 39 of the 47 states that indicate having taxes in place reported any revenue from them.[11]

TABLE 3a-1. State Medicaid Health Care Related Taxes, SFY 2011

Provider Class Taxed	No. of States	States
Nursing facilities	39	AL, AR, CA, CO, CT, DC, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NV, NH, NJ, NY, NC,OH, OK, OR, PA, RI, TN, UT, VT, WV, WI, WY
Hospitals	34	AL, AR, CA, CO, FL, GA, ID, IL, IA, KS, KY, ME, MD, MA, MI, MN, MS, MO, MT, NH, NJ, NY, OH, OR, PA, RI, SC, TN, UT, VT, WA, WV, WI, WY
ICFs-ID	32	AR, CA, CO, DC, FL, IL, IN, IA, KY, LA, ME, MD, MN, MS, MO, MT, NE, NJ, NY, NC, ND, OH, PA, SC, SD, TN, TX, UT, VT, WA, WV, WI
Managed care organizations	9	AZ, DC, MD, MN, NJ, NM, RI, TN, TX
Other*	11	AL, KY, LA, ME, MN, MO, NJ, NY, VT, WV, WI

Note: ICFs-ID are intermediate care facilities for the intellectually disabled.
*States were not asked to specify the provider classes included within the "other" category.
Source: Smith et al. 2011

[8] Provider donations are also permitted as a source of the non-federal share if they meet stringent conditions, including a requirement that no portion of a Medicaid or non-Medicaid payment to the provider, other providers furnishing the same class of services, or a related entity may vary based on the amount of the provider's donation or be conditional on the provider having made a donation. In other words, provider donations may not fund the non-federal share unless the provider does not receive a portion of the donation back (§1903(w)(2) of the Act). Without the ability to receive the donations back from the state, few providers are willing to donate funds, and thus the strict requirements imposed on provider donations act as an effective prohibition on such donations.

[9] States that did not have health care related taxes in SFY 2011 include Alaska, Delaware, Hawaii, and Virginia. According to the survey results, Virginia has enacted a tax on ICFs-ID for SFY 2012.

[10] An institution with the primary purpose of providing health or rehabilitative services for individuals with intellectual disabilities (§1905(d) of the Act).

[11] States report revenue from health care related taxes in Section 64.11 of their CMS-64 Quarterly Expenditure Reports. Reporting of tax collection amounts does not automatically generate a Medicaid expenditure claim for FFP, and this information is used solely for informational purposes.

Federal requirements. Health care related taxes are typically approved by state legislatures and are mandatory for providers. The tax revenue collected is then commonly used as the non-federal share of Medicaid payments. However, federal statute and regulations place limits on states' ability to use such tax revenue as the non-federal share of Medicaid payments. Statutory provisions regarding health care related taxes require that:[12]

- Health care related taxes must be broad-based and uniform. That is, they must be levied against all non-governmental providers in a particular class, not only those that accept Medicaid payments, and the tax rate must be uniform across all providers in the class.
- Providers cannot be "held harmless" through a direct or indirect guarantee that they will be repaid for the amount of taxes that they contribute. However, the indirect guarantee test does not apply if the tax rate falls within a "safe harbor" established under regulation.[13] The safe harbor is currently 6 percent of net patient revenue.
- The amount of Medicaid funding that may be generated through health care related taxes generally cannot exceed 25 percent of the total non-federal share in a given year.

Federal statute and regulations provide states the opportunity to request waivers of the broad-based and uniform requirements as long as states can demonstrate that the net impact of the tax program is generally redistributive and that the tax amount is not directly correlated to Medicaid payment amounts.[14] States commonly seek these waivers in an effort to develop more targeted tax programs by exempting certain providers or revenue sources from taxation.[15] For example, if a tax is based on each provider's number of beds, states may wish to exempt charity providers that do not take payment for services or other providers that do not typically accept Medicaid payments.

States' use of health care related taxes. While regulations permit health care related taxes for 18 different provider classes, such taxes have historically been used primarily to finance care provided by institutional providers (i.e., nursing facilities, ICFs-ID, and hospitals), nearly all of which typically participate in the Medicaid program.

- **Nursing facilities and ICFs-ID.** The tax revenue generated is typically used to increase (or mitigate reductions to) the per diem rates paid to these providers, meaning that the net effect of a tax on specific providers is driven by their actual Medicaid volume.

[12] These rules were enacted through the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234). Prior to the passage of this Act, states were able to specifically tax providers that accepted Medicaid payment and ensure that the tax revenue could be repaid to these providers after drawing down federal matching funds.

[13] Providers that pay a health care related tax cannot be "held harmless" through any direct or indirect payment, offset, or waiver that directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. Three tests are used to determine whether a hold-harmless arrangement exists: (1) a non-Medicaid payment to the providers is correlated to the tax amount, (2) any portion of Medicaid payments varies solely based on the tax amount, and (3) providers are directly or indirectly guaranteed to be held harmless. An indirect guarantee exists if 75 percent or more of the providers paying the tax receive 75 percent or more of their total tax costs back through enhanced Medicaid payments or other state payments. If the tax amount falls within the "safe harbor" of 6 percent of net patient revenue, however, the tax is permissible under this test (42 CFR 433.68(f)).

[14] According to federal regulations (42 CFR 433.55 – 433.74), in order to be granted a waiver of the broad-based and uniform requirements, tax programs must pass statistical tests to show that they are generally redistributive.

[15] Federal statute specifically allows states to exempt Medicare revenue from health care related taxes (§1903(w)(3)(C)(ii) of the Act). A waiver is not required to exclude Medicare revenue.

- **Hospitals.** Health care related taxes are typically used to finance supplemental payments (described further below) that can be targeted to particular providers, offering predictability with regard to the net effect of a health care provider's tax liability and increased Medicaid revenue (since the payments are not necessarily driven by current Medicaid volume).

Use of health care related taxes for hospitals, nursing facilities, and ICFs-ID has increased over the past decade (Figure 3a-4). In 2008, 18 states had a hospital tax compared to 34 states in 2011 (Figure 3a-5). By contrast, and particularly in recent years, the number of states using provider taxes for MCOs has decreased.[16]

States also increasingly use health care related tax programs to support other parts of their Medicaid programs (e.g., capitation payments to MCOs), rather than using them to support only those providers that pay the tax. Box 3a-2 describes several of the most common uses of health care related taxes.

Figure 3a-6 illustrates the scenario in which the health care related tax revenue is used both to support payment to the taxed providers and to fund payments to other Medicaid providers.

Data limitations regarding tax programs and implications for federal policymaking. States are required to report, for informational purposes, the total amount of revenue generated by health care related taxes by provider type on their CMS-64. However, it is difficult to identify health care related tax rates and other tax program characteristics from existing federal data sources. For states that request waivers of the uniform and broad-based requirements, tax rates can be discerned from the waiver requests that states provide to CMS. However, this information is not readily available for the many tax programs for which waivers are not requested. MACPAC analyses of publically available information (e.g., state statutes, websites, policy guidance) regarding health care related taxes applied to hospitals and nursing facilities indicate that, in the great majority of cases, the actual tax rate as a percent of net patient revenue could not be readily identified (Table 3a-2).

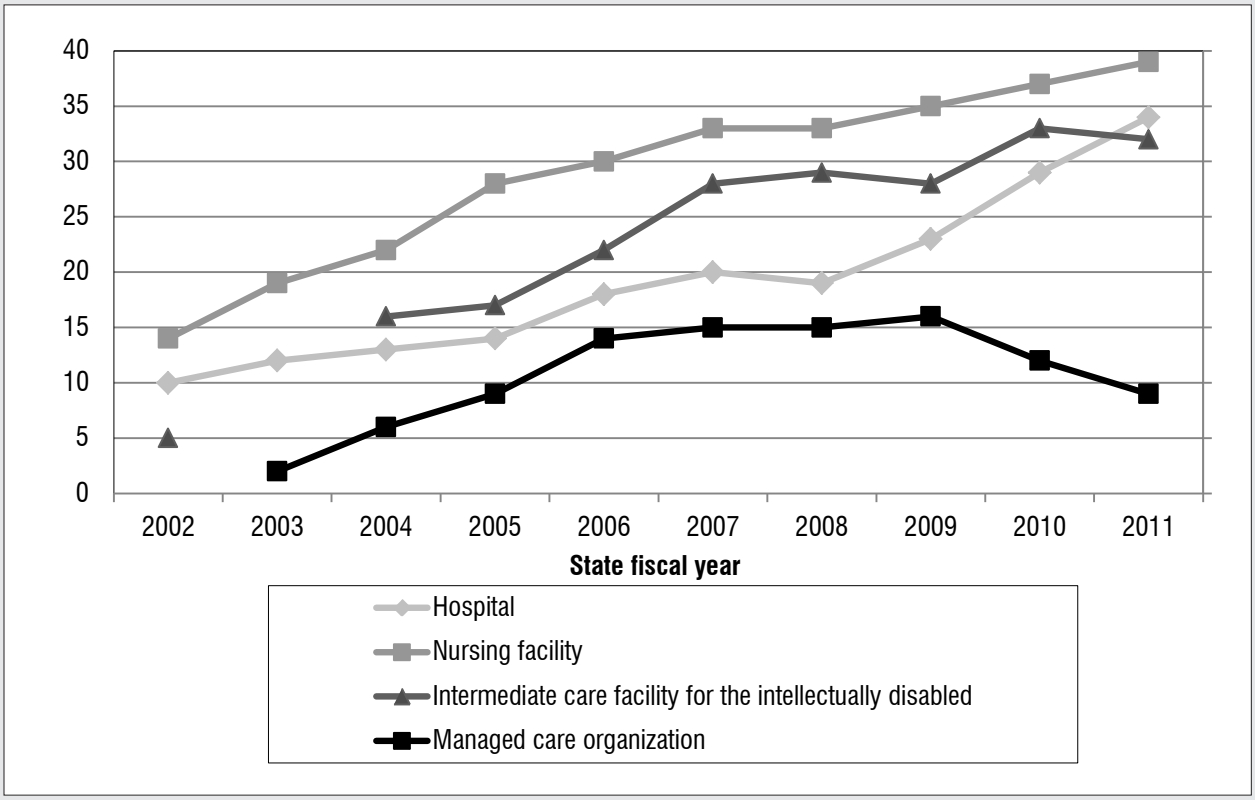
Health care related taxes are an important source of the non-federal share of Medicaid funding for states, and any changes to federal requirements should be carefully analyzed for their potential impact on both Medicaid payment rate levels for providers that pay the taxes as well as on other

BOX 3a-2. Common Uses of Health Care Related Taxes

- All of the tax revenue and associated FFP fund the payment rates for the class of providers that pay the tax (taxed providers).
- All of the tax revenue and associated FFP fund lump-sum supplemental payments for taxed providers.
- A portion of tax revenue and associated FFP funds payment rates for taxed providers. The remainder is paid to the taxed providers as a lump-sum supplemental payment.
- A portion of tax revenue and associated FFP funds payment rates for taxed providers, either as a lump-sum supplemental payment or through payment rates. The remainder funds payments to other Medicaid providers.

[16] Prior to 2005, states could limit a tax to MCOs that participated in Medicaid, allowing all of the companies that paid the tax to be repaid. The Deficit Reduction Act of 2005 required that the taxes apply to all MCOs (not only those participating in Medicaid). As a result, a number of states that had Medicaid managed care taxes have since ended these programs.

FIGURE 3a-4. States' Use of Health Care Related Provider Taxes, SFY 2002–2011



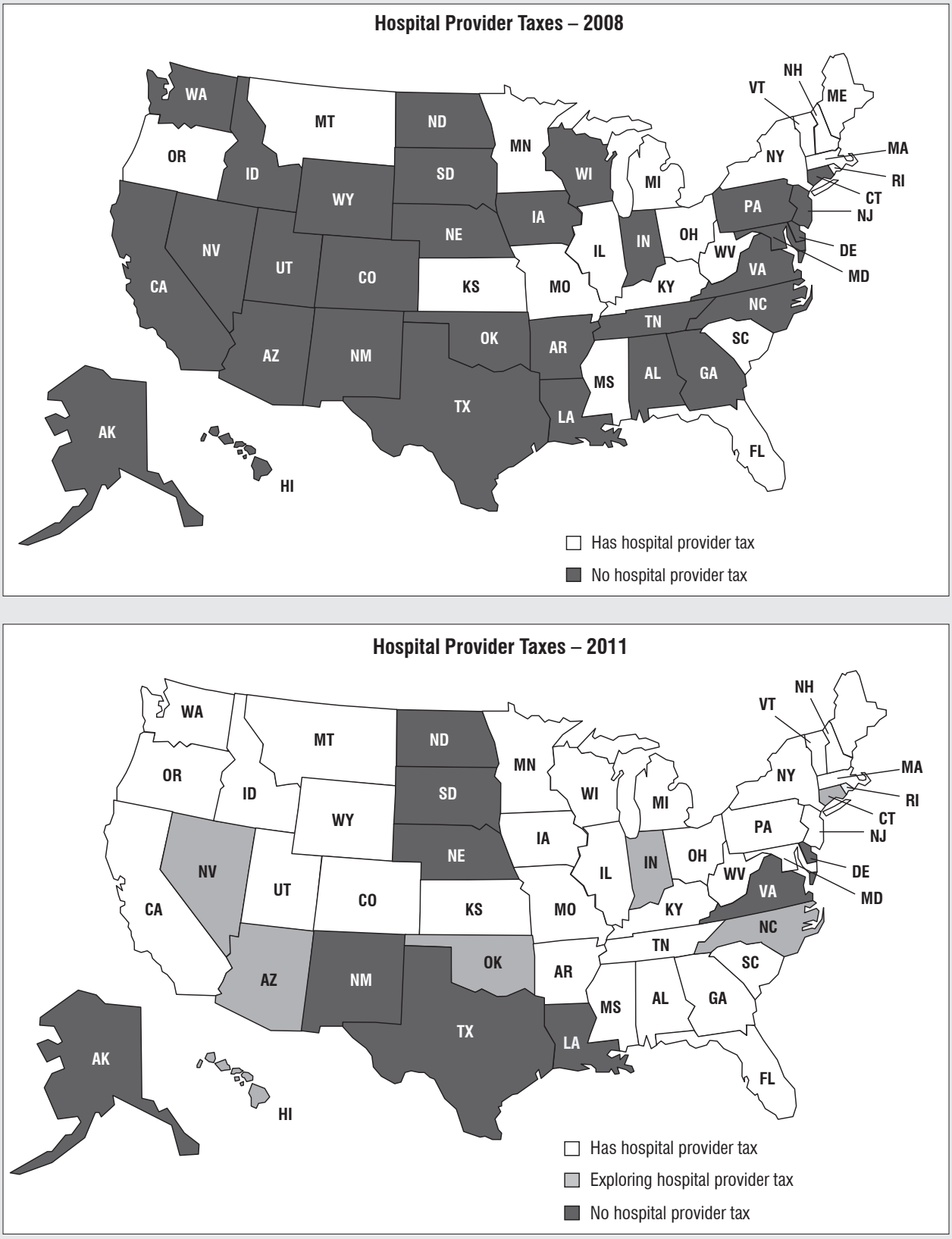
Note: 2003 data point for intermediate care facilities for the intellectually disabled not discernible from survey report.
Source: Kaiser Commission on Medicaid and the Uninsured: State Budget Surveys (2003-2011)

parts of the program financed through health care related tax revenue. However, such analysis is not currently possible based on existing federal data sources.

As an example, over the past decade, federal policymakers have considered reducing the "safe-harbor" percentage under which states can collect a health care related tax without performing the indirect hold-harmless test (currently 6 percent).[17] Changing this threshold, which acts as an effective cap on health care related tax rates, could have a significant impact on many of the states that have enacted such taxes and rely on them to finance aspects of their Medicaid programs. In fact, a recent survey of states found that at least 38 states have at least one health care related tax that exceeds 3.5 percent of net patient revenue (Smith et al. 2011). Yet, without knowing each state's actual tax rates as a percentage of net patient revenue, federal policymakers cannot determine the potential reduction in state revenue or federal matching funds that would result, or the potential impact on provider participation and access to services.

[17] Federal statute (§1903 (w)(4)(c)(ii)) temporarily reduced this percentage to 5.5 for fiscal years beginning on or after Jan. 1, 2008 and before Oct. 1, 2011.

FIGURE 3a-5. Health Care Related Taxes on Hospital Services, SFY 2008 and 2011



Source: Kaiser Commission on Medicaid and the Uninsured: State Budget Surveys (2008 and 2011)

FIGURE 3a-6. Illustration of a Permissible Health Care Related Tax on Hospitals

Health care related taxes are specifically authorized by federal statute as a source of non-federal Medicaid financing and have been implemented by nearly every state. The following example is illustrative only, based on an FMAP of 60 percent. Actual health care related tax amounts and the distribution of tax revenue vary across states and by each individual tax.

Tax Assessment (Step 1) – Each hospital is assessed a tax that results in $40 of tax revenue to the state.

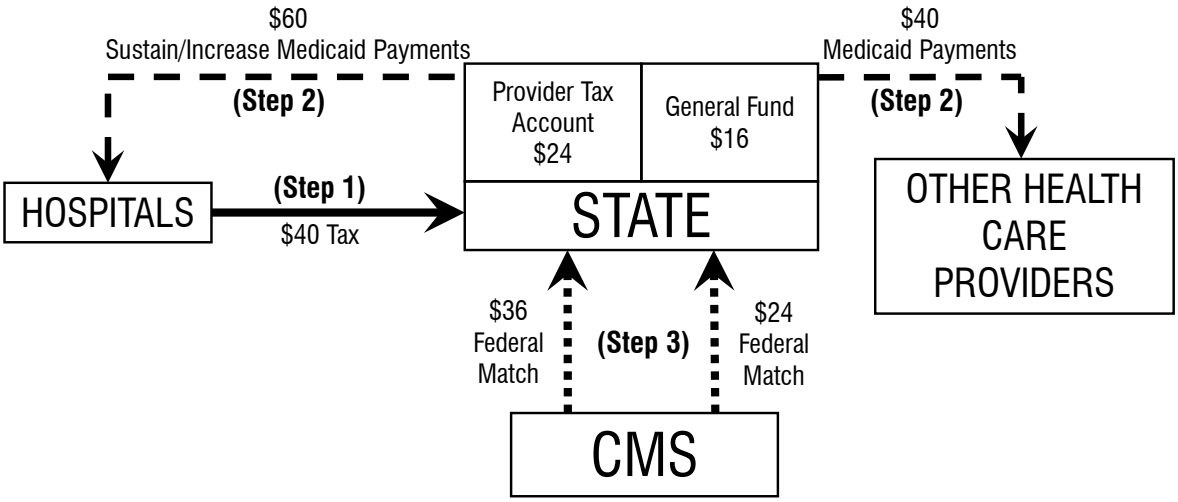
- $24 of this tax revenue is deposited into a provider tax account.
- $16 of this tax revenue is deposited into the state general fund.

Provider Payment (Step 2) – The state uses the tax revenue that is collected as the non-federal share of Medicaid payments to providers.

- $60 is used to sustain or increase Medicaid payment rates to hospitals, of which $24 is from the health care related tax.
- $40 in Medicaid payments is made to other health care providers, of which $16 is from the health care related tax.

Federal Match (Step 3) – The state may then claim federal matching funds for the Medicaid payments that it made and receive 60 percent of the amount paid to providers from CMS.

- CMS makes a $36 payment to the state, which is 60 percent of the $60 payment to hospitals.
- CMS makes a $24 payment to the state, which is 60 percent of the $40 payment to other health care providers.



Source: MACPAC analysis 2012

TABLE 3a-2. Health Care Related Tax Rates for Hospitals and Nursing Facilities Identified from State Statutes and Other Public Sources, FY 2011

	Number of States	
Tax rate	**Hospitals**	**Nursing facilities**
5.0% - 6.0%	4	5
3.6% - 5.0%	–	–
2.0% - 3.5%	5	–
Up to 2.0%	4	–
Unknown	21	34
Total states with taxes	**34**	**39**

Note: Public data sources reviewed include state statute and state government websites. States are permitted to tax providers using various provider-specific measures, such as hospital days or nursing facility beds. Thus, tax rates are often not presented as a percent of net patient revenue.

Source: MACPAC analysis of publically available information regarding health care related taxes 2012

Supplemental Payments to Providers

Some states make payments to providers above what they pay for individual services through Medicaid provider rates, with these payments commonly financed through local government contributions (most often IGTs) and health care related taxes. These additional payments fall into two categories:

- DSH – payments to hospitals serving low-income patient populations, which accounted for over $17 billion (including federal matching funds) in FY 2011; and
- UPL – supplemental payments, which comprise the difference between total base Medicaid payments for services and the maximum payment level allowed under the UPL for those services. States reported nearly $26 billion in these payments in FY 2011.

Because DSH and UPL payments are generally paid to providers in lump sums, their impact on Medicaid rates for services is difficult to isolate. As a result, it is also difficult to compare actual payment rates among providers, either within or across states, and to understand the actual specific uses of the federal Medicaid funds provided to states (i.e., which providers receive the funds, in what amounts, and for what specific Medicaid purposes). The large majority of supplemental payments go to hospitals, and such payments may be an especially important source of revenue for hospitals that serve a significant proportion of Medicaid enrollees and uninsured individuals.

DSH payments

States are statutorily required to "take into account the situation of hospitals serving a disproportionate share of low-income patients" when designing payment systems (§1902(a)(13)(A)(iv) of the Act).[18] In 1987, the Congress further strengthened this requirement to ensure the financial stability of disproportionate share hospitals by requiring states to make additional payments to such hospitals for

[18] As discussed in Chapter 5 of MACPAC's March 2011 *Report to the Congress on Medicaid and CHIP*, this requirement was enacted in 1981 when states were given broader discretion over Medicaid payment rates to hospitals.

uncompensated care costs, including both the costs of care for the uninsured and Medicaid costs that are not covered by Medicaid payments.

The Congress has refined the DSH program on several occasions, largely in response to concerns about states' use of DSH funds in making large DSH payments to hospitals operated by state or local government that were then transferred back to the state and used for other purposes. The most significant changes occurred in 1991 and 1993, when the Congress first placed state-specific caps on the DSH funds that could be allocated to hospitals (Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, P.L. 102-234), and then created hospital-specific limits equal to the actual cost of uncompensated care for hospital services provided to Medicaid enrollees and uninsured individuals (OBRA 1993, P.L. 103-166).[19] In 2003, the Congress added a requirement for annual independent audits to verify that DSH payments do not exceed allowable uncompensated care costs (P.L. 108-173; 42 CFR 447.299). In 2010, the Congress reduced state DSH allotments, beginning in 2014, to account for the decrease in uncompensated care anticipated with the implementation of PPACA (§1203 of P.L. 111-148, as amended).

The purpose of DSH payments continues to be to improve the financial stability of safety-net hospitals and preserve access to necessary health services for low-income patients. State methods for determining which hospitals receive DSH payments and in what amounts vary within broad federal guidelines. All hospitals with high Medicaid or low-income inpatient utilization rates must qualify for DSH payments, and states may designate other DSH hospitals as long as they have a Medicaid utilization rate of at least 1 percent.[20] As a result, states may include a wide range of hospitals in their designation of DSH hospitals, as long as those meeting the specified minimum criteria are included (§1923 of the Act).

Non-DSH (UPL) supplemental payments

Before 1980, states were required to pay rates for hospital and long-term care services based on the providers' "reasonable costs" (former §1902(a)(13) of the Act), and state payment methods for these providers mirrored Medicare's. Concerned with rapidly rising Medicaid costs, caused in part by the inflationary nature of cost-based reimbursement (U.S. House of Representatives 1981), the Congress passed the Boren Amendment (OBRA 1980, P.L. 96-499 for long-term care providers and OBRA 1981, P.L. 97-35 for hospitals) affording states more flexibility in determining payment rates. Delinking Medicaid rates from reported provider costs and the Medicare payment methodology gave states significant flexibility when crafting Medicaid payment policies, but necessitated a new measure by which to assess the reasonableness of states' Medicaid payment rates.

When considering the Boren Amendment, the Congress expected that Medicaid payments would not exceed Medicare payments for the same services (U.S. Senate 1979). Citing that opinion and the portion of the Act requiring that payments should be consistent with efficiency, economy, and quality of care, HHS promulgated regulations prohibiting FFP for Medicaid payments in excess of what would have been paid under Medicare

[19] In a 1994 letter to state Medicaid Directors, CMS (then HCFA) instructed states that the cost of "hospital services" includes both inpatient and outpatient costs (HCFA 1994).

[20] Statute requires a hospital to be deemed a disproportionate share hospital if its Medicaid inpatient utilization rate is at least one standard deviation above the mean for hospitals that receive Medicaid payments or if its low-income utilization rate exceeds 25 percent (§1923(b) of the Act).

payment principles.[21] This policy created what is known as a UPL.

The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, ICFs-ID, and freestanding non-hospital clinics. As discussed below, in practice, the UPL rules simply ensure that Medicaid does not pay a class of providers in the aggregate more than Medicare would have paid for the same or comparable services delivered by those same institutions. CMS requires that states demonstrate, in conjunction with its review of State Plan Amendments (SPAs), that any changes in their institutional payment amounts do not exceed the UPL. (See Annex 1 for a further discussion of UPL requirements.)

Payments under the UPL. Although the UPL regulations were intended to limit Medicaid payments to a group of institutions, some states have used the provisions to direct supplemental payments to providers (Box 3a-3). Under the UPL requirements, states may make—and receive federal matching dollars for—payments beyond the standard payment to any institution,

BOX 3a-3. Illustrative Examples of UPL Supplemental Payment Methods

Payments based on overall Medicaid utilization:

- Dividing supplemental payments among inner-city hospitals with high Medicaid volume based on each hospital's total number of inpatient Medicaid days relative to the total number of inpatient Medicaid days among all qualifying hospitals; and
- Making a fixed-dollar supplemental payment for each Medicaid discharge to promote access to acute care, and to children's, rehabilitation, and critical access hospitals.

Payments based on specific types of services provided to Medicaid enrollees:

- Distributing supplemental payments among hospitals with high Medicaid use in pediatric acute care or pediatric intensive care units;
- Providing enhanced inpatient Medicaid supplemental payments to certain children's hospitals based on the number of days of psychiatric or physical rehabilitation care provided to children and the total number of days of inpatient care provided to children during specified base years; and
- Making quarterly supplemental payments to general acute care hospitals with psychiatric units based on each hospital's total number of Medicaid days provided and, among other things, the number of total beds and psychiatric beds, and the psychiatric unit occupancy rate.

Payments based on specific types of services regardless of Medicaid use:

- Distributing supplemental payments each year to trauma hospitals. All eligible hospitals receive an equal share of the total funding, regardless of each hospital's size or Medicaid volume.

Source: MACPAC analysis of state hospital payment methodologies, 2011

[21] UPL regulations were initially promulgated in September of 1981 (46 Fed. Reg. 47964-47973). For the current UPL regulations, see 42 CFR 447.272(b) (defining upper payment limits for inpatient care); 42 CFR 447.321(b) (defining upper payment limits for outpatient care); 42 CFR 447.257 (establishing that FFP is not available for state expenditures in excess of the UPLs for inpatient care); and 42 CFR 447.304 (establishing that FFP is not available for state expenditures in excess of the UPLs for outpatient care).

TABLE 3a-3. UPL Supplemental Payments FY 2011 (millions)

	UPL Payments	Total Medicaid Payments (including DSH)	Percent of Total Medicaid Payments (including DSH)
Hospitals	$23,239.6	$91,894.9	25%
NFs/ICFs-ID	1,560.6	64,566.5	2
Physicians & Other Practitioners	1,125.3	15,420.8	7

Notes: Excludes payments made under managed care arrangements. CMS only began to require separate reporting of non-DSH supplemental payments in FY 2010 and is continuing to work with states to standardize this reporting. See MACStats Table 20 for additional information. NFs are nursing facilities. ICFs-ID are intermediate care facilities for the intellectually disabled.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data, February 2012. Includes both federal and non-federal share of payments

as long as they do not exceed the UPL for the specific group of institutions.[22] As a result, the term "UPL payments" is used to refer to the additional payments states make under this rule to supplement or enhance the standard Medicaid payment. If a state makes UPL payments, the payment methodology must be documented in the Medicaid state plan. UPL payments are not subject to provider-specific caps,[23] and individual providers may receive more than their reported Medicaid costs as long as the aggregate payments to all providers in their class fall below the aggregate UPL. Some states also make supplemental payments to physicians, typically those employed by state university hospitals. Although there is not a federal regulation that establishes a UPL for such non-institutional providers, CMS has used average commercial rates for physician services as a comparison (CMS 2011).

As of FY 2010, states are required to provide CMS with aggregate information on their UPL supplemental payments by type of service on the CMS-64.[24] In FY 2011, states reported $25.9 billion in UPL supplemental payments.[25] The vast majority of UPL payments are made to hospitals (Table 3a-3). In 2011, states reported total FFS hospital spending of $91.9 billion, including $23.2 billion in UPL payments (Table 3a-3). Total supplemental payments, including UPL and DSH, accounted for 41 percent of total FFS Medicaid payments to hospitals in FY 2011 (see MACStats Table 20).

[22] It is important to note that the reductions in Medicare payment updates enacted through the PPACA may have a corresponding impact on the amount of Medicaid payments that states are able to make to providers by reducing the UPL. OACT (2011) includes this scenario.

[23] However, payments for inpatient hospital services may not exceed a provider's customary charges to the general public for the services (42 CFR 447.271).

[24] The form defines inpatient "supplemental payments" as follows: "These are payments made in addition to the standard fee schedule or other standard payment for those services. These payments are separate and apart from regular payments and are based on their own payment methodology. Payments may be made to all providers or targeted to specific groups or classes of providers. Groups may be defined by ownership type (state, county or private) and/or by the (sic) other characteristics, e.g., caseload, services or costs. The combined standard payment and supplemental payment cannot exceed the upper payment limit described in 42 CFR 447.272." Similar definitions are provided for outpatient services.

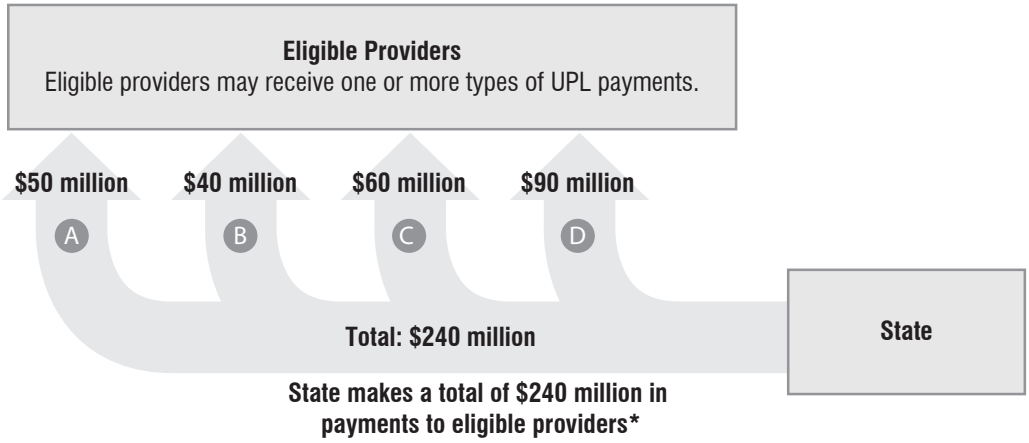
[25] CMS is continuing to work with states on how to break out UPL supplemental payment information; thus, the FY 2011 data may be incomplete or inaccurate in some cases. However, even these data suggest that states rely heavily on supplemental UPL payments.

In determining whether and how much money to allocate to UPL payments, states start by calculating the difference between the UPL for services provided by a class of governmental or private institutions and the aggregate amount Medicaid pays for those services. States then target the amount of the difference—or some portion of it—to a subgroup of institutions, allocating it among eligible institutions usually, but not always, based on Medicaid days, visits, or discharges.

Many states make supplemental UPL payments to providers, and these payments can account for more than half of a state's total payments to a given class of providers. In a 2008 report, the Government Accountability Office (GAO) found that each of the five states it studied made supplemental payments to a range of hospitals (GAO 2008). The GAO noted that, in all cases, these were quarterly or annual lump sum payments to a targeted subgroup of hospitals in amounts often calculated as a function of Medicaid days or visits.

Aside from the requirement that total payments to a class of institutions may not exceed the UPL, UPL payments are not subject to restrictions. Because UPLs are tied to the services rendered by entire classes of providers, rather than by individual providers, states have discretion in allocating these supplemental payments among institutions within the class. Further, unlike standard Medicaid payments, UPL payments are "add-ons" that may not be directly related to specific services or Medicaid patients. Figure 3a-7 provides a hypothetical example of how one state

FIGURE 3a-7. Illustrative Example of a Distribution of UPL Supplemental Payments



A Payments to acute care hospitals with psychiatric units, calculated by multiplying each hospital's relative share of total Medicaid psychiatric day in a base year times $50 million; paid out quarterly in lump sums.

B Payments to trauma centers, calculated by dividing $40 million by the number of qualifying hospitals; paid out quarterly in lump sums.

C Payments to designated inner-city hospitals, paid out on a fixed per Medicaid discharge basis, calculated using base year discharge data; paid out quarterly in lump sums.

D Payments to all hospitals, calculated by multiplying each hospital's relative share of Medicaid discharges during a base year by $90 million; paid out quarterly in lump sums.

*** Note:** This is a hypothetical example of a UPL supplemental payment distribution reflecting the types of allocation formulas that states use.
Source: MACPAC analysis 2012

might distribute UPL supplemental payments among hospitals.

Federal data limitations regarding UPL payments. UPL payments can be an important source of revenue for providers, particularly safety-net hospitals, and CMS has maintained aggregate (rather than provider-specific) UPLs in order to preserve states' flexibility to address their own unique programmatic challenges (HCFA 2001). However, because these payments are not necessarily associated with specific services or enrollees and are not reported at the provider level, it is difficult for state and federal policymakers to compare total Medicaid payments across providers and enrollment groups and to evaluate the impact of these lump-sum payments on payment methods and delivery models (Box 3a-4).[26]

Both the GAO and the HHS Office of Inspector General (OIG) have noted that CMS has limited information regarding supplemental payments to providers, especially hospitals (GAO 2008, 2004a; OIG 2001). Furthermore, supplemental payments are not directly associated with specific services or enrollees. As a result, it is not possible to:

- identify how much Medicaid actually spends on specific services and populations or to make meaningful intra- or cross-state comparisons of payment amounts or methods;
- determine the ultimate disposition of federal funds that are provided to states for their Medicaid programs (i.e., which providers receive supplemental payments and in what amounts); or
- assess fully the extent to which payment policies affect efficiency, quality, and access to appropriate services.

Furthermore, the impact of policies intended to promote certain outcomes through payment rates (e.g., pay for performance) may be muted by providers' ability to access supplemental payments. On the other hand, the supplemental payments themselves may be promoting access, efficiency, and quality. Without knowing what providers they are going to, and in what amounts, this is difficult to assess.

Interaction of UPLs and managed care. UPL supplemental payment policies have been shown to have important implications for states' decisions regarding the use of Medicaid managed care, due to the fact that UPLs are only based on FFS days in a hospital or institutional setting. Transitioning populations from FFS to managed care, therefore, means fewer FFS days and lower potential UPL supplemental payments. Under managed care arrangements, the state makes a capitated payment to a managed care entity, which then directly contracts with and pays providers. In response to comments on changes in the UPL regulations in 2001, CMS specifically stated that the UPL for institutional payments applies to FFS payments, and that managed care payments are subject to separate regulatory requirements that provide adequate flexibility for MCOs to pay appropriate rates. In the case of DSH, CMS pointed out that, as of January 1, 2001, states must consider managed care payment shortfalls to providers in the calculation and allocation of DSH payments (HCFA 2001).

As states increasingly turn to managed care delivery models for broader groups of Medicaid enrollees, FFS payments for acute and long-term care services are declining, along with the amount of supplemental UPL payments that states may make to providers. If the shift in inpatient days from FFS to managed care is large enough in a particular state, the loss of federal matching dollars for UPL payments may outweigh the savings to the

[26] The previously mentioned DSH audit reports are required to include UPL supplemental payments, by provider. However, the audit reports include only hospitals that receive DSH payments.

BOX 3a-4. Health Care Related Taxes and Supplemental Payments Complicate Analysis of Provider Payment

As discussed above in detail, Medicaid health care related taxes are often used to finance payments to Medicaid providers. However, the net Medicaid payments actually retained by providers are effectively reduced by the health care related taxes they pay, making it difficult to make comparisons across states and other payers such as Medicare and private insurance.

If health care related tax revenue is used to finance rates such as per diem nursing facility rates, it may be misleading to compare these rates to those that are not partially financed by these taxes. Consider the following example of three hypothetical states' average nursing facility rates:

	State A	State B	State C
Average daily rate	$150	$150	$150
Bed tax per day	–	5	10
Net average daily rate	150	145	140

Although claims data would indicate that all three states paid nursing facilities the same average daily amount, after accounting for health care related tax payments, the net amounts are actually different. This is an important consideration when comparing rates across states and payers; however, the lack of consistent and reliable national data regarding existing tax programs makes accounting for the impact of such taxes difficult.

The same "net payment" issues arise when health care related tax revenue is used to finance lump-sum supplemental Medicaid payments, which typically go to hospitals. Consider the following example of three hypothetical states' Medicaid payments to hospitals:

	State A	State B	State C
A) "Standard" Medicaid payments for services*	$500,000,000	$500,000,000	$500,000,000
B) Medicaid enrollees served	100,000	100,000	100,000
C) Average standard payment per enrollee (A/B)	5,000	5,000	5,000
D) Health care related taxes paid	–	50,000,000	100,000,000
E) Net standard payments per enrollee ((A-D)/B)	5,000	4,500	4,000
F) Supplemental payments	–	100,000,000	250,000,000
G) Net total medicaid payment per enrollee ((A-D+F)/B)	5,000	5,500	6,500

Claims data would indicate that each state made the same average payment of $5,000 per enrollee to hospitals. However, similar to the previous example, after accounting for health care related tax payments, the net hospital payments per enrollee in states B and C are lower than those in state A. If, however, the tax payments are used to finance supplemental payments, the net total Medicaid payment per enrollee may actually be higher. Such lump-sum supplemental payments are not included in claims data that reflect service use by individual Medicaid enrollees and are generally not reported to the federal government at the provider-specific level. As a result, it is difficult to account for these lump-sum payments in any comparison of payments for individual Medicaid services or populations.

***** Includes payments made based on a state's standard fee schedule or other standard payments for specific services provided to specific enrollees and included in a state's claims data. These payments are reported on the CMS-64 as "regular payments."

Source: MACPAC analysis 2012

state realized through managed care. Furthermore, since higher-cost populations such as individuals with disabilities account for a significant share of hospital days, transitioning these populations into managed care has the most significant effect on the UPL. On the other hand, enrolling populations such as children and parents, who typically use fewer inpatient days, has less of an impact on supplemental payment amounts and has posed less of a deterrent to enrolling these populations in managed care.

Faced with the choice between the potential benefits of shifting Medicaid beneficiaries into capitated programs and the desire to maintain or increase the use of UPL payments, states have explored alternative ways of maintaining supplemental payments to particular hospitals. However, CMS considers strategies that require MCOs to "pass through" supplemental payments to contracted providers to be inconsistent with the statute that requires capitation rates to be actuarially sound. According to federal regulations, the services covered by Medicaid managed care plans must be considered "paid in full" through the rate paid to the plan (42 CFR 438.60). Thus, supplemental payments are not permitted within risk-based managed care.

A few states have delayed implementation or expansion of Medicaid managed care because of the potential loss in federal matching dollars for supplemental payments; in some cases, states have applied for Section 1115 demonstration waiver authority to address this issue. In 2005, Florida was granted a waiver that preserved some of its hospital supplemental payments. In Texas, the state initially carved out inpatient care from the risk-based STAR+PLUS program to preserve supplemental payments. Recently, Texas was granted an 1115 demonstration waiver that allows the state to expand its managed care program, including inpatient hospital care, while preserving the hospital revenue made through UPL supplemental payments (Box 3a-5). As states expand the use of managed care, the Commission will assess the role of financing approaches and supplemental payments in state decisions regarding program design and populations served, and evaluate changes to federal Medicaid program policy.

Looking Forward

The Commission will continue to consider how non-federal financing approaches interact with payments to providers and access to high-quality and appropriate services. These issues are especially important at a time when states are seeking ways to reduce growth in Medicaid spending, introduce quality improvements and health care efficiencies, and prepare for implementation of PPACA in 2014.

The Commission intends to continue its analysis of:

- states' approaches to financing their share of the Medicaid program and the need for additional information regarding these approaches;
- the effect of state financing approaches on Medicaid payment methods and rates;
- the effect of variable federal matching rates and incentives on state financing and payment policies; and
- the potential interaction among financing, payment, and access to services.

This information will allow policymakers to assess the consistency of states' provider payment policies with the principles of efficiency, economy, and quality, as well as the relationship between payment policy and access to appropriate services.

BOX 3a-5. Texas' Section 1115 Demonstration Waiver to Expand Managed Care while Preserving Supplemental Payments

In 2011, the State of Texas applied for a Section 1115 demonstration waiver to expand risk-based managed care statewide and include inpatient hospital services within its managed care program. The proposed demonstration would also allow the state to continue making supplemental payments to hospitals based on the existing UPL.

Under the pre-existing STAR+PLUS managed care program for enrollees age 65 and over and individuals with disabilities, inpatient services were not included in order to preserve UPL supplemental payments to hospitals. Since higher-need populations such as individuals with disabilities account for a significant share of hospital days, transitioning these populations into managed care has the most significant effect on the UPL. In FY 2011, UPL supplemental payments to Texas hospitals totaled $2.6 billion.

In December 2011, the Section 1115 demonstration waiver request was approved by the Secretary of Health and Human Services. Under the terms of the agreement, existing UPL supplemental payments (along with DSH payments and managed care savings) will be used to fund an uncompensated care pool and a Delivery System Reform Incentive Payment (DSRIP) pool to incentivize improvements in service delivery. Without approval of this waiver, State law would have required the Medicaid program to remove the inpatient hospital benefit from all existing risk-based Medicaid managed care programs.

Under the pre-existing UPL program, some Texas hospitals were eligible to receive lump-sum supplemental payments based on the difference between the payments they receive and their charges. Under the approved waiver, uncompensated care payments will be limited to the actual cost of uncompensated care, and DSRIP payments will be contingent on demonstrated improvements in care coordination and quality based on predefined metrics. This change is intended to improve the transparency of supplemental payments and allow policymakers to determine the effect of these payments on services (Millwee 2011).

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Chapter 3a Annex 1

UPL Requirements and Calculations for Institutional Providers

UPL requirements. Under the current UPL regulations, states may not make aggregate FFS Medicaid payments for FFS Medicaid services rendered by all institutions within a given class (e.g., inpatient hospital, nursing facility) that exceed what those institutions would have received under Medicare payment principles. To determine the applicable UPL, each class of institutions is then divided into the following three classes of ownership:

- state-owned or operated government institutions;
- non-state-owned or operated government institutions (e.g., local government hospitals); and
- private institutions.

There is a separate UPL for each pairing of institution and class of ownership. In other words, state-owned government nursing facilities are subject to a different UPL than are private nursing facilities. Therefore, with five institutional provider classes (inpatient hospital, outpatient hospital, nursing facilities, ICFs-ID, and freestanding non-hospital clinics) and three ownership classes (private, state-owned, and other governmental), there are a total of 15 different UPLs.

Any payments that exceed the aggregate UPL for a given class of institutions are not eligible for FFP. Notably, Medicaid payments to any one institution may exceed the amount that institution would have received under Medicare payment principles as long as all payments to the entire class of institutions do not.

Methods for calculating the UPL. Although UPLs are based on Medicare payment principles, states are not required to determine exactly what Medicare would have paid for each individual service rendered by an institution; instead, they must develop, through discussions with CMS, an acceptable methodology that applies general Medicare payment principles.

CMS's State Medicaid Manual highlights the basic Medicare payment principles that states must consider when creating their processes for estimating UPLs. Specifically, states must consider the following:

- **Cost-based reimbursement.** Under Medicare payment principles, reimbursable costs may not exceed the costs necessary for the efficient delivery of needed health services. When CMS establishes limits on reimbursable costs for Medicare, it relies on facility cost reports from prior years, and then adjusts those costs to reflect growth in health care costs going forward. Although states are permitted to use Medicare's cost-based reimbursement principles when calculating UPLs, Medicare generally no longer uses cost-based reimbursement methodologies to determine payments for institutional providers. One exception is critical access hospitals, which continue to be reimbursed under a cost-based system (MedPAC 2010, 42 CFR 413.70).

  States may apply Medicare cost-based reimbursement principles to calculate UPLs by using data from each provider's Medicare cost reports. The state Medicaid agency uses these data to calculate each provider's cost-to-charges ratio for all payers, including Medicare, Medicaid, and commercial payers. The state then multiplies each provider's total Medicaid charges by the cost-to-charges ratio to determine Medicaid costs (based on Medicare cost-based reimbursement principles) for that provider. Next, the state tallies the Medicaid costs for each provider type within a class of ownership to determine the total for the class. This total is the UPL for that class of ownership, which is then compared to the total Medicaid payment for the same services rendered by the same group of providers.
- **Prospective payment.** Prospective payment is another core aspect of Medicare payment. As noted above, rates in prospective payment systems are fixed in advance and do not vary based on specific providers' costs or charges.

  In applying Medicare payment principles to calculate the UPL for inpatient hospital services paid on the basis of diagnosis-related groups (DRGs), a state Medicaid program may run each DRG-based, Medicaid-paid claim through the software that calculates Medicare payments based on the applicable DRG in order to calculate what Medicare would have paid the hospital for the particular DRG. The state Medicaid agency then adds up, for all hospitals within a given class of ownership, what Medicare would have paid for each Medicaid discharge. This total is the UPL for inpatient hospital services for hospitals in the given class of ownership.

Once UPLs are calculated, CMS will generally permit states to simply trend those amounts forward for several years rather than require new UPL calculations every year.

State flexibility in UPL calculations. States must consider the Medicare payment principles and describe in their Medicaid State Plans the specific processes by which they will determine their UPLs based on these broad principles. States may deviate from specific Medicare payment policies when calculating their UPLs as long as they describe how their methodologies differ and demonstrate that they are nonetheless in compliance with broad Medicare payment principles. CMS must approve each state's methodologies for calculating UPLs, and states work with their regional CMS officials to develop these methodologies.

In a 2004 report, the GAO reviewed several states' UPL calculation methods and identified wide variations and several potential errors (GAO 2004). As a result, the report recommended that CMS provide states with uniform guidance regarding how to calculate UPLs. CMS indicated that it concurred with the recommendation, but contended that "an exhaustive 'laundry' list of acceptable methods" could not be compiled.

Instead, CMS indicated that it would issue guidance on the characteristics and principles underlying acceptable methods, along with extensive examples of how these methods could be applied. A similar recommendation to provide definitive guidance for calculating UPLs can be found on the HHS OIG March 2011 list of unimplemented recommendations (OIG 2011).

Chapter 3a Annex 2

Key Statutory Provisions for Medicaid Financing and Supplemental Payments

TABLE 3a-A2. Provisions of the Social Security Act

Section 1101(a)(8)	Procedure for determining FMAP annually
Section 1902(a)(13)(A)	Public process for determination of payment rates to hospitals, nursing facilities, and ICFs-ID
Section 1902(a)(13)(A)(iv)	Requirement to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs
Section 1902(a)(30)(A)	Payment methods and procedures to safeguard against unnecessary utilization, consistent with efficiency, economy, and quality, and provide access equal to the general population
Section 1903(a)	Federal payment to states, including FMAP and other matching rates
Section 1903(d)	Quarterly payment estimates based on state reporting (CMS-37)
Section 1903(m)(2)(A)(iii)	Managed care capitation rates must be actuarially sound
Section 1903(w)(1)–1903(w)(5)	Requirements for the use of health care related taxes
Section 1903(w)(6)	Use of funds transferred from or certified by units of government (IGTs and CPEs)
Section 1905(b)	General FMAP formula
Section 1923	Payment for inpatient hospital services provided by disproportionate share hospitals

Chapter 3a Annex 3

Key Regulatory Requirements for Medicaid Financing and Supplemental Payments

TABLE 3a-A3. Federal Regulations

42 CFR 433.51	Public funds as the state share of financial participation
42 CFR 433.53	General requirements regarding state and local sources of non-federal financing
42 CFR 433.54	Bona fide provider-related donations
42 CFR 433.55	Health care related taxes defined
42 CFR 433.56	Classes of health care services and providers eligible for health care related taxes
42 CFR 433.57	General rules regarding revenue from provider-related donations and health care related taxes
42 CFR 433.66	Permissible provider-related donations
42 CFR 433.67	Limitations on level of FFP for permissible provider-related donations
42 CFR 433.68	Permissible health care related taxes
42 CFR 433.70	Limitation on level of FFP for revenue from health care related taxes
42 CFR 433.72	Waiver provisions applicable to health care related taxes
42 CFR 433.74	Reporting requirements for provider-related donations and health care related taxes
42 CFR 438.6(c)	Managed care capitation rates must be actuarially sound
42 CFR 438.60	Prohibition on direct payments to providers other than the managed care entity for services covered under a managed care contract
42 CFR 447.257	Restriction on FFP for payments to inpatient hospitals and nursing facilities in excess of upper limits
42 CFR 447.272	Upper payment limits for inpatient services in hospitals, nursing facilities, and ICFs-ID
42 CFR 447.297	Limitations on aggregate DSH payments
42 CFR 447.298	State DSH allotments
42 CFR 447.299	DSH audit reporting requirements
42 CFR 447.304	Restriction on FFP for payments for other institutional and non-institutional services
42 CFR 447.321	Upper payment limits for outpatient hospital and clinic services
42 CFR 447.325	Upper payment limits for other inpatient and outpatient services

CHAPTER 3b

Update on Federal Financing of CHIP

As part of the Commission's focus on the State Children's Health Insurance Program (CHIP), Chapter 3 of MACPAC's March 2011 *Report to the Congress on Medicaid and CHIP* provided a broad overview of CHIP. In September 2011, the Commission published a MACBasic that explored federal CHIP financing in detail. This section provides a brief overview of federal CHIP financing, which differs from federal Medicaid funding in several ways:

- Federal CHIP allotments to states, which are based on a formula using each state's previous CHIP spending, are capped; states can exhaust their federal CHIP funding, unlike typical federal Medicaid funding.
- Under current law, there are no appropriations for new federal CHIP allotments after FY 2015, while federal Medicaid funding will continue automatically.
- The federal matching rate—that is, the percentage of spending paid for by the federal government—is higher under CHIP than under Medicaid; although the amounts vary by state, the federal government pays for 70 percent of CHIP spending on average, compared to 57 percent historically under Medicaid.

Federal CHIP Allotments

States' CHIP spending is generally matched by the federal government, drawing on states' federal CHIP allotments and using a federal matching rate known as the Enhanced Federal Medical Assistance Percentage (E-FMAP). The E-FMAP lowers the state share by 30 percent relative to the state share under the Medicaid FMAP. For example, states with a 50 percent FMAP under Medicaid have an E-FMAP under CHIP of 65 percent, with the state share reduced to 35 percent, from 50 percent.

From FY 1998 to FY 2008, the annual appropriations for federal CHIP allotments ranged from $3.1 billion to $5.0 billion. From FY 2009 to FY 2015, allotment appropriations range from $10.6 billion to $21.1 billion, as set by Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) and the

Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). There are currently no appropriations for CHIP allotments beyond FY 2015.

Every year, CHIP allotment amounts are calculated for each state and territory, which they will receive unless the national appropriation is inadequate (MACPAC 2011a, 2011b). Every other year, the allotment is updated to reflect actual spending; for FY 2011, FY 2013 and FY 2015, the federal allotment for a state is based on its prior-year CHIP *spending* plus a state growth factor. For intervening years, the allotment is calculated primarily as the prior-year *allotment* plus a state growth factor; in these years, a state can also have its allotment increased to reflect an expansion of CHIP eligibility or benefits (§2104(m)(6) of the Act). Table 21 of MACStats shows states' federal CHIP allotments for FY 2011 and FY 2012. Table 8 of MACStats displays states' federal CHIP spending in FY 2011.

CHIPRA Contingency Fund

CHIPRA increased total CHIP appropriations over prior years and overhauled the allotment formula to align more closely with states' actual use of federal CHIP funds. In the event shortfalls still occur, CHIPRA created a child enrollment contingency fund, which was appropriated at $2.1 billion in FY 2009. The purpose of this fund was to ensure that the limited federal funds available for reducing CHIP funding shortfalls would first go to states with sizeable enrollment growth.

If a state is projected to exhaust its federal CHIP funding, the statutory contingency fund formula may provide funding in the amount derived by multiplying two numbers:

- CHIP child enrollment growth;[1] and
- the federal share of the state's per capita CHIP expenditures for those children.

As currently constructed and as described in previous Commission analyses (MACPAC 2011a, 2011b), this formula can provide states with federal funds beyond what they would need to eliminate potential shortfalls of federal CHIP funds. This occurred in FY 2011, when payments were made to a state from the contingency fund for the first time. In this case, the state's contingency fund payment ($28.9 million) significantly exceeded its projected shortfall ($3.8 million). A change in federal statute would be required to ensure that contingency funds pay only up to the amount of a state's shortfall. Such a change in policy could result in minimal federal savings that could affect a limited number of states in FY 2013–2015. The Commission's future work will follow this and other CHIP financing and coverage issues.

[1] Enrollment growth is the amount by which the average monthly unduplicated child enrollment in CHIP during the fiscal year exceeds the target number (that is, the FY 2008 average monthly unduplicated child enrollment in CHIP, as adjusted by the state's annual growth in child population plus one percentage point (§2104(n)(3)(B) of the Act)).

References

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CHAPTER 4

Program Integrity in Medicaid

Recommendations
Program Integrity in Medicaid

4.1 The Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:

- Create feedback loops to simplify and streamline regulatory requirements;
- Determine which current federal program integrity activities are most effective; and
- Take steps to eliminate programs that are redundant, outdated, or not cost-effective.

4.2 To enhance the states' abilities to detect and deter fraud and abuse, the Secretary should:

- Develop methods for better quantifying the effectiveness of program integrity activities;
- Assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective;
- Improve dissemination of best practices in program integrity; and
- Enhance program integrity training programs to provide additional distance learning opportunities and additional courses that address program integrity in managed care.

CHAPTER 4

Program Integrity in Medicaid

Program integrity consists of initiatives to detect and deter fraud, waste, and abuse and improve program administration.[1] These activities are important because they affect the ability of the federal and state governments to ensure that taxpayer dollars are spent appropriately. Fraud, waste, and abuse exist throughout the health care system, not just in Medicaid.

Program integrity efforts help to achieve value in the Medicaid program by ensuring that federal and state dollars are spent appropriately on delivering quality, necessary care and *preventing* fraud, waste, and abuse from taking place. Because fraud is particularly difficult to detect, its precise magnitude is unknown, though analysis has shown that the great majority of Medicaid providers do not engage in such actions (Rosenbaum et al., 2009).

When implemented well, program integrity initiatives help to ensure that:

- eligibility decisions are made correctly;
- prospective and enrolled providers meet federal and state participation requirements;
- services provided to enrollees are medically necessary and appropriate; and
- provider payments are made in the correct amount and for appropriate services.

This chapter examines how Medicaid programs work to prevent and detect provider fraud and abuse.[2] In the future, the Commission will address waste and program management as it affects program integrity in Medicaid in more detail, as these areas are not the focus of this chapter.

[1] Program administration can include federal and state program management (e.g., policy development and implementation), as well as ongoing monitoring and oversight.

[2] A State Children's Health Insurance Program (CHIP) that is part of a Medicaid expansion is likely included in that state's Medicaid program integrity efforts. A separate CHIP program likely enrolls their enrollees in managed care, so some program integrity activities are carried out by the health plan.

Key points addressed in this chapter include:

- A variety of program integrity statutory provisions and administration initiatives have been implemented over time. Yet, identification of provisions and initiatives that may no longer be effective is necessary.
- More than a dozen agencies at the federal and state levels are involved in program integrity. With so many agencies involved in these activities, their success and efficiency depend on effective coordination.
- Balance between program integrity activities and other management responsibilities is an important consideration. Initiatives that are not effective or timely may lead to federal and state funds being spent on services that may be unnecessary or were never delivered, while those that are too aggressive may place an undue burden on providers.
- The availability, timeliness, and accuracy of data used in program integrity activities may make it difficult to quantify and compare the value, success, and cost-effectiveness of these initiatives.

This chapter provides information about:

- federal and state oversight;
- federal and state coordination;
- challenges in quantifying program integrity outcomes; and
- how managed care plans address program integrity.

In addition, this chapter features two Annexes. Annex 1 includes a list of key legislative milestones and statutory requirements related to program integrity. Annex 2 includes more detailed information about the roles and activities of federal and state agencies with program integrity responsibilities.

The Commission's program integrity recommendations. Based on issues identified in this chapter, the Commission makes two recommendations regarding Medicaid program integrity. The first recommendation is intended to ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. The Commission recommends that the Secretary of the U.S. Department of Health and Human Services (the Secretary) determine which current federal program integrity activities are most effective and take steps to eliminate programs that are redundant, outdated, or not cost-effective. The second recommendation is intended to enhance the states' abilities to detect and deter fraud and abuse. The Commission recommends that the Secretary develop methods for better quantifying the effectiveness of program integrity activities, assess analytic tools for detecting and deterring fraud and abuse, promote the use of those tools that are most effective, and enhance program integrity training initiatives.

Defining fraud, waste, and abuse. Fraud and abuse are both defined in Medicaid regulations (Box 4-1). Fraud involves an intentional deception, such as billing for services that were never provided. Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices.

Although not the focus of this chapter, it is important to understand how waste differs from fraud and abuse. Waste, which is not defined in federal Medicaid regulations, includes inappropriate utilization of services and misuse of resources. An example is the duplication of tests that can occur when providers do not share information with each other. Waste is not a criminal or intentional act, but results in unnecessary expenditures to the Medicaid program that might be prevented.

Errors made by providers on submitted claims are also a program integrity issue, which may

BOX 4-1. Regulatory Definitions of Fraud and Abuse

Medicaid regulations define fraud and abuse as follows:

- **Fraud**: "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law."
- **Abuse**: "Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."

Source: 42 CFR 433.304 and 42 CFR 455.2

occur because of the complexity of the billing process.[3, 4] Catching and correcting these errors can be another important component of safeguarding program integrity.

Program Oversight

Many federal and state agencies have oversight authority for the Medicaid program, and these agencies' key Medicaid program integrity initiatives are included in Annex 2. Some of these activities relate directly to the administration of the Medicaid program (e.g., implementing Medicaid policy, addressing provider concerns, monitoring managed care plans), while others assess the administration of the program and identify areas where problems exist (e.g., federal and state audits and investigations). Some oversight programs focus on preventing fraud and abuse through effective program management, while others focus on addressing problems after they occur through investigations, recoveries, and enforcement actions.

At the federal level, the Deficit Reduction Act of 2005 (DRA, P.L. 109-107) gave the Centers for Medicare & Medicaid Services (CMS) significant new funding and responsibility for Medicaid program integrity.[5] Other federal agencies, including the U.S. Department of Health and Human Services (HHS), the HHS Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), and the Government Accountability Office (GAO) are also involved in this work. These agencies have different roles, and this differentiation may help the agencies carry out their responsibilities impartially, avoiding conflicts of interest.

Similarly, at the state level, program integrity may be shared by the state Medicaid agency and other state agencies. A state must have a Medicaid Fraud Control Unit (MFCU), which has certain responsibilities defined in law.[6] Other agencies that may be involved in Medicaid program integrity activities include the survey and certification agency, state OIG, Office of the Attorney General,

[3] For information about claims submission, see MACPAC 2011a.

[4] For more information about unintentional errors, see the presentation of William Hazel, MD before the Commission (Hazel 2011).

[5] For fiscal year 2004, the year before the enactment of the DRA, CMS allocated eight staff nationally and an additional budget of $26,000 for overseeing the states' Medicaid program integrity activities (GAO 2004).

[6] A state may be exempt from this requirement if it can show that such efforts would not be cost-effective because minimal fraud exists, and enrollees will be protected from abuse and neglect without such a unit. For more information about MFCUs, see Annex 2.

other law enforcement agencies, and Office of the State Auditor.

The way in which states design the management structure of their program integrity responsibilities may be influenced by the federal matching rates they receive for these activities (Table 4-1). For example, general state administrative costs, which fund program management functions aimed at preventing fraud and abuse, are matched at 50 percent, while the activities of a state's MFCU, aimed at detecting fraud and abuse after they have occurred, are matched at 75 percent. Regardless of how these programs are structured, states have to find the right balance for their program integrity initiatives to ensure that delivery of care to enrollees is not negatively impacted.

Depending on their specific mission and scope, federal and state agencies may use a number of tools to identify and address fraud and abuse in the Medicaid program. Specific methods can include:

- data mining to identify possible fraud and abuse for further examination;
- audits to determine compliance with federal and state rules and regulations or to identify fraud and abuse;
- investigations of suspected fraud and abuse;
- enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud;
- technical assistance and education for state staff so they are able to prevent and identify fraud and abuse; and
- outreach to and education of the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements).

Many oversight activities focus on identifying improper payments made to providers for services rendered.[7] When an improper payment is identified, the state must return the federal share

TABLE 4-1. Federal Matching Rates for Activities Related to Program Integrity

State Administrative Costs (day-to-day program operations)	50 percent
Medicaid Fraud Control Unit (MFCU)	
▶ First 3 years	90 percent
▶ After 3 years	75 percent
Medicaid Management Information System (MMIS)	
▶ Design, development, and upgrade	90 percent
▶ Operation	75 percent
Medical Professionals	75 percent
Medical and Utilization Review (prospective, concurrent, or retrospective)	75 percent

[7] "Improper payments" refer to payments that should not have been made or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements, and include any payments to an ineligible recipient, any duplicate payments, any payments for services not received, any payments incorrectly denied, and any payments that do not account for credits or applicable discounts (42 CFR 431.958).

to CMS. States may use their share of the recovery in any manner otherwise lawful for the use of state funds.

Federal and State Coordination

Many federal and state agencies are involved in program integrity activities, and interagency coordination plays an important role in these initiatives. Success in this area can prevent duplication of government activities and lessen administrative burden on providers. Because program integrity initiatives have developed over time, they have not always been examined as a whole to evaluate which are duplicative, which could be improved, and which may place an unnecessary burden on states or providers.

One example of the need for coordination involves audits, which consume resources of the federal or state agency conducting the audit, as well as of the state agency or provider being audited.[8] Different oversight agencies may conduct audits at the same time, sometimes on similar or identical topics. They are most often conducted through a field or desk audit, though in some instances, providers may conduct a self-audit. When multiple agencies are involved in similar examinations, coordination would help to ensure that program integrity efforts are conducted in a more efficient manner.

Providers have informed the Commission that, over the course of a year, they may be subject to multiple Medicaid and Medicare audits, as well as other state audits. Each audit may examine a different area regarding the provision of services, as well as aspects of business operations, which can contribute to the volume of reviews and create burden for providers.

Many audits identify errors made by providers when submitting claims for payment. Providers have indicated that the complexity of the billing process and the length of the provider manual can lead to inadvertent errors. The Commission has been advised by providers that feedback loops to the appropriate federal or state entity regarding administrative requirements would help to eliminate and prevent problems.

Federal and state coordination has many elements. Successful coordination can be difficult to achieve, as many agencies have differing mandates and goals. For example, a state Medicaid agency's priority may be to ensure service delivery for beneficiaries, a MFCU's priority may be to prosecute Medicaid fraud, and an auditor's priority may be to verify proper documentation that a service was provided. Such differing roles can complicate coordination processes, as each agency may measure success in its own way and may not consider issues important to other agencies. In addition, feedback loops that help to correct identified problems and prevent them from happening again may be absent or insufficient.

The following summarizes coordination activities among various agencies. Table 4-2 identifies the federal and state agencies that are involved in various aspects of program integrity.

Coordination among federal agencies

HHS and DOJ: Health Care Fraud and Abuse Control (HCFAC) Program. Created in 1996, the HCFAC program was designed to coordinate federal, state, and local law enforcement activities related to health care fraud and abuse across *all* health plan types, both public and private. This program funds federal health care law

[8] State staff educate federal auditors on their state's policies, procedures, and data, taking state resources and time away from other program activities.

BOX 4-2. Federal and State False Claims Acts

The False Claims Act. The federal False Claims Act (FCA) (31 U.S.C. §§3729-3733) imposes liability on any person who defrauds the federal government and enables private parties to bring an action on behalf of the federal government and to share in a percentage of the money recovered from an FCA action or settlement. States may also have their own FCAs. To encourage this, Section 1909 of the Social Security Act allows a state that has a qualifying FCA to receive an increase of 10 percentage points in its share of any amounts recovered under these laws.[9] Currently, 16 states have an FCA that qualifies for this enhanced match on recoveries.

Whistleblower provisions. The FCA contains *qui tam*, or whistleblower, provisions. This mechanism allows citizens with evidence of fraud relating to government contracts and programs to sue on behalf of the government in order to recover the stolen funds. In these cases, the whistleblower, also referred to as a relator, may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A *qui tam* suit initially remains under seal for at least 60 days during which the DOJ can investigate and decide whether to join the action.

enforcement activities at HHS through the OIG, the Administration on Aging, and the Office of the General Counsel; and at DOJ through the United States Attorneys' Offices, and Criminal, Civil, and Civil Rights Divisions. These activities include investigations, audits, inspections, and evaluations related to the delivery and payment of health care services. HHS and DOJ jointly issue an annual report quantifying the results of the previous year's fraud and abuse initiatives. In fiscal year (FY) 2011 the Secretary and the Attorney General certified $297.7 million in mandatory funding as necessary for the program, and Congress appropriated an additional $310.4 million in discretionary funding (OIG 2012).

HHS and DOJ: Health Care Fraud Prevention and Enforcement Action Team (HEAT). Created in 2009, HEAT coordinates activities across government agencies to prevent fraud in Medicare and Medicaid and enforce current anti-fraud laws around the country. This includes information and data sharing between HHS and DOJ to improve the efficiency in investigating and prosecuting complex health care fraud cases. It is comprised of top-level law enforcement agents, prosecutors, attorneys, auditors, evaluators, and other staff from DOJ and HHS and their operating divisions. It is funded through the HCFAC program.

CMS: Center for Program Integrity (CPI). Created in 2010, CPI oversees all CMS interactions and collaborations with federal and state partners (e.g., DOJ, OIG, state Medicaid offices, state program integrity offices, state law enforcement agencies, other federal entities, and across CMS Centers and Offices) to detect, deter, monitor, and combat fraud and abuse, as well as take action against those that commit or participate in fraudulent or other unlawful activities. The Medicaid Integrity Program, run by the Medicaid Integrity Group, is located within the CPI.

[9] For example, if a state's federal matching rate is normally 50 percent and if it has a qualifying state FCA, then the state's share of the recovered amount would be 60 percent. To qualify for this incentive, a state's FCA must be at least as stringent as the federal FCA.

TABLE 4-2. Federal and State Agencies and Offices Involved in Medicaid Program Integrity[1]

When interpreting this table, a • indicates that the agency plays a role in the program or activity listed. A ✓ indicates the agency has ad hoc or intermittent involvement in the listed program or activity, or provides oversight or guidance to other agencies involved in the listed program or activity. For example, nine agencies are involved in the Health Care Fraud and Abuse Control Program.

	Department of Health and Human Services				Department of Justice					State Agencies				Other	
Program or Activity	Centers for Medicare & Medicaid Services, including the CPI	Office of Inspector General	Administration on Aging	Office of the General Counsel	US Attorney	Civil Division	Civil Rights Division	Criminal Division	Federal Bureau of Investigation	State Medicaid Agency[2]	Medicaid Fraud Control Unit[3]	State Office of the Inspector General[4]	State Auditor	Government Accountability Office[5]	Providers[6]
Health Care Fraud and Abuse Control Program (HCFAC)[7]	•	•	•	•	•	•	•	•	•						
Health Care Fraud Prevention and Enforcement Action Team (HEAT)[8]	•	•		•	•	•		•	•	✓	✓	✓			
Review Medicaid Integrity Contractors (MICs)[9]	•									•	✓	•			
Audit MICs[9]	•									•	✓	•			•
Education MICs[9]	•									•					•
Medicare-Medicaid Data Match (Medi-Medi) Program[10]	•	•			•					•		•			
Audits	•	•								•		•	•	•	•
Payment Error Rate Measurement (PERM) Program[11]	•									•					•
Medicaid Eligibility Quality Control Program (MEQC)	✓									•					•
Recovery Audit Contractors (RACs)	✓									•					•
Provider exclusions		•								•					
Provider terminations	•									•					
Provider enrollment moratoria	•	✓								•					
Prosecution	•	•		•	•	•	•	•		•	•	•			
Investigations	•	•							•	•	•	•	•	•	

Notes: Many of the agencies, programs, and activities listed in this table are described in Annex 2 to this chapter.

1 Other agencies may be involved in specific program integrity activities under certain circumstances that are not included in this table. For example, the Drug Enforcement Agency (DEA) may be involved in investigations regarding prescription drugs.

2 In some states, certain activities listed in this table as being performed by the state Medicaid agency may be delegated to another state agency, such as a sister agency that administers certain Medicaid services or a surveillance and utilization review unit that is not a part of the Medicaid agency.

3 In some states, activities listed in this table as being performed by the Medicaid Fraud Control Unit (MFCU) may be performed by another office or agency. For example, in states where MFCUs do not have statewide prosecutorial authority, prosecutions are handled by other state or federal law enforcement agencies.

4 Some states address certain Medicaid program integrity issues through the state's Office of Inspector General, while others have an Office of the Medicaid Inspector General that is dedicated to addressing Medicaid issues.

5 The GAO also undertakes policy work, which could include evaluating programs listed in this table, when directed by the Congress.

6 Providers are included in this table to show where there are instances in which they must provide information to the federal or state governments for certain program integrity activities.

7 The Health Care Fraud and Abuse Control Program (HCFAC) also funds certain activities in the Office of the Assistant Secretary for Planning and Evaluation, Food and Drug Administration Pharmaceutical Fraud Program, and Office of the Assistant Secretary for Public Affairs.

8 The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is part of HCFAC. While most of its efforts are focused on the Medicare program, it does address fraud in Medicaid.

9 The Medicaid Integrity Group (MIG) uses Medicaid Integrity Contractors (MICs) to review, audit, and educate providers, as required in statute. See Annex 2 for more information about the roles of the three types of MICs.

10 CMS uses Zone Program Integrity Contractors (ZPICs) to coordinate the Medicare-Medicaid Data Match Program (Medi-Medi Program) with states.

11 Under the Payment Error Rate Measurement (PERM) program, CMS contractors conduct the reviews associated with fee-for-service claims data and managed care capitation payments, while states conduct the eligibility reviews, although a CMS contractor calculates the state and national eligibility error rate.

Coordination between federal and state governments

CMS: Medicaid Integrity Program (MIP). Created as part of the DRA, the MIP attempts to coordinate audits conducted by Medicaid Integrity Contractors (MICs) with program integrity work performed by other agencies.[10] It also provides training for state program integrity staff through the Medicaid Integrity Institute (MII) and conducts state program integrity reviews to help states improve their program integrity activities and disseminate best practices. In addition, the MIP provides technical assistance on a variety of issues (e.g., provider fraud, provider enrollment and exclusion, billing issues, regulations) and supports various state special projects to address issues that arise. To enhance coordination with states, the Medicaid Integrity Group (MIG), which operates the MIP, has indicated it is redesigning its national provider audit program to improve coordination with states on data, policies, and audit measures (GAO 2011c).

The MII was established by CMS in late 2007 in partnership with the DOJ. Located at the DOJ's National Advocacy Center in Columbia, South Carolina, it provides training to state staff on a variety of program integrity issues at no cost to the state. Currently, the MII has trained over 2,200 state staff (Brice-Smith 2011a). In FY 2011, the MII trained about 860 people and expended $1.7 million.

The MII curriculum is developed by CMS after consultation with the MII Advisory Committee, which includes state program integrity directors, state Medicaid directors, state MFCU directors, and MII staff. The courses, which are usually several days in length, are taught by experts in the field. They cover topics such as fraud investigation, data mining and analysis, case development, and emerging trends in specific areas (e.g., managed care, pharmacy, benefit design issues), as well as those intended to help prepare the state for new initiatives, such as the coding updates in the International Classification of Diseases, 10th Edition (ICD-10).

Those trained at the MII include program integrity employees (e.g., first-line investigators and clinicians, program managers and specialists, non-clinical case reviewers, directors, and audit staff). Other state Medicaid employees (e.g., those who work on contracts, enrollment, policy, and programs) who would benefit from understanding program integrity functions and goals may also attend. Staff from MFCUs and law enforcement agencies may also be invited to participate.

Based on discussions with states,[11] areas that could be further expanded include distance learning to allow state staff to attend courses remotely, the inclusion of more advanced topics, and providing introductory courses for more state staff.

CMS and states: Medicare-Medicaid Data Match Program (Medi-Medi Program). At the federal level, CMS combines and compares Medicare and Medicaid claims data to determine billing and payment abnormalities and to detect potential fraud and abuse patterns that previously were invisible to either program when examined independently.[12] Currently, 14 states participate

[10] These can include the state Medicaid agency, law enforcement, and Medicare contractors. If another stakeholder is conducting an audit of the provider, the MIP may cancel or postpone its audit.

[11] MACPAC spoke with representatives from a number of states. These individuals indicated that the MII was valuable.

[12] Zone Program Integrity Contractors (ZPICs), which identify overpayments and aberrant providers in the Medicare program, coordinate the Medi-Medi Program in participating states. Through this program, they may also make referrals to state agencies regarding Medicaid providers.

in the program.[13] In instances where Medicaid overpayments are identified, the state is responsible for taking action to recover the identified funds and handle any appeals that arise from such actions.

While certain states are satisfied with this program, others have identified problems. Reasons for this dissatisfaction include the lack of understanding of the Medicaid program among some of the contractors working on this program, as well as a focus on law enforcement referrals, rather than a wider range of program integrity issues. Better coordination of Medicare and Medicaid program integrity efforts could help to enhance the ability of both programs to identify broader patterns of fraud and abuse. For example, states report that while Medicaid data are shared with Medicare, there is no reciprocal data-sharing from Medicare to Medicaid. The Commission plans to examine the Medi-Medi program and other aspects of Medicare and Medicaid coordination.

OIG and states: Provider exclusion. Under OIG authority (42 CFR 1001), providers may be excluded for a number of different reasons. The type of exclusion depends on the offense and can be mandatory or permissive (where the Secretary has discretion to exclude a provider). The OIG maintains an online database (List of Excluded Individuals/Entities) available to states and providers to identify excluded individuals and entities. States must exclude any specified provider from participation in the Medicaid program if the provider was suspended, excluded, or terminated from Medicare or another state's Medicaid program (§1902(a)(39) of the Social Security Act (the Act)). States may also initiate their own provider exclusions from Medicaid (42 CFR 1002) for any reason the Secretary could use to exclude a provider from Medicare, Medicaid, or any other federal health care program. States may take this action regardless of whether the OIG has excluded the provider, though they must notify the OIG of any such actions taken.

In addition, states must have an information reporting system that allows them to report state actions to the federal government. This includes:

- formal proceedings concluded against a health care practitioner or entity by a state licensing or certification agency that result in an adverse action; and
- any final adverse action taken against a health care provider, supplier, or practitioner by a state law or fraud enforcement agency (§1921 of the Act).

CMS and states: Provider enrollment moratorium. CMS is able to impose a temporary enrollment moratorium on new Medicare providers if it determines that there is significant potential for fraud, waste, and abuse with respect to a particular provider type, geographic area, or both. States are required to comply with this moratorium, except when such steps would adversely affect Medicaid beneficiaries' access to care (§1902(kk)(4) of the Act). If a state is able to demonstrate this, it can still enroll new providers, despite the identified concern. States also have the option to impose their own temporary enrollment moratoria, numerical caps, or other limits on providers to combat fraud, waste, and abuse, provided that certain conditions are met (42 CFR 455.470).

Coordination within states

A number of state-level agencies have a role in program integrity in Medicaid, and the extent to which they are able to work together or coordinate their activities can affect their ability to address

[13] The following states participate in the Medi-Medi Program: Arkansas, California, Colorado, Florida, Georgia, Mississippi, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, and Utah.

fraud, waste, and abuse in the program effectively. Certain efforts are required in law, such as referring all cases of suspected provider fraud to the MFCU and providing the MFCU with access to and copies of all requested records, data, and other information kept by providers to which the Medicaid agency has access (42 CFR 455.21). Other activities that may or may not be required under state law can include sharing information and using interagency meetings to track emerging trends and avoid duplicating efforts. See Program Integrity in Managed Care for information about the coordination between Medicaid managed care plans and states.

Successful cooperation and coordination within a state can be complicated by the differing mandates and goals of various agencies (e.g., service delivery versus enforcement actions, recovering every dollar made in overpayment—regardless of the cost involved in getting the full recovery—versus maximizing limited state resources to recover the largest of overpayments). Because states have different approaches and structures in place to address program integrity, coordination approaches will also vary.

Challenges in Quantifying Program Integrity Effectiveness

Although there are estimates of the magnitude of the problem of health care fraud, no one really knows its full extent. For example, while reports from the Federal Bureau of Investigation (FBI) indicate fraudulent billing makes up roughly 3 to 10 percent of total health care spending across both public and private programs (FBI 2009), the broad range of this estimate suggests that the magnitude is largely unknown. Within Medicaid, this is due in part to the system being designed primarily to pay honest providers efficiently,[14] not to catch those committing fraud.

The most commonly cited numbers regarding program integrity initiatives pertain to the amounts of financial recoveries[15] and settlements, as well as the number of investigations and prosecutions. Initiatives and policies that *prevent* fraud and abuse may actually be more effective, but their success is hard to measure because of the difficulty of quantifying something that was avoided. This makes it extremely difficult to determine the return on investment of program integrity efforts and to quantify which are most successful and effective in detecting and deterring fraud and abuse. The ability to quantify results can play a key role in determining the allocation of program integrity resources, between those addressing program integrity problems *after* they have taken place and those devoted to *preventing* them from happening.

Data used in program integrity activities

Data are used in a number of ways in program integrity activities (Table 4-3). For example, auditors with appropriate credentials may examine clinical records to determine if a service was medically necessary, program administrators or contractors may run algorithms on claims data to identify areas of possible fraud and abuse, and state staff may use licensing information to determine whether a provider is qualified to enroll in the program. To be most effective and useful, these data must be complete, accurate, and timely.

Although data may provide useful information by helping to quantify the results of program integrity

[14] Section 1902(a)(37) of the Act requires states to pay Medicaid claims in a timely manner for services furnished by health care practitioners through individual or group practices or through shared health facilities.

[15] Recoveries are often a percentage of the total amount of fraudulent payments made.

efforts or to identify possible fraud and abuse in the program, there are certain issues that must be considered when interpreting program integrity information. They include:

Medicaid Statistical Information System (MSIS) data can be incomplete and dated for use in program integrity activities. MSIS is the only source of nationwide Medicaid claims and beneficiary eligibility information collected by CMS from the states. Although these data are used at the national level to help detect fraud, waste, and abuse in the program, this source does not capture many data elements that can help identify these problems. The database is also subject to significant time lags (OIG 2009). CMS is

TABLE 4-3. Sources of the Data Used in Program Integrity Activities

Data Type	Information
Eligibility data	Includes all information and supporting documents that are the basis for determining a person's eligibility for Medicaid, such as income, assets, date of birth, disability, and address. These data are used in audits such as the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs.
Claims data	A claim is a request for payment for services provided; it must include sufficient information so that the state can make the proper payment.* For example, states must require the National Provider Identifier (NPI) of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional (§1902(kk)(7)(B) of the Act). Data from claims can be used for data mining and identifying possible trends of fraud and abuse. Providers may have up to a year to submit claims for payment, as well as an additional year to make any adjustments to that claim. As a result, data can change over time.
Medicaid Statistical Information System (MSIS) data	Compiled by CMS from state reporting, this source includes eligibility-related information on each person enrolled in Medicaid, as well as a record of each paid claim for most services an enrollee receives. CMS uses these data for its algorithms that help to determine which providers to audit.
Other payer data	Includes information about providers that have been excluded from other programs (e.g., Medicare, other states' Medicaid programs, private insurers), as well as third-party liability information. States must have laws that require third-party insurers and other payers to furnish information to the state on eligibility and benefits under their plans, which strengthens the states' ability to recover payments made that should have been the responsibility of the third party.
Provider enrollment data	Includes information about providers, such as licensing information, whether the provider has a certificate of need (in the event one is required), and office location (to verify they have a legitimate business).
Provider operating data	Includes items such as cost reports, which are audited by states if provider payment is based on costs of services or on a fee plus cost of materials.

For information about claims submission, see MACPAC's MACBasic: The Medicaid fee-for-service provider payment process* (MACPAC 2011a).

BOX 4-3. Understanding Payment Error Rate Measurement (PERM) Results

The PERM program conducts audits of a random sample of state payment and eligibility records to assess whether state Medicaid payments and eligibility determinations are made in accordance with federal and state requirements and policies. PERM results are a calculated error rate, not a fraud rate. See Annex 2 for background information about PERM.

These audits identify improper payments, which include any payment made on behalf of an ineligible recipient, any duplicate payment, any payment for services not received, any payment incorrectly denied, and any payment that does not account for credits or applicable discounts. The payment error rate is the absolute value of all improper payments (both overpayments and underpayments), although almost all of the payments in error are overpayments. In FY 2011, the national error rate was 8.1 percent, or $21.9 billion (federal share only), with error rates for fee-for-service payments at 2.7 percent, managed care payments at 0.3 percent, and eligibility at 6.1 percent.

The 2011 reporting cycle is the first year an updated method was used to measure eligibility errors in an attempt to reflect federal and state policies more accurately. As a result, comparisons should not be made to previous years' eligibility error rates. In addition, although there are certain general trends in error data that emerge, there are significant differences in state-specific error rates, owing in part to how states implement and administer their programs.

The most commonly occurring errors identified through PERM are due to missing documentation. Such documentation may not actually be missing, but rather may not have been delivered by the provider in time to be included in the audit. Such cases are considered to be improper payments, a characterization that artificially inflates the reported improper payment rate for the program. In addition to providing potentially misleading results, PERM is often seen by states and providers as being an administrative burden.

Although PERM estimates a national payment error rate across the Medicaid program, the only funds that can be recovered are from claims that were actually sampled during the audit. As a result, the overpayments that are subject to recovery make up a small fraction of the total amount projected to be in error for the nation for each PERM cycle.

working with 10 volunteer states on a pilot project, Transformed-MSIS, to improve the data captured in the database (Brice-Smith 2011a).

CMS data initiatives may improve the quality of data used in program integrity activities. In 2006, CMS began to centralize and make more accessible the data needed for analyses that could identify possible fraud and abuse and to improve the analytical tools available to analysts conducting this work. The GAO has reviewed two of these initiatives—the Integrated Data Repository (IDR), which is intended to provide a single source of data related to Medicare and Medicaid claims,[16] and the One Program Integrity (One PI) system, a web-based portal and suite of analytical software tools used to extract data from the IDR and to allow staff to conduct complex analyses of these data. In its report, GAO notes that although implementation is behind schedule, CMS has shown some progress toward meeting the programs' goals. The GAO also indicates that

[16] Under Section 6402 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), CMS is required to include claims and payment data from specific programs, including Medicaid, in the IDR.

the current implementation of the IDR and One PI will not allow the agency to identify, measure, and track the financial benefits that will be achieved by reducing improper payments (GAO 2011a). In addition, the data for this system would come from MSIS, a data source with a number of shortcomings that are highlighted above.

As part of a broader data initiative, CMS has established a Medicaid and CHIP Business Information Solutions (MACBIS) council that is overseeing a project to transform the agency's data strategy and environment (Plewes 2010, Thompson 2010), which included a review of existing Medicaid and CHIP data sources and their uses (Borden et al. 2010). Ultimately, CMS expects to improve overall data quality and availability, including those used in program integrity activities (Brice-Smith 2011b).

There may be weaknesses in HHS' and DOJ's reporting of recoveries. Information provided in the HCFAC's annual report for FY 2011 indicates that almost $600 million in federal Medicaid money was transferred to the U.S. Treasury as a result of the program's activities for that fiscal year. For this same period, nearly $4.1 billion for all investigations was deposited with the Department of the Treasury and CMS (i.e., the Medicare Trust Fund), transferred to other federal agencies administering health care programs, or paid to private persons (e.g., those who file suits on behalf of the federal government under the *qui tam* provisions of the False Claims Act). A GAO audit for FY 2008 and 2009, however, found that there were problems with the numbers reported and that neither HHS nor DOJ provide sufficient controls to ensure the HCFAC report is accurate and supported (GAO 2011b). Both agencies are currently taking steps to address the issues cited in the report.

Reporting on recoveries and on other performance measures is not consistent across states. CMS uses its State Program Integrity Assessment tool to collect information on state Medicaid program integrity initiatives. This state-reported information shows that states track recoveries that result from various projects, including data mining, provider audits, settlements/judgments, overpayments and other collections, and MFCU investigations and prosecutions. Some states also include estimates of costs avoided. States choose which tracking metrics they use and the methodologies used in these calculations, complicating any possible cross-state comparisons.

Program Integrity in Managed Care

When using Medicaid managed care for service delivery, states cannot delegate to plans their federally mandated responsibility to ensure appropriate payment, access, and quality. States use their contracts with plans to require them to comply with a range of both federal and state requirements, including guarding against fraud, waste, and abuse.

In 2009, 47 percent of Medicaid enrollees were enrolled in comprehensive risk-based managed care plans and, in FY 2008, 18 percent of Medicaid benefit spending was on comprehensive risk-based managed care (MACPAC 2011b).[17] With states increasingly moving enrollees into managed care, it is important to understand program integrity challenges and opportunities in this area. The

[17] Historically, Medicaid managed care has covered families with children and pregnant women, populations that are relatively low-cost compared to other covered Medicaid populations. In addition, states may make fee-for-service payments on behalf of individuals enrolled in these plans if they carve out certain services from the managed care plan contract. The cost of providing these services is reflected in the amount of benefit spending under fee-for-service, not managed care.

Commission plans to examine these efforts in more detail in the future.

Tracking and implementing program integrity

While plans design their program integrity activities to address the requirements of the states in which they operate, addressing possible fraud and abuse committed by providers also helps to improve the effectiveness of their business operations. Plans operating in multiple states or with multiple lines of business (e.g., Medicaid, Medicare, private insurance) may develop program integrity programs that coordinate requirements across states and lines of business.

Tactics used by plans to identify possible fraud, waste, and abuse can be similar to those used by states. They use outside vendors, conduct these activities internally, or a combination of both. Reviews of post-payment reports can identify outliers among providers and anomalies that require further investigation. Plans also commonly use telephone hotlines for enrollees, employees, and providers to identify problems. These activities help identify instances when providers bill for services never performed, over-bill for services provided, or bill for tests, services, and products that are medically unnecessary. Plans have implemented formal compliance programs, which include installing compliance officers, conducting compliance training to educate employees about fraud and abuse laws, and having policies and procedures in place for staff to follow for reporting potential compliance issues.

Coordination between states and managed care plans

State agencies may coordinate certain fraud and abuse activities with managed care plans and may regularly communicate with plans on emerging trends and regulatory updates. Plans submit information (e.g., provider exclusions) to state regulators as required, though it is the states' responsibility to act on this information, when appropriate. States must determine how they address recoveries in managed care, including issues such as the adequate length of time for plans to make recoveries and when the state or its contractors should recover improper payments (Gordon 2011). The extent to which coordination occurs varies and is based on the processes put in place by a state to address these issues.

As states continue to expand into Medicaid managed care and search for ways to promote program integrity, it is important that state staff be trained to address program integrity issues specific to this delivery system, that staffing is adequate to properly oversee the contracts that are in place, and that states implement appropriate strategies for coordinating with plans to identify and take actions against providers who intentionally defraud the Medicaid program.

Program Integrity in Statute

As new statutory provisions have been added over time, there has not been a focused evaluation to determine which are most valuable and which are duplicative or unnecessarily burdensome. Moving forward, it is important to conduct such evaluations so the statute can be updated, as needed, to eliminate duplicative or ineffective programs and ensure that effective programs have adequate resources.

For example, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) requires coordination of the Medicaid Eligibility Quality Control (MEQC) and PERM programs and allows for data substitutions between these two programs. It should be assessed whether these efforts are adequate to address the overlap of these two programs.

BOX 4-4. Health Information Technology (HIT)

Technology provides the health care system with a number of tools to prevent fraud, waste, and abuse in the system through efficient program administration and to conduct prepayment and post-payment reviews of suspicious claims.[18] To truly improve program integrity, however, these issues must be incorporated into the product's design.

Tools to Identify Possible Fraud and Abuse. There are a variety of HIT tools that can be used to both prevent questionable payments from happening and identify paid claims that require further investigation. States use coding policies and edits to identify claims with common errors that should not be paid, and these efforts have recently been increased with the implementation of the National Correct Coding Initiative. States and the federal government also use data mining techniques (conducted either "in house" or by contractors) on paid claims to identify possible fraud or to target payment audits.

Predictive Analytics. There are initiatives to begin to move towards predictive analytics, a system that uses algorithms and models to examine claims in real time to flag suspicious billing,[19] similar to that which is used by the credit card industry.[20] This could help to decrease the cycle of "pay and chase," where claims are paid and then states attempt to recover inappropriate payments. These tools can help prevent bad actors from enrolling as Medicaid providers by identifying background information on potentially fraudulent actors and questionable affiliations. They also analyze claims before they are paid to identify emerging trends in potentially fraudulent activities, with flagged claims undergoing further scrutiny before any payment is released.

CMS is currently examining ways to apply advanced data analytics technology to the Medicaid Integrity Program (Brice-Smith 2011b), but because states are responsible for Medicaid claims payment, they ultimately will play a key role in the success of any such initiatives. Some states already have started to take steps to move in this direction.

Prevent waste. HIT can help to prevent waste and improve the quality of care provided. Examples of this, which are used throughout the health care system, include:

- Clinical decision support can help providers make evidence-based decisions around appropriate care;
- Health information exchange can decrease unnecessary or duplicative procedures;
- Electronic health records can provide a complete record of clinical care, help with continuity of care, and decrease duplication of tests and procedures;
- Computerized physician order entry can decrease delays in order completion, reduce errors related to handwriting or transcription, and provide error-checking for duplicate or incorrect doses or tests; and
- Bar code medication administration can help ensure that the right patient gets the right medication, in the right dose, at the right time, and through the right route.

[18] While technology is a tool that can help to address a number of program integrity issues, it should be noted that HIT is not a panacea and can also be used by providers to commit fraud and abuse.

[19] The system builds profiles of providers, networks, billing patterns, and enrollee utilization. These profiles are then used to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns before a claim is paid.

[20] The Small Business Jobs Act of 2010 (P.L. 111-240) mandated that CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. In 2014, CMS must report to the Congress on the cost-effectiveness and feasibility of expanding the use of predictive analytics to analyze Medicaid and CHIP claims. Reportedly, over 30 states are proceeding with legislation on the use of these tools, even though their effectiveness in Medicaid has yet to be determined.

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended), includes provisions regarding Medicaid Recovery Audit Contractors (RACs). It should be evaluated whether RACs are implemented in such a way to complement and coordinate other audits already in place. The PPACA also includes provisions regarding the suspension of Medicaid payments based upon pending investigations of credible allegations of fraud. It should be assessed whether these provisions limit the cycle of "pay and chase."

Looking Forward

The Commission plans to continue to examine program integrity activities, including examining the coordination of these initiatives across the Medicare and Medicaid programs, approaches to program management as they relate to program integrity, and problems of waste in the Medicaid program. The Commission will also continue to examine program integrity issues related to managed care, as well as the Medi-Medi and PERM programs.

Commission Recommendations

Recommendation 4.1

The Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:

- **Create feedback loops to simplify and streamline regulatory requirements;**
- **Determine which current federal program integrity activities are most effective; and**
- **Take steps to eliminate programs that are redundant, outdated, or not cost-effective.**

Rationale

Federal and state government agencies and providers are required by law to participate in various program integrity activities. There may be overlap and duplication of activities at times because newer initiatives sometimes repeat efforts already underway in existing programs. This recommendation would help address this problem by promoting administrative simplification—successful initiatives that should be expanded would be identified, while programs that are redundant, outdated, or not cost-effective would be eliminated.

Simplify and streamline regulatory requirements. When CMS identifies an area where a regulation or process could be simplified, updating relevant regulatory requirements or sub-regulatory manuals could ensure that relevant processes and requirements would prevent identified problems from recurring. For example, the Commission has heard from state Medicaid agencies that they are frequently audited by a

number of federal and other state agencies. Likewise, providers have indicated that they are frequently audited by a number of federal and state agencies. At the federal level, the Medicaid Integrity Group has attempted to prevent duplicative activities that place undue burden on providers by coordinating the audits its Medicaid Integrity Contractors conduct with other agencies with audit responsibilities. It is also working to redesign its national provider audit program to improve coordination with states on data, policies, and audit measures. The Commission encourages the Secretary to promote similar efforts.

In addition, the Commission has heard from providers that unintentional errors could occur when they submit claims for payment because of the complexity of the processes in place. Simplification of processes and development of feedback loops could help to identify problems more readily by referring them to the appropriate entity in a more timely manner.

The Commission strongly supports the promotion of program management efforts that prevent fraud and abuse from taking place, as effective management is a key component of ensuring the integrity of the Medicaid program.

Determine which programs are most effective and which should be eliminated because they are redundant, outdated, or are not cost-effective. As the chapter indicates, the Deficit Reduction Act of 2005 (P.L. 109-171) provided significant funding at the federal level for Medicaid program integrity. Given that many of these initiatives are relatively recent, assessing which are most effective could help determine those that should be enhanced or expanded to take full advantage of their success.

In addition, federal and state agencies and providers must participate in numerous program integrity initiatives. Because many program integrity provisions have been added over the years, there may be activities or programs that are duplicative or no longer effective. Identifying and eliminating these programs and activities could reduce administrative waste at the federal, state, and provider levels and allow resources and funding to be invested in program integrity efforts that are more effective.

Implications

Federal spending: There is no immediate and direct impact on the federal budget.

State spending: There is no immediate and direct impact on state budgets.

Beneficiaries: Although there would be no direct effects, reduction in state burden could redirect state and provider resources to Medicaid enrollees. If the reduction in administrative burden encouraged more providers to participate in the program, this could also improve access to care for enrollees.

Providers: Providers could gain efficiencies through administrative simplification and streamlining. Reduction in state burden could also free up state resources that could be directed to support Medicaid providers. Reduction in administrative burden on providers could possibly encourage more providers to participate in the program.

Recommendation 4.2

To enhance the states' abilities to detect and deter fraud and abuse, the Secretary should:

- **Develop methods for better quantifying the effectiveness of program integrity activities;**
- **Assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective;**

- **Improve dissemination of best practices in program integrity; and**
- **Enhance program integrity training programs to provide additional distance learning opportunities and additional courses that address program integrity in managed care.**

Rationale

Quantifying the impact of program integrity activities. States currently track and calculate program integrity performance metrics in a variety of different ways, complicating any possible cross-state comparisons. In addition, program integrity activities that *prevent* fraud and abuse are difficult to measure because they are an attempt to quantify something that was avoided. The ability to demonstrate the value of initiatives can play a key role in determining the allocation of program integrity resources, between those addressing program integrity problems *after* they have taken place and those devoted to *preventing* them from happening.

Developing methods to better quantify the impact of program integrity activities could provide states with tools they might use to report on program integrity activities and could help federal and state governments make better decisions about where to focus their efforts. In particular, providing states with guidance on ways to show the impact of activities that *prevent* fraud and abuse from taking place could help demonstrate the value of prevention activities. The Commission believes improving program management (and allocating sufficient resources to do so) is a key component of ensuring the integrity of the Medicaid program.

Analytic tools. There are many analytic tools that can help states prevent and identify possible fraud and abuse in the Medicaid program. Guidance issued by CMS could help states choose which tools to purchase for their specific program integrity needs. For example, guidance could include information about strengths of a specific tool or the types of analyses for which it would be best suited. Through this process, CMS could do once what each state must now do individually. CMS could help to negotiate a more competitive price at which states could, at their discretion, buy these products so that they could take advantage of economies of scale.

Dissemination of best practices. The Medicaid Integrity Group conducts a comprehensive review of each state's program integrity operations once every three years and releases an annual summary report of best practices based on comprehensive reviews conducted. The Commission would like to encourage the dissemination of this type of information and the use of additional communication outlets to ensure that it reaches all relevant stakeholders. For example, the HHS OIG recently issued a report (OEI-01-09-00550) that includes a recommendation that CMS could share best practices regarding ways to address fraud and abuse in Medicaid managed care through the Medicaid Integrity Institute (MII).

Enhancing program integrity training. Feedback from states has indicated that training received at the MII has helped them better address program integrity issues. As discussed in this chapter, the MII provides training to state employees at no cost to states and covers topics on a variety of issues. Expanding training programs to include additional distance learning opportunities could allow a broader group of state staff to take advantage of the MII's training opportunities without the need to travel. It would also make these opportunities available to staff whose states do not permit travel, even when it is at no cost to the state. Enhanced training could:

- Allow state staff whose primary focus is not program integrity to understand basic information about this topic and how their

job responsibilities affect the integrity of the program (e.g., training sessions that are a few hours in length that cover program integrity issues that are important for policy staff, eligibility staff, or program delivery staff to understand). This could also help with the dissemination of best practices, making such information available to a wider audience so that it could be more easily incorporated into laws; policies; and program design, management, and operation;

- Allow state staff to participate in self-paced learning; and
- Provide guidance to state staff on how to improve education and outreach to providers (e.g., to help providers understand billing procedures or program changes) and ensure that program policies and rules are as clear and simple as possible.

In 2009, 47 percent of Medicaid enrollees were enrolled in comprehensive risk-based managed care and 71 percent were enrolled in some form of managed care. States are continuing to move additional populations of Medicaid enrollees into managed care. Therefore, it is important that states be able to address program integrity issues in this area. Providing additional information to states about how to address program integrity issues in managed care, including best practices, would help states ensure they have effective program integrity initiatives in place.

Implications

Federal spending: There is no immediate and direct impact on the federal budget.

State spending: There is no immediate and direct impact on state budgets.

Beneficiaries: Although there would be no direct effects, reduction in state burden could free up resources that could be directed to Medicaid enrollees.

Providers: Enhanced program integrity activities could prevent paying claims to providers committing fraud, as well as result in additional provider terminations and exclusions. Reduction in state administrative burden could also make state resources available that could be directed to support Medicaid providers.

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Chapter 4 Annex 1

Key Legislative Milestones and Statutory Provisions in Program Integrity

TABLE 4-A1. Key Legislative Milestones in Program Integrity

Year	
1965	Medicaid was enacted (P.L. 89-97) as Title XIX of the Social Security Act (the Act) to provide health coverage for certain groups of low-income people; established Medicaid as an individual entitlement with federal-state financing. Medicare was also enacted as Title XVIII of the Act. During its first decade, Medicaid operated with few fraud controls and without any specific state or federal law enforcement agencies responsible for monitoring criminal activity within the program.
1977	The Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) provided special federal funding for the start-up of state Medicaid Fraud Control Units (MFCUs).
1980	The Mental Health Systems Act (P.L. 96-398) required most states to develop a computerized Medicaid Management Information System (MMIS). The Medicare and Medicaid Amendments of 1980 (P.L. 96-400) provided the authority in Section 1128 of the Act to exclude individuals and entities from participation in Medicare and Medicaid for fraud against the programs. The Omnibus Reconciliation Act of 1980 (P.L. 96-499) provided permanent federal funding for MFCUs beyond the initial three-year start-up period.
1981	The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) provided the authority for the imposition of civil money penalties as an intermediate sanction for fraud or abuse.
1986	False Claims Act Amendments (P.L. 99-562) made significant changes to the False Claims Act (FCA), including rewards for whistleblowers and fines for fraudulent activity.
1987	The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) strengthened authorities to sanction and exclude providers from the program and established criminal penalties for fraud against Medicare, Medicaid, and other federal health care programs.
1989	Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) placed limitations on physician self-referrals, commonly referred to as the "Stark law."

TABLE 4-A1, Continued

Year	
1993	Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) significantly amended the Stark law, with rules commonly referred to as "Stark II," and required each state to have a MFCU unless the state could demonstrate to the satisfaction of the Secretary that it has a minimal amount of Medicaid fraud and Medicaid enrollees would be protected from abuse and neglect.
1996	The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) defined numerous offenses relating to health care and set civil and criminal penalties for them. It also created several programs to control fraud and abuse within the health care system, including HCFAC and the Medicare Integrity Program (which was the model for the Medicaid Integrity Program that was created through the Deficit Reduction Act of 2005, described below).
1997	The Balanced Budget Act of 1997 (P.L. 105-33) allowed states to contract with a limited number of managed care plans; applied federal conflict-of-interest standards to state officials involved in Medicaid managed care contracting; required prior approval by HHS of all Medicaid managed care contracts that are over $1 million; and added conditions of participation for managed care plans that include areas of fraud and abuse, quality assurance, protections against patient billing, information and disclosure, and marketing.
2002	The Improper Payments Information Act of 2002 (P.L. 107-300) required every federal agency to report on improper payments and efforts to combat them; CMS created the Payment Error Rate Measurement (PERM) program to comply with the statute.
2005	The Deficit Reduction Act of 2005 (P.L. 109-171) established the Medicaid Integrity Program (MIP) and the Medicare-Medicaid data match program, strengthened third-party liability, and included provisions encouraging states to enact their own False Claims Acts.
2009	The Fraud Enforcement and Recovery Act (P.L. 111-21) further strengthened the FCA by broadening the range of conduct that can be subject to false claims prosecution by including the presenting of a false claim (even if not paid) and the knowing use of false records or statements related to a false claim. The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) provided states with the option to verify U.S. citizenship through data matches with the Social Security Administration, enrollment simplification, and required coordination of Medicaid Eligibility Quality Control (MEQC) and PERM program efforts, as well as substitution of data between these two programs.
2010	The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) included provisions regarding provider screening requirements, an integrated data repository for Medicare and Medicaid, Medicaid Recovery Audit Contractors (RACs), provider terminations, credible allegations of fraud, reporting managed care data in MMIS, participating in the National Correct Coding Initiative, the Stark law, and FCA actions. The Small Business Jobs Act of 2010 (P.L. 111-240) mandated that CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity and that it report to the Congress in 2014 on the cost-effectiveness and feasibility of expanding the use of predictive analytics to Medicaid and CHIP.

TABLE 4-A2. Key Program Integrity Provisions in Statute

Section 1893(g)	Medicare-Medicaid Data Match Program
Section 1902(a)(4) and Section 1903(u)	Medicaid Eligibility Quality Control (MEQC) Program
Section 1902(a)(4)(C)	Conflict-of-interest standards
Section 1902(a)(25)	Third-party liability
1902(a)(30)(A)	Payment methods and procedures to safeguard against unnecessary utilization, consistent with efficiency, economy, and quality, and provide access equal to the general population
Section 1902(a)(37)	Timely, prompt payment (per the matter in Section 1902(a) after (83), the Secretary can waive this requirement if he finds the state has exercised good faith in trying to meet this requirement)
Section 1902(a)(39)	Termination of provider participation under Medicaid if provider is terminated under Medicare or another state's Medicaid program
Section 1902(a)(42)(B)	Recovery Audit Contractors for the Medicaid program
Section 1902(a)(46)(A)	State Income and Eligibility Verification System (also in Section 1137)
Section 1902(a)(46)(B)	Citizenship documentation
Section 1902(a)(61)	A state must effectively operate a MFCU, unless it can show that such efforts would not be cost-effective because minimal fraud exists and enrollees will be protected from abuse and neglect without such a unit
Section 1902(a)(77)	State compliance with provider screening, oversight, and reporting requirements in Section 1902(kk)
Section 1902(a)(79)	Requires billing agents, clearinghouses, and other alternate payees that submit claims on behalf of a provider to register with the state and HHS
Section 1902(a)(80)	Prohibits payment for items and services to any financial institution or entity located outside the U.S.
Section 1902(e)(13)	Express lane eligibility
Section 1902(ee)	Provides states with the option to verify citizenship through the Social Security Administration data match
Section 1902(kk)	Provider and supplier screening, oversight, and reporting requirements
Section 1903(a)(6)	Federal match for MFCU expenses
Section 1903(d)(2)	Allows states one year to return the federal share of most overpayments
Section 1903(i)(2)	Prohibits payments to those excluded from the program
Section 1903(q)	Requirements MFCUs must meet
Section 1903(r)(1)(B)(iv)	National Correct Coding Initiative
Section 1903(r)(1)(F)	Requires states to report expanded set of data elements under MMIS to detect fraud and abuse
Section 1903(x)	Citizenship documentation
Section 1909	State False Claims Act requirements for increased state share of recoveries

Table 4-A2, Continued

Section 1921	Information reporting requirements concerning sanctions taken by state licensing authorities against health care practitioners and providers
Section 1927(g)	Drug use review
Section 1932(d)	Protections against fraud and abuse in managed care
Section 1936	Medicaid Integrity Program
Section 1124	Disclosure of ownership and related information
Section 1126	Disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses
Section 1128	Exclusion of certain individuals and entities from participation in Medicare and state health care programs
Section 1128A	Civil monetary penalties
Section 1128B	Criminal penalties for acts involving federal health care programs
Section 1128C	Fraud and Abuse Control Program
Section 1128D	Guidance regarding application of health care fraud and abuse sanctions
Section 1128E	Health Care Fraud and Abuse Data Collection Program
Section 1128F	Coordination of Medicare and Medicaid surety bond provisions (applies only to home health agencies)
Section 1128G	Transparency reports and reporting of physician ownership or investment interests
Section 1128H	Reporting information relating to drug samples
Section 1128I	Accountability requirements for facilities (skilled nursing facilities and nursing facilities)
Section 1128J	Medicare and Medicaid program integrity provisions
Section 1137	Requirements for state income and eligibility verification systems (also in Section 1902(a)(46)(A))
Section 1156	Obligations of health care practitioners and providers of health care services, sanctions and penalties, hearings and review

Chapter 4 Annex 2

Agencies and Programs Related to Program Integrity

This annex includes additional information about federal and state oversight agencies and activities related to Medicaid program integrity.

Federal Oversight Agencies

Department of Health and Human Services (HHS)

- **Centers for Medicare & Medicaid Services (CMS).** CMS oversees program integrity efforts that are run through the Center for Program Integrity (CPI) and the Office of Financial Management (OFM). CPI includes the Medicaid Integrity Group, which runs the Medicaid Integrity Program (MIP). The MIP is described below and in the Federal and State Coordination Section of Chapter 4. OFM is responsible for the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs, described below.
- **Office of Inspector General (OIG).** The OIG is an independent organization within HHS that provides oversight of HHS programs, including Medicaid and the State Children's Health Insurance Program. In this role, it conducts audits, investigations, and evaluations, as well as assists in the development of criminal, civil, and administrative enforcement cases. It also provides resources to help the health care industry comply with federal fraud and abuse laws, and to educate the public on these issues, including how to report suspicious activities. In FY 2011, OIG estimated that $345 million would be obligated to combat fraud, waste, and abuse within all HHS programs, of which approximately $269 million would support efforts pertaining to both Medicare and Medicaid.

Department of Justice (DOJ). Various divisions and offices within DOJ have a role in ensuring Medicaid program integrity through investigations and enforcement actions. They include the U.S. Attorneys, Civil Division, Civil Rights Division, Criminal Division, and the Federal Bureau of Investigation.

Government Accountability Office (GAO). The GAO, a nonpartisan Congressional agency, investigates how the federal government spends tax dollars, including those spent on the Medicaid program. The agency conducts audits of agency operations to determine whether federal funds are being spent efficiently and effectively, investigations

into allegations of illegal and improper activities, and research and reports assessing the extent to which government programs and policies are meeting their objectives.

State Oversight Agencies

State Medicaid Agency. Each state is responsible for the day-to-day operation of its Medicaid program. This includes not only setting policy and managing the program in such a way as to prevent fraud, waste, and abuse from taking place, but also having systems in place to identify and correct these problems if and when they do occur. While many of these activities take place within the Medicaid agency itself, in some states, some of these responsibilities may be delegated to other state-level agencies, such as the Office of the Inspector General, Office of the Attorney General, Office of the State Auditor, or sister agencies that may administer certain Medicaid services.

Medicaid Fraud Control Unit (MFCU). A MFCU is a single, identifiable entity of state government, usually located within the office of the state's attorney general (NAMFCU 2012), that is responsible for the following activities:

- investigating and prosecuting (or referring for prosecution) health care providers that defraud the Medicaid program;
- reviewing complaints of abuse or neglect of nursing-home residents and complaints of the misappropriation of patients' private funds in these facilities;
- investigating fraud in the administration of the program; and
- collecting or referring for collection (to the appropriate state agency) any overpayments it identifies in carrying out its activities (42 CFR 1007).

Each MFCU is certified by the OIG when implemented and then recertified annually thereafter. A MFCU is funded at a 90 percent federal matching rate for the first three years of operation; the match is 75 percent for subsequent years (§1903(a)(6) of the Act). In FY 2010, the combined federal and state grant expenditures for MFCUs totaled $205.5 million, of which federal funds represented $153.8 million (OIG 2010).

Other State Agencies. In addition to the organizations listed above, there are a number of other state agencies that can play a role in Medicaid program integrity. There are state agencies (e.g., state survey and certification agencies) that monitor providers to ensure the quality of care they provide, as well as receive and investigate complaints about such providers. Other state law enforcement agencies may be involved in prosecuting Medicaid fraud cases.

Federal and State Activities

Medicaid Integrity Program (MIP). The MIP is a comprehensive federal strategy to prevent and reduce Medicaid provider fraud, waste, and abuse. It funds the Medicaid Integrity Group within the CMS Center for Program Integrity. Under the MIP, CMS has two broad responsibilities:

- To hire contractors (Medicaid Integrity Contractors, MICs) to: 1) review Medicaid claims data for fraud, waste, or abuse; 2) audit provider claims and identify overpayments; and 3) educate providers and others on Medicaid program integrity issues; and
- To provide support, education, and technical assistance to states in their efforts to combat Medicaid provider fraud and abuse (CMS 2011).

The MIP was appropriated $75 million in FY 2010 (CMS 2011).

Medicaid Integrity Contractors (MICs). CMS contracts with three types of MICs. Review MICs analyze claims data to identify potential fraud and abuse; Audit MICS audit providers; and Education MICs educate providers, state staff, enrollees, and others about Medicaid payment integrity and quality of care issues. All processes are intended to ensure that claims are paid only for services that were provided and properly documented, billed using the correct procedure codes for covered services, and paid in accordance with federal and state laws, regulations, and policies. CMS is responsible for the MICs' activities, though states play a role in training contractors on their policies and rules.

Recovery Audit Contractors (RACs). Originally implemented under Medicare, RACs were expanded to include Medicaid under the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). Beginning in 2011, states are required to contract with RACs, which will identify Medicaid fee-for-service underpayments and overpayments and recoup overpayments (§1902(a)(42)(B) of the Act). RACs are paid on a contingency basis for collecting overpayments and in amounts specified by the state for identifying underpayments. States must have an appeals process in place for adverse determinations (this can be the process a state already has in place, provided it is able to handle RAC appeals), report certain information to CMS about the RACs' contract metrics, and coordinate RAC activities with other program integrity organizations (such as federal and state law enforcement). States are responsible for the RAC program.

While some states have expressed concern about the RAC program, others view it as an opportunity to enhance and target their oversight efforts in areas where they otherwise would not have been able because of tight state budgets.

Payment Error Rate Measurement (PERM) Program. The PERM program is designed to comply with the Improper Payments Information Act of 2002 (P.L. 107-300). In this program, which is managed by the CMS Office of Financial Management, state payment and eligibility records are reviewed to calculate payment error rates using a statistically valid random sample of claims and eligibility determinations. It is conducted annually on a rotating basis in 17 states. CMS contractors conduct the reviews associated with the fee-for-service claims data and managed care capitation payments, while states conduct the eligibility reviews (although a CMS contractor calculates the state and national eligibility error rate). Each state must develop a corrective action plan to reduce improper payments based on the error causes identified and is required to return the federal share of overpayments to CMS (42 CFR 431 Subpart Q). The error rate calculated through PERM is *not* a fraud rate. See Box 4-3 in Chapter 4 for a discussion of issues with PERM results.

Medicaid Eligibility Quality Control (MEQC) Program. Although processes exist to verify that Medicaid eligibility decisions are made correctly before a person is enrolled in (or disenrolled from) Medicaid, post-eligibility checks are also used to assess whether or not the proper determination was made. The MEQC program requires states to report to CMS an annual estimate of improper Medicaid payments based on eligibility reviews of people enrolled in the program. The threshold for improper payments is set at three percent per fiscal year and, if a state exceeds this amount, the Secretary may withhold payments to the state based on the amount of improper payments that exceeded the threshold (§1903(u) of the Act). However, no state has exceeded this threshold in a number of years.

Because states consistently had error rates below the threshold, CMS offered states the option to develop alternative ways to identify and reduce improper payments through either an MEQC pilot or as part of a Section 1115 demonstration waiver.[1] In FY 2010, 12 states were operating traditional MEQC programs and 39 were operating a pilot or waiver program (D'Annunzio 2010). Because MEQC shares certain characteristics with PERM, when a state is undergoing a PERM audit, it has the option to use the data collected in its PERM review for its MEQC review and vice versa (42 CFR 431.812; 42 CFR 431.980).

State Audit Requirements. In addition to meeting federal audit requirements, where the state agency must ensure appropriate audit of records for payments based on costs of services or on a fee plus cost of materials (§1902(a)(42)(A) of the Act and 42 CFR 447.202), states may also conduct their own audits, with the exact process (e.g., the agency conducting the audit, what is examined during the audit) varying by state.

[1] Section 1115 demonstration waivers allow states to test an "experimental, pilot, or demonstration project likely to assist in promoting the objectives of the programs" covered by the Social Security Act. For more information about these waivers, see the Commission's March 2011 *Report to the Congress on Medicaid and CHIP.*

Appendix

Acronym List

ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activity of Daily Living
AHRQ	Agency for Healthcare Research and Quality
APS	Annual Person Summary
ARRA	American Recovery and Reinvestment Act
ASPE	Assistant Secretary for Planning and Evaluation
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPE	Certified Public Expenditure
CPI	Center for Program Integrity
CSHCN	Children with Special Health Care Needs
DEA	Drug Enforcement Agency
DOJ	Department of Justice
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
E-FMAP	Enhanced Federal Medical Assistance Percentage
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ESI	Employer-Sponsored Insurance
FCA	False Claims Act
FERA	Fraud Enforcement and Recovery Act
FFP	Federal Financial Participation

FFS	Fee for Service
FMAP	Federal Medical Assistance Percentage
FMR	Financial Management Report
FPL	Federal Poverty Level
FY	Fiscal Year
FYE	Full Year Equivalent
GAO	Government Accountability Office
HCBS	Home and Community-Based Services
HCFAC	Health Care Fraud and Abuse Control Program
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HIU	Health Insurance Unit
ICD-10	International Classification of Diseases, 10th Edition
ICF-ID	Intermediate Care Facility for the Intellectually Disabled
IDR	Integrated Data Repository
IGT	Intergovernmental Transfer
IMD	Institution for Mental Diseases
IOM	Institute of Medicine
KCMU	Kaiser Commission on Medicaid and the Uninsured
LEA	Local Education Agencies
LTSS	Long-Term Services and Supports
MACBIS	Medicaid and CHIP Business Information Solutions
MACPAC	Medicaid and CHIP Payment and Access Commission
MAP	Measure Applications Partnership
MBES/CBES	Medicaid and CHIP Budget Expenditure System
MCO	Managed Care Organization
Medi-Medi Program	Medicare-Medicaid Data Match Program
MedPAC	Medicare Payment Advisory Commission
MEPS	Medical Expenditure Panel Survey
MEQC	Medicaid Eligibility Quality Control Program
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person
MIC	Medicaid Integrity Contractor
MIG	Medicaid Integrity Group
MII	Medicaid Integrity Institute

MIP	Medicaid Integrity Program
MMIS	Medicaid Management Information Systems
MSA	Metropolitan Statistical Area
MSIS	Medicaid Statistical Information System
MSP	Medicare Savings Program
NASBO	National Association of State Budget Officers
NCQA	National Committee for Quality Assurance
NHIS	National Health Interview Survey
NPI	National Provider Identifier
NQF	National Quality Forum
OACT	Office of the Actuary
OASI	Old-Age and Survivors Insurance
OFM	Office of Financial Management
OIG	Office of Inspector General
One PI	One Program Integrity System
OPM	Office of Personnel Management
PACE	Program of All-Inclusive Care for the Elderly
PCA	Personal Care Attendant
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PERM	Payment Error Rate Measurement Program
PPACA	Patient Protection and Affordable Care Act
RAC	Recovery Audit Contractor
SEDS	Statistical Enrollment Data System
SFY	State Fiscal Year
SGA	Substantial Gainful Activity
SPA	State Plan Amendment
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TWWIIA	Ticket to Work and Work Incentives Improvement Act
UPL	Upper Payment Limit
USC	Usual Source of Care
ZPIC	Zone Program Integrity Contractor

Authorizing Language from the Social Security Act (42 U.S.C. 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 dual eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as

personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Commission Votes on Recommendations

In its authorizing language in the Social Security Act (42 U.S.C. 1396), the Congress required MACPAC to review Medicaid and CHIP program policies and to make recommendations to the Congress, the Secretary and the states related to those policies in its report due to the Congress by March 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the report. The recommendations included in this Report and the corresponding voting record below fulfill this mandate.

Medicaid and Persons with Disabilities

1.1 The Secretary and the states should accelerate the development of program innovations that support high-quality, cost-effective care for persons with disabilities, particularly those with Medicaid-only coverage. Priority should be given to innovations that promote coordination of physical, behavioral, and community support services and the development of payment approaches that foster cost-effective service delivery. Best practices regarding these programs should be actively disseminated.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martinez Rogers, Moore, Riley, Rowland, Smith, Sundwall, Waldren

Not Present: Checkett, Rosenbaum

Medicaid and Persons with Disabilities

1.2 The Secretary, in partnership with the states, should update and improve quality assessment for Medicaid enrollees with disabilities. Quality measures should be specific, robust, and relevant for this population. Priority should be given to quality measures that assess the impact of current programs and new service delivery innovations on Medicaid enrollees with disabilities.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martinez Rogers, Moore, Riley, Rowland, Smith, Sundwall, Waldren

Not Present: Checkett, Rosenbaum

Program Integrity in Medicaid

4.1 The Secretary should ensure that current program integrity efforts make efficient use of federal resources and do not place an undue burden on states or providers. In collaboration with the states, the Secretary should:

- Create feedback loops to simplify and streamline regulatory requirements;
- Determine which current federal program integrity activities are most effective; and
- Take steps to eliminate programs that are redundant, outdated, or not cost-effective.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martinez Rogers, Moore, Riley, Rowland, Smith, Sundwall, Waldren

Not Present: Checkett, Rosenbaum

Program Integrity in Medicaid

4.2 To enhance the states' abilities to detect and deter fraud and abuse, the Secretary should:

- Develop methods for better quantifying the effectiveness of program integrity activities;
- Assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective;
- Improve dissemination of best practices in program integrity; and
- Enhance program integrity training programs to provide additional distance learning opportunities and additional courses that address program integrity in managed care.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martinez Rogers, Moore, Riley, Rowland, Smith, Sundwall, Waldren

Not Present: Checkett, Rosenbaum

Public Meetings of the Medicaid and CHIP Payment and Access Commission

September 2011—February 2012

The Commission convened public meetings to address the topics and issues presented in this Report. The presentations and deliberations in the public sessions established the foundation for the Commission's work. Based on presentations by MACPAC staff, federal and state officials, and other experts during the public meetings, the Commissioners discussed key policy questions facing Medicaid and CHIP, identified issues for more in-depth analytic work, and decided how best to present information on these policy issues in the Commission's Report to the Congress.

These discussions coalesced around the major issues that are addressed in this Report: Medicaid and persons with disabilities, access to care for children enrolled in Medicaid or CHIP, state Medicaid financing approaches and implications for provider payment, an update on CHIP financing issues, and program integrity in Medicaid. Below is a summary of major policy issues discussed during the public Commission meetings between September 2011 and February 2012. In addition, please refer to MACPAC's 2011 March and June Reports at http://www.macpac.gov/reports for lists of prior public meeting sessions that addressed issues presented in this Report. Transcripts and presentations from all public meetings are available at http://www.macpac.gov/home/meetings.

Policy Issue Area	Session Topic	Public Meeting Date
Medicaid and Persons with Disabilities	Assessing Value in Medicaid	September 22–23, 2011
	High-need, High-cost Medicaid Enrollees: Federal, State, and Beneficiary Perspectives on Coordinating Care	September 22–23, 2011
	Addressing the Continuum of Care Needs for High-need, High-cost Populations	September 22–23, 2011
	Lessons Learned in Serving High-need, High-cost Medicaid Populations in Managed Care	November 17–18, 2011
	Chapter Review: Medicaid and Persons with Disabilities	January 19, 2012
	Chapter Review continued: Medicaid and Persons with Disabilities	February 16, 2012
Access to and Quality of Care in Medicaid and CHIP	Staff Briefing: Medicaid Spending: Context for Value and Quality Discussions	September 22–23, 2011
	Access and Quality in Medicaid	November 17–18, 2011
	Staff Briefing: Children and Pregnant Women in Medicaid and CHIP	November 17–18, 2011
	Chapter Review: Access to Care for Children Enrolled in Medicaid or CHIP	January 19, 2012
	Chapter Review continued: Access to Care for Children Enrolled in Medicaid or CHIP	February 16, 2012
Medicaid Payment and Financing	Linking Payment to Quality in Medicaid	September 22–23, 2011
	Staff Briefing: Basics of Medicaid Financing	November 17–18, 2011
	Payment and Financing Issues in Medicaid	November 17–18, 2011
	Chapter Review: Medicaid and CHIP Financing	January 19, 2012
	Chapter Review continued: Medicaid and CHIP Financing	February 16, 2012
Program Integrity in Medicaid	Promoting Medicaid Program Integrity	November 17–18, 2011
	Chapter Review: Program Integrity in Medicaid	January 19, 2012
	Chapter Review continued: Program Integrity in Medicaid	February 16, 2012
Other Topics	Discussion of MACPAC's 2011–2012 Priorities	September 22–23, 2011
	Update on MACPAC Activities	November 17–18, 2011
	Overview of MACStats: Updates in 2012	January 19, 2012
	Continued: Update on MACStats, 2012	February 16, 2012

Commission Members and Terms

Diane Rowland, Sc.D., Chair
Washington, DC

David Sundwall, M.D., Vice Chair
Salt Lake City, UT

Term Expires
December 2012

Donna Checkett, M.P.A., M.S.W.
Hartford, CT

Patricia Gabow, M.D.
Denver, CO

Mark Hoyt, F.S.A., M.A.A.A.
Desert Hills, AZ

Patricia Riley, M.S.
Brunswick, ME

Diane Rowland, Sc.D.
Washington, DC

Steven Waldren, M.D., M.S.
Kansas City, MO

Term Expires
December 2013

Sharon Carte, M.H.S.
South Charleston, WV

Andrea Cohen, J.D.
New York, NY

Herman Gray, M.D., M.B.A.
West Bloomfield, MI

Norma Martínez Rogers, Ph.D., R.N., F.A.A.N.
San Antonio, TX

Sara Rosenbaum, J.D.
Alexandria, VA

Term Expires
December 2014

Richard Chambers
Irvine, CA

Burton Edelstein, D.D.S., M.P.H.
New York, NY

Denise Henning, C.N.M., M.S.N.
Ft. Myers, FL

Judith Moore
Annapolis, MD

Robin Smith
Awendaw, SC

David Sundwall, M.D.
Salt Lake City, UT

Commissioner Biographies

Sharon L. Carte, M.H.S., is executive director of the West Virginia Children's Health Insurance Program. From 1992 to 1998, Ms. Carte served as the deputy commissioner for the Bureau for Medical Services overseeing West Virginia's Medicaid program. Prior to that she was administrator of skilled and intermediate care nursing facilities in several states and coordinator of human resources development for the Division of Employee Services of the West Virginia Department of Health. Ms. Carte has also worked with senior centers and aging programs throughout the state of West Virginia and on policies related to behavioral health and chronic care for children with mental illness. She received her master of health science from the Johns Hopkins University.

Richard Chambers is chief executive officer of CalOptima, a County Organized Health System which provides publicly-funded health coverage programs for low-income families, seniors, and persons with disabilities in Orange County, California. CalOptima serves more than 420,000 members through Medicaid, CHIP, and Medicare Advantage Special Needs Plan programs. Before joining CalOptima in 2003, Mr. Chambers spent over 27 years working for the Centers for Medicare & Medicaid Services (CMS). He served as the director of the Family and Children's Health Programs Group, responsible for national policy and operational direction of Medicaid and CHIP. Prior to that, Mr. Chambers served as associate regional administrator for Medicaid in the San Francisco Regional Office and director of the Office of Intergovernmental Affairs in the Washington, DC office. He received his bachelor's degree from the University of Virginia.

Donna Checkett, M.P.A., M.S.W., is vice president of state government relations at Aetna. Prior to that, she was the chief executive officer of Missouri Care, a managed Medicaid health plan owned by the University of Missouri-Columbia Health Care, one of the largest safety net hospital systems in the state. For eight years Ms. Checkett served as the director of the Missouri Division of Medical Services (Medicaid), during which time she was the chair of the National Association of State Medicaid Directors and a member of the National Governors Association Medicaid Improvements Working Group. She served as chair of the Advisory Board for the Center for Health Care Strategies, a non-profit health policy resource center dedicated to improving health care quality for low-income children and adults. Ms. Checkett also served as chair of the National Advisory Committee for Covering Kids, a Robert Wood Johnson Foundation program fostering outreach and eligibility simplification efforts for Medicaid and CHIP beneficiaries. She received her master of public administration degree from the University of Missouri-Columbia and a master of social work from the University of Texas at Austin.

Andrea Cohen, J.D., is the director of health services in the New York City Office of the Mayor, where she coordinates and develops strategies to improve public health and health care services for New Yorkers. She serves on the board of the Primary Care Development Corporation and represents the deputy mayor for Health and

Human Services on the Board of the Health and Hospitals Corporation, the largest public hospital system in the country. From 2005 to 2009, Ms. Cohen was counsel with Manatt, Phelps & Phillips, LLP, where she advised clients on issues relating to Medicare, Medicaid and other public health insurance programs. Prior professional positions include senior policy counsel at the Medicare Rights Center, health and oversight counsel for the U.S. Senate Committee on Finance, and attorney with the U.S. Department of Justice. She received her law degree from Columbia University School of Law.

Burton L. Edelstein, D.D.S., M.P.H., is a board certified pediatric dentist and professor of dentistry and health policy and management at Columbia University. He is founding president of the Children's Dental Health Project, a national non-profit Washington DC-based policy organization that promotes equity in children's oral health. Dr. Edelstein practiced pediatric dentistry in Connecticut and taught at the Harvard School of Dental Medicine for 21 years prior to serving as a 1996-97 Robert Wood Johnson Foundation health policy fellow in the office of U.S. Senate leader Tom Daschle with primary responsibility for S-CHIP. Dr. Edelstein worked with the U.S. Department of Health and Human Services on its oral health initiatives from 1998 to 2001, chaired the U.S. Surgeon General's Workshop on Children and Oral Health, and authored the child section of *Oral Health in America: A Report of the Surgeon General*. His research focuses on children's oral health promotion and access to dental care with a particular emphasis on Medicaid and CHIP populations. He received his degree in dentistry from the State University of New York at Buffalo School of Dentistry, his master of public health from Harvard University School of Public Health, and completed his clinical training at Children's Hospital Boston.

Patricia Gabow, M.D., is chief executive officer of the Denver Health and Hospital Authority, an integrated public safety net health care system that is the state's largest provider of care to Medicaid and uninsured patients. Dr. Gabow is a member of the Commonwealth Fund's Commission on a High-Performing Health System. Previously she served as chair of the National Association of Public Hospitals, as well as on Institute of Medicine committees that addressed the future viability of safety net providers. Dr. Gabow joined Denver Health in 1973 as chief of the Renal Division and is a professor of medicine in the Division of Renal Diseases at the University of Colorado Denver School of Medicine. She received her medical degree from the University of Pennsylvania.

Herman Gray, M.D., M.B.A., is president of Children's Hospital of Michigan (CHM) and senior vice president of the Detroit Medical Center. At CHM, Dr. Gray served previously as pediatrics vice chief for education, director of the Pediatric Residency Program, chief of staff and then chief operating officer. He also served as associate dean for Graduate Medical Education (GME) and vice president for GME at Wayne State University School of Medicine and the Detroit Medical Center, respectively. Dr. Gray has also served as the chief medical consultant for the Michigan Department of Public Health Division of Children's Special Health Care Services and as vice president and medical director of clinical affairs for Blue Care Network. During the 1980s, he pursued private medical practice in Detroit. Dr. Gray serves on the board of trustees of the National Association of Children's Hospitals and Related Institutions, the board of trustees of the recently merged National Association of Children's Hospitals (NACHRI) and Child Health Corporation of America (CHCA) and the board of directors of the Child Health Corporation of America, now known as the Children's Hospital Association. He received his medical degree from the University of

Michigan in Ann Arbor and a master of business administration from the University of Tennessee.

Denise Henning, C.N.M., M.S.N., is service line leader for women's health at Collier Health Services, a federally qualified health center in Immokalee, Florida. A practicing nurse-midwife, Ms. Henning provides prenatal and gynecological care to a service population that is predominantly either uninsured or covered by Medicaid. From 2003 to 2008, she was director of clinical operations for Women's Health Services at the Family Health Centers of Southwest Florida, where she supervised the midwifery and other clinical staff. Prior to this, Ms. Henning served as a certified nurse-midwife in several locations in Florida and as a labor and delivery nurse in a Level III teaching hospital. She is president of the Midwifery Business Network and a chapter chair of the American College of Nurse-Midwives. She received her master of science in nurse-midwifery from the University of Florida in Jacksonville and her bachelor of science in nursing from the University of Florida in Gainesville.

Mark Hoyt, FSA, M.A.A.A., was the national practice leader of the Government Human Services Consulting group of Mercer Health & Benefits (H&B), LLC (prior to his retirement in 2012). This group helps states purchase health services for their Medicaid and CHIP programs and has worked with over 30 states. He joined Mercer in 1980 and has worked on government health care projects since 1987, including developing strategies for statewide health reform, evaluating the impact of different managed care approaches, and overseeing program design and rate analysis for Medicaid and CHIP programs. Mr. Hoyt is a fellow in the Society of Actuaries, a member of the American Academy of Actuaries, and the chair of the Society of Actuaries' Government Health Care Subgroup of the Social Insurance and Public Finance Section. He received a master of arts in mathematics from the University of California at Berkeley.

Judith Moore is an independent consultant specializing in policy related to health, vulnerable populations, and social safety net issues. Ms. Moore's expertise in Medicaid, Medicare, long-term supports and services, and other state and federal programs flows from her career as a federal senior executive who served in the legislative and executive branches of government. At the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services), Ms. Moore served as director of the Medicaid program and of the Office of Legislation and Congressional Affairs. Her federal service was followed by more than a decade as co-director and senior fellow at George Washington University's National Health Policy Forum, a non-partisan education program serving federal legislative and regulatory health staff. In addition to other papers and research, she is co-author with David G. Smith of a political history of Medicaid: *Medicaid Politics and Policy, 1965-2007*.

Patricia Riley, M.S., is the first distinguished visiting fellow and lecturer in state health policy at George Washington University, following her tenure as director of the Maine Governor's Office of Health Policy and Finance. She was a principal architect of the Dirigo Health Reform Act of 2003, which was enacted to increase access, reduce costs, and improve quality of health care in Maine. Ms. Riley previously served as executive director of the National Academy for State Health Policy and as president of its Corporate Board. Under four Maine governors, she held appointed positions including executive director of the Maine Committee on Aging; director of the Bureau of Maine's Elderly; associate deputy commissioner of health and medical services; and director of the Bureau of Medical Services, responsible for the Medicaid program, and health planning and

licensure. Ms. Riley served on Maine's Commission on Children's Health, which planned the state's SCHIP program. She is a member of the Kaiser Commission on Medicaid and the Uninsured and has served as a member of the Institute of Medicine's Subcommittee on Creating an External Environment for Quality and its Subcommittee on Maximizing the Value of Health. Ms. Riley has also served as a member of the board of directors of the National Committee on Quality Assurance. She received her master of science in community development from the University of Maine.

Norma Martínez Rogers, Ph.D., R.N., F.A.A.N., is a professor of family nursing at the University of Texas (UT) Health Science Center at San Antonio, where she has served on the faculty since 1996. Dr. Martínez Rogers 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 has initiated a number of programs at the UT Health Science Center in San Antonio including a support group for women transitioning from prison back into society and the Martínez Street Women's Center, a non-profit organization designed to provide support and educational services to women and teenage girls. Dr. Martínez Rogers is a fellow of the American Academy of Nursing and is the former president of the National Association of Hispanic Nurses. She received a master of science in psychiatric nursing from the UT Health Science Center at San Antonio and her doctorate in cultural foundations in education from the UT at Austin.

Sara Rosenbaum, J.D., 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 (GW) University School of Public Health and Health Services. She is also professor of health care sciences at GW's School of Medicine and Health Sciences, is a member of the faculty of GW's School of Law, and directs the Hirsh Health Law and Policy Program. 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 also has served on the board of numerous national organizations including AcademyHealth and is on many advisory boards. Professor Rosenbaum was recently appointed to 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 the 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 leading author of *Law and the American Health Care System*. She received her law degree from Boston University School of Law.

Diane Rowland, Sc.D., has served as chair of MACPAC since December 2009. She is the executive vice president of the Henry J. Kaiser Family Foundation and the executive director of the Kaiser Commission on Medicaid and the Uninsured. She is also an adjunct professor in the Department of Health Policy and Management at the Bloomberg School of Public Health of the Johns Hopkins University. Dr. Rowland has directed the Kaiser Commission since 1991 and has overseen the Foundation's health policy work since 1993. She is a noted authority on health policy, Medicare and Medicaid, and health care for low-income and disadvantaged populations and frequently testifies as an expert witness before the U.S. Congress on health policy issues. A nationally recognized expert with a distinguished career in public policy and research, focusing on health insurance coverage, access to care, and health care financing for low-income, elderly, and disabled populations, Dr. Rowland has published widely on

these subjects. She is a member of the Institute of Medicine, a founding member of the National Academy for Social Insurance, past president and fellow of the Association for Health Services Research (now AcademyHealth), and a member of the Board of Grantmakers in Health. Dr. Rowland holds a bachelor's degree from Wellesley College, a master of public administration from the University of California at Los Angeles, and a doctor of science in health policy and management from the Johns Hopkins University.

Robin Smith and her husband Doug have been foster and adoptive parents for many children covered by Medicaid, including many children with special needs. Her experience seeking care for these children has included working with an interdisciplinary Medicaid program called the Medically Fragile Children's Program, a national model partnership between the Medical University of South Carolina Children's Hospital, South Carolina Medicaid, and the South Carolina Department of Social Services. Ms. Smith serves on the Family Advisory Committee for the Children's Hospital at the Medical University of South Carolina. She has testified at congressional briefings and presented at the 2007 International Conference of Family Centered Care and at Grand Rounds for medical students and residents at the Medical University of South Carolina.

David Sundwall, M.D., serves as vice chair of MACPAC. He is a clinical professor of public health at the University of Utah School of Medicine, Division of Public Health, where he has been a faculty member since 1978. He served as executive director of the Utah Department of Health and commissioner of health for the State of Utah from 2005 through 2010. He currently serves on numerous government and community boards and advisory groups in his home state, including as chair of the Utah State Controlled Substance Advisory Committee. Dr. Sundwall was president of the Association of State and Territorial Health Officials (ASTHO) from 2007 to 2008. He has chaired or served on several committees of the Institute of Medicine (IOM) and is currently on the IOM Committee on Integration of Primary Care and Public Health, and the Standing Committee on Health Threats Resilience. Prior to returning to Utah in 2005, he was president of the American Clinical Laboratory Association (ACLA) and before that was vice president and medical director of American Healthcare Systems (AmHS). Dr. Sundwall's federal government experience includes serving as administrator of the Health Resources and Services Administration (HRSA), assistant surgeon general in the Commissioned Corps of the U.S. Public Health Service, and director of the Health and Human Resources Staff of the Senate Labor and Human Resources Committee. He received his medical degree from the University of Utah School of Medicine and completed his residency in the Harvard Family Medicine Program. He is a licensed physician, board certified in internal medicine and family practice, and volunteers in a public health clinic one-half day each week.

Steven Waldren, M.D., M.S., is director of the Center for Health Information Technology of the American Academy of Family Physicians. He also serves as vice chair of the American Society for Testing Materials' E31 Health Information Standards Committee. Dr. Waldren was a past co-chair of the Physicians EHR Coalition, a group of more than 20 professional medical associations addressing issues around health IT, and past co-chair of the Ambulatory Functionality Workgroup of the Certification Commission for Health IT (CCHIT). He received his medical degree from the University of Kansas School of Medicine. While completing a post-doctoral National Library of Medicine medical informatics fellowship, he completed a master of science in health care informatics from the University of Missouri, Columbia.

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MACPAC

Medicaid and CHIP Payment and Access Commission

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