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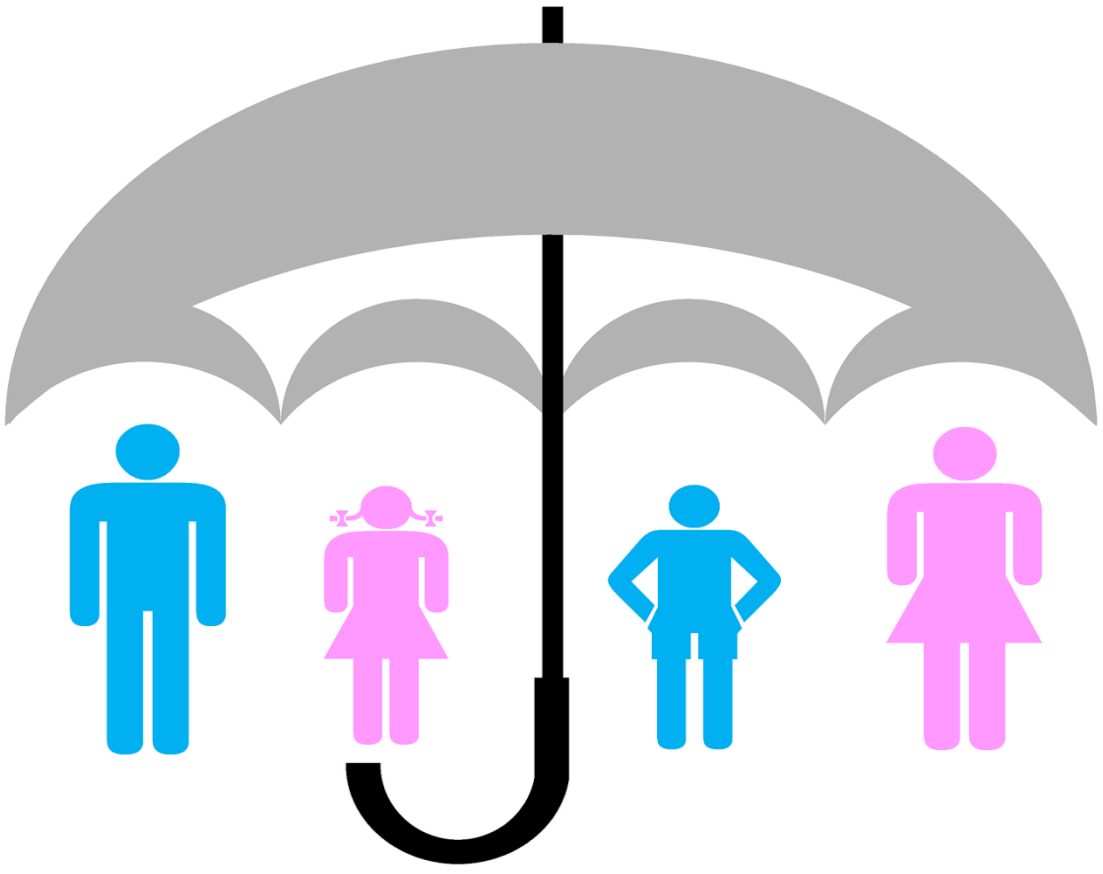
Continuing Education for Nursing Home Administrators

Medicaid: A Primer



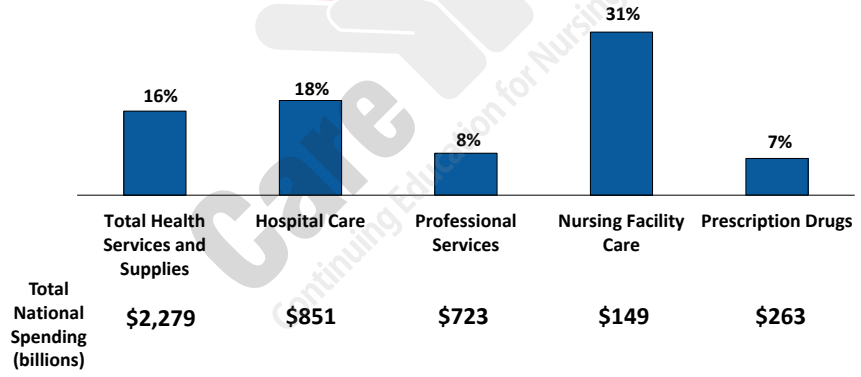
INTRODUCTION

The Medicaid program was established in 1965 by the same federal legislation that established Medicare. Originally conceived as a medical assistance supplement for people receiving cash welfare assistance – the poorest families with dependent children, and poor aged, blind, and disabled individuals – the Medicaid program has been expanded over time by Congress and the states to address widening gaps in the private health insurance system.

Medicaid now covers over 62 million Americans, more than Medicare or any single private insurer. Medicaid covers more than 1 in 3 children and over 40% of births. In addition, millions of persons with disabilities rely on Medicaid, and so do millions of poor Medicare beneficiaries, for whom Medicaid provides crucial extra help. More than 60% of people living in nursing homes are covered by Medicaid. During economic downturns like the recent Great Recession, Medicaid has provided a coverage safety-net for many Americans affected by loss of work and declining income – especially, children. As a mainstay of health coverage, Medicaid is also a major source of health care financing, funding a sixth of total national spending on personal health care (Figure 1), and providing core support for health centers and safety-net hospitals that are the backbone of the delivery system serving low-income and uninsured people. Medicaid is an engine in state economies, too.

Figure 1

Medicaid's Role in Financing Health Care



NOTE: Includes neither spending on CHIP nor administrative spending. Definition of nursing facility care was revised from previous years and no longer includes intermediate care facilities for individuals with intellectual disabilities (ICF/ID) or residential facilities for mental health or substance abuse treatment, but now includes continuing care and retirement communities (CCRC).
SOURCE: CMS, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Accounts*, 2013. Data for 2011.

While Medicaid already plays an integral role in our health care system, the Patient Protection and Affordable Care Act* (Affordable Care Act, or ACA), signed by President Obama on March 23, 2010, ushers in a significant new chapter in the program's evolution. Under the ACA, Medicaid eligibility will expand in 2014 to reach millions more poor Americans – mostly, uninsured adults.

* Health reform actually comprises two separate pieces of legislation, the ACA (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010, or HCERA (P.L. 111-152).

This federal reform of Medicaid establishes the program as the coverage pathway for most low-income people and the foundation of the broader public-private system of health coverage created under the new law. The ACA also makes other key investments and improvements to strengthen the program.

Soon after enactment of the ACA, a number of states challenged the constitutionality of several provisions of the law, including the Medicaid expansion, in *National Federal of Independent Business v. Sebelius*. In its June 28, 2012 ruling on the case, the Supreme Court upheld the law's constitutionality. However, the Justices limited the enforceability of the Medicaid expansion, effectively converting it to a state option. Thus, each state will decide whether to implement the Medicaid expansion. But regardless of states' decisions regarding the expansion, many other ACA changes to the Medicaid program will take effect across the states on January 1, 2014.

Given the broader role that Medicaid is slated to play in the coming years, and the new environment of health coverage and care in which it will operate, understanding the Medicaid program and how it fits into our health care system is more important than ever. The purpose of this Primer is to lay a foundation for that understanding by explaining the basics of Medicaid, providing key current information about the program, and describing significant changes in Medicaid that are on the horizon.

WHAT IS MEDICAID?

Medicaid is the nation's main public health insurance program for low-income people. Most Medicaid beneficiaries lack access to private insurance and many have extensive needs for care. Medicaid is also the dominant source of long-term care coverage in the U.S. As a major insurer of low-income people, Medicaid provides key financing for the safety-net institutions and providers that serve the low-income and uninsured population, as well as the larger public. Medicaid is financed through a federal-state partnership, and each state designs and operates its own program within broad federal guidelines. Medicaid's structure has enabled the program to evolve and facilitated state innovation.

What is Medicaid?

Medicaid is the nation's publicly financed health and long-term care coverage for low-income people. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is an entitlement program that was initially established to provide medical assistance to individuals and families receiving cash assistance, or "welfare." As an entitlement program, Medicaid provides assistance to all individuals who meet the criteria for eligibility; enrollment freezes and waiting lists for benefits are not allowed. Over the years, especially as private health insurance has eroded, both Congress and the states have expanded Medicaid to reach more uninsured Americans living below or near poverty. Today, Medicaid covers a broad low-income population, including pregnant women, children and some parents in both working and jobless families, children and adults with diverse physical and mental health conditions and disabilities, and poor elderly and disabled Medicare beneficiaries.

Currently, Medicaid also leaves out many of the poor, due to a federal exclusion of adults without dependent children, limited eligibility for parents in many states, and an array of barriers to participation. The ACA is expected to change this environment significantly. The new law provides for a broad expansion of Medicaid to adults under age 65 with income at or below 138% of the federal poverty level (FPL), effective January 1, 2014, with full federal funding for the newly eligible group in the first three years and at least 90% funding thereafter. However, following the Supreme Court's decision on the ACA, each state will decide whether or not to implement the Medicaid expansion.

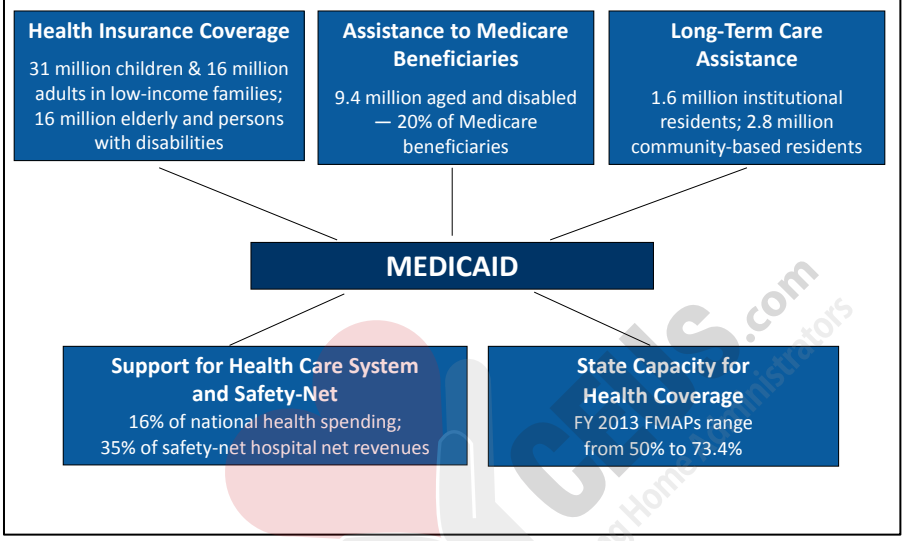
What is Medicaid's role in our health care system?

Medicaid fills large gaps in our health insurance system (Figure 2). Medicaid provides health coverage for millions of children and parents in low-income families who lack access to the private insurance system that covers most Americans. Medicaid also covers millions of people with chronic conditions and disabilities who are excluded from private insurance or cannot afford it or for whom such insurance, designed for a generally healthy population, is inadequate. Finally, Medicaid provides extra help for millions of low-income Medicare beneficiaries, known as "dual eligible" beneficiaries, assisting them with Medicare premiums and cost-sharing and covering key services, especially long-term care, that Medicare excludes or limits. Because poverty disproportionately affects racial and ethnic minorities, Medicaid plays a particularly important coverage role for these populations.

Medicaid provides a coverage safety-net during economic downturns. Because Medicaid eligibility is tied to having low-income, and enrollment caps and waiting lists are not allowed, Medicaid operates as a safety-net. During economic downturns, many individuals and families affected by unemployment, loss of job-based health coverage, and declining income become eligible for Medicaid and the program expands to cover them. It is estimated that, for every one percentage point increase in the unemployment rate, Medicaid enrollment grows by 1 million.[1]

Figure 2

Medicaid's Role in Filling Coverage Gaps

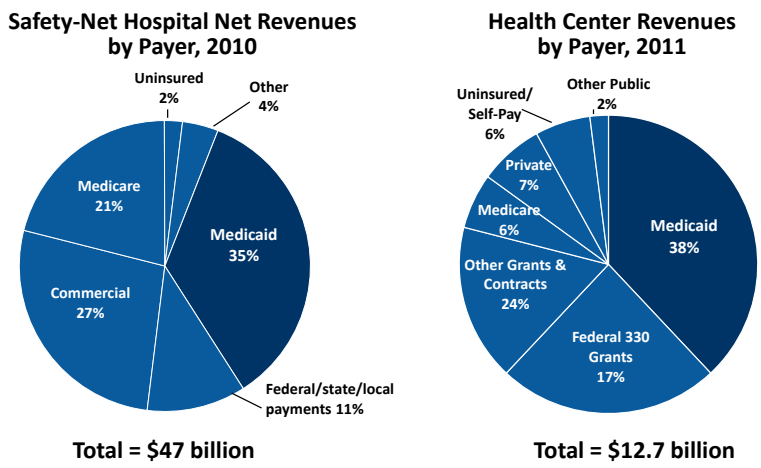


Medicaid funding is the dominant source of financing for safety-net providers that serve low-income and uninsured people (Figure 3). In 2010, Medicaid payments on behalf of enrollees accounted for more than one-third (35%) of safety-net hospitals' total net revenues.[2] In addition, supplemental Medicaid payments known as "DSH" payments financed 24% of the costs of uncompensated care provided by these hospitals, and other supplemental Medicaid funding financed another 11%. Community health centers, which provide care in many underserved areas, also rely heavily on Medicaid patient revenues, which accounted for 38% of their total operating revenues in 2011.[3]

Medicaid is the main source of coverage and financing for long-term services and supports (LTSS). Nearly 10 million Americans, about half of them elderly and about half of them children and working-age adults with disabilities, need LTSS.[4] LTSS are largely not covered by either Medicare or private insurance, but Medicaid covers nursing home and other institutional care as well as a broad range of home- and community-based LTSS that support independent living. Medicaid finances 40% of all long-term care spending, and more than 6 of every 10 nursing home residents are covered by Medicaid. Over half of Medicaid long-term care spending is for institutional care, but a steadily growing share – 45% in 2011, up from 20% in 2000 – is going to home and community-based care.[5]

Figure 3

Medicaid Financing of Safety-Net Providers



SOURCES: Data for hospitals from *America's Safety Net Hospitals and Health Systems, 2010*, National Association of Public Hospitals and Health Systems, May 2012. Health center data from 2011 Uniform Data System (UDS), BPHC/HRSA/HHS.

How is Medicaid structured?

Medicaid is financed through a federal-state partnership. The cost of Medicaid is shared by the federal government and the states. The federal government matches state Medicaid spending based on a formula specified in the Social Security Act. By statute, the federal match rate is at least 50% in every state, but the lower a state's per capita income, the higher the federal match rate it receives.

The states administer Medicaid within broad federal guidelines and state programs vary widely. Each state must have a single agency that administers Medicaid, subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). State participation in Medicaid is voluntary but all states participate. Federal law specifies core requirements that all state Medicaid programs must meet as a condition of receiving federal Mediaid funding. However, beyond the core requirements, states have broad flexibility regarding eligibility, benefits, provider payment, delivery systems, and other aspects of their programs, and Medicaid really operates as more than 50 distinct programs – one in each state, the District of Columbia, and each of the U.S. Territories.

Every state has a document called a Medicaid state plan that describes its program in detail. To make a change in its Medicaid program, a state must submit and receive CMS approval of a state plan amendment (SPA).

States can seek federal waivers to test new approaches to operating their Medicaid programs outside of regular federal rules, with federal Medicaid matching funds. Section 1115 of the Social Security Act gives the HHS Secretary authority to waive statutory and regulatory requirements for health and welfare programs, including Medicaid, for research and demonstration purposes that are "likely to assist in promoting the objectives of the program." Under longstanding administrative policy, federal Medicaid spending under a Section 1115

waiver must be "budget-neutral," meaning that it cannot exceed the amount of projected federal spending absent the waiver.

States have used Section 1115 waivers for a wide array of purposes, including to expand coverage to adults otherwise excluded from the program, to make changes in benefits and cost-sharing not otherwise allowed under federal rules, and to implement changes in their Medicaid delivery and/or payment systems. States have also obtained narrower Section 1115 waivers to implement initiatives focused on specific populations (e.g., people with HIV) or services (e.g., family planning services). Many states also have Section 1915 "program waivers" that permit them to mandate managed care for certain beneficiaries who are normally exempt from such mandates, and to obtain federal matching funds to provide community-based LTSS to beneficiaries who would otherwise need nursing facility care.

***Medicaid's structure enables the program to evolve and facilitates state innovation*.** Broad state flexibility in program design and guaranteed federal matching funds have enabled Medicaid to respond to economic and demographic changes and to address emergent needs – for example, by expanding during economic downturns, providing a coverage safety-net for many affected by the HIV/AIDS pandemic, and providing immediate, short-term benefits for 350,000 New Yorkers following the 9/11 terrorist attacks. Further, states have harnessed Medicaid's leverage as a major source of coverage and financing to drive innovation and improvements in care, including more patient-centered and coordinated care and wider use of community-based alternatives to institutional long-term care, and to advance payment reforms that align incentives with quality and health outcome goals.

Both the general public and those with experience in the program view Medicaid favorably. A large majority of Americans view Medicaid as a very important program and would be willing to enroll in the program if they needed health care and qualified. Over half of adults have a friend or family member who has benefited from Medicaid or have received Medicaid benefits themselves.[6] Findings from surveys and focus group studies show a high degree of satisfaction with Medicaid among families with program experience.[7] They value both the breadth of Medicaid's benefits and the affordability of the coverage.

WHO DOES MEDICAID COVER?

By design, Medicaid covers low-income people. Currently, the program covers more than 62 million Americans, or 1 in every 5, including many with complex health care needs. Medicaid plays an especially large role in covering children and pregnant women; it also covers millions of individuals with severe disabilities and provides extra assistance for millions of poor Medicare beneficiaries. Medicaid historically has excluded most non-elderly adults, but the ACA expands Medicaid to people under age 65 with income at or below 138% of the federal poverty level, effective January 1, 2014. The expanded Medicaid program is integral to the broader framework the ACA creates to cover the uninsured. Following the Supreme Court's ruling on the ACA, each state will decide whether or not to adopt the Medicaid expansion. However, all states must comply with ACA requirements to simplify and streamline Medicaid eligibility and enrollment to ensure seamless coordination between Medicaid and the health insurance exchanges, the other new major coverage pathway for the uninsured.

What is Medicaid's coverage role?

Medicaid is a bedrock source of coverage for children. Medicaid, together with the smaller Children's Health Insurance Program (CHIP), covers more than 1 in every 3 children and more than half of all low-income children. Medicaid is particularly important for children with disabilities and special needs. Because of Medicaid and CHIP, the uninsured rate among children has declined substantially over the last decade.

Medicaid covers certain low-income people, including many with complex health care needs. Most of the people Medicaid covers are in working families but lack access to job-based health insurance or cannot afford the premiums. Most are also unable to obtain individual (non-group) health insurance, either because they cannot afford it or, in the case of adults, because they are turned down for coverage based on their health status (children can no longer be rejected for coverage based on pre-existing health conditions). Overall, Medicaid beneficiaries are much poorer and in significantly worse health than low-income people with private insurance.

Individuals who qualify for Medicaid have a federal entitlement to coverage. Medicaid is an entitlement program. That means that any person who meets his or her state's Medicaid eligibility criteria has a federal right to Medicaid coverage in that state; the state cannot limit enrollment in the program or establish a waiting list. The guarantee of coverage and the obligation of states and the federal government to finance it distinguish Medicaid from CHIP and other block grant programs, in which funding levels are pre-set and enrollment can be capped.

Who can qualify for Medicaid?

States must cover federal core groups of low-income individuals and have broad flexibility to expand coverage. The federal core groups that states must cover to receive federal Medicaid matching funds are pregnant women, children, parents, elderly individuals, and individuals with disabilities, with income below specified minimum thresholds, such as 100% or 133% of the federal poverty level (FPL). One group that historically has been excluded from the core groups is non-elderly adults without dependent children ("childless adults"). States can choose to extend Medicaid eligibility to people in the core groups who have income above the federal minimum thresholds and receive federal matching funds.[8]

Medicaid eligibility is limited to American citizens and certain lawfully present immigrants. Only American citizens and specific categories of lawfully present immigrants can qualify for Medicaid, and most lawfully present immigrants are barred from enrolling in Medicaid during their first five years in the U.S. States have an option to eliminate the five-year wait for lawfully present children and pregnant women but not for other adults. As of January 2013, half of all states had adopted the option for one or both groups.[9] Undocumented immigrants are ineligible for Medicaid.

Medicaid payments for emergency services may be made on behalf of individuals who would be eligible for Medicaid but for their immigration status, including lawfully present immigrants who are ineligible or in the five-year waiting period for coverage and undocumented immigrants. Some states have used state-only funds to cover lawfully present or undocumented immigrants who are not eligible for Medicaid, although these programs are often limited to certain groups and/or provide a limited scope of services.

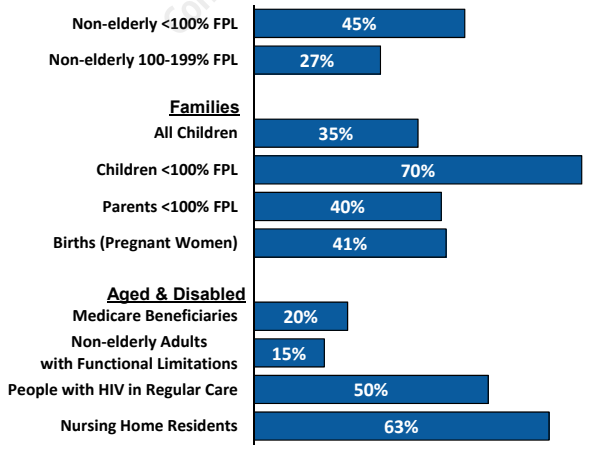
Documentation of citizenship and identity is required. Federal law requires most individuals applying for Medicaid coverage for the first time to document their citizenship status and identity.[10]

Who is covered currently?

Medicaid covers more than 62 million Americans, or 1 in every 5. Medicaid beneficiaries include low-income individuals of all ages, including newborns, children and parents, pregnant women, individuals with diverse physical, developmental, and intellectual disabilities and mental illnesses, and poor elderly and disabled Medicare beneficiaries, including many with long-term care needs. Half the people with HIV who are in regular care are covered by Medicaid.[11] The program plays a particularly large role for certain subpopulations who are disproportionately likely to be poor and who lack access to private coverage due to their low income or health status (Figure 4).

Figure 4

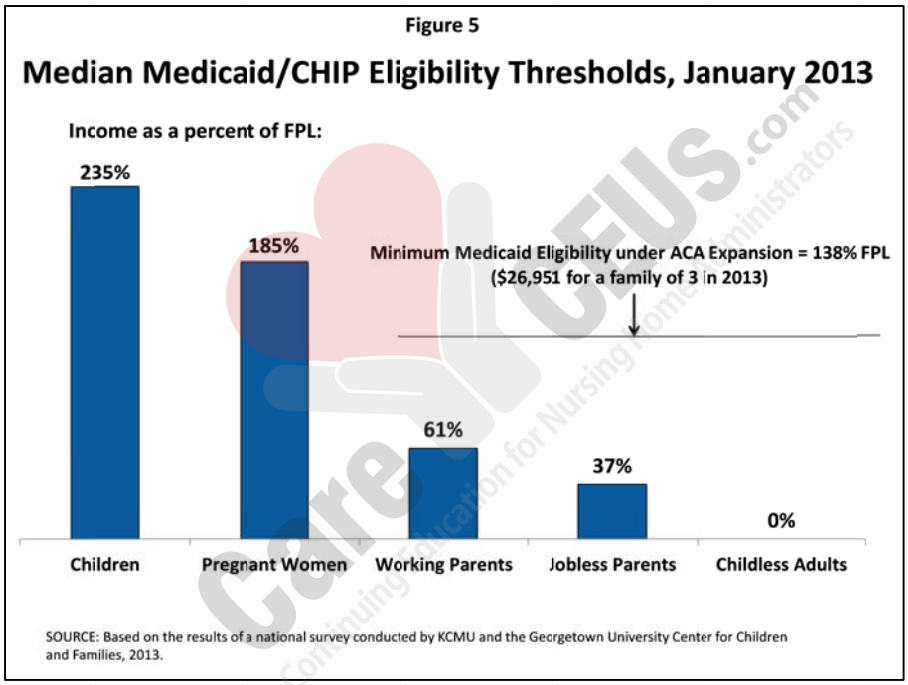
Medicaid's Role for Selected Populations



SOURCE: KCMU and Urban Institute analysis of 2012 ASEC Supplement to the CPS; birth data from *Maternal and Child Health Update: States Increase Eligibility for Children's Health in 2007*, National Governors Association, 2008; Medicare data from MCBS Cost and Use file, 2009; Functional Limitations from KCMU Analysis of 2011 NHIS data.

Medicaid is the largest source of health insurance for children in the U.S. Over the course of FY 2009, Medicaid covered nearly 31 million children, including roughly 1 million foster care children. CHIP builds on Medicaid, covering close to 8 million children in low- and moderate-income families with income too high to qualify for Medicaid. In most states, between Medicaid and CHIP, all children below 200% FPL are eligible for public coverage. Together, the two programs cover more than 1 in every 3 children. At any given point during the year, they cover 70% of all poor children and 50% of children between 100% and 200% FPL.[12]

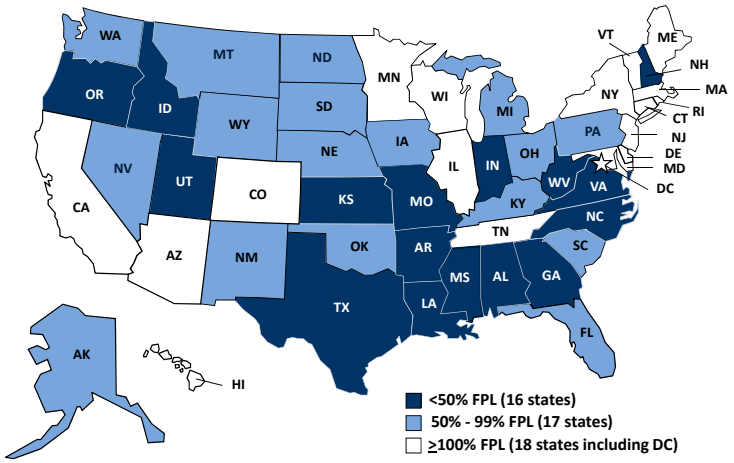
Medicaid is a key source of coverage for pregnant women. Most states have expanded coverage of pregnant women beyond the federal minimum income eligibility level of 133% FPL. Twenty states now cover pregnant women up to 185% FPL and another 17 states provide eligibility at higher income levels.[13] Medicaid improves access to prenatal care and neonatal intensive care for pregnant women and their babies, helping to improve maternal health and reduce infant mortality, rates of low birth weight, and avoidable birth defects. Medicaid funds over 40% of births in the U.S. and is the largest source of public funding for family planning.[14]



Medicaid coverage of low-income adults lags far behind Medicaid coverage of children. States typically have much more limited eligibility for parents than for children (Figure 5). As of January 1, 2013, 33 states set income eligibility for working parents at a level below 100% FPL ($19,530 for a family of three in 2013), including 16 states that limited eligibility to parents earning less than 50% FPL. In addition, as mentioned, federal law has excluded most childless adults from Medicaid. Reflecting their more constrained eligiblity, any given point during the year, only about 40% of poor parents and just a quarter of poor childless adults are covered by the program, and poor adults are more than two-and-a-half times as likely as poor children to be uninsured. Sharp variation in state income eligibility thresholds for working parents, from 16% in Arkansas to 215% in Minnesota (Figure 6), and the small number of states that provide full Medicaid benefits to any non-disabled childless adults, translate into marked inequities in low-income adults' access to Medicaid coverage across the country.[15]

Figure 6

Medicaid Eligibility for Working Parents, by Income
January 2013



NOTES: The federal poverty line (FPL) for a family of three in 2013 is $19,530. Several states also offer a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.
SOURCE: Based on the results of a national survey conducted by KCMU and the Georgetown University Center for Children and Families, 2013.

Medicaid covers 9.3 million non-elderly people with disabilities, including 1.5 million children. Medicaid provides health and long-term care coverage for people with severe physical and mental health conditions and disabilities (e.g., cerebral palsy, Down Syndrome, autism). Often, these individuals cannot obtain coverage in the private market or the coverage available to them falls short of their health care needs. Medicaid provides people with disabilities access to a fuller range of the services they need, helping to maximize their independence and, in the case of some disabled adults, supporting their participation in the workforce. Medicaid covers a large majority of all poor children with disabilities.

Medicaid provides assistance for over 9 million low-income Medicare beneficiaries**.** In 2012, the federal Medicare program provided health insurance for 50 million Americans, including about 42 million seniors and 9 million non-elderly individuals with permanent disabilities.[16] One in every 5 Medicare beneficiaries is also covered by Medicaid, based on low income. These individuals, known as "dual eligible" beneficiaries, are much poorer than other Medicare enrollees, and in worse health. Medicaid assists dual eligible beneficiaries with Medicare premiums and cost-sharing and covers important services that Medicare limits or does not cover, especially LTSS. In 2009, dual eligible beneficiaries accounted for 15% of Medicaid enrollees but 38% of all Medicaid spending.

What about participation in Medicaid?

While participation in Medicaid is high compared with other voluntary programs, many people who are eligible are not enrolled and remain uninsured. About 85% of children who are eligible for Medicaid or CHIP participate.[17] However, participation rates among adults are lower – 63% for adults overall and only 38% among childless adults.[18] More than 70% of uninsured children are potentially eligible for Medicaid or CHIP but not enrolled. Some low-income families are not aware of the programs or do not believe they are eligible, indicating that more effective outreach is needed. Research also shows that documentation and other administrative

requirements can pose significant obstacles to enrollment and cause many enrolled children and families to lose their Medicaid coverage at renewal time. This "churning" in Medicaid disrupts coverage and care and increases the number of individuals without insurance.

To improve participation in Medicaid, states have increasingly simplified and streamlined Medicaid enrollment and renewal processes. Important streamlining steps required by the ACA have already been implemented in many states over the last decade, mostly for children. Today, few states require face-to-face interviews for either children or adults applying for or renewing Medicaid. Likewise, few impose asset tests for children or pregnant women, and about half have eliminated asset tests for other adults. Over two-thirds of states now have electronic online applications in Medicaid or CHIP, and over half offer online renewal.[19] Most states verify citizenship for Medicaid and CHIP eligibility purposes through an electronic data match with the Social Security Administration.

States have also invested in outreach and enrollment assistance. Nearly all states offer in-person assistance at eligibility offices and a toll-free assistance hotline, and most provide assistance at the local level. The CHIP Reauthorization Act of 2009 (CHIPRA) established a program of grants to states for outreach and enrollment of children in Medicaid and CHIP, and federal performance bonuses for states that simplified enrollment and renewal for children and increased their enrollment and retention.

How will the ACA affect who is covered?

The ACA opens Medicaid to millions of uninsured adults. The ACA expands Medicaid by establishing a new Medicaid eligibility group for adults under age 65 with income at or below 138% FPL.* These adults make up about half the uninsured. Accounting for enrollment among adults who gain Medicaid eligibility due to the expansion, as well as increases in participation among children and adults eligible for Medicaid prior to the ACA, Medicaid enrollment is expected to increase by 21.3 million by 2022.[20] [21] (Note: The ACA does not change Medicaid eligibility for the elderly and people with disabilities.)

- ***The Medicaid expansion is effectively a state option***. Although the ACA required states to expand Medicaid, in its June 28, 2012 ruling on the constitutionality of the ACA, the Supreme Court curtailed HHS' ability to enforce the requirement. Specifically, the Justices ruled that HHS cannot withhold federal matching funds for the "traditional" Medicaid program if a state does not implement the Medicaid expansion. The Court's decision effectively converted the Medicaid expansion to a state option. States that do expand Medicaid must expand it to the 138% FPL threshold to receive the enhanced federal match.

- ***Non-citizens will continue to face restrictions from Medicaid under the ACA.*** Lawfully present immigrants will continue to face the five-year waiting period or, in the case of some categories, remain excluded from Medicaid. Undocumented immigrants will remain ineligible for Medicaid.

* The ACA establishes 133% FPL as the income eligibility threshold for the Medicaid expansion population, but because it also provides that the first 5% of income is automatically disregarded, the effective income eligibility threshold is 138% FPL. For simplicity, 138% FPL is used in the Primer.

State adoption of the Medicaid expansion would help reduce the number of uninsured. Without the Medicaid expansion, the ACA would reduce the number of uninsured in 2022 by an estimated 15.1 million (28%). If all states adopted the Medicaid expansion, the number of uninsured in 2022 would decline by 25.3 million (48%) – an additional 10.1 million people.[22]

The ACA simplifies Medicaid eligibility and calls for a "no wrong door" enrollment system, with seamless coordination between Medicaid and the new exchanges. Regardless of their decisions on whether to implement the Medicaid expansion, on January 1, 2014, all states must implement a number of provisions in the ACA that support the seamless coordination between coverage programs that the law requires. For most non-elderly applicants, states must replace the myriad methods of counting income they now use to determine Medicaid eligibility with Modified Adjusted Gross Income (MAGI), as defined in the Internal Revenue Code. States must also use a single, streamlined application for Medicaid, CHIP, and subsidies for exchange coverage developed by the HHS Secretary, unless they receive approval for an alternative application. Individuals must be able to apply online, by telephone, fax, and mail, and in person. Finally, states must streamline the enrollment process by eliminating in-person interviews and asset tests and relying first on electronic data matches rather than documents to verify eligibility criteria; they must also provide application assistance.

In 2011, HHS began providing a time-limited enhanced federal match rate (90%) for state expenditures to upgrade or replace aging Medicaid eligibility and enrollment systems to meet these requirements. Nearly all states applied for and received such funds, and most states have already begun moving forward to develop the capabilities and improvements that the ACA requires.

Effective Medicaid outreach, as well as application assistance, will be important for the ACA to achieve its coverage goals. Reductions in the number of uninsured will hinge to a large extent on high rates of participation in Medicaid. Robust and sustained outreach efforts will be important, especially to engage childless adults, who are largely new to Medicaid. Because the Medicaid-eligible population is diverse along many dimensions (e.g., age, income, race/ethnicity/language, health status, work status, urban/suburban/rural location), both broad and targeted outreach efforts will be needed. In addition, application assistance will be important – particularly, direct one-on-one assistance for hard-to-reach groups, such as individuals with limited English proficiency and families with mixed immigration status. Past experience suggests that this assistance is most effective when provided by individuals from the community being served, who can provide culturally competent help and have appropriate language skills. Increased awareness of and interest in coverage as the ACA is implemented will present new opportunities for Medicaid outreach, marketing, and assistance.

WHAT DOES MEDICAID COVER?

Medicaid covers a broad array of health and long-term care services, including many services not typically covered by private insurance. Cost-sharing is restricted to minimize financial barriers to access for the low-income people Medicaid serves. Medicaid benefits for children are uniquely comprehensive, while federal law gives states more latitude in defining the benefit package for adults. Under the ACA, most adults who become newly eligible for Medicaid due to the Medicaid expansion will receive Alternative Benefit Plans (ABP). ABPs must include the ten "essential health benefits" defined by the ACA and also meet other requirements. The ACA also establishes a new state Medicaid option for "health homes" to improve care for people with multiple chronic conditions, and increases states' opportunities to expand access to home and community-based LTSS.

What does the Medicaid benefit package include?

Because of the diverse and complex needs of the Medicaid population, Medicaid covers a broad range of both health and long-term care benefits. Medicaid covers a diverse population, including children and parents, pregnant women, people with physical and mental disabilities and chronic diseases of all kinds, and seniors. To address the spectrum of their needs and their limited ability to pay for care out-of-pocket, Medicaid covers benefits typically covered by private insurance, but also many additional services, such as oral and vision care, transportation, and nursing home and community-based long-term care. Services provided by federally qualified health centers and certain other providers are also covered, reflecting the special role of these providers in serving the low-income population. States use numerous tools, such as prior authorization and case management, to manage utilization in Medicaid.

Federal law specifies a set of "mandatory services" that states must cover for the traditional Medicaid population. Most Medicaid beneficiaries are entitled to receive the mandatory services listed below, subject to a determination of medical necessity by the state Medicaid program or a managed care plan under contract to the state:

- Physicians' services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under age 21
- Federally-qualified health center (FQHC) and rural health clinic (RHC) services
- Family planning services and supplies
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services
- Transportation services

States have flexibility to cover many additional services that federal law designates as "optional." Many of these optional services are particularly vital for persons with chronic conditions or disabilities and the elderly. Examples include prescription drugs (which all states cover), personal care services, rehabilitation services, and habilitation services. Notwithstanding their "optional" designation in statute, the fact that states choose to cover many of these

services in their Medicaid programs is evidence that they are widely considered to be essential for the Medicaid population. Nonetheless, when states are under severe budget strains, as in the recent economic recession, optional benefits like dental services for adults are particularly vulnerable to cuts, despite their importance and the well-documented adverse health consequences of reduced access to care. About one-third of total Medicaid spending is attributable to optional services.[23]

Commonly offered optional services include:

- Prescription drugs
- Clinic services
- Care furnished by other licensed practitioners
- Dental services and dentures
- Prosthetic devices, eyeglasses, and durable medical equipment
- Rehabilitation and other therapies
- Case management
- Nursing facility services for individuals under age 21
- Intermediate care facility for individuals with intellectual disabilities (ICF/ID) services
- Home and community-based services (including under waivers)
- Inpatient psychiatric services for individuals under age 21
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services

How do Medicaid benefits differ from typical private insurance benefits?

The pediatric Medicaid benefit, known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), encompasses a comprehensive array of health services. EPSDT is a mandatory benefit that entitles Medicaid enrollees under age 21 to all services authorized by federal Medicaid law, including services considered optional for other populations (e.g., dental care) and often not covered by private health insurance. In addition to screening, preventive, and early intervention services, EPSDT covers diagnostic services and treatment necessary to correct *or ameliorate* children's acute and chronic physical and mental health conditions. EPSDT covers services that are particularly important, often on an ongoing basis, for children with disabilities, such as physical therapy, personal care, and durable medical equipment. Private health insurance often excludes or limits these services.

The conception of medical necessity in EPSDT is expansive, consistent with the emphasis in Medicaid on promoting children's healthy development and maximizing their health and function. Accordingly, service limits that states may impose on adults, such as a limit on physical therapy sessions, or a maximum number of prescriptions per month, cannot be applied to children. As a model of uniform, comprehensive benefits that apply to a population nationally, EPSDT is unique in both Medicaid and the broader insurance market.

In addition to acute health services, Medicaid covers a wide range of LTSS that Medicare and most private insurance exclude or narrowly limit. Medicaid LTSS include services provided in nursing facilities and ICF/ID, as well as a wide range of services and supports needed by people, young and old, to live independently in the community – home health care, personal care, durable medical equipment and supplies, rehabilitative services, case management, home and community-based services, and other services. Both federal and state Medicaid policy have increasingly supported home and community-based alternatives to institutional long-term care,

driven partly by the Supreme Court's *Olmstead* decision concerning the civil rights of people with disabilities in public programs.

The broad spectrum of services that Medicaid covers is particularly important for people with chronic illnesses and disabilities who depend on Medicaid. Medicaid beneficiaries include pre-term babies, people with Alzheimer's disease, children and adults with mental illness, intellectual and developmental disabilities, and physical disabilities, people with HIV, and many others with high needs. Medicaid covers services that reflect the diverse and often extensive needs of the people it covers. The program fills major gaps in coverage for mental health and long-term care services.

States can impose premiums and cost-sharing in Medicaid subject to specific federal limitations, exemptions, and an aggregate cap. Premiums are prohibited for children and adults with income at or below 150% FPL, but states have limited flexibility to charge Medicaid premiums for people at higher income levels. Cost-sharing is largely prohibited for mandatory children and limited to nominal amounts (specified in regulations) for adults below 100% FPL. Other children and adults up to 150% FPL can be charged more cost-sharing, and those above 150% FPL can be charged still more, including any amount for non-emergency use of the emergency department (ED). States can terminate Medicaid coverage if premiums are not paid and can permit providers to deny care if Medicaid patients, except for mandatory children and poor adults, do not pay their cost-sharing amounts.[24]

Several services are exempt from cost-sharing, including preventive services for children, emergency services, family planning services and supplies, and pregnancy-related services including tobacco cessation services. Certain groups are also exempt, such as terminally ill individuals and individuals living in institutions. For all Medicaid beneficiaries, aggregate premiums and cost-sharing are capped at 5% of quarterly or monthly family income. CMS recently issued a proposed rule that would streamline Medicaid premium and cost-sharing regulations and give states additional flexibility, including authority to charge differential cost-sharing for preferred and non-preferred drugs and non-emergency ED use.

How do states define their Medicaid benefit packages?

In general, a state must provide the same Medicaid benefit package to all its residents. Generally, federal Medicaid law requires states to cover the same benefits statewide for all individuals in the federal core groups, and the covered services must be comparable, regardless of individuals' diagnoses or conditions. States define the amount, duration, and scope of the Medicaid services they cover, but federal law requires that coverage of each mandatory and optional service be "sufficient in amount, duration, and scope to reasonably achieve its purpose."

However, states have limited authority to provide narrower benefits to some groups. In the Deficit Reduction Act of 2005 (DRA), Congress changed the law to permit states to provide some groups with more limited benefits modeled on any of four specified "benchmark" plans, and to offer different benefits to different enrollees. The benchmark plans are:

- The BCBS Standard PPO option under the Federal Employees Health Benefit Plan (FEHBP);
- A generally available state employee plan;
- The HMO with the largest commercial, non-Medicaid enrollment; and
- Secretary-approved coverage appropriate for the population

States providing benchmark (or benchmark-equivalent) coverage must still provide EPSDT benefits for children. Most groups are exempt from mandatory enrollment in benchmark coverage, including mandatory pregnant women and parents, individuals with severe disabilities, individuals who are medically frail or have special needs, dual eligible beneficiaries, people with long-term care needs, and specified other groups. Only eight states have used the DRA benchmark authority, and all but one used the Secretary-approved coverage option. Most states used the authority to target additional benefits to certain groups, but some used it to provide reduced benefits, conditioning access to "enhanced" benefits on beneficiaries' health behaviors.

Medicaid benefits vary considerably from state to state. Medicaid benefit packages vary widely from state to state. States cover different optional services. They also define amount, duration, and scope differently. Except with regard to children, states can place limits on covered services – for example, by capping the number of physician visits or prescription drugs that Medicaid will cover. Finally, while federal law includes a "medically necessary" standard to ensure appropriate use of Medicaid services, states define and apply the medical necessity standard somewhat differently.

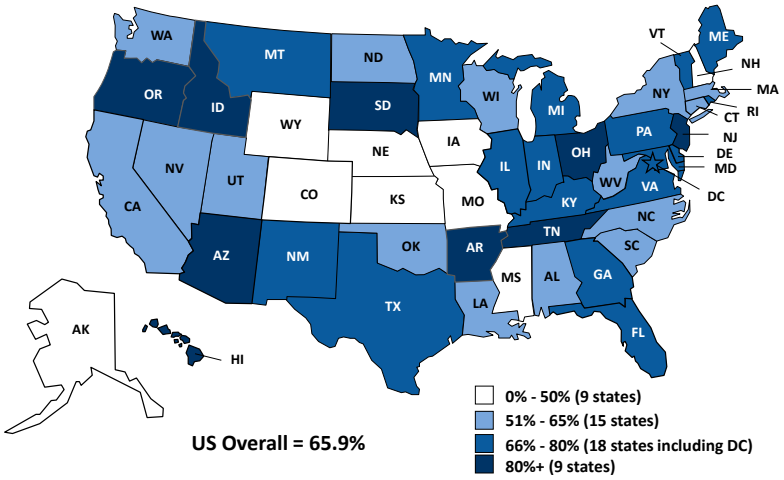
How do Medicaid enrollees receive their care?

Medicaid beneficiaries obtain their care primarily from private providers and health plans. Medicaid is publicly financed, but it is not a government-run health care delivery system. On the contrary, states pay physicians, hospitals, and other providers for services furnished to Medicaid beneficiaries. State Medicaid programs purchase services on a fee-for-service basis or through risk-based contracts with managed care plans, or by using a combination of these as well as other approaches.

Most Medicaid beneficiaries are enrolled in managed care plans. Nearly three-quarters of Medicaid beneficiaries receive all or at least some of their care through managed care arrangements (Figure 7).[25] The two main models of managed care in Medicaid are managed care organizations (MCO) and primary care case management (PCCM). MCOs are paid on a capitation basis – that is, they are paid a monthly premium for each enrolled beneficiary in exchange for assuming the financial risk for providing comprehensive Medicaid benefits or a defined set of benefits (e.g., ambulatory care, dental services). About half of all Medicaid beneficiaries are enrolled in these risk-based managed care plans. In contrast, PCCM programs build on the fee-for-service system. Medicaid pays contracted primary care providers (PCP) a small monthly per-enrollee fee to provide case management services to Medicaid beneficiaries assigned to them, including coordination and monitoring of primary health services and referrals for specialist care.

Figure 7

Comprehensive Medicaid Managed Care Penetration by State, October 2010



NOTE: Includes enrollment in MCOs and PCCMs. Most data as of October 2010.
SOURCE: KCMU/HMA 50-State Survey of Medicaid Managed Care Programs, September 2011.

States are expanding managed care to more complex populations and are also pursuing managed LTSS. The vast majority of Medicaid enrollees in managed care arrangements are children and parents in low-income families, a relatively healthy population. Increasingly, though, many states are moving individuals with more complex needs, including people with disabilities and special needs and dual eligible beneficiaries, into risk-based MCOs on a mandatory basis. In addition, there is growing interest among states in providing long-term services and supports through risk-based MCOs. Only about a dozen states now operate such programs, but a new demonstration program established by the ACA to test models for integrating care and aligning financing for dual eligible beneficiaries has generated more state activity in this area.[26]

States are using a variety of approaches to rebalance their long-term care delivery systems in favor of community settings. As the demand for LTSS provided in the community continues to grow, efforts to make Medicaid benefits more flexible and involve consumers in determining and managing their services are spreading and gaining momentum. Many states allow some form of consumer direction of personal care services, giving the Medicaid beneficiary more control over hiring, scheduling, and paying personal care attendants. The ACA provides states with increased opportunities to expand access to home and community-based services, and the law extends an existing demonstration program, known as "Money Follows the Person," that provides enhanced federal matching funds to states for each Medicaid beneficiary they transition from an institution to the community.

Safety-net providers play a major role in delivering health care to the Medicaid population. Whether they use managed care, fee-for-service, or a combination of delivery systems, many states rely heavily on community health centers in the underserved areas where many low-income people reside, and on public and other safety-net hospitals. These providers are often uniquely prepared and competent to meet the diverse social as well as health care needs of the Medicaid population.

State Medicaid programs have been innovators in the area of delivery system reform. Given high rates of disability and chronic disease in the Medicaid population and the public dollars at stake, both the opportunities and the incentives to improve care and accountability in Medicaid are great. Many states have developed model programs to improve disease management and enhance the coordination of care for people with ongoing and complex needs. A growing number of states are reforming primary care delivery by aligning Medicaid payment incentives with patient-centered care that emphasizes coordinated and team-based care.

How will Medicaid benefits work under the ACA?

Medicaid benefits for adults in the expansion group will be based on the Medicaid benchmarks already in law, but all benchmarks must include the ACA's ten "essential health benefits." Most newly eligible adults will receive Medicaid benefit packages based on or equivalent to the four benchmark plans described earlier. However, beginning January 1, 2014, all benchmark plans – for both new eligibles and the traditional population – must include the ten essential health benefits (EHBs) identified in the ACA and required of plans offered through the new exchanges.[*] The ACA also requires Medicaid benchmark plans to include family planning services and supplies and meet mental health parity requirements; any benchmark-equivalent plans must include prescription drugs and mental health services. The groups currently exempt from mandatory enrollment in benchmark plans are retained and carry over to the expansion population. Thus, for example, expansion adults who are medically frail or have long-term care needs will be entitled to traditional Medicaid benefits and cannot be required to enroll in benchmark coverage. Going forward, the Medicaid benchmark coverage options are known as "Alternative Benefit Plans" (ABP).

Traditional Medicaid benefits and ABPs could differ within a state. The ACA requirement that Medicaid ABPs include the ten EHBs does not apply to traditional Medicaid benefits. Thus, it is possible that, within a state, traditional adult beneficiaries might not receive important benefits that expansion adults receive, such as recommended preventive services. At the same time, it is possible that ABPs could lack important benefits that traditional Medicaid covers. CMS guidance has indicated that states could harmonize and strengthen Medicaid benefits by using the Secretary-approved ABP option and optional Medicaid benefits to align their ABPs and traditional Medicaid benefits as closely as possible. By taking these steps, states could reduce disruptions in services when individuals shift between Medicaid eligibility groups, and rationalize coverage for mixed-Medicaid families.

New federal initiatives reinforce and accelerate state efforts to improve the delivery of care. The ACA established a new state option to implement "health homes" for Medicaid beneficiaries with chronic conditions, including severe mental illness. Health homes involve the integration and coordination of primary, acute, mental and behavioral health, and long-term services and supports. More integrated care for dual eligible beneficiaries is another key ACA

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[*] The ten essential health benefits specified in the ACA are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

priority. To advance that goal, the law created a new Medicaid-Medicare Coordination Office within CMS, as well as a multi-state demonstration program to test new models of integrated service delivery and payment for dual eligible beneficiaries. In addition, a new Innovation Center in CMS is charged with testing an array of payment and service delivery reforms for the broader population.

The ACA creates new state opportunities to expand access to home- and community-based LTSS. The health reform law expands states' Medicaid options to provide LTSS in the community, both enlarging the scope of covered services and expanding access to them by broadening the financial and functional criteria for eligibility. The ACA also provides increased financial incentives for states to shift more long-term care services out of institutional settings and into the community.

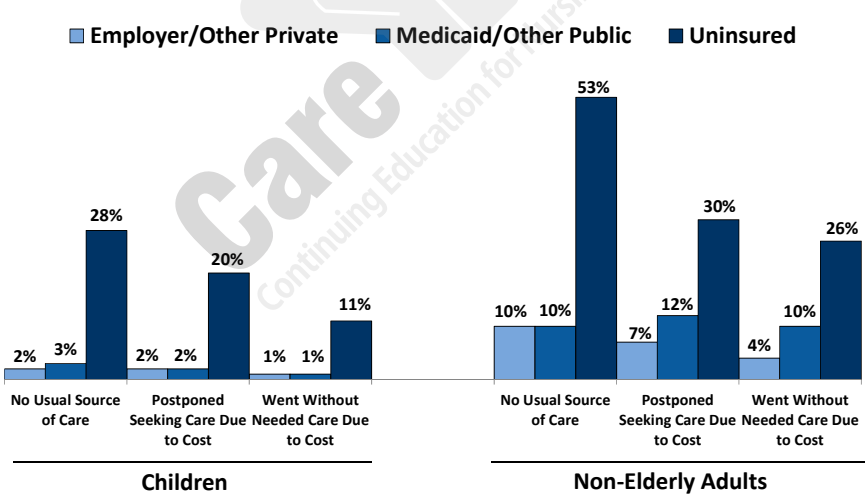
WHAT IS THE IMPACT OF MEDICAID ON ACCESS TO CARE?

Medicaid coverage of children and pregnant women has led to increased access to care and improved child health and birth outcomes. Children with Medicaid fare as well as privately insured children on core measures of preventive and primary care. Relative to their uninsured counterparts, adults with Medicaid have increased access to and use of preventive and primary care and reduced out-of-pocket burdens, and they are less likely to delay or forgo care due to cost. Still, provider shortages and low provider participation in Medicaid, particularly among specialists, are a major concern, and expanded coverage under the ACA can be expected to increase current pressures on access.

What does the research on access to care in Medicaid show?

Medicaid increases access to care and lowers financial barriers to care. Expansions of Medicaid to children and pregnant women have led to increased access to and use of medical care and improved child health and birth outcomes; expansions to cover more parents have increased rates of cancer screening and decreased the likelihood of going without doctor care due to cost.[27] [28] [29] [30] National data show that, among both children and non-elderly adults, the uninsured are much more likely to report no usual source of care and delaying or forgoing needed care due to cost (Figure 8). A recent analysis examining access among low-income adults with chronic conditions found that those enrolled in Medicaid had higher utilization and spending than their uninsured counterparts with the same illnesses, and lower out-of-pocket burdens. They were much more likely to have had a recent check-up and much less likely to report being unable to access necessary medical care.[31]

Figure 8



NOTE: In past 12 months.
Respondents who said usual source of care was the emergency room were included among those with no usual source of care. All differences between the uninsured and the two insurance groups are statistically significant (p<0.05).
SOURCE: KCMU analysis of 2011 NHIS data.

A new study provides powerful evidence of the impact of Medicaid on adults' access to care. The recent Oregon Health Study, using a unique experimental research design, compared access between adults who gained Medicaid through a lottery and a control group of low-income adults who did not win the lottery and remained uninsured. The first-year results of the study

show that Medicaid significantly increased the probability of having a usual source of primary care, the use of recommended preventive care, and the use of outpatient care, prescription drugs, and hospital care.[32] In addition, the Medicaid adults had lower out-of-pocket medical costs, less medical debt, and better self-reported physical and mental health. The gains in access for the adults with Medicaid were large as well as significant.

On key measures on access to preventive and primary care, children in Medicaid and CHIP fare as well as children with private insurance, but adults face more difficulty. A recent HHS report shows that, on several core measures of preventive and primary care, access and quality are fairly comparable between children with Medicaid or CHIP and children with private insurance, and the percentages of children who had at least one primary care visit during the year were high in both insured groups.[33] However, the low shares of children receiving all recommended well-child visits, childhood and adolescent immunizations, and screenings reveal troubling gaps in access for children in both insured groups, sometimes but not always worse for children with public coverage. Other research shows that children with Medicaid and CHIP are on par with privately insured children in terms of access to dental care. Importantly, working-age adults with Medicaid have greater difficulty obtaining needed medical care than similar adults with private insurance.[34]

Medicaid restricts cost-sharing, lowering financial barriers to access. Compared to low-income privately insured people, Medicaid enrollees are substantially less likely to face high financial burdens for health care.[35] A large body of research shows that cost-sharing impedes access to services, particularly for individuals with low income and significant health care needs. Such individuals often end up either delaying or not seeking needed care.[36]

For Medicaid patients as well as privately insured patients, the majority of emergency department (ED) visits are for urgent or serious symptoms. Medicaid patients do use EDs at significantly higher rates than people with private insurance. However, a recent study found that, in both groups, about three-quarters of all ED visits are for symptoms triaged as emergent, urgent, or semi-urgent by ED staff. About 10% of ED visits by Medicaid patients are for non-urgent symptoms, compared to 7% for privately insured patients. Adults with Medicaid have higher ED use than privately insured adults across all medical conditions, which is consistent with their higher burden of illness and disability. Also, adult Medicaid patients more often have a secondary diagnoises of a mental disorder, and a larger share of their visits involve more than one major diagnosis.[37] Findings from other research indicate that barriers to timely primary care, including wait times for an appointment, no after-hours care at the doctor's office or clinic, and lack of transportation, are associated with increased ED use.[38]

Evidence on access in MCOs relative to fee-for-service is limited and mixed. Federal law and regulations contain extensive state and MCO requirements to ensure access to care in Medicaid managed care, but the evidence on how access in Medicaid managed care and fee-for-service compares is mixed and suggests that the details of states' managed care programs matter.[39] Managed care has the potential to structure a provider network and coordinated delivery system for Medicaid beneficiaries who may face difficulty in the fee-for-service environment locating providers willing to serve them. But access can be jeopardized in managed care if provider networks are inadequate, beneficiary outreach, assistance, and appeals processes are lacking, or plans do not effectively connect enrollees with care. These issues are becoming more

important as states expand mandatory managed care to populations with complex health care needs, for whom disruptions in existing patient-provider relationships are also a major concern.

How do provider shortages and participation affect access?

A large majority of physicians serving children participate in Medicaid and CHIP, but only about half accept all new Medicaid and CHIP patients. A recent report of the General Accountability Office shows that 83% of primary care physicians (PCP) and 71% of specialists serving children participate in Medicaid and CHIP. However, among PCPs who participate, only 45% accept all new Medicaid and CHIP patients (children), compared to 77% who accept all new privately insured children. Among participating specialty care physicians, about half accept all new children covered by Medicaid and CHIP, while almost 85% accept all new privately insured children.[40]

Shortages and geographic inequalities in the distribution of health care providers and low Medicaid participation by some provider types result in gaps in access. Although access to primary care in Medicaid is quite robust, many states report challenges to ensuring enough providers, including dental and specialty providers, to serve Medicaid beneficiaries.[41] General shortages of physicians and other providers are worse in underserved areas, creating time, distance, and cost barriers to access for residents of these communities, and shortages are amplified in Medicaid by low provider participation. In provider surveys, low payment rates and administrative hassles consistently emerge as the leading barriers to provider acceptance of Medicaid.[42] Transportation has also emerged as a key barrier to access.[43] The expansion of Medicaid and private coverage under the ACA will likely increase current pressures on access.

Actions to address workforce challenges and low provider participation in Medicaid will be important to improve access. Increased state outreach to providers, higher and quicker payment, and streamlined enrollment and billing processes for providers may help foster increased participation. States could also seek to increase the supply of providers willing to serve Medicaid patients by liberalizing scope-of-practice laws related to nurse practitioners and dental therapists.[44] But closing access gaps is also a matter of workforce planning and investment (e.g., training more primary care physicians, and developing a more diverse workforce) that states may have limited levers to influence.[45]

A special commission known as MACPAC monitors access and payment in Medicaid and CHIP. The Medicaid and CHIP Payment and Access Commission (MACPAC), established by CHIPRA, is charged with monitoring access in both Medicaid and CHIP, identifying gaps, and making recommendations to Congress concerning payment and access issues. MACPAC reports to Congress every March and June on issues of key interest in Medicaid and CHIP and also maintains important statistics on many aspects of the program that are fundamental to understanding the program and guiding policy.

How is quality monitored and promoted in Medicaid?

States use an array of data and payment strategies to improve quality in Medicaid. Increasingly, states are using standardized data to measure and improve the quality of care provided by managed care plans and other providers in Medicaid. Most states require Medicaid MCOs to provide utilization and performance data using the Healthcare Effectiveness Data and

Information Set (HEDIS), and most MCOs also use a patient satisfaction survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS) as a quality gauge. In recent years, more states have begun to publicly report the quality data they collect to help beneficiaries choose plans and to drive performance improvements. A growing number of states require MCO accreditation by a recognized accreditation organization, or reward it through preferential contracting and other approaches.[46] Also, pay-for-performance (P4P) systems now in place in most states financially reward high performance by MCOs and/or physicians, hospitals, nursing homes, and other providers.[47] [48]

MCO quality is subject to external reviews of quality. Federal law requires all states with MCOs to contract with an External Quality Review Organization (EQRO) to provide an independent assessment of the quality performance of Medicaid plans. EQRO reviews assess access to, timeliness of, and outcomes of the care that each MCO is responsible for providing. EQROs also validate "performance improvement projects" that states require plans to conduct in a wide range of priority areas, such as improving birth outcomes, access to pediatric specialists, and improving outcomes for chronic conditions.[49]

States are using health information technology (HIT) to improve quality and safety in Medicaid, and substantial federal investments are likely to foster greater HIT activity. Medicaid programs in most states have initiatives for electronic prescribing and electronic health records (EHR) or electronic medical records (EMR) to promote better coordination of care. Some states are using Medicaid claims data to design evidence-based recommendations for care; some are facilitating data-sharing among agencies and providers that care for children.[50] The American Recovery and Reinvestment Act of 2009 (ARRA) provided more than $20 billion in Medicaid funding for incentive payments to physicians, hospitals, and other providers as they adopt, implement, upgrade, or demonstrate "meaningful use" of EHR technology, such as electronic prescribing and exchange of health information to improve quality. ARRA also provided 90% federal matching funds for states to administer the EHR incentives.[51]

Numerous HHS efforts are focused on measuring, reporting on, and improving the quality of care received by children in Medicaid and CHIP. In December 2012, the HHS Secretary released state-specific information from the second year of reporting on the initial core set of health quality measures for children in Medicaid and CHIP.[52] The pediatric quality measures will be updated annually to ensure that the measures are relevant to current care delivery approaches, reflect new clinical guidelines, and respond to other developments. HHS also has national efforts underway to improve the quality of perinatal care and oral health care provided to children in Medicaid and CHIP.

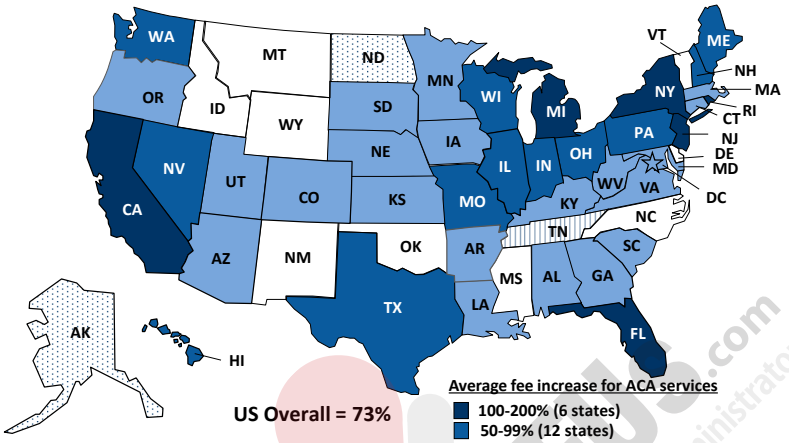
What does the ACA do to improve access to care in Medicaid?

The ACA temporarily boosts Medicaid payment rates to Medicare levels for primary care physicians. In 2012, Medicaid fees for primary care services averaged 59% of Medicare fees for the same services, and the Medicaid-to-Medicare fee ratio for services overall was 66%.[53] The ACA requires states to pay primary care physicians at least Medicare rates for many primary care services in 2013 and 2014, in both fee-for-service and managed care. The magnitude of the primary care fee increase for the affected services – 73% on average – is unprecedented in Medicaid (Figure 9). Full federal funding is available for the difference between the fees states

paid as of July 1, 2009 and Medicare rates in 2013 and 2014. The purpose of the fee increase is to improve support for physicians already serving Medicaid patients, and to promote wider Medicaid participation among primary care physicians in preparation for the Medicaid expansion. The fee increase also aligns Medicaid payment more closely with service delivery reforms that emphasize preventive and primary care.

Figure 9

Average Medicaid Fee Increases for ACA Primary Care Services in 2013, by State



NOTE: TN has no Medicaid FFS program.
SOURCE: 2012 KCMU/Urban Institute Medicaid Physician Fee Survey.

New models of patient-centered care are aimed at improving care, particularly for those with the most complex needs. The ACA contains a multitude of new Medicaid options, incentives, and initiatives designed to promote more patient-centered, coordinated, and integrated care that are expected to improve both access to care and the quality of care. Among these new Medicaid avenues are the new health home option for individuals with chronic illness and the demonstrations of integrated care and payment models for dual eligible beneficiaries.

The ACA establishes a program of voluntary reporting of adult quality measures in Medicaid. The Medicaid adult quality measures program required by the ACA is modeled closely on the program for children. In 2012, HHS published an initial core set of quality measures for Medicaid-eligible adults, covering areas such as prevention, care coordination, and chronic disease management. By September 30, 2014, HHS must collect, analyze, and make publicly available the information voluntarily reported by the states. Also on the quality front, CMS has issued guidance on a recommended core set of quality measures for assessing the Medicaid health home service delivery model introduced by the ACA.

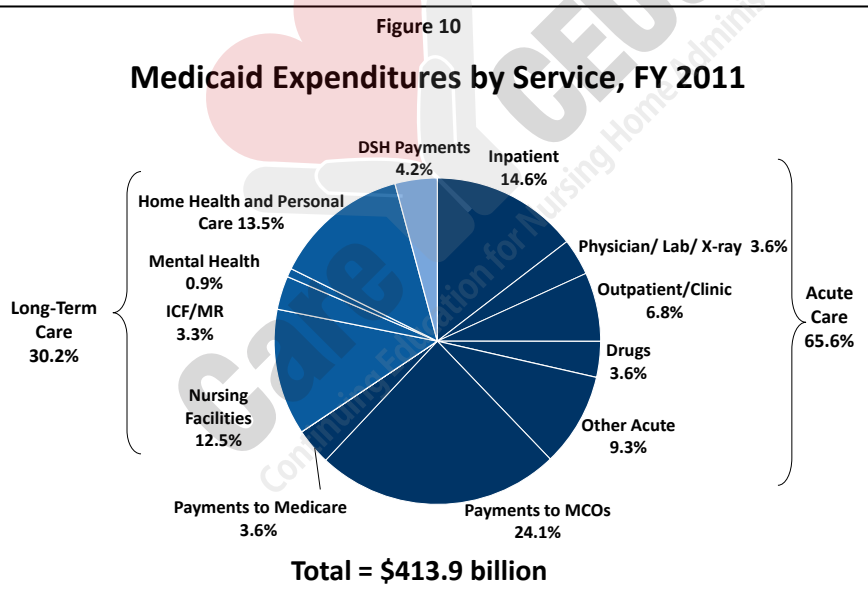
HOW MUCH DOES MEDICAID COST?

In FY 2011, Medicaid spending excluding administration totaled about $414 billion. Spending is distributed across a broad array of health and long-term care services. During the recent economic recession, the main driver of Medicaid spending was enrollment growth; as the economy has begun to recover, enrollment growth has slowed somewhat, and spending changes are instead driven by changes in service mix and utilization. Roughly two-thirds of Medicaid spending is attributable to seniors and people with disabilities, and a relatively small share of Medicaid beneficiaries with very high costs account for more than half of total spending. Dual eligible beneficiaries account for nearly 40% of all Medicaid spending. Medicaid spending per enrollee has been rising more slowly than medical care inflation, private insurance premiums, and national health spending per person. Medicaid spending will rise under the ACA as millions of additional people become eligible for the program and others who are already eligible enroll.

What does Medicaid cost?

In FY 2011, federal and state Medicaid spending excluding administration totaled about $414 billion, including payments for Medicare premiums and "DSH" payments (Figure 10). Two-thirds of Medicaid spending was attributable to acute care, including payments to managed care plans (24%). A little less than a third (30%) of spending went toward long-term care. Medicaid administrative costs accounted for an additional 5% of total Medicaid spending (data not shown).

Figure 10



NOTE: Includes DSH payments and payments to Medicare. Excludes administrative spending, adjustments and payments to the Territories.
SOURCE: Urban Institute estimates based on FY 2011 data from CMS-64, prepared for KCMU.

Medicaid makes special payments to hospitals that serve a disproportionate share of low-income and uninsured patients. In FY 2011, 4% of Medicaid spending was attributable to supplemental payments to hospitals that serve a disproportionate share of low-income and uninsured patients, known as "DSH" payments.[54] These payments help to support safety-net hospitals, including children's hospitals, that provide substantial uncompensated care in

addition to essential community services such as trauma and burn care and neonatal intensive care.[55]

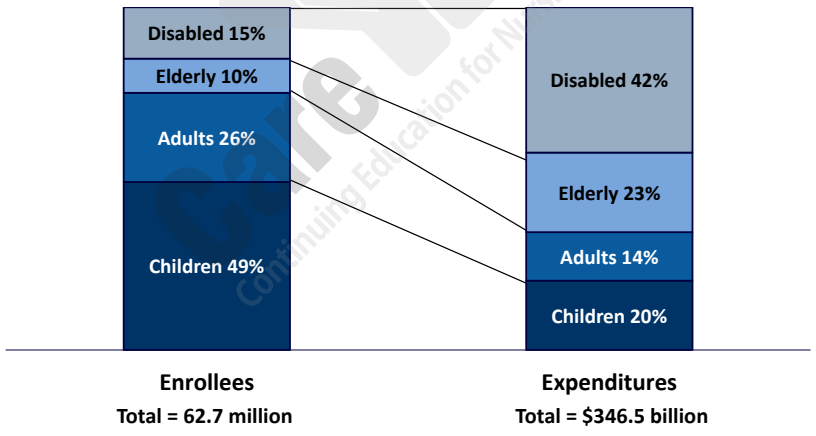
What drives Medicaid costs?

During the recent economic downturn, enrollment growth was the dominant driver of Medicaid costs. Several factors contribute to Medicaid costs and spending, including enrollment, health care cost inflation, demographic trends, and the use of services by Medicaid enrollees. During the Great Recession, enrollment growth was the chief driver of Medicaid spending, as more people became eligible for program due to rising unemployment and declining income. In state fiscal year 2012, Medicaid spending increased at one of the lowest annual rates on record – 2% on average across the states – as the economy started to improve and enrollment growth slowed.[56]

Although children and their parents make up the majority of Medicaid enrollees, most Medicaid spending is attributable to the elderly and people with disabilities (Figure 11)**.** Children and non-elderly adults, including pregnant women, make up three-quarters of the Medicaid population but account for only about a third (34%) of Medicaid spending. The elderly and disabled make up one-quarter of the Medicaid population, but account for about two-thirds of spending (65%). Notably, growth in per-enrollee spending for the elderly and disabled has been slow in recent years.

Figure 11

Medicaid Enrollees and Expenditures, FY 2009

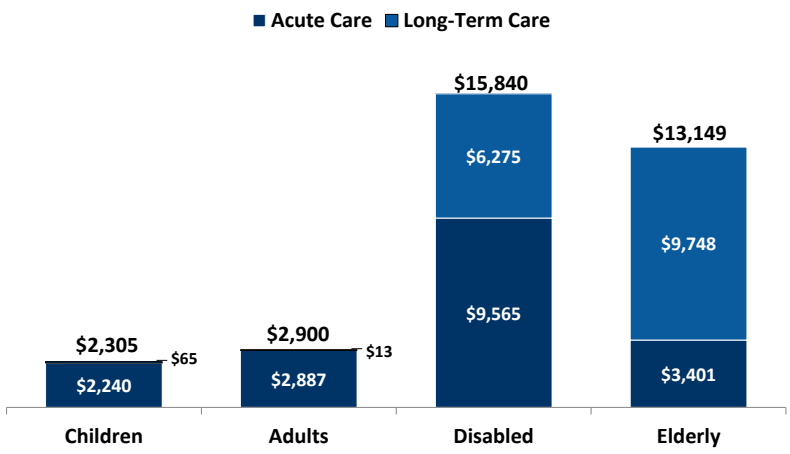


NOTE: Percentages may not add to 100 due to rounding.
SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012.
MSIS FY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.

Medicaid spending per enrollee varies sharply by eligibility group. In 2009, per enrollee payments for children covered by Medicaid were about $2,300, compared to $2,900 per non-elderly adult, $15,840 per disabled enrollee, and $13,150 per elderly enrollee (Figure 12). Higher per enrollee expenditures for disabled and elderly beneficiaries reflect their more intensive use of both acute and long-term care services.

Figure 12

Medicaid Payments Per Enrollee by Acute and Long-Term Care, FY 2009

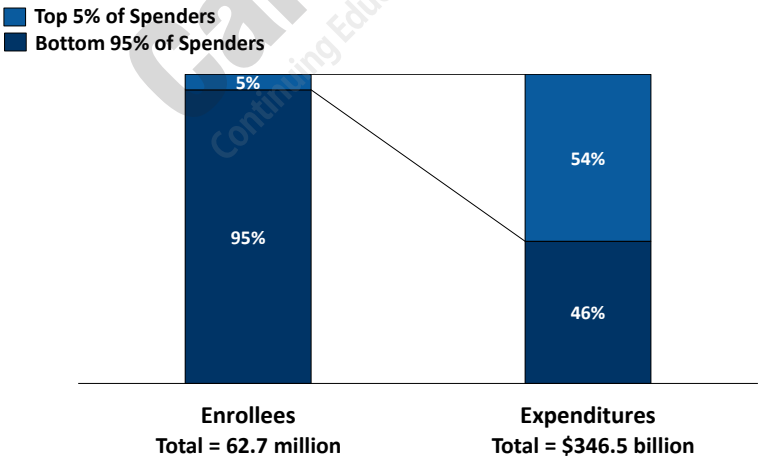


SOURCE: KCMU and Urban Institute estimates based on FY 2009 MSIS and CMS-64 data.
MSIS FY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.

The 5% of Medicaid beneficiaries with the highest costs account for over half of all Medicaid spending. As is true for all payers, spending in Medicaid is highly skewed. That is, a very small group of high-cost enrollees accounts for a large share of total spending. In FY 2009, the 5% of beneficiaries with the highest health and long-term care costs accounted for 54% of all Medicaid spending (Figure 13).The disabled individuals among these high-cost beneficiaries alone accounted for 30% of total Medicaid expenditures.

Figure 13

Highest-Cost 5% of Enrollees Account for Over Half of Medicaid Spending, FY 2009

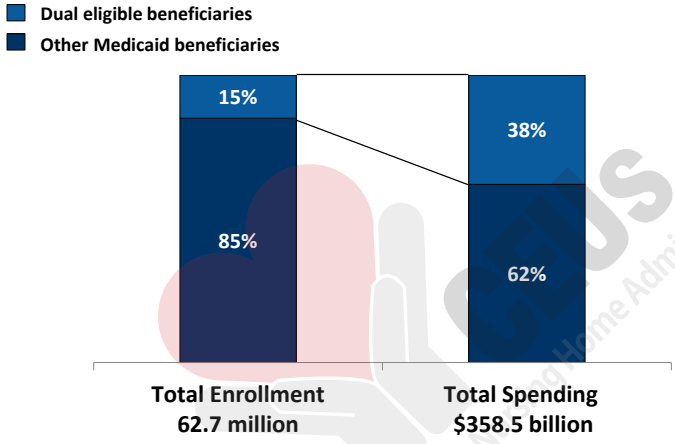


SOURCE: KCMU/Urban Institute estimates based on data from FY 2009 MSIS and CMS-64, 2012.
Spending does not include Medicaid payments to Medicare.
MSIS FFY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.

Almost 40% of all Medicaid spending for medical services is attributable to dual eligible beneficiaries. In 2009, dual eligible beneficiaries – low-income individuals who are enrolled in both Medicare and Medicaid – made up 15% of the Medicaid population, but accounted for 38% of Medicaid spending (Figure 14). Two-thirds of Medicaid spending for dual eligible beneficiaries was for long-term care services. Until 2006, Medicaid covered prescription drugs for dual eligible beneficiaries because Medicare did not include a drug benefit. A Medicare drug benefit was added in 2006, but states help finance it by making required monthly "clawback" payments to the federal government that roughly reflect what they would spend if they still paid for prescription drugs for dual eligible beneficiaries. In FY 2012, estimated state clawback payments totaled $8.1 billion.[57]

Figure 14

Dual Eligible Beneficiaries as a Share of Medicaid Enrollment and Spending, FY 2009



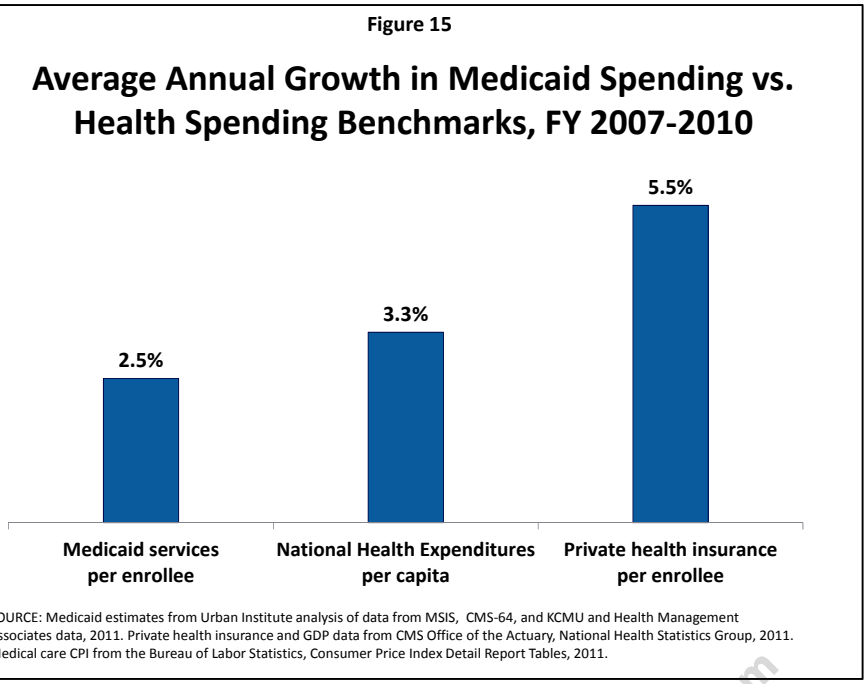
SOURCE: KCMU/ Urban Institute analysis of data from MSIS and CMS-64, 2010.

How effectively is Medicaid spending managed?

When the health status and needs of its beneficiaries are taken into account, Medicaid is a low-cost program. Medicaid enrollees are in significantly worse health than the low-income, privately insured population. When health status differences are controlled, per capita spending for both adults and children is lower in Medicaid than under private insurance. Medicaid's lower spending levels are due mostly to lower provider payment rates; differences in access to specialists and expensive technology for those in fair or poor health may also be a factor.[58]

On a per enrollee basis, Medicaid spending has been growing more slowly than growth in underlying medical care inflation and private health insurance premiums. Over the period 2007-2010, Medicaid spending per enrollee grew an average of 2.5% percent per year. The comparable rate of growth in national health expenditures per capita was 3.3% and the rate for per enrollee private health insurance costs (i.e., premiums) was 5.5% (Figure 15).[59]

Figure 15



SOURCE: Medicaid estimates from Urban Institute analysis of data from MSIS, CMS-64, and KCMU and Health Management Associates data, 2011. Private health insurance and GDP data from CMS Office of the Actuary, National Health Statistics Group, 2011. Medical care CPI from the Bureau of Labor Statistics, Consumer Price Index Detail Report Tables, 2011.

Cost-containment is a major focus in state administration of the Medicaid program. States have implemented a range of strategies to control costs in Medicaid, such as provider rate restrictions, benefit restrictions, and utilization controls. For example, nearly all states use sophisticated pharmacy management tools, including preferred drug lists and prior authorization, to manage drug spending. States have also implemented delivery system reforms to improve care and reduce spending growth, including managed care, patient-centered medical homes, and health homes, and they have made important strides in shifting the delivery of LTSS from institutions into the community.[60]

Program integrity measures at both the federal and state level help to ensure proper payment and improve Medicaid's efficiency. Ensuring program integrity in Medicaid is the responsibility of both the federal government and the states. States are responsible for the daily management of Medicaid, including verifying eligibility, licensing and enrolling providers, paying providers and detecting and addressing improper payment, conducting audits, monitoring quality, and investigating and prosecuting provider fraud and abuse. The federal government monitors and enforces state compliance with federal rules, reviews state agency performance, audits and investigates suspected fraud, imposes sanctions, and provides guidance and training to the states.[61]

What impact will the ACA have on Medicaid costs?

If all states expand Medicaid, total national Medicaid spending during the 2013-2022 period will increase by 16% (relative to what would have happened without the ACA). If all states implemented the Medicaid expansion, total national Medicaid spending during the ten-year period 2013-2022 would increase by an estimated $1 trillion, or 16%, relative to projected Medicaid spending over that period without the ACA.[62] The federal government would pay 93% of the increase in Medicaid costs if all states adopted the expansion; specifically, the federal government would pay $952 billion over 2013-2022 and states would pay $76 billion. While

total Medicaid spending would increase by 16%, federal spending would increase by 26% and state spending would increase by 3%, though the results would vary by state.

The federal government will bear the lion's share of the new costs. The very large federal share of the increased ten-year Medicaid spending if all states expanded Medicaid is explained by the fact that most additional spending would be attributable to the adults in the Medicaid expansion group, for whom the federal match is between 90% and 100% (depending on the year). States may also have some new costs over the decade because of the small required state share (up to 10%) for the expansion population and due to slightly higher participation among people who are eligible for Medicaid under pre-ACA eligibility rules.

Increased state costs associated with expanding Medicaid may be offset, in part, by reduced state spending for health under other programs. Expanded Medicaid coverage of the low-income population and the increased federal funds to states may lead to reductions in other state spending for health, such as spending for state coverage initiatives, indigent care, the mental health system, and other programs. These sources of savings are not reflected in estimates of the costs to states of implementing the Medicaid expansion.

HOW IS MEDICAID FINANCED?

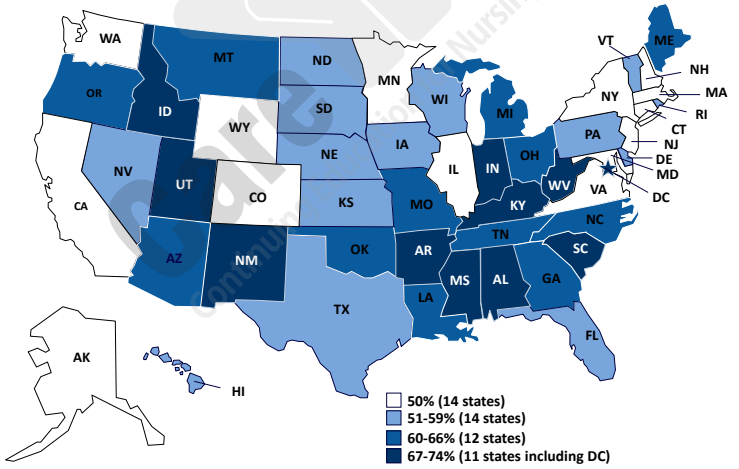
Medicaid is financed jointly by the federal government and the states. The federal government matches state Medicaid spending. The federal match rate varies across states based on a formula and ranges from a minimum of 50% to much higher levels in poorer states. Medicaid is a countercyclical program that expands during economic downturns, when states' fiscal capacity is also most strained. Under the ACA, the federal match rate for the adults who are newly eligible for Medicaid due to the expansion will be 100% in the first three years and at least 90% thereafter. If all states implemented the Medicaid expansion, the federal government would finance 93% of the total increase in Medicaid spending over the 2013-2022 decade. State Medicaid dollars and federal matching funds have a multiplier effect in state economies, supporting jobs and economic activity, and yielding increased state revenues from taxes.

Who pays for Medicaid?

Medicaid is financed through a partnership between the federal government and the states. The federal government matches state Medicaid spending according to a formula in the federal Medicaid law. The federal match rate, known as the Federal Medical Assistance Percentage, or FMAP, varies based on state per capita income – the lower a state's per capita income, the higher the state's FMAP. The FMAP for services ranges from a federal floor of 50% to 73.4%, currently, in the poorest state, Mississippi (Figure 16). The FMAP for most Medicaid administrative costs is 50%, but an enhanced federal match rate of 90% is available for certain services and state activities. The federal government funds about 57% of Medicaid spending overall.

Figure 16

Federal Medical Assistance Percentages (FMAP)
FY 2013



NOTE: Rates are rounded to nearest percent. These rates will be in effect October 1, 2012 through September 30, 2013.
SOURCE: Federal Register, Nov, 30, 2011 (Vol. 76, No. 230), pp. 74061-74063.
http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf

Medicaid is the largest source of federal revenue flowing to states. At the same time that Medicaid is a major spending program, it is also the largest source of federal revenue to the states. Federal Medicaid dollars accounted for estimated 44% of all federal grants to states in state fiscal year 2011.[63] In FY 2012, Medicaid accounted for 7.1% of federal budget outlays.[64]

States commit substantial funds to Medicaid. In FY 2011, states overall spent 16.7% of their general funds on Medicaid. It was the second-largest item in most states' general fund budgets, after elementary and secondary education, which accounted for 35.1% of state general fund spending that year.[65] Medicaid spending pressures are a perennial issue at the state level. This is because states have limited fiscal capacity to meet the many competing demands they face and must balance their budgets. State budget pressures intensify during economic downturns, when state revenues decline at the same time that Medicaid enrollment is growing.

Medicaid is a major engine in state economies. Economic research shows that state Medicaid spending has a "multiplier effect" as the money injected into the state economy through the program percolates through it, generating successive rounds of earning and purchasing by businesses and residents. This economic activity supports jobs and yields additional income and state tax revenues. Compared with other state spending, Medicaid spending is especially beneficial because it also triggers an infusion of new federal dollars into the state economy, intensifying the multiplier effect.[66]

How does Medicaid's financing structure support the program?

Medicaid's financing structure gives states flexibility to respond to changing needs and supports state efforts to cover the uninsured. When states spend their dollars on Medicaid, they draw down federal matching funds. Thus, the matching system at least doubles the impact of state investment in Medicaid and increases states' capacity to respond to changes in health care needs, demographics, health care prices, and the economy, and to disasters and epidemics. In contrast, federal block grant programs distribute a fixed sum of federal dollars to states based on projected need or a pre-set formula, with limited flexibility to respond to actual conditions. The guarantee of federal matching payments in Medicaid provides an incentive to states to invest in health care and discourages them from reducing coverage and benefits. At the same time, states have a stake in managing Medicaid costs to constrain their own spending.

The FMAP formula does not adequately address the countercyclical nature of the Medicaid program. Medicaid is a countercyclical program. That is, during economic downturns, when people lose their jobs and income declines, Medicaid enrollment expands, but state tax revenues also shrink, reducing state capacity to afford the increased enrollment. The FMAP formula, which uses lagged data and is based solely on per capita income, does not adequately increase federal assistance to states when economic conditions are weak. On two occasions, most recently in 2009 in ARRA, Congress has increased the FMAP temporarily to provide fiscal relief to state Medicaid programs during recessions. States used these federal funds to address shortfalls in Medicaid and across their budgets. The additional federal support under ARRA in the period of deepest recession proved a critical source of state revenue and resulted in the first decline in state Medicaid spending in the program's history.[67]

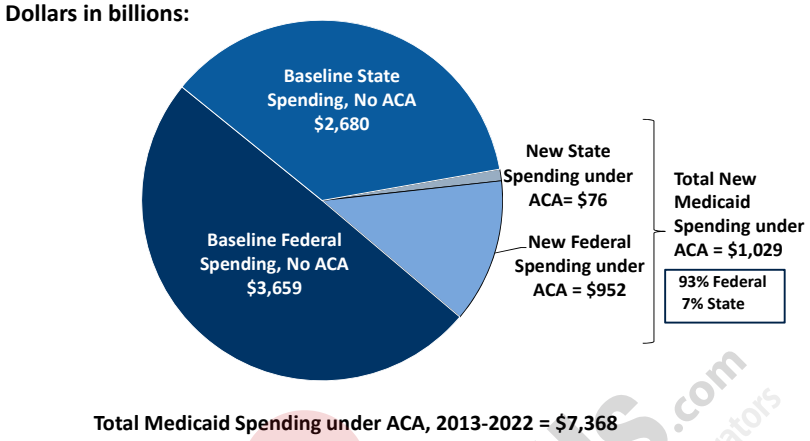
How does the ACA affect Medicaid financing?

The ACA provides almost full federal funding for the costs of adults newly eligible for Medicaid under the expansion. Under the ACA, the federal government will finance 100% of the costs states incur to cover the newly eligible adults in the first three years of reform (2014-2016) and at least 90% thereafter. If all states adopted the Medicaid expansion, the federal government

would finance 93% of the total increase in Medicaid spending attributable to the ACA over the ten-year period 2013-2022, and states would finance 7%, but this distribution would vary by state (Figure 17).

Figure 17

Medicaid Spending under the ACA, 2013-2022
State and Federal Share of Baseline and New Spending



NOTE: Individual components may not sum to totals due to rounding.
SOURCE: Urban Institute estimates prepared for KCMU, October 2012.

The ACA provides an enhanced federal match for selected services and purposes. The ACA provides for a temporary 90% federal match for specific services provided under the new health home option for beneficiaries with multiple chronic conditions. The law also provides a 100% federal match for the increase in Medicaid primary care fees to Medicare fee levels in 2013 and 2014. The ACA creates and extends several opportunities for enhanced federal matching funds to states to improve support for home and community-based LTSS. In addition, to help states prepare to implement the streamlined eligibility systems required by the ACA, HHS has made available a temporary 90% federal administrative matching rate for the costs of upgrading Medicaid eligibility and enrollment systems, and a 75% rate for maintenance and operations of systems built using these funds.

The ACA reduces federal DSH allotments. Corresponding to expansions in coverage under the ACA, the law also called for a reduction in federal Medicaid DSH allotments to states by $14.1 billion over the period 2014-2019; by 2019, the reductions will represent a 50% cut in DSH payments relative to the pre-ACA baseline. The amount by which any individual state's allotment is reduced will be determined by a methodology to be developed by the HHS Secretary. Under the methodology, the largest percentage reductions are to apply to states with the lowest percentages of uninsured individuals and states that do not target their DSH payments to hospitals with high volumes of Medicaid inpatients or high levels of uncompensated care. The ACA did not anticipate that states would be able to opt out of the Medicaid expansion, leaving larger numbers of uninsured. Thus, there is no provision in the law to adjust a state's DSH reduction if it does not expand Medicaid. As of this writing, the Secretary had not released plans regarding distribution of the DSH reductions.

LOOKING AHEAD

When the ACA is fully implemented in a few short months, important changes in Medicaid will occur across the states. The changes will be most far-reaching in the states that adopt the Medicaid expansion and coordinate it with the new exchanges and other insurance affordability programs, as envisioned by the ACA, to create a seamless system of coverage that will reach nearly all Americans. But regardless of what individual states decide about implementing the expansion, significant changes in Medicaid – from simplified eligibility and streamlined enrollment to payment increases for primary care physicians, and from changes in benefits and delivery systems to changes in financing – will take place in all states, enhancing the program's operations and increasing its potential impact.

Now and going forward, Medicaid will remain integral to our health care system, continuing to ensure coverage and care for millions of people in our nation. These people include many low-income children and working families with fairly typical health care needs, but also many children and adults with chronic illnesses and disabilities and elderly and disabled Medicare beneficiaries with complex and high-cost needs. Medicaid is vital to the health and well-being of its beneficiaries, connecting them with needed services and supports and protecting them against out-of-pocket burdens they cannot afford.

As Medicaid becomes an even larger source of coverage, financing, and innovation, understanding the program will be essential for policymakers, providers, educators and students, the media, and the general public, many of whom the Medicaid program touches. Further, how the changes in Medicaid play out in the coming years will influence how fully the ACA's goals for coverage, individual and community health, and cost control are realized. Going forward, the important tasks of analyzing, monitoring, and improving Medicaid as it evolves will remain key public policy and public health priorities.

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Table 1

Medicaid Enrollment by Group, FY 2009

	Enrollment (rounded to nearest 100)								
	Total	Aged		Disabled		Adult		Children	
State	Number	Number	%	Number	%	Number	%	Number	%
United States	62,692,700	6,124,700	10%	9,290,200	15%	16,490,700	26%	30,786,100	49%
Alabama	954,800	121,000	13%	206,500	22%	157,500	16%	469,800	49%
Alaska	121,300	8,500	7%	15,400	13%	25,600	21%	71,700	59%
Arizona	1,721,300	103,800	6%	150,100	9%	689,500	40%	777,900	45%
Arkansas	698,800	69,600	10%	138,500	20%	113,900	16%	376,800	54%
California	11,027,600	998,500	9%	1,015,400	9%	4,583,300	42%	4,429,500	40%
Colorado	618,300	49,800	8%	81,000	13%	112,800	18%	374,800	61%
Connecticut	586,700	69,000	12%	73,100	12%	141,400	24%	303,300	52%
Delaware	207,200	14,300	7%	24,200	12%	82,000	40%	86,700	42%
District of Columbia	170,200	15,700	9%	37,000	22%	40,100	24%	77,500	46%
Florida	3,420,900	445,500	13%	568,000	17%	671,600	20%	1,735,800	51%
Georgia	1,818,700	170,500	9%	290,100	16%	295,100	16%	1,063,000	58%
Hawaii	247,200	24,300	10%	26,400	11%	93,000	38%	103,500	42%
Idaho	227,800	17,000	7%	39,100	17%	30,000	13%	141,800	62%
Illinois	2,698,800	209,600	8%	318,900	12%	700,400	26%	1,470,000	54%
Indiana	1,145,600	85,200	7%	158,900	14%	248,500	22%	652,900	57%
Iowa	522,700	43,000	8%	77,500	15%	152,000	29%	250,300	48%
Kansas	372,500	36,400	10%	72,900	20%	52,400	14%	210,800	57%
Kentucky	885,000	95,700	11%	229,200	26%	138,800	16%	421,300	48%
Louisiana	1,148,900	112,400	10%	212,600	19%	209,300	18%	614,700	54%
Maine	358,000	60,800	17%	66,300	19%	100,100	28%	130,900	37%
Maryland	862,400	73,200	8%	133,400	15%	221,900	26%	433,900	50%
Massachusetts	1,619,500	170,000	10%	258,100	16%	685,600	42%	505,800	31%
Michigan	2,018,600	137,900	7%	332,900	16%	438,000	22%	1,109,700	55%
Minnesota	879,100	96,000	11%	126,800	14%	234,100	27%	422,200	48%
Mississippi	754,300	88,700	12%	161,100	21%	121,100	16%	383,400	51%
Missouri	1,065,300	94,300	9%	203,600	19%	184,900	17%	582,400	55%
Montana	115,000	10,600	9%	20,900	18%	19,900	17%	63,600	55%
Nebraska	253,500	23,900	9%	36,700	14%	39,700	16%	153,100	60%
Nevada	290,400	25,800	9%	40,900	14%	55,600	19%	168,100	58%
New Hampshire	159,300	15,500	10%	27,600	17%	21,400	13%	94,800	60%
New Jersey	1,010,100	148,500	15%	169,800	17%	140,500	14%	551,300	55%
New Mexico	546,500	36,100	7%	62,400	11%	112,600	21%	335,500	61%
New York	5,208,100	591,900	11%	669,900	13%	1,945,600	37%	2,000,700	38%
North Carolina	1,813,300	182,500	10%	309,100	17%	360,900	20%	960,800	53%
North Dakota	75,300	9,200	12%	11,100	15%	15,600	21%	39,500	52%
Ohio	2,180,600	176,500	8%	378,500	17%	519,100	24%	1,106,400	51%
Oklahoma	799,900	66,300	8%	115,800	14%	155,400	19%	462,400	58%
Oregon	564,500	55,700	10%	90,900	16%	129,900	23%	287,900	51%
Pennsylvania	2,199,400	235,700	11%	538,500	24%	427,600	19%	997,600	45%
Rhode Island	204,800	28,100	14%	40,900	20%	42,100	21%	93,700	46%
South Carolina	892,600	83,300	9%	150,800	17%	192,000	22%	466,500	52%
South Dakota	128,100	12,500	10%	17,800	14%	20,900	16%	76,800	60%
Tennessee	1,502,400	149,400	10%	307,900	20%	285,900	19%	759,100	51%
Texas	4,488,200	439,600	10%	599,800	13%	585,300	13%	2,863,400	64%
Utah	294,900	15,400	5%	37,300	13%	80,000	27%	162,100	55%
Vermont	182,000	20,200	11%	23,300	13%	70,800	39%	67,700	37%
Virginia	945,500	105,900	11%	167,000	18%	151,500	16%	521,200	55%
Washington	1,159,300	87,800	8%	182,100	16%	226,100	19%	663,300	57%
West Virginia	416,900	41,700	10%	115,500	28%	60,600	15%	199,000	48%
Wisconsin	1,028,300	146,300	14%	148,000	14%	296,700	29%	437,300	43%
Wyoming	82,400	5,700	7%	10,700	13%	12,100	15%	53,900	65%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS, 2012.
Because 2009 data were unavailable, 2008 MSIS data were used for PA, UT, WI.
Notes: Subtotals may not sum to totals due to rounding.
The pathway to eligibility of nearly 1,000 enrollees in CA was unknown. These enrollees are included in national totals.

Table 2

Medicaid Income Eligibility as a Percent of Federal Poverty Level (FPL), 2013

State	Infants	Children 1-5	Children 6-19	Pregnant Women	Working Parents	Other Working Adults
Alabama	133%	133%	100%	133%	23%	NA
Alaska	150%	150%	150%	175%	78%	NA
Arizona	140%	133%	100%	150%	106%	100% (closed)
Arkansas	133%	133%	100%	162%	16%	NA
California	200%	133%	100%	200%	106%	NA
Colorado	133%	133%	133%	185%	106%	20% (closed)
Connecticut	185%	185%	185%	250%	191%	70%
Delaware	185%	133%	100%	200%	120%	110%
District of Columbia	185%	133%	100%	185%	206%	211%
Florida	185%	133%	100%	185%	56%	NA
Georgia	185%	133%	100%	200%	48%	NA
Hawaii	185%	133%	100%	185%	133%	133%
Idaho	133%	133%	100%	133%	37%	NA
Illinois	133%	133%	100%	200%	139%	NA
Indiana	200%	133%	100%	200%	24%	NA
Iowa	133%	133%	100%	300%	80%	NA
Kansas	150%	133%	100%	150%	31%	NA
Kentucky	185%	133%	100%	185%	57%	NA
Louisiana	133%	133%	100%	200%	24%	NA
Maine	185%	133%	125%	200%	200%	NA
Maryland	185%	133%	100%	250%	122%	NA
Massachusetts	185%	133%	114%	200%	133%	NA
Michigan	185%	150%	150%	185%	64%	NA
Minnesota	275%	275%	275%	275%	215%	75%
Mississippi	185%	133%	100%	185%	29%	NA
Missouri	185%	133%	100%	185%	35%	NA
Montana	133%	133%	100%	150%	54%	NA
Nebraska	150%	133%	100%	185%	58%	NA
Nevada	133%	133%	100%	133%	84%	NA
New Hampshire	185%	185%	185%	185%	47%	NA
New Jersey	185%	133%	100%	185%	200% (closed > 133%)	NA
New Mexico	185%	185%	185%	235%	85%	NA
New York	200%	133%	100%	200%	150%	100%
North Carolina	185%	133%	100%	185%	47%	NA
North Dakota	133%	133%	100%	133%	57%	NA
Ohio	150%	150%	150%	200%	96%	NA
Oklahoma	133%	133%	100%	185%	51%	NA
Oregon	133%	133%	100%	185%	39%	NA
Pennsylvania	185%	133%	100%	185%	58%	NA
Rhode Island	185%	133%	100%	185%	181%	NA
South Carolina	150%	150%	150%	185%	89%	NA
South Dakota	133%	133%	100%	133%	50%	NA
Tennessee	185%	133%	100%	185%	122%	NA
Texas	185%	133%	100%	185%	25%	NA
Utah	133%	133%	100%	133%	42%	NA
Vermont	225%	225%	225%	200%	191%	160%
Virginia	133%	133%	100%	133%	30%	NA
Washington	200%	200%	200%	185%	71%	NA
West Virginia	150%	133%	100%	150%	31%	NA
Wisconsin	300%	185%	100%	300%	200%	NA
Wyoming	133%	133%	100%	133%	50%	NA

Source: *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in* Medicaid and CHIP, 2012-2013. Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013. Available at: http://www.kff.org/medicaid/8401.cfm.
Notes: Income eligibility levels for working adults are based on a family of three for parents and based on an individual for childless adults. The 2013 federal poverty levels are $19,530 for a family of three and $11,490 for an individual.

Table 3

Medicaid Payments by Group, FY 2009

	Payments (in millions)								
	Total	Aged		Disabled		Adult		Children	
State	$	$	%	$	%	$	%	$	%
United States	$346,490	$80,536	23%	$147,160	42%	$47,823	14%	$70,969	20%
Alabama	$3,897	$1,000	26%	$1,450	37%	$321	8%	$1,127	29%
Alaska	$1,065	$181	17%	$398	37%	$152	14%	$335	31%
Arizona	$8,341	$979	12%	$2,464	30%	$2,999	36%	$1,899	23%
Arkansas	$3,242	$875	27%	$1,459	45%	$141	4%	$767	24%
California	$38,892	$10,512	27%	$16,519	42%	$4,919	13%	$6,939	18%
Colorado	$3,375	$813	24%	$1,441	43%	$363	11%	$757	22%
Connecticut	$5,619	$1,708	30%	$2,408	43%	$545	10%	$958	17%
Delaware	$1,232	$205	17%	$422	34%	$375	30%	$229	19%
District of Columbia	$1,556	$346	22%	$856	55%	$158	10%	$196	13%
Florida	$14,258	$3,527	25%	$6,182	43%	$1,726	12%	$2,824	20%
Georgia	$7,237	$1,395	19%	$2,611	36%	$1,305	18%	$1,925	27%
Hawaii	$1,271	$315	25%	$428	34%	$326	26%	$202	16%
Idaho	$1,289	$217	17%	$663	51%	$134	10%	$275	21%
Illinois	$12,744	$2,118	17%	$5,077	40%	$2,211	17%	$3,338	26%
Indiana	$5,768	$1,240	21%	$2,494	43%	$797	14%	$1,238	21%
Iowa	$2,843	$611	21%	$1,413	50%	$321	11%	$499	18%
Kansas	$2,366	$537	23%	$1,166	49%	$195	8%	$468	20%
Kentucky	$5,213	$934	18%	$2,390	46%	$645	12%	$1,244	24%
Louisiana	$5,628	$960	17%	$2,756	49%	$653	12%	$1,258	22%
Maine	$2,468	$562	23%	$1,186	48%	$213	9%	$508	21%
Maryland	$6,340	$1,326	21%	$2,880	45%	$883	14%	$1,251	20%
Massachusetts	$12,275	$3,110	25%	$5,060	41%	$2,033	17%	$2,073	17%
Michigan	$10,022	$2,088	21%	$4,209	42%	$1,588	16%	$2,138	21%
Minnesota	$7,214	$1,644	23%	$3,348	46%	$848	12%	$1,374	19%
Mississippi	$3,689	$867	24%	$1,562	42%	$406	11%	$853	23%
Missouri	$6,928	$1,318	19%	$3,052	44%	$650	9%	$1,909	28%
Montana	$845	$242	29%	$331	39%	$87	10%	$185	22%
Nebraska	$1,538	$367	24%	$652	42%	$108	7%	$411	27%
Nevada	$1,245	$210	17%	$543	44%	$131	11%	$361	29%
New Hampshire	$1,111	$303	27%	$463	42%	$68	6%	$277	25%
New Jersey	$8,352	$2,628	31%	$3,724	45%	$677	8%	$1,322	16%
New Mexico	$3,204	$190	6%	$1,106	35%	$587	18%	$1,321	41%
New York	$46,665	$13,314	29%	$20,017	43%	$8,321	18%	$5,013	11%
North Carolina	$11,058	$1,946	18%	$4,961	45%	$1,465	13%	$2,686	24%
North Dakota	$573	$191	33%	$245	43%	$52	9%	$85	15%
Ohio	$13,335	$3,335	25%	$6,246	47%	$1,721	13%	$2,034	15%
Oklahoma	$3,878	$693	18%	$1,616	42%	$453	12%	$1,116	29%
Oregon	$3,540	$927	26%	$1,402	40%	$582	16%	$629	18%
Pennsylvania	$16,270	$5,012	31%	$6,937	43%	$1,579	10%	$2,742	17%
Rhode Island	$1,755	$427	24%	$799	46%	$192	11%	$336	19%
South Carolina	$4,625	$911	20%	$2,010	43%	$625	14%	$1,078	23%
South Dakota	$709	$149	21%	$285	40%	$84	12%	$192	27%
Tennessee	$7,124	$1,118	16%	$3,026	42%	$1,176	17%	$1,803	25%
Texas	$21,919	$3,872	18%	$8,369	38%	$1,793	8%	$7,884	36%
Utah	$1,615	$186	12%	$715	44%	$256	16%	$457	28%
Vermont	$971	$222	23%	$375	39%	$182	19%	$192	20%
Virginia	$5,550	$1,114	20%	$2,485	45%	$576	10%	$1,375	25%
Washington	$6,194	$1,275	21%	$2,684	43%	$869	14%	$1,366	22%
West Virginia	$2,441	$535	22%	$1,228	50%	$206	8%	$472	19%
Wisconsin	$6,675	$1,868	28%	$2,818	42%	$1,076	16%	$913	14%
Wyoming	$528	$112	21%	$229	43%	$50	10%	$136	26%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data were unavailable, 2008 MSIS data were used for PA, UT, and WI. Spending for these states was then adjusted to 2009 CMS-64 spending levels

Notes: Subtotals may not sum to totals due to rounding.

The pathway to eligibility of nearly 1,000 enrollees in California was unknown. Their spending is included in state and national totals

Table 4

Medicaid Payments Per Enrollee by Group, FY 2009

	Payments per Enrollee				
State	Total	Aged	Disabled	Adult	Children
United States	$5,527	$13,149	$15,840	$2,900	$2,305
Alabama	$4,081	$8,265	$7,020	$2,035	$2,398
Alaska	$8,782	$21,286	$25,793	$5,916	$4,666
Arizona	$4,846	$9,438	$16,415	$4,350	$2,441
Arkansas	$4,639	$12,564	$10,534	$1,237	$2,036
California	$3,527	$10,528	$16,269	$1,073	$1,567
Colorado	$5,458	$16,332	$17,803	$3,215	$2,021
Connecticut	$9,577	$24,761	$32,954	$3,854	$3,158
Delaware	$5,944	$14,330	$17,412	$4,578	$2,645
District of Columbia	$9,143	$22,094	$23,140	$3,946	$2,531
Florida	$4,168	$7,917	$10,883	$2,569	$1,627
Georgia	$3,979	$8,183	$8,999	$4,424	$1,811
Hawaii	$5,140	$12,961	$16,180	$3,508	$1,953
Idaho	$5,658	$12,802	$16,942	$4,486	$1,938
Illinois	$4,722	$10,105	$15,921	$3,157	$2,271
Indiana	$5,035	$14,552	$15,689	$3,206	$1,896
Iowa	$5,438	$14,207	$18,236	$2,109	$1,993
Kansas	$6,352	$14,761	$15,999	$3,724	$2,218
Kentucky	$5,890	$9,759	$10,430	$4,649	$2,952
Louisiana	$4,899	$8,548	$12,963	$3,122	$2,047
Maine	$6,895	$9,242	$17,899	$2,126	$3,879
Maryland	$7,352	$18,106	$21,590	$3,981	$2,883
Massachusetts	$7,579	$18,288	$19,602	$2,965	$4,098
Michigan	$4,965	$15,139	$12,642	$3,625	$1,926
Minnesota	$8,206	$17,119	$26,402	$3,624	$3,254
Mississippi	$4,890	$9,775	$9,697	$3,352	$2,225
Missouri	$6,504	$13,971	$14,986	$3,513	$3,278
Montana	$7,348	$22,824	$15,846	$4,382	$2,910
Nebraska	$6,069	$15,344	$17,745	$2,728	$2,687
Nevada	$4,286	$8,117	$13,265	$2,359	$2,149
New Hampshire	$6,978	$19,616	$16,793	$3,185	$2,918
New Jersey	$8,268	$17,705	$21,936	$4,817	$2,399
New Mexico	$5,862	$5,247	$17,744	$5,215	$3,936
New York	$8,960	$22,494	$29,881	$4,277	$2,505
North Carolina	$6,098	$10,664	$16,050	$4,059	$2,796
North Dakota	$7,608	$20,763	$22,135	$3,351	$2,153
Ohio	$6,116	$18,900	$16,501	$3,315	$1,838
Oklahoma	$4,848	$10,464	$13,952	$2,913	$2,414
Oregon	$6,272	$16,646	$15,415	$4,482	$2,185
Pennsylvania	$7,397	$21,268	$12,883	$3,692	$2,748
Rhode Island	$8,566	$15,211	$19,525	$4,569	$3,584
South Carolina	$5,181	$10,936	$13,331	$3,254	$2,312
South Dakota	$5,536	$11,874	$16,001	$4,011	$2,492
Tennessee	$4,742	$7,484	$9,826	$4,115	$2,376
Texas	$4,884	$8,808	$13,953	$3,063	$2,753
Utah	$5,475	$12,088	$19,154	$3,199	$2,821
Vermont	$5,331	$11,018	$16,079	$2,564	$2,835
Virginia	$5,870	$10,522	$14,879	$3,801	$2,639
Washington	$5,343	$14,519	$14,738	$3,846	$2,059
West Virginia	$5,855	$12,820	$10,635	$3,397	$2,371
Wisconsin	$6,491	$12,766	$19,050	$3,625	$2,089
Wyoming	$6,405	$19,518	$21,496	$4,164	$2,527

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2009 MSIS and CMS-64 reports, 2012.
Because 2009 data were unavailable, 2008 MSIS data were used for PA, UT, and WI. Spending for these states was then adjusted to 2009 CMS-64 spending levels.

Table 5

Medicaid Expenditures by Type of Service, FY 2011

	Expenditures (in millions)						
	Total	Acute Care*		Long-Term Care**		DSH Payments	
State	$	$	%	$	%	$	%
United States	$413,856	$271,570	65.6%	$124,984	30.2%	$17,302	4.2%
Alabama	$4,755	$2,840	59.7%	$1,465	30.8%	$449	9.4%
Alaska	$1,305	$827	63.4%	$463	35.5%	$15	1.2%
Arizona	$8,990	$6,822	75.9%	$2,002	22.3%	$166	1.8%
Arkansas	$4,006	$2,568	64.1%	$1,376	34.4%	$62	1.5%
California	$54,907	$39,615	72.1%	$13,017	23.7%	$2,275	4.1%
Colorado	$4,381	$2,778	63.4%	$1,418	32.4%	$185	4.2%
Connecticut	$6,116	$3,055	50.0%	$2,859	46.7%	$201	3.3%
Delaware	$1,406	$1,068	76.0%	$332	23.6%	$6	0.4%
District of Columbia	$2,141	$1,358	63.4%	$710	33.1%	$73	3.4%
Florida	$18,286	$13,057	71.4%	$4,870	26.6%	$360	2.0%
Georgia	$8,111	$5,673	69.9%	$2,028	25.0%	$410	5.1%
Hawaii	$1,620	$1,488	91.9%	$112	6.9%	$20	1.2%
Idaho	$1,535	$1,042	67.9%	$468	30.5%	$25	1.6%
Illinois	$12,997	$8,759	67.4%	$3,828	29.5%	$410	3.2%
Indiana	$6,606	$3,942	59.7%	$2,337	35.4%	$327	4.9%
Iowa	$3,384	$1,852	54.7%	$1,450	42.9%	$82	2.4%
Kansas	$2,693	$1,463	54.3%	$1,160	43.1%	$70	2.6%
Kentucky	$5,720	$3,892	68.0%	$1,625	28.4%	$203	3.5%
Louisiana	$6,664	$3,980	59.7%	$2,083	31.3%	$600	9.0%
Maine	$2,377	$1,653	69.5%	$673	28.3%	$52	2.2%
Maryland	$7,468	$5,259	70.4%	$2,120	28.4%	$88	1.2%
Massachusetts	$13,233	$9,582	72.4%	$3,651	27.6%	$0	0.0%
Michigan	$12,146	$9,092	74.9%	$2,666	22.0%	$388	3.2%
Minnesota	$8,423	$5,220	62.0%	$3,114	37.0%	$89	1.1%
Mississippi	$4,457	$2,948	66.1%	$1,306	29.3%	$204	4.6%
Missouri	$8,091	$5,135	63.5%	$2,257	27.9%	$700	8.6%
Montana	$961	$572	59.6%	$372	38.7%	$17	1.8%
Nebraska	$1,680	$973	57.9%	$669	39.8%	$39	2.3%
Nevada	$1,575	$1,089	69.1%	$398	25.3%	$88	5.6%
New Hampshire	$1,365	$620	45.4%	$596	43.7%	$149	10.9%
New Jersey	$10,579	$5,382	50.9%	$3,928	37.1%	$1,270	12.0%
New Mexico	$3,395	$3,017	88.9%	$349	10.3%	$29	0.9%
New York	$53,882	$28,201	52.3%	$22,523	41.8%	$3,158	5.9%
North Carolina	$10,547	$7,104	67.4%	$3,035	28.8%	$409	3.9%
North Dakota	$708	$267	37.6%	$440	62.1%	$2	0.3%
Ohio	$15,709	$8,968	57.1%	$6,079	38.7%	$663	4.2%
Oklahoma	$4,269	$3,034	71.1%	$1,192	27.9%	$44	1.0%
Oregon	$4,433	$3,003	67.7%	$1,377	31.1%	$53	1.2%
Pennsylvania	$20,533	$12,376	60.3%	$7,288	35.5%	$869	4.2%
Rhode Island	$2,112	$1,662	78.7%	$327	15.5%	$123	5.8%
South Carolina	$5,128	$3,404	66.4%	$1,194	23.3%	$531	10.3%
South Dakota	$759	$491	64.7%	$267	35.2%	$1	0.1%
Tennessee	$8,026	$6,918	86.2%	$969	12.1%	$139	1.7%
Texas	$28,565	$20,605	72.1%	$6,381	22.3%	$1,579	5.5%
Utah	$1,766	$1,314	74.4%	$428	24.2%	$24	1.4%
Vermont	$1,333	$1,178	88.3%	$118	8.9%	$37	2.8%
Virginia	$7,009	$4,478	63.9%	$2,336	33.3%	$195	2.8%
Washington	$7,447	$4,817	64.7%	$2,281	30.6%	$349	4.7%
West Virginia	$2,758	$1,574	57.1%	$1,110	40.3%	$73	2.7%
Wisconsin	$6,961	$5,272	75.7%	$1,689	24.3%	$0	0.0%
Wyoming	$534	$284	53.2%	$249	46.7%	$1	0.1%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64).
Notes: Does not include administrative costs, accounting adjustments, or the U.S. Territories.
Figures may not sum to totals due to rounding.
*Acute care services includes inpatient, physician, lab, X-ray, outpatient, clinic, prescripton drugs, family planning, dental, vision, other practitioners' care, payments to managed care organizations, and payments to Medicare.
**Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services.
"DSH Payments" refers to disproportionate share hospital payments.

Table 6

Federal Medical Assistance Percentages, FY 2009-2013

State	FY 2009	FY 2010	FY 2011*	FY 2012	FY 2013	Federal Funds Sent to State for Each Dollar of State Medicaid Spending, FY 2013
Alabama	77.5%	77.5%	68.5%	68.6%	68.5%	$2.18
Alaska	61.1%	62.5%	50.0%	50.0%	50.0%	$1.00
Arizona	75.9%	75.9%	65.9%	67.3%	65.7%	$1.91
Arkansas	80.5%	81.2%	71.4%	70.7%	70.2%	$2.35
California	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Colorado	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Connecticut	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Delaware	61.6%	61.8%	53.2%	54.2%	55.7%	$1.26
District of Columbia	79.3%	79.3%	70.0%	70.0%	70.0%	$2.33
Florida	67.6%	67.6%	55.5%	56.0%	58.1%	$1.39
Georgia	74.4%	75.0%	65.3%	66.2%	65.6%	$1.90
Hawaii	67.4%	67.4%	51.8%	50.5%	51.9%	$1.08
Idaho	79.2%	79.2%	68.9%	70.2%	71.0%	$2.45
Illinois	61.9%	61.9%	50.2%	50.0%	50.0%	$1.00
Indiana	74.2%	75.7%	66.5%	67.0%	67.2%	$2.05
Iowa	70.7%	72.6%	62.6%	60.7%	59.6%	$1.47
Kansas	69.4%	69.7%	59.1%	56.9%	56.5%	$1.30
Kentucky	79.4%	80.1%	71.5%	71.2%	70.6%	$2.40
Louisiana	80.8%	81.5%	63.6%	61.1%	61.2%	$1.58
Maine	74.4%	74.9%	63.8%	63.3%	62.6%	$1.67
Maryland	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Massachusetts	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Michigan	70.7%	73.3%	65.8%	66.1%	66.4%	$1.98
Minnesota	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Mississippi	84.2%	84.9%	74.7%	74.2%	73.4%	$2.76
Missouri	73.3%	74.4%	63.3%	63.5%	61.4%	$1.59
Montana	77.1%	78.0%	66.8%	66.1%	66.0%	$1.94
Nebraska	67.8%	68.8%	58.4%	56.6%	55.8%	$1.26
Nevada	63.9%	63.9%	51.6%	56.2%	59.7%	$1.48
New Hampshire	60.2%	61.6%	50.0%	50.0%	50.0%	$1.00
New Jersey	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
New Mexico	79.4%	80.5%	69.8%	69.4%	69.1%	$2.23
New York	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
North Carolina	74.5%	75.0%	64.7%	65.3%	65.5%	$1.90
North Dakota	70.0%	70.0%	60.4%	55.4%	52.3%	$1.10
Ohio	72.3%	73.5%	63.7%	64.2%	63.6%	$1.75
Oklahoma	75.8%	76.7%	64.9%	63.9%	64.0%	$1.78
Oregon	72.6%	72.9%	62.9%	62.9%	62.4%	$1.66
Pennsylvania	65.6%	65.9%	55.6%	55.1%	54.3%	$1.19
Rhode Island	63.9%	63.9%	53.0%	52.1%	51.3%	$1.05
South Carolina	79.4%	79.6%	70.0%	70.2%	70.4%	$2.38
South Dakota	70.6%	70.8%	61.3%	59.1%	56.2%	$1.28
Tennessee	74.2%	75.4%	65.9%	66.4%	66.1%	$1.95
Texas	69.9%	70.9%	60.6%	58.2%	59.3%	$1.46
Utah	80.0%	80.8%	71.1%	71.0%	69.6%	$2.29
Vermont	70.0%	70.0%	58.7%	57.6%	56.0%	$1.27
Virginia	61.6%	61.6%	50.0%	50.0%	50.0%	$1.00
Washington	62.9%	62.9%	50.0%	50.0%	50.0%	$1.00
West Virginia	83.1%	83.1%	73.2%	72.6%	72.0%	$2.58
Wisconsin	69.9%	70.6%	60.2%	60.5%	59.7%	$1.48
Wyoming	58.8%	61.6%	50.0%	50.0%	50.0%	$1.00

Source: Kaiser Commission on Medicaid and the Uninsured calculations based on FY 2009-2013 FMAPs published in the Federal Register as follows:
FY 2009 FMAP Vol. 74, No. 75, pp. 64697-64699; FY 2010 FMAP Vol. 75, No. 209, pp. 66763-66765; FY 2011 FMAP Vol. 76, No. 107, pp. 32204-32207;
FY 2012 FMAP Vol. 75, No. 217, pp. 69082-69084; FY 2013 FMAP Vol. 76, No. 230, pp. 74061-74063.
Note: FY 2009 and FY 2010 FMAPs reflect additional federal Medicaid funding available though the American Recovery and Reinvestment Act (ARRA) of 2009.
*FY 2011 FMAPs took effect on July 1, 2011, when enhanced funding under ARRA expired.

Table 7

Selected Measures of Health Needs Among Adults

State	Uninsured Adults <139% FPL[1] #	Uninsured Adults <139% FPL[1] %	% Adults with Disabilities[2]	% Adults with Diabetes[3]	% Adults with Poor Mental Health[4]	% of Population Living in Primary Care HPSAs[5]
United States	20,191,700	42%	10.4%	6.2%	35.8%	19.1%
Alabama	331,900	41%	15.5%	11.1%	37.6%	33.7%
Alaska	49,400	44%	12.0%	6.3%	34.0%	23.6%
Arizona	460,300	40%	10.3%	8.1%	37.6%	28.9%
Arkansas	232,900	47%	17.0%	9.2%	40.1%	18.9%
California	3,201,000	46%	8.4%	8.9%	39.1%	15.8%
Colorado	283,000	44%	8.2%	6.0%	36.2%	18.6%
Connecticut	117,100	30%	8.6%	6.4%	36.2%	12.2%
Delaware	35,900	29%	11.2%	7.7%	31.4%	21.4%
District of Columbia	28,500	25%	10.0%	8.0%	38.9%	43.0%
Florida	1,601,100	53%	9.9%	8.7%	37.0%	22.5%
Georgia	842,800	49%	10.5%	9.8%	34.4%	15.5%
Hawaii	50,400	23%	7.7%	7.8%	29.4%	3.7%
Idaho	116,100	50%	11.2%	7.7%	38.3%	27.2%
Illinois	845,600	44%	8.2%	8.2%	40.9%	28.5%
Indiana	330,800	35%	11.3%	9.1%	38.0%	15.2%
Iowa	131,700	36%	9.4%	6.9%	30.6%	18.6%
Kansas	148,900	41%	10.6%	8.0%	31.6%	20.5%
Kentucky	305,300	41%	16.4%	10.1%	36.8%	17.9%
Louisiana	419,700	50%	13.0%	10.3%	34.9%	57.8%
Maine	42,900	25%	14.4%	7.4%	38.0%	5.1%
Maryland	259,000	37%	8.4%	8.9%	32.7%	13.7%
Massachusetts	101,600	12%	9.2%	7.2%	35.2%	12.4%
Michigan	576,600	38%	11.9%	9.2%	37.3%	18.2%
Minnesota	166,500	31%	8.4%	6.2%	32.5%	7.7%
Mississippi	246,900	46%	15.1%	11.3%	33.7%	54.3%
Missouri	353,200	40%	12.6%	8.0%	33.8%	30.0%
Montana	72,500	50%	11.8%	6.2%	34.2%	28.8%
Nebraska	78,600	38%	9.2%	7.1%	33.0%	4.6%
Nevada	242,000	53%	9.0%	8.1%	35.0%	20.3%
New Hampshire	44,700	37%	9.2%	7.0%	37.1%	3.2%
New Jersey	500,000	44%	7.8%	8.3%	32.1%	0.7%
New Mexico	181,300	46%	12.3%	8.1%	34.1%	40.5%
New York	1,019,700	31%	9.1%	8.4%	37.7%	22.7%
North Carolina	671,000	47%	11.7%	9.3%	32.8%	10.1%
North Dakota	27,500	39%	9.2%	6.9%	32.9%	28.1%
Ohio	655,600	38%	12.0%	9.4%	35.2%	10.6%
Oklahoma	253,300	47%	15.2%	10.1%	36.4%	22.2%
Oregon	238,500	41%	11.2%	7.2%	36.2%	19.8%
Pennsylvania	547,700	32%	11.0%	8.7%	37.1%	6.7%
Rhode Island	54,600	36%	10.2%	6.8%	37.9%	14.7%
South Carolina	383,900	47%	12.2%	9.9%	33.8%	25.7%
South Dakota	44,700	42%	9.7%	6.4%	28.9%	25.9%
Tennessee	400,300	39%	13.9%	10.2%	30.1%	14.5%
Texas	2,531,600	58%	10.3%	9.8%	35.4%	22.2%
Utah	125,000	38%	8.3%	7.1%	38.1%	15.1%
Vermont	16,800	22%	11.4%	5.8%	37.7%	3.5%
Virginia	412,500	43%	9.3%	8.1%	31.4%	15.9%
Washington	386,000	41%	10.7%	7.4%	36.6%	18.2%
West Virginia	117,200	36%	18.4%	10.7%	34.0%	11.6%
Wisconsin	225,900	33%	8.9%	7.1%	33.6%	15.8%
Wyoming	30,700	47%	11.1%	6.6%	35.4%	34.5%

Sources: **1.** Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements). **2.** Erickson, W., Lee, C., von Schrader, S. (2010, March 17). Disability Statistics from the 2008 American Community Survey (ACS). Ithaca, NY: Cornell University Rehabilitation Research and Training Center on Disability Demographics and Statistics (StatsRRTC). Retrieved Jan 30, 2012 from www.disabilitystatistics.org.
3. Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: http://apps.nccd.cdc.gov/DDTSTRS/default.aspx. Retrieved 2/3/2012. U.S. totals available at http://www.cdc.gov/diabetes/statistics/prev/national/figbyage.htm. **4.** Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2011. Information about the BRFSS is available at http://www.cdc.gov/brfss/index.ht. **5.** Designated Health Professional Shortage Areas (HPSA) Statistics, Health Resources and Services Administration (HRSA), February 2012. Report available here. Percentages calculated using 2010 population data from U.S. Census Bureau; available at http://2010.census.gov/2010census/data/.