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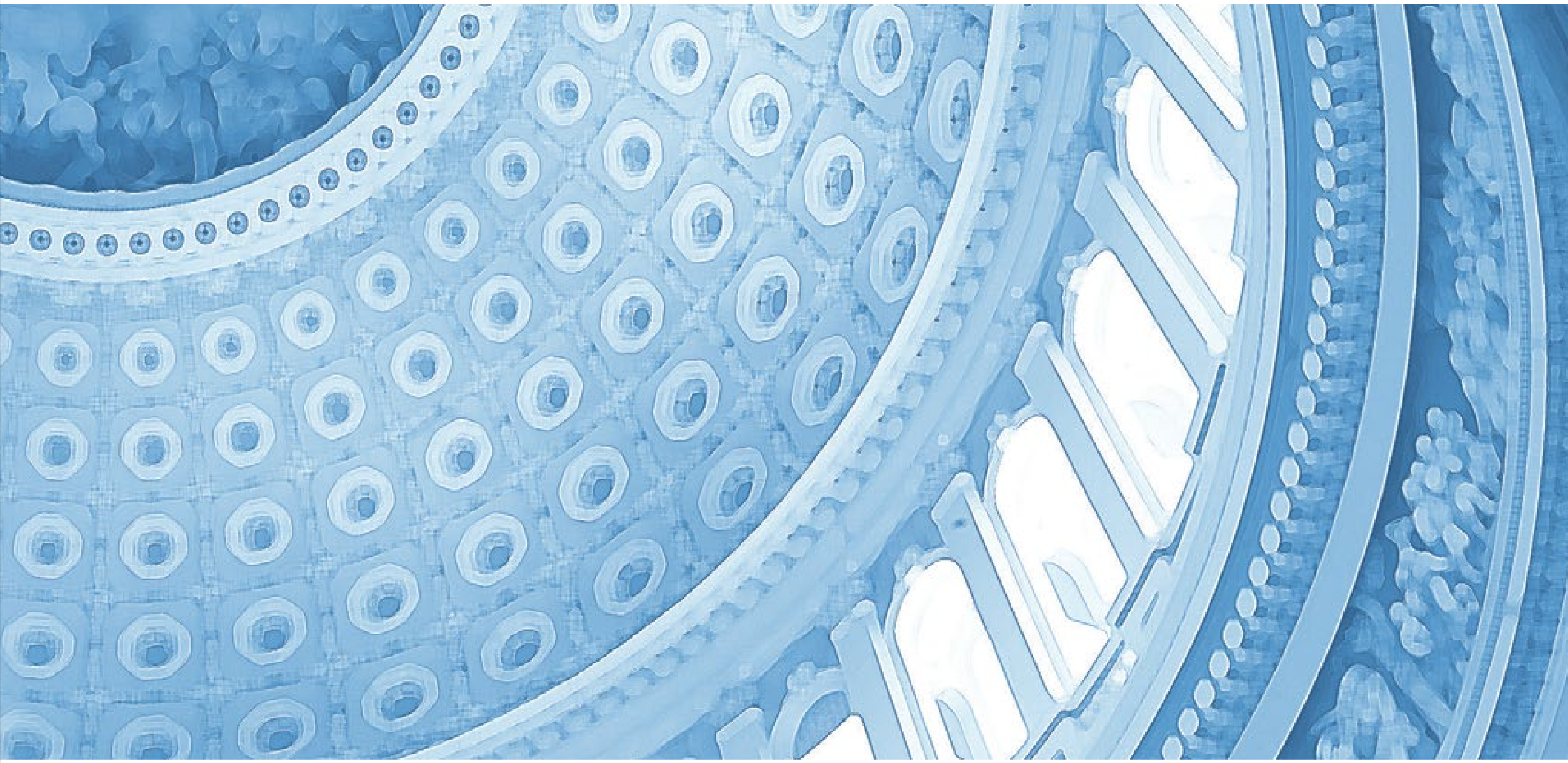

Report to the Congress on Medicaid and CHIP

June 2014

MACPAC

Medicaid and CHIP Payment and Access Commission

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a nonpartisan Congressional advisory commission that provides analytic support and makes policy recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of issues in Medicaid and the State Children's Health Insurance Program (CHIP). These include:

- eligibility and enrollment,
- access to care,
- payment policies,
- benefits and coverage policies,
- quality of care,
- the interaction of Medicaid and CHIP with Medicare and the health care system, and
- data to support policy analysis and program accountability.

MACPAC is statutorily required to submit two reports to the Congress by March 15 and June 15 of each year. The reports include MACPAC's policy recommendations and also provide the Congress and the public with a better understanding of the Medicaid and CHIP programs, their roles in U.S. health care, and the key policy and data issues outlined in the Commission's statutory charge.

Each of MACPAC's 17 Commissioners, appointed by the U.S. Government Accountability Office, votes on the recommendations contained in the reports. The Commissioners hail from different regions across the United States and the reports reflect the diverse perspectives they bring to policy deliberations from backgrounds in medicine, nursing, public health, and managed care, as parents and caregivers of Medicaid enrollees, and Medicaid and CHIP administration at the state and federal levels.

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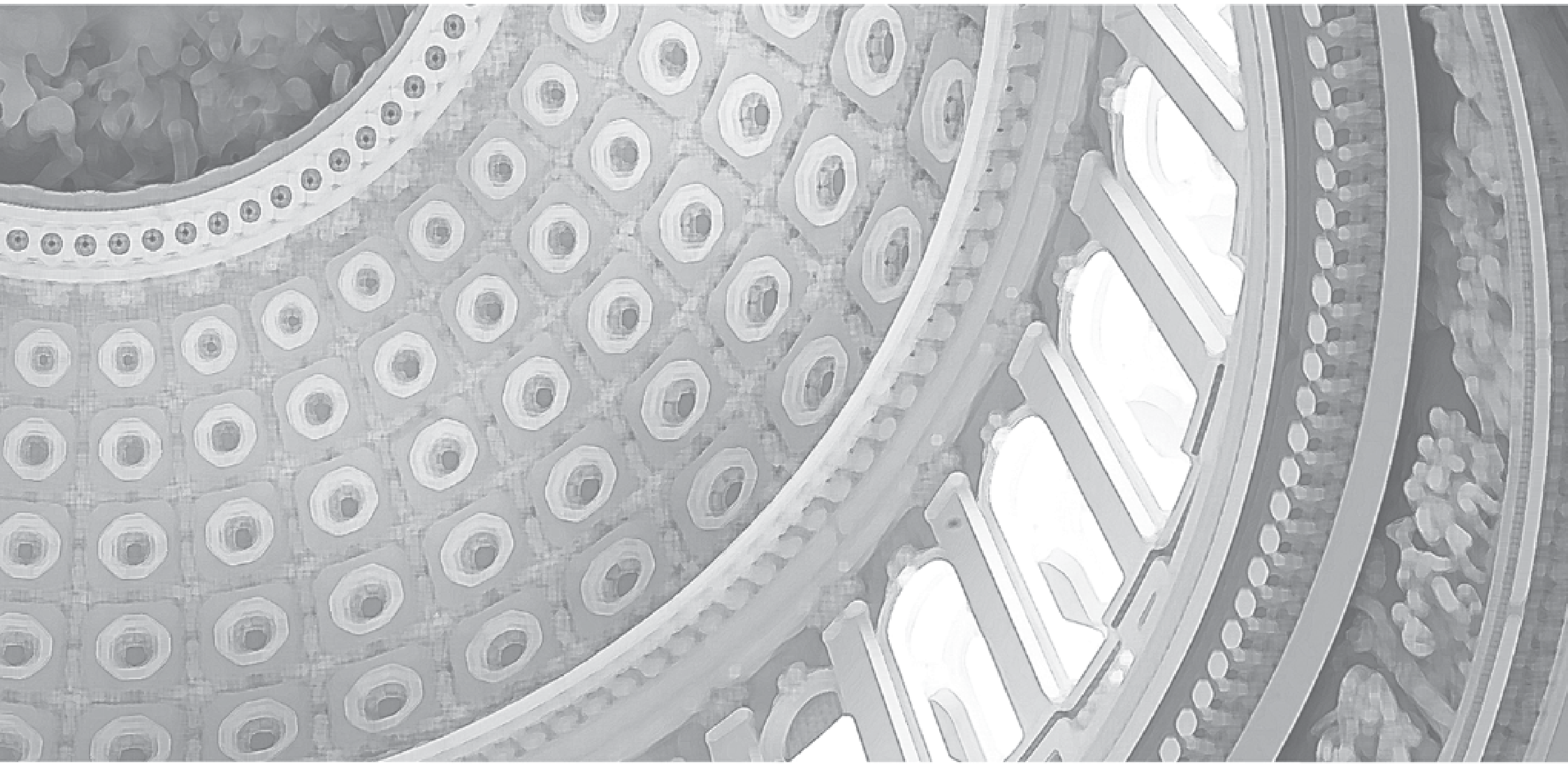
Medicaid and CHIP Payment and Access Commission



Report to the Congress on Medicaid and CHIP

June 2014

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Medicaid and CHIP Payment and Access Commission

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June 13, 2014

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The Honorable John A. Boehner
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U.S. House of Representatives
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Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit MACPAC's June 2014 *Report to the Congress on Medicaid and CHIP*. Established in 2010, MACPAC is a nonpartisan Congressional commission charged with providing policy and data analysis and recommendations on Medicaid and the State Children's Health Insurance Program (CHIP) to the Congress, the Secretary of the U.S. Department of Health and Human Services, and the states. This document fulfills our statutory mandate to report each year by June 15.

As part of the Commission's ongoing work to consider the interactions among Medicaid, CHIP, and the exchanges created under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the first chapter of this report focuses on the future of CHIP. CHIP is an important source of coverage for 8 million low- to moderate-income children. The enactment of the ACA brought new coverage options for these families, and the Commission is assessing the implications of these changes for the children now covered by CHIP.

With CHIP funding currently scheduled to run out shortly after fiscal year (FY) 2015, the question naturally arises as to how to address the program's future. One approach would be to allow funding to run out and encourage children now served by CHIP to seek coverage through Medicaid, the exchanges, or employers, if available. The Commission's analyses suggest, however, that such transitions would not be smooth or assure affordable, high-quality coverage for children, potentially leaving a significant number of children without adequate coverage or uninsured. An alternative approach would be to provide funding for CHIP indefinitely, maintaining a separate source of coverage not integrated with other coverage options.

The recommendation presented in this report looks for a middle ground. As described in Chapter 1, the Commission recommends extending federal funding for CHIP for a transition period of two additional years beyond 2015, during which time the key issues regarding the affordability and adequacy of children's coverage must be addressed, or additional transitional funding may be necessary.

The June report also focuses on the care of high-cost, high-need enrollees, exploring Medicaid's unique role in financing long-term services and supports (LTSS). Almost 70 million seniors and people with disabilities use LTSS, among them adults with significant physical disabilities, children who are medically fragile or have autism, seniors with advanced stages of dementia or multiple chronic conditions, people with intellectual disabilities, and people who are severely mentally ill. Medicaid's role in their support is significant, accounting, in 2012, for 61 percent of total national spending on LTSS.

The report takes a population-based approach by examining strategies to improve the overall health of Medicaid enrollees. Among the approaches highlighted are Medicaid programs' efforts to improve patient outcomes, including partnering with private sector companies and public agencies at all levels of government to improve enrollees' health.

Finally, we begin an examination of the role of state and federal administrative capacity—people, systems, and data—in managing Medicaid and CHIP most efficiently and effectively. This chapter describes the administrative requirements for state Medicaid programs, obstacles states and the federal government face in administering Medicaid, and models and strategies currently being used to strengthen administrative capacity. The need for effective program administration is essential as programs work to meet program requirements, promote value, and integrate Medicaid and CHIP into broader delivery system and financing reforms.

The report—like each of MACPAC's reports to the Congress—contains the standing MACStats section with comprehensive data and information on Medicaid and CHIP.

MACPAC is committed to providing in-depth, nonpartisan analyses of Medicaid and CHIP and these programs' impact on beneficiaries, states, providers, and other parts of our health care sector. We hope our analytic work, statistics, and recommendations will prove useful to the Congress as it considers legislative changes to Medicaid and CHIP.

Sincerely,

Diane Rowland

Diane Rowland, ScD
Chair

Enclosure

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Acknowledgements

The Commission would like to thank the following people who provided valuable guidance in the development of the June 2014 *Report to the Congress on Medicaid and CHIP*.

The Commission was fortunate to receive insight from staff of the Centers for Medicare & Medicaid Services as we were preparing this report. We would like to specifically thank Adam Goldstein, Stacey Green, Ralph Lollar, Amy Lutzky, Cindy Mann, Barbara Richards, and Jennifer Ryan. The Congressional Budget Office provided the Commission with budget estimates for the policy recommendation included in this report. We would like to thank Jean Hearne, Sarah Masi, and Robert Stewart for their assistance.

We also received indispensible feedback from several current and former state Medicaid and CHIP officials, including Andy Allison, Jerry Dubberly, Kay Ghahremani, Darin Gordon, Cindi Jones, Charles Milligan, and Colleen Sonosky.

Several research and policy experts provided the Commission with technical feedback and guidance, including John Agosta, Tricia Brooks, Alice Burton, Cheryl Austein Casnoff, Cheryl Camillo, James C. Capretta, Eileen Griffin, Elizabeth Hargrave, Joan Henneberry, Catherine Hess, Heather Howard, Carolyn Ingram, Genevieve Kenney, Aaron Larrimore, Kristina Lowell, Carisa Magee, Andrea Maresca, Colin Reusch, Sara Rudow, Matt Salo, Thomas Selden, Mary Selecky, Michelle Strollo, Laura Summer, Lilia Teninty, James Toews, Vikki Wachino, and Cynthia Woodcock.

The Commission received valuable programming and data support from Alina Bogdanov, Steven Merry, Ben Sheng, Nebyou Solomon, Nate Willard, and colleagues from Acumen, LLC, as well as Cynthia Saiontz-Martinez, Heather Seid, Lan Zhao, and colleagues from Social & Scientific Systems, Inc.

The Commission would like to thank Lynette Bertsche and the health care research staff at NORC at the University of Chicago for their assistance in editing this report. The Commission is also grateful for the work of Julia D'Esterre, Rachel Jochem, Kevin Kempske, Mary Knepper, and Danielle Koch at GKV Communications, who were instrumental in formatting and producing this report.

Finally, special thanks go to Molly McGinn-Shapiro, who recently left MACPAC's staff, for her contributions to the chapter on long-term services and supports.

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Executive Summary

Medicaid and the State Children's Health Insurance Program (CHIP) provided health coverage for about 80 million people for at least part of fiscal year (FY) 2013 and spent over $470 billion on their care. In addition to paying for medical care, Medicaid provides a safety net for long-term services and supports (LTSS) as well as a growing array of non-medical services that promote prevention and wellness. The agencies that administer Medicaid and CHIP also have duties that go beyond those of a typical health insurer, with additional responsibilities relating to public health and public financing.

In our June 2014 *Report to the Congress on Medicaid and CHIP,* the Medicaid and CHIP Payment and Access Commission (MACPAC) takes a close look at four policy issues now facing these programs: the future of CHIP, Medicaid's role in providing assistance with LTSS, efforts to promote population health, and administrative capacity to meet growing responsibilities. As with all of MACPAC's March and June reports, this report also includes the MACStats statistical supplement.

Chapter 1: CHIP and the New Coverage Landscape

CHIP is widely acknowledged to have played an important role in providing access to affordable and high-quality care for millions of children in low- to moderate-income families. Since its enactment in 1997, the share of children who are uninsured has fallen by half, reflecting in part CHIP's innovative strategies for outreach to children eligible for, but not previously enrolled in, either CHIP or Medicaid.

While lessons learned from CHIP should continue to inform public policy, with the implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the policy context has changed. Subsidized exchange plans potentially offer an alternative source of coverage to some of the children in the CHIP income range. The individual mandate to obtain coverage may also lead to additional enrollment in employer-sponsored coverage by some parents and children now enrolled in CHIP.

With CHIP funding currently scheduled to run out shortly after FY 2015, the question naturally arises as to how to address the program's future. One approach would be to allow funding to run out and leave the children now served by CHIP to find coverage elsewhere—through Medicaid, the exchanges, or employers, if available. MACPAC's analyses suggest, however, that such transitions would not be smooth and that many children could become uninsured. An alternative approach at the other end of the spectrum would be to provide funding for CHIP indefinitely, maintaining a separate source of coverage not integrated with other coverage options. MACPAC's recommendation takes a different approach, calling for additional funding through FY 2017, during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

Under current law, the children now covered under separate CHIP programs could face one of several scenarios if their CHIP coverage comes to an end. Some could enroll in a parent's employer-sponsored insurance. Those not eligible for employer-sponsored coverage may seek subsidized coverage through exchanges. Some affected families may not enroll their children in exchange or employer-sponsored coverage that is available to them—because the premiums are too high relative to their ability to pay, for example. Those shifting to exchange coverage may face higher cost sharing, different benefits, and different provider networks. Much remains to be learned about how well exchange plans meet the needs of lower-income children and whether they are a viable alternative to CHIP coverage.

Because so much is unknown about the post-CHIP landscape and the adequacy of new exchange coverage for children, the Commission recommends a two-year extension of CHIP financing. During this time, MACPAC will examine a range of issues about the design and adequacy of coverage for the population now covered by CHIP and will offer options to provide a more seamless continuum of children's coverage that better accommodates transitions in coverage among Medicaid, the exchanges, and employer-sponsored insurance. This timing should permit the Congress and the U.S. Department of Health and Human Services to consider the analyses and options, consult with states and stakeholders, and make any desired changes with sufficient lead time for states and the federal government to manage transitions effectively.

Chapter 2: Medicaid's Role in Providing Assistance with Long-Term Services and Supports

In Chapter 2, the Commission turns its attention to how Medicaid enrollees use LTSS and the variation in LTSS rules for eligibility, covered benefits, and access to services across states. Although LTSS users make up a small portion of total Medicaid enrollees—just over 6 percent in FY 2010—they account for almost half of total Medicaid benefit spending. These expenditures reflect the significant needs of vulnerable individuals for intensive, ongoing supportive services that are not usually covered by any other payer. Moreover, Medicaid's role in LTSS will likely increase as the population ages and more individuals with disabling conditions live longer.

Medicaid's coverage of LTSS was not a system that was built purposefully, but rather one that evolved from legacy programs that were designed to meet the needs of different populations, differing state approaches to policy, court decisions, client advocacy, and changing ideas about where and how LTSS should be provided. As a result, today, Medicaid LTSS is a patchwork of policies that determine how enrollees qualify for services and which services they ultimately receive, and policies vary from state to state.

When Medicaid was enacted, LTSS services were provided almost exclusively to public assistance recipients in institutions, and there are still only two mandatory LTSS benefits that must be provided under the Medicaid state plan: nursing facility and home health services. Over time, optional services, including services to enable independent living in the community, have been expanded through waivers, statutory changes, and litigation such as the landmark Supreme Court ruling in *Olmstead v. L.C.*

A more rational, equitable, and effective design is needed for the financing and delivery of services to a varied group of individuals with intensive support needs. MACPAC's future work on Medicaid LTSS will focus on examining issues associated with the movement to managed LTSS, the use of home and community-based services waivers, the merits of moving to standardized functional assessments for Medicaid LTSS, and improvements in available data on LTSS needed to support policy analysis, evaluation, and future program design.

Chapter 3: Medicaid and Population Health

As defined by the Institute of Medicine, population health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." Medicaid plays an important role in achieving healthy outcomes for the more than 70 million people it serves, but this requires allocating resources to more than acute-care medical services. Medical care has been estimated to account for only 10 to 25 percent of health outcomes.

Although Medicaid is primarily a source of health insurance coverage, it also covers many services that insurers do not typically cover. These include certain enabling services such as transportation and translation; the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program; and preventive benefits for adults.

The ACA added a number of provisions—such as requiring health plans, Medicare, and Medicaid coverage for the new adult group to cover specific preventive services without cost sharing—that aim to improve Medicaid enrollees' health along with that of the U.S. population in general. The ACA also authorizes funding for state-based demonstrations to improve vaccination rates and state-level grants to develop and evaluate Medicaid initiatives promoting behavior change.

In recent years, Medicaid programs have developed partnerships at the federal, state, and community levels, with both government and the private sector, to move efforts to improve health beyond the treatment of existing disease. Nevertheless, barriers to population health initiatives remain. These include separate funding streams, the belief that prevention may cost more than treatment in the long run, and the lengthy timeframes required for some population health interventions.

Initiatives to improve the health of the Medicaid—or any—population require the collection of measures to assess the baseline health of that population and changes to health over time. Although population health data for Medicaid enrollees lags behind the data for other populations, the Centers for Medicare & Medicaid Services (CMS) and others are making considerable strides to improve Medicaid data files and outcomes data in general. MACPAC will continue to track these initiatives and examine efforts to improve the overall health of Medicaid enrollees.

Chapter 4: Building Capacity to Administer Medicaid and CHIP

State Medicaid agencies must manage all of the operational functions of a large health insurer as well as a host of additional responsibilities relating to public health, social insurance, and public financing. At the same time Medicaid programs are increasing in size and scope, Medicaid agencies are also seeking to increase these programs' value and accountability. Limitations in administrative capacity make it difficult for agencies to meet regulatory requirements, deliver better quality and more accountable care, and integrate Medicaid and CHIP into broader delivery system and financing reforms.

Capacity constraints stem from several sources, including financial disincentives for administrative spending and increasing system demands and complexity. These problems are exacerbated by the lack of administrative performance standards in Medicaid to help states identify gaps in performance and prioritize investments, and by difficulties recruiting and retaining expert staff.

To overcome these limitations, CMS, the states, and private organizations have developed a variety of approaches to strengthen Medicaid administrative capacity. States are increasingly finding ways to partner together and with state universities to share information, resources, and technology assets. States are also turning to outside vendor contracts to fill needs for highly technical expertise, temporary capacity demands, and ongoing staff support. CMS and several private foundations have supported Medicaid-specific training and leadership development initiatives.

CMS is working to improve data collection and strengthen performance benchmarks to provide consistent and comprehensive information on state activities and policy choices. CMS also provides additional funding to support specific administrative activities through increased matching funds and dedicated funds.

MACPAC's future work on administrative capacity will focus on how administrative performance should be measured and which strategies are most effective in helping states develop adequate capacity.

MACStats: Medicaid and CHIP Program Statistics

MACStats is a standing section in all Commission reports to the Congress. In this report, MACStats includes five sections: (1) trends in Medicaid enrollment and spending, (2) health and other characteristics of Medicaid and CHIP populations, (3) Medicaid enrollment and benefit spending, (4) Medicaid managed care, and (5) a technical guide to the June 2014 MACStats.

Among the key findings in this edition of MACStats are the following:

- Rates of growth in Medicaid spending and enrollment have varied considerably over the years, reflecting shifts in federal and state policy along with changing economic conditions.
- Medicaid and CHIP enrollees generally report being in poorer health and using more services than individuals who have other health insurance or who are uninsured, in part because the programs serve individuals with low incomes and high needs. For example, Medicaid and CHIP cover a disproportionate share of children with disabilities and special health care needs (more than 20 percent of enrollees under age 19), pregnant women (10 percent of female enrollees age 19 to 64), and seniors below about 75 percent of the federal poverty level who receive Supplemental Security Income assistance (one-third of enrollees age 65 and older).
- Individuals eligible on the basis of a disability and those age 65 and older account for about a quarter of Medicaid enrollees but about two-thirds of program spending.
- A large share of Medicaid spending for enrollees eligible on the basis of a disability and enrollees age 65 and older is for LTSS, while a substantial portion of spending for non-disabled children and adults is for capitation payments to managed care plans.
- About half of Medicaid enrollees are in comprehensive risk-based managed care plans. When limited-benefit plans and primary care case management programs are also included, more than 70 percent of enrollees are in some form of managed care.

CHAPTER 1

CHIP and the New Coverage Landscape

Recommendation

CHIP and the New Coverage Landscape

- The Congress should extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

Key Points

- CHIP is widely acknowledged to have played an important role in increasing the number and share of children with health insurance coverage, and providing access to affordable and high-quality care. Since the enactment of CHIP, the percentage of uninsured children has been cut in half.
- Under current law, the final federal CHIP allotments will be distributed to states on October 1, 2014. These allotments are expected to last through fiscal year (FY) 2015 but begin running out shortly afterward.
- The Commission recommends an extension of CHIP funding for two years due to its concerns that when CHIP funding runs out shortly after FY 2015, as under current law:
    - The number of uninsured children would increase significantly. Not all children currently covered by CHIP would be eligible for subsidized exchange coverage. For some, premiums for other sources of coverage would be too high relative to families' ability to pay.
    - Cost sharing for services would increase substantially for many families.
    - It is unclear whether or not exchange plans are ready to serve as an appropriate alternative.
- The Commission recommends an additional two years of CHIP funding, through FY 2017, to enable policymakers to address these concerns so that children currently enrolled in CHIP can be integrated into other sources of coverage that are of high quality and affordable to families. To aid the Congress in this endeavor, the Commission's future analyses will explore such policy options and the associated trade-offs.
- If it becomes evident during this two-year transition period that more time is necessary to ensure that needed reforms are in place and that children's transitions into other coverage options are appropriate, further extending this transition period should be considered. The Commission remains confident that the changes necessary to ensure that children have access to high-quality coverage can be made during this transition period.

CHAPTER 1

CHIP and the New Coverage Landscape

Over the past two years, MACPAC has discussed a range of issues associated with implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) and its relationship to Medicaid and the State Children's Health Insurance Program (CHIP). These include changes in eligibility and enrollment, such as the transition to new income determination rules and eligibility processes, and the expansions in many states to cover childless adults and additional low-income parents. We have also examined how the coverage offered by subsidized exchange plans to many individuals between 100 and 400 percent of the federal poverty level (FPL) interacts with Medicaid, CHIP, and employer-sponsored coverage.

While Medicaid provides coverage to 39 million children, CHIP is an important source of coverage for 8 million children with low to moderate incomes (MACPAC 2014a). With implementation of the ACA, the coverage options for these children and their families could change. Subsidized exchange plans potentially offer an alternative source of coverage to some children in this income range. The individual mandate to obtain coverage may also lead to additional enrollment in employer-sponsored coverage by some parents and children now enrolled in CHIP.

With CHIP funding currently scheduled to run out shortly after fiscal year (FY) 2015, the question naturally arises as to how to address the program's future. One approach would be to allow funding to run out and leave many children now served by CHIP to find coverage elsewhere—through Medicaid, the exchanges, or employers, if available. As the analyses presented in this chapter suggest, however, such transitions would not be smooth, and a significant number of children could become uninsured. An alternative approach at the other end of the spectrum would be to provide funding for CHIP indefinitely, maintaining a separate source of coverage not integrated with other coverage options. MACPAC's recommendation looks for a middle ground. As described in this chapter, the Commission recommends extending federal funding for CHIP for a transition period of two additional years, during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

CHIP is a joint federal-state program that offers coverage that complements Medicaid (with $13 billion versus $460 billion in spending in FY 2013). And it is an important source of affordable coverage for enrolled children, 97 percent of whom were at or below 250 percent FPL in FY 2013 (MACPAC 2014a).

While the program's statutory authorization continues indefinitely, the final federal CHIP funding allotment under current law will be for FY 2015. These funds will be distributed to states on October 1, 2014, and will begin to run out a year later. States are required to maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019, a requirement referred to as maintenance of effort (MOE). If CHIP funding runs out between FY 2015 and FY 2019, states with Medicaid-expansion CHIP programs subject to the MOE must continue that coverage with Medicaid funds, but at Medicaid's lower federal matching rate. However, separate CHIP programs may limit their enrollment based on the availability of federal CHIP funds, which effectively provides an exception to the MOE requirement in the absence of such funds.

Under current law, the children currently covered under separate CHIP programs could face one of a number of scenarios if their CHIP coverage comes to an end. Some could enroll in a parent's employer-sponsored insurance. Those not eligible for employer-sponsored coverage may seek subsidized coverage through exchanges. Either way, however, some affected families may not enroll their children in exchange or employer-sponsored coverage that is available to them—because the premiums for such coverage are too high relative to their ability to pay, for example. One analysis estimated that the end of CHIP could lead to as many as 2 million more children becoming uninsured (Kenney et al. 2011).[1]

Those shifting to exchange coverage may face higher cost sharing, different benefits, and enrollment in plans with different provider networks. Much remains to be learned about how well exchange plans meet the needs of lower-income children and whether they are a viable alternative to CHIP coverage.

Because so much is unknown about the post-CHIP landscape under current law and the adequacy of new exchange coverage for children, the Commission recommends a two-year extension of CHIP financing through FY 2017. During this time, MACPAC will continue to examine a range of issues about the design and adequacy of coverage for the population now covered by CHIP and will offer options to provide a more seamless continuum of children's coverage that better accommodates transitions in coverage among Medicaid, the exchanges, and employer-sponsored insurance. This timing should permit the Congress and the U.S. Department of Health and Human Services (HHS) to consider the analyses and options, consult with states and stakeholders, and make desired changes with sufficient lead time for states and the federal government to manage any transitions effectively.

This chapter presents the analyses that led the Commission to its recommendation to extend CHIP funding through FY 2017. We begin by reviewing the impact that CHIP has had on children's coverage. We then examine how children currently covered by CHIP could be affected if funding is exhausted as under current law. The chapter concludes by outlining the options considered by the Commission and our recommendation for extending CHIP funding for two additional years as a transition plan is developed.

History and Impact of CHIP

This section describes CHIP's creation, how it has evolved over the past 17 years, and the impact it has had on children's coverage.

Creation of CHIP

In 1997, the Congress focused attention on expanding coverage to low-income children not eligible for Medicaid. The congressional proposals that emerged ranged from the provision of tax credits to the expansion of Medicaid with uncapped federal financing at an enhanced federal matching rate (Smith and Moore 2010).

The legislation that became CHIP (the Balanced Budget Act of 1997, P.L. 105-33, referred to as BBA 97) gave states flexibility either to use an expansion of Medicaid or to create CHIP programs separate from Medicaid. States could also use both approaches, in which they generally covered lower-income children with a Medicaid expansion.

Separate CHIP programs could be structured to differ from Medicaid in several ways. First, while Medicaid-eligible individuals are entitled to Medicaid coverage (including through Medicaid-expansion CHIP programs), there is no individual entitlement to coverage in separate CHIP programs. For example, states were permitted to institute enrollment caps and waiting periods in separate CHIP programs, policies not permitted in Medicaid without a waiver. In addition, while states with Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no minimum mandatory income level up to which CHIP programs must extend coverage. Moreover, states with separate CHIP programs have greater flexibility around the design of their benefit packages and enrollee cost sharing than is available for children in Medicaid.[2]

In addition to providing flexibility in program design, the Congress also made enhanced federal matching available through CHIP in order to encourage state participation. Since its enactment, CHIP spending has been reimbursed by the federal government at a matching rate higher than Medicaid's. In both separate CHIP and Medicaid-expansion programs, the enhanced Federal Medical Assistance Percentage (E-FMAP) varies by state but, on average, pays for 70 percent of CHIP spending, compared to 57 percent historically for Medicaid. Unlike Medicaid, however, federal CHIP funding is capped, and states could exhaust their federal CHIP allotments.

At the time of CHIP's creation, it was not clear how many states would respond to the new federal funding opportunity by extending eligibility to more children. By FY 2000, however, every state, territory, and the District of Columbia had enrolled children in CHIP-financed coverage.

Impact of CHIP

One of the hallmarks of CHIP was the aggressive effort it spurred to identify and enroll uninsured children who were eligible for coverage in CHIP and Medicaid. These efforts ultimately proved extremely successful, and CHIP is now widely acknowledged to have played an important role in increasing the number and share of children with health insurance coverage.

Since the enactment of CHIP in 1997, the share of children who are uninsured has fallen by half—from 13.9 to 7.1 percent (Martinez and Cohen 2013). The effects were even larger for children in the typical CHIP income range. Among children with family income above 100 percent FPL but below 200 percent FPL, uninsurance dropped by more than half—from 22.8 percent in 1997 to 10.0 percent in 2013. Over that time period, which included two recessions, private coverage for children between 100 and 200 percent FPL also declined substantially—from 55 percent in 1997 to 27.1 percent in 2013 (Martinez and Cohen 2013, 2012). Gains in Medicaid and CHIP enrollment more than offset the loss.[3]

Despite generally high rates of coverage for children relative to other groups, some children remain uninsured, with the rate varying significantly by state. In 2012, children's uninsurance rates ranged from 1.4 percent in Massachusetts to 17.0 percent in Nevada (Appendix Table 1-A-1). Thirty percent of the nation's uninsured children (1.8 million) live in Texas and California.

Some of CHIP's design features also provided a platform for state innovations to improve take-up of public coverage among eligible but uninsured children. Many states branded their CHIP programs separately from Medicaid and launched targeted outreach and marketing efforts. These strategies increased enrollment of children in both CHIP and Medicaid, further reducing uninsurance rates among children. Over time, these efforts and other policy changes contributed to changing the perception of Medicaid from a welfare program to a more mainstream source of health insurance coverage for children. Outreach and enrollment techniques that often began as experiments in CHIP in individual states were subsequently identified as best practices and, in some cases, are now required in all states for both CHIP and Medicaid—including through requirements in the ACA.[4]

As a result of these efforts, 88.1 percent of eligible children were enrolled in Medicaid or CHIP in 2012 (Kenney and Anderson 2014).[5] This is 6.4 percentage points higher than in 2008, potentially reflecting additional outreach and enrollment simplification efforts encouraged by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). However, these rates vary significantly by state—from 70.6 percent in Nevada to 97.4 percent in Massachusetts (Appendix Table 1-A-2). Of the shrinking number of uninsured children, an estimated 68.4 percent are eligible for Medicaid or CHIP (Kenney and Anderson 2014).

In addition to its role in boosting rates of coverage, CHIP is more affordable for low-income working families than private coverage, although most states charge CHIP premiums to at least some CHIP enrollees. Categories of covered benefits are often similar between separate CHIP and private plans, but CHIP is more comprehensive with regard to dental coverage. In addition, Medicaid-expansion CHIP programs are required under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) rules to provide children under age 21 with any medically necessary service named in the Medicaid statute, even if the service is otherwise not covered by the state.

Key legislative actions affecting CHIP financing

Although CHIP was enacted with federal appropriations through FY 2007, the Congress intervened to provide additional funding for FY 2006 and FY 2007, when several states were poised to exhaust all their available federal CHIP funding. While the first several years of the program saw CHIP allotments much larger than states' spending, the situation reversed as CHIP programs matured and expanded to other groups, including childless adults (Allen 2007). To avoid shortfalls, the Congress appropriated additional funding for FY 2006 ($283 million) and again for FY 2007 ($650 million).

CHIPRA extended the program by providing CHIP appropriations through FY 2013, at much higher levels than under the original 1997 legislation. The formula for allotting these funds to states was also overhauled to better target states' actual CHIP spending. Since CHIPRA's enactment, no congressional action has been necessary to eliminate state shortfalls. CHIPRA made several other changes to CHIP, such as requiring separate CHIP programs to cover dental benefits and ensuring that any covered mental health benefits had parity with medical benefits.

In 2010, as the ACA was being debated, policymakers raised questions as to whether CHIP should continue, or whether CHIP-eligible children should be enrolled in the health insurance exchanges created by the ACA. Ultimately, the Congress decided to extend federal CHIP allotments by two years, through FY 2015, leaving open the question of CHIP's long-term future. If CHIP allotments are extended again, the ACA requires the federal matching rate for CHIP to increase by 23 percentage points (up to 100 percent) for FY 2016 through FY 2019, the last four years of the ACA's MOE for children. Additional changes made by the ACA to CHIP include a shift to modified adjusted gross income for eligibility determinations and the movement of certain children from separate CHIP programs into CHIP-funded Medicaid.

Eligibility for CHIP and Other Insurance

As noted above, CHIP currently finances coverage for approximately 8 million children nationwide. This section explores the sources of health insurance coverage that would be available to current CHIP-eligible children in the absence of CHIP funding after FY 2015.

CHIP eligibility today

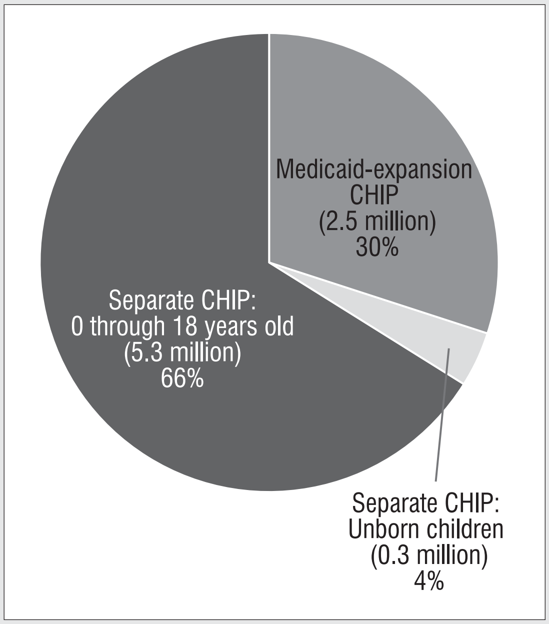
CHIP was designed to provide health insurance to low-income uninsured children above 1997 Medicaid eligibility levels.[6] Unlike Medicaid, CHIP has no requirement to cover children up to a specific income level. States' upper income limits for CHIP range from 175 to 405 percent FPL (Appendix Table 1-A-3). Although 19 states and the District of Columbia offer CHIP coverage to at least 300 percent FPL (with higher-income families generally subject to higher premiums and cost sharing), 89 percent of the children enrolled in CHIP-financed coverage had incomes at or below 200 percent FPL in FY 2013, and 97 percent were at or below 250 percent FPL (MACPAC 2014a).

As of January 2014, 7 states, 5 territories, and the District of Columbia ran CHIP entirely as a Medicaid expansion, 14 states operated separate CHIP programs, and 29 states elected to operate a combination program (Appendix Table 1-A-3).[7] As noted previously, under the ACA, states must maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019. However, this MOE does not obligate states to continue funding separate CHIP programs if federal CHIP funding is exhausted. A state may limit enrollment if it projects that it will exhaust its federal CHIP funding.

Sources of coverage if CHIP funding is exhausted

The type of coverage children will be eligible for if CHIP funding is exhausted will reflect state choices as to whether they use a Medicaid-expansion, separate CHIP program, or a combination of the two (Figure 1-1).

FIGURE 1-1. Children's CHIP Enrollment by Program Type and Unborn Status, Fiscal Year 2013



Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from the Centers for Medicare & Medicaid Services (CMS) as of March 4, 2014.

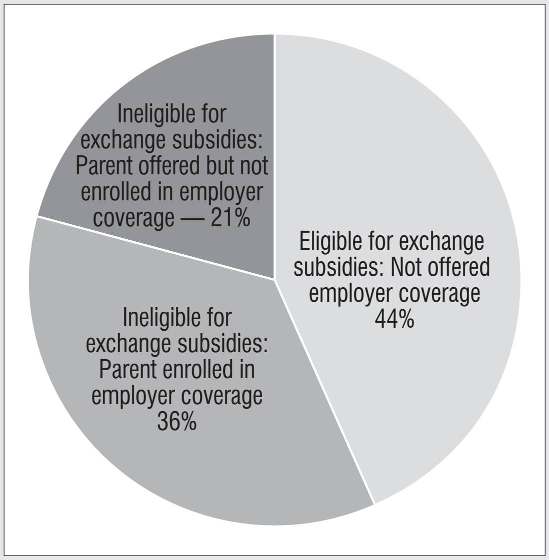
Children in Medicaid-expansion CHIP programs. Of the 8.1 million children enrolled in CHIP in FY 2013, 30 percent (2.5 million in 32 states and the District of Columbia) were in Medicaid-expansion CHIP (Figure 1-1). If CHIP funding runs out shortly after FY 2015, consistent with current law, these children would continue in Medicaid coverage but with federal funding from Medicaid at Medicaid's lower matching rate.[8]

Children age 0 through 18 in separate CHIP programs. Approximately two-thirds (5.3 million) of CHIP-funded children in FY 2013 were 0- to 18-year-olds in separate CHIP programs in 39 states (Figure 1-1, Appendix Table 1-A-3).[9] While one might assume that children in separate CHIP programs (who are generally in the income range for subsidized exchange coverage) would move to subsidized exchange coverage in the absence of CHIP funding, such coverage is likely to be available to less than half of these children.

There are several reasons why this would occur. First, while the ACA requires states to develop procedures to automatically transition children from separate CHIP to exchange coverage as CHIP allotments run out (§2105(d)(3)(B) of the Social Security Act (the Act)), it also requires a special certification that sets a high bar for such transitions. By April 1, 2015, the Secretary of the U.S. Department of Health and Human Services (the Secretary) must certify plans that are "at least comparable to" CHIP programs with respect to benefits and cost sharing (§2105(d)(3)(C) of the Act). As described below, while categories of covered benefits in separate CHIP and exchange coverage may be fairly comparable, cost sharing in exchange plans at current subsidy levels does not appear comparable to CHIP. If the Secretary finds that no exchange plans are comparable to CHIP, states are not required to seamlessly transition children from separate CHIP to exchange coverage, although families may obtain subsidized exchange coverage on their own.

Children are generally only eligible for subsidized exchange coverage if a parent is not offered affordable employer-sponsored insurance. According to an analysis of survey data for MACPAC by the Agency for Healthcare Research and Quality, among children in separate CHIP coverage (5.3 million in FY 2013), 44 percent are estimated to have parents who are not offered employer-sponsored insurance and therefore could qualify for subsidized exchange coverage (Figure 1-2). If CHIP funding were exhausted, however, it is not clear how many of

FIGURE 1-2. Eligibility for Subsidized Exchange Coverage If Separate CHIP Programs Did Not Exist, among Children Age 0 through 18 Currently Eligible for Separate CHIP Coverage



Notes: Assumes all employer-sponsored insurance is available to dependents and is affordable based on the definition in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Analysis is among non-disabled children not enrolled in employer-sponsored insurance or Medicare who are eligible for their state's separate CHIP program. Numbers do not sum to 100 percent due to rounding. In fiscal year 2013, 5.3 million children age 0 through 18 were enrolled in a separate CHIP program at some point during the year.

Source: Estimates for MACPAC from the Agency for Healthcare Research and Quality (AHRQ) from 2005 to 2010 Medical Expenditure Panel Survey (MEPS) with PUBSIM simulated 2014 eligibility.

these children would be enrolled in the subsidized exchange coverage for which they are eligible—particularly if it would require additional cost sharing and premium payments by families.

The parents of the remaining 56 percent of children in separate CHIP coverage report having access to employer-sponsored insurance—the vast majority of which would be considered affordable under the ACA, therefore disqualifying them from exchange subsidies. It is not clear, without CHIP, what share of these children would be enrolled in the employer-sponsored coverage their parents are offered or would become uninsured.

The ACA defines employer-sponsored coverage as affordable if an employee's out-of-pocket premiums for self-only coverage would account for no more than 9.5 percent of a family's income. This affordability test is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered. In 2013, the average annual worker contribution toward self-only coverage was $999, compared to $4,565 for family coverage (KFF and HRET 2013).[10]

For families not eligible for Medicaid, nearly all employer-sponsored coverage would be considered affordable based on the ACA's self-only coverage definition. Even at the 90th percentile of premiums for job-based coverage, the self-only premium paid by employees for a family of three at 138 percent FPL would comprise only 8.2 percent of income—still short of the 9.5 percent threshold to qualify for exchange subsidies (MACPAC 2013a).[11] There are no published estimates, however, specifically on how many CHIP parents' coverage would meet this definition of affordability and how many would not. There are also no published estimates of how many more parents would meet the definition if it were amended to be based on family rather than self-only coverage.

Unborn children in separate CHIP programs. About 4 percent of CHIP-funded enrollees (approximately 300,000) in FY 2013 were unborn children (Figure 1-1). The option to cover unborn children, in use by 16 states, was created through federal CHIP regulations in 2002 that revised the definition of the term child to include the period from conception to birth (Appendix Table 1-A-3, CMS 2002). States that elect this option are technically providing coverage to the unborn child, not the pregnant woman herself. As a result, the citizenship or immigration status of the mother is immaterial. However, unborn children are not eligible in their own right to be enrolled in Medicaid or exchange coverage. As a result, if the mother's immigration status, for example, makes her ineligible for Medicaid or exchange coverage, then the unborn children in those 16 states would lose access to federally subsidized coverage of prenatal care if CHIP ends.

Key policy issues: Eligibility

The potential for a significant number of children currently covered by CHIP to become uninsured if CHIP financing is not extended was one factor leading the Commission to recommend that the Congress extend federal CHIP funding for another two years to allow time to design a structure for children's coverage after FY 2017 without undoing the gains in improving the rate of coverage made since 1997. Issues meriting further exploration include the extent to which employer-sponsored coverage is available and affordable for affected children and whether they might enroll in that coverage or become uninsured.

MACPAC also plans to learn more about state actions affecting children covered under separate CHIP programs. For example, California recently moved most of its CHIP-enrolled children from a separate program into a Medicaid expansion. Arizona recently terminated its separate CHIP program, an action permissible because these enrollees were in an expansion that occurred after the ACA's enactment and thus was not subject to the MOE. The Commission hopes to learn more about how these children are now being covered and how their access to care has been affected.

Cost Sharing and Premiums in CHIP Compared to Subsidized Exchange Coverage

In assessing the future of the program, the out-of-pocket cost sharing and premiums in CHIP relative to other forms of coverage are key considerations. While the Secretary must publish (by April 1, 2015) an assessment of whether the cost sharing in CHIP and exchange plans is comparable, the findings of our analysis, outlined in this section, suggest that children moving from separate CHIP programs to exchange coverage would experience higher cost sharing in the form of deductibles, copays, and coinsurance.

For both cost sharing and premiums, this section provides an overview of current CHIP policy and practice before turning to how cost sharing and premiums are affected by the ACA. This is followed by a discussion of the affordability implications for a post-CHIP landscape.

Overview of CHIP cost sharing

Twenty-eight separate CHIP programs require cost sharing for at least some types of services. For example, 21 states impose cost sharing for non-preventive physician visits, and 21 states have service charges for non-emergency use of the emergency department. Other common service categories associated with enrollee cost sharing include inpatient hospital visits, emergency room visits, and prescription drugs (Cardwell et al. 2014).

As with Medicaid (including Medicaid-expansion CHIP), combined expenses for separate CHIP premiums and cost-sharing expenses may not exceed 5 percent of a family's income (§2103(e)(3)(B) of the Act). Among the 42 separate CHIP programs analyzed, 22 utilize the 5 percent limitation, while 20 states have a lower cap (Cardwell et al. 2014).

Overview of cost sharing in exchange plans

The ACA established four metal tiers that denote average levels of cost sharing in exchange plans, described in terms of actuarial values. Actuarial values measure the percentage of covered health care expenses that an insurer would pay, on average, for a typical enrollee population. The metal tiers for unsubsidized exchange plans are as follows:

- Bronze: Actuarial value of 60 percent
- Silver: Actuarial value of 70 percent
- Gold: Actuarial value of 80 percent
- Platinum: Actuarial value of 90 percent

Additionally, exchange plans in the silver tier are required to provide cost-sharing reductions to qualifying enrollees with incomes below 250 percent FPL.[12] Cost-sharing reductions must increase actuarial values as follows (Figure 1-3):

- Up to 150 percent FPL: Actuarial value of 94 percent
- 151–200 percent FPL: Actuarial value of 87 percent
- 201–250 percent FPL: Actuarial value of 73 percent

Individuals above 250 percent FPL do not qualify for cost-sharing reductions. For them, the default silver plan actuarial value of 70 percent would apply; however, individuals above 250 percent FPL may choose to enroll in a non-silver plan. For example, some individuals could choose a gold or platinum plan and pay higher premiums but lower deductibles, while others could choose a lower-premium bronze plan with higher deductibles.

States have the flexibility to allow insurers offering exchange plans to design differing cost-sharing structures as long as they meet the actuarial value requirements and are in accordance with other federal guidelines regarding benefits and out-of-pocket maximums. As a result, two exchange plans may have the same actuarial value, even though one may have a higher deductible and lower copayments relative to the other.

Assessing cost sharing using actuarial values

To provide insight into the comparability of plan affordability, MACPAC compared the actuarial values of cost sharing in five separate CHIP programs to the actuarial values of exchange plans with cost-sharing reductions. Because the medical benefits in separate CHIP and exchange coverage are largely consistent—with some exceptions, as described in the next section of this chapter—the differences in actuarial values between exchange plans and separate CHIP programs in this analysis can largely be attributed to cost sharing.

Actuarial values of selected separate CHIP programs. To estimate actuarial values of separate CHIP programs, MACPAC used a recent study by the U.S. Government Accountability Office (GAO) that provided detailed cost-sharing information for programs in five states—Colorado, Illinois, Kansas, New York, and Utah (GAO 2013). To obtain actuarial values for the CHIP cost-sharing structure in these five states, MACPAC utilized the actuarial value calculator from the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS).[13]

Two of the five states in the GAO analysis—Kansas and New York—charged no cost sharing for any children in the separate CHIP programs and therefore had actuarial values of 100 percent (Figure 1-3). Both states charged premiums to their higher-income CHIP enrollees, which are not reflected in actuarial values. For the lowest-income CHIP enrollees in Colorado (101 to 150 percent FPL), cost sharing is so small (e.g., $2 copayments for doctor's visits and inpatient hospitalization) that the actuarial value (99.5 percent) rounds to 100 percent.

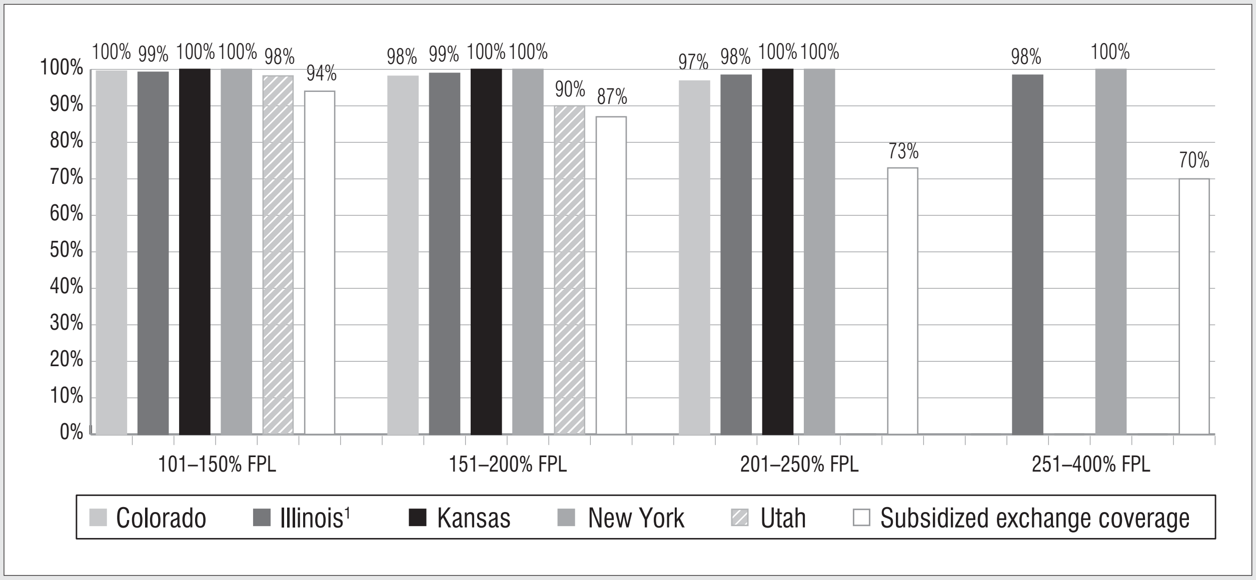
With one exception, all of the other states and income levels have actuarial values in their separate CHIP programs ranging from 97 to 99 percent (Figure 1-3). The exception is for Utah's highest income range in its CHIP program (151 to 200 percent FPL), which has an actuarial value of 90 percent. For these children, Utah has a deductible of $500, with $25 copays for a visit to a primary care physician and 20 percent coinsurance for inpatient hospital care (GAO 2013).

These actuarial values are comparable to those calculated in a 2009 analysis of separate CHIP programs. In that analysis, the actuarial values of 16 separate CHIP programs were all estimated to be above 95 percent—with separate estimates of the actuarial values based on the cost sharing charged to children at 175 and 225 percent FPL (Watson Wyatt Worldwide 2009).[14]

Comparison of CHIP and exchange plan cost-sharing amounts. Across income eligibility levels, the actuarial values of the five states' CHIP programs are consistently higher than the actuarial values prescribed for exchange plans with cost-sharing reductions. As a result, children moving from separate CHIP programs to exchange coverage would experience greater cost sharing.

Up to 150 percent FPL, all five states' CHIP programs had actuarial values in the range of 98 to 100 percent—levels significantly higher than

FIGURE 1-3. Actuarial Values of Five States' Separate CHIP Programs and of Subsidized Exchange Coverage, by Family Income



Notes: In 2014, 200 percent of the federal poverty level (FPL) is $23,340 for an individual and $8,120 for each additional family member in the lower 48 states and the District of Columbia. Bars are not shown where a state's CHIP program does not extend eligibility at that level.

[1] For the lowest income range in the figure, Illinois' separate CHIP program eligibility was between 134 and 150 percent FPL. For the highest income range in the figure, Illinois' eligibility extends up to 300 percent FPL.

Source: MACPAC analysis of GAO 2013 and CMS 2014a.

exchange plans' actuarial value of 94 percent at that income level (Figure 1-3).

Between 151 and 200 percent FPL, all five states' CHIP programs except Utah had actuarial values in the range of 98 to 100 percent—levels significantly higher than exchange plans' actuarial value of 87 percent at that income level. Even in Utah, the CHIP program's actuarial value of 90 percent exceeded the actuarial value of subsidized exchange coverage (87 percent) by more than a percentage point and therefore would not be considered comparable under federal regulations.[15]

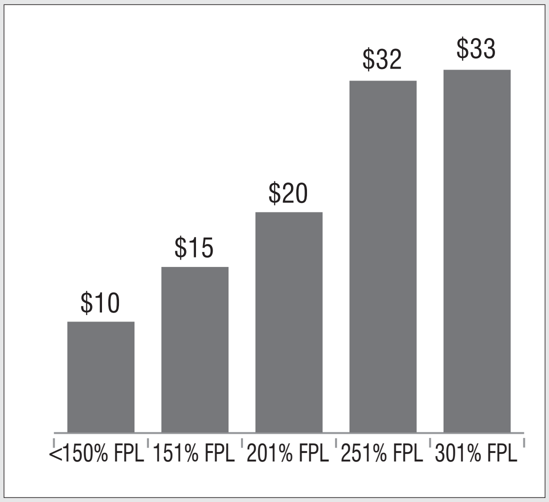
Between 201 and 250 percent FPL, subsidized exchange plans' actuarial value of 73 percent is eclipsed by the actuarial values of the four states analyzed with eligibility levels above 200 percent FPL (Colorado, Illinois, Kansas, and New York). In that income range, the CHIP actuarial values in those four states ranged from 97 to 100 percent.

Above 250 percent FPL, no cost-sharing reductions are available for exchange plans. Thus, above 250 percent FPL, the 70 percent actuarial value would apply to individuals enrolled in a silver plan. Above 250 percent FPL, the CHIP actuarial value is 97 percent in Illinois and 100 percent in New York; the other three states do not offer CHIP benefits at this income level (Figure 1-3).

Overview of CHIP premiums

In addition to cost sharing for services, premiums also affect CHIP's affordability. As the Commission has previously noted, the use of premiums in CHIP programs is fairly widespread. Based on policies in place in January 2013, MACPAC estimates that approximately 44 percent of CHIP-funded children (3.4 million) faced premiums in 33 states, including in some Medicaid-expansion states (MACPAC 2014a). In states that charge premiums, all require them when eligibility is extended beyond 200 percent FPL. The amount of those premiums also increases with family income (Figure 1-4).

FIGURE 1-4. Median Monthly CHIP Premium per Child Enrolled in CHIP, by Federal Poverty Level (FPL), 2013



Notes: Medians are calculated among states charging premiums at that income level. Premiums listed at 201, 251, and 301 percent include states whose upper income levels are 200, 250, and 300 percent FPL. Oregon and Pennsylvania were excluded because premiums vary by contractor.

Source: Cardwell et al. 2014.

In some states, lower-income CHIP enrollees also face premiums. As of January 2013, several states reported charging CHIP premiums below 150 percent FPL—Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, and Utah. Since then, California has changed most of its CHIP program to a Medicaid-expansion program and has eliminated premiums below 150 percent FPL. In the remaining eight states, approximately 110,000 children below 150 percent FPL are estimated to be subject to CHIP premiums (MACPAC 2014a).

In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Commission recommended—in MACPAC's March 2014 *Report to the Congress on Medicaid and CHIP*—that the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums (MACPAC 2014a). Based on evidence from research, the Commission concluded that eliminating CHIP premiums for families with incomes under 150 percent FPL would reduce uninsurance and would cause less crowd-out relative to higher-income enrollees (MACPAC 2014a, Abdus et al. 2013, Herndon et al. 2008). Moreover, the CHIP premiums charged in this income range, generally around $10 per month (Figure 1-4), are small enough that the revenue loss to states if they were eliminated would potentially be offset by reduced costs for collecting and administering the premiums (Kenney et al. 2007).

Interactions between CHIP and exchange premiums

While CHIP and exchange coverage each have a statutory limit on premiums (combined with cost sharing in the case of CHIP) based on family income, neither takes into account the effect of premiums required by the other. In states charging premiums of CHIP enrollees, the combination, or stacking, of both CHIP and exchange premiums could be substantial for families. With more than 3 million children facing CHIP premiums, many families will be subject to premium stacking if they purchase exchange coverage in addition to enrolling their children in CHIP.

As noted in the Commission's March 2014 report, a single mother with two children who earns $29,490 per year (151 percent FPL) would be eligible for an exchange subsidy limiting her premium contribution to approximately 4 percent of her income, or $1,193.[16] If eligible, her children would enroll in CHIP, not her exchange plan. In a state charging $20 per child per month for CHIP coverage ($480 annually), the additional cost for this coverage would be an additional 1.6 percent of her income. In total, she would pay 5.7 percent of her income for insurance coverage ($1,673), more than the limits established for subsidized exchange premiums in the ACA. If the children in this example were not eligible for CHIP, then they could enroll in the mother's exchange plan for the same out-of-pocket premium of $1,193—for a savings to the family of $480 in premiums. Similarly, if CHIP ends, children currently subject to CHIP premiums whose parents are enrolled in subsidized exchange coverage could see a reduction in total family premiums.

Key policy issues: Affordability

The affordability of children's health care coverage needs to be assessed as coverage options are developed for children enrolled in separate CHIP programs. At issue is the appropriate level of financial contribution to be expected of families toward their health coverage—whether for enrollment in CHIP, employer-sponsored coverage, the exchanges, or other sources of coverage.

In extending CHIP funding beyond FY 2015, the issue of premium stacking would remain, as families split between CHIP and exchanges face premiums from both sources and perhaps from stand-alone dental plans offered through exchanges as well. As noted in MACPAC's March 2014 report, the phenomenon of premium stacking is of concern to the Commission. The Commission has not come to a conclusion about how the associated costs of addressing the issue might be split between states and the federal government. The Commission also seeks data regarding the prevalence of split family coverage and premium stacking and is working with CMS to identify how many families are affected.

Covered Benefits in CHIP and Exchange Coverage

State flexibility in benefit design leads to differences in the benefits offered by separate CHIP programs, Medicaid (including Medicaid-expansion CHIP programs), and exchange plans. Separate CHIP programs can model their benefits based on specific private insurance benchmarks, a package equivalent to one of those benchmarks, or Secretary-approved coverage. The most flexible of these options is Secretary-approved coverage, which is the most common approach. As a result of this flexibility, covered benefits in CHIP have the potential to differ substantially from state to state. On the other hand, 14 programs use a benefit package similar to Medicaid for Secretary-approved separate CHIP programs (Cardwell et al. 2014).[17]

States also have flexibility to define the array of benefits that qualified health plans (QHPs) must cover in order to be certified, consistent with federal minimum requirements for exchange coverage. One of those requirements is that exchange plans must provide coverage of the 10 essential health benefits (EHBs) required by the ACA (§1302(b)).

Benefit design affects access to care. As a result, the differences in the benefits offered by Medicaid, separate CHIP programs, and exchange plans raise questions about which benefit design is appropriate for children's coverage. Exchange coverage is new relative to the CHIP program, so comparisons between the programs are just now emerging and are likely to evolve as the exchange market matures. Existing research points to three areas where some differences between separate CHIP and exchange coverage exist: certain covered benefits, benefit limits, and the approach to offering dental coverage. Medicaid-expansion CHIP benefits differ from both separate CHIP and private coverage due to Medicaid's EPSDT requirements.

Coverage of benefit categories

Exchange plans offer covered benefits that are largely consistent with separate CHIP coverage, but with a few differences. A GAO study comparing separate CHIP programs and EHB benchmarks in five states found that most benefit categories were covered in both programs. For example, benefits like inpatient and outpatient mental health services and chronic disease management services were covered in both separate CHIP programs and EHB benchmark plans in all five states. However, outpatient habilitative therapies and pediatric hearing services were covered inconsistently in separate CHIP programs and EHB benchmark plans (GAO 2013).[18] For example, separate CHIP programs in three of five states (Colorado, Illinois, and New York) covered outpatient habilitative therapies, while benchmark plans in two states (Illinois and Utah) covered the benefit.

Benefit limits

In the five states GAO examined, separate CHIP programs generally include fewer benefit limits relative to EHB benchmark plans. Comparisons of benefit limits between separate CHIP programs and EHB benchmark plans can be difficult to make because benefit limits can be applied differently. For example, the CHIP program in New York allows 6 weeks of physical therapy services, while the EHB benchmark plan allows up to 60 visits per condition. With this difficulty in mind, the GAO first compared whether limits were applied to the same benefit categories. They found that separate CHIP programs and EHB benchmark plans tend to apply limits to the same benefit categories, typically home and community-based services, outpatient therapies, and services that are mandated for children but not adults, such as dental, vision, and hearing services. And where benefit limit comparisons were clearer, the GAO found that CHIP programs tend to have higher benefit limits than benchmark plans. For example, Utah's benchmark plan limits home and community-based services to 30 visits per year, whereas the CHIP program does not impose any limits on this service.

Pediatric dental coverage

Another key difference is the approach to providing pediatric dental coverage. Separate CHIP programs are required to provide coverage for dental services. Although pediatric oral health is an essential health benefit, exchange plans are not required to cover pediatric oral health benefits if stand-alone dental plans are available in an exchange (§1302(b)(4)(F) of the ACA).[19] Thus some plans cover all 10 EHBs, including pediatric dental services, while others offer a stand-alone dental plan in addition to medical policies that exclude dental benefits.

When dental coverage is only available in an exchange as a stand-alone plan, families would need to purchase separate plans and pay two premiums.[20] Moreover, individuals and families are not required to purchase pediatric dental coverage when offered separately (unless required by state law).[21] Stand-alone dental plans may also establish separate cost sharing (45 CFR 156.150). Questions have been raised about the affordability of pediatric dental coverage and whether people will take up pediatric dental coverage in the absence of the requirement to do so (AAPD et al. 2013).

The approach to providing pediatric dental coverage in exchange plans varies by state; for example, in nine states with a federally facilitated or partnership exchange, two-thirds or more of the QHPs have pediatric dental benefits embedded within coverage. On the other hand, in 14 states with a federally facilitated or partnership exchange, 15 percent or fewer QHPs offer plans with embedded pediatric dental coverage (Reusch 2014). The Commission recognizes the importance of dental benefits to children's health and development and that there is more to be learned about how and the extent to which children in exchange plans get pediatric dental coverage.

Key policy issues: Covered benefits

While benefit design will be an important element of a long-term vision for children's coverage, systematic information comparing benefits between exchange plans and CHIP has only recently begun to emerge. Comparing covered benefits may be easier in the future. For example, more details are emerging on how insurers have designed exchange plans in light of the EHB requirements. In addition, QHP benefit design could change as health insurance issuers gain market experience in the coming years.

MACPAC will assess, for example, whether plans are adopting the limits set forth in EHB benchmark plans or are providing coverage beyond the benchmark. MACPAC will review how coverage of habilitative benefits in exchange plans compares to separate CHIP plans in terms of what services are covered and what limits are applied to coverage. And MACPAC will monitor the extent to which dental coverage is offered separately and what effect, if any, this has on access to pediatric dental services. This new information can be used to better compare the type of benefits and the amount of coverage available in CHIP and exchange plans, a critical element in understanding how CHIP and exchange plans address the health care needs of children.

In addition to developing a better understanding of what services are covered, MACPAC also seeks to strengthen its understanding about the quality of those services. CHIPRA provided $45 million per year for FY 2009 through FY 2013 ($225 million total) for the Secretary to identify, publish, and periodically update a core set of child health quality measures for states' voluntary use in Medicaid and CHIP.[22] Of the 22 child health quality measures currently in use as a result of this initiative, all states reported on 2 of the measures in FY 2012.[23] The median number of measures reported by states was 14 (HHS 2013). MACPAC strongly supports efforts to measure and improve the quality of health care for children in Medicaid and CHIP and will continue to monitor HHS efforts to improve quality in Medicaid and CHIP and the effectiveness of the efforts funded by CHIPRA.

Network Adequacy in CHIP, Medicaid, and QHPs

The adequacy of provider networks to provide access to necessary services for plan enrollees is another key consideration when evaluating the potential impact of moving children now covered by CHIP to subsidized exchange coverage. There is an often-stated assumption that CHIP networks are better than Medicaid and QHP networks, supported by the arguments that many CHIP networks mirror private plan networks or that CHIP networks are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, limited empirical information exists to support or refute this assertion.

While there are no data comparing networks in Medicaid, CHIP, and the exchanges, a comparison of federal requirements for Medicaid, CHIP, and QHP network adequacy shows that the provisions under each program are similar. There are exceptions, however. Medicaid and CHIP offer access to out-of-network providers when the network is not sufficient for an enrollee's medical needs. QHP network adequacy provisions do not require an out-of-network option except in cases of emergency, although some QHPs may be preferred provider organizations or point-of-service plans that may provide such an option with higher cost sharing. These federal requirements are broad standards, however, and in many cases substantially more detailed network adequacy requirements are established at the state level. QHP networks are still relatively new, so little information is available on their adequacy for children.

Medicaid and CHIP network adequacy requirements

Managed care plans in Medicaid and CHIP are subject to the same federal network adequacy requirements (§2103(f)(3) of the Act, CMS 2009). These requirements provide that states must establish "standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity" (§1932(c)(1)(A)(i) of the Act). In addition, each managed care organization (MCO) must demonstrate that it has "the capacity to serve the expected enrollment" in its service area and must also offer "an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled" and "[maintain] a sufficient number, mix, and geographic distribution of providers and services" (§1932(b)(5)(A) and (B) of the Act).

Medicaid also requires states to cover services at federally qualified health centers (FQHCs), which effectively ensures access to health center providers. No such federal rules exist for CHIP, but at the state level, more than 80 percent of fee-for-service separate CHIP programs and nearly 60 percent of managed care separate CHIP programs require FQHCs to be included (Hess et al. 2011). CHIP programs also frequently place other requirements on coverage of certain providers: more than 80 percent of fee-for-service separate CHIP programs and over 50 percent of managed care separate CHIP programs require contracting with rural health clinics. In addition, 62 percent of fee-for-service separate CHIP programs and 28 percent of managed care separate CHIP programs cover services at school-based health centers (Hess et al. 2011).[24]

Adding to these requirements, CHIP regulations specify that a state must assure "access to out-of-network providers when the network is not adequate for the enrollee's medical condition" (42 CFR 457.495). Medicaid MCOs also must cover out-of-network services if the network is unable to provide them (42 CFR 438.206, 42 CFR 438.52). In addition, children covered by Medicaid are entitled to EPSDT services regardless of network.

QHP network adequacy requirements

Federal rules govern minimum network adequacy standards for exchange plans. QHP provider networks must be sufficient "to permit access to care without unreasonable delay" (45 CFR 156.230). The QHP issuer must make its provider directory available to the exchange and identify those providers not accepting new patients (45 CFR 156.230(b)). CMS has clarified that within the initial open enrollment period, enrollees can move to another plan of the same issuer in the same metal tier to access a more inclusive provider network (CMS 2014b).

Oversight of network adequacy dependent on exchange type. In federally facilitated exchanges for 2014, HHS used a state's network adequacy review if it was at least as stringent as the federal requirements (CMS 2013a). However, CMS has issued new network adequacy standards for 2015 (CMS 2014c). In 2015, CMS will require issuers to submit a provider list detailing all in-network providers and facilities for all plans for which it seeks QHP certification. CMS will no longer use issuer accreditation status, network access plans, or state review to determine network adequacy. CMS will instead use a "reasonable access" review standard to assess whether a network will provide access without unreasonable delay. CMS will also use information gathered about provider networks to develop time and distance standards for federally facilitated exchange QHP standards in the future (CMS 2014c). HHS is also soliciting comments on its interpretation of the ACA's provider non-discrimination requirements (HHS 2014).

States running a state-based exchange can issue their own regulations that comply with federal network adequacy requirements. Similarly, states running a plan management partnership exchange recommend QHP certification to HHS. This allows states to use their regulatory authority to approve network adequacy, but HHS retains the ultimate responsibility for ensuring that federal requirements are met (CMS 2013b).

Essential community providers. QHP provider networks must include a sufficient number and geographic distribution of essential community providers (ECPs), defined as providers who serve low-income, medically underserved individuals (45 CFR 156.235). An alternate standard applies to QHP issuers that provide a majority of covered services through physicians they employ or through a single contracted medical group. These issuers must have a sufficient number and geographic distribution of such providers "to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the exchange's network adequacy standards" (45 CFR 156.235(b)). To monitor inclusion of ECPs in 2014, HHS verified that the issuer: (1) contracted with at least 20 percent of the ECPs in its service area, (2) contracted with at least one ECP of each available type—FQHC, Ryan White provider, family planning provider, Indian Health provider, certain hospitals, and other providers such as tuberculosis clinics—in each county, and (3) offered a contract to all available Indian Health providers. If an issuer could not meet this standard, it was required to provide a satisfactory justification (CMS 2013a, 2013b). In 2014, issuers under the alternate standard were also required to meet the 20 percent ECP guideline or provide a satisfactory justification (CMS 2013a, 2013b).

To evaluate ECP network adequacy in 2015, CMS will verify that an issuer contracts with at least 30 percent of available ECPs in the service area or that it provides a satisfactory justification if it cannot meet this standard. In addition, issuers must offer contracts in good faith to all available Indian Health providers and to at least one ECP in each ECP category. In 2015, issuers under the alternate standard must also meet the 30 percent ECP guideline or submit a narrative justification (CMS 2014c).

Key policy issues: Network adequacy

Unlike CHIP, QHP network adequacy provisions do not require access to out-of-network care if the network is not sufficient for the enrollee's condition, though some QHPs may offer such access with higher cost sharing. Narrow provider networks in QHPs could violate the ACA's prohibition of discrimination on the basis of disability and could therefore require access to out-of-network care if in-network care is not sufficient to address the enrollee's medical needs (§1557 of the ACA, 45 CFR 156.200, Keith et al. 2013).

In contrast with QHPs, CHIP programs are not federally required to contract with ECPs. Even so, many CHIP programs have requirements that plans include FQHCs and rural health clinics (Hess et al. 2011).

Many such network adequacy requirements are established at the state level, and how they are monitored and enforced via state law, state regulations, and contracts between state agencies and health plans varies by state. In future reports, MACPAC will examine network adequacy monitoring and enforcement to provide further context to these comparisons.

A fuller picture of QHP network adequacy for children will emerge as enrollees access care throughout the first year of the program. Complaint tracking and network adequacy reports from consumer advocates may be the first signals of access issues.

While some reports suggest that narrower networks are a trend in both employer-sponsored coverage and QHPs, it will be important to monitor the effect of such networks on children's access to necessary care (Kliff 2014, McKinsey 2013).[25] For future reports, MACPAC will continue to monitor differences in network adequacy between CHIP and QHPs.

Federal Financing Issues

If CHIP funding is extended, the Congress will have to make decisions about the program's federal financing. Before describing these issues, this section provides an overview of federal CHIP financing.

Overview of CHIP financing

Federal funding for CHIP is capped and is allotted to states annually based on a methodology that relies on each state's recent CHIP spending. States have two years to spend each allotment. Thus, in FY 2014, states have their new FY 2014 allotment available to them, as well as any leftover FY 2013 funds.[26] The current CHIP allotment formula has been in place since the enactment of CHIPRA in 2009.

If a state uses all of its available FY 2013 and FY 2014 CHIP allotments in FY 2014, two other sources of additional federal CHIP funds could be made available to qualifying states: (1) the CHIPRA contingency fund and (2) FY 2012 redistribution funds from states that did not exhaust their FY 2012 allotment after two years of availability.[27] Since the contingency fund was created by CHIPRA, it has only been used for one state, in 2009.

Under the ACA, appropriations for FY 2014 and FY 2015 are higher than previous levels, but at slightly lower levels of growth (10 percent) compared to those set in CHIPRA for FY 2010 to FY 2014 (13 percent, on average).[28] Within these total appropriations, states' FY 2014 CHIP allotments were based on their FY 2012 spending, and states' FY 2015 CHIP allotments will be based on their FY 2014 spending.

Based on state estimates of their projected spending made in February 2014, federal CHIP spending in FY 2014 is projected to be $9.6 billion, 6 percent higher nationally than in FY 2013 (Appendix Table 1-A-4). This average masks variation at the state level. For example, five states are projecting increases in federal CHIP spending of at least 40 percent—South Carolina (63 percent), Alaska (42 percent), North Carolina (41 percent), Alabama (40 percent), and Kansas (40 percent).[29] On the other hand, as a result of the termination of CHIP-funded coverage of parents required by CHIPRA, New Jersey and New Mexico are projecting large declines in federal CHIP spending in FY 2014 compared to FY 2013 (47 and 43 percent, respectively).[30]

Federal financing of former CHIP children in a post-CHIP landscape

This section describes, under current law, the timing of states' exhaustion of federal CHIP funds in FY 2016 and the financing implications of children's coverage in a post-CHIP landscape.

Timing of states' exhaustion of federal CHIP funds. While no new CHIP allotments are slated for FY 2016 or after, CHIP's authorization does not expire. In FY 2016, states may continue to use any unspent FY 2015 CHIP allotments. Under current law, however, contingency fund payments are not authorized past FY 2015, so this source of funding would not be available as states run out of CHIP funds (§2104(n)(3)(A) of the Act). Any redistribution amounts available in FY 2016 would likely be small.

Under current law, states will run out of CHIP funding at various points during FY 2016, depending on a number of factors. The primary determinant of when states will exhaust their federal CHIP funds would be how much of their FY 2015 allotment remains unspent at the beginning of FY 2016. Various federal policies would also affect when states run out of federal CHIP funds. For example, the ACA included a policy that increases the federal matching rate for CHIP by 23 percentage points for FY 2016 through FY 2019 (although it cannot exceed 100 percent). Thus, beginning in FY 2016, the federal CHIP matching rates will range from 88 to 100 percent, rather than the current range of 65 to 83 percent (Appendix Table 1-A-4). This will accelerate the pace at which states will use any remaining federal CHIP funds in FY 2016. From the state perspective, states' current share of CHIP expenditures ranges by state from 17 to 35 percent; a 23-point increase in the federal share would reduce the state share to a range of 0 to 12 percent—as long as funds are available.

State policies may also affect when states exhaust their federal CHIP funding. For example, while the ACA generally prohibits reducing children's eligibility for CHIP, states are permitted to impose enrollment limits "in order to limit expenditures… to those for which Federal financial participation is available" (§2105(d)(3)(A)(iii) of the Act). Other actions states may take to reduce CHIP spending that are not prohibited under the ACA's MOE include allowing CHIP waivers to expire and cutting payments to plans and providers.

Federal funding for children if CHIP funding is exhausted. As discussed earlier, states with a Medicaid-expansion CHIP program will generally be required to continue their Medicaid coverage if CHIP funding is exhausted shortly after FY 2015 as under current law. While Medicaid's matching rate is lower than CHIP's, Medicaid's federal funding is open ended. Thus, for states relying on Medicaid expansions, there is no prospect of federal Medicaid funds running out, as with CHIP, but the state contribution would increase. A reduction from the CHIP matching rate—not including the 23-point increase for FY 2016—to Medicaid's traditional matching rate would generally increase state expenditures for those children by 43 percent. The District of Columbia and seven states operating their CHIP programs entirely as an expansion of Medicaid (Alaska, Hawaii, Maryland, New Hampshire, New Mexico, Ohio, and South Carolina) could face the largest increases in state expenditures for continuing coverage through Medicaid if federal CHIP funding and its enhanced matching rate were not available.

States with separate CHIP programs would no longer be required to provide coverage after federal CHIP funding is exhausted. Forty-three states operate some portion of their CHIP programs separate from Medicaid, including 14 states with CHIP programs wholly separate from Medicaid (Appendix Table 1-A-3). These states' only federal requirement would be to have procedures to enroll children in exchange plans that are certified as being comparable to CHIP, if available. Thus, states with a separate CHIP program could be released from any state spending, while many of those affected children would become uninsured or face significantly higher cost sharing. For children who would qualify for subsidized exchange coverage if their CHIP coverage were to end, the cost of the subsidy would be entirely federal.

The federal cost of CHIP's continuation was a major legislative issue for reauthorization in 2009, but coverage changes made by the ACA have led the Congressional Budget Office (CBO) to assume that much of the cost of a CHIP extension would be offset by reductions in other federal spending.

Under current law, if CHIP allotments are not extended past FY 2015, CBO assumes that many enrollees would receive federally subsidized coverage from other sources, including through exchanges, Medicaid, and employer-sponsored insurance. Since an extension of CHIP would replace other forms of federally subsidized coverage, federal cost estimates of extending CHIP are partially offset by reductions in other programs. On the other hand, the 23-percentage point increase in the CHIP matching rate slated under current law for FY 2016–2019 has increased the federal cost of an extension of CHIP relative to prior law.

Key policy issues: Federal financing

The prospect of CHIP funding ending shortly after FY 2015 under current law and the extension of CHIP funding through FY 2017 under the Commission's recommendation raise questions regarding the appropriate level of federal versus state financing of public coverage. How much federal financing is necessary to ensure appropriate levels of program participation—not only by individuals but also by states? The federal government also subsidizes exchange coverage and employer-sponsored insurance. Considering all of the sources of coverage subsidized by the federal government, do the levels of federal spending toward each represent the optimal use of taxpayer dollars for ensuring access to appropriate care?

If the Commission's recommendation to extend CHIP funding through FY 2017 is adopted, a new set of issues will emerge around financing children's coverage in FY 2018 as policymakers consider the future of CHIP once more.

Options for the Future of CHIP

The Commission considered several options as it examined the role of CHIP given new coverage options for low-income individuals. These included what might happen if current law were allowed to stand or if CHIP funding were extended for four years or more. It concluded, for reasons discussed below, that neither option is desirable and thus recommended two additional years of funding. This transition period, which would last through the end of FY 2017, will, in the Commission's view, provide time to address the limitations that have become evident in the availability and adequacy of pediatric coverage, particularly through exchanges. The Commission believes that these limitations must be addressed so as not to step backward from the relatively high level of good coverage children now have through CHIP.

Maintain current law

The Commission considered what would happen under the current-law scenario, under which states would exhaust CHIP funding shortly after FY 2015. It found that many children now served by the program would not have a smooth transition to another source of coverage offering comparable benefits and cost sharing. The number of uninsured children would likely rise, and the cost sharing for children obtaining other coverage would often be significantly higher. In the Commission's view, it is not clear that exchange plans are ready to serve as an adequate alternative for CHIP children in terms of covered benefits and provider networks.

Under current law, the exhaustion of CHIP funding would also have an inequitable financial impact on states. Through FY 2019, Medicaid-expansion CHIP states would be required to continue Medicaid coverage at reduced federal matching rates. Approximately 3 million children enrolled in Medicaid-expansion CHIP would be protected with continued coverage. However, states operating separate CHIP programs (now serving over 5 million children) would have no legal obligation to continue financing coverage for these children.

From the Commission's perspective, there is insufficient time between now and the end of FY 2015 to address all these issues, either in law or regulation. A time-limited extension of CHIP funding appears warranted to minimize coverage disruptions and provide for a thorough examination of the coverage options for children.

Transition funding of CHIP through FY 2019

The Commission also considered extending CHIP funding through FY 2019, consistent with the ACA's MOE. In addition to aligning coverage and financing policies, this approach would also allow for completion and consideration of the Secretary's assessment of the comparability of CHIP and exchange coverage in terms of benefits and cost sharing.

The Commission believes that coverage for children under a separate CHIP authority should not be maintained indefinitely. The optimal outcome for children and families is to address affordability and adequacy so that low- and moderate-income children can be fully integrated into other sources of coverage, including Medicaid, exchange, and employer-sponsored coverage. In order for exchange coverage to meet the affordability and care standard of CHIP, it must become more responsive to the health needs of all children, including those whose families need financial assistance in order to make coverage affordable. In the view of the Commission, health coverage for children should be high quality, affordable to families, and be integrated with the full array of coverage options.

CHIP has clearly played a historic role in reducing the number of uninsured children, and lessons learned from that experience should continue to inform public policy. But the ACA transformed the policy context for CHIP such that CHIP-funded coverage represents a small wedge among coverage options, potentially adding complexity for families and administrative costs for the states and the federal government.

We have recommended the short-term extension of CHIP to provide the impetus to make the legislative and regulatory changes necessary to smooth the transition and to make coverage options work well for CHIP children. A shorter-term extension is also more fiscally prudent.

Commission Recommendation

Recommendation 1.1

The Congress should extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

Rationale

This recommendation calls for extending federal CHIP allotments through FY 2017, thereby enabling two additional years of transition. The Congress should act soon to extend CHIP allotments through FY 2017 so that states do not respond to the uncertainty around CHIP's future by implementing policies that reduce children's access to appropriate care. This recommendation assumes no changes in any other aspect of CHIP-funded coverage as it exists under current law, including the 23-percentage-point increase in the CHIP federal matching rate slated for FY 2016 through 2019, which states have built into their budget estimates.

This short-term extension would provide an opportunity for policymakers to develop sound policies for coverage of children now served by CHIP. During this time, a thoughtful, comprehensive assessment is needed to develop and implement specific changes in public policy that will ensure adequate and affordable coverage for low-income children, equitable treatment of states, appropriate use of public dollars when private dollars may be available (for example, through employer-sponsored coverage), and smooth transitions across sources of coverage.

There are three primary reasons for this extension. First, extending CHIP would prevent increased uninsurance among children. This projected increase could be mitigated substantially if the ACA's affordability test for employer-sponsored coverage accounted for the cost of family coverage, not just self-only coverage, or to allow more low-income working families to access exchange subsidies if employer-sponsored coverage is still too costly; however, such changes would result in increased federal costs for subsidies in the exchange.

Second, in the absence of CHIP, many families would see significant increases in cost sharing for health care services. The higher cost-sharing levels for exchange coverage would increase financial burden and may raise barriers to low-income children's access to care. This could be addressed in several ways—for example, by increasing cost-sharing assistance associated with exchange coverage, offering such assistance for those with employer-sponsored insurance, or by providing wraparound cost-sharing assistance through other means. These options raise additional design questions such as which children should be eligible for these additional cost-sharing protections and how such enhancements would be financed.

Third, there is little evidence on children's experience in exchange plans to determine whether or not the plans, benefits, and networks are adequate and appropriate for children currently enrolled in CHIP. For example, while children's dental care must be covered in CHIP and made available in exchange plans, parents may find that stand-alone dental plans in exchanges are too expensive, even with the subsidies, and forgo such coverage. In addition, little is known about how exchange plans' networks compare to those in CHIP and how low-income children are faring in these plans. Evidence needs to be further developed on the adequacy of coverage for children in exchange plans.

The Commission stresses that it considers this additional funding transitional. This means that during this time period, specific steps will need to be taken to ensure that exchange coverage adequately responds to the needs of children and that other options to improve employer-sponsored and Medicaid coverage are explored. If it becomes evident during this extended transition period that more time is necessary to ensure that needed reforms are in place and that children's transition into new coverage options is appropriate, further extending this transition period should be considered. However, the Commission remains confident that the changes necessary to ensure that children have access to high-quality coverage that addresses their needs can be made during this transition period.

Implications

Federal spending. Providing federal CHIP funding for an additional two years beyond FY 2015 is projected to increase federal spending, in part because of the ACA's increase in the CHIP matching rate (23 percentage points). As a result of this increase in the matching rate, the federal government will pay for approximately 93 percent of states' CHIP expenditures during this period, up from the historical average of 70 percent of CHIP expenditures.

CBO estimates that this recommendation, to provide federal CHIP allotments for FY 2016 through 2017, would increase net federal spending by $0–5 billion above the agency's current law baseline. The federal costs of providing CHIP allotments for two more years would be largely offset by reductions in federal spending for Medicaid and subsidized exchange coverage—sources of federally subsidized coverage in which many children are assumed to enroll if CHIP funding were to be exhausted under current law. CBO's estimate also reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2015 at $5.7 billion each year.

States. This recommendation would enable states to continue providing CHIP-funded coverage for another two years to 8 million children without the risk of increased uninsurance and increased state Medicaid spending if CHIP were to end.

The effect of this recommendation would not only extend the life of CHIP but also lower state CHIP matching payments relative to what states currently pay, as the 23-point increase in the CHIP matching rate under current law goes into effect.[31]

Enrollees. The effect on CHIP enrollees of a two-year extension of CHIP will differ depending on the type of CHIP program in their state and on enrollees' circumstances. Children in Medicaid-expansion programs would experience no change, since the MOE obligates states to continue that coverage even after federal CHIP funding is exhausted. Extending CHIP through FY 2017 would ensure that children currently covered in separate CHIP programs do not become uninsured or moved to coverage that requires higher cost sharing.

Plans and providers. Extending CHIP funding would ensure that the plans and providers currently participating in CHIP could continue that coverage without disruption.

Next Steps

In future analyses and reports, the Commission will explore in greater depth the issues raised in this chapter that must be addressed before children currently enrolled in CHIP can be integrated into other sources of coverage, including coverage through Medicaid, exchanges, and employers. The Commission will explore policy options that can address these known shortcomings in children's coverage that would exist without CHIP and what the trade-offs would be for each of them. We will also examine any emerging evidence regarding children's experiences in exchange plans to determine whether other issues need to be addressed to ensure coverage is adequate and appropriate for children currently enrolled in CHIP.

Endnotes

[1] While ending CHIP would lead to some children being uninsured, the magnitude of the effect depends on a number of factors, many of which are difficult to model with precision. In addition, this estimate was modeled using data from several years ago and does not take into account that some states, most notably California, have transitioned the vast majority of their enrollees from separate CHIP to Medicaid-expansion CHIP coverage.

[2] The most commonly chosen option for benefit design among separate CHIP programs is coverage approved by the Secretary (25 programs). Among the 25 Secretary-approved separate CHIP programs, 14 of the programs are based on the Medicaid benefits package offered in the same state (Cardwell et al. 2014).

[3] This decline in private coverage could be the result of multiple factors. It could, for example, reflect a broader decline in the availability of employer-sponsored health insurance for adults and children. It could also reflect a degree of substitution of public coverage for available private coverage, which is frequently referred to as crowd-out. Researchers have struggled to answer the question of whether CHIP eligibility expansions caused crowd-out of private coverage or whether private coverage declines would have occurred regardless and CHIP prevented uninsurance. Based on a review of the most reliable studies available in 2007, CBO determined that 25 to 50 percent of the increase in public coverage resulting from CHIP was from a decline in private coverage. In other words, for every 100 children who enroll in public coverage as a result of CHIP, private coverage falls by between 25 and 50 children (CBO 2007).

[4] Under the ACA, individuals whose Medicaid or CHIP eligibility is determined based on modified adjusted gross income must face no asset test or requirement for an in-person interview (§§1413(b)(1)(A) and 2002 of the ACA). In addition, ACA regulations require states to attempt to renew eligibility on the basis of data already available to the state before requiring information from enrollees (42 CFR 435.916(a)(2) and 457.343). Prior to these requirements, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) provided bonus payments to states implementing these (and other) strategies and that increased child Medicaid enrollment by certain amounts (§104 of CHIPRA). States often used CHIP as a forerunner to test the use of these strategies before applying them to populations in Medicaid.

[5] The analysis excludes children enrolled in employer-sponsored coverage.

[6] CHIP also funds coverage of pregnant women on a limited basis. In FY 2013, 10,149 adult pregnant women received CHIP-funded coverage, excluding unborn children (MACPAC 2014a).

[7] Although all states will be eligible to receive CHIP funding for at least some children in Medicaid as of 2014 due to the implementation of two ACA requirements, 14 states are still categorized as separate programs in this report because they did not have approved state plan amendments on the Centers for Medicare & Medicaid Services (CMS) website indicating whether they will characterize themselves as combination states. The two ACA requirements are: a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid coverage, and a mandatory 5 percent of income disregard that effectively requires Medicaid coverage for all children at or below 138 percent FPL.

[8] Because the MOE is tied to eligibility policies in place on March 23, 2010, it is not clear whether states that elected to convert much of their population from separate CHIP to Medicaid-expansion coverage, such as California, would be able to remove those children from Medicaid as CHIP funding is exhausted.

[9] FY 2013 CHIP-funded enrollment reflected states' coverage of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs. The ACA requires these children to be transitioned to Medicaid-expansion CHIP coverage, which will shift an estimated 700,000 children from separate CHIP to Medicaid-expansion CHIP. In FY 2013, at least 19 states reported enrollment of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs: Alabama, Arizona, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming.

[10] For a family of three, 200 percent FPL is $39,580. For such a family, the average worker contribution for self-only coverage would comprise 2.5 percent of income, while family coverage would consume nearly 12 percent of income.

[11] While 98 percent of employees who are eligible for their employers' coverage also have access to dependent coverage, that coverage may not be practically affordable.

[12] Excludes American Indians, for whom different cost-sharing levels apply in exchange plans.

[13] MACPAC used the proposed 2015 Actuarial Value Calculator publicly available in February 2014. The calculator draws upon 2010 claims data from Health Intelligence Company, LLC, which is licensed by the Blue Cross and Blue Shield Association. The claims data are from 54 million adults and children in commercial insurance plans, representing group and individual health plans. The calculator determines actuarial values based on enrollees' cost-sharing information and a standard population representing "those likely to be covered in the individual and small group markets in 2014" (Knuth 2013).

[14] A 17th state, West Virginia, was included in the original analysis. It has since reduced its CHIP cost sharing, which would increase its actuarial value. At the time of the 2009 analysis, the actuarial value for its coverage was estimated at 92 percent.

[15] See 45 CFR 156.400 regarding the definition of de minimis variation for a silver plan variation.

[16] This assumes the mother chooses the second-lowest cost silver plan, on which the premium credits are based. If she chooses a more expensive plan, she is also responsible for the difference.

[17] MACPAC has previously discussed the states' role in benefit design in CHIP programs and defining benefit standards for exchange plans (MACPAC 2014b). For example, states can implement a Medicaid-expansion CHIP program in which federal Medicaid rules apply, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service requirements. Essential health benefits do not apply to CHIP programs. For more information on benefit design, see MACPAC 2014b and MACPAC 2013b.

[18] In the study, the GAO compared the benefit categories offered by separate CHIP programs and the EHB benchmark definition in five states. The list of services available within each category may vary among separate CHIP and EHB benchmark definitions, and therefore coverage of a specific service may vary. EHB benchmark definitions establish a minimum standard that all exchange plans must meet in order to be certified. Issuers can provide additional services or establish higher benefit limits than those established in EHB definitions. When the GAO conducted their analysis, exchange plan details were not available. As a result, actual coverage may vary from the EHB benchmark used for comparison.

[19] Stand-alone dental plans cover dental services only and must meet the state-defined pediatric oral services EHB standard (§1311(b)(2)(B)(ii) of the ACA).

[20] Individuals who purchase both separate medical and stand-alone dental plans face premium payments for each policy.

[21] Three states (Kentucky, Nevada, and Washington) require families and individuals to purchase dental coverage for children when it is not embedded within a QHP (Snyder et al. 2014).

[22] The child quality measures are not funded by CHIP and are not part of the CHIP statute, but pertain to both Medicaid and CHIP.

[23] Nationally, 43 percent of children in Medicaid and CHIP received preventive dental services in FY 2012, and 24 percent received a dental treatment service.

[24] Forty-six states, including the District of Columbia, responded to this National Academy for State Health Policy survey (Hess et al. 2011).

[25] A recent study by McKinsey & Company found that 70 percent of silver plan networks studied were narrow or ultra-narrow (McKinsey 2013).

[26] The current CHIP allotment formula has been in place since CHIPRA's enactment in 2009. For even-numbered years (FY 2010, FY 2012, and FY 2014), allotments are calculated as last year's allotment and any shortfall payments (e.g., contingency funds), increased by a state-specific growth factor. For these years, a state can also have its allotment increased to reflect a CHIP eligibility or benefits expansion. For odd-numbered years (FY 2011, FY 2013, and FY 2015), the allotments are rebased, based on last year's federal CHIP spending in each state or territory, including from contingency funds, plus its growth factor.

[27] By the beginning of FY 2014, all but five states had exhausted their FY 2012 allotments. These states' unspent amounts (Arizona for $8.5 million, Michigan for $13.8 million, New Mexico for $148.7 million, Utah for $13.8 million, and Wisconsin for $1.0 million) total $185.8 million and are available for redistribution to any state facing a shortfall of federal CHIP funds in FY 2014.

[28] Under CHIPRA, appropriations for federal CHIP allotments were as follows: $10.6 billion for FY 2009, $12.5 billion for FY 2010, $13.5 billion for FY 2011, $15.0 billion for FY 2012, and $17.4 billion for FY 2013. Under the ACA, the federal CHIP appropriations for CHIP allotments are $19.1 billion for FY 2014 and $21.1 billion for FY 2015.

[29] Even with these projected increases, these states are not expected to exhaust their available federal CHIP funding in FY 2014.

[30] CHIPRA required states to eliminate CHIP-funded coverage of parents by September 30, 2013. In FY 2013, CHIP-funded enrollment of parents existed in New Jersey (183,717), New Mexico (14,790), and Arkansas (10,425).

[31] Based on the FY 2014 and FY 2015 federal CHIP matching rates, a 23-point increase would result in no state share for CHIP expenditures in the District of Columbia and 10 states (Alabama, Arizona, Arkansas, Idaho, Kentucky, Mississippi, New Mexico, South Carolina, Utah, and West Virginia). For other states, their share of CHIP expenditures would not exceed 12 percent, compared to the current maximum of 35 percent.

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Chapter 1 Appendix

APPENDIX TABLE 1-A-1. Percentage and Number of Uninsured Children under Age 19 by State, 2012

State	Percent of Children Who Are Uninsured	Number of Uninsured Children	Share of Total Uninsured Children
United States	**7.5%**	**5,866,000**	**100.0%**
Alabama	4.4	52,000	0.9
Alaska	13.4	26,000	0.4
Arizona	13.3	227,000	3.9
Arkansas	5.9	44,000	0.7
California	8.5	829,000	14.1
Colorado	8.9	117,000	2.0
Connecticut	3.9	33,000	0.6
Delaware	3.7	<10,000	–
District of Columbia	2.7	<10,000	–
Florida	11.4	484,000	8.3
Georgia	9.5	251,000	4.3
Hawaii	3.3	11,000	0.2
Idaho	8.0	36,000	0.6
Illinois	3.7	119,000	2.0
Indiana	8.2	138,000	2.4
Iowa	4.6	35,000	0.6
Kansas	7.4	56,000	1.0
Kentucky	6.4	69,000	1.2
Louisiana	5.8	69,000	1.2
Maine	4.9	14,000	0.2
Maryland	4.2	60,000	1.0
Massachusetts	1.4	21,000	0.4
Michigan	4.5	109,000	1.9
Minnesota	5.8	79,000	1.3
Mississippi	7.8	62,000	1.1
Missouri	7.7	114,000	1.9
Montana	11.6	27,000	0.5
Nebraska	5.9	29,000	0.5
Nevada	17.0	118,000	2.0
New Hampshire	4.4	13,000	0.2
New Jersey	5.4	116,000	2.0
New Mexico	8.6	47,000	0.8
New York	4.3	196,000	3.3
North Carolina	7.6	183,000	3.1
North Dakota	7.4	12,000	0.2
Ohio	5.7	161,000	2.8
Oklahoma	10.7	106,000	1.8
Oregon	6.0	54,000	0.9
Pennsylvania	5.2	152,000	2.6
Rhode Island	5.8	14,000	0.2
South Carolina	8.4	97,000	1.7
South Dakota	4.2	<10,000	–
Tennessee	5.9	94,000	1.6
Texas	13.0	958,000	16.3
Utah	9.8	91,000	1.6
Vermont	3.0	<10,000	–
Virginia	5.9	117,000	2.0
Washington	5.9	99,000	1.7
West Virginia	4.6	19,000	0.3
Wisconsin	4.9	69,000	1.2
Wyoming	10.2	15,000	0.3

Notes: Because three states and the District of Columbia are estimated to have less than 10,000 uninsured children, specific estimates are not provided due to concerns about the lack of precision. All other estimates are rounded to the nearest thousand. Dashes indicate the share of the national total is not included because the estimated number of children is below 10,000.

Source: Analysis for MACPAC by Social & Scientific Systems of 2012 data from the American Community Survey (ACS).

APPENDIX TABLE 1-A-2. Children's Medicaid/CHIP Participation Rates and Number and Share of Children under Age 19 Eligible for Medicaid or CHIP but Uninsured, by State, 2012

State	Children's Medicaid/CHIP Participation Rate	Estimated Number of Children Eligible but Uninsured	Share of National Total of Children Eligible but Uninsured
United States	**88.1%**	**3,722,000**	**100.0%**
Massachusetts	97.4	12,000	0.3
District of Columbia	97.1	< 10,000	–
Vermont	95.2	< 10,000	–
Maine	94.0	< 10,000	–
Delaware	93.9	< 10,000	–
Arkansas	93.9	22,000	0.6
Illinois	93.8	81,000	2.2
Connecticut	93.0	19,000	0.5
Alabama	92.6	40,000	1.1
Hawaii	92.6	< 10,000	–
Louisiana	92.5	44,000	1.2
New York	92.4	147,000	3.9
Michigan	92.2	71,000	1.9
South Dakota	92.1	< 10,000	–
Maryland	91.9	37,000	1.0
West Virginia	91.1	15,000	0.4
Rhode Island	90.4	< 10,000	–
Tennessee	90.3	64,000	1.7
Mississippi	90.3	41,000	1.1
Oregon	90.2	38,000	1.0
Kentucky	90.2	43,000	1.1
Iowa	89.8	27,000	0.7
New Hampshire	89.7	< 10,000	–
North Carolina	89.6	107,000	2.9
Ohio	89.5	108,000	2.9
Pennsylvania	89.4	115,000	3.1
Washington	89.4	67,000	1.8
New Mexico	89.3	30,000	0.8
Wisconsin	88.7	53,000	1.4
New Jersey	88.7	78,000	2.1
Nebraska	88.5	17,000	0.5
Virginia	87.5	67,000	1.8
South Carolina	87.5	63,000	1.7
California	87.0	570,000	15.3
Kansas	86.4	37,000	1.0
Idaho	86.3	22,000	0.6
Georgia	85.8	167,000	4.5
Oklahoma	85.8	62,000	1.7
Missouri	85.5	88,000	2.4
Florida	85.5	270,000	7.3
Minnesota	85.3	58,000	1.6
Wyoming	85.2	< 10,000	–
Colorado	85.0	69,000	1.8
North Dakota	84.5	< 10,000	–
Indiana	84.4	102,000	2.7
Texas	84.3	516,000	13.9
Arizona	81.8	136,000	3.6
Alaska	81.7	11,000	0.3
Montana	81.0	20,000	0.5
Utah	75.8	58,000	1.6
Nevada	70.6	75,000	2.0

Notes: Estimates reflect adjustments for possible misreporting of coverage on the American Community Survey (ACS). For the nine smallest states and the District of Columbia, all of which have estimated totals that are below 10,000, specific estimates are not provided because of concerns about the lack of precision. All other estimates are rounded to the nearest thousand. Dashes indicate the share of the national total is not included because the estimated number of children is below 10,000.

Source: Kenney and Anderson 2014.

APPENDIX TABLE 1-A-3. CHIP Enrollment (FY 2013) and Income Eligibility Levels (January 2014) by Program Type and State

State	Program Type[1] (as of January 1, 2014)	Children in Medicaid-Expansion CHIP[1]				Children in Separate CHIP							Total CHIP-Funded Child Enrollment
						Separate CHIP: Age 0–18				Separate CHIP: Unborn		Total Separate CHIP Enrollment	
		Infants <1	Age 1–5	Age 6–18	Enrollment	Infants <1	Age 1–5	Age 6–18	Enrollment	Eligibility	Enrollment		
Total	–	–	–	–	**2,481,333**	–	–	–	**5,338,939**	–	**310,521**	**5,649,460**	**8,130,793**
Alabama	Separate	–[2]	–[2]	108–146% FPL	–	147–317% FPL	147–317% FPL	147–317% FPL	113,490	–	–	113,490	113,490
Alaska	Medicaid expansion	160–208% FPL	160–208% FPL	125–208	16,566	–	–	–	–	–	–	–	16,566
Arizona	Separate	–[2]	–[2]	105–138	–	153–205	147–205	139–205	80,238	–	–	80,238	80,238
Arkansas	Combination	143–216	143–216	108–216	106,413	–	–	–	–	0–216% FPL	2,888	2,888	109,301
California[3]	Combination	209–266	143–266	109–266	510,424	267–321/416	267–321/416	267–321/416	975,699	0–313	117,160	1,092,859	1,603,283
Colorado[4, 5]	Combination	–[2]	–[2]	109–147	–	148–265	148–265	148–265	126,169	–	–	126,169	126,169
Connecticut	Separate	–[2]	–[2]	–[2]	–	202–323	202–323	202–323	18,999	–	–	18,999	18,999
Delaware	Combination	195–217	–[2]	111–138	79	–	148–217	139–217	8,535	–	4,566	13,101	13,180
District of Columbia	Medicaid expansion	207–324	147–324	113–324	9,057	–	–	–	–	–	–	–	9,057
Florida	Combination	193–211	–[2]	113–138	1,072	–	146–215	139–215	472,343	–	–	472,343	473,415
Georgia	Separate	–[2]	–[2]	114–138	–	211–252	155–252	139–252	269,906	–	–	269,906	269,906
Hawaii	Medicaid expansion	192–313	140–313	106–313	30,979	–	–	–	–	–	–	–	30,979
Idaho	Combination	–[2]	–[2]	108–138	19,881	148–190	148–190	139–190	25,518	–	–	25,518	45,399
Illinois	Combination	–[2]	–[2]	109–147	162,134	148–318	148–318	148–318	149,685	0–205	25,278	174,963	337,097
Indiana	Combination	158–213	142–163	107–163	105,655	214–255	164–255	164–255	46,760	–	–	46,760	152,415
Iowa	Combination	241–380	–[2]	123–172	22,159	–	173–307	173–307	61,511	–	–	61,511	83,670
Kansas	Separate	–[2]	–[2]	114–138	–	172–250	155–250	139–250	76,164	–	–	76,164	76,164
Kentucky	Combination	–[2]	143–164	110–164	51,391	201–218	165–218	165–218	32,678	–	–	32,678	84,069
Louisiana	Combination	143–217	143–217	109–217	140,876	218–255	218–255	218–255	4,956	0–205	4,136	9,092	149,968
Maine	Combination	–[2]	141–162	133–162	19,071	197–213	163–213	163–213	10,641	–	–	10,641	29,712
Maryland	Medicaid expansion	195–322	139–322	110–322	135,454	–	–	–	–	–	–	–	135,454
Massachusetts	Combination	186–205	134–155	115–155	69,113	206–305	156–305	156–305	70,735	0–205	8,871	79,606	148,719
Michigan	Combination	–[2]	144–165	110–165	19,229	201–217	166–217	166–217	62,985	0–190	7,456	70,441	89,670
Minnesota	Combination	276–288	–[2]	–[2]	91	–	–	–	–	0–283	3,744	3,744	3,835
Mississippi	Separate	–[2]	–[2]	108–138	–	200–214	149–214	139–214	93,120	–	–	93,120	93,120
Missouri	Combination	–[2]	–[2]	111–153	55,017	202–305	154–305	154–305	37,901	–	–	37,901	92,918
Montana[5]	Combination	–[2]	–[2]	110–148	–	149–266	149–266	149–266	31,496	–	–	31,496	31,496
Nebraska	Combination	163–218	148–218	112–218	53,790	–	–	–	–	0–202	1,993	1,993	**55,783**
Nevada[5]	Combination	–[2]	–[2]	123–138	–	165–205	165–205	139–205	20,277	–	–	20,277	**20,277**
New Hampshire	Medicaid expansion	197–323	197–323	197–323	19,450	–	–	–	–	–	–	–	**19,450**
New Jersey	Combination	–[2]	–[2]	108–147	90,512	200–355	148–355	148–355	116,249	–	–	116,249	**206,761**

APPENDIX TABLE 1-A-3, Continued

		Children in Medicaid-Expansion CHIP[1]				Children in Separate CHIP							
						Separate CHIP: Age 0–18				Separate CHIP: Unborn			
State	**Program Type[1] (as of January 1, 2014)**	**Infants <1**	**Age 1–5**	**Age 6–18**	**Enrollment**	**Infants <1**	**Age 1–5**	**Age 6–18**	**Enrollment**	**Eligibility**	**Enrollment**	**Total Separate CHIP Enrollment**	**Total CHIP-Funded Child Enrollment**
New Mexico	Medicaid expansion	201–305	201–305	139–245	9,368	–	–	–	–	–	–	–	**9,368**
New York[5]	Combination	197–223	–[2]	111–154	–	224–405	155–405	155–405	490,114	–	–	490,114	**490,114**
North Carolina	Combination	195–215	142–215	108–138	81,656	–	–	139–216	201,916	–	–	201,916	**283,572**
North Dakota	Combination	–[2]	–[2]	112–138	2,331	153–175	153–175	139–175	8,950	–	–	8,950	**11,281**
Ohio	Medicaid expansion	142–211	142–211	108–211	286,817	–	–	–	–	–	–	–	**286,817**
Oklahoma	Combination	170–210	152–210	116–210	140,373	–	–	–	456	0–190	7,082	7,538	**147,911**
Oregon	Separate	–[2]	–[2]	–[2]	–	191–305	139–305	139–305	124,731	0–190	3,330	128,061	**128,061**
Pennsylvania	Separate	–[2]	–[2]	120–138	–	221–319	163–319	139–319	267,073	–	–	267,073	**267,073**
Rhode Island	Combination	–[2]	–[2]	110–266	24,508	–	–	–	–	0–258	2,069	2,069	**26,577**
South Carolina	Medicaid expansion	195–213	144–213	108–213	76,191	–	–	–	–	–	–	–	**76,191**
South Dakota	Combination	178–187	178–187	125–187	13,357	188–209	188–209	188–209	4,275	–	–	4,275	**17,632**
Tennessee	Combination	–[2]	–[2]	110–138	22,906	201–255	148–255	139–255	72,695	0–255	10,872	83,567	**106,473**
Texas	Separate	–[2]	–[2]	101–138	–	204–206	150–206	139–206	939,469	0–205	95,144	1,034,613	**1,034,613**
Utah	Separate	–[2]	–[2]	106–138	–	145–205	145–205	139–205	63,001	–	–	63,001	**63,001**
Vermont	Separate	–[2]	–[2]	–[2]	–	238–317	237–317	237–317	7,393	–	–	7,393	**7,393**
Virginia	Combination	–[2]	–[2]	110–148	92,690	149–205	149–205	149–205	104,221	–	–	104,221	**196,911**
Washington	Separate	–[2]	–[2]	–[2]	–	213–305	213–305	213–305	32,139	0–198	11,934	44,073	**44,073**
West Virginia	Separate	–[2]	–[2]	109–138	–	164–305	147–305	139–305	37,065	–	–	37,065	**37,065**
Wisconsin	Combination	189–306	–[2]	102–156	92,723	–	192–306	157–306	70,571	0–305	3,998	74,569	**167,292**
Wyoming	Separate	–[2]	–[2]	120–138	–	160–205	160–205	139–205	8,815	–	–	8,815	**8,815**

Notes: FPL is federal poverty level. FY is fiscal year. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half), the individual would only be counted in the most recent category. Enrollment data shown in table are as of March 4, 2014; states may subsequently revise their current or historical data.

1 Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches. However, due to a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid eligibility levels by 5 percentage points, all states in 2014 are eligible to receive CHIP funding for at least some Medicaid-enrolled children. In addition, beginning in 2014, several states (including those previously considered separate CHIP programs) will have Medicaid-expansion CHIP enrollment due to a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL from separate CHIP programs to Medicaid; the 16 states with an upper-income level of 138 percent FPL are those that waited until after 2013 to transition these children. For five states (Nevada, North Dakota, South Carolina, Texas, and Utah), the income ranges for children in Medicaid-expansion CHIP do not reflect eligibility for CHIP-financed coverage solely due to the elimination of an asset test in Medicaid after 1997; in these states, affected children at Medicaid income-eligibility levels may qualify for CHIP-financed coverage.

2 Medicaid-expansion CHIP eligibility ranges of 5 percentage points attributable to the mandatory 5 percent disregard are not shown.

3 During 2013, California transitioned most of its separate CHIP children into a Medicaid-expansion CHIP program. California has a separate CHIP program in three counties that covers children up to 321 percent FPL and in one county up to 416 percent FPL.

4 Colorado data are from FY 2012.

5 Montana, Nevada, and New York were combination programs in FY 2013 but did not report any Medicaid-expansion enrollees in the CHIP Statistical Enrollment Data System (SEDS). Colorado became a combination program in FY 2013 but had not yet reported any SEDS data for that year as of March 4, 2014; as a result, FY 2012 data shown here do not include Medicaid-expansion enrollees.

Sources: For numbers of children: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) from Centers for Medicare & Medicaid Services (CMS) as of March 4, 2014; MACPAC 2014a.

APPENDIX TABLE 1-A-4. Projected Federal CHIP Spending, by State and Program Type, and Federal Matching Rates, FY 2014

	States' Projections of FY 2014 CHIP Spending (dollars in thousands)								
	Medicaid-expansion CHIP		Separate CHIP and administration		Total CHIP		FY 2014 CHIP Matching Rate	FY 2014 Medicaid Matching Rate	CHIP Matching Rate Plus 23 Percentage Points
State	Total	Federal	Total	Federal	Total	Federal			
Total	**$5,808,957**	**$4,082,044**	**$7,885,509**	**$5,556,158**	**$13,694,466**	**$9,638,202**	–	–	–
Alabama	48,105	37,368	224,368	174,292	272,473	211,660	77.68%	68.12%	100.00%
Alaska	42,915	28,005	3,276	2,130	46,191	30,135	65.00	50.00	88.00
Arizona	68,853	52,013	32,543	25,064	101,396	77,077	77.06	67.23	100.00
Arkansas	48,332	38,216	26,350	19,336	74,682	57,552	79.07	70.10	100.00
California	1,870,825	1,216,036	522,699	339,783	2,393,524	1,555,819	65.00	50.00	88.00
Colorado	51,509	33,481	182,430	118,580	233,939	152,061	65.00	50.00	88.00
Connecticut[1]	0	21,646	30,618	19,901	30,618	41,547	65.00	50.00	88.00
Delaware	775	535	24,026	16,514	24,801	17,049	68.72	55.31	91.72
District of Columbia	18,545	14,650	265	210	18,810	14,860	79.00	70.00	100.00
Florida	73,444	52,256	551,831	391,518	625,275	443,774	71.15	58.79	94.15
Georgia	45,688	34,792	432,396	329,270	478,084	364,062	76.15	65.93	99.15
Hawaii	46,169	30,418	2,639	1,748	48,808	32,166	66.30	51.85	89.30
Idaho	20,878	16,730	31,936	25,861	52,814	42,591	80.15	71.64	100.00
Illinois	146,682	96,515	359,223	233,569	505,905	330,084	65.00	50.00	88.00
Indiana	121,400	93,490	52,641	40,449	174,041	133,939	76.84	66.92	99.84
Iowa	30,559	21,558	114,517	80,792	145,076	102,350	70.55	57.93	93.55
Kansas[2]	0	0	105,334	73,566	105,334	73,566	69.84	56.91	92.84
Kentucky	120,183	94,800	70,207	55,379	190,390	150,179	78.88	69.83	100.00
Louisiana	175,925	127,880	32,202	23,408	208,127	151,288	72.69	62.11	95.69
Maine	22,757	16,633	16,279	11,898	39,036	28,531	73.09	61.55	96.09
Maryland	268,439	174,485	22,532	14,645	290,971	189,130	65.00	50.00	88.00
Massachusetts	241,330	156,865	287,497	186,874	528,827	343,739	65.00	50.00	88.00
Michigan	20,373	15,569	129,027	98,603	149,400	114,172	76.42	66.32	99.42
Minnesota[1]	125	21,853	25,620	16,737	25,745	38,590	65.00	50.00	88.00
Mississippi[2]	0	0	215,133	174,558	215,133	174,558	81.14	73.05	100.00
Missouri	122,619	90,033	68,408	50,232	191,027	140,265	73.42	62.03	96.42
Montana	2,508	1,917	79,306	68,990	81,814	70,907	76.43	66.33	99.43
Nebraska	63,426	43,333	10,680	7,295	74,106	50,628	68.32	54.74	91.32
Nevada	3,305	2,451	38,222	28,350	41,527	30,801	74.17	63.10	97.17
New Hampshire[1]	20,763	16,331	557	362	21,320	16,693	65.00	50.00	88.00

APPENDIX TABLE 1-A-4, Continued

	States' Projections of FY 2014 CHIP Spending (dollars in thousands)								
	Medicaid-expansion CHIP		Separate CHIP and administration		Total CHIP		FY 2014 CHIP Matching Rate	FY 2014 Medicaid Matching Rate	CHIP Matching Rate Plus 23 Percentage Points
State	Total	Federal	Total	Federal	Total	Federal			
New Jersey	$211,456	$137,446	$263,807	$171,475	$475,263	$308,921	65.00%	50.00%	88.00%
New Mexico	78,405	61,457	1,101	868	79,506	62,325	78.44	69.20	100.00
New York	276,714	179,864	761,735	495,193	1,038,449	675,057	65.00	50.00	88.00
North Carolina	139,444	106,047	418,555	318,311	557,999	424,358	76.05	65.78	99.05
North Dakota	12,244	7,953	17,659	11,478	29,903	19,431	65.00	50.00	88.00
Ohio	416,731	308,840	10,145	7,519	426,876	316,359	74.11	63.02	97.11
Oklahoma	168,541	126,086	12,717	9,513	181,258	135,599	74.81	64.02	97.81
Oregon[2]	0	0	223,333	165,713	223,333	165,713	74.20	63.14	97.20
Pennsylvania[2]	0	0	433,426	292,413	433,426	292,413	67.46	53.52	90.46
Rhode Island	52,164	33,948	19,402	12,633	71,566	46,581	65.08	50.11	88.08
South Carolina	203,949	161,902	12,274	9,746	216,223	171,648	79.40	70.57	100.00
South Dakota	18,027	12,157	7,083	4,778	25,110	16,935	67.48	53.54	90.48
Tennessee	72,656	55,000	225,900	170,894	298,556	225,894	75.70	65.29	98.70
Texas	235,362	167,296	1,204,118	855,861	1,439,480	1,023,157	71.08	58.69	94.08
Utah[2]	0	0	49,685	39,400	49,685	39,400	79.24	70.34	100.00
Vermont[1]	0	6,774	9,634	6,607	9,634	13,381	68.58	55.11	91.58
Virginia	127,467	82,853	209,401	136,111	336,868	218,964	65.00	50.00	88.00
Washington[1]	0	12,000	137,793	89,565	137,793	101,565	65.00	50.00	88.00
West Virginia	19,900	15,872	52,699	42,034	72,599	57,906	79.76	71.09	100.00
Wisconsin[1]	79,465	56,690	104,908	74,841	184,373	131,531	71.34	59.06	94.34
Wyoming[2]	0	0	17,372	11,291	17,372	11,291	65.00	50.00	88.00

Notes: FY is fiscal year.

[1] These are states with some projected Medicaid-expansion CHIP spending that is entirely federal, per Section 2105(g) of the Social Security Act, which permits qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level.

[2] Although every state should have some Medicaid-expansion CHIP spending in FY 2014 because of the new mandatory 5 percentage point disregard that applies in both Medicaid and CHIP, these states are projecting no Medicaid-expansion CHIP spending.

Source: MACPAC analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data from the Centers for Medicare & Medicaid Services (CMS) as of February 2014.

CHAPTER 2

Medicaid's Role in Providing Assistance with Long-Term Services and Supports

Key Points

Medicaid's Role in Providing Assistance with Long-Term Services and Supports

- Medicaid plays a major role in financing long-term services and supports (LTSS) for individuals who are functionally impaired, disabled, and critically ill, accounting for 61 percent of total national spending on LTSS in fiscal year (FY) 2012. This role will likely increase as the population ages and more individuals with disabling conditions live longer.
- Medicaid enrollees who use LTSS are a diverse group, from young to old, with many different types of physical, cognitive, and mental disabilities. They include:
    - working adults with significant physical disabilities,
    - children who are medically fragile,
    - individuals age 65 and older,
    - people with intellectual and developmental disabilities, and
    - individuals who are severely mentally ill.
- Patterns of use vary considerably across different subpopulations of LTSS users. For example, individuals dually enrolled in Medicare and Medicaid have high per enrollee spending on institutional LTSS. Non-dually enrolled individuals are more likely to use home and community-based services (HCBS).
- Although LTSS users make up a small portion of total Medicaid enrollees—just over 6 percent in FY 2010—these individuals account for almost half of all Medicaid spending.
- Medicaid LTSS is not a system that was purposefully built, but rather one that evolved over time out of legacy programs that were designed to meet the needs of different populations, differing state approaches to policy, court decisions, client advocacy, and changing ideas about where and how LTSS should be provided. The resulting patchwork of services and eligibility policies—which differ by state, enrollee group, statutory authority, and other factors—determines what services enrollees ultimately receive.
- While flexibility in LTSS benefit design and payment methods have allowed states to target groups of enrollees and to test new models, the broad array of programs and the lack of standardization make it difficult to determine which strategies best manage costs and improve the efficiency and effectiveness of care.
- MACPAC's future work on Medicaid LTSS will focus on building a better understanding and moving policy in the direction of a more efficient and effective system of LTSS. This includes examining the design and policy issues associated with the movement to managed long-term services and supports (MLTSS), studying the use of HCBS waivers, assessing the merits of moving to standardized functional assessments for Medicaid LTSS, and analyzing how to improve data on LTSS to support policy analysis, evaluation, and future program design.

CHAPTER 2

Medicaid's Role in Providing Assistance with Long-Term Services and Supports

One of the distinguishing features of the Medicaid program is its major role in financing long-term services and supports (LTSS) for populations who are functionally impaired, disabled, and critically ill. LTSS generally focus on maintaining (and sometimes improving) functioning, for example, providing assistance with basic tasks of everyday life, such as bathing or dressing, or with skills related to independent living such as preparing meals and managing money. Some are provided in institutional settings such as nursing homes, others in the community. They may be needed on a regular or occasional basis, for a few months or for many years.

Medicaid is the primary payer for LTSS in the United States, and as the population ages and technology allows persons with disabilities to live longer, its role in the provision of these services will likely increase. In 2012 Medicaid accounted for 61 percent of total national spending on LTSS—$134.1 billion (O'Shaughnessy 2014).

When it comes to LTSS, there are no simple solutions and no single path to a more efficient and effective system of high-quality care for a highly diverse population that includes frail individuals age 65 and older, adults and children with physical disabilities, persons with intellectual disabilities, and individuals who are severely mentally ill. Medicaid policies are extraordinarily complex, reflecting the program's evolution from an era in which most persons with disabilities resided in institutions to one where services are increasingly provided elsewhere, and responsibilities for administration are sometimes shared among multiple state agencies.

This system was not purposefully built, but rather evolved over time from public programs that primarily cared for poor and disabled populations living in institutional settings. New eligibility pathways and different types of benefits have been created, particularly through waiver programs designed to provide alternatives to institutional care. States have tailored their eligibility policies and applied for waivers to manage the number of individuals served and the breadth of services covered.

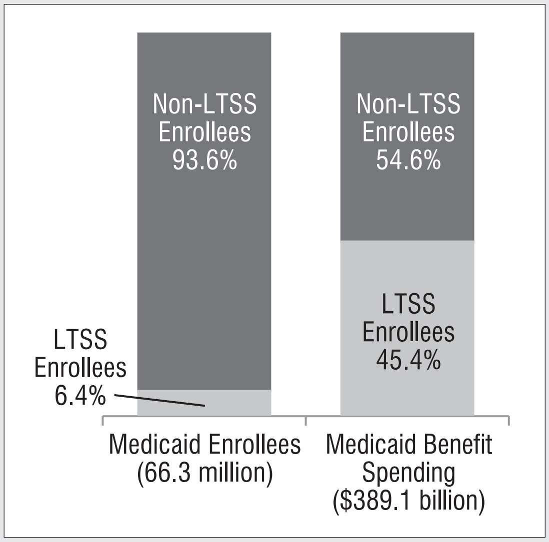
Enrollees who use LTSS are a diverse group, from young to old, with many different types of physical, cognitive, and mental disabilities. They include, among others: working adults with significant physical disabilities; children who are medically fragile and dependent on sophisticated medical technology, as well as those with autism spectrum disorders; individuals age 65 and older with advanced stages of dementia or multiple chronic conditions; people with intellectual disabilities; and those with severe mental illness. They use different types and mixes of LTSS. Their use of acute care services also varies, and they have different levels of family support. Like other Medicaid enrollees, most of these individuals have modest incomes. Some depleted their personal savings paying out of pocket for these services before becoming eligible. Others continue to spend down their income each month, helping to provide for some of the cost of their care in institutional and community settings.

The number of LTSS users overall, and those covered by Medicaid, is increasing. The number of older Americans is expected to more than double by 2050, with many people living longer (Census Bureau 2010). With advancing age comes the likelihood of increased disability, frailty, and chronic illness. The prevalence of other conditions that often require LTSS—such as autism spectrum disorder—have also been increasing over time independent of age (CDC 2014). In addition, people born with developmental or other disabilities or who suffer incapacitating injuries—such as traumatic brain injury—have greatly improved survival rates, but may need assistance throughout their lives.

In this report, MACPAC has turned its attention to better understanding how Medicaid enrollees use LTSS. This inquiry arises from several concerns. First, although LTSS users make up a small portion of total Medicaid enrollees, they account for a substantial share of Medicaid expenditures. In fiscal year (FY) 2010, just over 6 percent of all Medicaid enrollees used LTSS, and total Medicaid spending on these individuals accounted for almost half of all Medicaid spending (Figure 2-1). Their LTSS spending was high, at a per full-year equivalent (FYE) enrollee average of $31,989 (out of an average of $45,753 for all Medicaid services, including acute-care services) (MACPAC 2014a). With the aging of the population and the growth in Medicaid enrollment among individuals who qualify on the basis of a disability, these costs are expected to grow, creating new stresses on state and federal budgets.

Second, these expenditure patterns reflect the experience of vulnerable individuals with significant needs for medical care and high use of costly, intensive, and ongoing supportive services

FIGURE 2-1. Medicaid Enrollment and Benefit Spending by LTSS Utilization, FY 2010



Notes: LTSS refers to long-term services and supports. FY refers to fiscal year. Medicaid enrollees include individuals dually eligible for Medicaid and Medicare. Expenditures are for enrollees who used any LTSS and include expenditures for both acute care and LTSS. Medicaid benefit spending from MSIS has been adjusted to match CMS-64 totals based on the methodology described in Section 5 of MACStats in MACPAC's June 2013 report to the Congress. Amounts in the June 2014 MACStats differ and are not directly comparable to those shown here because they reflect more recent (FY 2011) data and an update to the methods used to adjust benefit spending; see Section 5 of the June 2014 MACStats for details.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data as of September 2013 and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2013.

such as personal care, home health care, therapies, and long-stay institutional care that are not usually covered by any payer except Medicaid. One of the key challenges is how to support their care and to provide the most cost-effective and high-quality services to these enrollees.

Given the significant spending on LTSS and the likelihood that it will continue to drive Medicaid budgets, policymakers are searching for ways to manage costs and to improve the efficiency and effectiveness of care. In addition, they are seeking to address enrollees' preferences and comply with the Supreme Court's 1999 decision in *Olmstead v. L.C.* to furnish services in the most integrated setting appropriate to an individual's needs by shifting service delivery away from institutions to home and community-based settings. They are also looking at how to better integrate acute care and LTSS and how to better match services to the needs of individuals with different types of disabilities and for whom there are likely to be different goals for care.

As MACPAC considers how the Medicaid program is serving high-cost, high-need enrollees, this chapter looks at one slice of this population and their experience—focusing on the policies and practices affecting access to and use of LTSS. MACPAC's work here is primarily descriptive, building a knowledge base about these individuals and how they interact with the Medicaid program.

The chapter begins by describing the evolution of Medicaid's role in providing LTSS. Medicaid policies affecting LTSS users have become increasingly complex over the years, with services financed and delivered in a siloed rather than an integrated manner. Over time, new programs and benefits have been added. Legal decisions have established rights for persons with disabilities and fostered a transition away from institutional settings, and multiple state agencies have become involved in the administration of the program. As a result, the overall design of Medicaid's approach to financing LTSS has become less coherent. While each element has a rationale and backstory, as a whole, it appears more accidental than systematic.

The chapter then describes LTSS users along several dimensions: how they become eligible for Medicaid, the types of services they use, and their use of services. Understanding who currently uses Medicaid LTSS, their routes to eligibility, and the extent to which policies for eligibility and coverage of benefits affect the services they receive is a necessary first step in considering how to create more rational, equitable, and effective policy for the future.

Although MACPAC has reported in the past on how Medicaid works for people with disabilities—both those enrolled only in Medicaid and those dually enrolled in Medicare and Medicaid—this is a first step in MACPAC's inquiry specific to LTSS. The chapter concludes with a discussion of policy areas that the Commission will explore in greater depth in the months ahead.

Medicaid LTSS: Program or Patchwork?

Medicaid LTSS rules for eligibility, covered benefits, and access to services vary substantially across states and among the populations receiving care. This system evolved over time from legacy programs designed to meet the needs of different populations, differing state approaches to policy, court decisions, client advocacy, and changing ideas about where and how LTSS should be provided.

When enacted, Medicaid LTSS were almost exclusively provided to public assistance recipients in institutions. Over time, there was a shift in federal policies allowing coverage of individuals who did not receive public assistance but who had extremely high medical expenses. With this shift, states were able to extend coverage to individuals and families who did not previously meet public welfare requirements (i.e., those who were not aged, blind, disabled, or families with dependent children) but whose spendable income was above the level permitted for cash assistance but did not exceed 133 percent of the public assistance standard. These three populations (aged, blind, and disabled) still account for the majority of Medicaid LTSS spending on both institutional and home and community-based services (HCBS), primarily through the personal care option, the HCBS waiver program, and the home health benefit.

The following section describes the ways in which many factors contribute to the increasing complexity of the LTSS landscape for the heterogeneous population of LTSS users. These factors include waivers, federal policy, litigation and the distribution of administrative responsibilities.

Waivers. New programs or benefits were added to respond to the concerns of specific LTSS users. In particular, in 1981, Section 1915(c) HCBS waivers were established to allow states to provide LTSS to enrollees in community-based settings. Most Medicaid HCBS are now provided under waiver authority. Waiver programs allow states to provide specific HCBS to targeted populations, cap enrollment, and to require mandatory enrollment in managed care for exempt populations. The eligibility requirements, services available, and operational elements of HCBS waivers are described later in the chapter.

The proliferation of waivers, however, can be administratively burdensome for states and may in some cases confuse enrollees who do not know the tradeoffs in benefits of various waiver programs for which they might be eligible. States are able to consolidate multiple waivers under either Section 1915(c) or Section 1115 waiver authority (CMS 2014a). Given the ability to combine multiple existing waiver programs into fewer waivers and new authority to provide HCBS under a state plan, states have options to reduce this complexity. However, states continue to weigh the flexibility offered by waivers in targeting populations against the administrative complexity of managing multiple waivers.

The complexities of implementing HCBS waivers make it hard to understand the use of such waivers across the entire Medicaid program. For example, Medicaid claims data do not always contain clear information about the specific services provided under waivers. In addition, basic information, such as functional eligibility thresholds and other cost containment strategies (e.g., whether and how a state maintains waiting lists for waiver services) are contained within waiver documents and other subregulatory policies that are challenging to catalogue. Finally, subregulatory guidance may be implemented inconsistently, which could result in some previously approved practices being disapproved at later points.

Federal legislation. Recent federal laws have expanded access to Medicaid HCBS. For example the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) created the Money Follows the Person (MFP) demonstration grant program, which provided states with additional resources to transition individuals from institutions to HCBS. This legislation also allowed states to provide HCBS under the Medicaid state plan without obtaining a waiver under Section 1915(c) (§1915(i) of the Social Security Act (the Act)).

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended) also expanded eligibility further and allowed states to provide Medicaid LTSS to more individuals in a community setting. For example, the Community First Choice (CFC) program (§1915(k) of the Act) gives states the option of providing HCBS to individuals who are eligible for Medicaid and have incomes below 150 percent of the federal poverty level (FPL) but who may not meet institutional level-of-care (LOC) criteria, or those with institutional LOC needs whose incomes exceed 150 percent FPL (CMS 2011). The ACA also includes the Health Homes option, extension and modification of the

MFP demonstration, establishment of the state Balancing Incentive Payments (BIP) program, and others (§1945 of the Act and §2403, §10202 and §2602 of the ACA).

These options provide states with new mechanisms for providing LTSS and for those that increase the proportion of spending on certain LTSS to receive enhanced federal matching payments. As of 2013, all but three states plan to pursue or are pursuing at least one ACA option, but it is too early to determine the full impact of the various LTSS options on spending and beneficiary outcomes (O'Shaughnessy 2013).

Litigation. Legal decisions, such as the Supreme Court *Olmstead v. L.C.* ruling in 1999, have also shaped the complex LTSS landscape. The *Olmstead* decision interpreted Title II of the Americans with Disabilities Act (ADA, P.L. 101-336) and its implementing regulations that oblige states to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (28 CFR 35.130(d)). States must now operate public programs (including Medicaid) in a non-discriminatory fashion and furnish services in the most integrated setting appropriate to an individual's needs, requiring placement of persons with disabilities in community settings rather than institutions.

The *Olmstead* ruling on state LTSS policies has been a major factor in the increased use of HCBS. The national share of Medicaid spending on HCBS has more than doubled from 20 percent of Medicaid LTSS spending in 1995 to 45 percent of Medicaid LTSS spending in 2011 (KCMU 2014a).

Other federal court decisions have clarified states' responsibilities related to LTSS. Federal courts have ruled consistently that the ADA's protections apply to persons living in the community, not just to persons already institutionalized. The suits filed under the ADA have reinforced states' obligations to operate state Medicaid programs in a way that does not lead to unnecessary institutionalization (NSCLC 2010).

In challenges related to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, courts have ordered state Medicaid agencies to develop and provide specific types of LTSS (e.g., intensive community-based mental health services) for enrollees.[1] Further, both in class actions and individual actions, courts have ordered Medicaid agencies to provide a certain level of Medicaid benefits beyond what was originally granted by the agency.[2] And although the Medicare program plays a much smaller role in providing LTSS than does Medicaid, a recent case affecting Medicare coverage of skilled care services (*Jimmo v. Sebelius*) raises questions about the extent to which Medicaid and Medicare will be responsible for covering such services to those dually enrolled in both programs.[3]

Medicaid LTSS have been affected by other federal litigation. For example, the Civil Rights of Institutionalized Persons Act (P.L. 96-247) authorizes the Attorney General of the United States to investigate conditions at certain residential institutions operated by state governments—including Medicaid-funded LTSS facilities. This law has resulted in multiple settlement agreements between the U.S. Department of Justice and states that required changes to certain elements of the Medicaid LTSS benefits offered by the states (DOJ 2012).

Shared administrative responsibility. The provision of Medicaid LTSS also differs by state because administration may be shared among multiple state agencies. Under federal regulations, the Medicaid agency is responsible for ensuring that LTSS is operating in accordance with federal requirements (42 CFR 431.10), even if LTSS may be operated by another state agency. Agreements among agencies specify the delegation of administrative and operational activities and functions that the other agency can perform under the supervision of the Medicaid agency. State agencies involved in LTSS typically include offices on aging, developmental disabilities agencies, and mental health authorities for the populations under their jurisdiction. (For state specific details, see Appendix Tables 2-A-1, 2-A-2, and 2-A-3.)

In some states, the agency operating the LTSS program is overseen by the Medicaid agency and may be a division or department within the Medicaid agency. In other states, the Medicaid agency may delegate responsibility to the LTSS agency while still ensuring that the LTSS agency meets specific federal and state reporting requirements and expectations. In such cases, the Medicaid agency serves primarily to provide oversight, passing funds through to the LTSS agency with a minimal role in operations. Separate agencies may also work alongside state Medicaid agencies to deliver targeted services (e.g., behavioral health services) to certain enrollees.

State agencies that serve specific populations with disabilities, or persons with specific diseases or conditions (e.g., HIV/AIDS, hemophilia) may also provide non-Medicaid LTSS to Medicaid enrollees. This, in turn, likely affects which LTSS Medicaid enrollees use. For example, some state developmental disability agencies provide respite services to family caregivers, allowing some Medicaid enrollees to stay in the community and receive LTSS. State mental health agencies often manage and provide certain LTSS in congruence with the state Medicaid agency and administer substance abuse and mental health block grants that provide services to individuals who may also have Medicaid coverage. Enrollees with HIV/AIDS may also receive services provided through state agencies that operate the Ryan White program, which provides support services to individuals and families affected by the disease, and may fill coverage gaps where benefits are limited (KFF 2013).

How Do Medicaid Enrollees Qualify for LTSS?

Medicaid policies determining eligibility focus on finances (income and assets) and measures of functional status, rather than the existence of a specific clinical condition. In other words, people become eligible because they have low incomes and assets and meet specific thresholds for clinical and functional impairment, not because they have, for example, particular physical or mental disabilities. Measures of functional status are referred to as LOC criteria.[4] These standards are set by states within federal guidelines (Table 2-1).[5]

Some enrollees who have slightly higher incomes than their state's financial eligibility income thresholds expend (spend down) their income on medical expenses to qualify for Medicaid. Studies have shown that just under 10 percent of the previously non-Medicaid eligible population has spent down to qualify for Medicaid. Of those Medicaid enrollees who spent down, over half (51.4 percent) used LTSS, including either HCBS or institutional services (Wiener et al. 2013).

Eligibility policies also dictate, to some extent, the services to which enrollees are entitled. States have considerable flexibility in setting specific eligibility standards and covered benefits. Thus, for each of the eligibility pathways described below, an individual may be entitled to different Medicaid LTSS benefits as determined by the state.

Changes made under the ACA to simplify eligibility and enrollment processes for many Medicaid eligibility pathways do not apply to LTSS pathways. Unlike populations now subject to the new simplified modified adjusted gross income (MAGI) methodology, individuals qualifying on the basis of disability or age (65 and older) must still provide documentation of income and assets in order to be determined financially eligible for Medicaid services, including LTSS, thus requiring states to

TABLE 2-1. Eligibility Criteria for Selected Medicaid Eligibility Pathways

	Group Served							Institutional Long-Term Services and Supports (LTSS)	Home and Community-Based (HCBS) Waiver
Eligibility Pathway	**65+**	**19–64**	**Less than 19**	**Functional Assessment Criteria**	**Income Threshold**	**Income Disregards**	**Full State Plan Benefits**	***Conditional upon LOC criteria***	
Supplemental Security Income (SSI)-Related	Yes	Yes	Yes	Adults 65+: None; Adults 18–65: Blindness or permanent, medically determinable impairment that results in the inability to do any substantial gainful activity	73% FPL	First $20 of unearned monthly income; first $65 of monthly earned income; half of earned income above the first $65	Yes	NF: Yes; all other institutions at state option	At state option
				Children <18: Permanent, medically determinable impairment that results in marked and severe functional limitations	Children <18: 109%–226% FPL	Children <18: Living expenses for parents and siblings, other parental income deductions		Children <18: Yes, if determined medically necessary under EPSDT, including HCBS	
Poverty-Related	Yes	Yes	Yes	Same as SSI	up to 100% FPL	Same as SSI	Yes	NF: Yes; all other institutions at state option	At state option
Medicaid Buy-In (MBI)									
BBA 97 Eligibility group	No	Yes	16–18 only	Same as SSI	up to 250% FPL	States may disregard additional income and resources	Yes	At state option	At state option
Basic Eligibility group	No	Yes	16–18 only	Same as SSI	State-defined limit above 250% FPL		Yes	At state option	At state option
Medical Improvement group	No	Yes	16–18 only	Must have a "medically improved" disability (based on SSI disability determination)	up to 250% FPL		Yes	At state option	At state option
Family Opportunity Act (FOA)	No	No	Yes	Same as SSI	up to 300% FPL		Yes	At state option	At state option
Medically Needy (MN)	Yes	Yes	Yes	Same as SSI	State-established income threshold	Spend down amount based on individual's medical expenses, income and state-established budget period	At state option	At state option	At state option
Special Income Level (SIL)	Yes	Yes	Yes	State-established LOC for NF, ICF/ID, or hospital	up to 300% SSI	If MN pathway not available, then any amounts above SIL limit that are placed in a Miller Trust	Yes	At state option	At state option
TEFRA/ Katie Beckett	No	No	Yes	State-established LOC for NF, ICF/ID, or hospital	No more than the income limits to receive Medicaid institutional LTSS	Parental income and resources are disregarded	Yes	No	At state option
1915(i) State-Plan HCBS	Yes	Yes	Yes	State-established LOC less than for NF, ICF/ID, or hospital	up to 150% FPL	States may use institutional deeming and spousal impoverishment to disregard parent or spousal income	At state option	No	At state option

Notes: For enrollees receiving institutional or home and community-based services (HCBS) long-term services and supports (LTSS) through a waiver under any eligibility pathway, states have the option to disregard parent or spousal income and to allow enrollees to retain income under personal needs allowances or monthly maintenance needs allowances. LOC criteria refers to level-of-care criteria. FPL is federal poverty level, which is $11,760 for an individual in 2014. NF is nursing facility. EPSDT is Early and Periodic Screening, Diagnostic, and Treatment services. ICF/ID is intermediate care facility for individuals with intellectual or developmental disabilities. TEFRA is the Tax Equity and Fiscal Responsibility Act (P.L. 97-248).

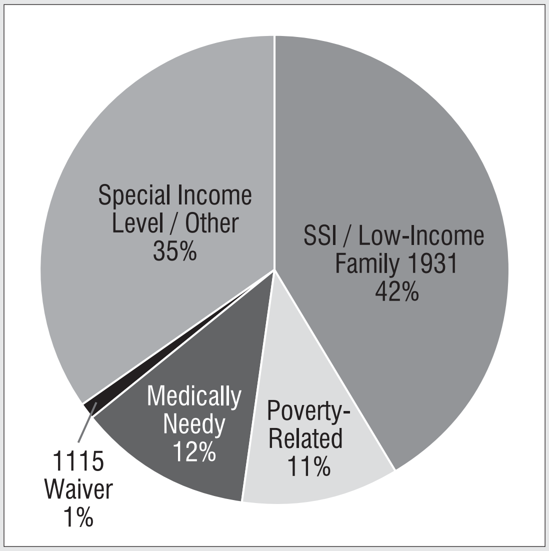
Sources: HRTW National Resource Center 2013, SSA 2013a, Stone 2011.

continue to run two administrative systems to determine Medicaid eligibility.

Supplemental Security Income-related eligibility. About two in five (42 percent) of Medicaid enrollees who used LTSS in FY 2010 enrolled through the Supplemental Security Income (SSI)-related eligibility pathway (Figure 2-2). Non-dually eligible enrollees who used LTSS were more likely to enter through the SSI-related eligibility pathway (62 percent) than LTSS users who were dually enrolled in Medicaid and Medicare (33 percent). (More discussion about LTSS users by dual eligibility status can be found below.)

SSI is a federal income support program for people with limited income and resources who are age 65 or older, blind, or have disabilities. To qualify, these individuals may have countable monthly income of no more than the federal benefit rate, which is $721 in FY 2014 (SSA 2013a). In all but 10 states, individuals eligible for SSI are automatically eligible for Medicaid, including LTSS offered under the state plan (if they meet specific functional eligibility criteria) (Table 2-2). The remaining 10 states—known as 209(b) states—have established more restrictive criteria (either income and asset thresholds or functional eligibility criteria) than SSI.[6] Enrollees must generally meet SSI's functional eligibility standards, which include being age 65 or older; or, for adults age 18 to 64, having a significant impairment that impedes their ability to do any gainful work; or, for children under the age of 18, having a significant impairment that results in marked or severe functional limitations to their ability to work (SSA 2013a) (Table 2-1). States may have the U.S. Social Security Administration (SSA) determine eligibility for Medicaid at the same time that it determines whether an individual meets the financial standards and disability requirements for SSI. Alternatively, a state may use the SSA financial and functional criteria to determine whether an individual qualifies for Medicaid on the basis of disability (SSA 2013b).[7]

FIGURE 2-2. Medicaid LTSS Enrollment by Eligibility Pathway, FY 2010



Notes: LTSS refers to long-term services and supports. FY refers to fiscal year. SSI refers to Supplemental Security Income. Medicaid benefit spending from MSIS has been adjusted to match CMS-64 totals based on the methodology described in Section 5 of MACStats in MACPAC's June 2013 report to the Congress. Amounts in the June 2014 MACStats differ and are not directly comparable to those shown here because they reflect more recent (FY 2011) data and an update to the methods used to adjust benefit spending; see Section 5 of the June 2014 MACStats for details.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data as of September 2013 and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2013.

States are only required to provide nursing facility and home health services to those considered eligible for Medicaid due to their receipt of SSI, so long as they meet LOC criteria (ASPE 2010). States may provide SSI enrollees additional LTSS (optional under the state plan or in a waiver) as long as they meet any targeting or LOC criteria established by the state for the particular service.

Poverty-related eligibility. Just 11 percent of Medicaid enrollees who used LTSS in FY 2010 received coverage through the poverty-related eligibility pathway (Figure 2-2). This is an optional pathway allowing the state to cover LTSS for individuals with incomes up to 100 percent FPL who have disabilities or are over age 65.[8] This pathway (as well as the Medicaid buy-in (MBI) and medically needy eligibility pathways discussed

TABLE 2-2. Medicaid Long-Term Services and Supports Eligibility Pathways by State

State	SSI-Related	Poverty-Related	Medicaid Buy-In[2]	Medically Needy	Special Income Level	§1915(i) HCBS[3]	Katie Beckett
Total	**51**	**24**	**37**	**35**	**43**	**12**	**27**
Alabama	✓				✓		
Alaska	✓		✓		✓		✓
Arizona	✓	✓	✓		✓		
Arkansas	✓	✓	✓	✓	✓		✓
California	✓	✓	✓	✓		✓	✓
Colorado	✓				✓	✓	✓
Connecticut[1]	✓		✓	✓	✓	✓	✓
Delaware	✓				✓		✓
District of Columbia	✓	✓		✓	✓		
Florida	✓	✓		✓	✓	✓	
Georgia	✓			✓	✓		✓
Hawaii[1]	✓	✓		✓			
Idaho	✓		✓		✓	✓	✓
Illinois[1]	✓	✓	✓	✓			
Indiana	✓	✓	✓		✓		
Iowa	✓		✓	✓	✓	✓	✓
Kansas	✓		✓	✓	✓		
Kentucky	✓			✓	✓		✓
Louisiana	✓	✓	✓	✓	✓	✓	
Maine	✓	✓	✓	✓	✓		✓
Maryland	✓		✓	✓	✓		
Massachusetts	✓	✓	✓	✓	✓		✓
Michigan	✓	✓	✓	✓	✓		✓
Minnesota[1]	✓	✓	✓	✓	✓		✓
Mississippi	✓				✓		✓
Missouri[1]	✓	✓		✓	✓		
Montana	✓			✓		✓	
Nebraska	✓	✓	✓	✓			✓
Nevada	✓		✓		✓	✓	✓
New Hampshire[1]	✓		✓	✓	✓		
New Jersey	✓	✓	✓	✓	✓		
New Mexico	✓		✓		✓		
New York	✓	✓	✓	✓			✓
North Carolina	✓	✓	✓	✓		✓	
NorthDakota[1]	✓		✓	✓			
Ohio[1]	✓		✓	✓	✓		✓
Oklahoma[1]	✓	✓		✓	✓		✓
Oregon	✓		✓		✓	✓	✓
Pennsylvania	✓	✓	✓	✓	✓		
Rhode Island	✓	✓	✓	✓	✓		✓
South Carolina	✓	✓			✓		✓
South Dakota	✓		✓		✓		✓
Tennessee	✓				✓		
Texas	✓		✓		✓		
Utah	✓	✓	✓	✓	✓		
Vermont	✓		✓	✓	✓		✓
Virginia[1]	✓	✓	✓	✓	✓		
Washington	✓		✓	✓	✓		
West Virginia	✓		✓	✓	✓		✓
Wisconsin	✓		✓	✓	✓	✓	✓
Wyoming	✓		✓		✓		

Notes: SSI refers to Supplemental Security Income. HCBS refers to home and community-based services.

[1] SSI-related pathways include 209(b) states using more restrictive eligibility criteria than SSI.

[2] Medicaid buy-in (MBI) includes any of the three MBI groups (Balanced Budget Act of 1997 Group, Basic Eligibility Group, and Medical Improvement Group).

[3] States may use Section 1915(i) as a separate eligibility pathway with access to existing state plan HCBS, Section 1915(c) HCBS waiver services, or specific services included in Section 1915(i) benefits. States shown include states with approved state plan amendments that include either benefits or eligibility groups.

Sources: MACPAC 2014b, NASUAD 2013, Stone 2011.

below) also uses the SSI functional eligibility criteria (Table 2-1). Like SSI-related enrollees, these enrollees are entitled to full Medicaid benefits, including state plan LTSS if the individual meets the state's LOC or targeting criteria.

States may extend HCBS authorized under a waiver to those eligible under the poverty-related pathway. In FY 2014, 24 states chose to provide Medicaid coverage to persons who are 65 and older or disabled whose incomes were below the poverty level but above the SSI or 209(b) level (MACPAC 2014b) (Table 2-2).

Medicaid buy-in. States have the option to cover individuals with disabilities who work and have incomes too high to qualify for Medicaid. In 2009, 37 states offered Medicaid to individuals with disabilities under at least one of three MBI pathways (Stone 2011):

- **Balanced Budget Act of 1997 (BBA 97) Eligibility Group.** States may use this option to cover individuals whose income does not exceed 250 percent FPL. In 2011, 16 states included this group in their MBI (Kehn 2013).
- **Basic Eligibility Group.** States may use this option to cover individuals above 250 percent FPL and whose income does not exceed a state-defined limit. This is the most frequently included group; 21 states included this group in their MBI in 2011 (Kehn 2013).
- **Medical Improvement Group.** States may use this option to cover individuals who would be in the Basic Eligibility Group, except for the fact that their disability no longer meets the SSI definition or that they work at least 40 hours per month. States include this group in their MBI less frequently than the other two groups; only eight states opt to cover this group (Kehn 2013).

There is a separate buy-in program for children with disabilities whose family income is too high to qualify for Medicaid. This option is referred to as the Family Opportunity Act (FOA) pathway, although it functions similarly to MBI. The FOA was established by the DRA and gives states the option to allow families with incomes up to 300 percent FPL to purchase Medicaid coverage for their children with disabilities under age 19 (Stone 2011).

The MBI pathway entitles enrollees to full Medicaid benefits, including state plan LTSS. States may extend HCBS waiver benefits to individuals eligible under this pathway if they meet level-of-care criteria. States may also impose a monthly premium or other cost-sharing requirements (discussed below).

Medically needy. Twelve percent of Medicaid LTSS users are eligible under the medically needy pathway that allows states to cover individuals age 65 and older or individuals with disabilities with high medical expenses relative to their income once they have spent a portion of their excess income on their medical expenses (referred to as the spend-down requirement) (Figure 2-2). For both dually enrolled and non-dually enrolled LTSS users, those who came through the medically needy eligibility pathway had the highest LTSS spending per enrollee of any eligibility group (Table 2-4 and Table 2-5).

The income threshold and the budget period used in medically needy eligibility determinations are state-specific. States may offer full Medicaid or a more limited set of state-specified benefits to this group. They may also provide institutional LTSS and HCBS waiver benefits to those meeting LOC criteria. In 2014, 35 states had a medically needy pathway (MACPAC 2014b) (Table 2-2).

Special income level. Many Medicaid LTSS users come through the special income pathway under which states may cover individuals age 65 and older or individuals with disabilities who meet LOC criteria for certain institutions and have incomes up to 300 percent of the SSI benefit rate.[9] LTSS users dually enrolled in Medicaid and Medicare were much more likely to come through the special income level pathway (1.2 million out of 2.9 million total or 43 percent) compared to non-dually enrolled LTSS users (229,000 out of 1.4 million total or 17 percent) (Table 2-4 and Table 2-5). In 2014, 43 states offered Medicaid coverage to individuals through this pathway (MACPAC 2014b) (Table 2-2).

Functional eligibility for this pathway (as well as Tax Equity and Fiscal Responsibility Act (TEFRA)/Katie Beckett, and Section 1915(i) state plan HCBS discussed below) is determined using the state-established LOC criteria that typically require enrollees to need institutional-level services and supports (Table 2-1). States may provide institutional LTSS and HCBS waiver benefits to individuals meeting LOC criteria to this group.

TEFRA/Katie Beckett. The TEFRA/Katie Beckett pathway provides Medicaid eligibility to children with severe disabilities whose family income would ordinarily be too high to qualify for Medicaid. This pathway was created to address the fact that Medicaid policies originally did not count parental income toward the child's Medicaid eligibility if that child was institutionalized in a hospital, nursing home, or an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/ID) for 30 days or more, but would count such income if the child was at home. Families of such children could get Medicaid coverage only by placing their child in an institution, becoming impoverished, or relinquishing custody. In 1982, TEFRA (P.L. 97-248) created an exception that allowed severely disabled children, like Katie Beckett for whom the provision was named, to receive their care at home while retaining their Medicaid coverage (Smith et al. 2000). Under this pathway, states may elect to count only the income and financial resources of a child with a disability who needs LTSS. States may provide institutional LTSS or HCBS waiver benefits to individuals eligible under this pathway who meet the level-of-care criteria. Twenty-seven states used the Katie Beckett option in 2009 (Stone 2011) (Table 2-2).

Section 1915(i) state plan HCBS. Section 1915(i) of the Act allows states to offer HCBS as part of the Medicaid state plan to individuals with incomes up to 150 percent FPL. The ACA amended this section to create a new eligibility pathway for individuals with disabilities who are not otherwise eligible for Medicaid and do not require an institutional level of care. Under the amended Section 1915(i), states may now offer full Medicaid coverage to individuals eligible under this pathway, and they may extend this pathway to individuals with income up to 300 percent of SSI who are receiving Section 1915(c) HCBS waiver services (Stone 2011). As of November 2013, 12 states had received approval of Section 1915(i) state plan amendments and 4 states were awaiting approval of submitted state plan amendments (NASUAD 2013) (Table 2-2).[10]

Enrollee contributions to the cost of Medicaid LTSS. In contrast to other aspects of the Medicaid program, most states do not set maximum income limits for those seeking Medicaid coverage of LTSS. This is not to say, however, that wealthy individuals are able to shelter assets or avoid spending their own resources on LTSS. Federal rules prohibit potential LTSS users from transferring assets such as homes or bank accounts to relatives in order to qualify for Medicaid.[11] In addition, states use a variety of different policies to ensure that Medicaid LTSS users contribute to the costs of their care, albeit without requiring that individuals impoverish themselves or their families. These include:

- **Cost sharing.** States may impose a monthly premium or other cost-sharing requirements for enrollees who come through certain eligibility pathways or use certain LTSS benefits (such as nursing facilities) (ASPE 2010). Individuals qualifying through the medically needy eligibility pathway must have applied a portion of their income to medical expenses in order to meet state-specified spend-down requirements.

- **Personal allowances.** States must establish monthly levels of income that an LTSS user may retain to cover the cost of certain personal expenses after fulfilling any cost-sharing requirements. Enrollees using either institutional or HCBS LTSS may retain a monthly allowance to pay for goods and services not provided by the facility or covered by Medicaid (e.g., clothing or room and board costs of HCBS users).[12]
- **Income disregards.** Medicaid law allows states to adopt rules that would prevent the impoverishment of a spouse of a Medicaid beneficiary receiving LTSS (§1924 of the Act). Under these rules, states establish the amount of assets a spouse residing in the community may retain, which must be no less than $23,448 and cannot exceed $117,240 in countable assets in 2014 (CMS 2014b). Additionally, the law exempts a community-residing spouse's income for the purposes of Medicaid eligibility and allows the institutionalized spouse to transfer income to a limited-income community spouse, up to a state-determined maximum level (but no less than $1,939 and no greater than $2,931 in 2014) (CMS 2014b). States may apply spousal impoverishment rules to HCBS waiver participants, and in 2009 all but five states applied these rules to their largest HCBS waiver program (Stone 2011).
- **Trusts.** Federal law allows for the establishment of certain trusts that may not be counted for the purposes of determining Medicaid eligibility, thereby allowing individuals with higher incomes or assets to qualify for Medicaid LTSS (§1917(d) of the Act). Miller Trusts (also known as Qualified Income Trusts) are used in some states that offer the special income level eligibility pathway and do not have a medically needy spend-down provision. Funds placed in a Miller Trust may be used to pay the cost of the individual's care, up to a state-specified amount. Certain other trusts established under Section 1917(d)(4)(A) of the Act, or "Type A" special needs trusts, can also be established on behalf of an individual with a disability under the age of 65 in some states. In addition, in some states pooled income trusts are run by nonprofit associations on behalf of individual beneficiaries. Upon the death of the enrollee, the remaining funds in the individual account of these trusts can either be retained or paid to the state as reimbursement for any Medicaid services the individual received, depending on the trust (Stone 2011).

Which Long-Term Services and Supports Does Medicaid Cover?

There are only two mandatory LTSS benefits that must be provided under the Medicaid state plan: nursing facility and home health services. Nursing facility services are those provided by an institution offering 24-hour medical care and skilled nursing care, rehabilitation, or health-related services to individuals who do not require hospital care (MACPAC 2012). Home health services must include nursing, home health aides, and medical supplies and equipment (ASPE 2010). States may choose to provide additional therapeutic services under home health (occupational or physical therapy, speech pathology, and audiology) and determine the medical necessity criteria by which home health service utilization is managed (42 CFR 440.70(b), Smith et al. 2000).

States may cover federally defined optional long-term services and supports, either under their state plans or via waivers (Table 2-3). Once a state includes an optional service within its state plan, it must provide that service to all individuals eligible under all eligibility pathways that grant access to the traditional benefit package (Table 2-1). States may establish targeting LOC criteria for some optional services, limiting who can access certain services. Optional services include both institutional LTSS (such as ICFs/ID) and HCBS (such as personal care services) (Table 2-3).

In order to offer community-based LTSS under a waiver, states must submit a waiver application to the Centers for Medicare & Medicaid Services (CMS). That application describes the services to be provided, the target population, service eligibility criteria, and the statutory requirements the state wishes to waive (e.g., the requirement to provide comparable services to all enrollees).[13] Waiver requests must also specify target enrollment numbers and, for Section 1915(c) waivers, must specify the participant limit, how the state will manage enrollment, and, if applicable, how the state will manage waiting lists (CMS 2008).[14] Waivers must be reapproved by CMS every three to five years.[15] States are required to post proposed Section 1115 demonstration waiver applications and any accompanying documents online at least 30 days prior to their submission to CMS; CMS also requires public notification of proposed changes to Section 1915(c) waivers as well (CMS 2014a, NSCLC 2012).

HCBS waivers permit states to restrict and expand coverage for LTSS in ways not permitted under their state plans, including flexibility in benefits provided to specific groups and caps on enrollment; they are the primary vehicle by which states offer HCBS. As of 2013, all but three states operate Section 1915(c) waivers (KCMU 2014a). States may operate multiple Section 1915(c) waivers, and in 2010, 284 separate waivers were providing LTSS to 1.4 million enrollees (KCMU 2014a). Other states rely on Section 1115 authority to provide LTSS to Medicaid enrollees. This includes three states that only provide LTSS under Section 1115 authority (Arizona, Rhode Island, and Vermont) and five states that include LTSS for certain populations in managed care programs operating under Section 1115 authority and provide separate Section 1915(c) HCBS waivers for other populations (KCMU 2014a).[16]

Although states can use HCBS state plan or waiver options to provide services in community-based settings, federal statute does not allow the Medicaid program to pay for housing for individuals who are not institutionalized (except in limited circumstances under HCBS programs) (§1915(c)(1) of the Act and 42 CFR 441.310). Some states may offer residential services under Medicaid HCBS provided in group homes or assisted living facilities to certain enrollees; however, the payment for these services does not cover the room and board costs for individuals receiving these supports.[17] Individuals who access out-of-home residential services under Medicaid HCBS may do so because their state does not allow them to retain enough income or assets to pay for a residence outside of a provider-owned setting. Lack of affordable housing options has been identified as a barrier to transitioning individuals out of LTSS institutions and into community settings, which may impede state efforts to significantly rebalance LTSS systems. The interplay between the lack of affordable community-based housing and the provision of HCBS warrants careful examination when considering LTSS policy changes.

As a result of the interplay among optional pathways, state-specific definitions of financial and functional eligibility, and the design of benefits, similarly situated Medicaid enrollees may receive vastly different services in different states, and two individuals with identical LTSS needs in different states (or eligible under different pathways within a state) may ultimately use different Medicaid LTSS.

For example, among children who need LTSS, a child with autism spectrum disorder, whose family income is 100 percent FPL ($19,790 for a family

TABLE 2-3. Medicaid Optional Long-Term Services and Supports

Availability	Specific Services
State plan services	
States must provide services to all eligible enrollees but may require enrollees to meet targeting or level-of-care (LOC) criteria for state plan long-term services and supports (LTSS).	▶ Intermediate care facilities for individuals with intellectual and developmental disabilities ▶ Mental health facilities for individuals younger than 21 or older than 65 ▶ Personal care ▶ Rehabilitation ▶ Targeted case management ▶ Private duty nursing ▶ Health homes for individuals with chronic conditions ▶ Speech, occupational, physical, or other rehabilitative and habilitative therapies ▶ Section 1915(i) home and community-based services ▶ Section 1915(j) self-directed personal assistance services ▶ Section 1915(k) Community First Choice ▶ Other services approved by the Secretary of the U.S. Department of Health and Human Services (the Secretary)
Waiver services	
States may provide services to individuals who are not otherwise eligible for Medicaid and may limit enrollment to individuals who meet state-established LOC criteria. States may also limit the number of enrollees, target specific populations, or may limit the geographic availability of waiver programs.	Section 1915(c) home and community-based services (HCBS): ▶ enable independent life in the community; ▶ are specified in the state's waiver application, which is approved by the Secretary; ▶ may not necessarily be covered for the rest of the population; and ▶ may include case management, personal care services, adult day, habilitation, respite, day treatment, psychosocial rehabilitation, and others. Section 1115 research and demonstration waiver services: ▶ are specified in the state's waiver application, which is approved by the Secretary; ▶ may include services not typically covered by Medicaid, including HCBS; and ▶ may use innovative delivery systems that differ from traditional Medicaid.

Notes: Optional state plan services can vary in terms of the specific services covered; the service delivery location; and the frequency, duration and scope of services included under each optional benefit. Within waiver programs, states may craft a very comprehensive, broad benefit package or conversely, a very narrow and limited set of services. Waiver services may also include services available under the state plan, but by including duplicative services in the waiver, states may provide the services to individuals not eligible under mandatory pathways or may provide services in excess of the limits on state plan services. States also have the ability to specify unique service delivery methods, such as self-direction, available to waiver participants. HCBS can be offered in a variety of community-based settings, including in the participant's home, in residential settings such as group homes or assisted living facilities, and in other community settings such as the participant's job or day habilitation center. Appendix Table 2-A-4 lists LTSS benefits by state.

Source: MACPAC 2014b.

of three in 2014) and does not qualify for SSI, may need certain LTSS such as Applied Behavioral Analysis (ABA) and other habilitative therapies to help acquire daily living skills.

In order to receive LTSS under Medicaid, the child would have to first be determined eligible according to state rules. In Florida, the child would likely qualify for Medicaid under the poverty-related pathway; in Georgia, the child would likely qualify under the Katie Beckett pathway. In both states, ABA services are only available under state plan EPSDT benefit if the services are determined medically necessary. Other states (for example, Michigan) offer ABA through HCBS waiver programs that may have different functional eligibility criteria.

Adult Medicaid enrollees face similar circumstances. For example, an adult living in the District of Columbia with paraplegia who requires personal care services to perform many activities of daily living and works outside of his or her home, not making more than $903 a month, can qualify for Medicaid under the poverty-related pathway and receive personal care services from Medicaid under the state plan benefit.

However, if the adult moves to another state—for example Indiana—and gets a better paying job, the individual could earn not more than $3,160 a month and could pay a premium and other cost-sharing to get Medicaid coverage through the Medicaid buy-in pathway. Because Indiana does not include personal care services under its Medicaid state plan, the individual must be enrolled in an HCBS waiver to receive those services. If the individual were to again change his or her life situation by getting married and moving to another state, like New Hampshire, the couple could not earn more than $4,063 per month in order to continue buying into and receiving Medicaid personal care services.

Who Uses Medicaid LTSS?

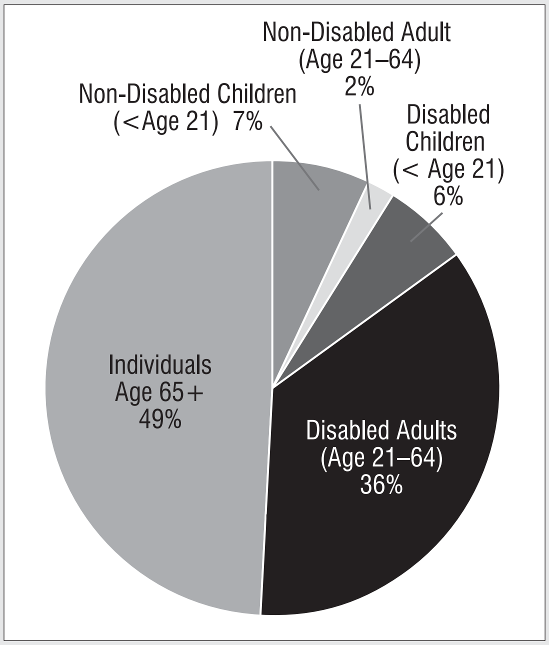
When we think about people receiving Medicaid LTSS, we think about them from the perspective of individuals: how such services contribute to their daily functioning and where they receive them. From a practical perspective, we can group them by their specific disabilities or ages, including for example, frail individuals age 65 and older or people with traumatic brain injury. And in fact, over time, Medicaid has assumed increasing responsibilities for such populations, many of whom were once primarily housed in public institutions. But for the most part, with the exception of certain waivers, Medicaid policy does not have separate eligibility categories or specific programs for these populations.

At the most aggregated level, about half (49 percent) of LTSS users were age 65 or over in FY 2010. Just over two in five (42 percent) were individuals under age 65 who qualified for Medicaid on the basis of a disability (Figure 2-3).

About half of Medicaid LTSS users were eligible as a result of having very low incomes, while the other half have comparatively higher incomes but qualified on the basis of also having significant LTSS needs (MACPAC 2014a).[18]

This latter group includes individuals who may have access to private health insurance, which does not typically cover LTSS (including such services as habilitation and respite for family caregivers), and who otherwise might face total impoverishment if they were to pay for services out of pocket. For these individuals, Medicaid acts as a wraparound to supplement private health insurance. For example, in 2010, about 8 percent of children with special health care needs had both private insurance and Medicaid.[19] Other populations, including working adults with disabilities, may also rely on Medicaid to act as a wraparound to their private health insurance.

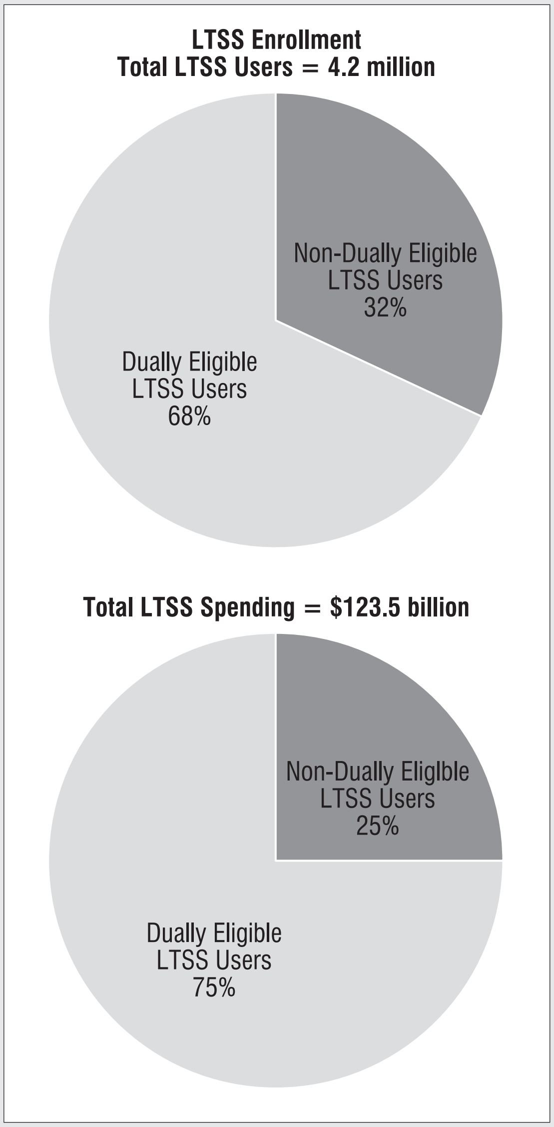
FIGURE 2-3. Medicaid LTSS Enrollment by Age and Disability Status, FY 2010



Notes: LTSS refers to long-term services and supports. FY refers to fiscal year. Medicaid enrollees include individuals dually enrolled in Medicaid and Medicare. Individuals age 65 and older, non-disabled children, and non-disabled adults are eligible for Medicaid on the basis of factors other than disability. Medicaid benefit spending from MSIS has been adjusted to match CMS-64 totals based on the methodology described in Section 5 of MACStats in MACPAC's June 2013 report to the Congress. Amounts in the June 2014 MACStats differ and are not directly comparable to those shown here because they reflect more recent (FY 2011) data and an update to the methods used to adjust benefit spending; see Section 5 of the June 2014 MACStats for details.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data as of September 2013 and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2013.

FIGURE 2-4. Medicaid LTSS Enrollment and Spending by Dually Eligible Status, FY 2010



Notes: LTSS refers to long-term services and supports. FY refers to fiscal year. Expenditures are for enrollees who used any LTSS and include expenditures for both acute care and LTSS. Medicaid benefit spending from MSIS has been adjusted to match CMS-64 totals based on the methodology described in Section 5 of MACStats in MACPAC's June 2013 report to the Congress. Amounts in the June 2014 MACStats differ and are not directly comparable to those shown here because they reflect more recent (FY 2011) data and an update to the methods used to adjust benefit spending; see Section 5 of the June 2014 MACStats for details.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data as of September 2013 and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2013.

LTSS users by dually eligible status

Service use and total expenditures vary considerably across different subpopulations of LTSS users. Even so, it can be difficult to assess whether differences in use reflect differences in need or the design of coverage, eligibility, and cost-sharing policies.

The majority (68 percent) of Medicaid LTSS users are dually enrolled in Medicare and Medicaid (Figure 2-4). Medicaid pays for LTSS but not for most acute medical care for dually eligible enrollees, whereas it covers both acute care and LTSS for non-dually eligible enrollees. It is important to note that not all persons dually enrolled in Medicaid and Medicare are disabled; almost two-thirds

TABLE 2-4. Medicaid Spending for Dually Eligible LTSS Users, by Type of LTSS User, Age, and Eligibility Pathway, FY 2010

Dually Eligible Enrollees Who Use LTSS	Number of LTSS Users (thousands)	Medicaid LTSS Spending Per FYE LTSS User			Medicaid Non-LTSS (Acute and Other) Spending Per FYE LTSS User*	Total Medicaid Spending Per FYE LTSS User
		Total	Institutional	HCBS		
Dually eligible LTSS users: Any type of LTSS						
Total	2,869	$35,396	$21,701	$13,695	$7,204	$42,600
Benefit package						
Full benefit	2,792	36,178	22,250	13,929	7,291	43,469
Partial benefit	78	7,712	2,292	5,420	4,112	11,824
Age						
Children (< Age 21)	5	34,544	14,554	19,990	22,133	56,677
Adults (Age 21–64)	842	41,565	16,919	24,647	9,009	50,575
Individuals Age 65+	2,023	32,628	23,868	8,760	6,352	38,980
Medicaid eligibility pathway						
SSI	917	23,697	5,035	18,662	8,909	32,606
Poverty-related	271	22,950	13,145	9,805	6,622	29,571
Medically needy	432	56,133	44,788	11,345	7,397	63,530
Section 1115 waiver	5	18,936	14,092	4,844	14,605	33,541
Special income level or other	1,244	40,599	29,152	11,446	5,873	46,472
Dually eligible LTSS users: Both HCBS and institutional						
Total	154	41,344	27,472	13,872	10,567	51,911
Dually eligible LTSS users: Institutional only						
Total	1,138	54,330	54,330	–	6,383	60,712
Dually eligible LTSS users: HCBS waiver only						
Total	798	32,855	–	32,855	6,733	39,588
Dually eligible LTSS users: HCBS state plan only						
Total	780	12,223	–	12,223	8,114	20,337

*Other spending may include Medicaid spending for acute care services not covered by Medicare (e.g., vision, dental) and Medicare cost sharing.

Notes: LTSS refers to long-term services and supports. FY refers to fiscal year. FYE refers to full-year equivalent. HCBS refers to home and community-based services. SSI refers to Supplemental Security Income. Nearly all dually eligible enrollees under the age of 65 qualify for Medicaid on the basis of a disability; numbers shown here include a small number of individuals (about 8,000 adults and 200 children) who are not eligible on the basis of a disability. Individuals age 65 and older are eligible for Medicaid on the basis of factors other than disability. Medicaid benefit spending from MSIS has been adjusted to match CMS-64 totals based on the methodology described in Section 5 of MACStats in MACPAC's June 2013 report to the Congress. Amounts in the June 2014 MACStats differ and are not directly comparable to those shown here because they reflect more recent (FY 2011) data and an update to the methods used to adjust benefit spending; see Section 5 of the June 2014 MACStats for details.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data as of September 2013 and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2013.

(62 percent) of persons dually enrolled in Medicaid and Medicare did not use Medicaid LTSS in FY 2010 (MACPAC 2014a).[20] Nonetheless, persons dually enrolled in Medicaid and Medicare account for three-quarters of Medicaid spending on LTSS (Figure 2-4). Almost all dually enrolled individuals in Medicare and Medicaid who used Medicaid LTSS qualified for full Medicaid benefits in their state, including coverage of LTSS (referred to as full-benefit enrollees).[21]

Individuals dually enrolled in Medicare and Medicaid. Persons dually enrolled in Medicare and Medicaid who use LTSS are more likely to be over age 65, and these older individuals are more likely to use institutional services. About 2 million out of the 2.9 million dually enrolled individuals who used LTSS in FY 2010 were age 65 or over; the remainder were younger adults with disabilities (Table 2-4). Moreover, individuals age 65 and over who were dually enrolled in Medicare and Medicaid had spending of $23,868 per FYE enrollee for their institutional LTSS, which was 73 percent of total Medicaid LTSS spending per enrollee for that group ($32,628 per FYE enrollee).

By contrast, adults age 21 to 64 who were dually enrolled had higher per FYE enrollee spending on HCBS ($24,647) than institutional LTSS ($16,919). Compared to other age groups who used LTSS, the dually enrolled adults age 21 to 64 had the highest total LTSS spending per FYE enrollee at $41,565 per enrollee (Table 2-4).

Among dually enrolled LTSS users, LTSS spending also differed by the types of services this population used. Those who only used institutional LTSS had the highest LTSS per enrollee spending, compared to dually eligible enrollees who used only HCBS or who used both institutional and HCBS in FY 2010 (Table 2-4).

Of those dually eligible enrollees who used only HCBS, there was a substantial difference in per enrollee spending between those who accessed HCBS through waivers ($32,855 per FYE enrollee) compared to those who accessed such services through the state plan ($12,223 per FYE enrollee) (Table 2-4). The types of HCBS that dually eligible enrollees may have been accessing through the state plan include home health services, personal care services, and other optional LTSS (Table 2-3).

Medicaid LTSS spending also varies as a function of the eligibility pathway through which dually eligible enrollees enter Medicaid. Those who entered through the medically needy pathway had the highest LTSS per enrollee spending at $56,133 per FYE enrollee, followed by enrollees who entered through the special income level pathway ($40,599 per FYE enrollee) (Table 2-4).

Non-dually enrolled LTSS users. Most non-dually enrolled LTSS users (sometimes called Medicaid-only users) were adults between the ages of 21 and 64 years in FY 2010 (Table 2-5). Most of these adults qualified through a disability pathway. Thirty-eight percent, or around 528,000, of non-dually eligible enrollees who used LTSS were children under the age of 21. Among those children, over half (280,000 or 53 percent) qualified for Medicaid on a basis other than a disability (i.e., through a low-income family or Section 1115 waiver pathway) meaning that they accessed LTSS through EPSDT or other state plan benefits (Table 2-5). The LTSS used by children who came through a non-disability eligibility pathway may include such services as habilitative or rehabilitative care available through the state plan.

Spending patterns for non-dually eligible LTSS users differ by Medicaid eligibility pathway. Those who entered through the SSI-related or special income level eligibility pathways had higher per enrollee spending on HCBS than on institutional LTSS (Table 2-5). Those enrollees who entered through the other major disability-related pathways (i.e., poverty-related, medically needy, or Section 1115 waiver), in contrast, had more spending for institutional LTSS than for HCBS.

Over 1 million out of almost 1.4 million non-dually eligible enrollees who used LTSS used only HCBS (79 percent). Two-thirds (65 percent or 703,000) of non-dually eligible enrollees who used only HCBS accessed those services through the state plan (MACPAC 2014a). And those who used HCBS through waivers had much higher LTSS per enrollee spending, five times that of those who used only state plan HCBS ($35,852 per FYE enrollee versus $7,104 per enrollee, respectively) (Table 2-5).

Among non-dually eligible enrollees who used LTSS, per enrollee spending was roughly the same for acute care ($27,306 per FYE enrollee) and LTSS ($24,957 per FYE enrollee). However, variation in per FYE enrollee spending for acute care existed by the type of LTSS used. Enrollees who used both institutional and HCBS during FY 2010 had substantially higher per enrollee spending on acute care ($65,993 per FYE enrollee) than other enrollees,

TABLE 2-5. Medicaid Spending for Non-Dually Eligible LTSS Users, by Type of LTSS User, Age, and Eligibility Pathway, FY 2010

Non-Dually Eligible Enrollees Who Use LTSS	Number of LTSS Users (thousands)	Medicaid LTSS Spending Per FYE LTSS User			Medicaid Non-LTSS (Acute and Other) Spending Per FYE LTSS User*	Total Medicaid Spending Per FYE LTSS User
		Total	Institutional	HCBS		
Non-dually eligible LTSS users: Any type of LTSS						
Total	1,373	$24,957	$10,340	$14,617	$27,306	$52,263
Age and disability status						
Children (< Age 21) eligible on the basis of a disability	248	26,300	6,991	19,309	29,683	55,984
Children (< Age 21) eligible on a basis other than disability	280	8,359	5,410	2,949	16,775	25,134
Adults (Age 21–64) elgible on the basis of a disability	687	32,605	13,385	19,220	30,705	63,310
Adults (Age 21–64) eligible on a basis other than disability	88	3,511	1,627	1,884	27,093	30,605
Individuals Age 65+	70	29,356	12,257	17,100	17,787	47,143
Medicaid eligibility pathway						
SSI	853	27,410	10,038	17,372	28,044	55,454
Poverty-related	179	6,443	3,657	2,786	18,749	25,192
Medically needy	82	34,921	25,419	9,503	38,873	73,795
Section 1115 waiver	31	4,558	2,759	1,799	23,800	28,358
Special income level or other	229	28,293	12,355	15,938	27,337	55,630
Non-dually eligible LTSS users: Both HCBS and institutional						
Total	44	49,051	33,595	15,456	65,993	115,044
Non-dually eligible LTSS users: Institutional only						
Total	243	55,262	55,262	–	32,298	87,560
Non-dually eligible LTSS users: HCBS waiver only						
Total	384	35,852	–	35,852	17,851	53,703
Non-dually eligible LTSS users: HCBS state plan only						
Total	703	7,104	–	7,104	28,650	35,754

* Acute and other spending includes, hospital care, prescription drugs, ambulatory care, and all Medicaid non-LTSS expenditures, as well as capitation payments to managed care plans.

Notes: LTSS refers to long-term services and supports. FY refers to fiscal year. FYE refers to full-year equivalent. HCBS refers to home and community-based services. SSI refers to Supplemental Security Income. Individuals age 65 and older are eligible for Medicaid on the basis of factors other than disability. Medicaid benefit spending from MSIS has been adjusted to match CMS-64 totals based on the methodology described in Section 5 of MACStats in MACPAC's June 2013 report to the Congress. Amounts in the June 2014 MACStats differ and are not directly comparable to those shown here because they reflect more recent (FY 2011) data and an update to the methods used to adjust benefit spending; see Section 5 of the June 2014 MACStats for details.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data as of September 2013 and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2013.

with the next highest acute care spending per FYE enrollee among those who used only institutional care ($32,298 per FYE enrollee) (Table 2-5).

As previously mentioned, the fact that non-dually enrolled LTSS users are more expensive to Medicaid than those individuals dually enrolled in Medicare and Medicaid reflects in part the fact that Medicare pays for most of the acute care services for individuals dually enrolled in Medicare and Medicaid. Even so, it is not clear to what extent other differences in spending and use reflect interactions between the Medicaid and Medicare programs versus the specific characteristics of the enrollees in each group.

LTSS users by disability-specific group

Examining LTSS utilization and spending by enrollees' specific disabilities, diagnoses, and functional abilities can shed light on the different types of services that are important to different groups. These distinctions can be useful in thinking about how policies might be changed to promote efficiency, quality, and access. This is because enrollees with specific disabilities may require similar LTSS; for example, enrollees with cognitive limitations are likely to have different LTSS needs than enrollees with profound physical functional limitations or enrollees with serious mental illness.

As mentioned previously, Medicaid's current role in providing LTSS to these subpopulations is in part a vestige of now defunct state programs. Over time, Medicaid policy has allowed states to develop HCBS waivers to target certain groups. Federal regulations implementing HCBS programs—specifically, Section 1915(c) and Section 1915(i) of the Act—require states to specify which subpopulations will be served by HCBS programs (CMS 2014a).[22] Spending by these groups, therefore, is in part reflective of historical state policies as opposed to deliberate decisions about what might be most appropriate for different LTSS users and their specific disabilities. Prior to the enactment of Medicaid, most of these individuals were cared for in institutions, including nursing facilities, institutions for individuals with developmental disabilities, and long-stay hospitals, including psychiatric hospitals. Medicaid has evolved to replace categorical programs serving them or to target services to their specific needs. Today, states may cover specific Medicaid LTSS benefits that target certain subpopulations independent of age. These subpopulations are:

- enrollees with intellectual and developmental disabilities who require ICF/ID level of services;
- enrollees with disabilities (and those over age 65) who qualify for nursing facility services;
- enrollees with serious mental illness who meet the level of care for inpatient psychiatric facilities; and
- enrollees with a disability or condition (such as brain injury) that requires the level of care provided in a hospital or who are otherwise medically frail.

Examples of services provided to major disability groups, using the patchwork of available data, are described here (Box 2-1). Analysis of Medicaid administrative data by disability-specific group was not available for this report; other data sources are used to illustrate key points related to each group.[23]

Individuals with intellectual or developmental disabilities (ID/DD). The majority of LTSS spending for individuals with ID/DD is for HCBS. Forty-seven states spent at least 50 percent of their Medicaid LTSS expenditures that targeted individuals with ID/DD on HCBS in FY 2012, primarily on services through HCBS waivers (Eiken et al. 2014). Enrollees in ID/DD waiver programs accounted for 40 percent of total HCBS waiver participants and 71 percent of all spending on HCBS waivers (KCMU 2014a).

The average per enrollee expenditure for an individual with ID/DD in HCBS waivers is among the highest of all users of LTSS waiver services (Table 2-6). These high expenses are in part because people with ID/DD use more in-home and out-of-home residential support that is frequently round-the-clock (Rizzolo et al. 2013). A study of 88 HCBS waivers found that over half (53 percent) of spending for individuals with ID/DD was for residential habilitation services, which can include such services as "assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs" (Rizzolo et al. 2013). LTSS facility services

BOX 2-1. Illustrative Examples of Medicaid Benefits for Selected Subpopulations

Services for people age 65 and older and people with disabilities

- In State A, adults who are over age 65 or who have physical disabilities that require nursing care can receive long-term services and supports (LTSS) in the community or nursing facilities if they are eligible for Supplemental Security Income (SSI). Individuals who earn too much for SSI can obtain Medicaid home and community-based services (HCBS) by paying a premium and other cost sharing, or they can enter a waiting list for HCBS services. Individuals who earn too much for SSI can obtain Medicaid LTSS in nursing facilities.
- In State B, adults over age 65 and who require a nursing facility level of care may receive HCBS if their monthly income does not exceed $903, they pay a premium or the costs of some of their care, or they enroll in the Medicaid waiver, which has a small waiting list.

Services for people with ID/DD

- In State A, adults with intellectual or developmental disabilities (ID/DD) who do not qualify for SSI, either because they earn too much or because they do not meet the functional definition, can receive services in an intermediate care facility for persons with intellectual disabilities (ICF/ID), or they can enter a waiting list for HCBS.
- In State B, adults with ID/DD who do not otherwise qualify for SSI will still receive Medicaid LTSS. There is no waiting list for services, although individuals seeking out-of-home residential services (such as group homes) may wait for these services based on the prioritization of their needs.

Services for individuals with SMI

- An individual with severe mental illness (SMI) who is eligible for SSI can receive partial hospitalization, habilitation, and adult day health services in State A. If they earn more than $721 per month, however, they will not receive Medicaid unless they pay a premium and other cost sharing.
- In State B, an individual with a severe, disabling mental illness (SDMI) may receive day habilitation, prevocational services, private duty nursing, homemaker and chore services, case management, and many other services under the HCBS waiver for individuals with SDMI. Only 155 individuals are served in this program and to receive these services, the individual must: qualify for SSI (or earn no more than $721/month in 2014), require a nursing facility level of care, and reside in one of the 21 counties served by the waiver.

Services for individuals who are medically frail

- State A operates an HCBS waiver that provides attendant care and other services to individuals with traumatic brain or spinal cord injury (TBI/SCI). Individuals with TBI/SCI who receive SSI do not have access to attendant care services unless they enroll in the waiver, which has a waiting list. Individuals with TBI/SCI who earn up to 300 percent of SSI may also enroll in the waiver, but individuals who have an acquired brain injury (such as one resulting from a stroke) are not eligible.
- An individual with any type of brain injury cannot get private duty nursing or personal care services in State B unless they enroll in the HCBS waiver whether or not they qualify for SSI. If their incomes are less than 300 percent of SSI, they will remain eligible for the waiver.

Notes: These examples are provided as an illustration of the variation in Medicaid LTSS across and within states. Individual circumstances and specific state policies determine whether an individual is eligible for Medicaid and what LTSS they may receive. Appendix Table 2-A-4 lists LTSS benefits by state.

TABLE 2-6. Section 1915(c) Home and Community-Based Services Waiver Enrollment and Spending by Subpopulation, FY 2010

	Total U.S. Waiver Expenditures (thousands)	Total Waiver Enrollment	Per Enrollee Spending
Total	**$36,803,080**	**1,403,736**	**$26,218**
ID/DD	26,175,736	567,117	46,156
Aged	1,752,171	168,966	10,370
Aged and disabled	5,984,075	512,480	11,677
Physically disabled	1,743,076	85,537	20,378
Children	423,230	36,270	11,669
HIV/AIDS	51,904	12,930	4,014
SMI	41,711	3,243	12,862
TBI/SCI	631,177	17,193	36,711

Notes: FY refers to fiscal year. Aged includes waivers targeting individuals age 65 and older. Aged and disabled includes waivers targeting both individuals age 65 and older and those with physical disabilities. Physically disabled includes waivers targeting individuals with physical disabilities. ID/DD refers to individuals with intellectual or developmental disabilities and includes waivers targeting this population. TBI/SCI refers to individuals with traumatic brain injury or spinal cord injury and includes waivers targeting this population. SMI refers to individuals with severe mental illness and includes waivers targeting this population.

Source: KCMU 2014a.

that provide round-the-clock residential support (such as ICFs/ID) also have higher per-person annual expenditures than other LTSS facilities (such as nursing facilities) (Eiken et al. 2014).

Individuals age 65 and older or individuals with physical disabilities. Individuals age 65 and older and individuals under age 65 with physical disabilities have lower expenditures on average than other LTSS users, despite the fact that individuals age 65 and older have higher institutional utilization rates (Eiken et al. 2014). They comprise the largest share of participants (49 percent) in HCBS waiver programs (Table 2-6) (KCMU 2014a). Per enrollee expenditures for this group in HCBS waivers are generally less than expenditures for ID/DD waivers but greater than those for persons in waivers serving individuals with mental illness (Table 2-6).

Individuals with serious mental illness (SMI). Individuals with SMI represent another substantial share of individuals who use LTSS. Adults with SMI represented over a third (37 percent) of SSI recipients nationwide; about 42 percent of all LTSS users enter through the SSI pathway (described previously) (SSA 2012).[24]

The population with SMI tends to use LTSS differently than other disability-specific groups. Whereas other LTSS users have needs that are relatively consistent over time, those with SMI may have episodic periods of need that would qualify them for LTSS combined with periods of relatively low functional impairment. In these periods of improvement, individuals with SMI may no longer qualify for services restricted to enrollees with severe disabilities, although providing continued services can prevent acute exacerbation of symptoms (ASPE 1995).

Persons with SMI account for an extremely small share of enrollment (0.2 percent) among HCBS waiver programs (Table 2-6). This may reflect the fact that states are not permitted to use Medicaid funds to operate institutions for the working age population with SMI (§1905(a)(29)(B)). Given the lack of Medicaid support for institutional care, states considering a Section 1915(c) HCBS waiver targeting adults with SMI often find it difficult to make the case that costs will be the same under HCBS (Shirk 2006).[25] States may therefore serve individuals with SMI by tailoring certain optional state plan services, such as rehabilitation or Section 1915(i) state plan HCBS.[26] Despite their relatively small enrollment in Section 1915(c) waiver programs, individuals with SMI have high per capita total Medicaid expenditures, which may include non-waiver LTSS (such as rehabilitation) and other acute services (GAO 2014).

Individuals who are medically frail or have hospital level-of-care needs. States have developed Section 1915(c) HCBS waiver programs to provide services to individuals who meet hospital level-of-care criteria and who are medically frail and have complex health needs. These may focus on individuals with conditions such as HIV/AIDS who require intensive, long-term medical care to maintain their functioning and quality of life and children who are medically complex and may have high medical expenses related to equipment and aids they need on a daily basis. Of those states that have developed waivers for these populations, 23 have targeted individuals with brain injury and 13 have targeted individuals with HIV/AIDS. Individuals with traumatic brain injury or spinal cord injury (TBI/SCI) made up 1 percent of HCBS waiver enrollment in FY 2010, and individuals with HIV/AIDS made up 0.9 percent (Table 2-6). Similar to individuals with SMI, total Medicaid expenditures for individuals with HIV/AIDS are substantial and may indicate use of other Medicaid services in addition to LTSS (GAO 2014).

Looking Ahead

LTSS are now provided to Medicaid enrollees who need them through a patchwork of services and eligibility policies that differ by state, enrollee group, statutory authority, and other factors. Policy has evolved over time such that the pieces do not fit together in a way that seems rational, efficient, or best suited to the needs of enrollees with varying needs for support. Moreover, coordination with other state agencies that provide LTSS or other services that affect the provision of Medicaid LTSS complicates the task of reform.

The flexibility given to states has had its advantages. Waiver and demonstration programs, and flexibility in service design and payment methods have allowed states to innovate with providing LTSS to targeted groups of enrollees and to test new models. On the other hand, the broad array of programs and the lack of standardization in eligibility, functional assessment, payment methodologies, and quality measures make it difficult to determine what program features are most worthy of replication.

Federal policy could be changed to standardize eligibility pathways and LTSS benefits to begin addressing some of the issues around state variation in covering LTSS, but this would provide states with less control over program budgets and less ability to tailor benefits and program design to target resources where they are most needed. Moreover, the extent to which such variation contributes to inequitable and inefficient service utilization is not clear. Because there are few standard metrics of service use, outcomes, payment methods, or quality, comparison of outcomes and costs is difficult to make. Without these metrics, it is difficult for policymakers to understand how federal dollars are being spent and whether certain policies should be incentivized or discouraged.

From the beneficiary's perspective, different eligibility criteria across different LTSS programs may be confusing, allow individuals with similar functional limitations to receive different services, and affect access. Enrollees using Medicaid LTSS are often enrolled in both Medicaid and state-only funded programs. They may have to communicate with multiple, uncoordinated entities, which can lead to delayed eligibility determinations, impeded access to services, and even unnecessary institutionalization.

Several other issues also complicate the task of designing a more rational and efficient system of LTSS.

First, decisions about how much and what type of assistance federal and state governments should provide are part of a broader unresolved conversation about the appropriate roles of individuals in planning for potential long-term care needs, family participation in caregiving, and the notion of independence and engagement for the individual. Not all families have the financial resources or skills to provide the care their loved ones need. And for some, leaving family caregivers for independent life in the community is consistent with autonomy and community engagement. Moreover, needs for LTSS are highly individualized. What might be sufficient support for one person might not work for another.

Second, the movement to keep individuals out of institutional settings assumes that people with LTSS needs have appropriate housing. While Medicaid can pay for individuals to reside in institutional and group home settings, the restriction makes it more difficult to keep people in the community when enrollees do not have the ability to pay for housing or housing modifications needed to accommodate their functional limitations, regardless of the other HCBS services Medicaid can provide.

Third, interactions between Medicaid LTSS and other payers create an additional set of challenges for policymakers to consider. As previously mentioned, over two-thirds of Medicaid enrollees who use LTSS are also covered by Medicare. Therefore, policy makers should consider how changes made to Medicare coverage of services affect Medicaid LTSS for this population. For example, CMS is testing new delivery systems for dually eligible enrollees through the Financial Alignment Initiative demonstrations, including how and where they receive LTSS. The recent court decision in *Jimmo v. Sebelius* that addressed Medicare coverage of skilled care services also raises questions around the interaction of Medicare and Medicaid in providing such services to those dually enrolled in both programs.

Changes in service delivery among payers in addition to Medicare may also directly affect how Medicaid covers LTSS for its enrollees. For individuals with private coverage, which services—including LTSS such as therapies, respite care or personal care—health plans choose to cover will also be a factor in how these LTSS can be provided to individuals in need.

Next Steps

Keeping in mind the complicated issues related to Medicaid LTSS, MACPAC has identified several areas where it could contribute to building understanding and moving policy in the direction of a more efficient and effective system of LTSS. These include examining the design and policy issues associated with the movement to managed long-term services and supports (MLTSS), studying the use of HCBS waivers, assessing the merits of moving to standardized functional assessments for Medicaid LTSS, and analyzing how to improve data on LTSS to support policy analysis, evaluation, and future program design.

Managed long-term services and supports (MLTSS)

The number of states with MLTSS programs doubled from 8 to 16 between 2004 and 2012, and the number of persons receiving LTSS through managed care programs increased from 105,000 to 389,000. The number of states projected to have MLTSS programs by 2014 is 26 (Saucier, et al. 2012). MLTSS programs differ in terms of populations and services covered, the types of organizations managing services, and the level of integration with other types of services.

MLTSS models are still developing, and there is limited systematic information across states about how well they perform on cost and quality metrics. However, there are recent efforts to address these concerns. For example, many states that are participating in the Financial Alignment Initiative are testing the capitated model, which requires managed care plans participating in the states' demonstrations to be at risk for LTSS for individuals dually enrolled in Medicare and Medicaid. The evaluations and outcomes that result from the Financial Alignment demonstrations will affect enrollees who receive LTSS. Although these demonstrations focus on people dually enrolled in Medicare and Medicaid, many of the state demonstrations have policies and protections that can inform how to best deliver MLTSS to all Medicaid enrollees who use LTSS.

In the year ahead, MACPAC will be conducting in-depth site visits to five states that have implemented managed care delivery of LTSS. This study is designed to address questions on how programs operate; what roles and responsibilities are delegated to different entities and how these activities are managed; how oversight and enforcement of the MLTSS contractor is conducted and by whom; what is known about the differences in cost, service utilization, level of integration across LTSS and other health care services including acute care and pharmacy, provider participation, and beneficiary satisfaction; and other issues. We will continue to track the growth and maturation of MLTSS and emerging information on how these arrangements affect access to care and expenditures.

HCBS waivers

Although HCBS waivers have proliferated, the significant variation in eligibility requirements and benefits makes it difficult to compare programs across states and populations. MACPAC will take a deeper look at the use of waivers and strategies to increase the efficiency of delivering HCBS. We plan to explore states' use of HCBS waivers, recent changes to reduce administrative burden, and any further steps that might be taken to respond to states' concerns around waiver complexity. The use of waiting lists for HCBS waivers also requires further exploration, including to what extent the waiver programs meet need and demand, different strategies states use to prioritize access to HCBS, and ways in which data can be improved to better document and describe the size and scope of unmet need for HCBS.

In the same regard, a better understanding of how service utilization of both acute and LTSS is affected for enrollees who must wait for services may help identify potential areas that can be improved. MACPAC will consider ways to balance states' desires to target programs to their specific populations with CMS' responsibility to oversee the programs by using reporting requirements that are effective and efficient.

Standardizing eligibility assessments

Medicaid LTSS may be improved in some ways by better matching LTSS to enrollee needs. Implementing standardized assessments has been identified as a potential strategy to achieve this result, and several states are in the process of doing so either independently or as a result of their participation in the BIP, which requires participating states to institute a core standardized assessment. As standardization increases, however, individualization may decrease and this may be at odds with efforts to develop person-centered services.

Additionally, standardized eligibility assessments and prestructured care plans may not capture information on individual circumstances and support and acute care needs that are integral to achieving optimal outcomes for the enrollee. The omission of an enrollee's individual support needs when subsequently developing the plan of care for that individual may lead to inappropriate allocation of services and supports.

MACPAC will monitor trends in standardization of functional eligibility assessments across states and programs. We hope to learn more about the relationship of these standardized measures to utilization, expenditures, and, ideally, outcomes. Further examination of states that have developed more advanced standardized assessment systems—as well as those states participating in the BIP—may provide useful insights on how to create a more streamlined and equitable assessment system for determining eligibility for Medicaid LTSS.

Data

Much of the information sought about Medicaid LTSS users—the types of services they need and use, the goals of service plans and expected outcomes, where they receive care, and payments at the service level—are not discernible from current data sources. For example, there is no federal data source that allows policymakers to compare HCBS utilization and expenditures across states and programs. This knowledge gap makes it difficult to develop effective policy solutions, although much can be learned from states' experiences operating HCBS programs. However, CMS has developed methods by which Medicaid administrative data can be analyzed by different disabling conditions and can further refine expenditures into more specific categories of LTSS (such as specific types of HCBS) (CMS 2013, Peebles and Bohl 2013).

Two areas appear to be promising avenues for MACPAC to pursue. First the Commission could monitor incorporation of the new HCBS taxonomy (a uniform classification system for HCBS) into the Transformed Medicaid Statistical Information System (T-MSIS) to integrate standardized definitions of HCBS; the Commission could then consider how such data might be used to compare and evaluate HCBS across states and programs and also to link provision of HCBS with clinical outcomes when possible.[27] On issues related to payment and financing, MACPAC will also document payment methodologies used by states to pay for LTSS and to set capitation rates that include LTSS, and investigate the adequacy of LTSS financing.

Endnotes

[1] *Katie A. v. Douglas,* CV-02-05662 AHM (SHX) (C.D. Cal. 2011) (Formerly *Katie A. v. Bonta*) and *T.R. et al. v. Kevin Quigley and Dorothy Teeter,* C09-1677 – TSZ (W.D. Wash. 2013) (Formerly *T.R. et al. v. Kevin Quigley and Dorothy Teeter,* C09-1677-JPD).

[2] *Moore v. Reese,* 637 F.3d 1220, 1224-29 (11th Circuit Court of Appeals 2011).

[3] On January 24, 2013, the U.S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius* that required the Centers for Medicare & Medicaid Services (CMS) to clarify that Medicare beneficiaries who required a covered level of skilled care could not be denied services if their health would not be restored or improved. Federal regulations specify that the restoration of a patient is not the deciding factor in determining whether skilled services are needed and even if full recovery or medical improvement is not possible, a beneficiary may still need (and receive) skilled services to prevent further deterioration or preserve current capabilities.

[4] Level-of-care (LOC) criteria may be based on specific diagnoses or conditions; on functional status as measured by activities of daily living (ADLs) such as bathing, dressing, or eating; on enrollees' functional performance measured by instrumental activities of daily living (IADLs) such as shopping, money management, or medication management; on other functional skills such as adaptive behaviors; or on other criteria. States may also examine an individual's cognitive, behavioral, or other impairments; medical or nursing needs; presence of informal supports; and functional limitations related to ability to perform ADLs and IADLs or major life activities. Some states have established a high threshold for the LOC criteria used to determine LTSS eligibility—such as requiring an individual to be dependent in four or more ADLs—while other states may require dependency in two ADLs. Most states also use a combination of specific diagnosis and some functionally based level of care for assessment purposes for both determining LOC eligibility for nursing facilities and intermediate care facilities for individuals with intellectual and developmental disabilities (ICFs/ID) as well as home and community-based services (HCBS) waiver programs (Hendrickson 2008, Zaharia 2008).

[5] Federal statute allows states to serve individuals with LTSS needs who have higher levels of income than other Medicaid enrollees (e.g., individuals who come through the special income level pathway (§1902(a)(10)(A)(ii)(V) of the Act)).

[6] The 209(b) states are: Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. These states have more restrictive financial and non-financial (e.g., definition of disability) criteria than SSI. However, these criteria may not be more restrictive than those in effect on January 1, 1972.

[7] Thirty-three states and the District of Columbia request the Social Security Administration (SSA) to make Medicaid eligibility determinations, under a 1634 agreement. Alaska, Idaho, Kansas, Nebraska, Nevada, Commonwealth of the Northern Mariana Islands, Oregon, and Utah make their own Medicaid determinations using SSA criteria.

[8] In FY 2014, the federal poverty level (100 percent FPL) is $11,670 for an individual and $4,060 for each additional family member in the lower 48 states and the District of Columbia.

[9] In FY 2010, 35 percent of LTSS users were eligible under the special income level or one of the other optional eligibility pathways such as Katie Beckett. Although a future version of the data source used to calculate this statistic (the federal Medicaid Statistical Information System) will collect additional detail on the eligibility categories under which individuals enroll in Medicaid, it is not currently possible to determine how many of this group were eligible under the special income level.

[10] As of November 2013, California had submitted three Section 1915(i) state plan amendments (one has been approved); North Carolina had submitted two Section 1915(i) state plan amendments.

[11] Federal statute prohibits individuals from transferring assets to another individual or transferring an asset into an irrevocable trust in the five years prior to applying for Medicaid (§1917(c) of the Act).

[12] Nursing home residents and residents of ICFs/ID may retain a monthly personal needs allowance (PNA) that can be used by the beneficiary to pay for goods and services not provided by the facility or covered by Medicaid (the facility payment covers room and board of the beneficiary). In 2009, PNA amounts ranged from $30 to $100 per month (Stone 2011). Medicaid beneficiaries in HCBS waiver programs are allowed a monthly maintenance needs allowance (MMNA), the amount of which is what an HCBS waiver participant may retain for living expenses. States that offer eligibility to individuals under the special income level pathway may also set an unlimited MMNA, so long as any income above the special income level (e.g., any amounts above 300 percent SSI) is placed in a Miller Trust (§1902(a)(10)(A)(ii)(V) and §1917(d) of the Act).

[13] The statutory authority waived under Section 1115 and Section 1915(c) of the Act may vary considerably across states and individual waiver requests. Under Section 1115 CMS may grant waivers as necessary to carry out an experimental, pilot or demonstration project likely to assist in promoting the objectives of the Medicaid program. Section 1915(c) provides states the option to modify their Medicaid programs to implement specific statutorily defined program options (e.g., home and community-based services). The application and approval processes also vary for Section 1115 and Section 1915(c) waiver requests.

[14] States often have more individuals requesting Section 1915(c) waiver services than the enrollment limit or program budget can accommodate. As a result, states may maintain waiting lists for these waivers.

[15] CMS requires states to renew Section 1115 waivers every three years and Section 1915(c) waivers every five years after the initial three-year approval.

[16] Delaware, Hawaii, New York, Tennessee, and Texas provide LTSS to various populations under both Section 1115 and Section 1915(c) authority.

[17] Housing costs include real estate costs (such as rent, furnishings, utilities, maintenance, etc.) and food costs (separate from the cost of meal preparation services provided by staff).

[18] Policies—such as spousal impoverishment, institutional deeming rules, income disregards, and special needs trusts—eliminate the upper income limits for receipt of Medicaid LTSS, allowing individuals who would otherwise not qualify due to income or assets to access Medicaid LTSS. States may also require individuals to contribute to the costs of their care above any established personal needs or monthly maintenance needs allowances retained by the individual and via estate recovery programs after their deaths.

[19] MACPAC analysis of the National Survey of Children's Health, online tabulations available from http://www.childhealthdata.org/browse/survey?s=2.

[20] A recent databook on dually eligible enrollees provides a more complete picture of spending on this population, including both Medicaid and Medicare spending (MACPAC and MedPAC 2013).

[21] The remaining share of Medicaid LTSS users who are dually enrolled in Medicaid and Medicare include individuals who received Medicaid assistance only with Medicare cost sharing for services provided in the Medicare program (referred to as partial-benefit dually eligible enrollees). See Chapter 4 in MACPAC's March 2013 report to the Congress for further information.

[22] States must designate target population groups for a single Section 1915(c) waiver or Section 1915(i) state plan amendment. The target population groups may include any of the three primary populations (individuals with intellectual or developmental disabilities, individuals with disabilities, or individuals who are over age 65), a subpopulation of these groups (e.g., individuals with mental illness), or any combination of groups (CMS 2014a).

[23] Sources of Medicaid administrative data are primarily designed to pay claims rather than to facilitate analysis of populations by their diagnosis or the functional impairment that was the original basis for an individual's disability determination. In order to determine the different types of disabilities and conditions that individuals with long-term care needs have, alternative data sources—such as the Social Security Administration data and HCBS waiver enrollment information—are often used. LTSS expenditures by condition subgroups is obtainable but has not been widely analyzed, and current data sources are limited in their ability to capture data on groups being served in managed care programs.

[24] According to SSA data, a mental disorder includes, for example, schizophrenia, bipolar disorder, psychosis, or depression. HCBS waivers may target individuals with mental illness that creates a need for institutional level of care, irrespective of diagnosis.

[25] To be approved by CMS, average per capita costs of a Section 1915(c) HCBS waiver program must not exceed what the average per capita institutional costs would have been under the state plan if the waiver had not been in operation (CMS 2008). Because state plan services do not include institutional services for adults age 18–64 with serious mental illness (institutes for mental disease), states may not have any institutional costs for this population.

[26] In 2007, 47 states provided some type of mental health services under rehabilitation state plan services, and in 2004, 73 percent of enrollees receiving these services had mental illnesses (KCMU 2007).

[27] CMS developed the HCBS taxonomy to create a common language for describing and categorizing HCBS (Peebles and Bohl 2013). See MACPAC's June 2013 report to the Congress on CMS' efforts to improve Medicaid data issues.

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Chapter 2 Appendix

APPENDIX TABLE 2-A-1. Individuals with Developmental Disabilities: Shared Responsibility among Medicaid and Other State Entities in Providing Medicaid LTSS by State, 2013

State	Part of the Same Agency as Medicaid?	Reports to Medicaid Director?	Location If Not under Medicaid Director
Alabama	No	No	Division of Developmental Disabilities, Department of Mental Health
Alaska	Yes	Yes	n/a
Arizona	No	No	Division of Developmental Disability Services, Department of Economic Security
Arkansas	Yes	No	Division of Developmental Disabilities Services, Department of Human Services
California	No	No	Department of Developmental Services
Colorado	Yes	Yes	n/a
Connecticut	No	No	Department of Developmental Services
Delaware	Yes	No	Division of Developmental Disabilities Services, Delaware Health and Social Services
District of Columbia	Yes	Yes[1]	n/a
Florida	No	No	Agency for Persons with Disabilities
Georgia	Yes	Yes	n/a
Hawaii	Yes	Yes[2]	n/a
Idaho	Yes	Yes[3]	n/a
Illinois	No	No	Department of Human Services
Indiana	No	No	Division of Disability and Rehabilitative Services, Family and Social Services Administration
Iowa	Yes	No	Division of Mental Health and Disability Services, Department of Human Services
Kansas	No	No	Department of Aging and Disability Services
Kentucky	No	No	Developmental and Intellectual Disabilities, Department of Behavioral Health
Louisiana	Yes	No	Office for Citizens with Developmental Disabilities, Department of Health and Hospitals
Maine	Yes	No	Office of Aging and Disability Services, Department of Health and Human Services
Maryland	Yes	No	Developmental Disabilities Administration, Department of Health and Mental Hygiene
Massachusetts	Yes	No	Department of Developmental Services
Michigan	Yes	No	Developmental Disability Administration, Department of Mental Health
Minnesota	Yes	No	Disability Services Division, Department of Human Services
Mississippi	No	No	Department of Mental Health
Missouri	No	No	Department of Mental Health
Montana	Yes	Yes	n/a
Nebraska	Yes	No	Division of Developmental Disabilities, Department of Health and Human Services
Nevada	Yes	No	Division of Public and Behavioral Health, Department of Health and Human Services
New Hampshire	Yes	No	Bureau of Developmental Services, Department of Health and Human Services
New Jersey	Yes	No	Division of Developmental Disabilities, Department of Human Services
New Mexico	No	No	Developmental Disabilities Services Division, Department of Health
New York	No	No	Office for People with Developmental Disabilities
North Carolina	Yes	No	n/a
North Dakota	Yes	No	Developmental Disabilities Division, Department of Human Services
Ohio	No	No	Department of Developmental Disabilities
Oklahoma	No	No	Department of Human Services
Oregon	No	No	Department of Human Services
Pennsylvania	Yes	No	Office of Developmental Programs, Department of Public Welfare
Rhode Island	No	No	Developmental Disabilities and Hospitals, Department of Behavioral Healthcare
South Carolina	Yes	Yes[4]	n/a
South Dakota	No	No	Department of Human Services
Tennessee	No	No	Department of Intellectual and Developmental Disabilities
Texas	Yes	No	Department of Aging and Disability Services
Utah	No	No	Department of Human Services
Vermont	Yes	No	Division of Disability and Aging Services, Department of Disabilities, Aging & Independent Living
Virginia	Yes	No	Department of Behavioral Health and Developmental Services
Washington	No	No	Developmental Disabilities Administration, Department of Social and Health Services
West Virginia	No	No	Bureau of Behavioral Health and Health Facilities Department of Health & Human Resources
Wisconsin	Yes	No	Division of Long Term Care, Department of Health Services
Wyoming	Yes	No	Behavioral Health Division, Department of Health

Notes: LTSS refers to long-term services and supports. HCBS refers to home and community-based services.

[1] Developmental Disabilities Administration of the Department of Disability Services is the operating agency for the HCBS waiver program, and the Department of Health Care Finance is the administrative agency.

[2] To receive services, an individual must be referred by a case manager from the Developmental Disabilities Division of the Department of Health.

[3] Idaho Medicaid shares responsibilities with Family and Children Services (FACS) and the Department of Health and Welfare. FACS administers case management for the children's developmental disabilities waiver. An independent contractor also plays a role in determining level-of-care eligibility for waiver services.

[4] Department of Health and Human Services partners with the Department of Disabilities and Special Needs to serve individuals with developmental disabilities.

Source: State website search, 2013.

APPENDIX TABLE 2-A-2. Individuals Age 65 and Older and Individuals Physically Disabled: Shared Responsibility among Medicaid and Other State Entities in Providing Medicaid LTSS by State, 2013

State	Part of the Same Agency as Medicaid?	Reports to Medicaid Director?	Location If Not under Medicaid Director
Alabama	No	No	Departments of Senior Services and Rehabilitation Services
Alaska	Yes	Yes	n/a
Arizona	Yes	Yes	n/a
Arkansas	Yes	Yes	n/a
California	Yes	Yes	n/a
Colorado	Yes	Yes	n/a
Connecticut	Yes	Yes	n/a
Delaware	Yes	Yes	n/a
District of Columbia	Yes	Yes	n/a
Florida	Yes	Yes	n/a
Georgia	Yes	Yes	n/a
Hawaii	Yes	Yes	n/a
Idaho	Yes	Yes	n/a
Illinois	Yes	Yes	n/a
Indiana	No	No	Division of Aging, Family and Social Services Administration
Iowa	Yes	Yes	n/a
Kansas	Yes	No	Department of Aging and Disability Services
Kentucky	Yes	Yes	n/a
Louisiana	Yes	No	Office of Aging and Adult Services, Department of Health and Hospitals
Maine	Yes	Yes	n/a
Maryland	Yes	No	Maryland Department of Aging
Massachusetts	Yes	Yes	n/a
Michigan	Yes	Yes	n/a
Minnesota	Yes	No	Aging and Adult Services Division, Department of Human Services
Mississippi	Yes	Yes	n/a
Missouri	No	No	Department of Health and Senior Services
Montana	Yes	No	Senior and Long Term Care Division, Department of Public Health and Human Services
Nebraska	Yes	Yes	n/a
Nevada	Yes	No	Division of Aging and Disability Services, Department of Health and Human Services
New Hampshire	Yes	No	Bureau of Elderly and Adult Services, Department of Health and Human Services
New Jersey	Yes	No	Division of Aging Services, Department of Human Services
New Mexico	Yes	Yes	n/a
New York	Yes	Yes	n/a
North Carolina	Yes	Yes	n/a
North Dakota	Yes	Yes	n/a
Ohio	Yes	Yes	n/a
Oklahoma	Yes	No	Long Term Care Services Division, Department of Human Services
Oregon	No	No	Department of Human Services
Pennsylvania	Yes	No	Office of Long Term Living, Department of Public Welfare
Rhode Island	Yes	No	Long Term Care Office, Department of Human Services
South Carolina	Yes	Yes	n/a
South Dakota	Yes	No	Division of Adult Services and Aging, Department of Social Services
Tennessee	Yes	Yes	n/a
Texas	Yes	No	Department of Aging and Disability Services
Utah	Yes	Yes	n/a
Vermont	Yes	No	Aging and Independent Living, Department of Disabilities
Virginia	Yes	Yes	n/a
Washington	No	No	Aging & Disability Services Administration, Department of Social & Health Services
West Virginia	Yes	Yes	n/a
Wisconsin	Yes	No	Division of Long Term Care, Department of Health Services
Wyoming	Yes	Yes	n/a

Note: LTSS refers to long-term services and supports.

Source: State website search, 2013.

APPENDIX TABLE 2-A-3. Individuals with Serious Mental Illness: Shared Responsibility among Medicaid and Other State Entities in Providing Medicaid LTSS by State, 2013

State	Part of the Same Agency as Medicaid?	Reports to Medicaid Director?	Location If Not under Medicaid Director
Alabama	Yes	Yes	n/a
Alaska	Yes	Yes	n/a
Arizona	No	No	Division of Behavioral Health Services, Department of Health Services
Arkansas	Yes	Yes	n/a
California	Yes	Yes	n/a
Colorado	Yes	Yes	n/a
Connecticut	No	No	Connecticut Behavioral Health Partnership
Delaware	Yes	Yes	n/a
District of Columbia	Yes	Yes	n/a
Florida	Yes	Yes	n/a
Georgia	Yes	Yes	n/a
Hawaii	Yes	Yes[1]	n/a
Idaho	Yes	Yes	n/a
Illinois	Yes	Yes	n/a
Indiana	Yes	Yes	n/a
Iowa	Yes	No	Division of Mental Health and Disability Services, Department of Human Services
Kansas	Yes	Yes[2]	n/a
Kentucky	Yes	Yes	n/a
Louisiana	Yes	No	Office of Behavioral Health, Department of Health and Hospitals
Maine	Yes	No	Office of Substance Abuse and Mental Health Services, Department of Health and Human Services
Maryland	Yes	No	Office of Behavioral Health and Disabilities, Department of Health and Mental Hygiene
Massachusetts	Yes	Yes	n/a
Michigan	Yes	No	Behavioral Health and Developmental Disabilities Administration, Department of Community Health
Minnesota	Yes	No	Mental Health Services Division, Department of Human Services
Mississippi	Yes	Yes	n/a
Missouri	Yes	Yes	n/a
Montana	Yes	Yes	n/a
Nebraska	Yes	No	Division of Behavioral Health, Department of Health and Human Services
Nevada	Yes	Yes	n/a
New Hampshire	Yes	Yes	n/a
New Jersey	Yes	No	Department of Children and Families
New Mexico	Yes	No	Behavioral Health Services Division, Department of Health
New York	Yes	Yes[3]	n/a
North Carolina	Yes	No	Division of Mental Health, Developmental Disabilities and Substance Abuse, Department of Health and Human Services
North Dakota	Yes	Yes	n/a
Ohio	Yes	Yes	n/a
Oklahoma	Yes	Yes	n/a
Oregon	Yes	No	Addictions and Mental Health Services, Department of Human Services
Pennsylvania	Yes	No	Office of Mental Health and Substance Abuse Services, Department of Public Welfare
Rhode Island	No	No	Developmental Disabilities and Hospitals, Department of Behavioral Healthcare,
South Carolina	Yes	Yes	n/a
South Dakota	Yes	No	Division of Community Behavioral Health, Department of Social Services
Tennessee	Yes	Yes	n/a
Texas	Yes	No	Department of State Health Services
Utah	Yes	Yes	n/a
Vermont	Yes	No	Department of Mental Health
Virginia	Yes	Yes	n/a
Washington	No	No	Division of Behavioral Health and Recovery, Department of Social & Health Services
West Virginia	Yes	Yes	n/a
Wisconsin	Yes	No	Division of Mental Health and Substance Abuse Services, Department of Health Services
Wyoming	Yes	No	Behavioral Health Division, Department of Health

Note: LTSS refers to long-term services and supports.

[1] Most behavioral health services for Medicaid enrollees (except for certain members) were consolidated under MedQuest, effective September 2013. The Adult Mental Health Division, Department of Health retains responsibilities for crisis and court-ordered treatment services.

[2] KanCare includes behavioral health benefits, but policy, licensure, and program development remains with the Department of Aging and Disability Services.

[3] Office of Mental Health is responsible for operation of state public mental health system, rate setting, and Medicaid Behavioral Health Organization initiative for Medicaid managed care enrollees.

Source: State website search, 2013.

APPENDIX TABLE 2-A-4. Medicaid Long-Term Services and Support (LTSS) Benefits by State

State	Nursing Facility	Home Health	ICF/ID	Mental Health Facility >65	Mental Health Facility <21	Personal Care	1915(c) HCBS Waiver[1]	1915(i) HCBS[2]	1915(j) Personal Assistance[3]	1915(k) Community First Choice[2]	Private Duty Nursing	Rehab-ilitation	Targeted Case Manage-ment[3]
Total	**51**	**51**	**48**	**46**	**51**	**31**	**48**	**15**	**1**	**3**	**23**	**51**	**40**
Alabama	✓	✓	✓	✓	✓		✓					✓	✓
Alaska	✓	✓	✓	✓	✓	✓	✓					✓	
Arizona	✓	✓	✓	✓	✓	✓					✓	✓	
Arkansas	✓	✓	✓		✓	✓	✓				✓	✓	✓
California	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
Colorado	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
Connecticut	✓	✓	✓	✓	✓		✓	✓				✓	✓
Delaware	✓	✓	✓	✓	✓		✓				✓	✓	
District of Columbia	✓	✓	✓	✓	✓	✓	✓				✓	✓	
Florida	✓	✓	✓	✓	✓		✓	✓	✓			✓	✓
Georgia	✓	✓	✓		✓		✓					✓	✓
Hawaii	✓	✓	✓		✓		✓					✓	✓
Idaho	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓
Illinois	✓	✓	✓	✓	✓		✓					✓	✓
Indiana	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓
Iowa	✓	✓	✓	✓	✓		✓	✓				✓	
Kansas	✓	✓	✓	✓	✓		✓					✓	✓
Kentucky	✓	✓	✓	✓	✓		✓					✓	✓
Louisiana	✓	✓	✓	✓	✓	✓	✓	✓				✓	
Maine	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
Maryland	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
Massachusetts	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
Michigan	✓	✓		✓	✓	✓	✓					✓	✓
Minnesota	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	
Mississippi	✓	✓	✓		✓		✓					✓	
Missouri	✓	✓	✓	✓	✓	✓	✓					✓	✓
Montana	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓
Nebraska	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
Nevada	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
New Hampshire	✓	✓		✓	✓	✓	✓				✓	✓	✓
New Jersey	✓	✓	✓	✓	✓	✓	✓					✓	✓
New Mexico	✓	✓	✓	✓	✓	✓	✓					✓	✓
New York	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
North Carolina	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
North Dakota	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
Ohio	✓	✓	✓	✓	✓		✓				✓	✓	✓
Oklahoma	✓	✓	✓	✓	✓	✓	✓					✓	✓
Oregon	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓	✓
Pennsylvania	✓	✓	✓	✓	✓		✓					✓	✓
Rhode Island	✓	✓	✓	✓	✓	✓					✓	✓	✓
South Carolina	✓	✓	✓	✓	✓		✓					✓	✓
South Dakota	✓	✓	✓	✓	✓	✓	✓					✓	
Tennessee	✓	✓	✓	✓	✓		✓				✓	✓	✓
Texas	✓	✓	✓	✓	✓	✓	✓					✓	✓
Utah	✓	✓	✓	✓	✓	✓	✓				✓	✓	✓
Vermont	✓	✓	✓	✓	✓						✓	✓	✓
Virginia	✓	✓	✓	✓	✓		✓					✓	✓
Washington	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	
West Virginia	✓	✓	✓		✓	✓	✓					✓	
Wisconsin	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓
Wyoming	✓	✓	✓	✓	✓		✓					✓	✓

Notes: FY refers to fiscal year. HCBS refers to home and community-based services. ICF/ID refers to intermediate care facilities for individuals with intellectual or developmental dissabilities. Although these Medicaid benefits are listed in statute, the breadth of coverage (i.e., amount, duration, and scope) and included services within specific benefits (e.g., HCBS) varies by state. The table lists Medicaid LTSS benefits that are described in federal statute or regulations and reflect available benefits as of October 2012, except where noted. The presence of a service within a states' benefit package does not always mean that enrollees are able to utilize those services.

1 Four states (AZ, HI, RI, VT) provide HCBS via Section 1115 waiver. This number is different from the three states mentioned in the text of the chapter because of the different source years used for the data.

2 Includes only states that have submitted state plan amendments (including those who have not yet received approval) as of November 2013 for 1915(i) and as of April 2014 for 1915(k).

3 Information on Section 1915(j) and targeted case management was derived from expenditures reported by states in FY 2013.

Sources: KCMU 2014b, NASUAD 2014, NASUAD 2013, MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

MACStats: Medicaid and CHIP Program Statistics

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Overview

MACStats, a standing section in all MACPAC reports to the Congress, presents data and information on Medicaid and the State Children's Health Insurance Program (CHIP) that otherwise can be difficult to find and are spread out across multiple sources. The June 2014 edition of MACStats is divided into five sections.

Section 1: Trends in Medicaid Enrollment and Spending

- Growth in Medicaid spending and enrollment has varied over the years, reflecting shifts in federal and state policy along with changing economic conditions (Figures 1 and 2).
- Enrollment trends vary by eligibility group. Non-disabled children experienced the largest enrollment increase in absolute numbers between fiscal year (FY) 1975 and FY 2011 (Table 1). However, enrollment among the smaller group of individuals qualifying for Medicaid on the basis of a disability showed the largest percentage increase over this time period.

Section 2: Health and Other Characteristics of Medicaid/CHIP Populations

- The characteristics of individuals enrolled in Medicaid and CHIP differ from those with other types of coverage, but there is also great diversity within the Medicaid/CHIP population (Tables 2–10).
- Medicaid/CHIP enrollees generally report being in poorer health and using more services than individuals who have other health insurance or who are uninsured (Tables 3, 6, and 9).

Section 3: Medicaid Enrollment and Benefit Spending

- Individuals eligible on the basis of a disability and those age 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Tables 11 and 12).
- Medicaid spending per enrollee is affected by large numbers of individuals with limited benefits in some states (Table 13).
- Users of Medicaid long-term services and supports are a small but high-cost population (Figures 5–7).

Section 4: Medicaid Managed Care

- About half of Medicaid enrollees are in comprehensive risk-based managed care plans. When limited-benefit plans and primary care case management programs are also included, more than 70 percent of enrollees are in some form of managed care (Table 14).
- The national percentage of Medicaid benefit spending on any form of managed care ranges from about 10 percent among enrollees age 65 and older to more than 40 percent among non-disabled child and adult enrollees (Table 15).

Section 5: Technical Guide to the June 2014 MACStats

This section provides supplemental information to accompany the tables and figures in Sections 1–4 of MACStats. It describes some of the data sources used in MACStats, the methods that MACPAC uses to analyze these data, and reasons why numbers in MACStats tables and figures—such as those on enrollment and spending—may differ from each other or from those published elsewhere.

SECTION 1

Key Points

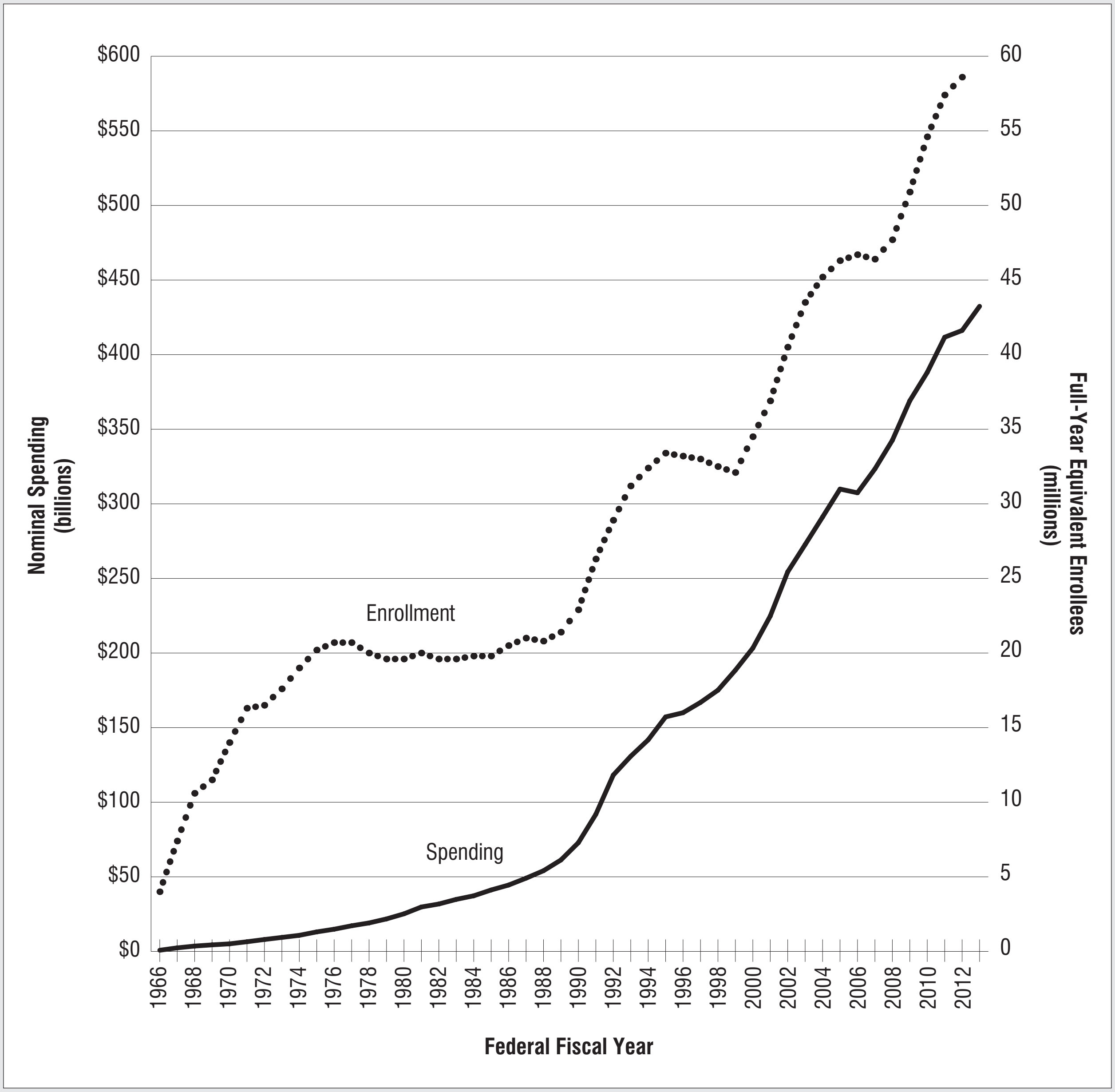
Trends in Medicaid Enrollment and Spending

- Medicaid spending and enrollment are affected by both federal and state policy choices and economic factors. For example, the Congress made a number of changes that expanded eligibility for pregnant women and children between 1984 and 1990, with delayed effective dates or phase-in provisions that resulted in substantial growth in the number of enrollees through the mid-1990s (Figure 1). Economic recessions spurred enrollment growth at the beginning and end of the first decade of the 2000s.

- Prior to the 1990s, spending tended to grow at a faster annual rate than enrollment (Figure 2). In recent decades, annual growth rates for spending and enrollment have tracked more closely.

- Enrollment trends vary by eligibility group. Children (excluding those eligible on the basis of a disability) experienced the largest enrollment increase in absolute numbers, from 9.6 million in FY 1975 to 30.2 million in fiscal year (FY) 2011 (Table 1). However, enrollment among the smaller group of individuals qualifying for Medicaid on the basis of a disability showed the largest percentage increase over this time period (3.9 percent).

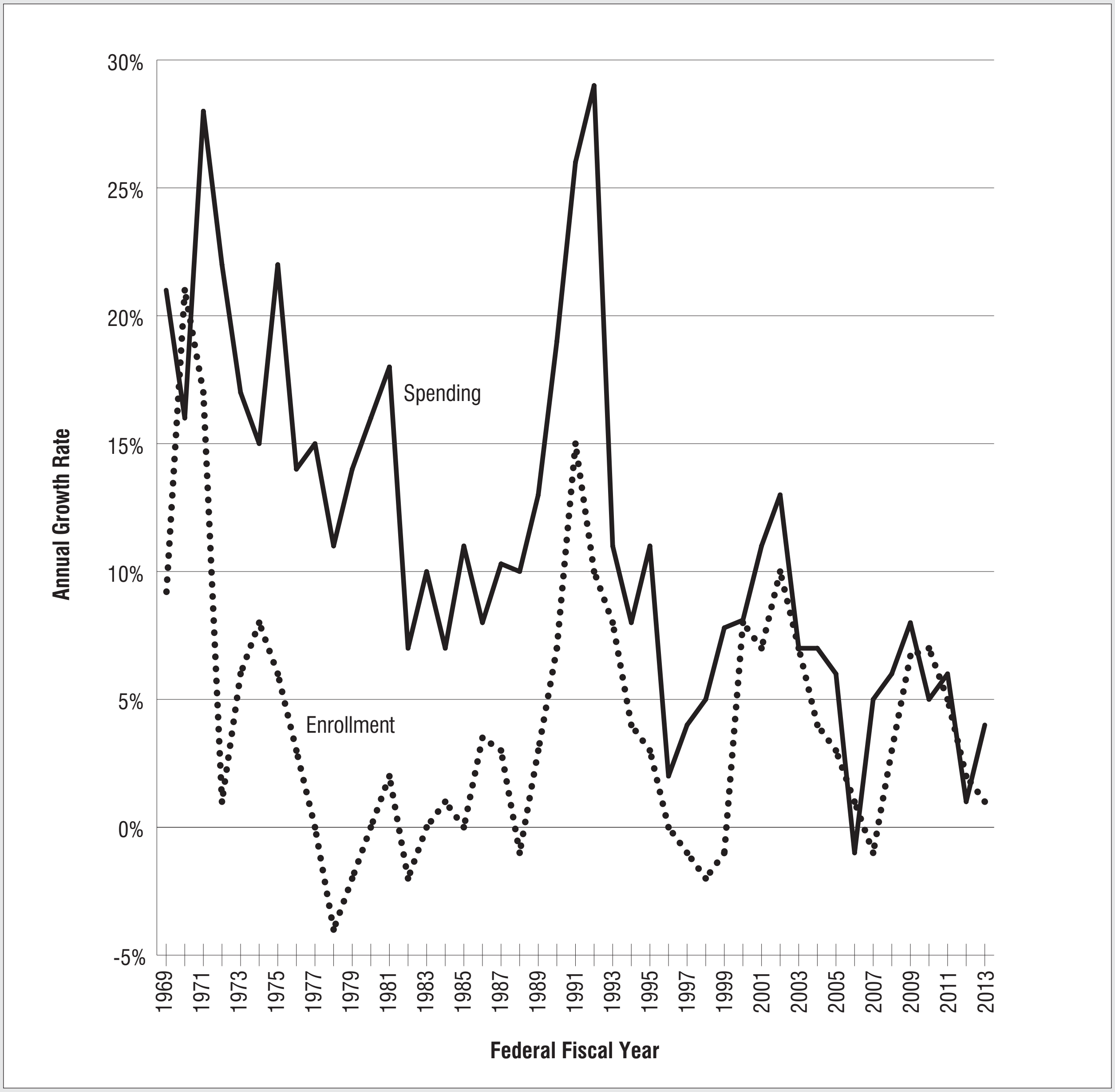
FIGURE 1. Medicaid Enrollment and Spending, FY 1966–FY 2013



Notes: Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Numbers exclude coverage financed by CHIP. Enrollment data for fiscal year (FY) 2011–2013 are projected. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). The amounts in this figure may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Enrollment counts are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served. (See Section 5 of MACStats for a discussion of how enrollees are counted.)

Source: Data compilation provided to MACPAC by the Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), April 2014.

FIGURE 2. Annual Growth in Medicaid Enrollment and Spending, FY 1969–FY 2013



Notes: Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Numbers exclude coverage financed by CHIP. Enrollment data for fiscal year (FY) 2011–2013 are projected. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). Annual growth rates prior to FY 1969 (not shown here) exceed 30 percent, reflecting the program's initial startup period. The amounts in this figure may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Enrollment counts used to calculate growth rates are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served. (See Section 5 of MACStats for a discussion of how enrollees are counted.)

Source: Data compilation provided to MACPAC by the Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), April 2014.

TABLE 1. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FY 1975–FY 2011 (thousands)

Year	Total	Children	Adults	Disabled	Aged	Unknown
1975	**22,007**	9,598	4,529	2,464	3,615	1,801
1976	**22,815**	9,924	4,773	2,669	3,612	1,837
1977	**22,832**	9,651	4,785	2,802	3,636	1,958
1978	**21,965**	9,376	4,643	2,718	3,376	1,852
1979	**21,520**	9,106	4,570	2,753	3,364	1,727
1980	**21,605**	9,333	4,877	2,911	3,440	1,044
1981	**21,980**	9,581	5,187	3,079	3,367	766
1982	**21,603**	9,563	5,356	2,891	3,240	553
1983	**21,554**	9,535	5,592	2,921	3,372	134
1984	**21,607**	9,684	5,600	2,913	3,238	172
1985	**21,814**	9,757	5,518	3,012	3,061	466
1986	**22,515**	10,029	5,647	3,182	3,140	517
1987	**23,109**	10,168	5,599	3,381	3,224	737
1988	**22,907**	10,037	5,503	3,487	3,159	721
1989	**23,511**	10,318	5,717	3,590	3,132	754
1990	**25,255**	11,220	6,010	3,718	3,202	1,105
1991	**27,967**	12,855	6,703	4,033	3,341	1,035
1992	**31,150**	15,200	7,040	4,487	3,749	674
1993	**33,432**	16,285	7,505	5,016	3,863	763
1994	**35,053**	17,194	7,586	5,458	4,035	780
1995	**36,282**	17,164	7,604	5,858	4,119	1,537
1996	**36,118**	16,739	7,127	6,221	4,285	1,746
1997	**34,872**	15,791	6,803	6,129	3,955	2,195
1998	**40,096**	18,969	7,895	6,637	3,964	2,631
1999	**39,748**	18,233	7,446	6,690	3,698	3,682
2000	**41,212**	18,528	8,538	6,688	3,640	3,817
2001	**45,164**	20,181	9,707	7,114	3,812	4,349
2002	**46,839**	21,487	10,847	7,182	3,789	3,534
2003	**50,716**	23,742	11,530	7,664	4,041	3,739
2004	**54,250**	25,415	12,325	8,123	4,349	4,037
2005	**56,276**	25,979	12,431	8,205	4,395	5,266
2006	**56,264**	26,358	12,495	8,334	4,374	4,703
2007	**55,210**	26,061	12,264	8,423	4,044	4,418
2008	**56,962**	26,479	12,739	8,685	4,147	4,912
2009	**60,880**	28,344	14,245	9,031	4,195	5,066
2010	**63,730**	30,024	15,368	9,341	4,289	4,709
2011[1]	**65,831**	30,175	16,069	9,609	4,331	5,646

Notes: Beneficiaries (enrollees for whom payments are made) are shown here because they provide the only historical time series data directly available prior to fiscal year (FY) 1990. Most current analyses of individuals in Medicaid reflect enrollees. For additional discussion, see Section 5 of MACStats. The increase in FY 1998 reflects a change in how Medicaid beneficiaries are counted: beginning in FY 1998, a Medicaid-eligible person who received only coverage for managed care benefits was included in this series as a beneficiary. Excludes Medicaid-expansion CHIP and the territories.

Children and adults who qualify for Medicaid on the basis of a disability are included in the disabled category. In addition, although disability is not a basis of eligibility for aged individuals, states may also report some enrollees age 65 and older in the disabled category. Unlike the majority of the June 2014 MACStats, this table does not recode individuals age 65 and older who are reported as disabled, due to a lack of necessary detail in the historical data. Generally, individuals whose eligibility group is unknown are persons who were enrolled in the prior year but had a Medicaid claim paid in the current year.

[1] This table shows the number of beneficiaries. See Table 11 for the number of Medicaid enrollees in FY 2011, which is larger than the number of beneficiaries. Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for FY 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, FY 2011 figures shown here are not directly comparable to earlier years. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The beneficiary counts shown here are unduplicated using this national ID.

Sources: For FY 1999 to FY 2011: MACPAC analysis of Medicaid Statistical Information System (MSIS) data. For FY 1975 to FY 1998: Centers for Medicare & Medicaid Services (CMS), *Medicare & Medicaid statistical supplement, 2010 edition,* Table 13.4. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2010.html.

SECTION 2

Key Points

Health and Other Characteristics of Medicaid/CHIP Populations

Children under age 19, 2010–2012 (Tables 2–4)

- More than a third (37.4 percent) of children were reported to be Medicaid or CHIP enrollees at the time of the survey, while 53.8 percent of children were in private coverage, and 7.4 percent were uninsured.
- Children enrolled in Medicaid or CHIP were more likely to be Hispanic (35.2 percent) than are privately insured children (12.7 percent) and less likely to be Hispanic than are uninsured children (39.9 percent); Medicaid/CHIP children were more likely to be non-Hispanic black (23.2 percent) than are privately insured (10 percent) or uninsured children (11.7 percent).
- Children enrolled in Medicaid or CHIP were more likely than privately insured or uninsured children to be in fair or poor health and to have certain impairments and health conditions (e.g., attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD), asthma, autism).
- Children enrolled in Medicaid or CHIP were more likely to have had a visit to the emergency department in the past year and to have been regularly taking prescription medications for at least three months.
- Differences in self-reported health status exist among children enrolled in Medicaid or CHIP. Among these children, 21.6 percent of those receiving Supplemental Security Income (SSI) were reported to be in fair or poor health, compared to 14.6 percent for non-SSI children with special health care needs (CSHCN) and 1.1 percent for children who are neither SSI nor CSHCN.

- Prevalence of specific health conditions varies among children enrolled in Medicaid or CHIP. The prevalence of ADHD/ADD among children enrolled in Medicaid or CHIP was 38.5 percent for children receiving SSI, 38.7 percent for non-SSI CSHCN, and 2.1 percent for children who were neither receiving SSI nor CSHCN. The prevalence of asthma for children receiving SSI was 31.9 percent, compared to 39.4 percent for non-SSI CSHCN and 11.7 percent for children who were neither SSI nor CSHCN.
- SSI children and non-SSI CSHCN were each nearly twice as likely to visit health care providers four or more times within a year as are children with Medicaid or CHIP who are neither SSI nor CSHCN.

Adults age 19 to 64, 2010–2012 (Tables 5–7)

- Nearly 1 in 10 (9.7 percent) of non-institutionalized adults age 19 to 64 reported that they were enrolled in Medicaid.
- Medicaid enrollees in this age group were more likely to be female and to be the parent of a dependent child, compared to those with private insurance, Medicare, or no insurance.
- Adults younger than 65 enrolled in Medicaid (who are generally eligible on the basis of being the parent of a dependent child, pregnant, or disabled) reported that they were in worse health than were those enrolled in private coverage or the uninsured, but were in better health than those enrolled in Medicare (nearly all of whom are eligible for that program on the basis of a disability).
- Adults younger than 65 enrolled in Medicaid were more likely than those with private insurance to have had four or more visits to a doctor or other health professional in the past 12 months.
- Adults with Medicaid were more likely than those with private insurance or no insurance to have visited the emergency department during the past year.
- Among adults younger than 65 enrolled in Medicaid, 11.4 percent reported they also were enrolled in Medicare. Conversely, of the Medicare enrollees in this age group, 30.9 percent also were enrolled in Medicaid.
- Differences in self-reported health exist among 19- to 64-year-olds enrolled in Medicaid. Individuals dually enrolled in Medicaid and Medicare, as well as non-dual SSI beneficiaries, report fair or poor health (62.0 and 57.1 percent, respectively) at much higher rates than do non-SSI, non-dual enrollees (20.6 percent).
- Among 19- to 64-year-olds enrolled in Medicaid, those who were also enrolled in Medicare or SSI were more likely to have limitations in activities of daily living (ADLs)—as well as the presence of chronic conditions such as depression, hypertension, heart disease, diabetes, arthritis, asthma, and chronic bronchitis—than the overall Medicaid population for this age group.

- Adults younger than 65 who enrolled in Medicaid as well as Medicare or SSI also had higher use of care—in particular, for at-home care and visits to a doctor or other health professional in the past 12 months—than 19- to 64-year-old Medicaid enrollees overall. They were also more likely than 19- to 64-year-old Medicaid enrollees overall to have had an emergency department visit in the past 12 months.

Adults age 65 and older, 2010–2012 (Tables 8–10)

- Among non-institutionalized adults age 65 and older, 7.6 percent reported being enrolled in Medicaid. Most of these Medicaid enrollees (91.8 percent) reported being dually eligible for Medicare, which covered nearly all individuals age 65 and older.
- Medicaid enrollees age 65 and older were more likely to be female and less likely to be white (non-Hispanic) than were those with Medicare or private coverage.
- Compared to those enrolled in private coverage or Medicare, Medicaid enrollees age 65 and older were more likely to report being in fair or poor health, being in worse health compared to 12 months before, and having any of several limitations in their ADLs. Medicaid enrollees age 65 and older were also more likely to have lost all of their natural teeth or have any of a number of specific chronic conditions (such as depression, diabetes, and chronic bronchitis).
- Medicaid enrollees age 65 and older were also more likely than those with private or Medicare coverage to have received at-home care, to have had multiple visits to a doctor or other health professional, and to have visited an emergency department in the past 12 months.
- Because more than three-quarters of Medicaid enrollees age 65 and older had functional limitations and therefore drive the overall characteristics of enrollees in this age range, this group of Medicaid enrollees does not show significant differences from the total Medicaid population age 65 and older as often as do those with no functional limitations.
- Compared to the overall group of Medicaid enrollees age 65 and older, Medicaid enrollees who had no functional limitations were less likely to be 85 years old or older, to report being in fair or poor health, and to have any of several specific chronic health conditions. They were also less likely to have visited a doctor or other health professional or to have visited an ED in the past 12 months.

This section uses data from the federal National Health Interview Survey (NHIS) to describe how Medicaid and State Children's Health Insurance Program (CHIP) enrollees differ from individuals with other types of coverage in terms of their self-reported demographic, socioeconomic, and health characteristics as well as their use of care. It also explores how subpopulations of individuals enrolled in Medicaid or CHIP can differ markedly from one another, even within the same age group.

Our analysis divides the U.S. population into three age groups corresponding to key eligibility pathways in Medicaid and CHIP: children age 0 to 18, adults age 19 to 64, and adults age 65 and older. Tables for each age group explore the following self-reported characteristics from the survey data: health insurance coverage and demographics, health characteristics, and use of health care. (See Section 5 for a discussion of how estimates of insurance coverage may vary depending on the data source and the time period examined.)

The data are presented in two parts. First, we provide comparisons of Medicaid/CHIP enrollees in that age group to individuals with other sources of health insurance. Second, we show estimates for selected subgroups of Medicaid/CHIP enrollees in that age group. The data presented are for the combined Medicaid/CHIP population because, as described in Section 5, surveys like the NHIS generally do not support valid estimates separately for Medicaid and CHIP enrollees.

Our analyses of subgroups of children are divided into three groups:

- children who receive Supplemental Security Income (SSI) benefits and are therefore disabled under that program's definition;
- children who do not receive SSI, but who are classified as children with special health care needs (CSHCN); and
- children who neither receive SSI nor are considered CSHCN.

Our analyses of Medicaid enrollees age 19 to 64 years old are divided into three categories, the first two of which are primarily composed of persons with disabilities:

- individuals also enrolled in Medicare (dually eligible individuals), nearly all of whom have obtained their Medicare coverage after a two-year waiting period following their initial receipt of Social Security Disability Insurance (SSDI) benefits;
- Medicaid enrollees receiving SSI who are not enrolled in Medicare; and
- Medicaid enrollees who are neither SSI nor Medicare enrollees.

Our analyses of Medicaid enrollees age 65 and older focus on the differences between those reporting a functional limitation and those not reporting a functional limitation. Individuals with a functional limitation are those who reported any degree of difficulty—ranging from "only a little difficult" to "can't do at all"—performing any of a dozen activities (such as walking specified distances, moving objects such as a chair, or going out to do things like shopping) by themselves and without special equipment. It should be noted that individuals with functional limitations can vary substantially in their health needs—from being bedridden to being relatively healthy but responding that walking a quarter of a mile is "only a little difficult." (Individuals in institutions such as nursing homes or assisted living facilities are not interviewed in the NHIS.)

MAC Stats

TABLE 2. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Age 0–18 by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]			Medicaid/CHIP[2]			
	All children	Medicaid/CHIP[2]	Private[3]	Uninsured[4]	Medicaid/CHIP children	SSI	Non-SSI CSHCN[5]	Neither SSI nor CSHCN
Health Insurance Coverage		**37.4%**	53.8%	7.4%	**100.0%**	3.4%	17.6%	79.1%
Age (categories sum to 100%)								
0–5	32.2%*	**38.8%**	28.9%*	23.0%*	**38.8%**	19.5%*	26.7%*	42.4%*
6–11	31.3	**31.5**	31.6	29.3	**31.5**	38.7*	37.5*	29.8*
12–18	36.5*	**29.7**	39.5*	47.7*	**29.7**	41.7*	35.8*	27.8*
Gender (categories sum to 100%)								
Male	51.3%	**50.5%**	51.8%	51.6%	**50.5%**	62.5%*	60.6%*	47.8%*
Female	48.7	**49.5**	48.2	48.4	**49.5**	37.5*	39.4*	52.2*
Race (categories sum to 100%)								
Hispanic	23.4%*	**35.2%**	12.7%*	39.9%*	**35.2%**	20.6%*	24.1%*	38.4%*
White, non-Hispanic	55.5*	**37.1**	70.7*	40.9*	**37.1**	41.3	47.6*	34.6*
Black, non-Hispanic	15.2*	**23.2**	10.0*	11.7*	**23.2**	35.7*	25.4	22.1
Other and multiple races, non-Hispanic	5.9*	**4.5**	6.5*	7.5*	**4.5**	2.3*	2.9*	4.9
Health insurance								
Medicaid/CHIP	37.4%*	**100.0%**	2.3%*	–	**100.0%**	100.0%	100.0%	100.0%
Private	53.8*	**3.3**	100.0*	–	**3.3**	5.5	5.8*	2.7

See Table 4 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 3. Health Characteristics of Non-Institutionalized Individuals Age 0–18 by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]			Medicaid/CHIP[2]			
	All children	Medicaid/ CHIP[2]	Private[3]	Uninsured[4]	Medicaid/ CHIP children	SSI	Non-SSI CSHCN[5]	Neither SSI nor CSHCN
Children with disabilities or with special health care needs								
Receives Supplemental Security Income (SSI)	1.5%*	**3.4%**	0.4%*	0.7%	**3.4%**	100.0%*	–	–
Children with special health care needs (CSHCN)[5]	15.4*	**20.1**	13.3*	10.9	**20.1**	74.0*[6]	100.0%*	–
Current health status (categories sum to 100%)								
Excellent or very good	82.5%*	**73.5%**	88.9%*	78.9%	**73.5%**	44.4%*	54.5%*	79.0%*
Good	15.3*	**22.3**	10.2*	18.9	**22.3**	33.9*	30.9*	19.9*
Fair or poor	2.2*	**4.2**	1.0*	2.2	**4.2**	21.6*	14.6*	1.1*
Impairments								
Impairment requiring special equipment	1.1%*	**1.7%**	0.9%*	0.7%	**1.7%**	12.6%*	5.5%*	0.4%*
Impairment limits ability to crawl, walk, run, play[7]	1.9*	**3.0**	1.4*	1.1	**3.0**	20.3*	11.3*	0.4*
Impairment lasted, or expected to last 12+ months[7]	1.7*	**2.7**	1.2*	0.8	**2.7**	19.9*	9.8*	0.3*
Specific health conditions								
Ever told child has:								
ADHD/ADD[8]	8.2%*	**10.7%**	7.1%*	5.7%	**10.7%**	38.5%*	38.7%*	2.1%*
Asthma	14.0	**17.3**	12.5*	10.4*	**17.3**	31.9*	39.4*	11.7*
Autism[7]	1.0	**1.3**	1.0*	0.7	**1.3**	12.4*	4.3*	0.0*
Cerebral palsy[7]	0.3*	**0.4**	0.2*	†	**0.4**	5.8*	1.2*	0.0*
Congenital heart disease	1.2*	**1.6**	1.1*	1.0	**1.6**	8.1*	4.3*	0.7*
Diabetes	0.2	**0.2**	0.2	†	**0.2**	†	1.1*	†
Down syndrome[7]	0.1	**0.2**	0.1	†	**0.2**	3.0*	0.4	†
Intellectual disability (mental retardation)[7]	0.9*	**1.5**	0.6*	†	**1.5**	16.9*	5.1*	0.1*
Other developmental delay[7]	4.5*	**5.8**	4.0*	3.2	**5.8**	37.5*	21.3*	0.9*
Sickle cell anemia[7]	0.2*	**0.3**	0.1*	0.2	**0.3**	†	0.7*	0.2

See Table 4 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 4. Use of Care by Non-Institutionalized Individuals Age 0–18 by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]			Medicaid/CHIP[2]			
	All children	Medicaid/ CHIP[2]	Private[3]	Uninsured[4]	Medicaid/ CHIP children	SSI	Non-SSI CSHCN[5]	Neither SSI nor CSHCN
Received well-child check-up in past 12 months[7]	80.1%*	**81.8%**	82.5%	53.6%*	**81.8%**	85.7%	85.9%*	80.7%
Regularly taking prescription drug(s) for 3+ months[7]	13.4*	**15.9**	12.9*	5.7*	**15.9**	46.7*	54.6*	5.6*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)								
None	9.7%*	**8.8%**	7.4%*	30.2%*	**8.8%**	5.3%*	3.1%*	10.2%*
1	21.2*	**19.3**	21.6*	26.6*	**19.3**	14.0*	10.7*	21.5*
2–3	36.6	**35.5**	38.3*	28.0*	**35.5**	25.2*	26.0*	38.1*
4+	32.5*	**36.3**	32.7*	15.2*	**36.3**	55.4*	60.3*	30.2*
Number of emergency room visits in past 12 months (categories sum to 100%)								
None	80.4%*	**73.1%**	85.0%*	83.8%*	**73.1%**	64.4%*	58.0%*	76.8%*
1	12.8*	**15.8**	11.0*	10.4*	**15.8**	18.4	18.6*	15.0
2–3	5.4*	**8.3**	3.4*	4.5*	**8.3**	9.8	15.9*	6.5*
4+	1.5*	**2.8**	0.6*	1.3*	**2.8**	7.4*	7.5*	1.6*

Notes: CHIP is State Children's Health Insurance Program. SSI is Supplemental Security Income. CSHCN is children with special health care needs. ADHD is attention deficit hyperactivity disorder. ADD is attention deficit disorder.

* Difference from Medicaid/CHIP is statistically significant at the 0.05 level.

† Estimate has a relative standard error of greater than 50 percent.

– Quantity zero; amounts shown as 0.0 round to less than 0.1.

1 Health insurance coverage is defined at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of children covered by Medicare (generally children with end-stage renal disease), any type of military health plan (VA, TRICARE, and CHAMP-VA), or other government-sponsored programs.

2 Medicaid/CHIP also includes persons covered by other state-sponsored health plans.

3 Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.

4 Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state-sponsored or other government-sponsored health plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

5 Due in part to changes in the 2011 National Health Interview Survey (NHIS) questionnaire, the CSHCN definition differs slightly from the definition used in MACPAC reports prior to 2013. The CSHCN definition applied here is based on an approach developed by the Child and Adolescent Health Measurement Initiative (CAHMI) to identify "children with chronic conditions and elevated service use or need" in the 2007 NHIS and other prior research. (See CAMHI, Identifying children with chronic conditions and elevated service use or need (CCCESUN) in the National Health Interview Survey (NHIS), Portland, OR: Oregon Health and Science University, 2012; A.J. Davidoff, Identifying children with special health care needs in the National Health Interview Survey: a new resource for policy analysis, Health Services Research 39 (1): 53-71, 2004). CSHCN in this analysis must have at least one diagnosed or parent-reported condition expected to be an ongoing health condition and also meet at least one of five criteria related to elevated service use or elevated need, including reported unmet need for care. For more information on the methods used to identify CSHCN, see text and endnotes in Section 5 of MACStats.

6 For a child to be eligible for SSI, one of the criteria is that the child has a medically determinable physical or mental impairment(s) that results in marked and severe functional limitations and generally is expected to last at least 12 months or result in death. Thus, children who are eligible for SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that these Medicaid/CHIP children who are reported to have SSI did not meet the criteria for CSHCN, it could be because: (1) the parent erroneously reported in the survey that the children received SSI, or (2) the NHIS condition list did not capture, or the parent did not recognize, any of the NHIS conditions as reflecting the child's circumstances.

7 Question only asked for children age 0 to 17.

8 Question only asked for children age 2 to 17.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 5. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Age 19–64 by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Health Insurance Coverage		**9.7%**	65.1%	3.6%	21.0%	**100.0%**	11.4%	15.1%	73.5%
Age (categories sum to 100%)									
19–24	13.8%*	**20.3%**	11.6%*	2.4%*	18.6%*	**20.3%**	3.5%*	13.5%*	24.2%*
25–44	43.1*	**45.5**	41.8*	19.5*	50.0*	**45.5**	27.1*	34.5*	50.8*
45–54	23.4*	**19.4**	25.1*	27.8*	19.6	**19.4**	33.1*	27.1*	15.8*
55–64	19.7*	**14.7**	21.6*	50.2*	11.8*	**14.7**	36.2*	24.9*	9.2*
Gender (categories sum to 100%)									
Male	49.1%*	**35.8%**	49.0%*	49.3%*	54.2%*	**35.8%**	41.9%*	45.6%*	32.9%*
Female	50.9*	**64.2**	51.0*	50.7*	45.8*	**64.2**	58.1*	54.4*	67.1*
Race (categories sum to 100%)									
Hispanic	15.7%*	**21.5%**	10.0%*	9.6%*	31.1%*	**21.5%**	10.1%*	13.6%*	25.0%*
White, non-Hispanic	65.7*	**49.4**	73.9*	68.6*	48.3	**49.4**	62.8*	54.9*	46.2*
Black, non-Hispanic	12.5*	**23.8**	9.6*	19.0*	14.9*	**23.8**	24.4	27.0	22.9
Other and multiple races, non-Hispanic	6.1*	**5.3**	6.4*	2.8*	5.7	**5.3**	2.7*	4.5	5.9
Family characteristics									
Parent of a dependent child[5]	37.3*	**47.7**	37.4*	12.9*	35.5*	**47.7**	11.3*	18.5*	59.5*
Health insurance									
Medicaid	9.7%*	**100.0%**	0.4%*	30.9%*	–	**100.0%**	100.0%	100.0%	100.0%
Medicare	3.6*	**11.4**	1.1*	100.0*	–	**11.4**	100.0*	–	–
Private	65.1*	**2.8**	100.0*	19.7*	–	**2.8**	3.3	2.6	2.7

See Table 7 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 6. Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Disability and work status									
Receives Supplemental Security Income (SSI)	2.4%*	**19.8%**	0.3%*	20.8%	0.5%*	**19.8%**	41.8%*	100.0%*	–
Receives Social Security Disability Insurance (SSDI)	3.6*	**14.7**	1.4*	62.2*	0.6*	**14.7**	65.7*	19.3*	5.9%*
Working	70.4*	**34.3**	81.3*	10.4*	60.4*	**34.3**	10.2*	7.8*	43.5*
Current health status (categories sum to 100%)									
Excellent or very good	63.5%*	**40.4%**	71.2%*	14.3%*	55.4%*	**40.4%**	12.7%*	15.1%*	49.8%*
Good	25.3*	**28.8**	22.6*	26.6	31.4*	**28.8**	25.2	27.8	29.6
Fair or poor	11.2*	**30.9**	6.2*	59.1*	13.2*	**30.9**	62.0*	57.1*	20.6*
Health compared to 12 months ago (categories sum to 100%)									
Better	19.4%*	**21.4%**	19.6%*	17.3%*	17.9%*	**21.4%**	20.3%	20.9%	21.7%
Worse	7.7*	**14.4**	5.6*	25.1*	9.5*	**14.4**	23.2*	21.3*	11.7*
Same	72.9*	**64.2**	74.8*	57.6*	72.6*	**64.2**	56.5*	57.9*	66.6*
Activities of daily living (ADLs)									
Help with any personal care needs[6]	1.3%*	**6.6%**	0.5%*	13.9%*	0.6%*	**6.6%**	19.8%*	18.4%*	2.1%*
Help with bathing/showering	0.8*	**4.4**	0.3*	8.5*	0.3*	**4.4**	12.8*	14.0*	1.1*
Help with dressing	0.7*	**3.8**	0.3*	7.7*	0.3*	**3.8**	11.7*	11.1*	1.1*
Help with eating	0.3*	**1.9**	0.1*	3.7*	0.1*	**1.9**	6.1*	6.2*	0.4*
Help with transferring (in/out of bed or chairs)	0.6*	**3.3**	0.2*	6.7*	0.3*	**3.3**	11.0*	9.2*	0.9*
Help with toileting	0.4*	**2.5**	0.2*	4.8*	0.1*	**2.5**	7.7*	7.9*	0.6*
Help getting around in home	0.6*	**2.9**	0.2*	6.1*	0.2*	**2.9**	9.6*	8.3*	0.8*
Number of above ADLs reported (categories sum to 100%)									
0	98.7%*	**93.5%**	99.5%*	86.1%*	99.4%*	**93.5%**	80.2%*	81.7%*	97.9%*
1	0.2*	**0.9**	0.1*	2.2*	0.1*	**0.9**	2.7*	2.1*	0.4*
2	0.3*	**1.1**	0.1*	2.8*	0.2*	**1.1**	2.7*	3.2*	0.4*
3	0.2*	**1.1**	0.1*	2.6*	0.1*	**1.1**	3.9*	2.6*	0.4*
4+	0.6*	**3.4**	0.2*	6.4*	0.2*	**3.4**	10.5*	10.4*	0.9*

TABLE 6, Continued

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Specific health conditions									
Currently pregnant[7]	3.5%*	**9.5%**	2.8%*	†	1.6%*	**9.5%**	†	3.3%*	10.9%
Functional limitation[8]	29.5*	**47.1**	25.6*	84.3%*	27.8*	**47.1**	83.0%*	75.9*	35.7*
Difficulty walking without equipment	3.4*	**11.8**	1.7*	31.7*	2.0*	**11.8**	32.9*	26.3*	5.7*
Health condition that requires special equipment (e.g., cane, wheelchair)	4.2*	**11.9**	2.7*	33.2*	2.4*	**11.9**	33.4*	25.6*	5.8*
Lost all natural teeth	4.6*	**8.9**	3.4*	18.8*	5.0*	**8.9**	21.3*	16.1*	5.5*
Depressed/anxious feelings[9]	12.4*	**25.9**	8.3*	36.2*	16.7*	**25.9**	39.1*	40.5*	21.0*
Ever told had hypertension	23.7*	**30.4**	23.0*	56.3*	18.9*	**30.4**	54.0*	45.2*	23.8*
Ever told had coronary heart disease	2.5*	**4.5**	2.1*	14.5*	1.5*	**4.5**	12.7*	7.6*	2.6*
Ever told had heart attack	1.8*	**4.0**	1.3*	11.6*	1.5*	**4.0**	10.4*	6.3*	2.5*
Ever told had stroke	1.6*	**4.4**	1.0*	10.7*	1.2*	**4.4**	12.2*	9.0*	2.2*
Ever told had cancer	5.2*	**5.9**	5.7	14.4*	2.8*	**5.9**	12.9*	9.0*	4.2*
Ever told had diabetes	6.7*	**12.3**	5.9*	24.8*	5.0*	**12.3**	26.5*	21.5*	8.3*
Ever told had arthritis	17.3*	**23.8**	17.0*	55.0*	11.4*	**23.8**	54.8*	37.0*	16.2*
Ever told had asthma	13.0*	**20.0**	12.2*	23.4*	11.5*	**20.0**	30.0*	26.8*	17.0*
Past 12 months, told had chronic bronchitis	3.8*	**8.0**	2.9*	15.8*	3.3*	**8.0**	18.8*	13.0*	5.3*
Past 12 months, told had liver condition	1.4*	**3.3**	1.0*	5.6*	1.1*	**3.3**	5.6*	7.1*	2.2*
Past 12 months, told had weak/failing kidneys	1.2*	**4.0**	0.7*	8.8*	1.2*	**4.0**	12.2*	6.8*	2.2*

See Table 7 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 7. Use of Care by Non-Institutionalized Individuals Age 19–64 by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Had a usual source of care	80.1%*	**87.4%**	89.6%*	93.9%*	45.4%*	**87.4%**	95.1%*	92.1%*	85.3%*
Received at-home care in past 12 months	1.2*	**4.6**	0.8*	9.9*	0.4*	**4.6**	16.9*	8.3*	2.0*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)									
None	22.2%*	**14.1%**	15.5%*	6.4%*	48.4%*	**14.1%**	5.5%*	8.7%*	16.4%*
1	18.3*	**12.9**	19.8*	5.8*	17.4*	**12.9**	5.0*	9.2*	14.8*
2–3	25.9*	**20.8**	29.6*	15.7*	17.3*	**20.8**	14.3*	17.8	22.4
4+	33.6*	**52.3**	35.0*	72.1*	16.9*	**52.3**	75.2*	64.3*	46.4*
Number of emergency room visits in past 12 months (categories sum to 100%)									
None	80.3%*	**60.9%**	84.1%*	60.4%	79.4%*	**60.9%**	54.4%*	56.4%*	62.7%
1	12.4*	**18.0**	11.5*	18.6	12.0*	**18.0**	18.0	17.6	18.2
2–3	5.1*	**13.0**	3.4*	12.2	5.9*	**13.0**	16.5*	15.3	12.0
4+	2.2*	**8.1**	1.0*	8.7	2.6*	**8.1**	11.1*	10.7*	7.1

Notes: SSI is Supplemental Security Income.

* Difference from Medicaid is statistically significant at the 0.05 level.

† Estimate has a relative standard error of greater than 50 percent.

– Quantity zero; amounts shown as 0.0 round to less than 0.1 in this table.

[1] Health insurance coverage is defined as coverage at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of individuals covered by any type of military health plan (VA, TRICARE, and CHAMP-VA) or other government-sponsored programs.

[2] Medicaid also includes adults reporting coverage through the CHIP program or other state-sponsored health plans. Medicaid and CHIP cannot be distinguished from each other in the National Health Interview Survey. CHIP enrollment of adults is small, totaling approximately 218,000 ever enrolled during FY 2012. (See March 2014 MACStats Table 3.)

[3] Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state-sponsored or other government-sponsored health plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

[5] Parent of a dependent child is defined as an adult with at least one dependent child (biological, adopted, step, or foster) in the household; a dependent child is defined as a child age 18 and under or a child age 23 and under who is not working because of going to school.

[6] Only adults who report needing assistance with personal care needs are asked about each of the specific personal care needs. Each specific personal care need is reported as the overall population prevalence (rather than the prevalence among those needing help with any personal care needs).

[7] Question only asked for females age 18 to 49.

[8] Individuals with a functional limitation are those who reported any degree of difficulty—ranging from “only a little difficult” to “can’t do at all”—doing any of a dozen activities (e.g., walking a quarter of a mile, stooping or kneeling) by themselves and without special equipment.

[9] Reports feeling sad, hopeless, worthless, nervous, restless, or that everything was an effort all or most of the time.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 8. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Health Insurance Coverage		**7.6%**	52.6%	95.1%	**100.0%**	79.0%	21.0%
Age (categories sum to 100%)							
65–74	55.7%	**55.5%**	55.3%	54.6%	**55.5%**	53.9%	62.1%*
75–84	32.6	**32.8**	32.9	33.4	**32.8**	33.1	31.4
85+	11.7	**11.7**	11.8	12.0	**11.7**	13.0	6.6*
Gender (categories sum to 100%)							
Male	43.8%*	**32.2%**	43.7%*	43.3%*	**32.2%**	29.7%	41.8%*
Female	56.2*	**67.8**	56.3*	56.7*	**67.8**	70.3	58.2*
Race (categories sum to 100%)							
Hispanic	7.4%*	**23.1%**	3.3%*	6.8%*	**23.1%**	21.9%	28.1%
White, non-Hispanic	79.8*	**49.0**	87.8*	80.9*	**49.0**	50.7	42.8
Black, non-Hispanic	8.5*	**17.4**	6.0*	8.3*	**17.4**	17.4	17.4
Other and multiple races, non-Hispanic	4.3*	**10.5**	2.9*	4.0*	**10.5**	10.0	11.7
Health insurance							
Medicaid	7.6%*	**100.0%**	0.9%*	7.3%*	**100.0%**	100.0%	100.0%
Medicare	95.1*	**91.8**	93.9*	100.0*	**91.8**	92.6	88.8
Private	52.6*	**6.2**	100.0*	52.0*	**6.2**	5.5	8.6

See Table 10 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 9. Health Characteristics of Non-Institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Disability and work status							
Receives Supplemental Security Income (SSI)	3.8%*	**29.4%**	0.8%*	3.8%*	**29.4%**	32.6%	17.4%*
Working	15.9*	**4.5**	19.3*	14.5*	**4.5**	3.1	9.9*
Current health status (categories sum to 100%)							
Excellent or very good	43.8%*	**20.8%**	48.4%*	43.6%*	**20.8%**	13.9%*	47.1%*
Good	33.7*	**29.9**	34.0*	33.8*	**29.9**	29.0	33.3
Fair or poor	22.5*	**49.3**	17.6*	22.6*	**49.3**	57.1*	19.6*
Health compared to 12 months ago (categories sum to 100%)							
Better	13.7%	**14.2%**	13.6%	13.7%	**14.2%**	15.3%	10.3%*
Worse	11.8*	**21.0**	10.5*	11.8*	**21.0**	25.0*	5.8*
Same	74.6*	**64.8**	75.9*	74.5*	**64.8**	59.7*	83.8*
Activities of daily living (ADLs)							
Help with any personal care needs[5]	6.8%*	**20.4%**	5.1%*	6.9%*	**20.4%**	24.7%*	3.1%*
Help with bathing/showering	5.0*	**15.5**	3.6*	5.1*	**15.5**	18.8*	2.4*
Help with eating	1.5*	**4.8**	0.9*	1.5*	**4.8**	5.8	1.4*
Help with transferring (in/out of bed or chairs)	3.0*	**9.6**	2.1*	3.0*	**9.6**	11.4	2.1*
Help with toileting	2.3*	**7.1**	1.7*	2.3*	**7.1**	8.3	1.9*
Help getting around in home	2.8*	**9.5**	1.9*	2.8*	**9.5**	11.5	1.9*
Number of above ADLs reported (categories sum to 100%)							
0	93.2%*	**79.8%**	94.9%*	93.1%*	**79.8%**	75.5%*	96.9%*
1	0.9*	**2.6**	0.7*	0.9*	**2.6**	3.1	†
2	1.4*	**2.8**	1.1*	1.4*	**2.8**	3.5	†
3	1.4*	**4.1**	1.2*	1.4*	**4.1**	5.2	0.0*
4+	3.1*	**10.6**	2.1*	3.1*	**10.6**	12.7	2.1*

TABLE 9, Continued

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Specific health conditions							
Functional limitation[4]	65.1%*	**79.0%**	63.9%*	65.7%*	**79.0%**	100.0%*	0.0%*
Difficulty walking without equipment	18.6*	**38.8**	16.0*	18.9*	**38.8**	47.2*	6.8*
Health condition that requires special equipment (e.g., cane, wheelchair)	20.7*	**38.9**	18.5*	21.0*	**38.9**	47.0*	8.5*
Lost all natural teeth	22.7*	**41.2**	18.5*	22.9*	**41.2**	43.7	30.9*
Depressed/anxious feelings[6]	9.3*	**20.6**	8.0*	9.3*	**20.6**	25.3*	3.1*
Ever told had hypertension	62.0*	**70.5**	61.1*	62.3*	**70.5**	73.9	57.6*
Ever told had coronary heart disease	15.8*	**19.6**	16.0*	16.1*	**19.6**	22.4	8.8*
Ever told had heart attack	10.4*	**13.6**	10.0*	10.6*	**13.6**	15.3	7.2*
Ever told had stroke	8.2*	**15.1**	7.1*	8.3*	**15.1**	17.9	4.5*
Ever told had cancer	24.2*	**18.8**	26.4*	24.7*	**18.8**	20.5	12.1*
Ever told had diabetes	20.7*	**31.1**	19.2*	20.8*	**31.1**	33.7	20.8*
Ever told had arthritis	49.7*	**57.4**	51.2*	50.4*	**57.4**	65.6*	25.9*
Ever told had asthma	10.6*	**16.0**	10.1*	10.7*	**16.0**	17.9	8.0*
Past 12 months, told had chronic bronchitis	5.8*	**10.3**	5.5*	5.9*	**10.3**	11.7	4.7*
Past 12 months, told had liver condition	1.4*	**2.9**	1.2*	1.4*	**2.9**	3.6	†
Past 12 months, told had weak/failing kidneys	4.3*	**9.3**	3.5*	4.4*	**9.3**	11.0	2.9*

See Table 10 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

TABLE 10. Use of Care by Non-Institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2010–2012

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Received at-home care in past 12 months	8.2%*	**19.0%**	7.4%*	8.4%*	**19.0%**	22.9%*	3.9%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)							
None	6.4%*	**6.5%**	4.8%*	5.9%	**6.5%**	4.7%	13.0%*
1	10.4*	**6.4**	10.4*	10.3*	**6.4**	4.8	12.5*
2–3	25.5*	**20.4**	26.2*	25.3*	**20.4**	19.0	25.6
4+	57.7*	**66.7**	58.6*	58.5*	**66.7**	71.5*	48.8*
Number of emergency room visits in past 12 months (categories sum to 100%)							
None	76.9%*	**66.9%**	78.0%*	76.7%*	**66.9%**	63.2%	80.8%*
1	15.3	**17.1**	14.9	15.5	**17.1**	18.8	10.7*
2–3	5.9*	**10.7**	5.5*	6.0*	**10.7**	11.6	7.1*
4+	1.9*	**5.3**	1.6*	1.9*	**5.3**	6.4	1.3*

Notes:

* Difference from Medicaid is statistically significant at the 0.05 level.

† Estimate has a relative standard error of greater than 50 percent.

– Quantity zero; amounts shown as 0.0 round to less than 0.1 in this table.

1 Health insurance coverage is defined as coverage at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of individuals covered by any type of military health plan (VA, TRICARE, and CHAMP-VA) or other government-sponsored programs.

2 Medicaid also includes adults reporting coverage through CHIP or other state-sponsored health plans.

3 Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.

4 Individuals with a functional limitation are those who reported any degree of difficulty—ranging from “only a little difficult” to “can’t do at all”—doing any of a dozen activities (e.g., walking a quarter of a mile, stooping or kneeling) by themselves and without special equipment.

5 Only adults who report needing assistance with personal care needs are asked about each of the following specific personal care needs. Each need is reported as the overall population prevalence (rather than the prevalence among those needing help with any personal care needs).

6 Reports feeling sad, hopeless, worthless, nervous, restless, or that everything was an effort all or most of the time.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

SECTION 3

Key Points

Medicaid Enrollment and Benefit Spending

- Individuals eligible on the basis of a disability and those age 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Tables 11 and 12).
- Medicaid spending per enrollee is affected by large numbers of individuals with limited benefits in some states (Table 13).
- Among individuals dually enrolled in Medicaid and Medicare, those age 65 and older account for about 60 percent of enrollment and Medicaid benefit spending (Tables 11 and 12).
- A large share of Medicaid spending for enrollees eligible on the basis of a disability and enrollees age 65 and older is for long-term services and supports (LTSS), while a substantial portion of spending for non-disabled children and adults is for capitation payments to managed care plans (Figures 3 and 4).
- LTSS users account for only about 6 percent of Medicaid enrollees, but nearly half of all Medicaid spending (Figure 5). Acute care represents a minority of Medicaid spending for most LTSS users (Figure 6), and average Medicaid benefit spending for these individuals is more than 10 times that of enrollees who are not using LTSS (Figure 7).
- Medicaid benefit spending per enrollee varies substantially across states (Table 13). Reasons for this variation may include the breadth of benefits that states choose to cover; the proportion of enrollees receiving the full benefit package or a more limited version; enrollee case mix (based on health status and other characteristics); the underlying costs of delivering health care services in specific geographic areas; and state policies regarding provider payments, care management, and other program features.

TABLE 11. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2011 (thousands)

		Percentage of Enrollees in Eligibility Group[1]				Dually eligible Enrollees[2]					
						All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
State	Total	Children	Adults	Disabled	Aged	Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
Total	**67,605**	**47.4%**	**28.3%**	**14.7%**	**9.5%**	**10,179**	**59.0%**	**7,552**	**59.3%**	**2,627**	**58.3%**
Alabama	**1,061**	50.7	17.3	20.8	11.1	**212**	55.1	**97**	52.4	**115**	57.4
Alaska	**135**	54.7	25.0	13.3	7.0	**15**	53.7	**15**	53.2	**0**	68.9
Arizona	**1,283**	44.5	37.5	10.9	7.1	**148**	57.9	**118**	54.5	**30**	71.1
Arkansas	**693**	51.5	16.6	21.8	10.2	**128**	53.2	**70**	59.3	**58**	45.8
California	**11,690**	39.0	43.2	8.9	8.8	**1,295**	70.2	**1,260**	70.0	**35**	75.2
Colorado	**762**	57.4	21.3	13.5	7.9	**94**	58.2	**69**	60.6	**25**	51.4
Connecticut	**785**	40.4	36.1	9.8	13.7	**155**	66.5	**83**	57.7	**72**	76.8
Delaware	**243**	39.9	43.1	10.8	6.2	**27**	53.1	**12**	54.0	**15**	52.3
District of Columbia	**232**	35.6	40.1	16.2	8.1	**23**	62.4	**16**	61.4	**7**	64.5
Florida	**3,983**	50.5	21.2	15.6	12.7	**739**	64.8	**387**	68.8	**352**	60.4
Georgia	**1,953**	58.3	15.8	16.5	9.4	**306**	58.4	**158**	58.8	**148**	58.0
Hawaii	**280**	41.2	39.5	10.1	9.2	**37**	67.4	**32**	67.7	**4**	65.1
Idaho	**267**	61.8	14.8	16.2	7.2	**40**	46.0	**27**	44.4	**13**	49.5
Illinois	**2,883**	52.6	28.3	11.2	7.9	**372**	56.3	**333**	55.7	**40**	61.3
Indiana	**1,189**	55.2	21.3	15.8	7.8	**173**	47.8	**107**	53.2	**66**	39.0
Iowa	**589**	46.6	31.6	14.3	7.5	**88**	49.3	**71**	46.2	**17**	62.3
Kansas	**416**	56.8	14.7	19.2	9.4	**72**	50.1	**49**	52.6	**23**	44.9
Kentucky	**937**	47.9	15.7	25.8	10.6	**195**	50.0	**113**	51.3	**82**	48.2
Louisiana	**1,292**	52.8	19.7	18.4	9.2	**204**	57.1	**113**	55.4	**91**	59.3
Maine	**435**	29.6	26.8	28.3	15.3	**104**	59.3	**59**	45.6	**45**	77.1
Maryland	**1,036**	47.0	30.8	14.4	7.7	**129**	55.8	**84**	55.3	**45**	56.7
Massachusetts	**1,519**	25.2	41.7	22.8	10.3	**259**	51.7	**237**	47.7	**22**	95.1
Michigan	**2,340**	50.5	27.2	16.0	6.3	**291**	46.3	**249**	45.4	**42**	51.4
Minnesota	**1,106**	41.6	37.0	12.4	9.0	**149**	53.1	**135**	52.2	**15**	60.6
Mississippi	**781**	52.0	14.7	21.8	11.5	**162**	55.2	**84**	57.9	**78**	52.4
Missouri	**1,138**	50.7	21.0	19.7	8.6	**194**	48.0	**168**	47.4	**26**	51.8
Montana	**135**	56.1	16.8	17.4	9.7	**25**	52.0	**17**	51.2	**8**	53.5
Nebraska	**254**	58.2	19.1	16.0	6.7	**37**	42.1	**37**	42.1	**0**	58.5
Nevada	**395**	60.4	19.3	12.5	7.8	**51**	58.9	**24**	64.4	**26**	53.7
New Hampshire	**171**	58.6	13.8	18.0	9.5	**35**	44.4	**23**	44.8	**12**	43.5

TABLE 11, Continued

		Percentage of Enrollees in Eligibility Group[1]				Dually eligible Enrollees[2]					
						All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
State	**Total**	**Children**	**Adults**	**Disabled**	**Aged**	**Total**	**Percentage age 65+**	**Total**	**Percentage age 65+**	**Total**	**Percentage age 65+**
New Jersey	**1,194**	52.7%	18.1%	15.9%	13.3%	**236**	62.6%	**206**	61.6%	**30**	69.4%
New Mexico	**651**	56.3	25.7	11.1	6.9	**74**	59.4	**41**	60.3	**33**	58.2
New York	**5,790**	36.7	40.1	12.0	11.2	**844**	67.7	**724**	66.4	**120**	75.2
North Carolina	**1,948**	51.7	21.1	17.5	9.7	**340**	54.4	**263**	54.0	**77**	56.0
North Dakota	**85**	53.1	21.5	14.2	11.1	**16**	57.1	**13**	56.6	**3**	59.0
Ohio	**2,339**	47.5	27.1	17.1	8.3	**374**	48.2	**255**	49.9	**120**	44.6
Oklahoma	**907**	54.3	24.4	13.9	7.5	**124**	52.5	**101**	52.3	**23**	53.4
Oregon	**729**	48.2	29.1	14.2	8.5	**109**	55.5	**68**	57.6	**40**	52.0
Pennsylvania	**2,529**	43.8	21.0	25.2	10.0	**444**	54.1	**367**	52.7	**77**	60.7
Rhode Island	**199**	45.0	21.3	20.5	13.2	**41**	56.4	**35**	55.2	**6**	63.4
South Carolina	**961**	49.6	24.1	17.3	9.0	**163**	53.3	**140**	52.6	**23**	57.4
South Dakota	**132**	57.9	17.5	14.9	9.8	**22**	58.1	**14**	60.1	**8**	54.8
Tennessee	**1,533**	51.8	21.0	17.6	9.5	**279**	51.7	**156**	50.7	**123**	53.0
Texas	**5,136**	63.4	14.0	13.4	9.2	**714**	64.5	**435**	66.4	**278**	61.5
Utah	**372**	58.7	24.5	12.2	4.7	**36**	45.6	**31**	44.7	**5**	51.6
Vermont	**201**	34.1	42.3	12.4	11.2	**37**	58.8	**28**	54.7	**8**	72.6
Virginia	**1,045**	54.2	17.2	17.8	10.8	**192**	55.7	**127**	58.5	**65**	50.1
Washington	**1,397**	56.3	21.3	15.2	7.2	**181**	54.1	**132**	57.4	**48**	45.2
West Virginia	**440**	47.2	14.8	28.1	9.9	**87**	49.1	**51**	50.5	**36**	47.1
Wisconsin	**1,274**	39.0	36.2	13.2	11.5	**227**	62.7	**206**	62.5	**21**	64.1
Wyoming	**89**	65.2	14.9	13.1	6.8	**12**	51.5	**7**	51.0	**4**	52.5

Notes: Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month; however, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, figures shown here are not directly comparable to earlier years. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. Although state-level information is not yet available, the estimated number of individuals ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 71.2 million for FY 2012 and 71.7 million for FY 2013. These FY 2012–FY 2013 figures exclude about 1 million enrollees in the territories (MACPAC communication with the Office of the Actuary at the Centers for Medicare & Medicaid Services, March 2014).

1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

2 Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing. Zeroes indicate enrollment counts less than 500 that round to zero.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014.

TABLE 12. Medicaid Benefit Spending by State, Eligibility Group, and Dually Eligible Status, FY 2011 (millions)

		Percentage of Benefit Spending Attributable to Eligibility Group[1]				Dually eligible Enrollees[2]					
						All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
State	Total	Children	Adults	Disabled	Aged	Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
Total[3]	**$386,354**	**19.0%**	**15.3%**	**42.7%**	**23.0%**	**$140,298**	**59.7%**	**$134,315**	**60.1%**	**$5,983**	**52.3%**
Alabama	**4,416**	24.1	10.0	40.6	25.3	**1,626**	67.8	**1,424**	69.6	**203**	55.7
Alaska	**1,290**	27.2	16.5	38.5	17.8	**354**	54.4	**353**	54.3	**1**	71.3
Arizona	**8,824**	18.8	32.4	34.9	13.9	**1,971**	56.4	**1,907**	56.2	**64**	63.4
Arkansas	**3,944**	22.1	5.1	46.7	26.0	**1,630**	60.5	**1,432**	63.9	**198**	36.6
California	**52,631**	17.5	16.3	40.9	25.3	**17,805**	67.6	**17,695**	67.6	**110**	66.2
Colorado	**4,196**	21.9	14.3	42.0	21.8	**1,422**	60.5	**1,385**	60.9	**37**	45.6
Connecticut	**5,844**	16.1	20.3	34.3	29.3	**2,858**	56.9	**2,729**	56.6	**129**	64.2
Delaware	**1,401**	19.6	33.2	31.7	15.5	**367**	57.1	**335**	58.1	**32**	46.5
District of Columbia	**2,067**	11.3	20.0	48.6	20.1	**521**	63.1	**502**	63.4	**19**	55.0
Florida	**17,930**	18.4	13.7	41.9	26.0	**7,002**	63.0	**6,186**	64.4	**816**	52.0
Georgia	**7,701**	27.0	14.7	37.3	20.9	**2,383**	65.8	**2,084**	67.8	**298**	52.0
Hawaii	**1,600**	14.6	28.2	29.2	28.0	**585**	73.5	**577**	73.6	**9**	68.0
Idaho	**1,510**	21.8	12.8	49.0	16.3	**505**	46.3	**483**	46.5	**22**	42.3
Illinois	**12,587**	23.1	16.5	41.1	19.3	**3,954**	54.5	**3,882**	54.5	**72**	51.3
Indiana	**6,280**	16.6	11.4	48.4	23.7	**2,570**	55.6	**2,403**	57.1	**168**	33.6
Iowa	**3,302**	17.2	11.3	48.6	22.9	**1,498**	50.1	**1,461**	49.9	**36**	56.7
Kansas	**2,623**	22.1	8.6	43.0	26.2	**1,066**	62.3	**1,025**	63.2	**41**	40.3
Kentucky	**5,517**	22.4	12.4	46.6	18.6	**1,817**	55.6	**1,659**	56.6	**159**	45.3
Louisiana	**6,063**	19.8	11.5	49.6	19.1	**1,950**	57.7	**1,781**	58.1	**169**	53.8
Maine	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Maryland	**7,380**	19.2	18.8	43.0	19.1	**2,158**	58.6	**2,039**	59.1	**118**	48.8
Massachusetts	**13,233**	11.8	18.3	45.9	24.1	**5,339**	55.5	**5,297**	55.2	**42**	95.1
Michigan	**11,758**	18.8	17.1	44.7	19.4	**3,639**	58.5	**3,446**	58.0	**193**	67.2
Minnesota	**8,334**	18.8	17.4	42.0	21.8	**3,401**	51.2	**3,376**	51.2	**25**	52.9
Mississippi	**4,253**	21.1	10.7	43.9	24.3	**1,587**	64.7	**1,386**	67.3	**201**	46.2
Missouri	**7,392**	22.0	9.2	49.1	19.7	**2,589**	52.0	**2,529**	52.1	**61**	48.5
Montana	**944**	24.1	12.1	37.9	26.0	**383**	64.5	**363**	65.4	**20**	47.7
Nebraska	**1,641**	20.3	11.8	44.8	23.1	**672**	51.5	**671**	51.5	**0**	58.5
Nevada	**1,487**	28.1	13.1	41.3	17.6	**392**	62.7	**340**	65.0	**51**	47.5
New Hampshire	**1,217**	24.1	7.3	39.6	29.0	**599**	56.1	**572**	56.5	**26**	49.2

TABLE 12, Continued

		Percentage of Benefit Spending Attributable to Eligibility Group[1]				Dually eligible Enrollees[2]					
						All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
State	**Total**	**Children**	**Adults**	**Disabled**	**Aged**	**Total**	**Percentage age 65+**	**Total**	**Percentage age 65+**	**Total**	**Percentage age 65+**
New Jersey	**$9,309**	15.8%	7.5%	44.6%	32.0%	**$4,696**	60.4%	**$4,650**	60.3%	**$45**	68.4%
New Mexico	**3,366**	38.7	28.9	29.3	3.1	**349**	28.5	**294**	23.4	**55**	56.4
New York	**50,724**	10.4	19.3	41.4	28.8	**22,615**	61.2	**22,336**	61.0	**279**	72.7
North Carolina	**10,138**	22.1	13.9	44.7	19.3	**3,353**	57.9	**3,223**	58.3	**130**	47.7
North Dakota	**707**	15.7	8.9	43.4	32.0	**398**	56.2	**393**	56.3	**5**	48.8
Ohio	**15,046**	14.4	15.7	45.1	24.9	**6,257**	55.1	**5,904**	55.9	**354**	41.9
Oklahoma	**4,225**	28.7	13.5	40.3	17.5	**1,304**	53.2	**1,272**	53.3	**32**	50.2
Oregon	**4,380**	16.3	23.3	37.7	22.7	**1,523**	63.7	**1,447**	64.8	**76**	44.2
Pennsylvania	**19,663**	16.9	9.2	49.6	24.3	**7,366**	62.5	**7,241**	62.7	**126**	56.3
Rhode Island	**1,989**	22.8	15.5	42.3	19.5	**719**	52.0	**709**	52.0	**10**	50.9
South Carolina	**4,598**	19.6	17.4	42.7	20.2	**1,583**	58.6	**1,555**	58.7	**28**	54.2
South Dakota	**759**	25.5	12.4	43.1	19.1	**265**	54.2	**245**	54.6	**19**	49.3
Tennessee	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Texas	**26,986**	33.8	8.6	40.3	17.3	**7,153**	63.2	**6,408**	63.2	**745**	63.2
Utah	**1,742**	26.7	15.2	47.7	10.4	**464**	38.1	**458**	38.1	**7**	32.2
Vermont	**1,260**	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Virginia	**6,814**	23.2	11.3	44.6	20.9	**2,348**	55.3	**2,216**	56.1	**132**	42.2
Washington	**7,098**	23.5	14.7	41.9	20.0	**2,259**	61.1	**2,146**	62.2	**113**	40.5
West Virginia	**2,685**	16.6	9.4	49.6	24.4	**1,023**	63.1	**956**	64.3	**67**	46.7
Wisconsin	**6,966**	11.7	17.1	41.5	29.7	**3,502**	58.1	**3,467**	58.1	**35**	54.3
Wyoming	**534**	20.7	9.5	45.0	24.9	**256**	51.5	**238**	52.2	**18**	41.0

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information.

[1] Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

[2] Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing.

[3] Maine ($2.3 billion) and Tennessee ($7.9 billion) were excluded due to MSIS spending data anomalies.

[4] Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, MACPAC's adjustment methodology is only applied to total Medicaid spending.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

TABLE 13. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2011

	Total			Children			Adults			Disabled			Aged		
		Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE	
State	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]
Total[3]	**11.9%**	**$7,236**	**$7,903**	**1.3%**	**$2,854**	**$2,875**	**28.2%**	**$4,368**	**$5,380**	**10.5%**	**$19,031**	**$20,800**	**23.5%**	**$16,236**	**$20,336**
Alabama	23.1	4,865	5,671	0.1	2,318	2,316	74.0	3,111	5,294	21.6	9,015	10,911	56.5	10,430	21,546
Alaska	0.4	12,049	12,083	–	5,851	5,851	0.0	9,256	9,254	0.7	31,262	31,479	3.2	27,953	28,790
Arizona	6.0	8,133	8,268	1.6	3,399	3,391	7.5	7,492	7,738	6.2	23,277	23,561	24.5	14,689	18,210
Arkansas	20.4	6,606	7,702	2.3	2,789	2,819	72.9	2,346	5,452	20.7	13,590	15,948	38.3	16,464	24,814
California	28.5	5,857	7,625	6.5	2,621	2,744	63.9	2,397	4,227	0.8	22,411	22,503	4.0	14,235	14,577
Colorado	4.0	7,025	7,114	0.1	2,700	2,677	2.6	5,159	4,836	11.0	19,738	21,755	20.9	17,724	21,845
Connecticut	9.0	8,943	9,604	0.0	3,421	3,421	0.1	5,429	5,410	20.2	28,828	35,300	49.5	18,924	35,679
Delaware	14.1	7,057	7,856	1.3	3,410	3,448	16.4	5,770	6,489	27.0	18,300	24,101	53.3	16,409	32,723
District of Columbia	3.1	10,371	10,533	–	3,210	3,210	0.3	5,501	5,328	5.9	28,690	30,235	24.2	25,271	32,443
Florida	11.2	5,894	6,181	0.2	2,070	2,048	6.5	5,275	4,959	22.5	13,882	16,882	41.9	10,597	16,454
Georgia	8.6	5,091	5,318	0.0	2,345	2,343	0.8	6,233	6,024	19.0	10,133	11,880	47.1	10,103	17,234
Hawaii	1.5	6,725	6,787	0.0	2,284	2,283	0.0	5,168	5,164	4.8	18,010	18,802	10.2	19,816	21,761
Idaho	5.0	7,161	7,400	0.0	2,482	2,479	0.4	8,226	8,045	13.6	19,202	21,854	32.3	15,344	21,767
Illinois	5.0	4,933	5,094	0.1	2,133	2,133	13.2	2,998	3,192	4.8	17,429	18,156	10.8	12,158	13,406
Indiana	6.0	6,494	6,722	–	1,899	1,899	0.0	4,066	4,065	21.2	18,377	22,458	29.2	19,068	25,903
Iowa	10.7	6,975	7,496	1.1	2,530	2,533	25.0	2,803	2,829	7.1	20,673	22,037	25.0	20,223	26,239
Kansas	6.1	7,881	8,233	0.0	3,037	3,036	0.5	5,930	5,723	15.9	15,904	18,494	27.5	21,124	28,411
Kentucky	9.5	7,210	7,716	0.0	3,371	3,368	0.5	7,275	7,199	16.9	11,823	13,745	40.5	11,784	18,402
Louisiana	15.6	5,655	6,353	0.0	2,141	2,139	44.6	3,680	5,299	15.7	14,001	16,149	46.2	10,816	18,502
Maine	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Maryland	7.0	8,486	8,730	0.2	3,380	3,365	8.8	5,627	5,304	12.2	23,416	26,158	32.2	20,332	28,704
Massachusetts	6.7	12,485	13,239	3.8	6,334	6,540	9.6	5,879	6,350	0.5	22,159	22,210	16.5	24,840	29,146
Michigan	6.4	6,054	6,308	0.9	2,200	2,213	16.5	4,260	4,915	5.2	15,508	16,133	15.6	18,190	20,264
Minnesota	4.7	10,161	10,534	0.7	4,212	4,225	8.6	5,734	6,120	4.2	28,168	29,183	12.0	25,470	28,484
Mississippi	15.3	6,551	7,123	0.1	2,708	2,707	34.5	5,504	5,942	22.0	12,135	14,648	45.3	12,742	21,186
Missouri	11.3	7,913	8,654	0.0	3,340	3,340	46.5	3,787	5,491	6.0	19,408	20,398	13.7	18,029	20,469
Montana	6.7	8,836	9,272	–	3,739	3,739	–	7,794	7,794	16.2	17,561	20,345	35.4	22,223	33,053
Nebraska	0.1	8,149	8,134	0.0	2,704	2,701	0.3	6,540	6,436	0.0	20,347	20,348	0.0	30,539	30,551
Nevada	7.7	5,134	5,284	0.1	2,368	2,362	2.1	4,160	3,925	23.9	14,898	18,592	44.4	10,244	16,503
New Hampshire	7.1	8,820	9,291	–	3,545	3,545	–	5,767	5,767	20.8	18,238	22,379	32.1	26,154	37,106

TABLE 13, Continued

State	Total			Children			Adults			Disabled			Aged		
		Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE	
	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]
New Jersey	3.0%	$9,709	$9,907	0.0%	$2,835	$2,835	1.3%	$5,473	$5,232	4.9%	$24,120	$25,233	13.7%	$21,390	$24,468
New Mexico	12.5	6,140	6,601	0.0	4,238	4,233	29.2	7,136	8,621	18.4	15,191	18,141	41.9	2,667	3,248
New York	5.8	10,426	10,813	2.1	2,961	3,008	6.7	5,297	5,321	4.1	31,989	33,164	15.9	25,382	29,403
North Carolina	9.4	6,479	6,940	0.1	2,720	2,718	29.3	5,247	6,611	9.8	14,844	16,183	22.6	11,768	14,711
North Dakota	4.5	10,830	11,269	–	3,139	3,139	0.0	5,574	5,573	11.2	28,914	32,316	22.2	28,468	36,240
Ohio	5.2	7,615	7,839	0.0	2,244	2,244	0.0	4,703	4,702	16.3	19,531	22,632	28.1	23,290	31,104
Oklahoma	9.2	6,058	6,483	0.1	3,110	3,110	32.4	4,226	5,346	8.1	15,066	16,228	18.1	12,538	14,967
Oregon	10.4	7,502	8,131	2.5	2,573	2,629	11.6	6,424	6,928	18.0	17,499	20,795	34.3	18,555	27,255
Pennsylvania	8.6	9,244	9,932	0.2	3,576	3,573	27.9	4,475	5,572	4.9	16,874	17,591	18.6	22,085	26,688
Rhode Island	3.5	11,401	11,668	0.0	5,810	5,802	3.8	8,891	8,900	3.4	22,041	22,688	14.4	16,334	18,727
South Carolina	10.4	5,736	6,099	0.2	2,234	2,233	37.1	4,673	5,756	5.4	13,145	13,771	13.9	12,177	13,895
South Dakota	6.6	7,117	7,421	0.0	3,054	3,053	0.2	6,347	6,333	17.9	18,721	22,101	35.3	13,081	18,880
Tennessee	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Texas	10.1	6,789	7,117	0.0	3,567	3,547	40.1	6,153	7,942	15.1	17,409	19,757	36.6	11,183	15,498
Utah	1.7	6,434	6,436	0.0	2,922	2,914	0.9	4,575	4,286	4.9	21,118	22,060	13.9	12,553	14,345
Vermont	4.5	7,633	[4]	–	[4]	[4]	–	[4]	[4]	8.3	[4]	[4]	27.8	[4]	[4]
Virginia	7.7	7,966	8,389	0.0	3,345	3,344	8.3	6,419	6,625	16.8	18,372	21,451	28.8	14,543	19,506
Washington	11.2	6,206	6,595	0.2	2,489	2,473	42.4	5,155	6,885	12.3	15,954	17,648	21.4	16,362	19,981
West Virginia	8.6	7,566	8,073	–	2,662	2,662	0.0	6,228	6,226	14.6	12,119	13,812	38.8	17,533	27,275
Wisconsin	9.8	6,548	7,079	4.2	1,980	2,023	18.5	3,254	3,616	4.8	18,513	19,253	9.5	16,055	17,570
Wyoming	7.6	7,748	8,004	0.9	2,445	2,462	15.4	5,944	6,195	15.9	23,625	26,850	37.6	26,327	39,833

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information.

Zeroes indicate amounts less than 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

[1] These percentages are likely to be underestimated because comparisons with other data sources indicate that some states do not identify all of their limited-benefit enrollees in MSIS.

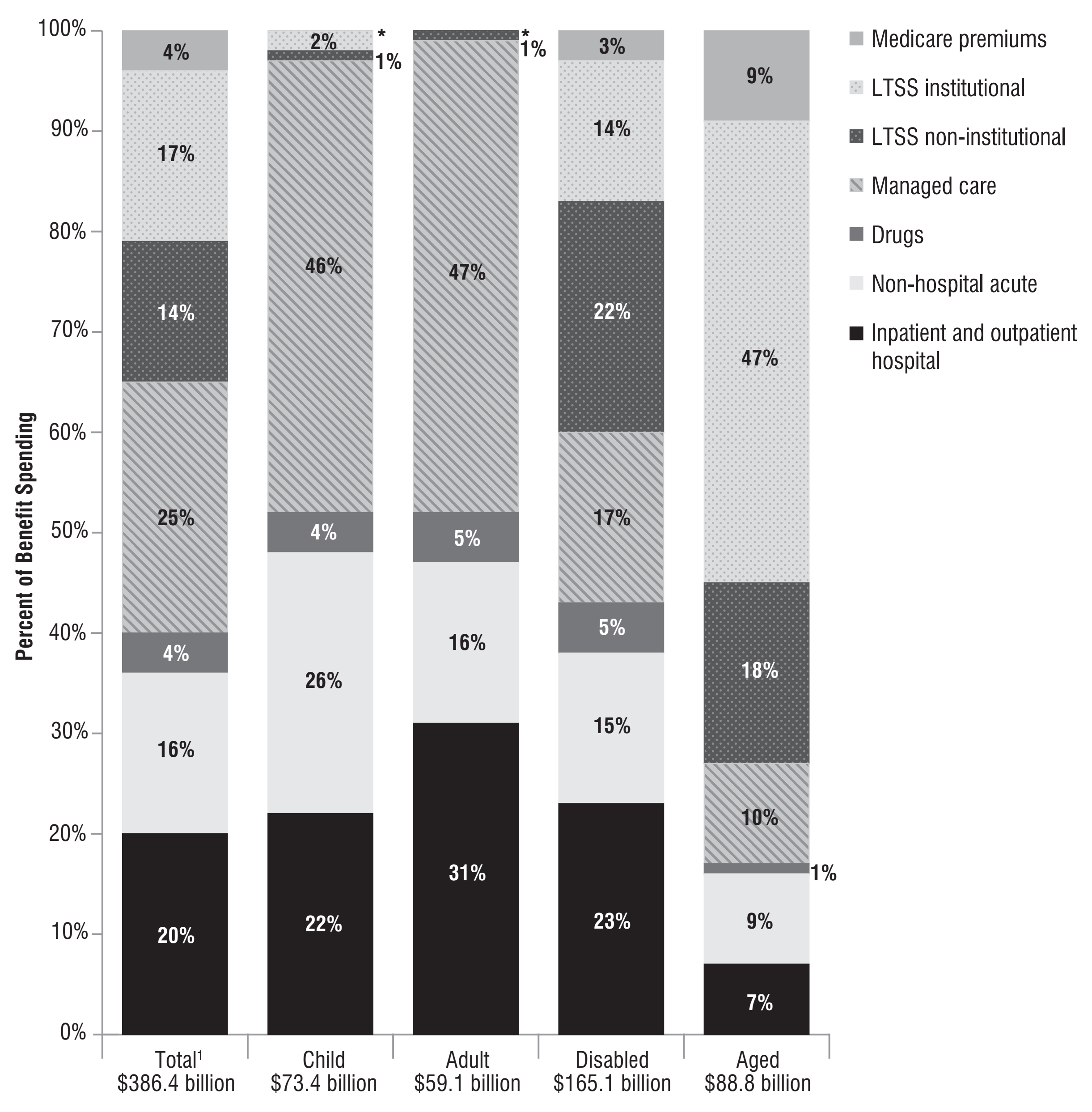
[2] Calculated by removing limited-benefit enrollees and their spending. In this table, enrollees with limited benefits are defined as those reported by states in MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services. Additional individuals may receive limited benefits for other reasons, but are not broken out here.

[3] Maine ($2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee ($7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

[4] Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, MACPAC's adjustment methodology is only applied to total Medicaid spending.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

FIGURE 3. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2011



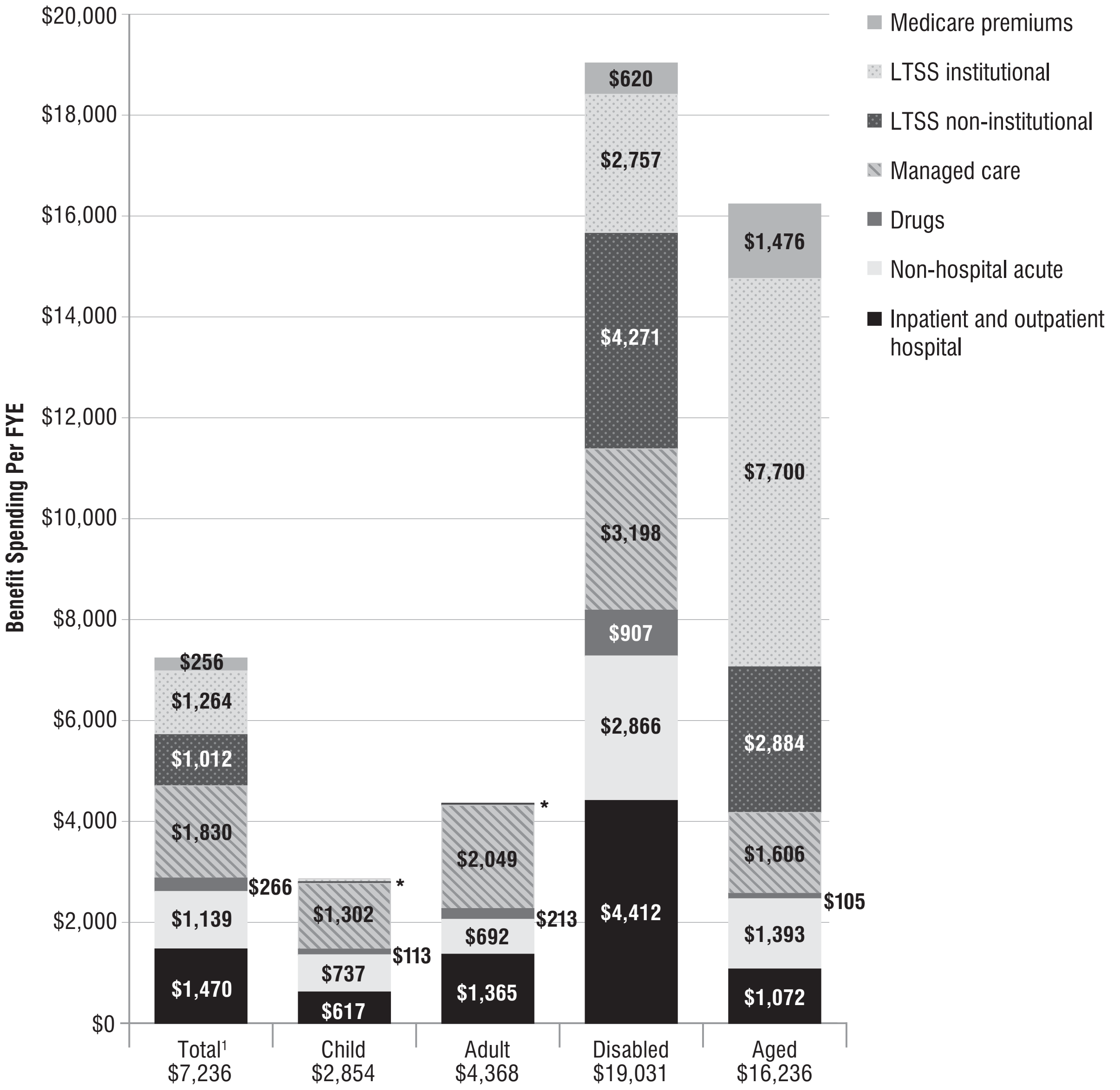
Notes: LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information.

* Values less than 1 percent are not shown.

1 Maine ($2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee ($7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

FIGURE 4. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2011



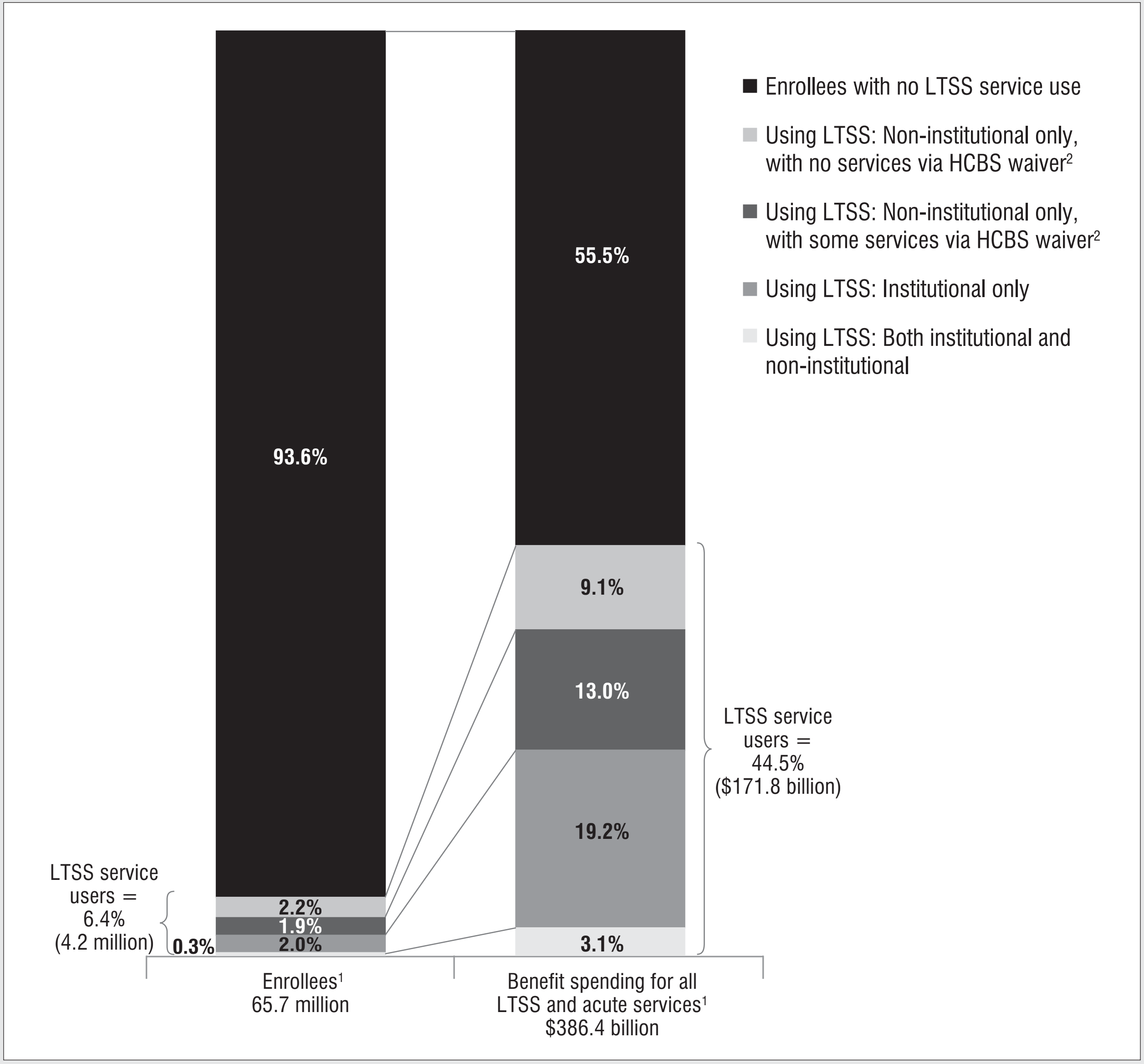
Notes: LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits (see Table 13 notes for more information). Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

* Values less than $100 not shown.

1 Maine ($2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee ($7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

FIGURE 5. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2011



Notes: HCBS is home and community-based services. LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals and enrollment counts are unduplicated using unique national identification numbers. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

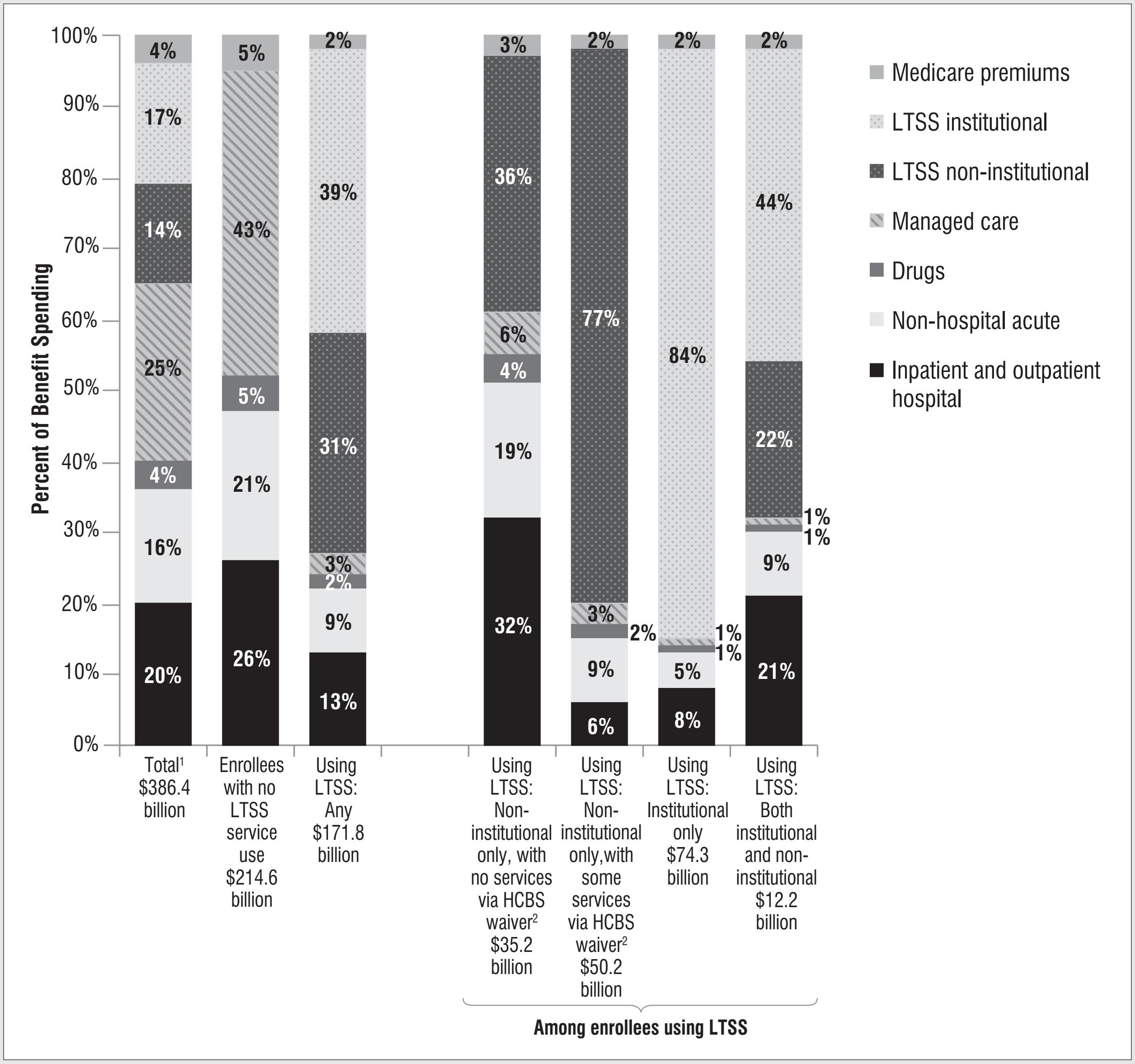
LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement, regardless of the amount. (The data do not allow a breakout of LTSS services delivered through managed care.) For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. More refined definitions that take these and other factors into account would produce different results and will be considered in future Commission work.

1 Maine ($2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee ($7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

2 All states have HCBS waivers that provide a range of LTSS for targeted populations of enrollees who require institutional levels of care. Based on a comparison with CMS-372 data (a state-reported source containing aggregate spending and enrollment for HCBS waivers), the number of HCBS waiver enrollees may be underreported in MSIS.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

FIGURE 6. Distribution of Medicaid Benefit Spending by Long-Term Services and Supports Use and Service Category, FY 2011



Notes: HCBS is home and community-based services. LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Amounts are fee for service unless other use noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

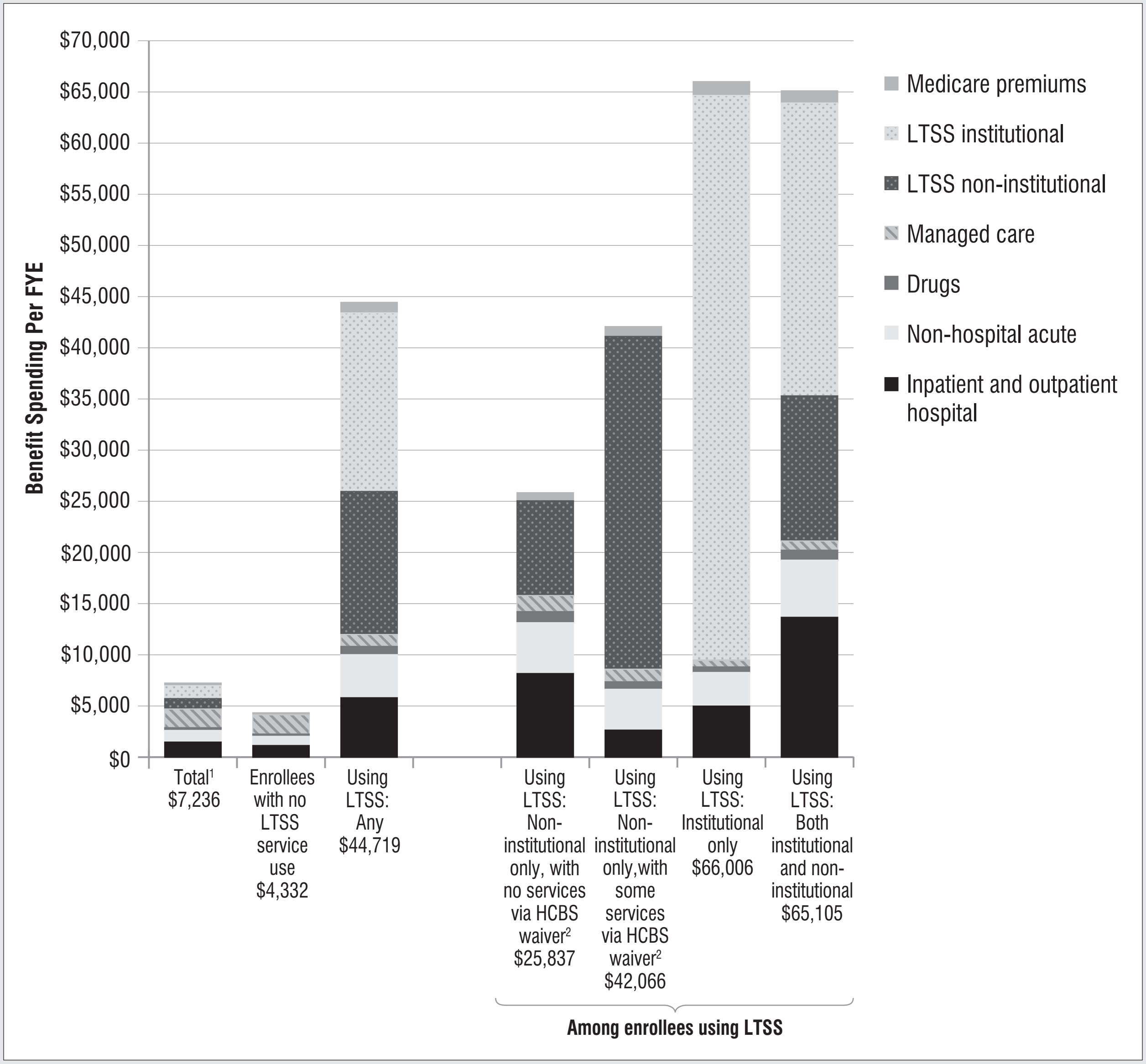
LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement, regardless of the amount. (The data do not allow a breakout of LTSS services delivered through managed care.) For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. More refined definitions that take these and other factors into account would produce different results and will be considered in future Commission work.

[1] Maine ($2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee ($7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

[2] All states have HCBS waivers that provide a range of LTSS for targeted populations of enrollees who require institutional levels of care. Based on a comparison with CMS-372 data (a state-reported source containing aggregate spending and enrollment for HCBS waivers), the number of HCBS waiver enrollees may be underreported in MSIS.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

FIGURE 7. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Long-Term Services and Supports Use and Service Category, FY 2011



Notes: HCBS is home and community-based services. LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits (see Table 13 notes for more information). Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement, regardless of the amount. The data do not allow a breakout of LTSS services delivered through managed care. For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. More refined definitions that take these and other factors into account would produce different results and will be considered in future Commission work.

1 Maine ($2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee ($7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

2 All states have HCBS waivers that provide a range of LTSS for targeted populations of enrollees who require institutional levels of care. Based on a comparison with CMS-372 data (a state-reported source containing aggregate spending and enrollment for HCBS waivers), the number of HCBS waiver enrollees may be underreported in MSIS.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

MAC Stats

SECTION 4

Key Points

Medicaid Managed Care

- The term managed care may refer to several different arrangements, including comprehensive risk-based and limited-benefit plans that provide a contracted set of services in exchange for a capitated (per member per month) payment, as well as primary care case management (PCCM) programs that typically pay primary care providers a small monthly fee to coordinate enrollees' care. Depending on the definition that is used, the national percentage of Medicaid enrollees in managed care ranges from about half (reflecting individuals in comprehensive risk-based plans) to more than 70 percent (Table 14).
- The use of managed care varies widely by state, both in the arrangements used and the populations served. In fiscal year (FY) 2011, nearly all states reported using some form of managed care, including comprehensive risk-based plans, limited-benefit plans, or PCCM programs (Table 14).
- The national percentage of Medicaid enrollees in any form of managed care ranged from 41 percent among enrollees age 65 and older to 87 percent among non-disabled child enrollees in FY 2011 (Table 14). Participation in comprehensive risk-based managed care plans was lowest among the aged and disabled eligibility groups (14 and 33 percent, respectively) and highest among non-disabled adults and children (48 and 63 percent).
- For individuals dually enrolled in Medicaid and Medicare, enrollment in Medicaid limited-benefit plans (which typically cover only behavioral health, transportation, or dental services) is more common than enrollment in Medicaid comprehensive risk-based plans or PCCM programs. Forty-one percent of individuals dually enrolled in Medicaid and Medicare were enrolled in some form of Medicaid managed care in FY 2011 (Table 14).
- The national percentage of Medicaid benefit spending on any form of managed care ranges from about 10 percent among enrollees age 65 and older to more than 40 percent among non-disabled child and adult enrollees (Table 15). In states with comprehensive risk-based managed care, these plans account for the majority of managed care spending.

TABLE 14. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2011

	Percentage of Enrollees											
	Any managed care						Comprehensive risk-based managed care					
State	**Total**	**Children**	**Adults**	**Disabled**	**Aged**	**Dual-eligible enrollees[1]**	**Total**	**Children**	**Adults**	**Disabled**	**Aged**	**Dual-eligible enrollees[1]**
Total[2]	**71.8%**	**86.5%**	**61.0%**	**64.9%**	**41.0%**	**41.4%**	**49.8%**	**63.3%**	**48.0%**	**33.0%**	**13.9%**	**13.2%**
Alabama	**52.2**	72.3	25.8	44.5	16.3	17.2	**3.1**	–	0.0	7.0	14.8	15.6
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	**92.9**	97.3	90.9	94.0	74.0	79.7	**86.3**	91.3	83.1	88.6	68.3	74.8
Arkansas	**80.6**	98.2	49.6	78.1	46.9	47.1	**0.0**	–	0.0	–	0.1	0.1
California	**58.2**	76.3	28.8	91.5	88.2	91.0	**40.8**	64.9	24.6	35.4	18.7	19.1
Colorado	**91.1**	95.0	89.5	85.6	76.7	72.6	**12.7**	13.4	11.7	12.9	10.4	8.6
Connecticut	**59.2**	95.1	57.2	0.9	0.0	0.7	**59.2**	95.1	57.2	0.9	0.0	0.7
Delaware	**87.6**	95.9	88.8	74.6	47.9	47.6	**78.5**	90.8	84.9	49.1	6.6	5.6
District of Columbia	**94.7**	98.0	96.1	93.8	74.9	71.5	**72.4**	90.3	91.9	20.5	1.2	2.4
Florida	**71.0**	90.5	69.8	54.6	15.6	11.7	**71.0**	90.5	69.8	54.6	15.6	11.7
Georgia	**88.1**	97.4	90.5	74.0	51.2	50.5	**68.8**	93.6	85.1	4.6	0.0	0.7
Hawaii	**95.3**	97.3	95.0	94.3	88.1	88.2	**95.3**	97.3	95.0	94.3	88.1	88.2
Idaho	–	–	–	–	–	–	–	–	–	–	–	–
Illinois	**71.8**	85.3	78.1	37.6	8.5	3.9	**7.7**	9.2	6.7	6.7	3.0	0.4
Indiana	**76.9**	93.9	89.9	36.2	2.8	3.5	**71.2**	90.9	89.8	12.1	0.2	1.4
Iowa	**79.1**	95.9	49.8	91.0	74.7	79.8	**0.0**	–	–	0.1	0.2	0.1
Kansas	**82.2**	96.6	79.6	62.8	38.8	42.3	**57.0**	81.8	67.8	3.2	0.5	0.8
Kentucky	**79.8**	91.4	90.8	62.0	54.2	50.6	**17.7**	23.2	19.4	11.4	5.7	6.7
Louisiana	**58.9**	83.0	38.1	40.1	1.8	3.3	**0.0**	–	–	0.0	0.2	0.1
Maine	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Maryland	**73.4**	96.0	64.7	57.0	1.3	4.3	**73.4**	96.0	64.7	57.0	1.3	4.3
Massachusetts	**74.0**	90.6	82.8	65.3	16.9	14.8	**50.2**	62.5	61.1	32.0	15.7	12.5
Michigan	**89.2**	96.3	77.1	90.7	80.7	84.4	**71.7**	87.1	70.5	52.2	3.4	5.9
Minnesota	**68.4**	85.3	70.2	13.0	58.7	43.2	**68.4**	85.3	70.2	13.0	58.7	43.2
Mississippi	**9.2**	0.5	0.2	40.5	1.0	1.1	**9.2**	0.5	0.2	40.5	1.0	1.1

TABLE 14, Continued

	Percentage of Enrollees											
	Any managed care						Comprehensive risk-based managed care					
State	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]
Missouri	**69.7%**	67.0%	49.4%	91.4%	86.1%	87.5%	**44.5%**	67.0%	49.0%	1.6%	0.0%	0.3%
Montana	**70.3**	88.4	75.1	46.2	1.0	2.2	**–**	–	–	–	–	–
Nebraska	**45.0**	53.7	49.4	24.7	5.5	2.4	**45.0**	53.7	49.4	24.7	5.5	2.4
Nevada	**82.7**	87.6	86.7	71.6	52.0	47.6	**57.6**	72.1	71.6	2.0	0.0	0.4
New Hampshire	**–**	–	–	–	–	–	**–**	–	–	–	–	–
New Jersey	**83.5**	89.2	60.9	91.1	83.1	83.8	**67.9**	87.0	54.9	61.2	18.0	20.5
New Mexico	**67.6**	79.3	68.6	45.0	3.6	5.0	**67.0**	79.1	67.1	44.2	3.4	4.6
New York	**66.9**	80.1	74.0	50.7	15.9	13.3	**66.9**	80.1	74.0	50.7	15.9	13.3
North Carolina	**82.8**	96.8	77.6	75.5	33.1	43.2	**0.0**	–	–	0.0	0.1	0.1
North Dakota	**57.8**	75.6	74.9	9.1	1.3	1.0	**2.3**	4.0	0.1	0.2	0.7	0.4
Ohio	**76.2**	92.8	92.7	38.6	5.1	6.3	**76.2**	92.8	92.7	38.6	5.1	6.3
Oklahoma	**84.0**	96.5	57.0	84.8	79.4	77.6	**0.0**	–	–	0.0	0.1	0.0
Oregon	**88.9**	96.0	86.7	82.6	66.5	65.3	**76.8**	86.2	80.2	63.0	35.7	38.0
Pennsylvania	**86.5**	95.7	78.2	91.9	49.9	64.9	**60.0**	75.0	60.5	54.0	8.0	8.3
Rhode Island	**60.0**	88.0	79.1	17.1	0.1	1.0	**60.0**	88.0	79.1	17.1	0.1	1.0
South Carolina	**86.0**	94.9	69.7	86.9	79.0	80.6	**52.1**	68.6	52.7	30.9	0.6	2.6
South Dakota	**45.6**	58.7	54.9	13.8	0.3	0.8	**–**	–	–	–	–	–
Tennessee	**[2]**	[2]	[2]	[2]	[2]	[2]	**[2]**	[2]	[2]	[2]	[2]	[2]
Texas	**75.5**	93.3	54.5	49.8	22.1	24.4	**52.9**	65.6	35.0	32.5	21.7	23.0
Utah	**89.0**	97.5	68.5	91.7	82.5	87.2	**3.4**	5.3	0.1	1.9	0.1	0.9
Vermont	**[3]**	[3]	[3]	[3]	[3]	[3]	**[3]**	[3]	[3]	[3]	[3]	[3]
Virginia	**65.8**	83.3	68.7	41.5	13.6	8.3	**60.5**	78.7	64.6	35.3	4.0	1.8
Washington	**84.3**	96.4	69.0	73.5	58.2	59.0	**84.0**	96.3	68.8	71.9	58.1	59.0
West Virginia	**55.1**	90.2	79.1	2.7	0.0	0.5	**52.8**	86.5	76.9	2.0	0.0	0.4
Wisconsin	**85.1**	95.1	89.8	88.7	32.5	52.3	**80.4**	95.1	89.7	65.2	18.5	35.6
Wyoming	**–**	–	–	–	–	–	**–**	–	–	–	–	–

TABLE 14, Continued. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2011

	Percentage of Enrollees											
	Limited-benefit plan						Primary care case management					
State	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]
Total[2]	**35.8%**	**41.2%**	**25.4%**	**41.6%**	**31.3%**	**32.0%**	**13.4%**	**18.7%**	**9.0%**	**12.0%**	**1.8%**	**2.4%**
Alabama	**2.3**	0.4	11.8	0.4	–	0.0	**47.2**	72.2	15.1	37.4	1.5	1.7
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	**88.3**	96.3	89.9	71.7	54.6	60.5	–	–	–	–	–	–
Arkansas	**79.4**	96.4	48.5	78.0	46.7	46.8	**61.8**	87.8	25.8	55.0	4.1	5.5
California	**54.6**	70.1	26.5	90.8	87.0	90.3	–	–	–	–	–	–
Colorado	**90.9**	95.0	89.5	85.4	74.4	71.1	–	–	–	–	–	–
Connecticut	–	–	–	–	–	–	–	–	–	–	–	–
Delaware	**87.5**	95.7	88.8	74.5	47.9	47.6	–	–	–	–	–	–
District of Columbia	**31.8**	15.3	16.9	83.8	74.6	70.3	–	–	–	–	–	–
Florida	–	–	–	–	–	–	–	–	–	–	–	–
Georgia	**87.5**	96.7	89.4	73.9	51.2	50.5	**7.6**	0.1	0.0	44.2	2.9	3.2
Hawaii	**0.5**	1.1	–	0.6	–	–	–	–	–	–	–	–
Idaho[2]	–	–	–	–	–	–	–	–	–	–	–	–
Illinois	**3.2**	4.4	3.1	0.1	–	0.0	**65.5**	76.9	72.3	35.9	8.0	3.7
Indiana	–	–	–	–	–	–	**9.9**	3.5	18.1	24.9	2.7	2.6
Iowa	**79.0**	95.9	49.8	91.0	74.7	79.8	**38.8**	62.9	29.1	1.5	0.0	0.2
Kansas	**82.1**	96.6	79.4	62.6	38.3	42.0	**4.5**	3.0	1.2	13.3	1.2	0.9
Kentucky	**79.6**	91.2	90.8	61.8	54.1	50.5	**40.4**	61.4	58.8	6.6	0.7	0.7
Louisiana	–	–	–	–	–	–	**58.8**	83.0	38.1	40.1	1.6	3.2
Maine	**[2]**	[2]	[2]	[2]	[2]	[2]	**[2]**	[2]	[2]	[2]	[2]	[2]
Maryland	–	–	–	–	–	–	–	–	–	–	–	–
Massachusetts	**29.0**	35.9	26.6	38.3	1.3	2.7	–	–	–	–	–	–
Michigan	**85.3**	96.2	63.5	90.1	80.2	84.1	–	–	–	–	–	–
Minnesota	–	–	–	–	–	–	–	–	–	–	–	–
Mississippi	–	–	–	–	–	–	–	–	–	–	–	–
Missouri[2]	**25.5**	0.1	0.7	91.0	86.1	87.4	–	–	–	–	–	–
Montana	–	–	–	–	–	–	**70.3**	88.4	75.1	46.2	1.0	2.2
Nebraska	–	–	–	–	–	–	–	–	–	–	–	–
Nevada	**82.6**	87.5	86.5	71.6	52.0	47.6	–	–	–	–	–	–
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	**82.5**	88.8	56.8	90.9	82.9	83.6	–	–	–	–	–	–

TABLE 14, Continued

	Percentage of Enrollees											
	Limited-benefit plan						Primary care case management					
State	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]
New Mexico	**60.8%**	79.3%	43.3%	43.6%	1.9%	3.2%	**–**	–	–	–	–	–
New York	**–**	–	–	–	–	–	**–**	–	–	–	–	–
North Carolina	**75.0**	93.9	75.3	56.5	6.4	10.8	**78.4%**	94.8%	70.2%	66.7%	29.7%	39.4%
North Dakota	**5.0**	5.0	5.9	7.4	0.5	0.3	**55.3**	73.7	73.6	1.8	0.0	0.3
Ohio	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Oklahoma	**81.9**	96.4	48.8	84.7	79.3	77.6	**57.3**	77.3	41.7	36.8	1.2	2.3
Oregon	**88.7**	95.7	86.7	82.5	66.4	65.2	**0.4**	0.3	0.1	0.7	0.8	0.7
Pennsylvania	**85.9**	95.4	76.9	91.6	48.9	64.2	**16.8**	21.0	16.4	15.9	1.0	1.7
Rhode Island	**–**	–	–	–	–	–	**–**	–	–	–	–	–
South Carolina	**80.4**	88.6	61.5	84.1	78.9	80.1	**17.3**	21.8	11.6	17.2	7.7	10.8
South Dakota	**–**	–	–	–	–	–	**45.6**	58.7	54.9	13.8	0.3	0.8
Tennessee	**[2]**	[2]	[2]	[2]	[2]	[2]	**[2]**	[2]	[2]	[2]	[2]	[2]
Texas	**10.9**	13.3	5.5	9.5	4.2	4.6	**25.0**	31.3	21.0	15.9	0.3	1.0
Utah	**89.0**	97.5	68.5	91.7	82.5	87.2	**–**	–	–	–	–	–
Vermont	**[3]**	[3]	[3]	[3]	[3]	[3]	**[3]**	[3]	[3]	[3]	[3]	[3]
Virginia	**–**	–	–	–	–	–	**5.5**	4.8	4.2	6.4	9.7	6.5
Washington	**–**	–	–	–	–	–	**1.4**	0.9	1.0	3.8	0.4	0.3
West Virginia	**–**	–	–	–	–	–	**2.4**	4.0	2.5	0.7	0.0	0.0
Wisconsin	**6.3**	0.2	0.1	33.3	15.4	19.0	**–**	–	–	–	–	–
Wyoming	**–**	–	–	–	–	–	**–**	–	–	–	–	–

Notes: Excludes the territories and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, figures shown here are not directly comparable to earlier years. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs. Enrollees are counted as participating in managed care if they were enrolled during the fiscal year and at least one managed care payment was made on their behalf during the fiscal year; this method underestimates participation somewhat because it does not capture enrollees who entered managed care late in the year but for whom a payment was not made until the following fiscal year. Managed care types do not sum to total because individuals are counted in every category for which a payment was made on their behalf during the year.

Zeroes indicate amounts less than 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

[1] Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; these figures include those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For dually eligible enrollees in a comprehensive Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state.

[2] Maine (0.4 million enrollees) and Tennessee (1.5 million enrollees) were excluded due to MSIS spending data anomalies.

[3] Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, managed care enrollment (which, for this table, is based on the presence of managed care spending in MSIS for a given enrollee) is not reported here.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) data from CMS as of February 2014.

TABLE 15. Percentage of Medicaid Benefit Spending on Managed Care by State and Eligibility Group, FY 2011

	Percentage of Benefit Spending											
	Any managed care						Comprehensive risk-based managed care					
State	**Total**	**Children**	**Adults**	**Disabled**	**Aged**	**Dual-eligible enrollees[1]**	**Total**	**Children**	**Adults**	**Disabled**	**Aged**	**Dual-eligible enrollees[1]**
Total[2]	**25.3%**	**45.6%**	**46.9%**	**16.8%**	**9.9%**	**8.7%**	**23.9%**	**44.2%**	**46.1%**	**15.1%**	**8.6%**	**6.8%**
Alabama	**2.3**	1.6	13.3	0.8	1.0	1.3	**0.5**	–	0.0	0.5	1.0	1.3
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	**84.4**	85.4	87.0	83.0	80.1	81.1	**83.3**	84.3	85.2	82.7	79.4	80.5
Arkansas	**0.4**	1.1	0.5	0.2	0.1	0.1	**0.0**	–	0.0	–	0.0	0.0
California	**20.7**	47.9	20.1	12.8	14.9	15.9	**19.8**	47.4	19.9	12.4	12.7	14.1
Colorado	**12.1**	17.1	10.4	11.0	10.4	10.2	**6.1**	5.7	5.5	4.8	9.5	6.9
Connecticut	**14.4**	48.4	32.5	0.1	0.0	0.1	**14.4**	48.4	32.5	0.1	0.0	0.1
Delaware	**50.6**	65.4	83.6	30.4	2.7	2.2	**50.5**	65.3	83.5	30.3	2.5	2.0
District of Columbia	**29.7**	67.7	79.2	12.3	1.1	1.8	**28.8**	67.1	79.1	10.9	0.2	0.4
Florida	**18.1**	34.5	21.2	15.0	10.0	5.9	**18.1**	34.5	21.2	15.0	10.0	5.9
Georgia	**35.4**	84.3	81.8	1.4	0.3	0.7	**35.2**	84.3	81.8	1.0	0.0	0.4
Hawaii	**78.2**	76.8	79.5	66.8	89.4	79.2	**78.2**	76.8	79.5	66.8	89.4	79.2
Idaho	–	–	–	–	–	–	–	–	–	–	–	–
Illinois	**2.9**	5.3	6.1	1.1	0.9	0.2	**2.1**	3.4	4.2	1.0	0.9	0.2
Indiana	**18.1**	54.3	70.0	2.3	0.1	0.2	**17.9**	54.1	70.0	2.1	0.0	0.2
Iowa	**4.8**	10.7	6.3	4.1	1.2	2.4	**0.1**	–	–	0.1	0.2	0.2
Kansas	**24.2**	59.9	71.2	9.8	2.4	3.4	**18.6**	53.9	70.4	1.1	0.6	0.5
Kentucky	**12.9**	24.3	21.6	9.5	1.8	2.1	**11.9**	21.7	20.4	9.1	1.4	1.8
Louisiana	**0.2**	0.6	0.1	0.1	0.4	0.2	**0.1**	–	–	0.0	0.4	0.2
Maine	**[2]**	[2]	[2]	[2]	[2]	[2]	**[2]**	[2]	[2]	[2]	[2]	[2]
Maryland	**38.3**	56.0	79.6	29.0	0.8	1.9	**38.3**	56.0	79.6	29.0	0.8	1.9
Massachusetts	**29.4**	49.3	58.6	19.8	15.6	9.6	**26.5**	44.8	54.4	16.5	15.6	9.5
Michigan	**51.2**	71.4	71.9	54.0	7.1	20.9	**45.0**	69.8	70.8	43.2	2.1	3.8
Minnesota	**39.0**	78.1	78.0	3.9	41.7	22.4	**39.0**	78.1	78.0	3.9	41.7	22.4
Mississippi	**6.1**	0.3	0.3	13.5	0.2	0.2	**6.1**	0.3	0.3	13.5	0.2	0.2
Missouri	**14.8**	47.0	43.0	0.8	0.9	0.9	**14.4**	47.0	43.0	0.2	0.0	0.0
Montana	**0.8**	2.4	0.9	0.3	0.0	0.0	–	–	–	–	–	–
Nebraska	**14.8**	22.7	40.7	10.9	2.2	0.6	**14.8**	22.7	40.7	10.9	2.2	0.6
Nevada	**22.4**	51.5	58.7	0.4	0.3	0.4	**22.1**	51.2	58.5	0.2	0.0	0.1
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	**24.4**	58.3	71.7	18.4	5.0	4.6	**24.0**	58.2	71.6	18.1	4.2	3.9

TABLE 15, Continued

	Percentage of Benefit Spending											
	Any managed care						Comprehensive risk-based managed care					
State	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees[1]
New Mexico	**68.5%**	78.0%	83.3%	47.2%	15.4%	5.9%	**68.5%**	78.0%	83.3%	47.2%	15.5%	5.9%
New York	**22.4**	52.5	50.3	10.1	10.6	7.0	**22.4**	52.5	50.3	10.1	10.6	7.0
North Carolina	**3.5**	5.3	4.0	3.6	0.9	1.9	**0.1**	–	–	0.0	0.2	0.2
North Dakota	**0.7**	2.2	0.4	0.1	0.8	0.5	**0.5**	1.5	0.0	0.0	0.8	0.5
Ohio	**32.8**	71.4	80.2	20.7	2.5	2.5	**32.8**	71.4	80.2	20.7	2.5	2.5
Oklahoma	**4.1**	5.3	1.9	3.6	4.7	3.9	**0.2**	–	–	0.0	1.1	0.2
Oregon	**47.0**	79.8	81.0	36.3	6.6	9.3	**45.3**	75.8	80.0	34.3	6.0	8.1
Pennsylvania	**47.5**	84.7	76.4	49.1	7.3	7.3	**43.7**	79.6	74.4	44.9	4.9	4.0
Rhode Island	**35.9**	75.3	84.8	13.2	0.0	0.3	**35.9**	75.3	84.8	13.2	0.0	0.3
South Carolina	**28.8**	49.5	58.3	20.0	1.8	2.4	**28.1**	48.2	57.9	19.7	0.3	1.3
South Dakota	**0.2**	0.7	0.3	0.0	0.0	0.0	–	–	–	–	–	–
Tennessee	**[2]**	[2]	[2]	[2]	[2]	[2]	**[2]**	[2]	[2]	[2]	[2]	[2]
Texas	**21.3**	38.4	26.3	11.5	8.5	8.9	**21.1**	37.9	26.1	11.4	8.5	8.9
Utah	**21.0**	23.0	11.2	25.6	9.4	22.9	**1.3**	3.0	0.0	1.1	0.1	0.8
Vermont	**21.7**	[3]	[3]	[3]	[3]	[3]	**[3]**	[3]	[3]	[3]	[3]	[3]
Virginia	**27.7**	43.1	62.8	21.8	4.3	1.0	**27.7**	43.0	62.8	21.8	4.3	0.9
Washington	**26.6**	69.8	57.6	3.6	1.6	1.6	**26.6**	69.8	57.6	3.5	1.6	1.6
West Virginia	**12.8**	47.2	51.8	0.2	0.0	0.1	**12.8**	47.1	51.8	0.2	0.0	0.1
Wisconsin	**44.3**	55.9	58.5	39.2	38.7	40.9	**21.8**	55.8	58.3	7.3	7.5	7.0
Wyoming	–	–	–	–	–	–	–	–	–	–	–	–

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs.

Zeroes indicate amounts less than 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

[1] Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; these figures include those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For dually eligible enrollees in a comprehensive Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state.

[2] Maine ($2.3 billion in benefit spending) and Tennessee ($7.9 billion in benefit spending) were excluded due to MSIS spending data anomalies.

[3] Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, benefit spending based on MACPAC's adjustment methodology is not reported at a level lower than total Medicaid managed care.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

SECTION 5

Technical Guide to the June 2014 MACStats

This section provides supplemental information to accompany the tables and figures in Sections 1–4 of MACStats. It describes some of the data sources used in MACStats, the methods that MACPAC uses to analyze these data, and reasons why numbers in MACStats tables and figures—such as those on enrollment and spending—may differ from each other or from those published elsewhere.

Interpreting Medicaid and CHIP Enrollment and Spending Numbers

Previous MACPAC reports have discussed reasons why estimates of Medicaid and State Children's Health Insurance Program (CHIP) enrollment and spending may vary.[1] Here, Tables 16–19 are used to illustrate how various factors can affect enrollment numbers. Table 16 shows enrollment numbers for the entire U.S. population in 2011.[2] Tables 17–19 divide the U.S. population into the three age groups that are commonly used in MACPAC analyses because they correspond to some of the key eligibility pathways in Medicaid and CHIP: children age 0 to 18; adults age 19 to 64; and adults age 65 and older.

Data sources

Medicaid and CHIP enrollment and spending numbers are available from administrative data, which states and the federal government compile in the course of administering these programs. The latest year of available data may differ, depending on the source. The administrative data used in this edition of MACStats include the following, which are submitted by the states to the Centers for Medicare & Medicaid Services (CMS):

- Form CMS-64 data for state-level Medicaid spending, which is used throughout MACStats;

- Medicaid Statistical Information System (MSIS) data for person-level detail, which is used throughout MACStats;[3]
- Medicaid managed care enrollment reports, which are used in previous editions of MACStats; and
- Statistical Enrollment Data System (SEDS) data for CHIP enrollment, used in Tables 16–19.

Additional information is available from nationally representative surveys based on interviews of individuals. The survey data used in Tables 2–10 are from the federal National Health Interview Survey (NHIS), which is described below in more detail.

Tables 16–19 show 2011 survey-based estimates of Medicaid/CHIP enrollment as well as comparable (point-in-time) estimates from the administrative data. Estimates of Medicaid/CHIP enrollment from survey data tend to be lower than numbers from administrative data because survey respondents tend to underreport Medicaid and CHIP, among other reasons described later in this section.

Enrollment period examined

The number of individuals enrolled at a particular point during the year will be lower than the total number enrolled at any point during an entire year. For example, the administrative data in Table 17 show that 51.3 percent of children (40.3 million) were enrolled in Medicaid or CHIP at some time during fiscal year (FY) 2011. However, numbers from the same data source illustrate that the number of children enrolled at a particular point in time (32.4 million, or approximately 41.3 percent of children) is much smaller than the number ever enrolled during the year.

Point-in-time data may also be referred to as average monthly enrollment or full-year equivalent enrollment.[4] Full-year equivalent enrollment is often used for budget analyses (such as those by the CMS Office of the Actuary) and when comparing enrollment and expenditure numbers (such as in Figure 1). Per enrollee spending levels based on full-year equivalents (Table 13) ensure that amounts are not biased by individuals' transitions in and out of Medicaid coverage during the year.

Enrollees versus beneficiaries

Depending on the source and the year in question, data may include slightly different numbers of individuals in Medicaid. Certain terms commonly used to refer to people with Medicaid have very specific definitions in administrative data sources provided by CMS:[5]

- Enrollees (less commonly referred to as eligibles) are individuals who are eligible for and enrolled in Medicaid or CHIP. Prior to FY 1990, CMS did not track the number of Medicaid enrollees, only beneficiaries. For some historical numbers, CMS has estimated the number of enrollees prior to FY 1990 (Figure 1).
- Beneficiaries or persons served (less commonly referred to as recipients) are enrollees who receive covered services or for whom Medicaid or CHIP payments are made. Prior to FY 1998, individuals were not counted as beneficiaries if managed care payments were the only Medicaid payments made on their behalf. Beginning in FY 1998, however, Medicaid managed care enrollees with no fee-for-service (FFS) spending were also counted as beneficiaries, which had a large impact on the numbers (Table 1).[6]

The following example illustrates the difference in these terms. In FY 2011, there were 32 million non-disabled child Medicaid enrollees (Table 11). However, there were 30.2 million beneficiaries in this eligibility group—that is, during FY 2011, a Medicaid FFS or managed care capitation payment was made on their behalf (Table 1).[7] Generally, the number of beneficiaries will approach the number of enrollees as more of these individuals use Medicaid-covered services or are enrolled in managed care.

Institutionalized and limited-benefit enrollees

Administrative Medicaid data include enrollees who were in institutions such as nursing homes, as well as individuals who received only limited benefits (for example, only coverage for emergency services). Survey data tend to exclude such individuals from counts of coverage; the NHIS estimates in Tables 2–10 do not include the institutionalized.

Table 19 shows point-in-time enrollment among those age 65 and older—5.6 million from the administrative data and 3.1 million from the survey data (NHIS). In percentage terms, the difference between the administrative data and the survey data is largest for this age group. This is primarily because the NHIS excludes the institutionalized and because, when Medicaid pays only for Medicare enrollees' cost sharing, the NHIS generally does not count it as Medicaid coverage. Based on administrative data, 1.6 million Medicaid enrollees age 65 and older received only limited benefits from Medicaid.

State Children's Health Insurance Program Enrollees

Medicaid-expansion CHIP enrollees are children who are entitled to the covered services of a state's Medicaid program, but whose Medicaid coverage is generally funded with CHIP dollars. Depending on the data source, Medicaid enrollment and spending figures may include both Medicaid enrollees funded with Medicaid dollars and Medicaid-expansion CHIP enrollees funded with CHIP dollars. We generally exclude Medicaid-expansion CHIP enrollees from Medicaid analyses where possible in MACStats, but in some cases data sources do not allow these children to be broken out separately.

Methodology for Adjusting Benefit Spending Data

The FY 2011 Medicaid benefit spending amounts shown in the June 2014 MACStats were calculated based on MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[8] Although the CMS-64 provides a more complete accounting of spending and is preferred when examining state or federal spending totals, MSIS is the only data source that allows for analysis of benefit spending by eligibility group and other enrollee characteristics.[9] We adjust the MSIS amounts for several reasons:

- CMS-64 data provide an official accounting of state spending on Medicaid for purposes of receiving federal matching dollars; in contrast, MSIS data are used primarily for statistical purposes.
- MSIS generally understates total Medicaid benefit spending because it excludes disproportionate share hospital payments and additional types of supplemental payments made to hospitals and other providers, Medicare premium payments, and certain other amounts.[10]
- MSIS generally overstates net spending on prescribed drugs because it excludes rebates from drug manufacturers.
- Even after accounting for differences in their scope and design, MSIS still tends to produce lower total benefit spending than the CMS-64.[11]
- The extent to which MSIS differs from the CMS-64 varies by state, meaning that a cross-state comparison of unadjusted MSIS amounts

may not reflect true differences in benefit spending. See Table 20 for unadjusted benefit spending amounts in MSIS as a percentage of benefit spending in the CMS-64.

The methodology MACPAC uses for adjusting the MSIS benefit spending data involves the following steps:

- MACPAC aggregates the service types into broad categories that are comparable between the two sources. This is necessary because there is not a one-to-one correspondence of service types in the MSIS and CMS-64 data. Even service types that have identical names may still be reported differently in the two sources due to differences in the instructions given to states. Table 21 provides additional detail on the categories used.
- MACPAC calculates state-specific adjustment factors for each of the service categories by dividing CMS-64 benefit spending by MSIS benefit spending.
- MACPAC then multiplies MSIS dollar amounts in each service category by the state-specific factors to obtain adjusted MSIS spending. For example, in a state with a FFS hospital factor of 1.2, each Medicaid enrollee with hospital spending in MSIS would have that spending multiplied by 1.2; doing so makes the sum of adjusted hospital spending amounts among individual Medicaid enrollees in MSIS total the aggregate hospital spending reported by states in the CMS-64.[12]

By making these adjustments to the MSIS data, MACPAC attempts to provide more complete estimates of Medicaid benefit spending across states that can be analyzed by eligibility group and other enrollee characteristics. Other organizations, including the Office of the Actuary at CMS, the Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute use methodologies that are similar to MACPAC's but may differ in various ways—for example, by using different service categories or producing estimates for future years based on actual data for earlier years.

Readers should note that due to changes in both methods and data, the MSIS figures shown in this edition of MACStats are not directly comparable to earlier years. Key differences between the current and previous methodologies include:

- The exclusion of disproportionate share hospital (DSH) payments from CMS-64 totals used to adjust MSIS spending. In previous editions of MACStats, DSH payments were included in the CMS-64 totals. This was due in part to the fact that DSH payments are used to support hospitals that serve a large number of low-income and Medicaid patients, and could therefore be partially attributed to Medicaid enrollees in MSIS. However, an examination of annual DSH report data submitted by states indicates that for some hospitals, Medicaid DSH payments far exceed their uncompensated care costs for Medicaid patients and may therefore be attributed largely to uninsured patients.[13] As a result, we now exclude DSH payments from CMS-64 totals when we adjust MSIS spending.
- A more precise separation of home and community-based (HCBS) waiver spending in MSIS. As described later in this section, this edition of MACStats uses more detailed MSIS data files than in previous years.

With regard to changes in data, MSIS Annual Person Summary (APS) files—which are created by CMS and are typically used in MACStats—for FY 2011 were unavailable for many states when MACPAC's 2014 reports to Congress were completed. As a result, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. In general, our calculations closely match those used to create the APS. However, our development of enrollment counts is a notable exception. In MACPAC's analysis of the full MSIS data files, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts were then unduplicated using this national ID, which results in slightly lower enrollment counts as compared to the APS files.

Understanding Data on Health and Other Characteristics of Medicaid/CHIP Populations

Section 2 of MACStats, which encompasses Tables 2–10, uses data from the federal National Health Interview Survey to describe Medicaid and CHIP enrollees in terms of their self-reported demographic, socioeconomic, and health characteristics as well as their use of care. Background information on the NHIS is provided here, along with information on how children with special health care needs are identified in Tables 2–4 using this data source.

National Health Interview Survey data

Every year, thousands of non-institutionalized Americans are interviewed about their health insurance and health status for the NHIS.[14] Individuals' responses to the NHIS questions are the basis for the results in Tables 2–10. The NHIS is an annual face-to-face household survey of civilian non-institutionalized persons designed to monitor the health of the U.S. population through the collection of information on a broad range of health topics.[15] Administered by the National Center for Health Statistics within the Centers for Disease Control and Prevention, the NHIS consists of a nationally representative sample from approximately 35,000 households containing about 87,500 people.[16] Tables 2–10 are based on NHIS data, pooling the years 2010 through 2012.[17] Although there are other federal surveys, the NHIS is used here because it is generally considered to be one of the best surveys for health insurance coverage estimates, and it captures detailed information on individuals' health status.[18]

As with most surveys, information about participation in programs such as Medicaid, CHIP, Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) may not be accurately reported by respondents in the NHIS. As a result, they may not match estimates of program participation computed from the programs' administrative data. In addition, although the NHIS asks separately about participation in Medicaid and CHIP, estimates for the programs are not produced separately from the survey data for several reasons. For example, many states' CHIP and Medicaid programs use the same name, so respondents would not necessarily know whether their children's coverage was funded by Medicaid or CHIP. The separate survey questions are used to reduce surveys' undercount of Medicaid and CHIP enrollees, not to produce valid estimates separately for each program. Thus, survey estimates generally combine Medicaid and CHIP into a single category, as is done in Section 2 of MACStats.

Children with special health care needs

Tables 2–4 in MACStats present figures for children with special health care needs (CSHCN) who are enrolled in Medicaid or CHIP. As described here, MACPAC uses NHIS data to construct a CSHCN indicator based on responses to a number of questions contained in the survey.

CSHCN are defined by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration as a group of children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[19] This definition is used by all states for policy and program planning purposes for CSHCN and encompasses children with disabilities and also children with chronic conditions (e.g., asthma, juvenile diabetes, sickle cell anemia) that range from mild to severe. Children with special health care needs are a broader group than children with conditions severe enough and family incomes so low as to qualify for SSI.[20] Table 2 shows that only 3.3 percent of children with Medicaid or CHIP receive SSI.

To operationalize the MCHB definition of CSHCN, researchers developed a set of survey questions referred to as the CSHCN Screener.[21] The CSHCN Screener is currently used in several national surveys, but not the NHIS. It incorporates four components of the definition of CSHCN considered by researchers as essential: functional limitations, need for health-related services, presence of a health condition, and minimum expected duration of health condition (e.g., 12 months).[22]

It should be noted that CSHCN can vary substantially in their health status and use of health care services. A CSHCN could be a child with intensive health care needs and high health care expenses who has severe functional limitations (e.g., spina bifida, paralysis) and would qualify for SSI if his or her family income were low enough.[23] On the other hand, a CSHCN could also be a child who has asthma, attention deficit disorder, or depression that is well managed through the use of prescription medications. Regardless of whether functional limitations are mild, moderate, or severe, however, CSHCN share a heightened need for health care services in order to maintain their health and to be able to function appropriately for their age.

Since the NHIS does not include the validated CSHCN Screener, MACPAC's analysis is based on an alternative approach developed by the Child and Adolescent Health Measurement Initiative (CAHMI 2012), specifically for use in the 2007 NHIS, and on other prior research.[24] The CAHMI definition of CSHCN (CAHMI uses the term "children with chronic conditions and elevated service use or need–CCCESUN") includes children with at least one diagnosed or parent-reported condition expected to be an ongoing health condition, and who also meet at least one of five criteria related to elevated service use or elevated need:

- is limited or prevented in his or her ability to do things most children of the same age can do;
- needs or uses medications prescribed by a doctor (other than vitamins);
- needs or uses specialized therapies such as physical, occupational, or speech therapy;
- has above-routine need or use of medical, mental health, home care, or education services; or
- needs or receives treatment or counseling for an emotional, behavioral, or developmental problem.[25]

The NHIS varies from year to year in the diagnoses and health conditions that parents are asked about, so establishing a consistent definition across the 2010–2012 NHIS data in this analysis required modifying the survey items used in the CAHMI construct of CSHCN. Estimates for CSHCN in this analysis are not directly comparable to those in MACPAC reports prior to 2013 because the definition of CSHCN used in the 2013 and 2014 reports differs slightly from earlier versions.[26]

Understanding Managed Care Enrollment and Spending Data

There are four main sources of data on Medicaid managed care available from CMS.

- **Medicaid Managed Care Data Collection System (MMCDCS).** The MMCDCS provides state-reported aggregate enrollment statistics and other basic information for each managed care plan within a state. CMS uses the MMCDCS to create an annual Medicaid managed care enrollment report, which is the source of information on Medicaid managed care most commonly cited by CMS, as well as by outside analysts and researchers.[27] CMS also uses the MMCDCS to produce an annual summary of state Medicaid managed care programs that describes the managed care programs within a state (generally defined by the statutory authority under which they operate), each of which may include several managed care plans.[28]
- **Medicaid Statistical Information System (MSIS).** The MSIS provides person-level and claims-level information for all Medicaid enrollees.[29] With regard to managed care, the information collected for each enrollee includes: (1) plan ID numbers and types for up to four managed care plans (including comprehensive risk-based plans, primary care case management programs, and limited-benefit plans) under which the enrollee is covered, (2) the waiver ID number, if enrolled in a 1915(b) or other waiver, (3) claims that provide a record of each capitated payment made on behalf of the enrollee to a managed care plan (generally referred to as capitated claims), and (4) in some states, a record of each service received by the enrollee from a provider under contract with a managed care plan (which generally do not include a payment amount and are referred to as encounter or "dummy" claims). All states collect encounter data from their Medicaid managed care plans, but some do not report them in MSIS. Managed care enrollees may also have FFS claims in MSIS if they used services that were not included in their managed care plan's contract with the state.
- **CMS-64.** The CMS-64 provides aggregate spending information for Medicaid by major benefit categories, including managed care. The spending amounts reported by states on the CMS-64 are used to calculate their federal matching dollars.
- **Statistical Enrollment Data System (SEDS).** The SEDS provides aggregate statistics on CHIP enrollment and child Medicaid enrollment that include the number covered under FFS and managed care systems. SEDS is the only comprehensive source of information on managed care participation among separate CHIP enrollees across states.

CMS's FY 2012 Medicaid managed care enrollment report was unavailable when MACPAC's June 2014 report to the Congress was completed. Although the enrollment report generally contains the most recent information available from CMS on Medicaid managed care for all states, it does not provide information on characteristics of enrollees in managed care aside from dual eligibility for Medicare (e.g., basis of eligibility and demographics such as age, sex, race, and ethnicity). As a result, we supplement statistics from the enrollment report with MSIS and CMS-64 data; for example, Tables 14 and 15 use MSIS data to show the percentage of various populations in managed care and the percentage of their Medicaid benefit spending accounted for by managed care.

When examining managed care statistics from various sources, the following issues should be noted:

- Figures in the annual Medicaid managed care enrollment report published by CMS include Medicaid-expansion CHIP enrollees. Although we generally exclude these children (about 2 million, depending on the time period) from Medicaid analyses, it is not possible to do so with the CMS's annual Medicaid managed care enrollment report data. Tables 14 and 15—which show the percentage of child, adult, disabled, aged, and dually eligible enrollees who are enrolled in Medicaid managed care and the percentage of their Medicaid benefit spending that was for managed care—are based on MSIS data and exclude Medicaid-expansion CHIP enrollees.[30]

- The types of managed care reported by states may differ somewhat between the Medicaid managed care enrollment report and the MSIS. For example, some states report a small number of enrollees in comprehensive risk-based managed care in one data source but not the other. Anomalies in the MSIS data are documented by CMS as it reviews each state's quarterly submission, but not all issues may be identified in this process.[31]

- The Medicaid managed care enrollment report provides point-in-time figures (e.g., as of July 1, 2012). In contrast, CMS generally uses MSIS to report on the number of enrollees ever in managed care during a fiscal year (although point-in-time enrollment can also be calculated from MSIS based on the monthly data it contains).

TABLE 16. Medicaid and CHIP Enrollment by Data Source and Enrollment Period, 2011

	Administrative Data		Survey Data (NHIS)
Medicaid and CHIP Enrollment (All Ages)	**Ever enrolled during the year**	**Point in time**	**Point in time**
Medicaid	67.6 million	55.0 million	Not available
CHIP	8.2 million	5.5 million	Not available
Totals for Medicaid and CHIP	75.8 million	60.4 million	50.5 million
U.S. Population	**Census Bureau**		**Survey Data (NHIS)**
	312.3 million	311.0 million	305.9 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	24.3%	19.4%	16.5%

See Table 19 for notes.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

TABLE 17. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Children Under Age 19, 2011

	Administrative Data		Survey Data (NHIS)
Medicaid and CHIP Enrollment Among Children Under Age 19	**Ever enrolled during the year**	**Point in time**	**Point in time**
Medicaid	32.3 million	27.1 million	Not available
CHIP	7.9 million	5.3 million	Not available
Totals for Medicaid and CHIP	40.3 million	32.4 million	29.5 million
Children Under Age 19	**Census Bureau**		**Survey Data (NHIS)**
	78.5 million	78.4 million	78.7 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Children			
	51.3%	41.3%	37.5%

See Table 19 for notes.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

TABLE 18. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Adults Age 19–64, 2011

Medicaid and CHIP Enrollment Among Adults Age 19–64	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	28.8 million	22.2 million	Not available
CHIP	0.2 million	0.2 million	Not available
Totals for Medicaid and CHIP	29.0 million	22.4 million	17.8 million
Adults Age 19–64	**Census Bureau**		**Survey Data (NHIS)**
	192.1 million	191.4 million	187.4 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 19–64			
	15.1%	11.7%	9.5%

See Table 19 for notes.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

TABLE 19. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Adults Age 65 and Older, 2011

Medicaid and CHIP Enrollment Among Adults Age 65 and Older	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	6.5 million	5.6 million	Not available
CHIP	–	–	Not available
Totals for Medicaid and CHIP	6.5 million	5.6 million	3.1 million
Adults Age 65 and Older	**Census Bureau**		**Survey Data (NHIS)**
	41.7 million	41.1 million	39.7 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 65 and Older			
	15.5%	13.7%	7.9%

Notes: Excludes U.S. territories. Medicaid enrollment numbers obtained from administrative data include 8.8 million individuals ever enrolled during the year who received limited benefits (e.g., emergency services only, Medicaid payment only for Medicare enrollees' cost sharing), of whom 0.5 million were under age 19, 6.7 million were age 19 to 64, and 1.6 million were age 65 or older. In the event individuals were reported to be in both Medicaid and CHIP during the year, individuals were counted only once in the administrative data based on their most recent source of coverage. Overcounting of enrollees in the administrative data may occur because individuals may move and be enrolled in two states' Medicaid or CHIP programs during the year; however, Medicaid enrollment counts shown here are unduplicated using unique national identification (ID) numbers. The National Health Interview Survey (NHIS) excludes individuals in institutions (such as nursing homes) and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage. Administrative data and Census Bureau data are for FY 2011 (October 2010 through September 2011); the NHIS data are for sources of insurance at the time of the survey in calendar year 2011. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population in the month in FY 2011 with the largest count; the number of residents ever living in the United States during the year is not available. The Census Bureau point-in-time number is the average estimated monthly number of U.S. residents for FY 2011.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

TABLE 20. Medicaid Benefit Spending in MSIS and CMS-64 Data by State, FY 2011 (billions)

	Excluding DSH from CMS-64 Total			Including DSH in CMS-64 Total		
State	**MSIS**	**CMS-64**	**MSIS as a percentage of CMS-64**	**MSIS**	**CMS-64**	**MSIS as a percentage of CMS-64**
Total[1]	**$352.5**	**$386.4**	**91.2**	**$352.5**	**$403.5**	**87.4**
Alabama	4.2	4.4	94.7	4.2	4.9	86.0
Alaska	1.3	1.3	98.4	1.3	1.3	97.3
Arizona	9.4	8.8	107.0	9.4	9.0	105.0
Arkansas	3.5	3.9	89.8	3.5	4.0	88.4
California	37.2	52.6	70.8	37.2	54.9	67.8
Colorado	3.5	4.2	82.9	3.5	4.4	79.4
Connecticut	5.8	5.8	99.9	5.8	6.0	96.6
Delaware	1.5	1.4	105.2	1.5	1.4	104.8
District of Columbia	2.1	2.1	102.2	2.1	2.1	98.7
Florida	19.3	17.9	107.7	19.3	18.3	105.7
Georgia	8.4	7.7	108.8	8.4	8.1	103.3
Hawaii	1.4	1.6	89.0	1.4	1.6	87.9
Idaho	1.4	1.5	94.1	1.4	1.5	92.6
Illinois	11.7	12.6	93.3	11.7	13.0	90.3
Indiana	5.7	6.3	90.2	5.7	6.6	85.8
Iowa	3.2	3.3	98.2	3.2	3.4	95.8
Kansas	2.7	2.6	102.3	2.7	2.7	99.6
Kentucky	5.5	5.5	99.8	5.5	5.7	96.2
Louisiana	5.3	6.1	87.4	5.3	6.7	79.5
Maine	[1]	[1]	[1]	[1]	[1]	[1]
Maryland	7.0	7.4	94.6	7.0	7.5	93.5
Massachusetts	11.1	13.2	84.0	11.1	13.2	84.0
Michigan	11.6	11.8	98.8	11.6	12.1	95.7
Minnesota	7.9	8.3	95.3	7.9	8.4	94.3
Mississippi	3.7	4.3	86.3	3.7	4.5	82.3
Missouri	6.2	7.4	83.5	6.2	8.1	76.3
Montana	0.8	0.9	82.9	0.8	1.0	81.4
Nebraska	1.5	1.6	94.3	1.5	1.7	92.2
Nevada	1.4	1.5	93.9	1.4	1.6	88.7
New Hampshire	1.0	1.2	84.8	1.0	1.4	75.6
New Jersey	8.3	9.3	89.1	8.3	10.6	78.4
New Mexico	2.6	3.4	75.9	2.6	3.4	75.2
New York	51.2	50.7	100.9	51.2	53.9	95.0
North Carolina	9.5	10.1	94.1	9.5	10.5	90.4
North Dakota	0.7	0.7	102.7	0.7	0.7	102.4
Ohio	15.4	15.0	102.3	15.4	15.7	98.0
Oklahoma	3.6	4.2	86.3	3.6	4.3	85.4
Oregon	3.6	4.4	81.8	3.6	4.4	80.8
Pennsylvania	17.7	19.7	90.0	17.7	20.5	86.2
Rhode Island	1.5	2.0	76.0	1.5	2.1	71.5
South Carolina	5.0	4.6	109.4	5.0	5.1	98.1
South Dakota	0.7	0.8	98.3	0.7	0.8	98.2
Tennessee	[1]	[1]	[1]	[1]	[1]	[1]
Texas	22.4	27.0	83.1	22.4	28.6	78.5
Utah	2.1	1.7	120.0	2.1	1.8	118.4
Vermont	1.1	1.3	83.3	1.1	1.3	80.9
Virginia	6.1	6.8	89.0	6.1	7.0	86.5
Washington	6.3	7.1	88.3	6.3	7.4	84.2
West Virginia	2.9	2.7	109.0	2.9	2.8	106.1
Wisconsin	5.6	7.0	80.8	5.6	7.0	80.8
Wyoming	0.6	0.5	108.1	0.6	0.5	107.9

Notes: See text for a discussion of differences between Medicaid Statistical Information System (MSIS) and CMS-64 data. Both sources reflect unadjusted amounts as reported by states. Includes federal and state funds. Both sources exclude spending on administration, the territories, and Medicaid-expansion CHIP enrollees; in addition, the CMS-64 amounts exclude $7.4 billion (excluding Maine and Tennessee) in offsetting collections from third-party liability, estate, and other recoveries. In previous editions of MACStats, disproportionate share hospital (DSH) payments were included in the CMS-64 totals used to adjust MSIS spending. However, as described in the text of this section, we now exclude DSH payments from the CMS-64 totals when we adjust MSIS spending. For comparison purposes, MSIS spending as a percentage of the CMS-64 is shown here including and excluding DSH payments.

[1] Maine ($2.4 billion in CMS-64 spending with DSH, $2.3 billion without) and Tennessee ($8.0 billion in CMS-64 spending with DSH, $7.9 billion without) were excluded due to MSIS spending data anomalies.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) spending data and CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

TABLE 21. Service Categories Used to Adjust FY 2011 Medicaid Benefit Spending in MSIS to Match CMS-64 Totals

Service Category	MSIS Service Types[1]	CMS-64 Service Types
Hospital	Inpatient hospital Outpatient hospital	Inpatient hospital non-DSH Inpatient hospital non-DSH supplemental payments Inpatient hospital GME payments Outpatient hospital non-DSH Outpatient hospital non-DSH supplemental payments Emergency services for aliens[2] Emergency hospital services Critical access hospitals
Non-hospital acute care	Physician Dental Nurse midwife Nurse practitioner Other practitioner Non-hospital outpatient clinic Lab and X-ray Sterilizations Abortions Hospice Targeted case management Physical, occupational, speech, and hearing therapy Non-emergency transportation Private duty nursing Rehabilitative services Other care, excluding HCBS waiver	Physician Physician services supplemental payments Dental Nurse midwife Nurse practitioner Other practitioner Other practitioner supplemental payments Non-hospital clinic Rural health clinic Federally qualified health center Lab and X-ray Sterilizations Abortions Hospice Targeted case management Statewide case management Physical therapy Occupational therapy Services for speech, hearing, and language Non-emergency transportation Private duty nursing Rehabilitative services (non-school-based) School-based services EPSDT screenings Diagnostic screening and preventive services Prosthetic devices, dentures, eyeglasses Freestanding birth center Health home with chronic conditions Tobacco cessation for pregnant women Care not otherwise categorized
Drugs	Drugs (gross spending)	Drugs (gross spending) Drug rebates

TABLE 21, Continued

Service Category	MSIS Service Types[1]	CMS-64 Service Types
Managed care and premium assistance	▶ HMO (i.e., comprehensive risk-based managed care; includes PACE) ▶ PHP ▶ PCCM	▶ MCO (i.e., comprehensive risk-based managed care) ▶ MCO drug rebates ▶ PACE ▶ PAHP ▶ PIHP ▶ PCCM ▶ Premium assistance for private coverage
LTSS non-institutional	▶ Home health ▶ Personal care ▶ HCBS waiver	▶ Home health ▶ Personal care ▶ Personal care – 1915(j) ▶ HCBS waiver ▶ HCBS – 1915(i) ▶ HCBS – 1915(j)
LTSS institutional	▶ Nursing facility ▶ ICF/ID ▶ Inpatient psychiatric for individuals under age 21 ▶ Mental health facility for individuals age 65 and older	▶ Nursing facility ▶ Nursing facility supplemental payments ▶ ICF/ID ▶ ICF/ID supplemental payments ▶ Mental health facility for under age 21 or age 65+ non-DSH
Medicare[3, 4]		▶ Medicare Part A and Part B premiums ▶ Medicare coinsurance and deductibles for QMBs

Notes: DSH is disproportionate share hospital; EPSDT is Early and Periodic Screening, Diagnostic, and Treatment; GME is graduate medical education; HCBS is home and community-based services; HMO is health maintenance organization; ICF/ID is intermediate care facility for persons with intellectual disabilities; LTSS is long-term services and supports; MCO is managed care organization; MSIS is Medicaid Statistical Information System; PACE is Program of All-inclusive Care for the Elderly; PAHP is prepaid ambulatory health plan; PIHP is prepaid inpatient health plan; PHP is prepaid health plan, either a PAHP or a PIHP; PCCM is primary care case management; QMB is qualified Medicare beneficiary.

Service categories and types reflect fee-for-service spending unless noted otherwise. Service types with identical names in MSIS and CMS-64 data may still be reported differently in the two sources due to differences in the instructions given to states; amounts for those that appear only in the CMS-64 (e.g., drug rebates) are distributed across Medicaid enrollees with MSIS spending in the relevant service categories (e.g., drugs).

1 Claims in MSIS include both a service type (such as inpatient hospital, physician, personal care, etc.) and a program type (including HCBS waiver). When adjusting MSIS data to match CMS-64 totals, we count all claims with an HCBS waiver program type as HCBS waiver, regardless of their specific service type. Among claims with an HCBS waiver program type, the most common service types are other, home health, rehabilitation, and personal care.

2 Emergency services for aliens are reported under individual service types throughout MSIS, but primarily inpatient and outpatient hospital. As a result, we include this CMS-64 amount in the hospital category.

3 Medicare premiums are not reported in MSIS. We distribute CMS-64 amounts proportionately across dually eligible enrollees in MSIS for each state.

4 Medicare coinsurance and deductibles are reported under individual service types throughout MSIS. We distribute the CMS-64 amount for QMBs across CMS-64 spending in the hospital, non-hospital acute, and institutional LTSS categories prior to calculating state-level adjustment factors, based on the distribution of Medicare cost sharing for hospital, Part B, and skilled nursing facility services among QMBs in 2009 Medicare data. See MedPAC and MACPAC, *Data book: Beneficiaries dually eligible for Medicare and Medicaid,* Table 4 (2013). http://www.macpac.gov/publications/Duals_DataBook_2013-12.pdf.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data.

Endnotes

[1] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP,* March 2012 (Washington, DC: MACPAC, 2012): 87–89. http://www.macpac.gov/reports/.

[2] Table 16 is modeled after Table 1 in the March 2014 edition of MACStats (Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP,* March 2014 (Washington, DC: MACPAC, 2014): 75. http://www.macpac.gov/reports/). Table 1 of the March 2014 MACStats shows estimates for 2013 and is partly based on projections by the Office of the Actuary at the Centers for Medicare & Medicaid Services. To produce the age breaks used in Tables 16–19, however, numbers were calculated by MACPAC directly from the MSIS. FY 2011 is the latest year for which enrollment data are available in MSIS for all states.

[3] MACPAC has adjusted benefit spending from MSIS to match CMS-64 totals; see the discussion later in Section 5 for details.

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

[5] See, for example, Centers for Medicare & Medicaid Services (CMS), *Medicare & Medicaid statistical supplement, 2010 edition,* Brief summaries and glossary (Baltimore, MD: CMS, 2010). http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2010.html.

[6] States make capitated payments for all individuals enrolled in managed care plans, even if no health care services are used. Therefore, all managed care enrollees are currently counted as beneficiaries, regardless of whether or not they have any health service use.

[7] Some individuals who are counted as beneficiaries in CMS data for a particular fiscal year were not enrolled in Medicaid during that year; they are individuals who were enrolled and received services in a prior year, but for whom a lagged payment was made in the following year. These individuals are often reported as having an unknown basis of eligibility in CMS data.

[8] Medicaid benefit spending reported here excludes amounts for Medicaid-expansion CHIP enrollees, the territories, administrative activities, the Vaccines for Children program (which is authorized by the Medicaid statute but operates as a separate program), and offsetting collections from third-party liability, estate, and other recoveries.

[9] For a discussion of these data sources, see Medicaid and CHIP Payment and Access Commission (MACPAC), Improving Medicaid and CHIP data for policy analysis and program accountability, in *Report to the Congress on Medicaid and CHIP,* March 2011 (Washington, DC: MACPAC, 2011). http://www.macpac.gov/reports/MACPAC_March2011_web.pdf.

[10] Some of these amounts, including certain supplemental payments to hospitals and drug rebates, are lump sums that are not paid on a claim-by-claim basis for individual Medicaid enrollees. Nonetheless, we refer to these CMS-64 amounts as benefit spending, and the adjustment methodology described here distributes them across Medicaid enrollees with MSIS spending in the relevant service categories.

[11] Government Accountability Office (GAO), *Medicaid: Data sets provide inconsistent picture of expenditures* (Washington, DC: 2012). http://www.gao.gov/assets/650/649733.pdf; Administrative databases, in *Databases for estimating health insurance coverage for children: A workshop summary,* edited by T. Plewes (Washington, DC: The National Academies Press, 2010): 72. http://www.nap.edu/catalog/13024.html.

[12] The sum of adjusted MSIS benefit spending amounts for all service categories totals CMS-64 benefit spending, exclusive of offsetting collections from third-party liability, estate, and other recoveries. These collections, $7.4 billion in FY 2011 (excluding Maine and Tennessee), are not reported by type of service in the CMS-64 and are not reported at all in MSIS.

[13] See Centers for Medicare & Medicaid Services (CMS), *Medicaid disproportionate share hospital (DSH) payments.* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html.

[14] Although the discussion in this section generally omits the term non-institutionalized for brevity, all estimates exclude individuals living in nursing homes and other institutional settings.

[15] Centers for Disease Control and Prevention (CDC), About the National Health Interview Survey (Atlanta, GA: CDC, 2012). http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[16] The annual NHIS questionnaire consists of three major components—the Family Core, the Sample Adult Core, and the Sample Child Core. The Family Core collects information for all family members regarding household composition and socioeconomic and demographic characteristics, along with basic indicators of health status, activity limitation, and health insurance. The Sample Adult and Sample Child Cores obtain additional information on the health of one randomly selected adult and child in the family.

[17] Data were pooled to yield sufficiently large samples to produce reliable subgroup estimates and to increase the capacity to detect meaningful differences between subgroups and insurance categories.

[18] G. Kenney and V. Lynch, Monitoring children's health insurance coverage under CHIPRA using federal surveys, in *Databases for estimating health insurance coverage for children: A workshop summary,* edited by T. Plewes (Washington, DC: National Academies Press, 2010): 72. http://www.nap.edu/catalog/13024.html.

[19] M. McPherson, et al., A new definition of children with special health care needs, *Pediatrics* 102 (1998): 137–140.

[20] For children under age 18 to be determined disabled under SSI rules, the child must have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to cause death or last at least 12 months (§1614(a)(3)(C)(i) of the Social Security Act). For additional discussion of disability as determined under the SSI program and its interaction with Medicaid eligibility, see Chapter 1 in MACPAC's March 2012 report to the Congress.

[21] The CSHCN Screener was developed by CAHMI and is currently used in the National Survey of Children with Special Health Care Needs, the Medical Expenditure Panel Survey, and other federal surveys. For more information on the CSHCN Screener, see C.D. Bethell, D. Read, R.E. Stein, et al., Identifying children with special health care needs: Development and evaluation of a short screening instrument, *Ambulatory Pediatrics* 2 (2002): 38–48.

[22] Child and Adolescent Health Measurement Initiative (CAHMI), *Approaches to identifying children and adults with special health care needs: A resource manual for state Medicaid agencies and managed care organizations* (Baltimore, MD: Centers for Medicare and Medicaid Services, 2002).

[23] Children who are receiving SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that children who are reported to have SSI did not meet the criteria for CSHCN, it could be because: (1) the parent erroneously reported in the survey that the child received SSI, or (2) the NHIS condition list did not capture, or the parent did not recognize, any of the NHIS conditions as reflecting the child's health circumstances.

[24] Child and Adolescent Health Measurement Initiative (CAHMI), *Identifying children with chronic conditions and elevated service use or need (CCCESUN) in the National Health Interview Survey (NHIS)* (Portland, OR: Oregon Health and Science University, 2012); Davidoff, A.J., Identifying children with special health care needs in the National Health Interview Survey: A new resource for policy analysis, Health Services Research 39 (2004): 53–71.

[25] The CAHMI algorithm differs from the CSHCN Screener in three main respects (CAHMI 2012—see endnote 24 for source). First, the CSHCN Screener uses a non-condition specific approach, which identifies a broader range of children with chronic childhood conditions who have special needs. The CAHMI algorithm limits CSHCN to children identified by parents as having a specific diagnosis in a condition set collected in the NHIS. Second, the CSHCN Screener captures children with above routine use of medical and health services that is the result of an ongoing condition, based on brief follow-up questions. The NHIS does not include the duration of conditions or identify elevated service use or need directly related to each condition. Thus, the CAHMI algorithm collects data on elevated service use and need independent from the condition set. Third, the CAHMI algorithm identifies a small number of additional children as having elevated need when parents report an unmet need due to cost through one of three survey items. As a result of these differences, the children identified from the CAHMI algorithm in the NHIS are not equivalent in health and function characteristics to children identified by the CSHCN Screener in other surveys. The CAHMI criteria differ from criteria developed by Davidoff (2004—see endnote 24 for source) in that Davidoff does not recognize unmet need due to cost as part of the definition of elevated need.

[26] The algorithm in this analysis begins with the NHIS conditions referred to as the limited condition set by CAHMI (2012—see endnote 24 for source), then excludes seven conditions that were dropped in the 2011 NHIS (depression, learning disability, cancer, neurological problem, phobia or fears, gum disease, lung or breathing problem). To capture CSHCN potentially lost from this change and other children with a broader range of chronic conditions, affirmative responses to three other survey items were treated as qualifying conditions (has difficulties with emotions/concentration/behavior or getting along in last four weeks, has chronic condition that limits activity, and fair or poor health). These items were also added to better align the CSHCN definition with the 18-year-olds, whom the NHIS treats as adults. The NHIS Sample Adult Core contains slightly different condition items. In order to align the CSHCN definitions more closely, the condition set for 18-year-olds was expanded to add mental retardation or developmental problems that cause difficulty with activity, cancer, symptoms of depression in the past 30 days, fair or poor health, and any unspecified condition that causes functional limitation and is chronic. In the MACPAC analysis, two or more emergency department visits reported in the last 12 months was added as another measure of elevated service use.

[27] Centers for Medicare & Medicaid Services (CMS), *Medicaid managed care enrollment report* (Baltimore, MD: CMS). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Managed-Care/Medicaid-Managed-Care-Enrollment-Report.html.

[28] Centers for Medicare & Medicaid Services (CMS), *National summary of state Medicaid managed care programs as of July 1, 2011* (Baltimore, MD: CMS). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Managed-Care/State-Program-Descriptions.html.

[29] For enrollees with no paid claims during a given period (e.g., fiscal year), their MSIS data are limited to person-level information (e.g., basis of eligibility, age, sex, etc.).

[30] We generally exclude Medicaid-expansion CHIP children from Medicaid analyses because their funding stream (CHIP, under Title XXI of the Social Security Act) differs from that of other Medicaid enrollees (Medicaid, under Title XIX). In addition, spending (and often enrollment) for the Medicaid-expansion CHIP population is reported by CMS in CHIP statistics, along with information on separate CHIP enrollees.

[31] See Centers for Medicare & Medicaid Services (CMS), *MSIS state data characteristics/anomalies report,* January 7, 2013 (Baltimore, MD: CMS, 2013). http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

CHAPTER 3

Medicaid and Population Health

Key Points

Medicaid and Population Health

- Achieving healthy outcomes for Medicaid enrollees requires allocating resources to more than acute care services. Although Medicaid is primarily a source of health insurance coverage, it also covers services other payers may not cover. Examples include counseling and education, targeted case management, habilitative services, enabling services such as transportation and translation, and health promotion programs.
- Medicaid programs are increasingly using innovative methods to promote better health outcomes, such as rewarding enrollees and providers for improved outcomes and partnering with other agencies and organizations. Many of these efforts also affect the health of the population at large.
- The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) authorizes incentives for preventive care for both the U.S. population in general and Medicaid enrollees in particular, including:
    - a mandate to provide many preventive services with no cost sharing to individuals enrolled in exchange plans, Medicare, and the new adult group under Medicaid;
    - grants to states to provide incentives to Medicaid enrollees of all ages to improve health, including incentives that encourage adoption of healthy behaviors; and
    - funding for state-based demonstrations to improve vaccination rates and state-level grants to develop and evaluate Medicaid initiatives promoting behavioral change.
- Medicaid programs have found innovative ways to improve health rather than simply treating existing disease by working with governmental and private sector partners at the federal, state, and community levels. Among them are:
    - collaborations with public health departments to promote immunizations, provide public health outreach, and reduce sexually transmitted diseases;
    - federal-state partnerships with multiple U.S. Department of Health and Human Services agencies; and
    - partnerships with private organizations and multisector collaboratives to make services available that are not typically provided through Medicaid.
- There are barriers to organizational collaboration, including financing challenges such as separate funding streams, the length of time it takes to see the results of prevention initiatives, and differences in organizational culture and objectives.
- Initiatives to improve the health of the Medicaid—or any—population require the collection of measures to assess the baseline health of that population and changes to health over time. Currently, such efforts require use of multiple datasets. In addition, population health data for Medicaid enrollees also lags behind the data for other populations. The Centers for Medicare & Medicaid Services and others are making considerable strides to improve Medicaid data and outcomes data in general.

CHAPTER 3

Medicaid and Population Health

The Medicaid program plays an important role in improving and maintaining the health of the more than 70 million low-income people and people with disabilities it serves. It covers more than a third of all children and almost half of all births in the United States. In addition to inpatient and outpatient medical services, Medicaid provides access to preventive services, screenings to aid in early diagnosis and treatment, and other health education and support services that also affect health status and outcomes.

Medicaid programs are increasingly using innovative methods to pay providers for better health outcomes for their enrollees and to partner with other agencies and organizations to promote health. In particular, Medicaid can improve the overall health of its enrollees by providing services in addition to those usually provided by health insurance and by tracking the overall health status of its enrollees to determine key population groups or geographic areas that warrant targeted interventions. Many of these services, while provided to individuals, affect the health of the population at large, through such practices as immunizations, smoking cessation, and sexually transmitted infection screening and treatment.

This chapter examines Medicaid's role in promoting population health, defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart 2007, IOM 2003). When considering health through the lens of a population, if the desired product of a program is health, then resources must be allocated to more than the provision of acute-care medical services. Health care has been estimated to account for only 10 to 25 percent of the variance in health outcomes. The rest is shaped by genetics; health behaviors; social and economic factors such as income, education, employment, and culture; and physical environmental factors, including clean air and water, and the built environment (UWPHI 2014a, McGinnis et al. 2002).

Medicaid enrollees fare worse with respect to many of the social determinants that affect overall health status, relative to wealthier and less disabled populations. For example, over one-third of Medicaid beneficiaries between the ages of 19 and 64 have not completed a high school education (Chang and Davis 2013). Poorer people are more likely to report fair or poor health status, disability, serious psychological distress, heart disease, stroke, hypertension, and many other health conditions (NCHS 2013). They are more likely to smoke and to be obese than persons above 400 percent of the federal poverty level. Medicaid enrollees are poorer (by definition) and have a poorer health profile compared with both the privately insured and the uninsured, even when the comparison is limited to low-income adults (Paradise and Garfield 2013, Koroukian et al. 2011). Thus, the effects of social determinants on health are substantial in analyses that examine how health status compares between Medicaid enrollees and other populations (Paradise and Garfield 2013).

As a source of health insurance, Medicaid clearly cannot address all social determinants of health. Even so, Medicaid programs—often in partnership with other organizations—have found ways to address factors such as exposure and vulnerability to disease, risk-taking behaviors, unhealthy health habits (e.g., smoking, obesity, poor nutrition), compliance with provider recommendations for medical treatments and preventive care such as prenatal care, and others. State policymakers have determined that there are ways to address some of these factors within the construct of what is primarily a source of insurance coverage, promoting, improving, and maintaining the health of Medicaid enrollees, while improving the health of the population overall. Often the provision of these services can reduce the need for future more costly medical care services.

Population health is often equated with public health, but the two terms are not interchangeable. For the purposes of this chapter, public health is more narrowly defined to consist of the types of activities provided by public health departments to control disease—such as infectious disease surveillance, control of disease outbreaks and epidemics, environmental health surveillance and improvement (e.g., lead paint removal), and control of food and water-borne illnesses. Thus, public health is a component of population health, but not its equivalent.

This chapter examines Medicaid programs from a population health perspective. The chapter first describes the different mechanisms that Medicaid currently uses to provide non-treatment-oriented services to promote health, including:

- screening and other services provided through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits, designed to ensure that children and adolescents receive appropriate dental, mental health, developmental, and specialty services, including services that are preventive and not merely medical;
- screening and preventive services for adults, including coverage of these services when provided by non-traditional providers;
- non-medical enabling and support services such as transportation, health education, and counseling that help ameliorate the health effects of socioeconomic disadvantage;
- incentive programs for enrollees, providers, and plans that promote healthy behaviors and lifestyles;
- telephone counseling on smoking cessation and other services paid for with Medicaid administrative funds; and
- programs targeting pregnant women to improve birth outcomes.

These Medicaid efforts on population health are being augmented by activities under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which requires that all qualified health plans and many other plans must cover specific preventive services without charging copayments or coinsurance. The law also authorized new and innovative programs—such as tobacco cessation counseling and chronic disease prevention demonstration programs—that address population health. Some of these provisions relate specifically to Medicaid populations; others are not targeted to Medicaid populations but to low-income groups more generally that include a substantial proportion of Medicaid enrollees.

The chapter then describes selected successful partnerships designed to promote population health that Medicaid programs have had with government agencies and non-governmental organizations. It provides many examples of innovative ways that Medicaid programs—either individually or in concert with others—work to promote health rather than just provide treatment for existing disease. Examples include collaborations with public health departments to provide immunizations, lead abatement, and reduction of sexually transmitted diseases, among others.

The chapter concludes with a discussion of how population health initiatives can be monitored, and in particular, the data available and the data needed to do so. MACPAC will continue to monitor and to track best practices in Medicaid population health programs, the resources needed to promote them, and regulations that may impede or promote their implementation.

Medicaid Population Health Initiatives and Programs

Although Medicaid is primarily a source of health insurance coverage, it also covers many preventive, counseling, and educational health services, as well as certain enabling services (for example, transportation and translation) and special programs to promote health that are not usually provided by other insurers. In part, this is because Medicaid covers vulnerable populations that were historically covered by other public programs, which provided social services, food, institutional and non-institutional housing, and income support not traditionally covered by health insurance but vitally important to the well-being of these populations. Over time, use of waivers and demonstrations have allowed Medicaid programs to provide some of these services in addition to medical care to achieve cost savings and improve outcomes of care—for example, targeted case management and nutritional counseling for pregnant women (MACPAC 2013). Implementation of the ACA will further broaden population health efforts in some Medicaid programs.

Mandatory or optional Medicaid-covered services

State Medicaid programs have the ability to cover certain non-medical services that may promote health, but there are limits on the services they may provide. All mandatory and optional Medicaid services are defined in statute and must be medically necessary. State Medicaid agencies may also "place appropriate limits on a service based on such criteria as medical necessity" (42 CFR 440.230(d)). However, there is no federal statutory or regulatory definition of medical necessity for benefits. It is left to the states to define in their state plans (Schneider and Garfield 2005).

The Medicaid program currently covers some non-medical services associated with access to health services and also with improving health. These services are covered both under explicit Medicaid benefit categories as well as under demonstration projects aimed at improving health and reducing costs through an approach that includes more than medical treatment.

Early and Periodic Screening, Diagnostic, and Treatment program. The EPSDT benefit for children and adolescents was created in 1967 in response to studies that showed that many disabilities in young adults could have been prevented by earlier prevention and treatment while they were children. EPSDT is a key part of Medicaid for children and adolescents: it covers all health care, treatment, and other measures necessary to correct or ameliorate physical or mental conditions found by a screening or a diagnostic procedure, regardless of whether that treatment is part of the state's normal Medicaid benefit package. This includes treatment for any vision and hearing problems, including eyeglasses and hearing aids. For children's oral health, coverage includes regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health. Some orthodontia is also covered. States must establish distinct periodicity schedules for screening, vision, dental, and hearing services. In addition, interperiodic screens must be made available based on medical necessity.

In 1989, the Congress significantly strengthened the EPSDT section of the Medicaid statute via amendments to the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) to more clearly specify the screening services that states must cover, and also to require states to cover treatment for any problems discovered by those screening services—even if those services are not normally part of the state's Medicaid benefits (§1905(r) of the Social Security Act (the Act)). This makes the EPSDT benefit one of the most generous packages available, with an emphasis on providing all services necessary to promote children's health, including preventive, supportive and habilitative services.

Preventive benefits for adults. Preventing the onset of disease or health conditions is one method of improving health. The distinctions between types of prevention include primary prevention to promote health prior to the development of disease or injuries, secondary prevention to detect disease in early (asymptomatic) stages, and tertiary prevention to reverse, arrest, or delay the progression of disease (Starfield et al. 2008). Medicaid currently pays for most secondary and tertiary prevention, as it is usually considered diagnosis or treatment for an existing disease or condition. However, primary prevention—which takes place before diseases or conditions occur (because they have been prevented)—may not be automatically considered to be medically necessary.

While most preventive benefits for adults are not mandatory services under Medicaid, they are provided by most states. A survey conducted in 2010 found that while there is some variation among states in which services (from among 42 selected preventive services) were covered under Medicaid for adults under 65, each preventive service was covered by at least half and often up to two-thirds of states. Forty-four states reported covering at least 30 of the 42 preventive services, including 25 states that covered 40 or more such services (Snyder 2012).

A study by Wilensky and Gray (2013) concluded that Medicaid preventive benefits are not well defined for several reasons. First, there is a lack of detail in Medicaid provider information (such as provider manuals) and beneficiary information about age-appropriate screening. Although groups such as the U.S. Preventive Services Task Force (USPSTF) and Bright Futures have established standards of care, federal Medicaid guidelines often do not include such guidelines.

Second, there is some confusion about which preventive services are medically necessary and therefore able to be covered by Medicaid. As discussed above, all services provided by Medicaid must be medically necessary, but the term is not defined in statute. In general, if services are only covered based on medical necessity after a patient presents with a specific concern, the coverage simply provides for diagnostic testing, not preventive screening (Wilensky and Gray 2013). For example, a screening colonoscopy would be considered a preventive test if done when a patient has no symptoms or indication of disease. If coverage is limited to cases when an individual has a positive fecal occult blood test, then it would be diagnostic and thus considered medically necessary.

To expand access to preventive services, the Centers for Medicare & Medicaid Services (CMS) issued an information bulletin in November 2013 that clarifies that preventive services do not have to be provided exclusively by physicians or other licensed practitioners. States may choose to also cover preventive services that are provided by individuals such as community health workers or doulas, as long as the service has been recommended by a physician or other licensed practitioner (CMS 2013a). This rule change is effective January 1, 2014, and applies to preventive services, including preventive services furnished pursuant to Section 4106 of the ACA. Previously, services had to be provided by licensed providers.

Non-medical support and education services. One mechanism for providing programs that promote health is through waiver and demonstration programs negotiated with CMS. These waivers are state-specific and can be population-specific. They allow states to target specific populations, limit services, and experiment with new ways of providing services to promote health and contain or reduce costs. Over time, states have been using waiver authority to expand the use of non-medical services and the use of non-traditional providers in Medicaid, including case managers, outreach workers, social workers, doulas, and other practitioners who may promote health but do not provide direct medical care. Numerous Medicaid waivers also provide enabling services, targeted case management, and provider payment incentives to promote enrollee health and reduce unnecessary utilization.

Medicaid managed care plans may also provide benefits over and above what is included in the Medicaid state plan. Specific benefits are specified in their contract with the state. For example, in its contracts with managed care organizations (MCOs), the Commonwealth of Virginia goes beyond mandatory and optional state plan benefits to contract for primary care coordination and disease management programs for enrollees with multiple chronic conditions. Care is delivered through a multidisciplinary team of providers that can include primary care physicians, specialist physicians, nurses, therapists, nutritionists, pharmacists, and others to educate individuals about their condition and manage their care (Virginia DMAS 2014).

Enrollee incentives. New flexibility under the Deficit Reduction Act of 2005 (P.L. 109-171) has enabled states to target and tailor programs for select populations, expand innovative strategies for beneficiary engagement, and identify practices that work. Several states have also proposed innovative programs to encourage Medicaid enrollees to practice healthy behaviors (Blumenthal et al. 2013). Florida's program, for example, provides enrollees with a credit worth $15 to $25 that can be redeemed for health-related products such as over-the-counter medications. The strategy is aimed at both simple preventive behaviors, such as obtaining an influenza immunization, and more complex behaviors, such as quitting smoking (Redmond et al. 2007). Another example is the Healthy Michigan Plan, which includes health behavior incentives, including potential reductions in premiums and cost sharing if enrollees adopt healthy behaviors (MDCH 2014).

Plan or provider financial incentives. Many states offer payment incentives to encourage providers to recommend wellness or preventive services for enrollees. Two such models are accountable care organizations (ACOs) and coordinated care organizations (CCOs). ACOs are provider-run organizations in which participating providers are collectively responsible for the care of an enrolled population. An ACO may share in any savings associated with improvements in the quality and efficiency of care (Gold et al. 2012). Colorado, Maine, Minnesota, and New Jersey are among the first states to implement ACOs for their Medicaid populations, but the number continues to increase (NASHP 2014).

In Oregon, CCOs are networks of all types of health care providers (physical health care, addictions and mental health care, and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions (OHPB 2014). The Oregon CCO is funded by the CMS Center for Medicare & Medicaid Innovation's State Innovation Models Initiative (SIM) grant program. These programs are in their early stages and have not yet been evaluated, but future findings should offer important lessons for others considering this approach.

Tobacco quitlines. In June 2011, CMS issued a State Medicaid Director Letter (June 24, 2011) on tobacco cessation services that, in part, announced a new policy allowing costs related to tobacco telephone quitline activities provided to Medicaid enrollees to be claimed by Medicaid as an administrative expenditure. CMS will regard tobacco quitlines that follow the evidence-based protocols set forth in the U.S. Public Health Service clinical practice guideline on treating tobacco use and dependence as an allowable Medicaid administrative activity, to the extent that the quitline provides support to Medicaid enrollees under the auspices of the state Medicaid agency (CMS 2011a).

Pregnancy benefits. Medicaid's coverage of pregnant women has served an important population health function by providing prenatal and postnatal care for millions of women and babies. Almost all state Medicaid programs have some enhanced benefits for pregnant women. Currently, a state may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid (42 CFR 440.210(a)(2), 42 CFR 440.250(p)). For example, several states have extended dental coverage only to pregnant women due to an emerging link between periodontal disease and an increased risk for preterm birth and low birth weight infants (MACPAC 2013). Others provide targeted case management, medical home programs, and nutrition counseling not available to other Medicaid enrollees. At the federal level, the Strong Start for Mothers and Newborns initiative is a joint effort between CMS, the Health Resources and Services Administration (HRSA), and the Administration for Children and Families (ACF). Strong Start goals are to reduce preterm births and improve outcomes for newborns and pregnant women enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) through a variety of programs.

Affordable Care Act Programs and Regulations Affecting Population Health and Medicaid Enrollees

The ACA further expands Medicaid's responsibilities by increasing the population it covers. The ACA includes several provisions that promote preventive care, as well as programs designed to improve the health of the U.S.

population in general. Many of these provisions affect Medicaid enrollees and providers indirectly, because they apply to systems and providers who serve both Medicaid and other patients. For example, the ACA seeks to incentivize providers to take responsibility for population health outcomes. Also included are expansions of primary health care training; requirements that health plans and Medicare provide specific preventive services without cost sharing; and incentives for workplace wellness programs, including grants to small businesses to develop comprehensive wellness programs and insurance discounts for employees participating in wellness plans (Stoto 2013).[1] Selected ACA provisions affecting the Medicaid population are described below.

Community health needs assessment for non-profit hospitals. The ACA adds a new Internal Revenue Service (IRS) requirement that has the potential to leverage the strengths and resources of both the health care and public health systems to create healthier communities (Stoto 2013, Rosenbaum and Margulies 2011). Non-profit hospitals must conduct a community health needs assessment (CHNA) once every three years. These reports must describe the community served, identify existing health care resources, and prioritize community health needs. Hospitals must also develop an implementation strategy to meet the needs identified through the CHNA.

The IRS requirements call for two different sets of population health measures: (1) measures of population health outcomes for which health care providers, public health agencies, and many other community stakeholders share responsibility, and (2) performance measures capable of holding these same entities accountable for their contributions to population health goals (Stoto 2013). The assessment must take into account input from people who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and is made widely available to the public. In theory, this would include Medicaid agencies and enrollees who use the hospital.

Mandated preventive benefits. The ACA mandates that many preventive services be provided with no cost sharing to individuals enrolled in exchange plans, Medicare, and Medicaid expansions to childless adults (who are often referred to as the new adult group) (HHS 2014). These include:

- routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children, women, and adolescents, as recommended in evidence-based guidelines supported by HRSA;
- preventive care and screening for women, as recommended in evidence-based guidelines supported by HRSA;
- evidence-based items or services that have a rating of A or B in the current recommendations of the USPSTF with respect to the individual involved;
- contraceptive methods, sterilization procedures, and patient education and counseling on reproductive health (not including abortifacient drugs), except in health plans sponsored by certain exempt religious employers (HRSA 2014); and
- tobacco cessation counseling for pregnant women (CMS 2011b).[2]

States are eligible for a one percentage point increase in the federal medical assistance percentage (FMAP) effective January 1, 2013, applied to expenditures for adult vaccines and

USPSTF-recommended preventive services if they cover the full list of these services without cost sharing. The increase applies to such expenditures whether or not the services are provided on a fee-for-service or managed care basis, or under a benchmark or benchmark-equivalent benefit package also referred to as an alternative benefit plan (CMS 2013b).

It is not clear whether the ACA financial incentive to cover USPSTF services is sufficient to motivate all states to provide all ACA-mandated preventive services. Nevada, New Hampshire, Hawaii, New Jersey, Kentucky, Ohio, and New York have had Medicaid state plan amendments approved by CMS to receive the increased matching rate (CMS 2014a, CMS 2013c–h).

Public awareness campaigns. The ACA calls for states to design public awareness campaigns to educate Medicaid enrollees on the availability and coverage of preventive services, including obesity-related services. To help states meet this requirement, CMS will host calls and webinars regarding coverage and promotion of preventive services, develop fact sheets that address Medicaid coverage of preventive services, and share examples of state Medicaid program efforts to increase awareness of preventive services.

Incentives for prevention of chronic diseases in Medicaid. Building on the incentive programs that some states were already using, the ACA authorizes grants to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and who demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors (§4108 of the ACA). The initiatives or programs are to be “comprehensive, evidence-based, widely available, and easily accessible.” The programs must use relevant evidence-based research and resources. An application by a state for a grant under the program must address one or more of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes, or, in the case of a diabetic, improving the management of the condition. Ten states are currently participating in this program (CMS 2014b).

Grants for immunization and other prevention programs. The ACA also authorizes funding for state-based demonstrations to improve vaccination rates and creates state-level grants for the development and evaluation of Medicaid initiatives promoting behavioral change. The Community Transformation Grant program funds health departments implementing community-based preventive initiatives deemed potentially effective by the federal task force (§4201 of the ACA).

Partnering to Improve Population Health

Medicaid is designed as a federal-state partnership in which state Medicaid programs work with CMS to pay for health services for enrollees. State Medicaid programs also work in concert with other federal and state agencies and non-governmental organizations to promote the health of their enrollees. In recent years, funds for public health have been decreasing, putting a greater responsibility on the Medicaid program to find ways to work with public health departments to promote health for its enrollees (Trust for America’s Health 2013). Some examples of these partnerships, as well as some barriers to partnering with other organizations, are described here.

CMS and other federal agency partnerships

Most state Medicaid programs partner with CMS, other federal agencies, and non-governmental organizations to promote access to and use of health services to improve the health of their enrollees. Notably, the Center for Medicare & Medicaid Innovation awards grants to organizations to test various payment and service delivery models that aim to achieve better care for patients, better health for communities, and lower costs. Some other examples include:

- **CDC: Newborn Screening Programs.** State newborn screening programs routinely test blood spots collected from newborns for more than 30 metabolic and congenital conditions, with initial short-term follow-up services to ensure that families are informed of suspect results and linked to additional testing to confirm the child's condition. Medicaid contributes to newborn screening by providing about 10 percent of the costs—either in direct funding or through reimbursement for the screening fees that hospitals pay to public health laboratories that provide these screenings (Johnson et al. 2006).
- **CDC: Breast and Cervical Cancer Detection Program.** The Breast and Cervical Cancer Prevention and Treatment Act (P.L. 106-354), passed in 2000, gave states the option to offer women who are diagnosed with cancer access to treatment through Medicaid. To date, all 50 states and the District of Columbia have taken up this option. In 2012, the CDC Breast and Cervical Cancer Detection Program funded a five-year cooperative agreement with the Minnesota and New York state departments of health to carry out innovative programs to increase population-level colorectal, breast, and cervical cancer screening rates. The Minnesota Department of Health is collaborating with the state Medicaid program to increase screening among the state's unscreened Medicaid enrollees through direct mail reminders and a modest financial incentive.
- **HRSA: Maternal and Child Health Block Grants.** HRSA administers federal block grants to states to support comprehensive services to women and children with limited access to health care services under Title V of the Act. Successful coordination of Title V programs with Medicaid and CHIP programs assists in maximizing federal, state, and local funds to meet the health care needs of low-income women and children and to assist in the identification of pregnant women and infants eligible for Medicaid. State Title V and Medicaid programs must coordinate EPSDT activities to minimize duplication of effort. Medicaid programs may pay Title V agencies for providing Medicaid-covered services (§505(a)(F)(iv) of the Act). They also must enter into cooperative agreements to share information and education on pediatric vaccinations and delivery of immunization services (§1902(a)(11)(B) of the Act).

State partnerships with public health and other state agencies

State Medicaid programs also partner with other state agencies to share resources, data, and staff to promote population health. Such partnerships allow both partners to have a better understanding of the social determinants of health experienced by state residents, as well as better information about services received outside of the Medicaid program. For example, immunization rates can be better determined through population-based registries than through claims or encounter data using only Medicaid data because enrollees may have received immunizations at public health departments or other locations. Examples of interstate agency partnerships follow.

Washington state. At the February 2013 MACPAC meeting, representatives from Washington state presented on collaborative efforts between the state's Department of Health (DOH) and its Health Care Authority (HCA), which administers their Medicaid program (Selecky and Porter 2013). The DOH and HCA are working together to improve access to preventive services and integrated health care for the state's Medicaid enrollees. Some examples of key collaborations include:

- The state's immunization registry shares data with Medicaid and social services to facilitate reports on immunization rates. The DOH shares immunization data with managed care plans to help them meet their Healthcare Effectiveness Data and Information Set (HEDIS) performance measure contract requirements for Medicaid.
- The state provides about $1.8 million a year to pay for tobacco cessation benefits for Medicaid enrollees, including free quitline calls and nicotine replacement therapy.
- The DOH trains "health home care coordinators" on counseling, patient activation, and stepped-up treatment for enrollees in Medicaid's health home program for chronically ill individuals.
- A statewide prescription monitoring program was launched in 2011 to monitor commonly abused controlled substances to ensure Medicaid enrollees are not taking narcotics in dangerous amounts or combinations.

Wyoming. Another example of a state agency partnership is the Wyoming integrated data program (NWCPHP 2014). This is a program for all Wyoming providers (most accept Medicaid payment) that provided access, at no cost, to an electronic health record system called the Total Health Record. Wyoming has had a functioning health information exchange for over four years that links various Wyoming Department of Health databases, such as Medicaid claims and immunization data, with the Total Health Record.

In the area of maternal and child health, Medicaid personnel notify public health nurses when Medicaid clients become pregnant, and the nurses can set up home visits with the newly pregnant mothers. Depending on the situation, nurses can then refer expectant mothers to services that promote the health of the mother and the child. The information flow works the other way as well. For example, if a nurse knows that a pregnant or new mother smokes, this information is shared in the record so the physician is aware and can promote smoking cessation. At times, the clinician may seek information from a public health nurse if there is information he or she is not able to get during an appointment.

The partnership also allows data available through the Wyoming Immunization Registry to be analyzed to show where immunization rates are low. This information can be given to Medicaid providers and public health nurses for follow-up. Efforts to increase immunizations can be targeted to the areas or vaccines that need them the most (NWCPHP 2014).

State partnerships with health plans and providers

Medicaid MCOs must specify the services they provide in their contracts with state Medicaid programs. In these contracts, they may provide services not included as mandatory or optional Medicaid services, as long as they are willing to pay for them under their negotiated payment rate or capitated rate. Many Medicaid managed care programs provide education, case management, counseling, and other non-treatment-oriented services not provided through traditional fee-for-service Medicaid.

Minnesota. In Minnesota, health insurers must file collaboration plans every four years (and updates every two years) that show how they will support high-priority public health goals, measure and evaluate progress, and collaborate with local public health and other community organizations. The collaboration plans focus on the under-65 population (Silow-Carroll and Rodin 2013).

Pennsylvania. In 2011, Pennsylvania's Medicaid agency began including in its MCO contracts what it calls pillars to promote community involvement, although these do not include numerical targets or financial incentives. The four pillars are: (1) embed care managers in medical practices, (2) develop transitions of care, (3) help primary care physicians achieve medical home status, and (4) work with collaborative learning networks. The state Medicaid agency also uses efficiency adjustments that increase or decrease payments to health plans if their regions do better or worse than expected on measures of population health (Silow-Carroll and Rodin 2013).

United Healthcare. United Healthcare offers JOIN for ME—a community-based childhood obesity lifestyle intervention program—to Medicaid enrollees who live in several states, including Louisiana, Texas, and Kansas. The program engages overweight and obese children and adolescents age 6 to 17, along with their parents, in a series of learning sessions to achieve healthier weights through healthier family nutrition choices, increased activity, and lifestyle improvement tracking (United HealthCare 2012).

Multisector partnerships and collaboratives

For public health issues that are of major importance to a large number of stakeholders, federal, state, and private organizations can partner to improve health for a defined population. These consortiums may pool funding, or private organizations may contribute funds or other resources to provide services not covered by Medicaid. Examples of these consortiums include:

- **The Ohio Perinatal Quality Collaborative's 39-Week Project.** One component of this initiative was to publicly share hospital-level data on the prevalence of scheduled deliveries less than 39 weeks (MACPAC 2013).
- **Strong Start for Mothers and Newborns.** The Strong Start for Mothers and Newborns Initiative is a joint effort between CMS, HRSA, and ACF that aims to reduce preterm births and improve outcomes for newborns and pregnant women. One component is a public-private partnership and awareness campaign to reduce the rate of early elective deliveries prior to 39 weeks for all populations (MACPAC 2013).[3]
- **Text4baby.** Several states are collaborating in a pilot program that involves public-private collaboration to target pregnant Medicaid enrollees with health messages sent by text (Text4baby 2014). Messages include reminders on prenatal care and immunization, information about nutrition and smoking cessation, and tips on developmental milestones and warning signs, all keyed to a mother's due date.

Challenges in partnering to promote population health

The many partnerships between federal agencies, state Medicaid programs, and other organizations demonstrate that some progress is being made in breaking down silos and moving to a more population-oriented approach to improving the health status of Medicaid enrollees. Barriers to organizational collaboration to implement population health initiatives remain, however (Richardson 2012).

These barriers include:

- the standards for proving cost-effectiveness sometimes placed on these interventions;
- the belief that, in the long run, prevention may cost more than treatment;
- the lengthy time frames required for some population health interventions (in particular ones that require behavioral change for individuals); and
- the inability to identify specific individuals who are prevented from developing the disease or condition (Richardson 2012).

These and other barriers are discussed in more detail below.

Separate funding streams and other financing challenges. A longstanding barrier to coordinating care has been the misalignment of funding streams among potential or actual partners. For example, for individuals dually enrolled in Medicare and Medicaid, Medicaid pays for most long-term services and supports and case-management services, while Medicare sees the savings from keeping these individuals out of the hospital. To address this particular issue, CMS's Financial Alignment demonstration is currently testing models that better align the financing of these two programs and integrate primary care, acute care, behavioral health, and long-term services and supports for their dually eligible Medicare-Medicaid enrollees (CMS 2014c).

Federally Qualified Health Centers (FQHCs) are also a major player in the safety net that provides a comprehensive set of services to uninsured and low-income populations, including many Medicaid enrollees. FQHCs often partner with Medicaid agencies on various preventive and other initiatives designed to improve overall health, notably oral and behavioral health services. FQHCs also may participate in Medicaid ACOs and other financing demonstration programs.

However, the FQHC payment system sometimes raises questions regarding health centers' eligibility to participate in incentive-based payment models such as ACOs that necessitate more aggressive financial integration. These models may also require information about performance that may go beyond what is captured on FQHC cost reports, which focus on health center costs but not necessarily on costs to which payment incentives apply. At the same time, CMS has stated in guidance that the FQHC payment structure does not require MCOs to recoup incentives such as shared savings. Rather, FQHCs are entitled to the full amount of their Medicaid payment rate, regardless of whether and the extent to which shared savings are achieved (Burton et al. 2013).

Different time frames for evaluating effectiveness. Population health programs generally create future benefits rather than helping someone immediately. They also may benefit the public at large more significantly than targeted individuals. Prevention in particular, as one mechanism for promoting population health, does not always save money, particularly in the short-term (Richardson 2012, Russell 2009).

Thus, different goals and time horizons may create barriers to collaboration among organizations. The length of time necessary to benefit from the cost-saving potential of prevention services may be longer than necessary for MCOs to get a return on their investment, for example, or outside of the five-year time frame generally used by the Congressional Budget Office in its estimates (Richardson 2012).

Conflicting eligibility rules and program coordination issues. In some cases, different programs have conflicting eligibility rules for benefits. This can make collaborations difficult, because it is not always clear which program's regulations or eligibility standards take precedence. For example, Medicaid and block grant programs may cover overlapping populations, but not all of their participants are eligible for both programs. An enrollee with both a mental disorder and a substance abuse problem may be found eligible for services under either one Medicaid eligibility pathway or a block grant, but not for services through both, creating conflicts between the programs when some services authorized by one program cannot be provided or paid for by the partner program. Similarly, Medicaid may fund only services provided to a child (but not the family) when the parents are not themselves Medicaid-eligible, which could conflict with partners who provide family counseling or other services (Koyanagi and Boudreaux 2003).

Incompatible data systems. In several population health partnerships, a core activity is the linkage of different data systems that can be used to monitor health care and health outcomes. For example, all-payer immunization registries are useful in determining whether low immunization rates for Medicaid enrollees are real, or whether some enrollees are actually receiving their immunization outside of the Medicaid program. But such registries require a common identifier for the population covered. Linking these data at the individual level requires that the data be physically linked by identifiers and that the data be in a common format. Many states, as well as federal initiatives to standardize electronic data exchange, are actively working to overcome the many barriers to effective health information exchange.

Differences in organizational culture or goals. Managed care offers considerable flexibility in providing non-medical benefits that are not offered by traditional Medicaid, as discussed above. However, some MCOs have proprietary approaches to care management that make it challenging to collaborate with competitors on community-based initiatives (Bovbjerg et al. 2011).

Contracting between plans and public health providers may be complicated because these providers may not have traditionally contracted with private health plans. They may lack the experience necessary to work through contracting requirements such as billing, credentialing, or rate negotiations.

It can also be difficult for national plans to adapt to the unique needs of a local environment and have the flexibility to work with local partners to leverage community-based public health initiatives (Burton et al. 2013). Alternatively, national plans may have the capital to invest in communities that small plans do not.

Monitoring Population Health among Medicaid Enrollees

A large part of improving the health of any population is determining what the current health of that population is, assessing what its target level should be, and tracking progress towards those goals. As described for the U.S. Department of Health and Human Services (HHS) Healthy People 2010 and 2020 initiatives, setting measurable targets for process objectives requires judgment and is not an exact science. HHS has recommended that to set process targets, planners should (1) identify the population at risk, (2) identify care gaps, (3) identify and target high-risk groups, (4) consider the current status (baseline), (5) seek stakeholder input on the desired level of improvement, and (6) make a realistic assessment of what can be accomplished (HHS 1997). Many of these tasks are informed by data that is collected by CMS, CDC, and other agencies.

Need for data to monitor population health

Initiatives to improve the health of the Medicaid (or any) population require collection of measures and methodologies that can be used to assess: (1) the baseline health of that population, and (2) changes to health over time. Such information can be used to identify populations with poor health that could benefit from some sort of intervention, and also to identify and reduce disparities in health across population groups.

Currently, there are few Medicaid datasets that can be used for this purpose, although CMS has a considerable amount of work underway to improve its Medicaid data files. Medicaid data issues and CMS efforts to improve them are discussed in detail in MACPAC's June 2013 report to the Congress (MACPAC 2013).

Some reasons for this lack of data—for Medicaid enrollees but also for populations in general—include:

- hesitancy to ask for data from enrollees or patients;
- misinformation about how health status and determinants data will be used (including privacy concerns), which may make enrollees reluctant to cooperate in surveys or data collection efforts;
- lack of agreement on which measures to collect;
- lack of standardization of health status measures for specific population groups of interest (In part, this stems from different data elements collected on different surveys. However, there is a considerable amount of work in the research community that is attempting to define and standardize measures of mental health and disability, but these standardized measures are not yet consistently used in data collection efforts.); and
- lack of funding for data initiatives, but specifically for data initiatives with information on both Medicaid and non-Medicaid populations at the community level.

Current datasets

Because no single data source provides a national picture of access to health services in Medicaid, monitoring the health of Medicaid enrollees requires multiple sources of data that measure different aspects of health status and its determinants. The major sources of Medicaid data that could help measure and track health status and social determinants of health for Medicaid enrollees include:

Claims and encounter data (MSIS, MAX, T-MSIS). Medicaid's administrative data are available in systems known as the Medicaid Statistical Information System (MSIS) and the Medicaid Analytic eXtract (MAX). The agency is working with states on an improved system known as the Transformed Medicaid Statistical Information System (T-MSIS). These administrative and claims data can be used to identify enrollees with specific diagnoses or conditions available from claims data. However, they have limited usefulness for self-rated health, functional status, health behaviors, or socioeconomic and environmental characteristics that could be classified as social determinants of health.

EPSDT reporting data (Form CMS-416). Form CMS-416 is used by CMS to collect basic information on state Medicaid programs to assess the effectiveness of certain EPSDT services. States must provide CMS data on screening, corrective treatments, dental services, and a few selected other indicators (OIG 2010).

Attempts have been made to improve the quality of CMS-416 data, but problems persist with the completeness, accuracy, and standardization of the data. In a U.S. Government Accountability Office report, state and national health association officials noted inconsistencies in how states report data, data inaccuracies, and problems with the data captured that preclude calculating accurate rates of the provision of dental and other required EPSDT services (Cosgrove 2007). Further, the usefulness of the CMS-416 for federal oversight purposes is limited by the data currently requested, which consists of a very limited set of measures mandated by law.

National health surveys. Nationally representative health surveys—such as the National Health Interview Survey, the Medical Expenditure Panel Survey, the National Survey of Children's Health, and others—are commonly used to examine the health of different groups of people, including persons with Medicaid compared to those with other types of coverage. The surveys contain health behaviors, sociodemographic information, and other health determinants. However, they have limited ability to do subnational analyses or to evaluate the effect of specific Medicaid programs or initiatives.

Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a state-run telephone survey of non-institutionalized adults age 18 and older. It includes topics such as health status, risk behaviors, health care access, and prevalence of chronic conditions. While the survey includes questions on insurance, there was no question specific to Medicaid or CHIP until 2013. The 2013 data are not yet available; however, when they are, states should be able to use them to identify localities with a high prevalence of health risk factors, health behaviors, and health conditions that could be targeted for programmatic interventions (for example, areas with high smoking rates, high obesity rates, or high rates of hypertension). It is unclear if the Medicaid and CHIP questions will be retained in future years.

Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) for adults. While many states currently conduct a CAHPS survey of adults covered by Medicaid, they do not collect the data in a standardized way that can be used to compare enrollees across states. The goal of this new national survey (to be fielded in the fall of 2014) is to attain national and state-by-state estimates of adult Medicaid enrollees' access and experiences and satisfaction with care across different financing and delivery models (e.g., managed care and fee for service) and population groups (e.g., enrollees with physical or mental disabilities, enrollees dually enrolled in Medicare and Medicaid, all other enrollees). The questionnaire contains several health status measures, measures of functioning, information on sociodemographics (e.g., age, sex, race/ethnicity), and some information on health behaviors (e.g., smoking). However, it does not contain questions to assess economic circumstances such as family income or size.

Looking Forward

Many Medicaid programs have realized that a traditional, narrow definition of medical assistance may not be the most effective way to improve the health of their enrollees. Multiple examples of how Medicaid programs provide services in addition to medical treatment to promote the health of their enrollees are presented in this chapter. These initiatives and services range from providing screening and preventive services and education and counseling, to partnering with providers and others to provide financial and other incentives for improving the health status of defined populations. These initiatives are consistent with the Institute of Medicine report *Primary Care and Public Health: Exploring*

Integration to Improve Population Health, which stresses the importance of CMS and other collaborations to improve the nation's health (IOM 2012).

These initiatives are part of an ongoing trend to measure health for specific groups (in this case Medicaid enrollees); target populations for whom health status is poor or social determinants of health are problematic and could be improved (e.g., areas with no grocery stores, areas with high rates of communicable disease, areas with no playgrounds or other places to exercise); and develop interventions to help improve health for those identified populations.[4] Medicaid ACOs and CCOs in particular are often grounded in the Triple Aim model developed by the Institute for Healthcare Improvement, which has a focus on population health—improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care (IHI 2014, OHPB 2014).

Medicaid programs have many additional opportunities and vehicles for enhancing the health of enrollees in addition to providing acute medical care. Most of these vehicles do not require any changes to current legislation or regulations. States can, for example, use waivers to develop demonstration programs—such as ACOs and CCOs—that provide incentives to providers to improve the health of their enrolled populations.

CMS can also continue to take steps to promote the value of Medicaid for improving population health. The agency can clarify existing regulations and laws (e.g., prevention, EPSDT, and ACA regulations) to assure that states maximize the benefits under Medicaid to promote access to preventive benefits. CMS and states can improve data collection and data dissemination on the health status, social determinants of health, and utilization of health services by enrollees. States can also develop new partnerships to share data with other organizations, including other federal, state, and private partners and relevant providers. CMS's Center for Medicare & Medicaid Innovation in particular supports the development and testing of innovative health care payment and service delivery models to improve the health of covered populations, improve quality of care, and control costs.

Medicaid expansions under the ACA provide an unprecedented opportunity for states to find ways to maintain and improve population health. Looking forward, MACPAC will continue to track these initiatives and to support efforts to improve the overall health of Medicaid enrollees.

Endnotes

[1] Workplace wellness programs are not without controversy and risks; for example, they have the potential to shift costs to sicker people (a backdoor way around the ban on health status rating) or violate the ACA's antidiscrimination provisions (James 2012).

[2] Section 4107 of the ACA amends Section 1905 of the Social Security Act to require coverage of counseling and pharmacotherapy for cessation of tobacco use by pregnant women. For pregnant individuals, the U.S. Public Health Service guideline recommends that because of the serious risk of smoking to the pregnant smoker and the fetus, whenever possible, pregnant smokers should be offered person-to-person counseling that goes beyond minimal advice to quit. The guideline does not recommend pharmacotherapy for pregnant women because there is insufficient evidence of the specific safety and effectiveness of pharmacotherapy in pregnant women. However, such use may be evaluated on a case-by-case basis as determined by the woman and her physician (CMS 2011a).

[3] See MACPAC 2013 for a discussion of other state programs to reduce preterm births.

[4] Initiatives such as Mobilizing Action Toward Community Health focus on assessing population health and working with communities to help them (1) identify opportunities for improving community health, and (2) find and implement evidence-based programs and policies to address these issues (UWPHI 2014b). The HHS Healthy People 2020 initiative is tracking population health and measuring progress towards goals, which include: attaining high-quality, longer lives free of preventable disease, disability, injury, and premature death; achieving health equity, eliminating disparities, and improving the health of all groups; creating social and physical environments that promote good health for all; and promoting quality of life, healthy development, and healthy behaviors across all life stages (HHS 2010). Many other examples of similar initiatives are sponsored by foundations and government agencies at all levels.

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CHAPTER 4

Building Capacity to Administer Medicaid and CHIP

Key Points

Building Capacity to Administer Medicaid and CHIP

- Medicaid and CHIP are jointly administered by the states and the federal government. Both partners face challenges in administering these large, growing, and dynamic programs.
- State Medicaid and CHIP programs must manage a host of responsibilities related to insurance program operations, public health, social insurance, and public financing. These responsibilities include defining covered populations, benefits, and provider qualifications; establishing payment rates; overseeing delivery systems; determining eligibility; maintaining enrollee protections; providing customer service; managing utilization; documenting expenditures; reporting program data; managing quality performance; responding to audits; and ensuring program integrity.
- The Centers for Medicare & Medicaid Services (CMS) has primary responsibility for federal administration of the Medicaid and CHIP programs. In addition to developing regulations and policy guidance, CMS reviews and approves state plan amendments and waiver requests, oversees state program implementation, and processes state claims for federal reimbursement of program expenditures.
- As new options and mandates are added to Medicaid, state and federal staff are continually assuming new responsibilities, including automating and streamlining eligibility processes; synchronizing Medicaid, CHIP, and exchange eligibility; developing incentives to collaborate with providers and other state agencies; aligning provider payment with quality and improved outcomes; developing data analytics to strengthen program accountability; and expanding access to community-based care.
- Increasing demands hinder Medicaid programs' ability to continue to meet regulatory requirements; to improve quality, outcomes, and value; and to integrate Medicaid and CHIP into broader delivery system and financing reforms. Constraints include:
  - financial disincentives to invest in program administration;
  - increasing system demands and complexity;
  - few administrative performance standards; and
  - difficulty recruiting and retaining expert staff.
- CMS, states, and private organizations have developed a variety of innovative approaches to strengthen Medicaid administrative capacity. These include:
  - leadership development and training;
  - multistate collaborations and partnerships with academia;
  - contracts with outside vendors;
  - federal initiatives to improve data collection and strengthen performance; and
  - enhanced federal match or dedicated funds.
- While there is general consensus that program administrators should aim for value, high performance, and efficiency in Medicaid, there are few clear standards to assess these objectives and little evidence on best practices. MACPAC's future work on administrative capacity will focus on how administrative performance should be measured and which strategies are most effective in helping states develop adequate capacity.

CHAPTER 4

Building Capacity to Administer Medicaid and CHIP

Medicaid and the State Children's Health Insurance Program (CHIP) are major purchasers of health care services. Together they accounted for over $470 billion in state and federal expenditures in fiscal year (FY) 2013, or 15 percent of national health care spending (MACPAC 2014). These programs cover a substantial number of people—more than 70 million in Medicaid and 8 million in CHIP in FY 2013. This number is growing as states implement the expansion of coverage to adults at or below 138 percent of the federal poverty level and as outreach efforts associated with Medicaid, CHIP, and the exchanges result in additional eligible persons being referred and coming forward to enroll in coverage (MACPAC 2014). The demands on state Medicaid agencies are extensive and diverse and continue to grow as these programs increase in size and scope and seek to increase value and accountability through more sophisticated purchasing strategies (NASBO 2014). However, Medicaid experts have noted that administrative capacity constraints already hinder states' ability to meet program requirements; to implement proactive strategies to improve quality, outcomes, and value; and to integrate Medicaid and CHIP into broader delivery system and financing reforms (Griffin et al. 2014).

Medicaid and CHIP are jointly administered by the states and the Centers for Medicare & Medicaid Services (CMS). While CMS is responsible for program administration at the federal level, state agencies have the flexibility to establish many policies—within federal guidelines—and to manage their own programs on a day-to-day basis. State responsibilities include determining eligibility, enrolling providers, setting payment rates, developing coverage policies, adjudicating claims, overseeing contractors, managing information systems, monitoring access to and quality of services, addressing casework, and ensuring program integrity. Federal statute (§1902(a) of the Social Security Act (the Act)) requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. (See Box 4-1 for more information on requirements relating to administration of CHIP.) In many states, the single state agency contracts with other public or private entities, including other state or local government agencies, to perform various program functions that may encompass extensive policy and operational aspects of program administration.

Consistent with MACPAC's statutory charge to review the factors affecting expenditures for the efficient provision of items and services by Medicaid (§1900(b)(2) of the Act), the Commission is focusing attention in this report on state administrative capacity. This chapter describes the administrative requirements for state Medicaid programs, obstacles states and the federal government face in administering Medicaid effectively, and models and strategies that have been implemented to strengthen administrative capacity. The Commission recognizes that sufficient administrative support and adequate capacity are needed for the state responsibilities related to effective and efficient operation of the Medicaid program, yet there are few clear performance standards or metrics to assess state capacity, identify gaps in performance, prioritize investments, and identify appropriate responses. The chapter concludes by noting the Commission's ongoing concern about Medicaid administrative capacity and by highlighting potential areas for future work.

Medicaid Administrative Responsibilities

State roles and responsibilities

As governmental health insurance programs, state Medicaid programs must manage all of the operational functions of a large health insurer as well as a host of additional responsibilities

BOX 4-1. CHIP Has Specific Administrative Requirements

The State Children's Health Insurance Program (CHIP) pays for the health insurance coverage of targeted low-income children whose family income is above the state's Medicaid eligibility levels in 1997, when CHIP was created. States operate their CHIP programs as a CHIP-funded expansion of Medicaid, a CHIP program separate from Medicaid, or a combination of both approaches. Like Medicaid, states administer their programs within federal rules and receive federal matching funds for program expenditures. However, while states receive an enhanced federal matching rate for CHIP, funding for each state is capped by an annual allotment, and the amount of the CHIP allotment that a state can spend on certain non-benefit activities is limited to 10 percent of total CHIP expenditures. These non-benefit activities can include outreach conducted to identify and enroll eligible children in CHIP, program administration costs, health services initiatives, and other child health assistance. These expenditures are matched at the enhanced CHIP matching rate (unlike Medicaid, which provides 50 percent match for most administrative expenditures) and are counted against both the 10 percent limit and the allotment.

CHIP programs that are operated as CHIP-funded expansions of Medicaid are subject to the same administrative requirements as Medicaid. Many states operate CHIP programs as stand-alone programs but in practice use the same staff and systems that support Medicaid such that the two programs are administratively integrated. Some states operate fully separate CHIP programs. These fully separate programs are typically smaller in size and are subject to fewer and different federal administrative requirements. For these reasons, the administrative capacity issues unique to stand-alone CHIP programs are generally excluded from this chapter, which focuses on the requirements that apply to Medicaid and by extension to CHIP programs that are CHIP-funded Medicaid expansions or separate CHIP programs that states choose to administer by Medicaid staff and systems.

relating to public health, social insurance, and public financing. For example, while state Medicaid agencies must manage traditional insurer responsibilities such as eligibility, provider enrollment, claims adjudication, and financial management, they must also manage coverage of long-term services and supports, provide access to non-traditional support services such as non-emergency transportation and language translation, attend to the program's role in supporting the health care safety net and health information exchange, accept appeals and grievances and conduct fair hearings, and coordinate enrollment with health insurance exchanges and separate CHIP programs. The demands on state Medicaid agencies are extensive and diverse and have grown substantially over the nearly 50-year history of the program (Box 4-2).

BOX 4-2. Medicaid Programs Manage a Large and Diverse Set of Responsibilities

Manage and oversee delegation agreements: Develop, manage, and oversee delegation agreements with state agencies and local governments, as appropriate.

Define covered populations, benefits, and provider qualifications: Implement coverage of mandatory eligibility groups and services, determine which optional eligibility groups and services will be covered, determine how to enroll and pay providers of mandatory services, and decide what optional provider types may enroll and receive payment.

Define and make payments: Establish payment rates consistent with efficiency, economy, and quality of care and sufficient to enlist multiple types of providers; adjudicate claims and process payments.

Design, operate, and oversee delivery systems: Develop, implement, and oversee delivery systems (e.g., fee for service, managed care, alternative approaches).

Determine eligibility: Accept and process eligibility applications consistent with state and federal requirements for timeliness and accuracy.

Implement enrollee protections and safeguards: Provide systems and support to ensure that Medicaid enrollees receive protections and rights granted by federal law; manage appeals and fair hearings processes.

Manage utilization: Control utilization of Medicaid services, safeguard against unnecessary and inappropriate use, and provide specific controls for institutional services and outpatient drug use.

Claim federal financial participation: Collect and document expenditures according to appropriate federal matching rates; submit budget and expenditure reports to the Centers for Medicare & Medicaid Services.

Collect and monitor program data: Collect and report information necessary for program administration and accountability; maintain statistical, fiscal, and other records.

Measure and manage quality and performance: Assess the quality of Medicaid services and the performance of providers and vendors and take prompt and appropriate action when concerns are noted.

Defend state practices and reports: Respond to an array of federal auditing inquiries (e.g., Office of Inspector General, Recovery Audit Contractors, Payment Error Rate Measurement).

Ensure program integrity: Identify and address instances of fraud, abuse, and mismanagement and ensure that federal and state funds are spent appropriately; initiate state investigations and participate in federal reviews and audits.

Source: Griffin et al. 2013.

Federal statute and regulations not only spell out minimum requirements and expectations for state program administration, but also give states flexibility as long as these requirements are met. As a result of this flexibility, there is significant variation in how states organize, staff, and operate their Medicaid programs. Additional administrative demands (and variation) stem from state efforts to go beyond basic program expectations and leverage Medicaid's purchasing power to contain cost growth, drive value, and improve population health (Box 4-3).

Federal roles and responsibilities

Medicaid and CHIP are jointly administered by the states and the federal government. States have primary responsibility for day-to-day program operations, including the activities described above, while the federal government develops regulations and guidance to implement federal laws, reviews and approves state plan amendments and waiver requests, oversees state program implementation and operations, and processes state claims for federal reimbursement of program expenditures. Responsibility for executing these federal functions is generally divided between the CMS central office, which is responsible for setting overall Medicaid policy, and 10 CMS regional offices, each of which is responsible for program and financial oversight of a group of states. Additional oversight responsibilities are shared among other federal organizations, including the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) and the U.S. Government Accountability Office (GAO).

BOX 4-3. Medicaid Programs Continually Assume New Responsibilities

Streamline eligibility policies and processes: Automate eligibility processes; interface with a federal data services hub; coordinate with exchanges.

Maximize efficiency across Medicaid, exchanges, and CHIP: Coordinate Medicaid and State Children's Health Insurance Program (CHIP) eligibility with coverage through the exchange via a no-wrong-door eligibility and enrollment process; minimize the effects of churn among programs.

Implement delivery system and payment reforms: Become more active purchasers to obtain better value; develop incentives to promote coordination and collaboration across providers and the use of evidence-based practices; develop strategies for aligning provider payment with quality and improved outcomes.

Rebalance long-term services and supports: Expand access to community-based care options and manage transitions between settings.

Support Medicaid and interagency collaboration: Improve coordination between Medicaid and state public health, insurance oversight, income support, housing, educational, employment, transportation, and justice systems to support common goals.

Improve performance management, quality measurement, and data management: Develop data reporting and analytic capacity to incorporate quality and performance management into program operations and strengthen program accountability.

Provide transparency and public accountability: Collect information and present it in a format accessible to a variety of audiences; provide timely information and data to support policymakers.

Source: Griffin et al. 2013.

Within CMS, primary federal responsibility for ensuring the efficient and effective administration of Medicaid and CHIP rests with the Center for Medicaid and CHIP Services (CMCS). As directed by the Secretary of HHS (the Secretary), CMCS staff interpret and help operationalize statutory requirements through the development of federal regulations and subregulatory guidance (e.g., state Medicaid director letters and responses to frequently asked questions). CMCS staff provide states with direct technical assistance, negotiate the terms and conditions of waivers of state plan requirements, and respond to requests for information from a wide variety of stakeholders including the Congress, providers, and enrollees. CMCS is also responsible for monitoring the quality and performance of Medicaid and CHIP. Other offices within CMS that maintain some responsibility for Medicaid and CHIP policy development and program oversight include the Center for Medicare and Medicaid Innovation, the Center for Program Integrity (CPI), and the Federal Coordinated Health Care Office.

CMS also has 10 regional offices, each with an associate regional administrator responsible for Medicaid and CHIP program oversight and organized as the Consortium for Medicaid and Children's Health Operations. Regional office staff serve as the front line for CMS in monitoring the implementation of federal policies, interacting directly with state Medicaid agencies through oversight of the state plan amendment process, Medicaid managed care contracting and rate setting, information systems design, and states' claims for federal financial participation. Regional office staff also help to convey policy information from the central office to state officials and advise the central office based on their direct interactions with the states.

Obstacles Facing States and the Federal Government

Meeting these broad statutory, regulatory, and efficiency demands requires funding, staff, data, technology, and systems to support operations and innovation, and leadership to provide ongoing oversight. At MACPAC's January 2014 meeting, state Medicaid directors and policy experts described how administrative capacity constraints can limit states' ability to meet program requirements such as eligibility determination timeliness and claims payment accuracy and can hinder their ability to be more proactive in activities such as oversight, quality, outreach, and analytics (Griffin et al. 2014). They also noted that while Medicaid has undergone significant changes and that the pace of change continues to quicken, little attention has been paid to the effort needed to take advantage of opportunities to evolve and expand. Moreover, state Medicaid program administrative costs (shared by states and the federal government) have remained relatively constant at about 5 percent of total Medicaid spending.[1] State Medicaid directors speaking at the January meeting identified a variety of barriers to developing and maintaining Medicaid administrative capacity, as described in the following sections.

Financial constraints

State disincentive for administrative spending. From a budget perspective, one of the biggest challenges for states is how to finance the growing demand for health care services while still making needed investments in other areas such as education and transportation (NASBO 2014). Nearly all states are required to balance their budgets, so greater spending on Medicaid requires either less spending on other activities or additional revenue; similarly, greater spending on Medicaid administrative activities is often offset by less spending on Medicaid services. The zero-sum nature of state budget decisions creates a powerful incentive for state agencies to limit spending on program administration.

Federal disincentive for administrative spending. In addition, the structure of the federal match for program administration exerts added downward pressure on Medicaid administrative resources, particularly in states where the federal medical assistance percentage (FMAP) for health care services is much greater than the matching rate for administration (50 percent for most activities).[2] At a 50 percent matching rate, every dollar a state spends on Medicaid administration is matched by a dollar of federal money, but in the 37 states that receive greater than 50 percent match for services, every dollar a state spends on services is matched by more than a dollar of federal money. In Utah and South Carolina, for example, which have matching rates over 70 percent, every dollar spent on medical care is matched by over 2 dollars in federal money (HHS 2014).

Most states can maximize the federal funding they can draw down to support Medicaid (and thereby maximize the total budget available for Medicaid) by prioritizing spending on services, not administration. During times of economic stress, states can maximize federal support by cutting spending on administrative expenses (which result in a dollar of federal funding lost for every state dollar cut) instead of services (which in most states results in more than a dollar of federal funding lost for every state dollar cut).

Increasing system demands and complexity

More delivery system and payment options. Over the decades, the Congress has significantly expanded the populations and services states can cover and the delivery and payment systems they use. New options provided to states in recent years include the flexibility to provide an alternative benchmark benefit package, implement Express Lane Eligibility for children, enroll low-income pregnant women in CHIP, cover family planning services as a stand-alone benefit, provide health homes for enrollees with chronic conditions, and form pediatric accountable care organizations (MACPAC 2013a). The Congress has also mandated new program requirements, such as the requirement to increase payments for certain primary care services to the Medicare payment rate for 2013 and 2014. While new options and mandates provide attractive opportunities for states, the administrative requirements for participation in both mandatory and optional activities are added to already competing priorities and capacity constraints.

Tracking and reporting. For state staff, such opportunities almost always mean additional responsibilities, which are often absorbed into existing workloads, according to state Medicaid directors (Griffin et al. 2014). In addition, they often mean that states must devote additional resources to recordkeeping, financial reporting, and audit support to comply with federal spending rules. This is particularly true when optional programs include enhanced federal matching funds. All expenditures associated with programs with a special federal matching rate must be tracked and reported separately so that the appropriate amount of federal funding can be drawn down and so that federal auditors can ensure that enhanced funds are provided only for spending on services and activities entitled to the higher matching rate (Table 4-1). As a case in point, to supplement the rule and state plan template that states must follow to implement the temporary Medicaid primary care physician payment increase, CMS has had to issue eight sets of Q&As to guide states in appropriately tracking and documenting requests for additional federal matching funds (CMS 2014a).

State Medicaid directors told MACPAC that these administrative requirements factor into the

TABLE 4-1. Examples of Programs with Different Federal Matching Rates

Program	Enhanced Matching Rate	Citation
Primary care payment rate increase up to the Medicare payment rate for primary care services furnished by a physician with a primary specialty designation of family, general internal, or pediatric medicine	100 percent for expenditures attributable to the amount by which Medicare exceeds the Medicaid payment rates in effect on July 1, 2009, available in calendar year (CY) 2013 and CY 2014	P.L. 111-148, as amended; §1902(a)(13)(C) of the Act
Health homes and associated services to certain individuals with chronic conditions	90 percent, available for the first eight quarters that the health home option is in effect in the state	P.L. 111-148, as amended; §1945(c)(1) of the Act
Community First Choice initiative to provide home and community-based attendant services and supports for certain individuals at or below 150 percent of the federal poverty level, or a higher income level applicable to those who would otherwise require an institutional level of care	Six percentage point increase in the federal medical assistance percentage (FMAP), available as long as an approved state plan amendment is in effect	P.L. 111-148, as amended; §1915(k)(2) of the Act
Competitive Balancing Incentive Payment Program for states in which less than 25 percent or 50 percent of Medicaid expenditures for long-term services and supports (LTSS) are non-institutional and that implement a plan to increase the percent of expenditures that are for non-institutional LTSS	Two or five percentage point increase in FMAP for non-institutional LTSS depending on baseline, available from fiscal year (FY) 2011 through FY 2015	P.L. 111-148, as amended
Money Follows the Person (MFP) Rebalancing Demonstration to provide grants to states to transition individuals from institutional to community-based LTSS	MFP-enhanced FMAP equal to the state's regular FMAP increased by a number of percentage points equal to 50 percent of the number of percentage points by which the regular FMAP is less than 100 percent, not to exceed 90 percent FMAP, available (through competitive grants) beginning in FY 2007	P.L. 109-171, as amended by P.L. 111-148
Electronic medical records incentives for provider adoption of electronic health records and state administrative expenses related to such incentive payments	100 percent federal financial participation for payments to eligible providers and 90 percent for state administrative expenses, available to providers for a six-year period beginning no earlier than 2011 and no later than 2016	P.L. 111-5; §1903(a)(3)(F) of the Act

Source: MACPAC analysis.

decisionmaking process for new programs. In a presentation to the Commission, the Medicaid director for the state of Maryland described seven temporary or optional program changes in his state with enhanced federal matching rates: the Medicaid expansion for low-income adults, the temporary increase in payment for primary care services provided by primary care physicians, the Community First Choice initiative, a health home initiative, the Competitive Balancing Incentive Payment Program, the Money Follows the Person initiative, and certain eligibility worker activities associated with implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (Milligan 2014). The state chose to implement many of these programs in part because of the availability of enhanced federal matching rates even though this created considerable demands on the agency to appropriately track and allocate costs and then support responses to multiple federal audits.

Complex compliance requirements. The compliance requirements can be particularly complex when administrative staff support multiple programs or activities that have different matching rates, or when programs overlap or have similar structures. States must be able to track and document staff time and costs at the activity or task level so that they can be applied to the correct program. For example, a state can receive 75 percent federal match for certain eligibility activities, but not for outreach prior to enrollment or for post-eligibility activities such as managed care choice counseling. To appropriately claim federal match, states must allocate the cost of individual workers among these various activities.

The Congress has also expanded the demands on state agencies; for example, the ACA requires states to develop new eligibility policies and systems to improve the accuracy and timeliness of eligibility determinations, and it also requires states to submit additional data to support program integrity, program oversight, and administration. Some of these new federal requirements include provisions to support their implementation. For example, states may receive 90 percent federal match for the design, development, and implementation of new eligibility policies and systems through 2015 and are exempted from federal audits of eligibility systems for three years (CMS 2013a, CMS 2012a). Other new provisions create demands on top of existing requirements. For example, in response to ACA provisions regarding Medicaid data, CMS has published requirements for states to submit a Transformed Medicaid Statistical Information System dataset (T-MSIS) that includes hundreds of additional data elements (CMS 2013b). CMS is providing technical assistance to states but has not exempted states from complying with existing data reporting requirements during the T-MSIS implementation period.

The federal government also designates administrative, coding, and system requirements for insurers and requires Medicaid agencies to comply with these standards. For example, in 2009, HHS published a final rule adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding (HHS 2009). The final rule noted that the transition from the current ICD code set to the new code set was anticipated to cost the Medicaid program over $300 million, which would be shared between the federal government and states. States commented that the implementation of ICD-10 created short- and long-term costs and put stress on safety net payer systems that were already under duress (HHS 2012). The transition to ICD-10 is one of several national administrative data requirements that state Medicaid programs are currently in the process of implementing; others include new provider enrollment requirements, implementation of a standard unique health plan identifier, and additions to the national provider identifier requirements.

Changing role of state Medicaid staff

Need for greater technical expertise. Historically, many state Medicaid staff have been responsible for insurance functions such as claims examination, identification of third-party liability, and audits of provider cost reports. Today, some of these activities are becoming automated or replaced by more analytical processes that require fewer or more targeted personnel, including staff with more sophisticated knowledge and skills than were previously required. For example, some states have implemented prepayment predictive models that can identify those claims most likely to be in error through statistical analysis, reducing the need for manual review of low-risk claims. At the same time, as these systems become more sophisticated, state Medicaid staff may require new skills to take on additional responsibility for contract oversight, data analytics, information technology systems development, and implementation of delivery system reform efforts.

The Medicaid Information Technology Architecture (MITA) initiative, a multiyear federal effort designed to improve the administration of the Medicaid program by integrating business and information technology across the Medicaid enterprise, identified human resources as a key element of system change (CMS 2006a). As the supporting information systems are modernized and integrated, Medicaid agency roles can change from performing operations that require a large administrative staff to those that require executive management and smaller professional teams who have the expertise and experience to understand and use timely and actionable data.

Staff attrition. State Medicaid agencies need high-level analytic, financial, and clinical expertise to implement and oversee these modernized systems, yet they struggle to attract and retain staff with the necessary qualifications. There is tremendous labor market competition for people with this expertise, so states often find that while they are able to attract high-quality staff interested in public service and the opportunity to work on issues such as health reform, many will leave state government for more lucrative private-sector opportunities. In 2013 and 2014, nearly a third of states experienced vacancy rates of greater than 10 percent for funded positions (NAMD 2014). Medicaid agencies are also subject to statewide hiring freezes and furloughs, and, like many government agencies at the state and federal levels, experience brain drain as seasoned program leaders retire from public service. While Medicaid leadership positions are not political appointments in all states, both leaders and staff frequently turn over when there is a change in administration. The median tenure for state Medicaid directors is just three years (NAMD 2014). High turnover at both leadership and staff levels compromises the ability to sustain focus and achieve larger program goals.

Inflexible civil service rules. State civil service rules that apply to many public employees can also create challenges when job classifications are not calibrated to reflect the level of responsibility in a Medicaid agency or the higher level of private market competition for these types of expertise. For example, the defined roles and responsibilities (and pay scale) for a contract manager position may be sufficient to support the contract oversight needs of some state agencies but not Medicaid, where individual vendor contracts can exceed $1 billion per year. Furthermore, collective bargaining agreements may require Medicaid agencies to negotiate before reconfiguring job descriptions or caseloads. This can make it difficult for states to reassign staff quickly when programs demand change; for example, a state may be unable to task eligibility workers with additional outreach and choice counseling activities even if automation has replaced many of the eligibility verification checks and calculations that were previously their responsibility.

Need for training. State Medicaid directors who spoke to the Commission stated a need for leadership development for senior leaders and for additional training for managers and staff to improve both performance and retention (Griffin et al. 2014). This training is needed to support the modernization of the Medicaid program, as new initiatives often share the common goal of moving away from paper-based, compliance-focused processes to person-centered and automated processes. This change is occurring across all aspects of the Medicaid program, from eligibility streamlining to proactive program integrity to long-term care system rebalancing. Changes that rely on staff to apply more analysis, judgment, and autonomy also require more highly skilled staff and, thus, more training. Where new initiatives seek to integrate multiple programs and processes, staff from legacy programs may need basic training in Medicaid program requirements.

In some cases, the federal government has been able to provide training resources to support states. For example, to help improve the effectiveness of state efforts to update fraud, waste, and abuse reduction practices, CMS partnered with the U.S. Department of Justice (DOJ) to form the Medicaid Integrity Institute (MII), which provides training to hundreds of state staff each year (MII 2014). For most new initiatives, states must develop additional capacity internally.

Federal capacity constraints. Administrative capacity at the federal level is also challenged by a combination of budget constraints, staff attrition, and the changing nature of health care program oversight. For example, while states increasingly use capitated managed care programs to deliver and pay for Medicaid services, with payments subject to actuarial soundness rules, CMS does not have actuaries in the regional offices who are responsible for the initial review of capitation rates (GAO 2010).

Lack of administrative performance standards and measures

Few performance metrics. Medicaid's lean administrative costs are often cited as one of its virtues, but little is known about the appropriate level of investment in program administration and where this would do the most good. States must individually develop the capacity to effectively administer the Medicaid program—and to respond to changing demands and opportunities to innovate—without clear performance standards or metrics to judge the effectiveness of specific investments. Without evidence to support greater investment in administrative resources, states may struggle to identify and correct performance gaps or to justify spending on new initiatives (Griffin et al. 2014).

The performance of some Medicaid administrative activities can be measured and this information used to justify additional investments. Program integrity is an example of an area where results can be quantified and the information used to support greater spending, as states and CMS can measure the increase in the amount of overpayments identified and collected through enhanced program integrity activities and calculate a return on investment for these efforts. For example, during a five-year period, the federal government spent $7.2 million on the MII, and states reported more than $31 million in overpayments, cost avoidance, and budget reductions resulting from this training (Box 4-4) (CMS 2013c). This return on investment in the MII has been recognized by states, the Congress, and the GAO and used to support its continued funding.

Short-term outlook for investment. Lack of outcome data for other administrative functions may result in less emphasis being placed on these activities or bias investment toward activities with short-term, quantifiable returns. In the case of the MII, $31 million is significant compared to the amount spent on training, but small compared to over $400 billion in annual Medicaid benefit spending (MACPAC 2014). A lack of comparable return on investment information on activities with indefinite returns (e.g., implementing stronger up-front management controls, more efficient payment mechanisms, and strategies to promote evidence-based care) may lead to underinvestment in these activities, even though they could also strengthen the integrity and effectiveness of the Medicaid program.

Lack of accreditation standards. Accreditation is used in other health care activities to gain consensus around standards of quality and improvement, recognize high performers, and demonstrate accountability. Health plans can obtain accreditation through the National Committee for Quality Assurance, which has developed performance standards in several areas of health plan operations (e.g., quality management and improvement, utilization management, member rights) and a process for assessing and reporting plan performance against these standards (NCQA 2014). State and local public health departments can be accredited through the Public Health Accreditation Board, a non-profit organization that has developed standards and measures that reflect domains relevant to public health agencies, such

BOX 4-4. The Medicaid Integrity Institute: A Model to Develop State Capacity

The Medicaid Integrity Institute (MII) is one of several initiatives developed as a result of the Deficit Reduction Act of 2005 (P.L. 109-171), which established the federal Medicaid Integrity Program, appropriated funding for Medicaid program integrity activities, and directed the Secretary of the U.S. Department of Health and Human Services to provide education and training for state program integrity staff (§1936 of the Act).

The MII was created in 2007 as a partnership between the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Justice (DOJ), which shares responsibility for investigating health care fraud and operates a professional training facility. The MII provides no-cost training to state staff, focusing primarily on employees from Medicaid program integrity units. Between fiscal year (FY) 2008 and FY 2012, CMS spent $7.2 million to operate the MII. Over that five-year period, more than 3,300 state staff attended 82 courses on topics such as fraud investigation, data mining and analysis, and case development. States self-reported more than $31 million in identified overpayments, recovered overpayments, disallowances, avoided costs, and budget reductions resulting from participation in the MII, for an estimated return on investment of as much as 431 percent.

The MII has been widely cited as a model for state capacity development. The U.S. Government Accountability Office reported that the modest spending on the MII enhanced states' capabilities in program integrity. The National Association of Medicaid Directors also reported that the MII enabled state staff to more successfully identify fraud, waste, and abuse and make more efficient use of state and federal Medicaid funds. CMS and DOJ have announced plans to expand the MII by offering more classes, developing a credentialing program, and extending the reach of the MII to more participants through distance learning. The MII is expected to maintain its primary focus on fee-for-service fraud detection.

Sources: MII 2014, CMS 2013c, GAO 2012, NAMD 2012.

as community assessment, public education, and workforce development (PHAB 2014). However, no such entities exist for Medicaid programs, although some states have expressed interest in performance standards and accreditation programs, perhaps tied to enhanced funding that could be used to justify additional investments in state capacity (Griffin et al. 2014).

Misalignment of priorities and responsibilities

Conflicting responsibilities. Both federal and state Medicaid administrators face the sometimes conflicting responsibilities of quickly implementing required program modifications, providing access to necessary services, and assuring program integrity. At the state level, for example, program managers are often concerned with maintaining or increasing provider participation and therefore may prefer policy decisions that lessen administrative burden on providers and assure prompt payment. Program integrity managers, on the other hand, may prefer increased front-end assurance of proper payment, even at the risk of some delay as a result of verification.

Similar conflicts play out at the federal level. CMCS has primary responsibility for Medicaid policy and program development and a vested interest in disseminating policy guidance as quickly as possible to help states implement new requirements and keep funds flowing to the providers that are serving enrollees. At the same time, however, CMCS staff are also responsible for issuing regulations that are consistent with statutory requirements, reviewing states' payment policies to assure compliance with federal rules, and reviewing states' claims for matching funds. The deliberation required by these activities can be at odds with efforts to speed implementation and maintain state flexibility. Further, a number of other federal offices and agencies—including the CPI and the Office of Financial Management (OFM) within CMS, the HHS OIG, and the GAO—are responsible for examining the use of public funds and protecting the integrity of public programs. From the state perspective, the priorities of these various federal agencies can sometimes appear misaligned.

Administrative conflicts are likely to arise during times of significant and rapid program change, as has been the case recently with implementation activity related to the ACA. Among the most significant of these changes are the new requirements for states to determine Medicaid eligibility using automated systems and new income counting rules. CMCS invested millions of dollars to support state-level systems changes and published extensive policy guidance for states but deferred issuing detailed regulations on issues relating to program integrity (MACPAC 2014). The OFM, which manages the Payment Error Rate Measurement (PERM) program, elected to forgo measurement of Medicaid eligibility error rates for three years beginning in FY 2014 to give CMS and states time to develop and test new approaches to measure the accuracy of eligibility determinations (CMS 2013a). The OIG, however, has published a plan to begin conducting eligibility reviews in FY 2014 in order to determine the extent to which states improperly enrolled individuals in Medicaid programs and to estimate national enrollment error rates (OIG 2013).

Models and Strategies to Strengthen Administrative Capacity

CMS, states, and private organizations have developed a variety of strategies to strengthen Medicaid administrative capacity. These include methods to increase the effectiveness of existing resources, mechanisms to supplement state resources, and ways to share costs with other states or other state agencies.

Increasing the effectiveness of existing resources

As noted above, state Medicaid programs—like many public programs—struggle with a mismatch between the skills of program staff and the evolving needs of the program, as well as labor market competition for staff that possess in-demand skills. Programs to help develop agency leaders and managers and improve both performance and retention have had limited reach but some success in helping to fill skill and leadership gaps in Medicaid agencies. CMS has also developed multiple strategies to promote cross-state information sharing and provide technical assistance.

- **Medicaid Integrity Institute (MII),** developed and funded by CMS in collaboration with DOJ, provides ongoing training for state Medicaid program integrity staff, with the goal of raising national program integrity performance standards and professionalism (MII 2014) (Box 4-4). Since 2007, the MII has provided professional education to more than 3,300 Medicaid employees (CMS 2013c).

- **State Operations and Technical Assistance Initiative and Medicaid State Technical Assistance Teams** were developed by CMS to provide federal technical assistance to states on day-to-day operations and new initiatives, promote communication and information sharing with states, facilitate ACA implementation efforts, and support states in developing strategies to improve the efficiency of Medicaid programs in response to state budget challenges (CMS 2011).

- **Medicaid and CHIP Learning Collaboratives** were developed by CMS to facilitate policy and operational discussions among state and federal staff to address common challenges and pursue innovations in areas such as coverage, data analytics, value-based purchasing, and interfaces with the federally facilitated exchange. The collaboratives use virtual meetings to share ideas and documents, including technical assistance tools, state resources, and background materials (CMS 2014b).

- **Medicaid Leadership Institute (MLI),** a private initiative funded by The Robert Wood Johnson Foundation and directed by the Center for Health Care Strategies, was a 12-month fellowship program for state Medicaid directors that was designed to increase their substantive knowledge, strategic thinking, problem solving, technical, and leadership skills. Thirty Medicaid directors participated in the MLI program between 2010 and 2014, when funding expired (MLI 2014).

- **California Department of Health Care Services (DHCS) Academy** is a state-specific initiative funded by the California HealthCare Foundation to provide training for managers in DHCS. The curriculum focuses on core aspects of an effective, accountable program, including the basics of managing Medicaid, access to coverage and care, and delivery system innovation. Eight cohorts of 30 to 35 competitively selected staff will participate over four years.

Sharing resources among states

Traditionally, states developed Medicaid policies, operational procedures, and systems independently, even when responding to the same federal requirement or implementing a program model used by another state. Regular federal funding for information systems and policy development was previously available to each state, such that the federal government could reimburse multiple states for the development of similar infrastructure. The development of individualized systems and programs limited each state's ability to easily use policies and processes developed by other states.

Partnerships among states. To support efficiency and cost-effectiveness, states have begun to develop ways to partner with each other to share information, resources, and technology assets. Some states have formed organizations to foster collaboration. For example, the six New England states and the University of Massachusetts Medical School formed the New England States Consortium Systems Organization (NESCSO), a non-profit corporation that identifies collaborative opportunities (e.g., staff training), manages multistate projects (e.g., research on evidence-based procurement practices), and provides technical assistance to member states on policy and systems (NESCSO 2014). NESCSO is also developing a regional data warehouse with Medicaid Management Information System (MMIS) claims data to provide member states the ability to conduct timely comparative analyses using a shared data source (NESCSO 2014).

A small number of states have closely partnered to share information technology systems. Hawaii, which has one of the smallest Medicaid programs, has contracted with the Arizona Medicaid program to provide MMIS hardware and software for nearly 15 years. Michigan and Illinois recently announced a partnership that allows Illinois to access Michigan's MMIS as a shared service, rather than implement a stand-alone system. The partnership will allow Illinois to acquire a modernized MMIS more quickly and cost-effectively than if it procured its own system, and it is expected to reduce Michigan's cost to operate and maintain the system by 20 percent (IGNN 2013).

Federal support for sharing systems. CMS has encouraged states to leverage other states' business processes and systems where possible and explicitly makes enhanced federal funding for eligibility system development projects contingent (among other requirements) on the development of systems that promote sharing, leveraging, and reuse of Medicaid technologies within and among states (CMS 2012b). CMS also maintains the Collaborative Application Lifecycle Tool, a secure website where states can obtain other states' system development documents, including business process models, templates for concepts of operations and other planning and development artifacts, business and technical requirements, requests for proposals, statements of work, and system design documents (CMS 2014c).

Leveraging other state assets

At least 15 states have contracted with state universities to provide policy and analytical support to the Medicaid program (Coburn et al. 2007). Six states, including Maryland, Massachusetts, and Ohio, have developed full-time partnerships between the Medicaid agencies and research institutes associated with their state university that provide various types of support, including data warehousing and analysis, policy research, program evaluation, workforce development, and provider training (Scott 2012). University-based institutes provide a link between policy experts and students, which may stimulate interest in Medicaid program administration as a career path. The direct involvement of university staff in Medicaid operations may also inform curriculum innovations that help future agency staff and leaders develop the skills needed by the Medicaid program.

These partnerships experience challenges, including tensions around the objectivity and independence of the university research center when working for Medicaid on a politically controversial or sensitive issue (Coburn et al. 2007). However, both Medicaid agencies and universities report that they benefit from a long-term relationship that can support the identification of relevant research for the Medicaid program, as well as opportunities to leverage federal Medicaid funding (through contracts between the state Medicaid agency and the university) and private research funding (secured by university staff) to support Medicaid research initiatives.

Procuring external support

Under federal law, states can contract with external entities for most administrative functions, with the exception of enrollee outreach and enrollment (42 CFR 431.10, §1902(a)(5) of the Act). States can fill needs for highly technical expertise, short-term capacity demands, and ongoing staff support through consulting contracts or extensions to program support contracts. States commonly procure information technology support; 29 percent of programs have outsourced MMIS operations to outside vendors (NAMD 2014). Other areas for which states often procure support include program integrity, data analysis, managed care enrollment support, cost containment, call-center operations, program evaluation, and policy analysis.

It can be more costly (on a per hour basis) for states to hire external contractors to perform a task than to assign it to state staff, but in some cases it can be the more cost-effective approach. For example, federal rules require that managed care payment rates must be certified by an actuary (42 CFR 438.6), but between the high salaries commanded by actuaries (typically greater than public salaries) and intermittent demand for this expertise, most states find it more efficient to contract with an actuary, when needed. On the other hand, many states contract with long-term staff extenders to provide needed capacity when the agency is prevented (due to hiring freezes or labor rules) from directly employing or assigning the necessary staff. This approach can be more costly overall, as states generally pay contractors higher hourly rates than state employees and must reimburse travel and other expenses.

States that rely on contracting support for key program functions should have strong procurement and oversight capabilities and a variety of elements in place, including a well-constructed contract, multiple incentives (or disincentives) related to compliance, and clearly defined performance metrics. Effective oversight of these contracts also requires staff with adequate technical and management expertise to provide oversight and the authority to hold contractors accountable. However, a comprehensive review of Missouri's Medicaid operations found that oversight of contracted activities appeared limited as a result of staffing levels, skill sets, and a historical lack of institutional emphasis, and was further complicated by the fact that several Medicaid contractors were direct competitors and therefore required proactive state facilitation to ensure cooperation (The Lewin Group 2010). Recommendations for improvement included incorporating performance metrics such as key dates and activities into each contract and assigning a contract manager to each contractor to ensure adherence to contract terms (The Lewin Group 2010).

Streamlining information collection and support dissemination

In recent years, CMS has launched several initiatives designed to improve both the collection and dissemination of operational information for the Medicaid and CHIP programs, including:

- **Transformed Medicaid Statistical Information System (T-MSIS),** a data source that builds on existing person-level and claims-level MSIS data submitted by states to improve timeliness, reliability, and completeness;

- **Quality reporting systems,** systems to capture state-reported quality data based on measures developed by CMS as required by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) and the ACA;
- **Business process performance indicators,** a new set of core indicators for Medicaid and CHIP developed by CMS that will focus initially on individual (applicant and enrollee) experience with eligibility and enrollment and provider experience with enrollment and claims payment; and
- **MacPro,** a web-based system designed by CMS to replace paper-based state plan, waiver, and other programmatic documents with a structured electronic data format, which will provide more consistent and comprehensive information on state activities for use by CMS, states, and analysts.

As noted in MACPAC's June 2013 report to the Congress, modernizing the systems that collect programmatic information on Medicaid and CHIP would help strengthen the administrative capacity of states and the federal government in several ways (MACPAC 2013b). CMS could strengthen its program oversight by providing consistent and comprehensive information on state activities, and states could more easily learn about the policy choices made by others as they consider their own program changes. Better data would help CMS reduce reporting burdens by directly calculating certain measures reported elsewhere by states and could also help CMS and states understand the effectiveness of different strategies. However, implementation of these initiatives, which requires both information system and business process changes, is a multiyear endeavor, and none has been fully implemented as of early 2014.

Federal funding for specific activities

The federal government provides additional funding to support specific administrative activities through two mechanisms: increased matching funds and dedicated funds. These additional funds may allow states to, for example, invest in delivery system reforms that create the potential for long-term savings, even if they incur immediate operational costs. At MACPAC's April 2014 meeting, Medicaid policy experts speaking about the Medicaid health homes initiative emphasized to the Commission that offering enhanced match is a good way to encourage states to implement new program options that they would not be able to otherwise consider given state resource constraints (Moses et al. 2014).

Enhanced matching funds. States can receive a 75 percent federal match for certain administrative activities, including several that require clinical or information systems expertise (e.g., work done by skilled professional medical personnel, survey and certification of nursing facilities, operation of an approved MMIS for claims and information processing, certain eligibility worker activities, performance of medical and utilization review activities or external independent review of managed care activities, and operation of a state Medicaid fraud control unit). States can receive a 90 percent federal match during the design and implementation phases of certain activities, including new information systems and new fraud control units and a 75 percent match to operate these systems. States are allowed 100 percent match for the implementation and operation of immigration status verification systems.

Dedicated funds. The Congress has periodically provided funding to assist with the design, implementation, and initial operation of a variety of administrative activities intended to improve the efficiency and effectiveness of state

Medicaid programs. For example, the Deficit Reduction Act of 2005 established the Medicaid Transformation Grants program to encourage states to adopt innovative methods to improve their effectiveness and efficiency in providing medical assistance under Medicaid. Funding of $150 million was appropriated for federal FY 2007 and FY 2008 (CMS 2006b). The ACA included funding to support the Adult Medicaid Quality Grant Program, a two-year program designed to support state Medicaid agencies in developing staff capacity to collect, report, and analyze data on the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid through grants of up to $1 million per year over a two-year project period (CMS 2014d).

Next Steps for MACPAC

State Medicaid programs are required to "provide for methods of administration that are found by the Secretary to be necessary for the proper and efficient operation of the plan" (§1902(a)(4) of the Act). There is a general consensus that, given the scale of responsibilities of the Medicaid program—which includes the provision of health coverage to over 70 million individuals as well as the management of over $450 billion in public money—state and federal policymakers should seek value and high performance as well as efficiency. However, there are few clear standards to assess efficiency, value, or performance in state and federal Medicaid program administration. There is also little strong evidence on best practices in Medicaid program management and decision making, particularly compared to other large-scale public programs such as education.

MACPAC's future work in this area will focus on learning more to inform two key questions: (1) how should administrative performance be measured and (2) what strategies are most effective in helping states develop adequate capacity? We will focus on areas where Medicaid policy experts have identified critical needs: data analytics, staff development, and payment and delivery system reform.

Activities that will inform these questions may include a survey of the range of organizational models used by state Medicaid programs; a review of the performance metrics used by states, federal agencies, and private sector payers; and collection of the methods states use to assess the return on capacity-building investments. MACPAC will learn more about the strategies to strengthen Medicaid administrative capacity described in this chapter and how promising approaches can be better shared among states and with federal administrators and policymakers. We will also learn more about administrative standards, benchmarks, and methods used in other fields—such as information technology, employer-sponsored insurance, and public education—and look for opportunities to adapt to Medicaid those approaches that have worked well elsewhere.

Moving forward, the Commission will continue to focus on how to improve and modernize Medicaid at the state and federal levels, including reviewing administrative capacity, performance measures, and efforts to ensure accountability.

Endnotes

[1] MACPAC analysis of CMS-64 Financial Management Report net expenditure data. Excludes administrative activities that are exclusively federal (e.g., program oversight by CMS staff).

[2] The federal match for Medicaid administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions have a higher federal match. Those with a 75 percent federal match include compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency; pre-admission screening and resident review for individuals with mental illness or intellectual disability who are admitted to a nursing facility; survey and certification of nursing facilities; translation or interpretation services in connection with the enrollment of, retention of, and use of services by children of families for whom English is not the primary language; operation of an approved Medicaid Management Information System for claims and information processing; performance of medical and utilization review activities or external independent review of managed care activities; and operation of a state Medicaid fraud control unit.

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Appendix

Acronym List

AAPD	American Academy of Pediatric Dentistry
ABA	Applied Behavioral Analysis
ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families
ACO	Accountable Care Organization
ACS	American Community Survey
ADA	Americans with Disabilities Act
ADLs	Activities of Daily Living
AHRQ	Agency for Healthcare Research and Quality
APS	Annual Person Summary
ASPE	Assistant Secretary for Planning and Evaluation
BBA 97	Balanced Budget Act of 1997
BIP	Balancing Incentive Payments Program
BRFSS	Behavioral Risk Factor Surveillance System
CAHMI	Child and Adolescent Health Measurement Initiative
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBO	Congressional Budget Office
CCCESUN	Children with Chronic Conditions and Elevated Service Use or Need
CCIIO	Center for Consumer Information and Insurance Oversight
CCO	Coordinated Care Organization
CDC	U.S. Centers for Disease Control and Prevention
CHAMP-VA	Civilian Health and Medical Program of the Department of Veterans Affairs
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHNA	Community Health Needs Assessment
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
CSHCN	Children with Special Health Care Needs
CY	Calendar Year
DHCS	Department of Health Care Services
DOH	Department of Health
DOJ	U.S. Department of Justice
DSH	Disproportionate Share Hospital
ECP	Essential Community Provider
E-FMAP	Enhanced Federal Medical Assistance Percentage
EHB	Essential Health Benefit

EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FACS	Family and Children Services
FMAP	Federal Medical Assistance Percentage
FMR	Financial Management Report
FOA	Family Opportunity Act
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
FYE	Full-Year Equivalent
GAO	U.S. Government Accountability Office
GME	Graduate Medical Education
HCA	Health Care Authority
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
HRET	Health Research and Educational Trust
HRSA	Health Resources and Services Administration
IADLs	Instrumental Activities of Daily Living
ICD	International Classification of Diseases
ICF/ID	Intermediate Care Facility for Persons with Intellectual Disabilities
ID/DD	Intellectual or Developmental Disabilities
IGNN	Illinois Government News Network
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
IPUMS	Integrated Public Use Microdata Series
IRS	Internal Revenue Service
KCMU	Kaiser Commission on Medicaid and the Uninsured
KFF	Kaiser Family Foundation
LOC	Level of Care
LTSS	Long-Term Services and Supports
MACPAC	Medicaid and CHIP Payment and Access Commission
MAGI	Modified Adjusted Gross Income
MAX	Medicaid Analytic eXtract
MBES/CBES	Medicaid and CHIP Budget Expenditure System
MBI	Medicaid Buy-In
MCHB	Maternal and Child Health Bureau
MCO	Managed Care Organization
MDCH	Michigan Department of Community Health
MEPS	Medical Expenditure Panel Survey
MFP	Money Follows the Person
MII	Medicaid Integrity Institute
MITA	Medicaid Information Technology Architecture
MLI	Medicaid Leadership Institute
MLTSS	Managed Long-Term Services and Supports

MOE	Maintenance of Effort
MMCDCS	Medicaid Managed Care Data Collection System
MMIS	Medicaid Management Information System
MMNA	Monthly Maintenance of Need Allowance
MN	Medically Needy
MSIS	Medicaid Statistical Information System
MSTAT	Medicaid State Technical Assistance Teams
NAMD	National Association of Medicaid Directors
NASBO	National Association of State Budget Officers
NASHP	National Academy for State Health Policy
NASUAD	National Association of States United for Aging and Disabilities
NCHS	National Center for Health Statistics
NCQA	National Committee for Quality Assurance
NESCSO	New England States Consortium Systems Organization
NF	Nursing Facility
NHIS	National Health Interview Survey
NSCLC	National Senior Citizens Law Center
OFM	Office of Financial Management
OIG	Office of Inspector General
PACE	Program of All-Inclusive Care for the Elderly
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PERM	Payment Error Rate Measurement
PHAB	Public Health Accreditation Board
PHP	Prepaid Health Plan
PIHP	Prepaid Inpatient Health Plan
PNA	Personal Needs Allowance
QHP	Qualified Health Plan
QMB	Qualified Medicare Beneficiary
SDMI	Severe Disabling Mental Illness
SEDS	Statistical Enrollment Data System
SIL	Special Income Level
SMI	Serious Mental Illness
SOTA	State Operations and Technical Assistance Initiative
SSA	U.S. Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TBI/SCI	Traumatic Brain or Spinal Cord Injury
TEFRA	Tax Equity and Fiscal Responsibility Act
T-MSIS	Transformed Medicaid Statistical Information System
USPSTF	U.S. Preventive Services Task Force
VA	U.S. Department of Veterans Affairs

Authorizing Language from the Social Security Act (42 U.S.C. 1396)

MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as "MACPAC").

(b) DUTIES.—

  (1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

    (A) review policies of the Medicaid program established under this title (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI (in this section referred to as "CHIP") affecting access to covered items and services, including topics described in paragraph (2);

    (B) make recommendations to Congress, the Secretary, and States concerning such access policies;

    (C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

    (D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

  (2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

    (A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

      (i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

      (ii) payment methodologies; and

      (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

    (B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

    (C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

- (D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.
- (E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.
- (F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.
- (G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dually eligible individuals.
- (H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

- (A) review national and State-specific Medicaid and CHIP data; and
- (B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

- (A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.
- (B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—

- (A) IN GENERAL.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.
- (B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—
  - (i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on

disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).

(ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:

(I) Data relating to changes in the number of uninsured individuals.

(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term "appropriate committees of Congress" means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as "MedPAC") established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dually eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.— MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dually eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member

of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

  (5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.
  (6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—
  (1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);
  (2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;
  (3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));
  (4) make advance, progress, and other payments which relate to the work of MACPAC;
  (5) provide transportation and subsistence for persons serving without compensation; and
  (6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—
  (1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.
  (2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—
    (A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;
    (B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and
    (C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.
  (3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Commission Vote on Recommendation

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

CHIP and the New Coverage Landscape

1.1 The Congress should extend federal CHIP funding for a transition period of two additional years during which time the key issues regarding the affordability and adequacy of children's coverage can be addressed.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes:	Carte, Chambers, Checkett, Cohen, Gabow, Henning, Hoyt, Martínez Rogers, Moore, Riley, Rosenbaum, Rowland, Smith, Sundwall, Waldren
Not Present:	Edelstein,* Gray

*Commissioner Edelstein expressed support for the recommendation in writing based on his involvement in the previous day's discussions.

Biographies of Commissioners

Sharon L. Carte, M.H.S., has served as executive director of the West Virginia Children's Health Insurance Program since 2001. From 1992 to 1998, Ms. Carte was deputy commissioner for the Bureau for Medical Services overseeing West Virginia's Medicaid program. Prior to that, she was an administrator of skilled and intermediate care nursing facilities and before that, a coordinator of human resources development in the West Virginia Department of Health. Ms. Carte's experience includes work with senior centers and aging programs throughout the state of West Virginia and policy issues related to behavioral health and long-term care services for children. She received her master of health science from the Johns Hopkins University School of Public Health.

Richard Chambers is president of Molina Healthcare of California, a health plan serving more than 425,000 Medicaid, Medicare Advantage Special Needs Plan, dually eligible demonstration, and Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as ammended) marketplace members in six counties in California. Nationally, Molina Healthcare arranges for the delivery of health care services or offers health information management solutions for nearly 5.2 million individuals and families in 16 states. Before joining Molina Healthcare in 2012, Mr. Chambers was chief executive officer for nine years at CalOptima, a County Organized Health System providing health coverage to more than 400,000 low-income residents in Orange County, California. Mr. Chambers spent over 27 years working for the Centers for Medicare & Medicaid Services (CMS). While at CMS, he served as the director of the Family and Children's Health Programs Group, responsible for national policy and operational direction of Medicaid and CHIP. Mr. Chambers also served as associate regional administrator for Medicaid in the San Francisco regional office and as director of the Office of Intergovernmental Affairs in Washington, DC. He received a bachelor of arts in psychology from the University of Virginia. Mr. Chambers is a member of the Congressional Budget Office's Panel of Health Advisers.

Donna Checkett, M.P.A., M.S.W., is vice president of business development for Aetna's Medicaid division. Previously, she served as Aetna's vice president for state government relations, during which time a considerable focus of her work was the company's response to the ACA at the state insurance and Medicaid level. In her capacity as chief executive officer of Missouri Care, a managed Medicaid health plan owned by the University of Missouri-Columbia Health Care, Ms. Checkett started and directed all aspects of the plan. For eight years, Ms. Checkett served as the director of the Missouri Division of Medical Services (Medicaid), during which time she implemented a managed care program for more than 50 percent of the beneficiaries and also oversaw several significant optional eligibility expansions. Ms. Checkett was elected by her peers to serve as the chair of the National Association of State Medicaid Directors and was also a member of the National Governors Association Medicaid Improvements Working Group whose initial focus was on the use of 1115 waivers for health system reform purposes. She received a master of public administration from the University of Missouri-Columbia and a master of social work from The University of Texas at Austin.

Andrea Cohen, J.D. is senior vice president for program at the United Hospital Fund, a nonprofit health services research and philanthropic organization whose mission is to shape positive change in health care for New Yorkers. She directs the Fund's program work and oversees grantmaking and conference activities. From 2009 to 2014, she served as director of health services in the New York City Office of the Mayor, where she coordinated and developed strategies to improve public health and health services. Prior professional positions include counsel with Manatt, Phelps & Phillips, LLP; senior policy counsel at the Medicare Rights Center; health and oversight counsel for the U.S. Senate Committee on Finance; and trial attorney with the U.S. Department of Justice. She received her law degree from Columbia University School of Law.

Burton L. Edelstein, D.D.S., M.P.H., is a board-certified pediatric dentist and professor of dentistry and health policy and management at Columbia University. He is founding president of the Children's Dental Health Project, a national, non-profit, Washington, DC-based policy organization that promotes equity in children's oral health. Dr. Edelstein practiced pediatric dentistry in Connecticut and taught at the Harvard School of Dental Medicine for 21 years prior to serving as a 1996–1997 Robert Wood Johnson Foundation health policy fellow in the office of U.S. Senate leader Tom Daschle, with primary responsibility for CHIP. Dr. Edelstein worked with the U.S. Department of Health and Human Services (HHS) on its oral health initiatives from 1998 to 2001, chaired the U.S. Surgeon General's Workshop on Children and Oral Health, and authored the child section of *Oral Health in America: A Report of the Surgeon General*. His research focuses on children's oral health promotion and access to dental care, with a particular emphasis on Medicaid and CHIP populations. He received his degree in dentistry from the State University of New York at Buffalo School of Dentistry, his master of public health from Harvard University School of Public Health, and completed his clinical training at Boston Children's Hospital.

Patricia Gabow, M.D., was chief executive officer of Denver Health from 1992 until her retirement in 2012, transforming it from a department of city government into a successful, independent governmental entity. She is a trustee of the Robert Wood Johnson Foundation, serves on the Institute of Medicine (IOM) Roundtable on Value and Science Driven Health Care and on the National Governors Association Health Advisory Board, and was a member of the Commonwealth Commission on a High Performing Health System throughout its existence. Dr. Gabow is a professor of medicine at the University of Colorado School of Medicine and has authored over 150 articles and book chapters. She received her medical degree from the University of Pennsylvania School of Medicine. Dr. Gabow has received the American Medical Association's Nathan Davis Award for Outstanding Public Servant, the Ohtli Award from the Mexican government, the National Healthcare Leadership Award, the David E. Rogers Award from the Association of American Medical Colleges, and the Health Quality Leader Award from the National Committee for Quality Assurance (NCQA). She was elected to the Association for Manufacturing Excellence Hall of Fame for her work on applying the Toyota Production Systems to health care.

Herman B. Gray, M.D., M.B.A., is executive vice president for pediatric health services for the Detroit Medical Center (DMC), a member of the Tenet Healthcare Corporation. Prior to assuming his current responsibility in 2013, Dr. Gray served as CEO/president of the DMC Children's Hospital of Michigan (CHM) for eight years. At CHM, Dr. Gray also served as the chief operating officer, chief of staff, and vice chief of education in the department of pediatrics. He also served as the vice president for graduate medical education (GME) at the DMC and associate dean for GME at Wayne State University School of Medicine. Dr.

Gray has served as the chief medical consultant at the Michigan Department of Public Health, Children's Special Health Care Services, as well as vice president/medical director of clinical affairs at Blue Care Network, a subsidiary of Blue Cross Blue Shield of Michigan. Dr. Gray has received the Michigan Hospital Association Health Care Leadership Award, *Modern Healthcare's* Top 25 Minority Executives in Healthcare Award, and is a member of the board of trustees for the Children's Hospital Association and the Skillman Foundation. He received his medical degree from the University of Michigan, a master of business administration from the University of Tennessee, and completed his pediatrics training at the Children's Hospital of Michigan/Wayne State University.

Denise Henning, C.N.M., M.S.N., is clinical director for women's health at Collier Health Services, a federally qualified health center in Immokalee, Florida. A practicing nurse midwife, Ms. Henning provides prenatal and gynecological care to a service population that is predominantly uninsured or covered by Medicaid. From 2003 to 2008, she was director of clinical operations for Women's Health Services at the Family Health Centers of Southwest Florida, where she supervised the midwifery and other clinical staff. Prior to this, Ms. Henning served as a certified nurse midwife in Winter Haven, Florida, and as a labor and delivery nurse in a Level III teaching hospital. She is a former president of the Midwifery Business Network. She received her master of science in nurse midwifery from the University of Florida in Jacksonville and her bachelor of science in nursing from the University of Florida in Gainesville. She also holds a degree in business management from Nova University in Fort Lauderdale, Florida.

Mark Hoyt, F.S.A., M.A.A.A., was the national practice leader of the Government Human Services Consulting group of Mercer Health & Benefits, LLC, until his retirement in 2012. This group helps states purchase health services for their Medicaid and CHIP programs and has worked with over 30 states. He joined Mercer in 1980 and worked on government health care projects starting in 1987, including developing strategies for statewide health reform, evaluating the impact of different managed care approaches, and overseeing program design and rate analysis for Medicaid and CHIP programs. Mr. Hoyt is a fellow in the Society of Actuaries and a member of the American Academy of Actuaries. He received a bachelor of arts in mathematics from the University of California at Los Angeles and a master of arts in mathematics from the University of California at Berkeley.

Judith Moore is an independent consultant specializing in policy related to health, vulnerable populations, and social safety net issues. Ms. Moore's expertise in Medicaid, Medicare, long-term services and supports, and other state and federal programs flows from her career as a federal senior executive who served in the legislative and executive branches of government. At the Health Care Financing Administration (now CMS), Ms. Moore served as director of the Medicaid program and of the Office of Legislation and Congressional Affairs. Her federal service was followed by more than a decade as co-director and senior fellow at The George Washington University's National Health Policy Forum, a non-partisan education program serving federal legislative and regulatory health staff. In addition to other papers and research, she is co-author with David G. Smith of a political history of Medicaid: *Medicaid Politics and Policy*.

Trish Riley, M.S., is a senior fellow of health policy and management at the Muskie School of Public Service, University of Southern Maine. Following her tenure as director of the Maine Governor's Office of Health Policy and Finance, she was the first distinguished visiting fellow in state health policy at The George Washington University where she serves as a lecturer. She was a principal architect of the Dirigo Health Reform Act of 2003, which was enacted to increase access, reduce costs, and improve quality of health care in Maine. Ms. Riley previously served as executive director of the National Academy for State Health Policy and as president of its corporate board. Under four Maine governors, she held appointed positions, including executive director of the Maine Committee on Aging, director of the Bureau of Maine's Elderly, associate deputy commissioner of health and medical services, and director of the Bureau of Medical Services responsible for the Medicaid program and health planning and licensure. Ms. Riley served on Maine's Commission on Children's Health, which planned the State Children's Health Insurance Program. She is a member of the Kaiser Commission on Medicaid and the Uninsured and has served as a member of the IOM's Subcommittee on Creating an External Environment for Quality and its Subcommittee on Maximizing the Value of Health. Ms. Riley has also served as a member of the board of directors of NCQA. She received her master of science in community development from the University of Maine.

Norma Martínez Rogers, Ph.D., R.N., F.A.A.N., is a professor of family nursing at The University of Texas (UT) Health Science Center at San Antonio. Dr. Martínez Rogers has held clinical and administrative positions in psychiatric nursing and at psychiatric hospitals, including the William Beaumont Army Medical Center in Fort Bliss during Operation Desert Storm. She has initiated a number of programs at the UT Health Science Center at San Antonio, including a mentorship program for retention of minorities in nursing education. She was a founding board member of a non-profit organization, Martínez Street Women's Center, designed to provide support and educational services to women and teenage girls. Dr. Martínez Rogers is a fellow of the American Academy of Nursing and a past president of the National Association of Hispanic Nurses. She received a master of science in psychiatric nursing from the UT Health Science Center at San Antonio and her doctorate in cultural foundations in education from The University of Texas at Austin. She is dedicated to working with those who face health disparities.

Sara Rosenbaum, J.D., is founding chair of the Department of Health Policy and the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University Milken Institute School of Public Health. She also serves on the faculties of The George Washington Schools of Law and Medicine. Professor Rosenbaum's research has focused on how the law intersects with the nation's health care and public health systems, with a particular emphasis on insurance coverage, managed care, the health care safety net, health care quality, and civil rights. She is a member of the IOM and has served on the boards of numerous national organizations, including AcademyHealth. Professor Rosenbaum is a past member of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices and also serves on the CDC Director's Advisory Committee. She has advised the Congress and presidential administrations since 1977 and served on the staff of the White House Domestic Policy Council during the Clinton administration. Professor Rosenbaum is the lead author of *Law and the American Health Care System*, published by Foundation Press (2012). She received her law degree from Boston University School of Law.

Diane Rowland, Sc.D., is executive vice president of the Kaiser Family Foundation and executive director of the Foundation's Kaiser Commission on Medicaid and the Uninsured. She is a nationally recognized health policy expert with a distinguished career in public policy and research focusing on health insurance coverage, access to care, and health care financing for low-income, elderly, and disabled populations. She has directed the Kaiser Commission on Medicaid and the Uninsured since 1991 and overseen the foundation's health policy work on

Medicaid, Medicare, private insurance, global health and HIV, women's health, and disparities since 1993. A noted authority on Medicaid, Medicare and health care policy, Dr. Rowland frequently testifies and has published widely on these issues. Appointed in 2009 as the inaugural chair, Dr. Rowland continues to serve as the chair of MACPAC. Dr. Rowland is an elected member of the IOM and holds a bachelor's degree from Wellesley College, a master of public administration from the University of California at Los Angeles, and a doctor of science in health policy and management from The Johns Hopkins University.

Robin Smith and her husband Doug have been foster and adoptive parents for many children covered by Medicaid, including children who are medically complex and have developmental disabilities. Her experience seeking care for these children has included working with an interdisciplinary Medicaid program called the Medically Fragile Children's Program, a national model partnership between the Medical University of South Carolina Children's Hospital, South Carolina Medicaid, and the South Carolina Department of Social Services. Ms. Smith serves on the Family Advisory Committee for the Children's Hospital at the Medical University of South Carolina. She has testified at congressional briefings and presented at the 2007 International Conference of Family Centered Care and at grand rounds for medical students and residents at the Medical University of South Carolina.

David Sundwall, M.D., serves as vice chair of MACPAC. He is a clinical professor of public health at the University of Utah School of Medicine, Division of Public Health, where he has been a faculty member since 1978. He served as executive director of the Utah Department of Health and commissioner of health for the state of Utah from 2005 through 2010. He currently serves on numerous government and community boards and advisory groups in his home state, including as chair of the Utah State Controlled Substance Advisory Committee. Dr. Sundwall was president of the Association of State and Territorial Health Officials from 2007 to 2008. He has chaired or served on several committees of the IOM and is currently on the IOM Standing Committee on Health Threats Resilience. Prior to returning to Utah in 2005, he was president of the American Clinical Laboratory Association and before that was vice president and medical director of American Healthcare Systems. Dr. Sundwall's federal government experience includes serving as administrator of the Health Resources and Services Administration, assistant surgeon general in the Commissioned Corps of the U.S. Public Health Service, and director of the health staff of the U.S. Senate Labor and Human Resources Committee. He received his medical degree from the University of Utah School of Medicine, and completed his residency in the Harvard Family Medicine Program. He is a licensed physician, board-certified in internal medicine and family practice, and works as a primary care physician in a public health clinic two half-days each week.

Steven Waldren, M.D., M.S., is senior strategist for health information technology (IT) at the American Academy of Family Physicians. He also serves as vice chair of the American Society for Testing Materials' E31 Health Information Standards Committee. Dr. Waldren sits on several advisory boards dealing with health IT, and he was a past co-chair of the Physicians Electronic Health Record Coalition, a group of more than 20 professional medical associations addressing issues around health IT. He received his medical degree from the University of Kansas School of Medicine. While completing a post-doctoral National Library of Medicine medical informatics fellowship, he completed a master of science in health care informatics from the University of Missouri-Columbia. Dr. Waldren is a co-founder of two start-up companies dealing with health IT systems design: Open Health Data, Inc., and New Health Networks, LLC.

Biographies of Staff

Annie Andrianasolo, M.B.A., is executive assistant. She previously held the position of special assistant for global health at the Public Health Institute and was a program assistant for the World Bank. Ms. Andrianasolo has a bachelor of science in economics and a master of business administration from the Johns Hopkins Carey Business School.

Amy Bernstein, Sc.D., M.H.S.A., is policy director and contracting officer. She manages and provides oversight and guidance for all MACPAC research, data, and analysis contracts, including statements of work, research plans, and all deliverables and products. She also directs analyses on Medicaid dental and maternity care policies and Medicaid's role in promoting population health. Her previous positions have included director of the Analytic Studies Branch at the U.S. Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, and senior analyst positions at the Alpha Center, the Prospective Payment Assessment Commission, the National Cancer Institute, and the Agency for Healthcare Research and Quality (AHRQ). Dr. Bernstein earned a master of health services administration from the University of Michigan School of Public Health and a doctor of science from the School of Hygiene and Public Health at The Johns Hopkins University.

James Boissonnault, M.A., is chief information officer. Prior to joining MACPAC, he was the information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he also worked on several federal government projects, including those for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts degree in Slavic languages and literatures from the University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

Vincent Calvo is an administrative assistant. Previously, he was an intern at Financial Executives International, where he focused on researching the effects of health and tax laws on Fortune 500 companies. Mr. Calvo holds a bachelor of science from Austin Peay State University.

Kathryn Ceja is director of communications. Previously, she worked in the press office at the Centers for Medicare & Medicaid Services (CMS), where she served as the lead spokesperson on Medicare issues. Prior to her assignment in the CMS press office, Ms. Ceja served as a speechwriter to the Secretary of the U.S. Department of Health and Human Services (HHS) and as the speechwriter to a series of CMS administrators. Ms. Ceja holds a bachelor of science from American University.

Veronica Daher, J.D., is a senior analyst. Her work has focused on implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148). Previously, she was a health policy analyst for the Health Safety Net program at the Massachusetts Executive Office of Health and Human Services, where she focused on developing policy in response to the ACA. Ms. Daher received her law degree from the University of Richmond and a bachelor of arts from the University of Virginia.

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Moira Forbes, M.B.A., is a policy director focusing on issues relating to payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and CHIP. Previously, Ms. Forbes served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. At Lewin, Ms. Forbes worked with every state Medicaid and CHIP program on issues relating to program integrity and eligibility quality control. She also has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

April Grady, M.P.Aff., is a policy director. Prior to joining MACPAC, Ms. Grady worked at the Congressional Research Service and the Congressional Budget Office, where she provided non-partisan analyses of Medicaid, private health insurance, and other health policy issues. She also has held positions at the LBJ School of Public Affairs at The University of Texas at Austin and at Mathematica Policy Research. Ms. Grady received a master of public affairs from the LBJ School of Public Affairs and a bachelor of arts in policy studies from Syracuse University.

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Angela Lello, M.P.Aff., is a senior analyst. Her work focuses on Medicaid for people with disabilities, particularly long-term services and supports (LTSS). Previously, she was a Kennedy Public Policy Fellow at the Administration on Intellectual and Developmental Disabilities, conducting policy research and analysis on a variety of HHS initiatives. Her prior work included analyzing and developing LTSS for people with disabilities while at the Texas Department of Aging and Disability Services and the Texas Council for Developmental Disabilities. Ms. Lello received a master of public affairs from the LBJ School of Public Affairs at The University of Texas.

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Chris Park, M.S., is a senior analyst. His work focuses on issues related to managed care payment and Medicaid drug policy and on providing data analyses using Medicaid administrative data. Prior to joining MACPAC, he was a senior consultant at The Lewin Group. At Lewin, he provided quantitative analyses and technical assistance on Medicaid policy issues, including Medicaid managed care capitation rate setting and pharmacy reimbursement and cost-containment initiatives. Mr. Park has a master of science in health policy and management from the Harvard School of Public Health and a bachelor of science in chemistry from the University of Virginia.

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Ken Pezzella is chief financial officer. He has more than 10 years of federal financial management and accounting experience in both the public and private sectors. Mr. Pezzella also has broad operations and business experience, and is a veteran of the U.S. Coast Guard. He holds a bachelor of science in accounting from Strayer University.

Anne L. Schwartz, Ph.D., is executive director. Dr. Schwartz previously served as deputy editor at *Health Affairs*; as vice president at Grantmakers In Health, a national organization providing strategic advice and educational programs for foundations and corporate giving programs working on health issues; and as special assistant to the executive director and senior analyst at the Physician Payment Review Commission, a precursor to the Medicare Payment Advisory Commission (MedPAC). Earlier, she held positions on committee and personal staff for the U.S. House of Representatives. Dr. Schwartz earned a doctorate in health policy from the School of Hygiene and Public Health at The Johns Hopkins University.

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Anna Sommers, Ph.D., M.S., M.P.Aff., is a principal analyst. Dr. Sommers has conducted health services research related to Medicaid programs for over 15 years. Previously, she was a senior health researcher at the Center for Studying Health System Change in Washington, DC. Prior to that, she was a senior research analyst at The Hilltop Institute, University of Maryland, Baltimore County, and a research associate at the Urban Institute. Dr. Sommers received a doctorate and master of science in health services research, policy, and administration from the University of Minnesota School of Public Health, and a master of public affairs from the University of Minnesota's Hubert H. Humphrey Institute of Public Affairs.

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