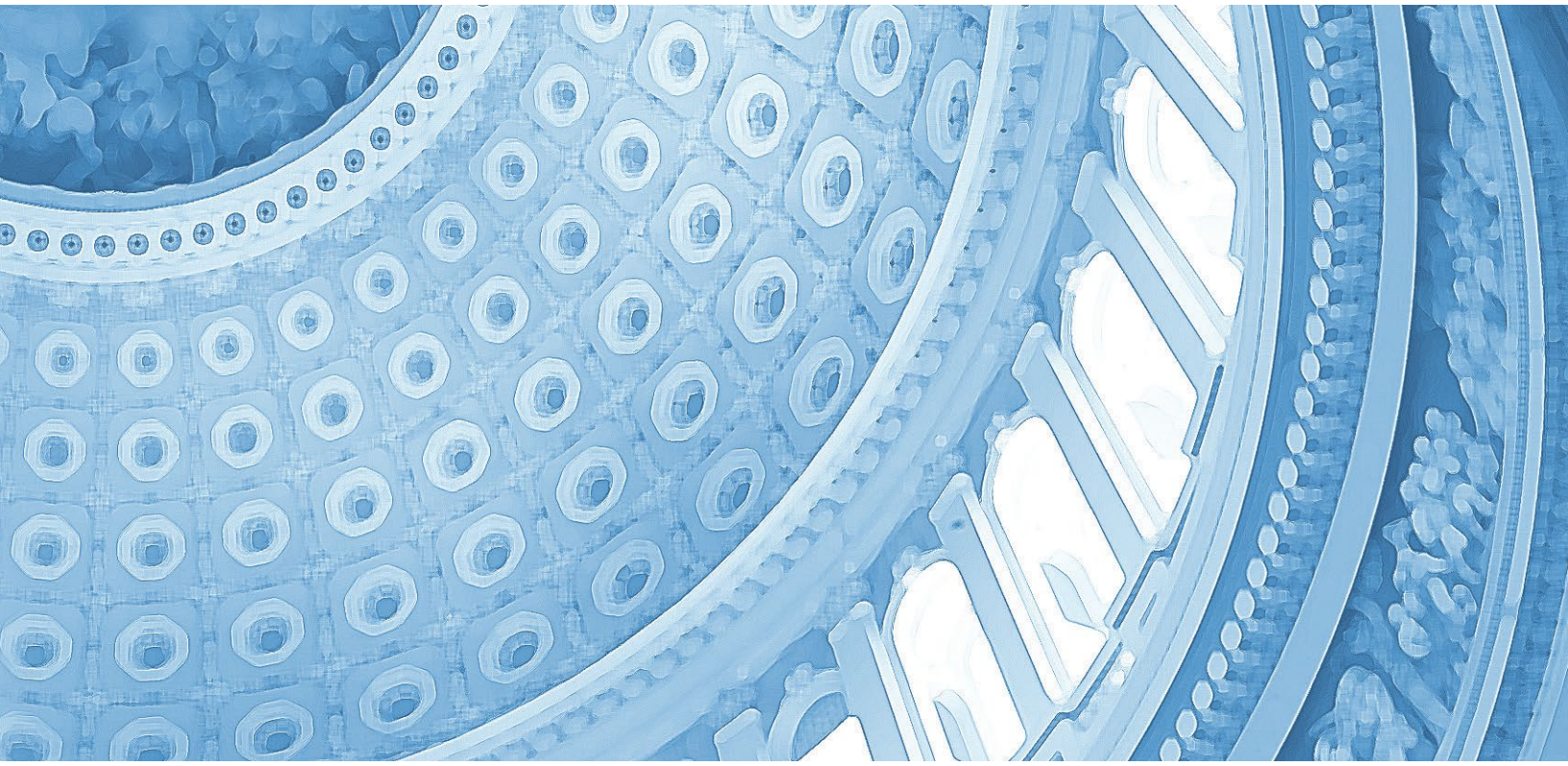
MACPAC

Medicaid and CHIP Payment and Access Commission



Report to the Congress on Medicaid and CHIP

March 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:

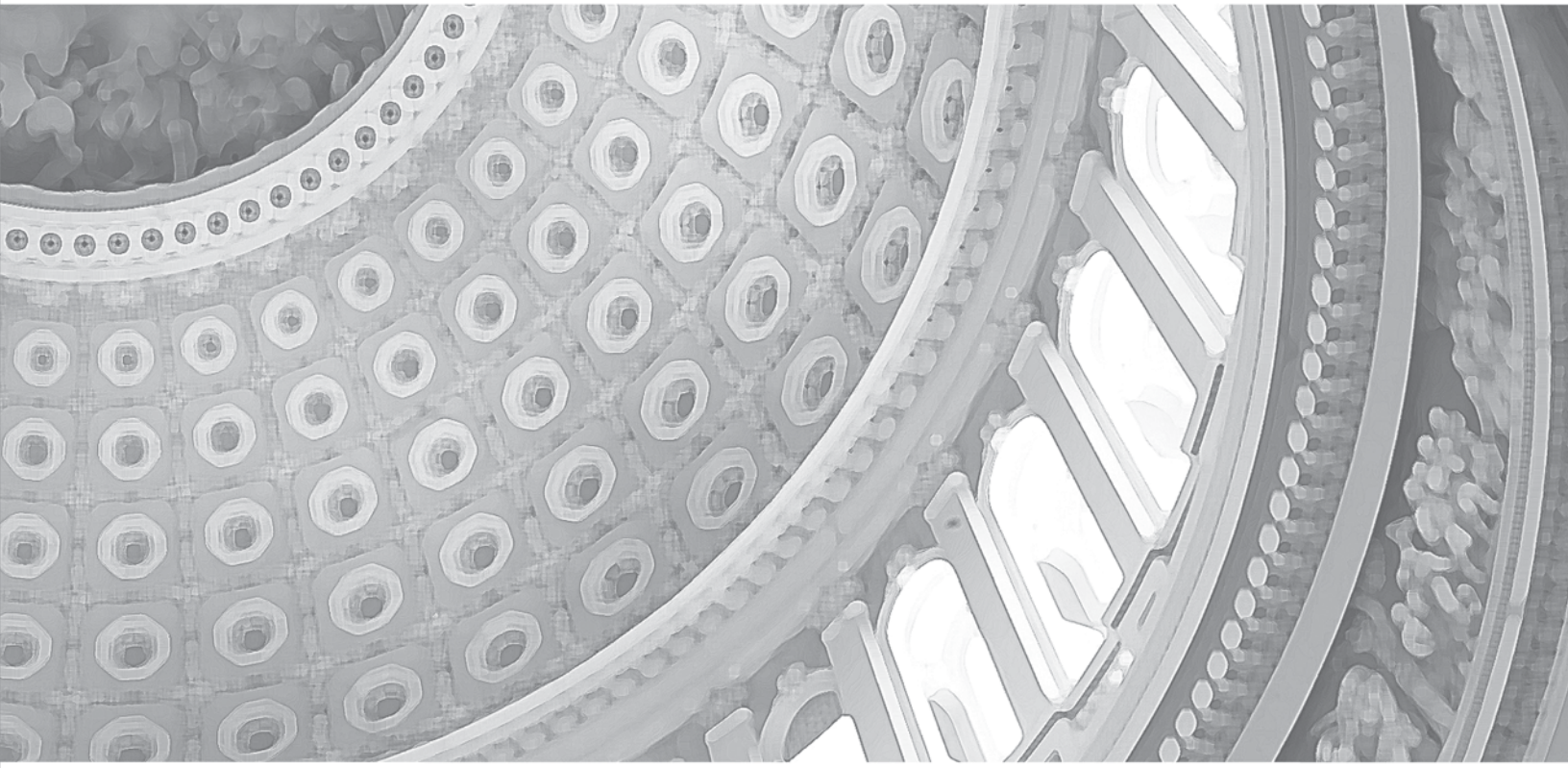
- eligibility and enrollment,
- access to care,
- payment policies,
- benefits and coverage policies,
- quality of care, and
- the interaction of Medicaid and CHIP with Medicare and the health care system, and
- data to support policy analysis and program accountability.

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.

MACPAC

Medicaid and CHIP Payment and Access Commission



Report to the Congress on Medicaid and CHIP

March 2014

MACPAC

Medicaid and CHIP Payment and Access Commission

1800 M Street, NW
Suite 350 N
Washington, DC 20036
Phone: (202) 273-2460
Fax: (202) 273-2452
www.macpac.gov

Commissioners

Diane Rowland, ScD, *Chair*

David Sundwall, MD, *Vice Chair*

Sharon Carte, MHS

Richard Chambers

Donna Checkett, MPA, MSW

Andrea Cohen, JD

Burton Edelstein, DDS, MPH

Patricia Gabow, MD

Herman Gray, MD, MBA

Denise Henning, CNM, MSN

Mark Hoyt, FSA, MAAA

Norma Martinez Rogers, PhD, RN, FAAN

Judith Moore

Trish Riley, MS

Sara Rosenbaum, JD

Robin Smith

Steven Waldren, MD, MS

Anne L. Schwartz, PhD, *Executive Director*

March 14, 2014

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

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

Dear Mr. Vice President and Mr. Speaker:

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit MACPAC's *March 2014 Report to the Congress* in accordance with the statutory requirement that we submit an annual report to the Congress no later than March 15. As in prior years, our work focuses on the important and longstanding role of Medicaid and the State Children's Health Insurance Program (CHIP) in providing health care coverage to one-third of all children, many low-wage workers and their families, low-income seniors also covered by Medicare, people with physical and mental disabilities, and other low-income individuals. Jointly administered by the federal government and the states, the programs reach about a quarter of the U.S. population. They account for 15.4 percent of total U.S. health care spending.

As a nonpartisan analytic commission charged with providing policy and data analysis to the Congress on Medicaid and CHIP and making recommendations to the Congress, with the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of issues affecting these programs, MACPAC has set five priorities to guide its analyses in 2014. These include:

- implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148 as amended), focusing on areas of interaction among Medicaid, CHIP, and exchange coverage;
- children's coverage and the current status and future of CHIP;
- cost containment and delivery and payment system improvements to promote efficiency and value;

- Medicaid's role in providing care for high-cost high-need enrollees including those dually eligible for Medicare and Medicaid; and
- state and federal administrative capacity to manage the programs.

The analyses and recommendations presented in the March 2014 report reflect these priorities, beginning with four chapters focused on the interaction among Medicaid, CHIP, and exchange coverage. As in our March 2013 report, the Commission considers the issue of insurance stability, making recommendations to the Congress for ways to smooth transitions among sources of coverage as income and family circumstances change. We also look closely at aligning pregnancy coverage within state Medicaid programs and between Medicaid and the exchanges. The final chapter in this section looks at program integrity issues raised by new eligibility and income verification policies and processes.

As we continue to analyze payment policy, in this report the Commission considered the impact of non-DSH supplemental payments on total Medicaid payments to hospitals and nursing facilities. In light of these analyses, the Commission recommends steps to promote transparency through public reporting of non-DSH supplemental payments in a standardized format.

The March report also begins to address the future of CHIP, an important issue given that federal funding currently runs out after fiscal year 2015. The context for this program serving low-income children with incomes too high to qualify for Medicaid has changed substantially since it was first enacted in 1997, providing a new opportunity to consider a long-term vision for children's health coverage. In this report, we recommend eliminating waiting periods and eliminating premiums for those at the lowest end of the income scale. We plan to broaden our analyses of CHIP in our June 2014 report to consider other aspects of the program, including cost sharing, benefits, network adequacy, enrollment, and financing.

Finally MACStats, a standing supplement on key Medicaid statistics, has been enhanced to include new information to track Medicaid beneficiaries' access to care.

MACPAC is committed to providing the Congress and others with in-depth, nonpartisan analysis of Medicaid and CHIP and their impact on beneficiaries, states, providers, and the larger health care sector. We hope our analytic work and recommendations in this report will prove useful in assisting the Congress in identifying ways to strengthen the programs, particularly at this time of change in health care and health policy.

Sincerely,

Diane Rowland, ScD
Chair

Enclosure

Commission Members and Terms

Diane Rowland, Sc.D., Chair
Washington, DC

David Sundwall, M.D., Vice Chair
Salt Lake City, UT

Term Expires December 2014

Richard Chambers
Palm Springs, CA

Burton Edelstein, D.D.S., M.P.H.
New York, NY

Denise Henning, C.N.M., M.S.N.
Ft. Myers, FL

Judith Moore
Annapolis, MD

Robin Smith
Awendaw, SC

David Sundwall, M.D.
Salt Lake City, UT

Term Expires December 2015

Donna Checkett, M.P.A., M.S.W.
Phoenix, AZ

Patricia Gabow, M.D.
Denver, CO

Mark Hoyt, F.S.A., M.A.A.A.
Phoenix, AZ

Trish Riley, M.S.
Brunswick, ME

Diane Rowland, Sc.D.
Washington, DC

Steven Waldren, M.D., M.S.
Kansas City, MO

Term Expires December 2016

Sharon Carte, M.H.S.
South Charleston, WV

Andrea Cohen, J.D.
New York, NY

Herman Gray, M.D., M.B.A.
West Bloomfield, MI

Norma Martínez Rogers, Ph.D., R.N., F.A.A.N.
San Antonio, TX

Sara Rosenbaum, J.D.
Alexandria, VA

Commission Staff

Anne L. Schwartz, Ph.D.
Executive Director

Office of the Executive Director

Annie Andrianasolo, M.B.A.

Amy Bernstein, Sc.D., M.H.S.A.

Kathryn Ceja

Lindsay Hebert, M.S.P.H.

Mary Ellen Stahlman, M.H.S.A.

Analytic Staff

Veronica Daher, J.D.

Benjamin Finder, M.P.H.

Moira Forbes, M.B.A.

April Grady, M.P.Aff.

Angela Lello, M.P.Aff.

Molly McGinn-Shapiro, M.P.P.

Chinonye Onwunli Onwuka, M.P.H., M.S.

Chris Park, M.S.

Chris Peterson, M.P.P.

Anna Sommers, Ph.D., M.S., M.P.Aff.

James Teisl, M.P.H.

Operations and Management

Ricardo Villeta, M.B.A.
Deputy Director of Operations, Finance, and Management

Vincent Calvo

Benjamin Granata

Saumil Parikh, M.B.A.

Ken Pezzella

Eileen Wilkie

Acknowledgements

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

The Commission was fortunate to receive insight from staff of the U.S. Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, as we were preparing this report. We would like to specifically thank Nancy DeLew, Kristin Fan, Chrissy Fowler, Adam Goldstein, Cindy Mann, Linda Nablo, Christie Peters, and Andy Schneider for their contributions and guidance. The Congressional Budget Office provided the Commission with budget estimates for the policy recommendations included in this report. We would like to thank Kristin Blom, Jean Hearne, Lisa Ramirez-Branum, Robert Stewart, and Ellen Werble for their assistance.

We also received indispensible feedback from several state Medicaid and CHIP officials, including Cathy Caldwell, Jerry Dubberly, Rebekah Gee, Darin Gordon, Lawrence Kissner, Lisa Lee, Rebecca Mendoza, Justin Senior, and Colleen Sonosky.

Several research and policy experts provided the Commission with technical feedback and guidance, including Deborah Bachrach, Christina Bethell, Matt Bramlett, Tricia Brooks, Cheryl Camillo, Cheryl Austein Casnoff, Mike Cheek, Robin A. Cohen, Sarah Dash, Tom Dehner, Gretchen Engquist, Brett Fried, Ray Hanley, Elizabeth Hargrave, Martha Heberlein, Joan Henneberry, Cathy Hess, Steve Hill, Xiaoyi Huang, Julie Hudson, Genevieve Kenney, Ann Kohler, Alice Lam, Kristina Lowell, Kevin Lucia, Andrea Maresca, Jim Marton, Billy Millwee, Meg Murray, Mark Podrazik, Stan Rosenstein, Matt Salo, Thomas Selden, Dipti Singh, Dennis Smith, Craig Srsen, Michelle Sternthal, Michelle Strollo, Jim Verdier, and Vikki Wachino.

The Commission received valuable programming and data support from Alina Bogdanov, Steven Merry, Ben Sheng, Nebyou Solomon, Nate Willard, and colleagues from Acumen, LLC; Salam Abdus, Jacob Feldman, Heather Seid, Lan Zhao, and colleagues from Social & Scientific Systems, Inc.; and from Sandra Decker and Esther Hing from the National Center for Health Statistics.

Finally, the Commission would like to thank Lynette Bertsch 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 Kevin Kempske, Rachel Jochem, Jennifer Dame, Mary Knepper, and Danielle Koch at GKV Communications, who were instrumental in formatting and producing this report.

Table of Contents

Commission Members and Terms ..... **vii**

Commission Staff ..... **ix**

Acknowledgements ..... **xi**

Executive Summary ..... **xix**

Chapter 1: Medicaid and CHIP in the Context of the ACA **1**

Health Insurance Coverage under the ACA 4
The Intersection of Medicaid, CHIP, and the Exchanges 9
Future Issues 11
Endnotes 13
References 14
Chapter 1 Appendix 16

Chapter 2: Promoting Continuity of Medicaid Coverage among Adults under Age 65 ..... **19**

Impact of Coverage Changes 22
Income Changes among Parents and Childless Adults below 138 Percent FPL 23
Strategies to Improve Continuity of Coverage among Parents and Childless Adults 27
Endnotes 34
References 35

Chapter 3: Issues in Pregnancy Coverage under Medicaid and Exchange Plans **39**

Medicaid Eligibility and Benefits for Pregnant Women 42
Changes to Medicaid Coverage in 2014 44
Interactions between Medicaid and Exchange Coverage for Pregnant Women 48
Commission Recommendations 50
Recommendation 3.1 50
Recommendation 3.2 52
Endnotes 54
References 56
Chapter 3 Appendix 57

MACStats: Medicaid and CHIP Program Statistics **61**

Overview 64
MACStats Appendix 129

Chapter 4: ACA Eligibility Changes: Program Integrity Issues **143**

Eligibility Policy and Process Issues Post-MAGI 146
Strategies to Support Program Integrity 150

Policy Considerations 151
Endnotes 153
References 153

Chapter 5: Children's Coverage under CHIP and Exchange Plans....155

Key Features of CHIP Today 158
Weighing the Future of CHIP 159
Issues for CHIP in the Near Term....162
Promoting continuity of children's coverage in CHIP 162
Commission Recommendations 167
Recommendation 5.1 167
CHIP premiums....168
Commission Recommendations 174
Recommendation 5.2 174
Endnotes 176
References 178
Chapter 5 Appendix....180

Chapter 6: Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments 183

Background 187
Supplemental payments 187
Health care related taxes....190
Insufficient data on health care related taxes and supplemental payments complicate Medicaid payment analysis 190
Understanding Medicaid Payments to Hospitals and Nursing Facilities: State Analysis 192
Methods 192
State payment and financing policies....194
Findings....197
Interpreting the results....200
Commission Recommendations 202
Recommendation 6.1 202
Endnotes 206
References 208

Appendix.... 211

Acronym List 213
Authorizing Language from the Social Security Act (42 U.S.C. 1396)....217
Record of Commission Votes on Recommendations....223
Biographies of Commissioners 227
Biographies of Staff 233

List of Figures

FIGURE 1-1. States Expanding Medicaid in 2014, as of February 18, 2014 5

FIGURE 1-2. West Virginia Income Eligibility Levels in 2013 and 2014 as a Percentage of FPL 6

FIGURE 1-3. Texas Income Eligibility Levels in 2013 and 2014 as a Percentage of FPL 7

FIGURE 1-4. Point-in-Time Eligibility Estimates for Insurance Coverage and Simulated Eligibility for ACA Insurance Affordability Programs for Non-Elderly, Non-Disabled Children, Parents, and Other Adults at or below 400 Percent FPL, 2014 8

FIGURE 2-1. Income Eligibility Levels for Parents under the Section 1931 and New Adult Eligibility Groups by State 23

FIGURE 2-2. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 4 Months 24

FIGURE 2-3. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 8 Months 25

FIGURE 2-4. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 12 Months 25

FIGURE 2-5. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases above 138 Percent FPL Observed at 4, 8, and 12 Months 26

FIGURE 2-6. Percent of Parents under Age 65 Who Experience an Increase in Income Level Observed at 4 Months 26

FIGURE 3-1. Women in Pregnancy-Related Pathways Over 100 Percent of the Federal Poverty Level (FPL): Coverage Options 46

FIGURE 4-1. Illustrative Impact of Medicaid Eligibility Determination Process Changes on Potential for Eligibility Errors 147

FIGURE 5-1. Source of Health Insurance in September for Children between 125 Percent and 199 Percent Federal Poverty Level (FPL) Who Were Uninsured in December 166

FIGURE 5-2. Estimated Distribution of CHIP-Enrolled Children Charged CHIP Premiums, by Federal Poverty Level (FPL) 171

FIGURE 5-3. Simulated Effect of $120 Increase in Annual Premiums on Medicaid and CHIP Children above 100 Percent Federal Poverty Level (FPL) 172

FIGURE 5-4. Percent of Income for Out-of-Pocket Premiums for Subsidized Exchange Coverage in the Second Lowest-Cost Silver Plan, by Federal Poverty Level (FPL) 173

FIGURE 6-1. Proportion of Claims-Based and Supplemental Payments to Hospitals in Each Study State, Including and Excluding DSH Payments (SFY 2012) 198

List of Boxes

Box 3-1. Example of Medicaid Coverage for a Woman Below 138 Percent of the Federal Poverty Level (FPL) in an Expansion State with Pregnancy-Related Service Coverage Only 47

Box 3-2. Example of Coverage for a Woman above 138 Percent of the Federal Poverty Level (FPL) in a State with Medicaid Coverage for Pregnancy-Related Services Only 47

Box 6-1. Glossary of Key Terms 186

Box 6-2. The Interaction between Upper Payment Limits (UPLs) and Medicaid Managed Care 189

Box 6-3. State-Specific Features of Diagnosis-Related Group (DRG) Hospital Payment Methods in Study States 196

List of Tables

TABLE 3-1. Benefits under Mandatory and Optional Medicaid Eligibility Pathways for which Pregnancy Status is an Eligibility Factor 43

TABLE 3-A-1. Medicaid Eligibility Levels, Limits on Pregnancy-Related Benefits, Number of Medicaid Births, and Status of Medicaid Expansion 57

TABLE 5-1. CHIP Waiting Periods by State (Months) 165

TABLE 5-2. Premium and Enrollment Fee Requirements for Children in CHIP-Funded Coverage as of January 2013 169

TABLE 5-3. Premiums for CHIP-Financed Children at Selected Income Levels for States Charging CHIP Premiums as of January 2013 170

TABLE 5-4. Examples of the Impact of Combined CHIP and Exchange Premiums for a Family of Three with Two CHIP-Enrolled Children 172

TABLE 5-A-1. Examples of Premiums and Cost Sharing (Out-of-Pocket Maximum) for a Family of Three with Two Adults (Age 40) and One Child in the Silver Plan with the Second-Lowest Premium 180

TABLE 6-1. Upper Payment Limit (UPL) Supplemental Payments Reported on CMS-64, Fiscal Year 2013 (Millions) 189

TABLE 6-2. Summary of Hospital Payment and Financing in Study States 195

TABLE 6-3. Summary of Nursing Facility Payment and Financing in Study States 196

TABLE 6-4. Uses of Health Care Related Taxes in Study States 197

TABLE 6-5. Comparison among Average Claims-Based, Total, and Net Medicaid Payment to Hospitals across Four Study States (SFY 2012) 199

TABLE 6-6. Comparison among Claims-Based, Total, and Net Medicaid Payment to Nursing Facilities across Four Study States (SFY 2012) 199

TABLE 6-7. Medicaid Payment to Cost Ratios with and without Supplemental Payments (SFY 2012) across Four Study States 200

Note: MACStats tables are listed separately on pages 62 and 63.

Executive Summary

Jointly administered by the federal government and the states, Medicaid and the State Children's Health Insurance Program (CHIP) have long been integral to this country's health care delivery system. The programs reach about a quarter of the U.S. population, with Medicaid covering more than 70 million people for at least part of fiscal year (FY) 2013 and CHIP covering more than 8 million. They serve the lowest-income Americans—children, seniors, and people with physical and mental disabilities, among others—who also have some of the greatest health care needs. The programs are major health care payers, accounting for about 15 percent of total U.S. health care spending today.

But as the Medicaid and CHIP Payment and Access Commission (MACPAC) releases our *March 2014 Report to the Congress*, the roles of Medicaid and CHIP are changing. Medicaid has expanded, with about half the states covering a new group of low-income adults as of January 1, 2014. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created new health insurance exchanges that interact with both Medicaid and CHIP. With CHIP funding scheduled to run out after FY 2015, policymakers also have a new opportunity to consider a long-term vision for children's health coverage.

MACPAC is a nonpartisan analytic commission charged with providing policy and data analysis to the Congress, and with making 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 affecting Medicaid and CHIP. In this March report, we explore specific issues raised by the changing roles of Medicaid and CHIP. The March report is divided into six chapters, four of which contain recommendations for the Congress, as well as MACStats, a statistical supplement:

- Medicaid and CHIP in the Context of the ACA;
- Promoting Continuity of Medicaid Coverage among Adults under Age 65;
- Issues in Pregnancy Coverage under Medicaid and Exchange Plans;
- ACA Eligibility Changes: Program Integrity Issues;
- Children's Coverage under CHIP and Exchange Plans;
- Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments; and
- MACStats: Medicaid and CHIP Program Statistics.

Chapter 1: Medicaid and CHIP in the Context of the ACA

The ACA is changing the insurance landscape by creating new health coverage opportunities for millions of people. The ACA's highest-profile change—which the U.S. Supreme Court effectively made optional for states—expanded Medicaid to adults with incomes under 138 percent of the federal poverty level (FPL). In the one-half of states implementing the expansion, nearly 70 percent of people who were uninsured in 2013 are now eligible for Medicaid, CHIP, or subsidized coverage in the exchanges. In the states that are not expanding Medicaid, fewer than 40 percent of uninsured people are eligible for assistance.

It is still too early to comment on many of the key questions about the law's impact. However, MACPAC will continue to monitor whether new benefit packages meet the needs of medically frail and disabled individuals and how increased Medicaid enrollment affects the ability of providers to serve current and new enrollees, particularly in the new adult group.

Other issues for future discussion may include alignment between Medicaid and the exchanges in the managed care market, and whether states that had previously covered adults through Medicaid are rolling back their coverage as the exchanges begin operations.

Chapter 2: Promoting Continuity of Medicaid Coverage among Adults under Age 65

MACPAC continues to examine the issue of insurance stability under the ACA—a topic that we began to take a close look at in March 2013—and to consider how to smooth transitions among sources of coverage for adults under age 65 as their income and family circumstances change.

Churning between sources of insurance or to uninsurance is a cause for concern because it disrupts continuity of care, leading people to forgo primary and preventive care that might avert more costly medical treatment later. Churning may cause some people to forgo health coverage altogether after losing Medicaid eligibility if they are not eligible for, or fail to take up, private coverage.

New analyses suggest that there are significant intra-year income changes among adults under age 65, which are likely to contribute to churning in the new eligibility group. In the initial four months of the study period, 23 percent of adults with incomes at or below 138 percent FPL saw their incomes rise above that income limit. Of those, a third were back below the limit by the end of the year. Income changes are more common among the lowest-income adults, who may be particularly affected if they are living in non-expansion states.

Transitional Medical Assistance (TMA) provides an additional 6 to 12 months of Medicaid to certain low-income families, excluding the new adult group. However, if TMA reverts to its reduced, pre-1990 level of coverage in April 2014, additional families could become uninsured.

MACPAC also reiterates support for two of our March 2013 recommendations: first, that Congress provide states with an option for 12-month continuous eligibility for adults, as children have in Medicaid; and second, that it eliminate the sunset date for extended TMA while allowing states to opt out of TMA if they expand Medicaid to the new adult group.

Chapter 3: Issues in Pregnancy Coverage under Medicaid and Exchange Plans

Medicaid has long played an important role in financing health care for low-income pregnant women, covering a vulnerable population and promoting healthy birth outcomes. The program covers almost half of all births in the United States. All states are required to provide pregnancy-related care for women below 138 percent FPL (referred to as the mandatory poverty-related pregnancy pathway).

Although states must provide services to all pregnant women at this income level, they are not required to provide full Medicaid benefits. Instead, states may limit coverage to services related to pregnancy. As a result, covered Medicaid benefits for pregnant women may differ both across and within states, depending on how a woman becomes eligible for Medicaid.

In Medicaid-expansion states, this ability to limit benefits in the mandatory poverty-related pregnancy pathway can lead to inequities in coverage. In those states, women in the new adult group will receive an alternative benefit package consisting of all essential health benefits (including maternity and non-maternity care), and these women may retain their new adult group coverage once pregnant.

But uninsured women who are already pregnant when they apply for Medicaid are not eligible for this new adult group. They will instead qualify for Medicaid under a mandatory poverty-related pregnancy pathway, and may have more limited benefits.

The U.S. Department of the Treasury has ruled that women who become eligible for Medicaid under the poverty-related pregnancy pathway are not considered to have minimum essential coverage under the ACA—regardless of whether a state limits benefits to pregnancy-related services only. That means if a woman's income is above 100 percent FPL, she might be able to hold Medicaid coverage and subsidized exchange coverage concurrently. Pregnant women might have compelling reasons to do this if concurrent coverage provided better benefits, broader provider networks, lower out-of-pocket premium and cost-sharing amounts, or family coverage. However, even with a subsidy, exchange coverage will be more expensive than Medicaid coverage.

Current policies also have the potential to create discontinuities in care at a time when continuity of care is especially desirable. After two months postpartum, women enrolled in Medicaid via the poverty-related pregnancy pathway will no longer be eligible for pregnancy-related coverage and will have to transition to the new adult group, to other coverage, or become uninsured.

To ensure the best possible pregnancy and birth outcomes, coverage for pregnant women should not be restricted to coverage of only pregnancy-related services. To this end, we recommend that the Congress require states to provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children. If this recommendation is adopted, we have made a companion recommendation that women enrolled in qualified health plans should be allowed to retain their qualified health plan coverage even if their pregnancy makes them eligible for Medicaid.

Chapter 4: ACA Eligibility Changes: Program Integrity Issues

The ACA requires states to implement eligibility policy and process changes to reduce complexity in Medicaid and CHIP. These new processes affect all states, whether or not they have adopted the Medicaid expansion, and apply to both expansion and existing eligibility groups for children, parents, pregnant women, and non-disabled adults under age 65. At the same time, states must continue to operate legacy systems for determining eligibility for people who are eligible on the basis of age or disability. A no-wrong-door policy requires coordination and sharing of eligibility information among Medicaid, CHIP, and the exchanges, since some people who apply for premium subsidies have income low enough to qualify for Medicaid or CHIP in their states.

The new policies prohibit states from requiring applicants to provide documentation, unless self-reported information is not reasonably compatible with the information in government databases. States may choose to verify this information by matching it with electronic data sources after an eligibility determination is made. The ACA also encourages using available information such as third-party databases and information otherwise known to the state to streamline the annual redetermination process.

Although these ACA changes simplify many aspects of the application and renewal process for enrollees, the overall system remains complex to administer. Moreover, the new processes are generally untested. They have not been used on a wide scale and will require the development of new systems and additional training for eligibility workers to ensure program integrity.

The Centers for Medicare & Medicaid Services are pursuing two strategies—which the Commission will continue to monitor—to enable states to develop appropriate methods that ensure the accuracy of eligibility decisions and to supplement existing safeguards. These are:

- requiring states to submit verification plans that detail how the state will implement and comply with new eligibility regulations and that will serve as the basis for eligibility quality control audits; and
- a pilot program that will provide timely feedback about the accuracy of determinations based on new eligibility rules. The pilots will help support the development of improvements or corrections where problems are found.

Chapter 5: Children's Coverage under CHIP and Exchange Plans

The context for CHIP has changed substantially since it was first enacted almost two decades ago. CHIP's purpose was to serve low-income children with incomes too high to qualify for Medicaid. Today, children in separate CHIP coverage with family incomes below 138 percent FPL have been moving into Medicaid (with CHIP funding), leaving up for discussion the long-term future of those with higher incomes remaining in separate CHIP programs.

New forms of coverage under the ACA also raise issues for children currently enrolled in CHIP. Many CHIP children have parents who are eligible for subsidized exchange coverage. The parents' contribution for this subsidized coverage is tied to income, ranging from 2 percent of income (for those below 133 percent FPL) to 9.5 percent of income (for those between 300 percent and 400 percent FPL). However, some families face an issue

referred to as premium stacking: if children are eligible for CHIP, they are not eligible for exchange coverage and must instead enroll in CHIP, and their parents must pay any CHIP premium in addition to their exchange premium.

However, if CHIP coverage were to be replaced by exchange coverage, approximately 1.9 million formerly CHIP-eligible children could lose financial assistance with health coverage as a result of what has come to be known as the family glitch in employer-sponsored insurance. This is because the exchange subsidies are not available to families in which the worker is offered employer-sponsored insurance that the ACA considers affordable.

CHIP programs generally require higher out-of-pocket premiums and cost-sharing amounts than Medicaid, but lower amounts than subsidized exchange plans. This raises questions about what is a reasonable level of contribution on the part of a child's family without becoming a financial obstacle that impedes access to and use of appropriate care.

These and other issues present an opportunity for policymakers to consider a long-term vision, not just for CHIP, but also for coverage of lower-income children more broadly beyond FY 2015. The Commission's two recommendations focus on short-term changes to the program that will align with a possible long-term vision for continuity of coverage, benefit design, financing, and network adequacy for children's coverage overall.

First, the Commission recommends that the Congress should provide that children in CHIP not be subject to waiting periods, which have not been shown to be particularly effective in reducing crowd-out over the years. This also would reduce uninsurance and improve stability of coverage while reducing states and plans' administrative burdens.

Second, MACPAC recommends ending CHIP premiums for children with family incomes below 150 percent FPL. This would align CHIP and Medicaid policy on premiums. It would also end premium stacking for these families, whereby they must pay two premiums: one for the parents' insurance on the exchange and one for their children enrolled in CHIP.

Chapter 6: Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

The Medicaid program is a major purchaser of health care services, accounting for about $431 billion in benefit spending in FY 2013, not including the territories. MACPAC is charged with examining all aspects of Medicaid payment and the relationships between payment, access, and quality of care, and it has begun to take a closer look at states' payments to providers and their methods for determining them.

Medicaid fee-for-service (FFS) non-disproportionate share (DSH) supplemental payments and the health care related taxes that states have used, in part, to finance non-DSH payments merit closer attention. Non-DSH supplemental payments account for more than 20 percent of total Medicaid FFS payments to hospitals nationally and more than 50 percent in some states.

Determining whether Medicaid payments are consistent with efficiency, economy, quality, access, and appropriate utilization requires a complete understanding of net Medicaid payment. However, these payments are not reported to the federal government at the provider level in a readily usable format, so it is not possible to determine total payments to individual providers or the effect of these payments on policy objectives such as efficiency, quality, and access to necessary services.

A MACPAC analysis of five state Medicaid programs' payment and financing approaches using data supplied by these states confirms that non-DSH supplemental payments can be a significant source of Medicaid payments, particularly to hospitals. In addition, net Medicaid payments are effectively reduced by health care related taxes that providers pay.

Without additional data on both health care related taxes and supplemental payments, it is not possible to meaningfully analyze Medicaid payments at either the provider or state level.

The Commission's recommendation that the Secretary of the U.S. Department of Health and Human Services collect provider-level non-DSH supplemental payment data is an important first step toward greater understanding of Medicaid payments to providers. MACPAC will continue to examine this and related issues, including states' approaches to financing their programs.

MACStats: Medicaid and CHIP Program Statistics

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

New in this report are five tables presenting access to care measures. The measures reflect five access domains: provider availability, connection with the health care system, contact with health professionals, timeliness of care, and receipt of appropriate care.

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

- Total Medicaid spending grew by about 6 percent in FY 2013 to $460 billion. Total CHIP spending grew by about 8 percent to $13 billion.
- The number of individuals ever covered by Medicaid remained steady at an estimated 72.7 million in FY 2013, compared to 72.2 million in FY 2012. CHIP enrollment also remained steady at 8.4 million.
- The Medicaid and CHIP programs accounted for 15.4 percent of national health expenditures in calendar year 2012, and their share is projected to reach about 17 percent in the next decade.
- Medicaid and CHIP eligibility levels for most child and adult populations have been converted as of 2014 to reflect the application of uniform modified adjusted gross income (MAGI) rules across states.

CHAPTER 1

Medicaid and CHIP in the Context of the ACA

Key Points

Medicaid and CHIP in the Context of the ACA

Medicaid and the State Children's Health Insurance Program (CHIP) are undergoing many changes as provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) continue to be implemented. The Medicaid expansion, the creation of health insurance exchanges, premium tax credits for insurance coverage purchased through the exchanges, and both individual and employer mandates for insurance coverage are changing the insurance landscape as well as bringing new opportunities for health coverage. However, these changes are also creating new complexities in existing programs.

- Twenty-five states and the District of Columbia have made the decision to expand Medicaid up to 138 percent of the federal poverty level (FPL) for adults under age 65. States continue to consider their options, and this number could change over time.
- Despite the focus on expanding coverage, some people will remain uninsured, including certain individuals in states that choose not to expand Medicaid and individuals who remain uninsured due to affordability or other reasons. In addition, because citizens below 100 percent FPL are not eligible for premium tax credits, there will be a coverage gap in non-expansion states for those who are between the state's Medicaid eligibility limit for adults and 100 percent FPL.
- There are changes that affect every state, regardless of expansion status, including implementing a standardized income-counting methodology (using modified adjusted gross income (MAGI) for most non-disabled and non-elderly adults and children in place of income-counting and disregard rules that vary by state). Additional changes include moving many formerly paper-based processes online and replacing documentation requirements with applicants' self-attestation verified by third-party data checks.
- MACPAC has identified several issues that merit the attention of the Congress, discussed in subsequent chapters. These issues include stability of insurance coverage for childless adults and parents, equity in benefits between pregnant and non-pregnant enrollees, continuity of care for low-income pregnant women, and program integrity.
- MACPAC will continue to examine emerging issues, including characteristics of the new adult group; provider capacity; market alignment between qualified health plans (QHPs) and Medicaid managed care plan offerings; Medicaid eligibility rollbacks; use of waivers for Medicaid expansions; the ACA's impact on special populations, such as persons with disabilities and medically frail individuals; and program integrity developments.

CHAPTER 1

Medicaid and CHIP in the Context of the ACA

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) represents the most sweeping change to U.S. health care since the creation of Medicare and Medicaid in 1965. With an expansion of Medicaid, the creation of health insurance exchanges offering access to insurance policies for individuals and small businesses in every state, premium tax credits for coverage purchased through the exchanges for those with income between 100 percent and 400 percent of the federal poverty level (FPL), and both individual and employer mandates for insurance coverage, the ACA is changing the insurance landscape and creating new health coverage opportunities for millions of people.[1]

The existence of multiple sources of coverage targeted to people of different incomes, however, adds new complexities to an already complex landscape and creates particular challenges for Medicaid and the State Children's Health Insurance Program (CHIP). For example, while the number of people with insurance coverage will grow, coverage over time will not be seamless for everyone. Medicaid and CHIP enrollees in particular may move among different sources of coverage as their income fluctuates. In addition, the U.S. Supreme Court's ruling that the expansion of Medicaid to adults at or below 138 percent FPL could not be enforced by withholding funds for a state's entire Medicaid program has effectively made the expansion optional.[2] About half of the states are not implementing the expansion, though this number could shift over time as states continue to assess their options.

There are other challenges as well. For Medicaid, these include integrating new enrollees into systems of care, adopting more streamlined eligibility policies for some populations such as non-disabled adults and children, and ensuring accurate transfer of applicant information from the federal and state exchanges to state Medicaid programs. For CHIP, which primarily serves low-income children above Medicaid eligibility levels, the availability of subsidized exchange coverage for families at CHIP income levels and a federal funding stream assured only through 2015 have raised new questions about CHIP's future role.

Further, although state decisions about Medicaid expansion have garnered significant attention in the media, it is important to note that the ACA requires certain changes in eligibility procedures for all state Medicaid and CHIP programs, whether or not the state is expanding coverage. These changes include moving from income-counting and disregard rules that previously varied by state to a standard methodology that uses modified adjusted gross income (MAGI) for most non-disabled and non-elderly adults and children, as well as moving many in-person and paper eligibility processes online and replacing applicant documentation requirements with self-attestation verified by third-party data checks. Such changes are designed to streamline the eligibility and verification process, providing a more user-friendly experience for applicants and making eligibility determinations more accurate and less costly to process.

These issues set the context for MACPAC's examination of the ACA in this report, and they are discussed in greater detail below. Although it is still too early to comment on many of the key questions about the law's impact, such as the extent to which newly eligible individuals will enroll in Medicaid and what stresses this enrollment growth and changes in financing will place on safety net providers, MACPAC has identified several issues that merit the attention of the Congress. These issues, analyzed in Chapters 2, 3, and 4, include stability of insurance coverage for childless adults and parents, equity in benefits between pregnant and non-pregnant enrollees, continuity of care for low-income pregnant women, and concerns about program integrity.

Health Insurance Coverage under the ACA

The ACA provides for a Medicaid expansion up to 138 percent FPL for children and adults under age 65.[3] Those childless adults and parents newly eligible will be financed at a 100 percent federal match rate from 2014 through 2016, phasing down to 90 percent by 2020. Beginning in 2014, children age 6 through 18 between 100 and 138 percent FPL who were enrolled in a separate CHIP program must be covered in Medicaid, with CHIP funding. The benefit package offered to the new adult group, called the alternative benefit plan (ABP), is not required to contain all the benefits that the state offers in traditional Medicaid. For example, a state that has extended optional benefits such as adult dental care to its traditional Medicaid enrollees is not required to extend those benefits to the new adult group. However, the ABP must be benchmarked to one of several insurance plans in the state, and it must provide all 10 of the essential health benefits (EHBs) mandated by the ACA.[4]

The ACA also created, in each state, health insurance exchanges (also referred to as marketplaces) where residents can purchase coverage from a menu of qualified health plans (QHPs) that provide the full range of EHBs. Every exchange offers a variety of plans—catastrophic, bronze, silver, gold, and platinum—with each level defined by actuarial value, a measure of the share of expenses covered by the plan. Lower-tier plans require higher cost sharing but typically have lower monthly premiums, and higher-tier plans require less cost sharing but typically have higher premiums.[5] Platinum plans have the highest actuarial value and highest premiums. Enrollment in exchange plans will be limited to annual open enrollment periods, with exceptions for certain qualifying life events, such as the birth of a baby or loss of minimum essential coverage (45 CFR 155.420). Individuals with incomes between 100 percent and 400 percent FPL who are not eligible for Medicaid, Medicare, CHIP, or affordable employer-sponsored insurance are eligible for premium tax credits to help with the cost of QHPs, and those at or below 250 percent FPL may receive additional cost-sharing reductions.

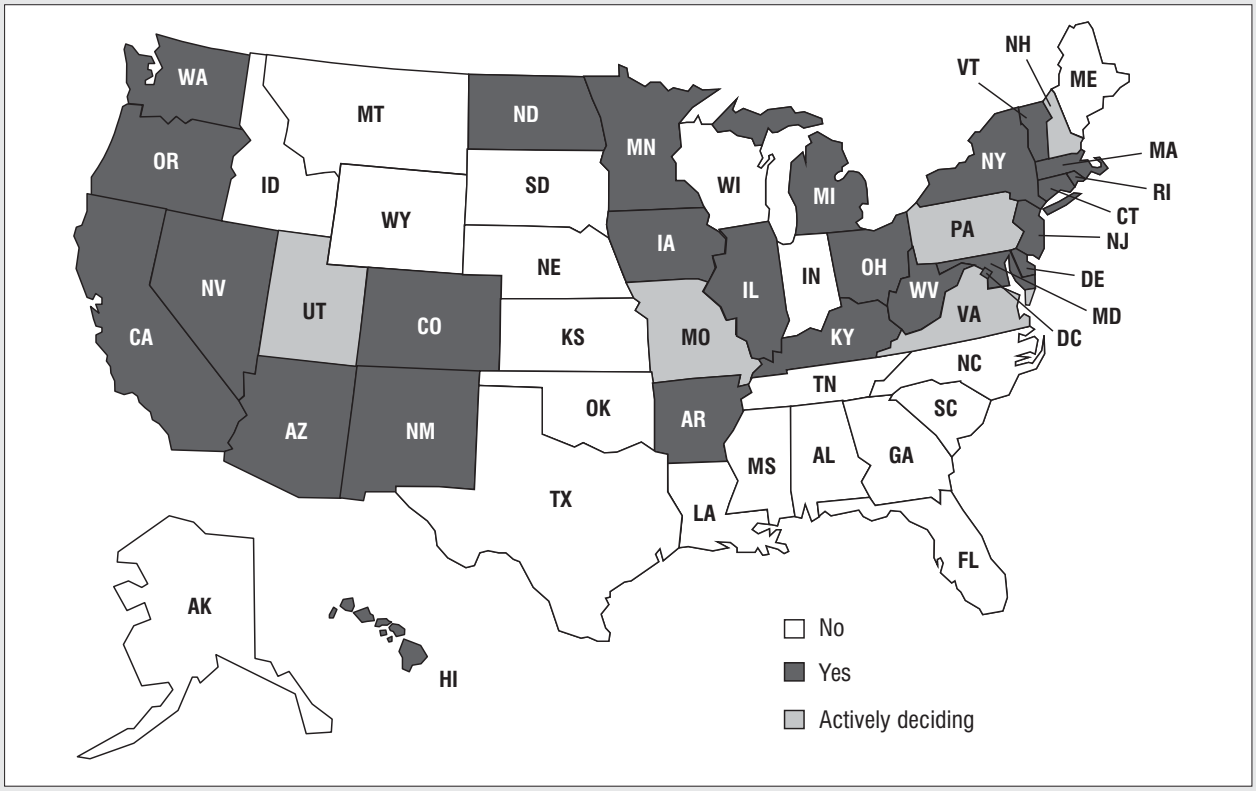
For 2015, employers with at least 100 full-time or full-time equivalent employees will be required to offer health insurance to at least 70 percent of those working full-time and their dependents. Starting in

2016, these employers, as well as employers with 50 to 99 full-time or full-time equivalent employees, will be required to offer health insurance to at least 95 percent of those working full-time and their dependents. Medicare will continue its role as the primary payer for individuals age 65 and older and for certain persons with disabilities. Medicaid will continue to be the primary source of coverage for low-income people.

The ACA's expansion of Medicaid to those up to 138 percent FPL also streamlines aspects of coverage for children. Previously, states could choose whether to cover children 6 through 18 years old between 100 and 138 percent FPL who were not already eligible for Medicaid through a Medicaid expansion or separate CHIP program. Under the ACA, states that had covered these so-called stairstep children in separate CHIP programs are now required to cover these children in Medicaid, albeit with CHIP funding.[6] The ACA also extends CHIP funding through FY 2015.

Medicaid expansion effectively optional. As envisioned, the ACA provided for expansion to the new adult group in all states, making this population one of several groups that state Medicaid programs are required to cover. In June 2012, however, the U.S. Supreme Court ruled that the expansion mandate could not be enforced by withholding funds for a state's entire program, leaving the law otherwise intact but effectively making the expansion optional. Twenty-five states and the District of Columbia have made the decision to expand Medicaid (Figure 1-1). In these states, certain individuals at or below 400 percent FPL without an

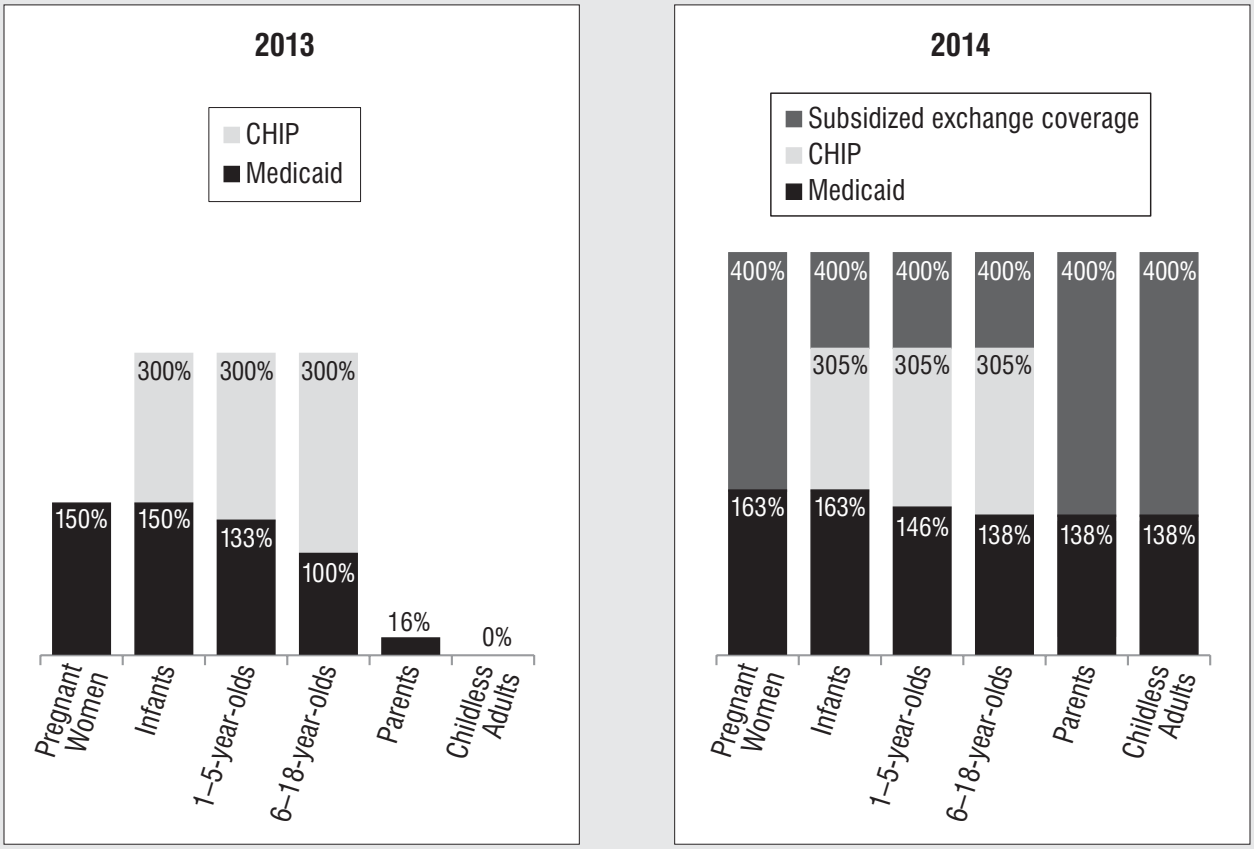
FIGURE 1-1. States Expanding Medicaid in 2014, as of February 18, 2014



Note: Michigan's Medicaid expansion is planned to take effect on April 1, 2014. Several states continue to debate expanding Medicaid in 2014. Missouri's state legislature continues to consider expanding Medicaid but has not yet enacted legislation to do so. New Hampshire is considering a proposal to use federal funds to subsidize the purchase of private insurance for low-income adults, but the proposal has not been approved by the state legislature nor has it been submitted to HHS. Pennsylvania is considering the use of federal funds for the purchase of private coverage. Utah and Virginia continue to actively debate Medicaid expansion.

Source: MACPAC analysis of KFF 2014, The Advisory Board Company 2014, State Refor(u)m 2014, and media accounts.

FIGURE 1-2. West Virginia Income Eligibility Levels in 2013 and 2014 as a Percentage of FPL



Notes: These figures show eligibility levels for citizens. Eligibility for lawfully present non-citizens varies. Non-citizens who are not lawfully present are ineligible for full Medicaid and subsidized exchange coverage. Some citizens in the exchange subsidy income range will be ineligible for exchange subsidies—for example, if they receive an offer of employer-sponsored insurance that is deemed affordable. The 2013 levels do not reflect disregards for certain types of income, such as earnings. In 2014, for populations shown here, Medicaid and CHIP eligibility is determined using modified adjusted gross income (MAGI) rules that require states to disregard an amount of income equal to 5 percent of the federal poverty level (FPL). The income eligibility levels shown here include an increase of 5 percentage points to account for the effect of this disregard. States may receive CHIP funding for some children eligible through Medicaid.

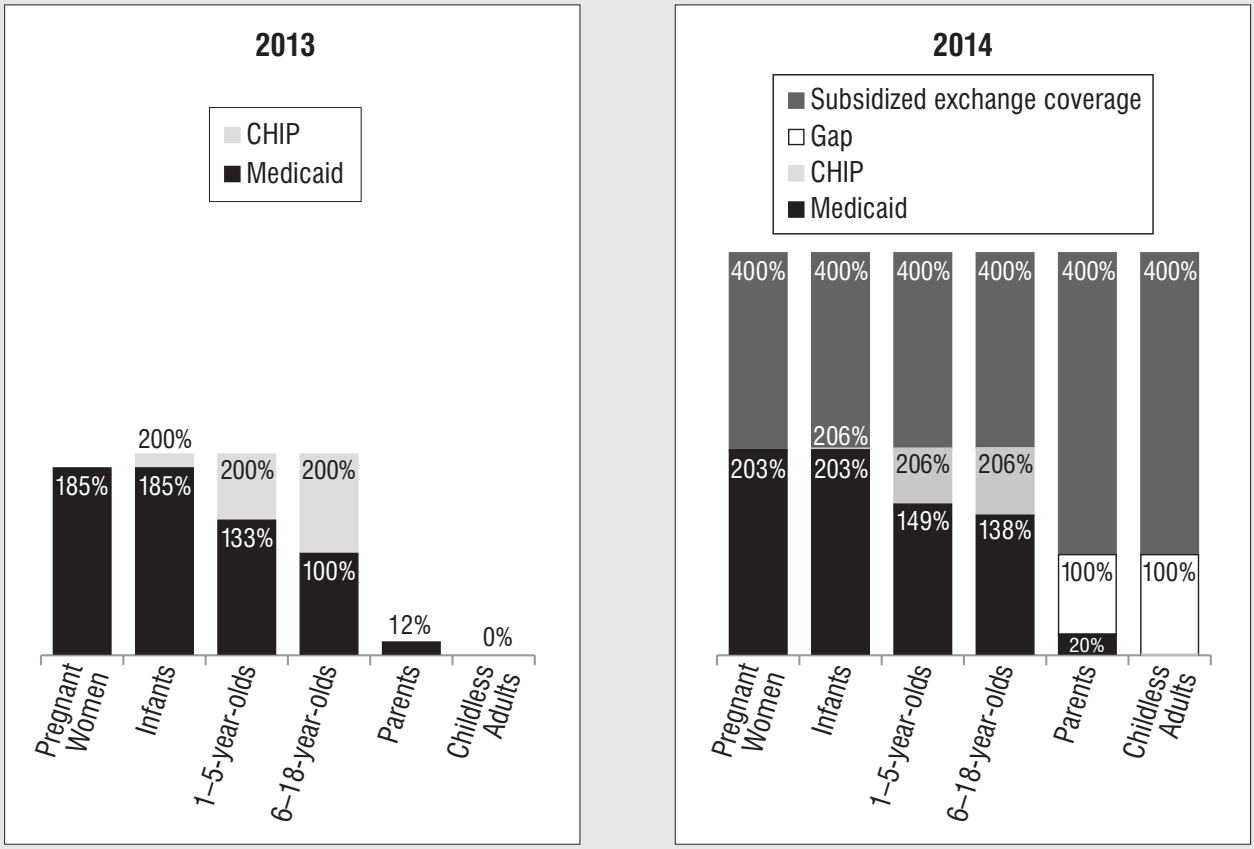
Sources: MACPAC 2013a; CMS 2013a; MACPAC analysis of CMS 2013b.

offer of affordable employer-sponsored insurance have access to either Medicaid, CHIP, or subsidized exchange coverage in 2014. Among the 25 states not yet electing to expand coverage for 2014, several continue to actively debate expansion alternatives (Figure 1-1). State expansion decisions have created different coverage landscapes across the states. Texas and West Virginia are two states that illustrate eligibility changes from 2013 to 2014 as well as the differing picture of coverage in expansion and non-expansion states (Figures 1-2 and 1-3).

Remaining uninsurance. While many people will find themselves newly eligible for insurance affordability programs under the ACA or will realize that they were already eligible for Medicaid or CHIP, not everyone will be covered. Those without coverage include individuals in states that have chosen not to expand Medicaid. In these states, individuals with income below 100 percent FPL who do not qualify for Medicaid or CHIP will fall into a gap in coverage (Figure 1-3).

Though nearly 70 percent of all those without insurance in expansion states will be eligible for Medicaid, CHIP, or subsidized QHP coverage, fewer than 40 percent will be eligible for assistance in states not expanding Medicaid coverage

FIGURE 1-3. Texas Income Eligibility Levels in 2013 and 2014 as a Percentage of FPL



Notes: These figures show eligibility levels for citizens. Eligibility for lawfully present non-citizens varies. Non-citizens who are not lawfully present are ineligible for full Medicaid and subsidized exchange coverage. Some citizens in the exchange subsidy income range will be ineligible for exchange subsidies—for example, if they receive an offer of employer-sponsored insurance that is deemed affordable. The 2013 levels do not reflect disregards for certain types of income, such as earnings. In 2014, for populations shown here, Medicaid and CHIP eligibility is determined using modified adjusted gross income (MAGI) rules that require states to disregard an amount of income equal to 5 percent of the federal poverty level (FPL). The income eligibility levels shown here include an increase of 5 percentage points to account for the effect of this disregard. States may receive CHIP funding for some children eligible through Medicaid.

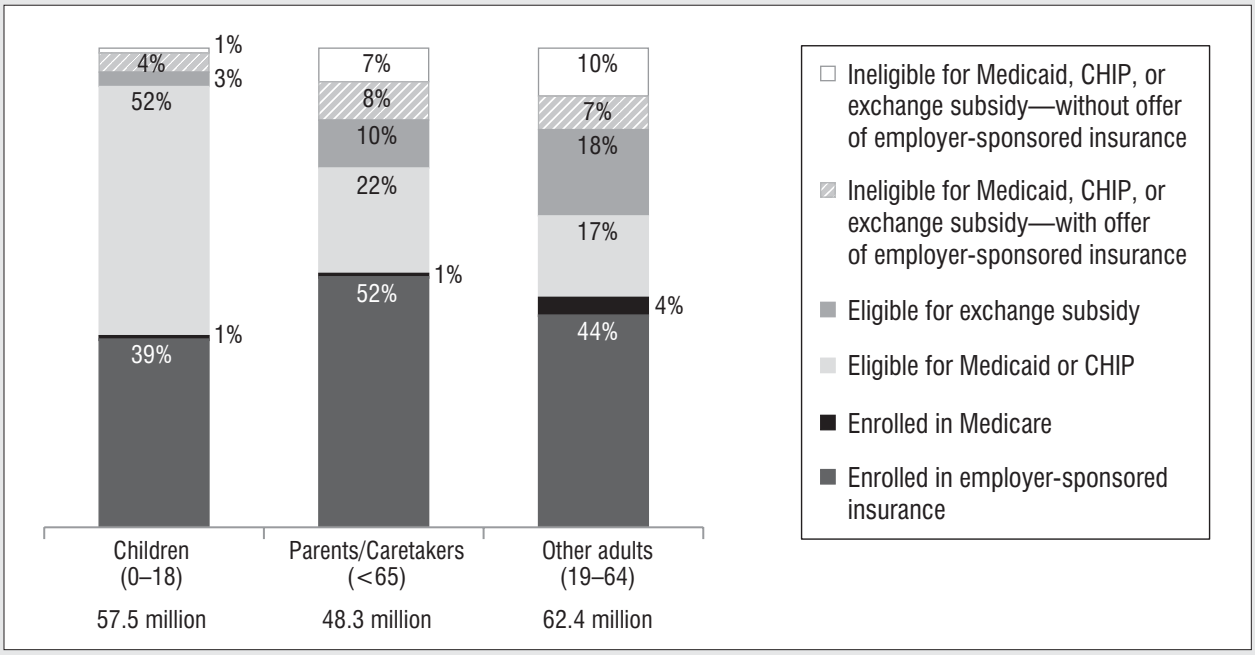
Sources: MACPAC 2013a; CMS 2013a; MACPAC analysis of CMS 2013b.

(Buettgens et al. 2013). In addition, because citizens below 100 percent FPL are not eligible for premium tax credits, the gap between where the state's Medicaid eligibility for adults ends and premium tax credits begin (100 percent FPL) will result in 4.8 million adults who are ineligible for both Medicaid and premium tax credits in non-expanding states (26 CFR 1.36B-2(b)(1), KCMU 2013).

Others remaining uninsured include those who are not lawfully present and thus are both barred from purchasing exchange coverage and ineligible for Medicaid. Non-pregnant adults who are lawfully present but have been in the country for less than five years generally do not qualify for Medicaid and CHIP, but they can qualify for premium tax credits. States have the option to extend Medicaid and CHIP coverage to lawfully present children and pregnant women who have been in the country for less than five years.[7]

Further, an estimated 10.5 million children and adults below 400 percent FPL are not enrolled in coverage offered by their employer (one reason may be that they don't find it affordable), but will not have access to premium tax credits because that offer is considered affordable under the ACA (§36B(c)(2)(C)(i) of the Internal Revenue Code,

FIGURE 1-4. Point-in-Time Eligibility Estimates for Insurance Coverage and Simulated Eligibility for ACA Insurance Affordability Programs for Non-Elderly, Non-Disabled Children, Parents, and Other Adults at or below 400 Percent FPL, 2014



Notes: ACA is the Patient Protection and Affordable Care Act. FPL is the federal poverty level. Coverage and eligibility are assigned hierarchically as follows: employer-sponsored insurance, Medicare, Medicaid/CHIP eligible, exchange subsidy eligible, and ineligible by employer-sponsored insurance offer status. Individuals ineligible for Medicaid, CHIP or exchange subsidy without an offer of employer-sponsored insurance could be ineligible for other reasons, such as being undocumented, subject to the five-year bar, or a citizen under 100 percent FPL. Individuals ineligible for Medicaid, CHIP or exchange subsidy with an offer of employer-sponsored insurance could be ineligible for other reasons, such as being undocumented or subject to the five-year bar.

Source: AHRQ analysis for MACPAC of 2005–2010 Medical Expenditure Panel Survey (MEPS) data.

AHRQ 2014). Employer-sponsored insurance is considered affordable for all members of the family as long as the employee's contribution to a self-only plan is 9.5 percent or less of family income. This measure of employer-sponsored insurance affordability has been called the family glitch or kid glitch because it does not factor in the cost to insure family members and dependents (Figure 1-4). For example, for a family of three with income at 100 percent FPL ($19,530 annually in 2014), the average annual employee contribution for individual coverage ($999 annually) is 5.1 percent of income. However, the average employee contribution for family coverage is $4,565, which is 23.4 percent of this family's annual income.[8] In this example, family members eligible to be covered under the employee's plan would be deemed to have access to affordable insurance, even though the cost of family coverage is well above 9.5 percent of family income (KFF and HRET 2013).

Variation in the operation of exchanges. States have significant flexibility in the design and operation of the exchanges. They can choose to establish and operate their own state-based exchange, participate in a federally facilitated exchange, or establish a federal-state partnership exchange.

As of January 2014:

- Fifteen states plus the District of Columbia are operating a state-based exchange.
- Twenty-six states have opted for a federally facilitated exchange.

- Seven states are operating a federal-state partnership exchange.
- Two states are operating a federally facilitated individual exchange with a state Small Business Health Options Program (SHOP) exchange.

States operating their own exchanges manage enrollment through state websites and certify QHPs according to federal and state requirements. These states have the flexibility to include additional certification requirements beyond federal standards. They can also encourage plan participation through additional requirements or incentives such as requiring certain issuers to participate in the exchange, or accepting any plan that meets exchange requirements (Dash et al. 2013). States defaulting to a federally facilitated exchange cede plan management responsibilities to the federal government, although all QHPs must still be licensed to operate in the state and must comply with its insurance regulations.

Implementation of other key provisions. Several provisions of the ACA came into effect before 2014. For example, children may stay on their parents' employer-based coverage until age 26, health plan issuers are prohibited from imposing lifetime limits, and many preventive services are now available without a copayment. Some of the most significant changes took place in January 2014, including new coverage under the Medicaid expansion and exchange plans, the individual mandate, and the requirement that QHPs offered both on and off the exchanges cover EHBs. The Centers for Medicare & Medicaid Services (CMS) announced in late 2013 that issuers may renew plans that are not fully ACA compliant for another year even when making changes that would have otherwise caused the plan to lose grandfathered status. However, it is unclear how many states will permit issuers to renew these plans and how many issuers will choose to renew them.[9] In addition, individuals whose plans were canceled and who state that they have difficulty paying for an existing exchange plan are eligible for a hardship exemption from the individual mandate. The hardship exemption would allow these individuals to either remain uninsured without penalty or purchase a lower-premium catastrophic plan.

Open enrollment for the exchanges began on October 1, 2013, and coverage for Medicaid's new adult group and under QHPs began on January 1, 2014. Technical troubles have plagued the technology infrastructure powering the eligibility and enrollment functions for exchanges, although some state-based exchanges—including those in Washington, Kentucky, and Connecticut—initially fared better than the federally facilitated exchange. It is not clear whether the problems that dominated headlines at launch are short-term implementation issues or evidence of more systemic problems.[10]

The Intersection of Medicaid, CHIP, and the Exchanges

Historically, Medicaid has played a unique role in U.S. health care, initially providing health insurance coverage to the nation's poorest women, children, individuals age 65 and older, and those with blindness or disabilities who also received other forms of government assistance. As the Congress expanded coverage to other poor children and as states began to use waivers to expand coverage to additional groups and cover optional populations such as the medically needy, Medicaid eligibility moved away from being linked solely to welfare programs.

Gaps in the safety net. In seeking to provide Medicaid coverage for nearly all persons at or below 138 percent FPL including childless adults, the ACA positioned Medicaid in a broader role, as a safety net with primarily income-based eligibility rather than income combined with categorical eligibility.[11] The Supreme Court's decision and

subsequent decisions by states not to expand to the new adult group, however, left gaps in this strategy to ensure coverage for all people with low incomes. Some of these gaps may disappear if additional states choose to expand. However, many people will remain uninsured, including those ineligible due to their immigration status. Safety net providers may face increased pressure in providing care for these uninsured individuals given a scheduled decrease in disproportionate share hospital (DSH) payments.[12]

Continuity of coverage. For Medicaid and CHIP, the existence of exchange coverage will create new market dynamics with potentially wide-ranging effects on individuals, providers, and health plans, as well as states and the federal government. Relatively small changes in income may lead individuals to change coverage between Medicaid, CHIP, the exchange, and uninsurance—a phenomenon known as churning.[13] Churning may disrupt care by requiring individuals to change providers. Likewise, individuals who churn from Medicaid to exchange coverage may need to adjust to paying premiums and copayments. Providers may find it difficult to continue to treat patients who move in and out of their networks. Health plans, states, and the federal government may find churning to be administratively burdensome as they process disenrollments and reenrollments throughout the year.

MACPAC recommended in March 2013 that the Congress create a statutory option for 12-month continuous eligibility for adults in Medicaid and children in CHIP, parallel to the current state option for children in Medicaid. Use of this statutory option would reduce churning and promote continuity of care. The Commission continues to support this recommendation. The ACA also provides an option designed to mitigate churn: allowing states to create a Basic Health Program (BHP) that uses federal tax subsidies to provide lower-cost exchange coverage for people with incomes above 138 but below 200 percent FPL. This option is intended to promote continuity of care by absorbing some of the cost of private plans for people who are just above the Medicaid income eligibility threshold. CMS announced in February 2013 that the BHP will not be operational until 2015 and followed with a proposed rule in September 2013 to establish the BHP (CMS 2013c, HHS 2013).

States can also promote continuity of care for Medicaid and CHIP enrollees by establishing so-called bridge plans offered by Medicaid managed care organizations on the exchanges. Bridge plans would be available to limited groups—such as individuals transitioning from Medicaid or CHIP, parents with children enrolled in Medicaid, or those earning more than the Medicaid threshold but below a certain FPL cap—and would allow those who transitioned to keep the same provider network. The federally facilitated exchange is not implementing bridge plans in 2014, and among the state-based exchanges, only California and Wisconsin appear to be to implementing bridge plans (ACAP 2013a, Covered California 2013, Johnson 2013).

Complex interaction among eligibility policies. Under the ACA, the exchanges will serve as a single entry point to assess all applicants' eligibility for Medicaid, CHIP, or premium tax credits.[14] This no wrong door policy means that the exchanges must use an eligibility system in which Medicaid, CHIP, and QHP eligibility rules interact and can connect eligible individuals to Medicaid. While this process should appear relatively seamless to enrollees, it requires complex system programming on the part of states and the federal government. In addition, the move from paper-based processes to online, real-time adjudication through the exchanges is a monumental change. Intended to streamline enrollment and renewal and create alignment across

insurance affordability programs, it has proved challenging both for state and federal exchanges.

Future Issues

The initial rollout of the ACA was rocky. Some problems will be corrected over time; others may develop as time goes on. MACPAC will be monitoring a number of issues over the next year, with a particular eye on those where the Commission could offer recommendations for improvement.

Enrollment among newly eligible adults. MACPAC, along with federal and state policymakers, will be monitoring enrollment trends. Of particular interest is the extent to which those eligible for the new adult group actually enroll in Medicaid and the health status of enrollees. While some research suggests that members of this group are generally in better health than current Medicaid enrollees, there are also concerns about potential high utilization due to pent-up demand as well as potential significant initial enrollment by those with greater than average health care needs (Chang and Davis 2013, Decker et al. 2013, Holahan et al. 2010, Somers et al. 2010).

Provider capacity. MACPAC will also keep a close eye on how increased Medicaid enrollment may affect the ability of providers to serve current enrollees as well as those newly eligible. The fate of safety net hospitals is of particular interest, as the ACA introduces changes to provider payments via reduced DSH allotments to states. The ACA reduced state DSH allotments in anticipation of a decrease in uncompensated care expected to result from the expansion of insurance coverage. These reductions will proceed despite the Medicaid expansion no longer being universally implemented. However, the budget agreement signed into law on December 26, 2013, delayed the reductions until October 1, 2015 (the Bipartisan Budget Act of 2013, P.L. 113-67). While it remains to be seen how safety net hospitals in expansion states will fare when the reductions are implemented, safety net providers in non-expansion states face an even more challenging future.

Market alignment. The extent to which continuity of care can be facilitated for those who churn is also of concern. Because the ACA provides a continuum of coverage that extends from Medicaid to QHPs, plan participation in both markets has the potential to smooth transitions associated with churning. States have undertaken a variety of efforts to encourage plan participation in both markets (Lucia and Dash 2013). A recent analysis shows that 41 percent of QHP issuers also offer Medicaid managed care plans in the same state and that most new entrants to the individual market on exchanges are Medicaid managed care plans (ACAP 2013b, McKinsey 2013). Plan networks may vary even if a carrier offers products on both markets, so more analysis is needed to determine the extent to which multimarket plans can ease the transition for those who churn. Access to providers who participate in multiple plan networks may also ease transitions and help maintain access to ongoing treatment or preventive care.

Medicaid rollbacks. Another concern is that states that had previously extended coverage to adult Medicaid enrollees may roll back coverage for some adult Medicaid enrollees in 2014, given that the exchanges now present an opportunity for these individuals to obtain health insurance. Maine, Rhode Island, Wisconsin, and Vermont have announced plans to reduce eligibility for some enrollees (Galewitz 2013). Louisiana is rolling back eligibility for pregnant women, and Minnesota is reducing eligibility for parents (Backstrom 2013, Shuler 2013). Additionally, states may roll back or eliminate optional disability pathways (e.g., poverty-related or Medicaid buy-in) for adults. This would result in individuals with disabilities and incomes above Supplemental Security Income (SSI) limits being placed into the new adult group or into

subsidized coverage, where they would be ineligible for certain benefits that they could have received under traditional Medicaid.

Use of waivers for Medicaid expansions. MACPAC will also be watching the experience of states that enroll Medicaid expansion populations in the exchanges through demonstration waivers and how these demonstrations affect costs and churning. Arkansas and Iowa have received approval to pursue the premium assistance option to use Medicaid funds to purchase coverage in the exchange (CMS 2013d, CMS 2013e). As other states continue to debate expansion alternatives, waiver proposals will be an important area to monitor.

Impact on special populations. Still to be seen is how new eligibility policies will affect special populations, including persons with disabilities and medically frail individuals. During the application process, states must identify those who are medically frail and offer them the choice of the ABP or the full Medicaid benefit package. States must also accurately identify individuals with disabilities to ensure that they are determined eligible through disability rules. Individuals with disabilities or those who are medically frail who are not determined eligible under the proper pathway may not receive all the benefits they could have received under Medicaid. For example, if individuals with disabilities were to receive coverage through a QHP, they may not have access to the long-term services and supports (LTSS) that they would have had under Medicaid, if they were income eligible. It will also be important to continue to monitor access and enrollment issues for the traditional Medicaid populations with high needs and high costs, such as individuals age 65 and older and the disabled, whose eligibility is not affected by the ACA.

Program integrity. Finally, policymakers will be monitoring the impact of administrative and implementation issues on program integrity. The ACA mandates many changes to Medicaid and CHIP eligibility processes and policies. These include using MAGI as the methodology for determining Medicaid eligibility for many applicants and replacing paper-based documentation with online, near real-time adjudication. These changes are intended to streamline enrollment and renewal and create alignment across insurance affordability programs. Some of these changes may reduce eligibility errors, while others may increase the risk of error. These changes raise questions about how eligibility quality control processes should be revised in light of ACA policy changes.

Endnotes

[1] Although eligibility for Medicaid and CHIP is determined using the most current FPLs, eligibility for subsidized exchange coverage is based on FPLs for the prior year, consistent with statute. Throughout this report, Medicaid and CHIP FPL dollar amounts reflect calendar year (CY) 2014 levels; dollar amounts for subsidized exchange coverage reflect FPLs in CY 2013.

[2] Before 2014, when determining eligibility, states had the flexibility to disregard whatever sources or amounts of income they chose. Beginning in 2014, a new methodology called MAGI is used to determine subsidized exchange coverage eligibility as well as Medicaid and CHIP for children, their parents, pregnant women, and the new adult group. Only one income disregard exists under MAGI for Medicaid and CHIP. States are required to disregard income equal to 5 percent FPL. For this reason, eligibility for the new adult group is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[3] For a family of three in 2014, 138 percent FPL is $27,310.

[4] See Section 1302(b) of the ACA for a list of the 10 EHBs, and Section 1937 of the Social Security Act for a description of benchmark options.

[5] Catastrophic plans are only available to those under 30 years of age and those exempt from the individual mandate due to lack of affordable insurance or a hardship waiver (§1302(e) of the ACA).

[6] Pennsylvania has been granted an extension and will place these children in Medicaid by 2015 (Esack and Darragh 2014).

[7] Twenty-five states have opted to cover five-year barred children, 20 states have opted to cover five-year barred pregnant women, and 15 states cover a pregnant woman's prenatal care, labor, and delivery regardless of immigration status by covering her unborn child through CHIP (Hasstedt 2013).

[8] State Medicaid and CHIP programs will implement FPLs updated as of January 24, 2014 as soon as possible, but no later than April 1, 2014. However, 2013 FPLs will be used to determine eligibility for subsidized exchange coverage for the remainder of calendar year 2014.

[9] Health insurance plans in existence at the time the ACA was signed into law are exempt from risk adjustment as well as many other provisions of the ACA. A plan can retain grandfathered status as long as it does not significantly raise premiums or decrease benefits.

[10] To better understand individuals' experience with the Medicaid eligibility and enrollment process, MACPAC conducted focus groups with individuals newly enrolled in Medicaid, as well as individuals who are eligible but not enrolled, in Maryland, Nevada, and California in December 2013.

[11] Categorical eligibility means that an individual must be a member of a certain group, such as parents, pregnant women, or children, in addition to meeting income and other guidelines, in order to qualify for Medicaid.

[12] The federal government allots DSH funds to states, which in turn make DSH payments as additional compensation to hospitals that serve a high number of Medicaid or low-income patients. DSH payments to a hospital cannot exceed allowable uncompensated care costs (P.L. 108–173, 42 CFR 447.299). For more information on the primary care physician payment increase, see MACPAC's June 2013 report to the Congress.

[13] For more information on stability of coverage, see Chapter 2 of MACPAC's March 2013 report to the Congress.

[14] State-based exchanges that are government entities can make Medicaid eligibility determinations for both MAGI and non-MAGI groups. Federally facilitated exchange states can choose to be a determination or assessment state. Determination states will accept the federally facilitated exchange's eligibility determination for MAGI eligibility groups. A state that chooses the assessment model will receive eligibility information electronically from the federally facilitated exchange and make its own determination.

References

Advisory Board Company, The. 2014. Where the States Stand on Medicaid Expansion. Washington, DC: The Advisory Board Company. http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap.

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. 2014. Analysis for MACPAC of 2013 Medical Expenditure Panel Survey (MEPS) data.

Association for Community Affiliated Plans (ACAP). 2013a. CCIIO FFE *monthly policy issuer engagement call.* Washington, DC: ACAP. http://www.ahcahp.org/portals/0/Policy/Medicaid/ACA%20Act/Consolidated%20ACAP%20ACHP%20MHPA%20Complete%20Questions%20and%20Notes%20for%20CCIIO.pdf.

Association for Community Affiliated Plans (ACAP). 2013b. *Overlap between Medicaid health plans and QHPs in the marketplaces: An examination.* Washington, DC: ACAP. http://www.communityplans.net/Portals/0/Policy/Medicaid/ACA%20Act/ACAP%20QHP%20Analysis%20Brief.pdf.

Backstrom, C. 2013. Reducing churn: Minnesota's approach to Basic Health Program. Presentation before the National Academy for State Health Policy, October 10, 2013, Seattle, WA.

Buettgens, M., G. Kenney, H. Recht, and V. Lynch. 2013. *Eligibility for assistance and projected changes in coverage under the ACA: Variation across states.* Washington, DC: Urban Institute. http://www.urban.org/publications/412918.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. State Medicaid and CHIP income eligibility standards effective January 1, 2014. Baltimore, MD: CMS. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. Medicaid moving forward in 2014. Baltimore, MD: CMS. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013c. Questions and answers: Medicaid and the Affordable Care Act. Baltimore, MD: CMS. http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013d. Letter from Marilyn Tavenner to Andy Allison regarding "Arkansas' request for a three-year Medicaid premium assistance demonstration." September 27, 2013. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013e. Letter from Marilyn Tavenner to Jennifer Vermeer regarding "Iowa's request for two new three-year Medicaid demonstrations." December 10, 2013. http://www.healthreformgps.org/wp-content/uploads/CMS-Response-to-Iowa.pdf.

Chang, T. and M. Davis. 2013. Potential adult Medicaid beneficiaries under the Patient Protection and Affordable Care Act compared with current adult Medicaid beneficiaries. *Annals of Family Medicine* 11, no. 5: 406–411. http://www.annfammed.org/content/11/5/406.full.pdf+html.

Covered California. 2013. Letter from Peter V. Lee to Gary Cohen regarding "Request for approval of bridge program demonstration project." August 20, 2013. http://www.healthexchange.ca.gov/BoardMeetings/Documents/August%2022,%202013/Bridge%20Program%20Letter%20to%20Gary%20Cohen%20(with%20Attachments).pdf.

Dash, S., K. Lucia, K. Keith, and C. Monahan. 2013. *Implementing the Affordable Care Act: Key design decisions for state-based exchanges.* Washington, DC: The Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Jul/1696_Dash_key_design_decisions_state_based_exchanges.pdf.

Decker, S., D. Kostova, G. Kenney, and S. Long. 2013. Health status, risk factors, and medical conditions among persons enrolled in Medicaid vs. uninsured low-income adults potentially eligible for Medicaid under the Affordable Care Act. *Journal of the American Medical Association* 309, no. 24: 2579–2586. http://jama.jamanetwork.com/article.aspx?articleid=1699906.

Esack, S. and T. Darragh. 2014. U.S. gives Pennsylvania until 2015 to move poorest children into Medicaid under Obamacare. *Morning Call,* January 22.

Galewitz, P. 2013. Some states trim Medicaid rolls as ACA kicks in. *Medpage Today,* August 20. http://www.medpagetoday.com/PublicHealthPolicy/Medicaid/41088.

Hasstedt, K. 2013. Toward equity and access: Removing legal barriers to health insurance coverage for immigrants. *Guttmacher Policy Review* 16, no. 1: 2–8.

Holahan, J., G. Kenney, and J. Pelletier. 2010. The health status of new Medicaid enrollees under health reform. Washington, DC: Urban Institute. http://www.urban.org/uploadedpdf/412206-health-status.pdf.

Johnson, N. 2013. Apple Health Plus—Washington's churn solution. Presentation before the National Academy for State Health Policy, October 10, 2013, Seattle, WA. http://www.nashpconference.org/wp-content/uploads/2013/presentations/n.johnson.3.churn.pdf.

Kaiser Commission on Medicaid and the Uninsured (KCMU). 2013. *The coverage gap: Uninsured poor adults in states that do not expand Medicaid.* Washington, DC: Kaiser Family Foundation. http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8505-the-coverage-gap-uninsured-poor-adults8.pdf.

Kaiser Family Foundation (KFF). 2014. Status of state action on the Medicaid-expansion decision. Washington, DC: KFF. http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET). 2013. *Employer health benefits: 2013 annual survey.* Menlo Park, CA: KFF. http://ehbs.kff.org.

Lucia, K., and S. Dash. 2013. Plan participation and market alignment in health insurance exchanges: Key design decisions for 2014. Presentation before the Medicaid and CHIP Payment and Access Commission, September 19, 2013, Washington, DC. http://www.macpac.gov/home/transcripts/MACPAC_2013-09_Transcript.pdf.

McKinsey & Company (McKinsey). 2013. *Exchanges go live: Early trends in exchange dynamics.* Washington, DC: McKinsey. http://www.mckinsey.com/client_service/healthcare_systems_and_services/latest_thinking.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. *Report to the Congress on Medicaid and CHIP.* March 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. *Overview of Medicaid and CHIP. January 2013.* Washington, DC: MACPAC. http://www.macpac.gov/reports.

Shuler, M. 2013. Changes to Medicaid expected. *The Advocate,* July 1. http://theadvocate.com/home/6377454-125/changes-to-medicaid-expected.

Somers, S., A. Hamblin, J. Verdier, and V.L.H. Byrd. 2010. *Covering low-income childless adults in Medicaid: Experiences from selected states.* Hamilton, NJ: Center for Health Care Strategies, Inc. http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf.

State Refor(u)m. 2014. Tracking Medicaid expansion decisions: a closer look at legislative activity. Washington, DC: State Refor(u)m. https://www.statereforum.org/node/11675.

U.S. Department of Health and Human Services (HHS). 2013. Basic Health Program: State administration of Basic Health Programs; Eligibility and enrollment in standard health plans; Essential health benefits in standard health plans; Performance standards for Basic Health Programs; Premium and cost sharing for Basic Health Programs; Federal funding process; Trust fund and financial integrity. Notice with comment period. *Federal Register* 78, no. 186 (September 25): 59122–59151.

Chapter 1 Appendix

Selected Changes under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) Relevant to Medicaid

- Expands Medicaid eligibility to nearly all individuals under age 65 with incomes up to 138 percent FPL regardless of categorical eligibility (effectively made optional by the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*)
- Implements modified adjusted gross income (MAGI) method of income calculation for determining eligibility for most non-disabled and non-elderly adults and children
- Implements reduction to state disproportionate share hospital (DSH) allotments in anticipation of a decrease in uncompensated care resulting from an expected increase in those covered by insurance
- Increases payment rate for primary care services provided by certain physicians to 100 percent of the Medicare payment rates for 2013 and 2014
- Extends CHIP funding through 2015
- Prohibits Medicaid payments for health care acquired conditions
- Establishes the Center for Medicare and Medicaid Innovation to support pilot programs for innovative payment and delivery arrangements in Medicare and Medicaid
- Establishes the Federal Coordinated Health Care Office to improve integration between Medicaid and Medicare with regard to dual eligible populations
- Includes funding for bundled payment demonstrations, global payment demonstrations for safety net hospitals, pediatric accountable care organization demonstrations, and a demonstration project to provide Medicaid payment to institutions for mental disease in certain cases
- Requires the development of an adult quality measurement program for Medicaid-eligible adults
- Provides that children who were in foster care and receiving Medicaid on their 18th birthday will continue to be eligible for full Medicaid until age 26
- Allows states to implement health home state plan amendments to provide more integrated care to Medicaid enrollees with chronic conditions
- Extends the Money Follows the Person demonstration program, supporting states as they shift towards providing more long-term services and supports (LTSS) in the home or community, rather than institutional settings
- Requires termination of providers in Medicaid who are terminated in Medicare; suspension of Medicaid payments where there is a credible allegation of fraud; adherence to National Correct Coding Initiative methodologies; establishment of recovery audit contractors in Medicaid; and in-person encounter with a provider prior to the provision of home health services

CHAPTER 2

Promoting Continuity of Medicaid Coverage among Adults under Age 65

Recommendations

Promoting Continuity of Medicaid Coverage among Adults under Age 65

This chapter underscores the Commission's support for two recommendations made in its March 2013 report to the Congress:

- The Congress should extend a statutory option for 12-month continuous eligibility for adults in Medicaid, parallel to the current state option for children in Medicaid.

- The Congress should eliminate the sunset date for extended Transitional Medical Assistance (TMA), while allowing states to opt out of TMA if they expand to the new adult group added under the Patient Protection and Affordable Care Act.

Key Points

- Low-income parents and childless adults experience substantial income volatility during the year, which can cause churning on and off of Medicaid coverage. Among adults under age 65 with income below 138 percent of the federal poverty level (FPL), 23 percent would have income above 138 percent FPL by four months. Of those, a third (34 percent) would be back below 138 percent FPL by their regular annual redetermination.
- After losing Medicaid eligibility, many parents and childless adults will not be eligible for, or take up, exchange or other coverage.
- Twelve-month continuous eligibility, which allows states to disregard the requirement in federal Medicaid regulations that enrollees report changes in income prior to their regularly scheduled redetermination, has been shown to reduce churning among children. However, this state plan option is no longer available for adults in Medicaid as a result of changes from the Patient Protection and Affordable Care Act (ACA, P.L. 111–148, as amended). To promote continuity of coverage, the Commission reaffirms its March 2013 recommendation that the Congress extend a statutory option for 12-month continuous eligibility for adults in Medicaid, parallel to the current state option for children in Medicaid.
- For decades, TMA has promoted employment and continuity of coverage. Subject to congressional authorization and funding, TMA provides 6 to 12 additional months of Medicaid eligibility to low-income parents and their children whose earnings would otherwise make them ineligible. To prevent unnecessary gaps in coverage, the Commission reaffirms its March 2013 recommendation that the Congress eliminate the sunset date for extended TMA, while allowing states to opt out of TMA if they expand to the new adult group.
- Other state strategies, such as bridge plans and premium assistance for exchange coverage, may be effective at mitigating some of the effects of churning. The Commission will continue to monitor the effectiveness of these new efforts and the extent to which churning and uninsurance still occur.

CHAPTER 2

Promoting Continuity of Medicaid Coverage among Adults under Age 65

For years, program administrators and policymakers have explored options to reduce churning, where individuals transition from one program to another or to uninsured status, often in a relatively short period of time. This chapter focuses on some of the churning that is expected to occur beginning in 2014 as the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) is fully implemented. Parents and childless adults, many of whom are newly eligible for Medicaid, will churn between Medicaid and exchange coverage as their incomes and other eligibility criteria change.[1] Even in expansion states, some parents and childless adults will not be eligible for, or take up, exchange or other coverage after losing Medicaid eligibility. Churning is of concern to policymakers because it causes disruptions in the continuity of care and causes individuals to forgo primary and preventive care that can prevent more costly health care utilization. Our focus in this chapter is on changes in coverage among parents and childless adults that occur between annual redeterminations because of changes in family income.[2, 3]

The chapter begins by briefly reviewing analyses on the impact of churning presented in MACPAC's March 2013 report to the Congress and the Commission's prior recommendations. We then present new analyses projecting significant income changes among parents and childless adults at or below 138 percent of the federal poverty level (FPL), which may cause these adults to move back and forth between various sources of coverage, or to uninsurance.[4] The final section describes policy interventions to promote continuity of coverage, including the Commission's continued support of prior recommendations on two specific strategies: 12-month continuous eligibility and Transitional Medical Assistance (TMA).

Impact of Coverage Changes

In its March 2013 report, MACPAC provided examples and evidence, both from the research literature and from MACPAC analyses, regarding the effects of churning and strategies to mitigate it (MACPAC 2013a). Reducing movement in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, and reduces the likelihood of inpatient hospital admissions and emergency room visits (Ku et al. 2009). Churning between insurance programs is disruptive for enrollees as well as for the plans, providers, and government entities that must process those changes. Twelve-month continuous eligibility, which allows states to disregard the requirement in federal regulations that enrollees report changes in income during the year that could affect their eligibility, has been shown to reduce churning among children. To enable states to maintain options for promoting continuity of coverage that were permitted prior to the ACA's implementation, the Commission recommended in March 2013 that the Congress statutorily authorize a state's option to provide 12-month continuous eligibility to adults enrolled in Medicaid, as exists for children in Medicaid.[5]

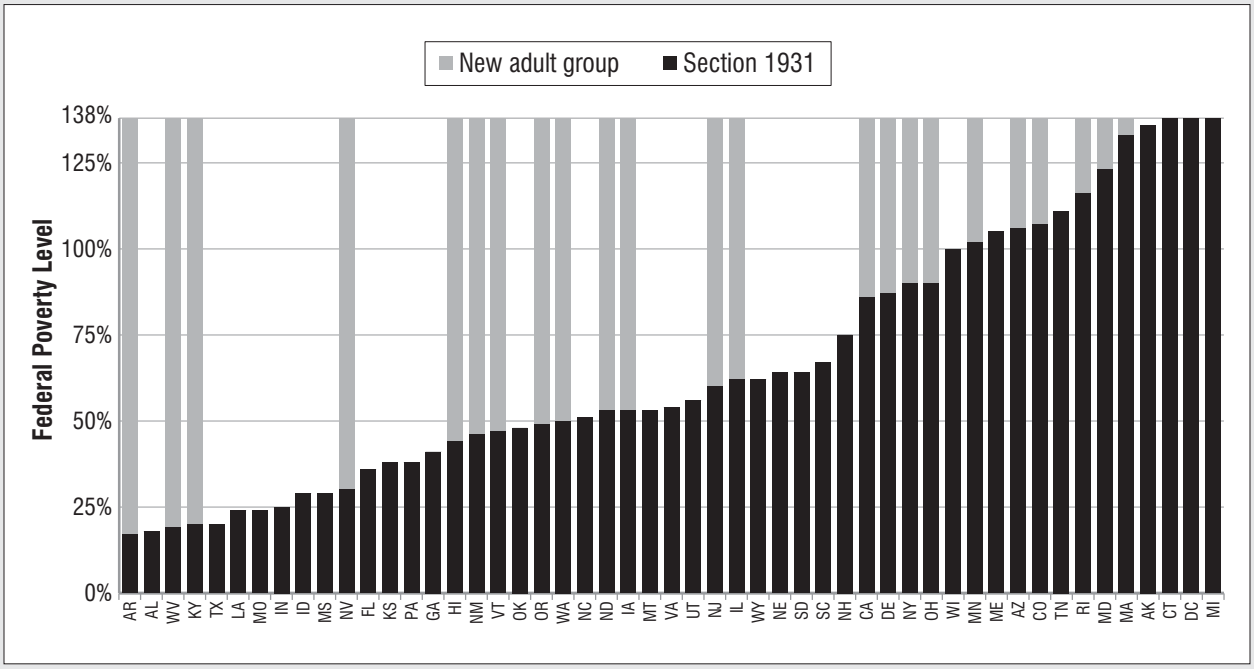
Since that recommendation was made, additional research has shown that non-disabled adults under age 65 have the lowest levels of continuous coverage of any Medicaid eligibility group (Ku and Steinmetz 2013).[6] According to the authors, widespread use of 12-month continuous eligibility for children may explain why children have lower churning rates than non-disabled adults under age 65.

Churning between sources of insurance, or to no insurance, occurs in every state, but churning dynamics in 2014 and beyond will differ depending on whether or not states expand Medicaid to the new adult group. Approximately half the states are not implementing this expansion in 2014, which means the vast majority of poor childless adults in these states will continue to be ineligible for Medicaid.[7] In all states, however, the lowest-income parents will continue to be eligible for Medicaid based on the state-specific levels that continue to be in effect under Section 1931 of the Social Security Act (the Act). Current Section 1931 eligibility levels vary by state from 17 percent FPL in Arkansas (less than $3,312 in annual income for a family of three) to levels above 100 percent FPL in a number of states (Figure 2-1).

Section 1931 was created in the welfare reform legislation of 1996. Prior to welfare reform, individuals eligible for the cash welfare program Aid to Families with Dependent Children (AFDC) were automatically eligible for Medicaid. When AFDC was eliminated by welfare reform, that eligibility pathway to Medicaid for low-income families was replaced by Section 1931 so that parents and children who would have been eligible for the state's AFDC program could still qualify for Medicaid. During fiscal year 2010, approximately 10.3 million children and 5.7 million adults were enrolled in Medicaid under Section 1931 (MACPAC analysis of the Medicaid Statistical Information System (MSIS) State Summary Datamart).

Another statutory provision that can mitigate churning is TMA. TMA has been available since 1974 to provide additional months of Medicaid coverage to certain low-income parents and their children whose increase in income would otherwise make them ineligible for Medicaid. Although TMA began by providing 4 months of extended Medicaid coverage, TMA currently requires states to provide at least 6 and up to 12 months of coverage (§1925 of the Act). Unlike most Medicaid provisions, Section 1925 TMA relies on regular extensions of its authority and funding by the Congress. TMA is only available to low-income parents and their children eligible for Medicaid under Section 1931. While the welfare reform legislation of 1996 delinked Medicaid eligibility from welfare assistance,

FIGURE 2-1. Income Eligibility Levels for Parents under the Section 1931 and New Adult Eligibility Groups by State



Notes: FPL is federal poverty level. Eligibility levels reflect a disregard equal to 5 percent FPL. This disregard only applies at the highest Medicaid eligibility level. Thus, in states that expanded to the new adult group, the disregard effectively increases eligibility from 133 percent FPL to 138 percent FPL but is not applied to these states' Section 1931 levels. For states not expanding to the new adult group, the disregard is applied to Section 1931 eligibility. In some states, Section 1931 eligibility levels as a percent of FPL vary by family size; this figure shows eligibility for a family of three, although levels may be slightly higher for smaller families. When Section 1931 eligibility levels vary within a state by region or other factors, the highest level is shown. For Section 1931 levels in Hawaii and New Jersey, Aid to Families with Dependent Children (AFDC) levels as of 1996 were used.

Sources: MACPAC analysis of: Centers for Medicare & Medicaid Services (CMS), *State Medicaid and CHIP income eligibility standards effective January 1, 2014 (for MAGI groups, based on state decisions as of February 26, 2014)*; and CMS, *Medicaid moving forward 2014, State-specific documents, MAGI conversion plan* and *SIPP-based MAGI conversion results*, http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html.

the Congress retained TMA for families eligible under Section 1931, to ensure that the poorest families could transition from welfare assistance to work without losing health insurance coverage.

To mitigate churning from Medicaid to uninsurance that may result from the coverage gap between Medicaid and subsidized exchange coverage in non-expansion states (which begins at 100 percent FPL for citizens), the Commission recommended in its March 2013 report that the Congress end the sunset date for 6- to 12-month TMA. For states implementing the expansion in which there is no coverage gap between Medicaid and subsidized exchange coverage, the Commission recommended that states be able to opt out of TMA.

Income Changes among Parents and Childless Adults below 138 Percent FPL

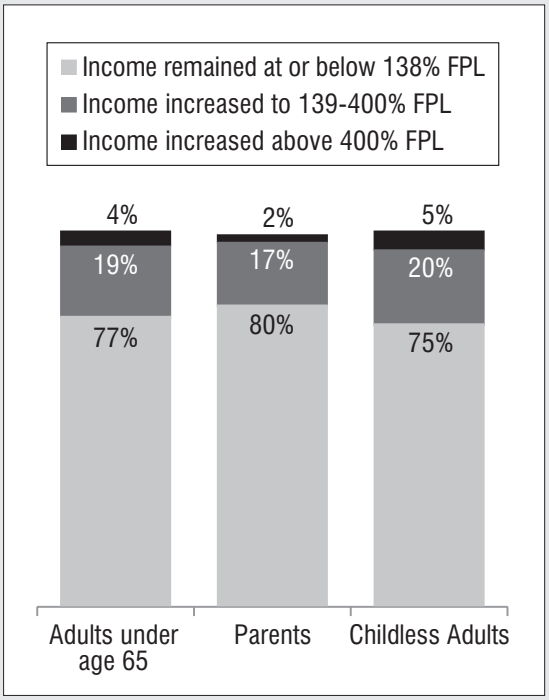
For parents and childless adults enrolled in Medicaid in expansion states, transitions out of Medicaid will occur primarily because of income changes from below to above 138 percent FPL ($16,105 in annual income for an individual). New analyses suggest that there is significant intra-year income changes among adults under age 65 moving from below to above 138 percent FPL and back again. Because of frequent income changes, these individuals may be required to move back and forth between Medicaid and other sources of coverage (or uninsurance).

In expansion states, when parents and childless adults lose eligibility for Medicaid because of a reported income change, many may become uninsured. Not all those eligible for subsidized exchange coverage will enroll because some out-of-pocket cost sharing and premium payments will generally still be required. In addition, many parents and childless adults losing Medicaid eligibility will be ineligible for subsidized exchange coverage because they are offered employer-sponsored insurance that is considered affordable under the law, but may not be practically affordable. Under the ACA, employer-sponsored insurance is considered affordable if employees' out-of-pocket premiums for self-only coverage comprise less than 9.5 percent of family income. This affordability test—sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered—could contribute to many former Medicaid enrollees moving to uninsurance if families find that employer-sponsored insurance and unsubsidized exchange coverage are not affordable. In fact, of those enrolled in Medicaid, more would become uninsured at least part of the year than would enroll in exchange coverage at least part of the year (Buettgens 2013).

Many parents and childless adults who are below 138 percent FPL at a point in time experience increases in income that could make them ineligible for Medicaid—as shown at 4 months (Figure 2-2), 8 months (Figure 2-3), and 12 months (Figure 2-4). If all individuals reported income changes during the year as required, 23 percent of these adults would move out of regular Medicaid by 4 months, and 28 percent by 8 months (Figure 2-5).[8] Nearly one-third (32 percent) of adults initially below 138 percent FPL would be above 138 percent FPL by the time of their annual redetermination and would thus be ineligible for Medicaid, unless TMA were available (Figure 2-5).

The vast majority of adults projected to have income changes from below to above 138 percent FPL would still be below 400 percent FPL

FIGURE 2-2. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 4 Months



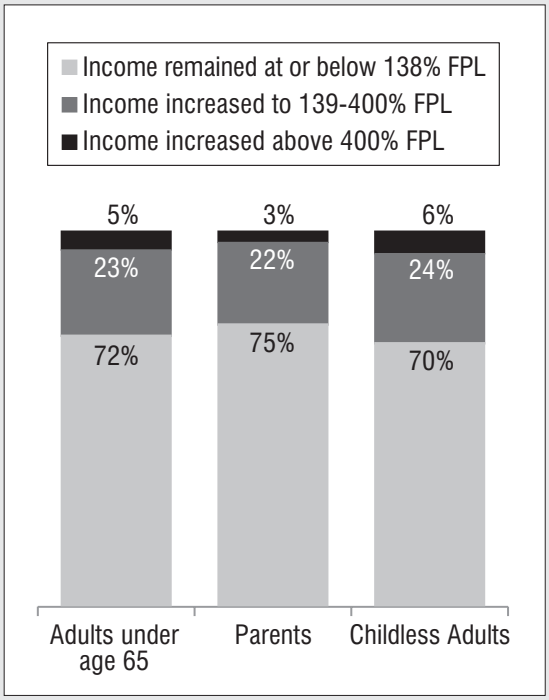
Note: This figure shows income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

(Figures 2-2, 2-3, and 2-4) and thus potentially eligible for subsidized exchange coverage unless they had access to employer-sponsored coverage that was considered affordable.

Income changes are more common among the lowest-income adults, which could lead to significant uninsurance if TMA did not exist for parents, particularly in non-expansion states. In states not implementing the Medicaid expansion, Medicaid eligibility for parents will only be available under Section 1931, typically at 50 percent FPL or below. At these states' relatively low-income eligibility levels, changes in income from below to

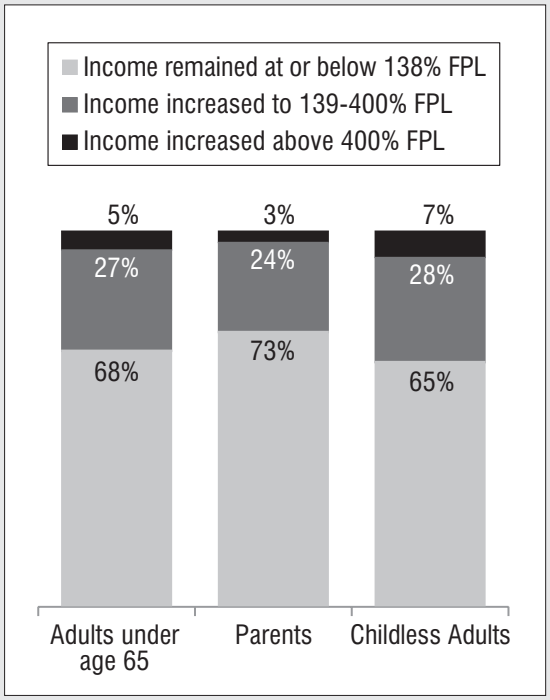
FIGURE 2-3. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 8 Months



Note: This figure shows income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

FIGURE 2-4. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases Observed at 12 Months



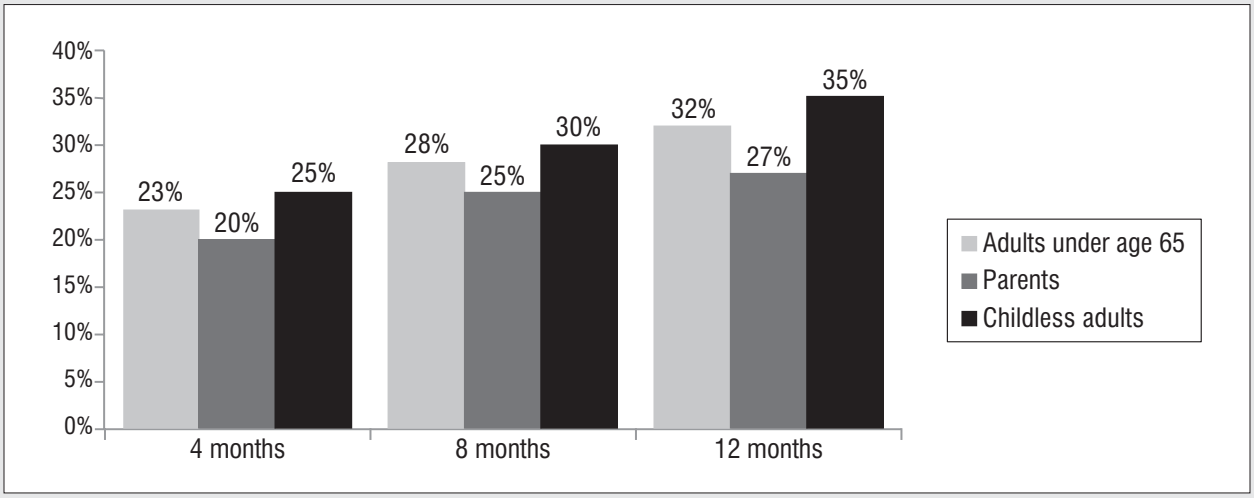
Note: This figure shows income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

above these thresholds are double that of parents at 138 percent FPL (Figure 2-6).

For example, Texas is not currently planning to implement the expansion to the new adult group, and, in 2014, the state will cover parents up to 15 percent FPL, or $2,969 in annual income for a family of three (CMS 2013a). Because of the ACA requirement that all state Medicaid and CHIP programs count income for most enrollees according to modified adjusted gross income (MAGI), states will be required to disregard income equal to 5 percent FPL when determining eligibility. Thus, the effective level for parents' eligibility in Texas will be 20 percent FPL, or $3,958 in annual income for a family of three. Among parents nationwide below 20 percent FPL, 49 percent would have income above that level after just four months (Figure 2-6) compared to 20 percent of parents who would have income increased from below to above the threshold of 138 percent FPL after four months (Figure 2-5).[9] Considering the additional income volatility among the lowest-income parents enrolled in Medicaid under Section 1931, TMA will play an important role in non-expansion states to reduce the extent to which parents churn off of Medicaid to uninsurance.

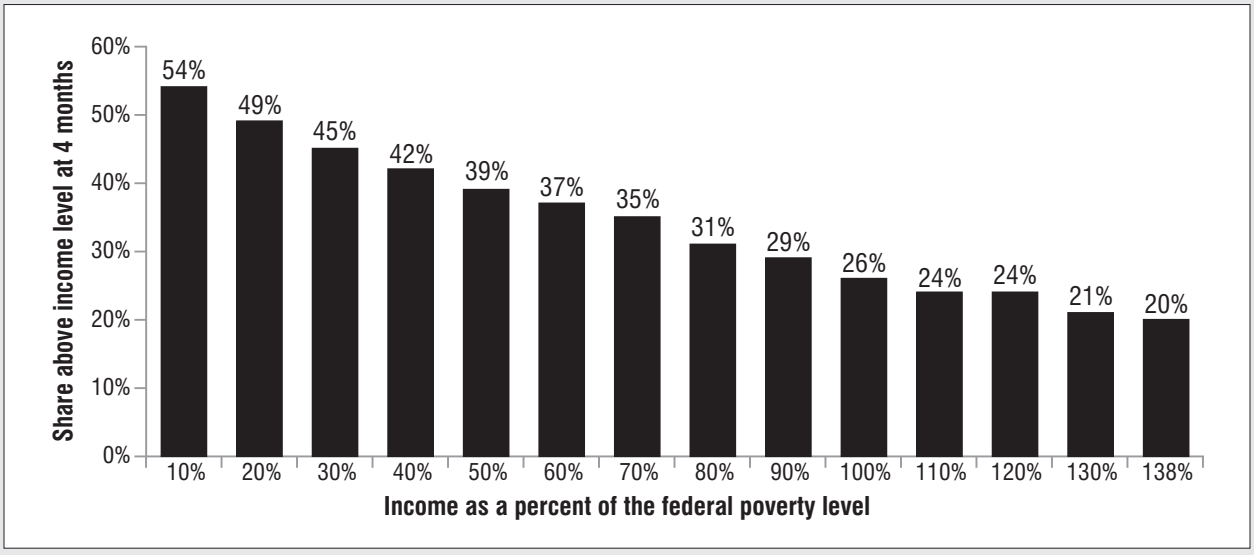
FIGURE 2-5. Percent of Adults under Age 65 at or below 138 Percent FPL with Income Increases above 138 Percent FPL Observed at 4, 8, and 12 Months



Note: This figure shows the income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Source: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

FIGURE 2-6. Percent of Parents under Age 65 Who Experience an Increase in Income Level Observed at 4 Months



Notes: This figure shows the income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. FPL is the federal poverty level. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

Sources: Analysis for MACPAC by Brett Fried of the State Health Access Data Assistance Center (SHADAC), using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) for April 2010, August 2010, December 2010, and April 2011.

Strategies to Improve Continuity of Coverage among Parents and Childless Adults

Changes in income and family situations can cause a change in individuals' health coverage affecting benefits to which they are entitled, cost sharing, participating providers, and the plan in which they are enrolled. But experiences will vary among individuals. Some may move to TMA, employer-sponsored insurance, or uninsurance. In non-expansion states, the gap between Medicaid eligibility and exchange coverage for parents may result in greater churning to uninsurance once their TMA is exhausted.

Some churning is inevitable. For example, the eligibility of parents and childless adults enrolled in Medicaid must be redetermined annually, with changes in income or family status potentially leading to a change in source of coverage. Steps can be taken, however, to smooth transitions and mitigate the consequences of churning—thus ensuring continued coverage and preserving access to current providers, benefits, and cost-sharing protections. The remainder of this chapter describes various strategies to improve the stability of coverage, or, when churning cannot be avoided, to mitigate some of its negative effects. The strategies are discussed in terms of whether or not they are effective in preventing changes in the providers that enrollees can see, the plan in which they are enrolled, and the benefits and cost-sharing protections they can access. Few of the strategies can address all of these factors.

Managed care plan participation in both Medicaid and exchange markets. As individuals transition between Medicaid and exchange coverage, the change may be less disruptive if the same insurer participates in both the Medicaid and exchange markets. In this case, individuals could stay with the same insurer and potentially the same network of providers. However, the provider networks may not be identical across markets. Moreover, the presence of such plans would not prevent other significant impacts of churning—for example, changes in benefits and cost sharing resulting from a move from Medicaid to exchange-based coverage.

The prevalence of Medicaid managed care could provide opportunities for large enrollment in plans that participate in both Medicaid and exchange markets. Currently, more than two-thirds of state Medicaid programs contract with full-risk Medicaid managed care plans, which account for half of all Medicaid enrollees (MACPAC 2013b). Most states that are implementing the expansion to the new adult group are enrolling the majority in managed care (Sommers et al. 2013). A recent study by the Association for Community Affiliated Plans found that 41 percent of insurers offering exchange coverage also offer a Medicaid managed care plan in the same state (ACAP 2013). More analysis will be needed to determine the extent to which provider networks vary even if an insurer offers products in both markets.

An insurer's decision to participate in both Medicaid and exchange markets is affected by many factors. Business and strategic considerations appear to be the most significant contributors to plan decisions about whether to participate in both markets. Participation in exchanges requires substantial investments in time and resources, and the potential return on the investment is still unknown. In addition, plans must also be able to negotiate sufficiently competitive provider contracts to support competitive pricing within the exchange (Holahan 2012). As a result, some insurers decided to opt out of the exchanges in 2014 and are waiting to see how the market unfolds before deciding whether to participate in future years. Other insurers chose to participate in the exchanges for a number of reasons, including a desire to gain membership in the first year of exchange operation,

capture family members of current enrollees, and retain enrollees who transition between Medicaid and the exchanges.

Whether differing requirements for exchange plans versus Medicaid managed care plans might pose a barrier to multimarket participation remains to be seen. However, federal requirements for exchange plans and Medicaid managed care plans are relatively similar, allowing for substantial state flexibility and control. While there are some differences between the federal rules governing each market, these differences do not appear to be a barrier for plans that wish to participate in both markets. Exchange rules vary considerably among states that operate their own exchanges. As with Medicaid, states operating their own exchanges have the ability to make many of their own management decisions, which may affect plan willingness and ability to participate in the exchange market. On the other hand, for some plans interested in operating in multiple states, this variation is a concern. MACPAC plans to monitor the presence of multimarket plans and their effect on reducing disruptions in enrollees' access to providers.

Bridge plans. Bridge plans are another mechanism that could mitigate some of the negative effects of churning—in particular, the need to switch plans and providers. Bridge plans are a type of multimarket plan that is permitted to cover only a fraction of individuals in the other market. For example, bridge plans may be exchange plans that are also permitted to enroll family members who are eligible for Medicaid or CHIP or vice versa (Johnson 2013, CMS 2012). This allows the family to be enrolled in the same plan, albeit with different cost sharing. Bridge plans must meet the requirements of both Medicaid and exchanges, and, in 2014, they can only be offered in states with a state-based exchange (CMS 2012). As a result, take-up of this approach has been quite limited. At this time, only two states appear to be implementing bridge plans—California and Washington (Covered California 2013, Johnson 2013).

Premium assistance for exchange coverage. Premium assistance is another vehicle to bring exchange plans to Medicaid enrollees. Premium assistance permits Medicaid-eligible individuals to enroll in exchange plans, with Medicaid paying for the premiums and cost-sharing reductions. Like multimarket plans and bridge plans, premium assistance has the potential to provide access to the same plans and provider networks as individuals churn between Medicaid and exchange coverage. Like multimarket plans and bridge plans, premium assistance cannot be used to preserve Medicaid's benefits and cost-sharing protections as an individual's income increases from Medicaid to exchange levels. However, as long as individuals remain eligible for Medicaid, those enrolled in exchange-based premium assistance generally cannot face cost sharing in excess of what they would face in regular Medicaid (CMS 2013b).

Premium assistance is distinct from multimarket plans and bridge plans in that the exchange plan is not required to meet federal requirements that otherwise apply to Medicaid managed care plans. An exchange plan does not need to be certified as a Medicaid managed care organization in order to enroll Medicaid beneficiaries when the state has elected to implement premium assistance. However, states may elect to add certain plan requirements.

While premium assistance prevents enrollees from having to switch plans when their income reaches or exceeds 138 percent FPL, it may simply move the point at which such a switch is required. For example, in 2014, Arkansas will maintain traditional fee-for-service Medicaid coverage for its Section 1931 parents, up to 17 percent FPL. Thus, if parents' income increases from below to above 17 percent FPL—that is, to the new premium assistance option—they would have to choose an exchange plan, with a different network although

still with virtually no cost sharing (CMS 2013c). To eliminate this effect of churning, Arkansas has expressed an interest in enrolling Section 1931 parents, as well as children, in its premium assistance program in the future (Arkansas 2013a).

Although states can implement premium assistance without a waiver, most states wanting to use premium assistance with exchange plans are seeking waivers in order to implement it in a way not otherwise permitted. For example, a waiver is required if states want to mandate enrollment in exchange-based premium assistance, as implemented by Arkansas and Iowa. However, the Centers for Medicare & Medicaid Services (CMS) is only willing to approve "a limited number of premium assistance demonstrations" (CMS 2013d). Approval of such waivers would have additional limitations—for example, that enrollees have a choice of at least two exchange plans and that the demonstration end by December 31, 2016 (CMS 2013d).

Other states are considering the premium assistance approach (Sommers et al. 2013). While it can reduce the extent of plan switching necessitated by churning, exchange-based premium assistance raises a number of other questions that the Commission will be exploring in the future, such as whether the state Medicaid agency has a role in overseeing exchange plans receiving premium payments from Medicaid and whether enrollees are able to access the benefits to which they are entitled.

Basic Health Program. The ACA permits states to create a Basic Health Program that covers individuals above 138 and up to 200 percent FPL. If offered in their state, eligible individuals would be required to enroll in the Basic Health Program in lieu of obtaining subsidized coverage in the exchanges. States would receive 95 percent of the money the federal government would have paid for subsidized exchange coverage. Depending on how it is implemented by states and how much coverage states can purchase with the federal funds, a Basic Health Program could require little or no cost sharing from enrollees. If this occurs, a state may be able to implement a Basic Health Program to reduce the effects of churning from below to above 138 percent FPL by maintaining the same plans, benefits, and cost sharing as in Medicaid. These programs are intended not only to reduce churning, but also to reduce the likelihood that low-income families would be forced to repay premium tax credits they received should they experience an increase in income or a change in family composition (CMS 2013e). Because CMS delayed the implementation of the Basic Health Program until 2015, it will be some time before the effects of this ACA provision can be assessed (CMS 2013e). Seven states are known to be considering this option for 2015 (Sommers et al. 2013).

Twelve-month continuous eligibility. By disregarding income changes, 12-month continuous eligibility has the potential to eliminate income-related churning altogether between annual redeterminations, thus avoiding mid-year changes in benefits, cost sharing, plans, and networks.

In its March 2013 report, the Commission addressed the issue of churning by recommending that the Congress statutorily authorize the option for states to implement 12-month continuous eligibility to adults enrolled in Medicaid (MACPAC 2013a).[10]

Under current rules, Medicaid enrollees are generally required to report changes that may affect eligibility between regularly scheduled redeterminations (42 CFR 435.916(c)). Based on these requirements, enrollment in Medicaid can change in any month. Medicaid applications clearly state the requirement to report income changes. For example, the model application available through the federally facilitated exchange asks applicants for their signature, acknowledging that "I know that I must tell the Health Insurance Marketplace if anything changes (and is different than) what I wrote on this application" (CMS

2013f). The application then describes how individuals can report any changes. Many state Medicaid applications have similar language.

Twelve-month continuous eligibility allows states to enroll individuals in Medicaid or CHIP for 12 months, regardless of changes in family income that occur in the interim. For example, among parents and childless adults who begin the year at or below 138 percent FPL but then experience an income change by four months to above 138 percent FPL, 34 percent are back below 138 percent FPL at the time of the regular annual redetermination. Among those whose income is above 138 percent FPL at the 8-month mark, 26 percent are back below 138 percent FPL by the 12-month mark (Fried 2013). Twelve-month continuous eligibility would prevent these individuals from churning off and back on to Medicaid during the year.

Twelve-month continuous eligibility is an explicit statutory option for children in Medicaid used by 23 states but, as of 2014, is no longer available as a state plan option for adults in Medicaid (CMS 2013b, HHS 2012). Prior to the implementation of MAGI in 2014, states had the ability to implement 12-month continuous eligibility for adults without a waiver, by using their income-counting flexibility to disregard all changes in income between redeterminations. Because MAGI permits no state-specific income disregards, this approach for implementing 12-month continuous eligibility for adults is no longer available.

For adults in Medicaid, 12-month continuous eligibility is now available only through a Section 1115 waiver; however, waivers are accompanied by requirements that do not apply for regular state plan options (CMS 2013b). For states without an existing waiver, the process would be more difficult, requiring the state to go through the full array of transparency rules in addition to the full waiver application process. To facilitate the application process, CMS provides an online template for Section 1115 waivers, which includes space for states to note their desire to implement 12-month continuous eligibility (CMS 2013g).

CMS' interpretation of how 12-month continuous eligibility for adults is financed under a waiver may have contributed to reduced state interest in the approach. No state has yet implemented 12-month continuous eligibility for adults through a waiver, although five states reported in 2013 that they were planning to do so (Sommers et al. 2013). For example, Arkansas's original Section 1115 application in 2013 sought to implement 12-month continuous eligibility for newly eligible adults (Arkansas 2013b), but the provision was dropped in the final waiver application (CMS 2013c). While the state is eligible for 100 percent federal funding for newly eligible adults in 2014, CMS informed the state that some adjustment to the enhanced matching rate for newly eligible adults would be required to account for an estimate of those adults who would have become ineligible due to reported changes in income.

To ensure that states continue to have the flexibility to implement 12-month continuous eligibility for adults, the Commission recommended in its March 2013 report that the Congress create a statutory option for 12-month continuous eligibility for adults in Medicaid. The Commission continues to support this recommendation as an approach that promotes stability of coverage and reduces administrative burden associated with intra-year redeterminations. This would give states the option to align their redetermination policies for families, so that if children are eligible for 12-month continuous eligibility, their parents can be as well. Congressional action should also clarify that states implementing 12-month continuous eligibility for adults in Medicaid would continue to receive the appropriate matching rate for those populations, as with

enhanced federal matching for children enrolled using 12-month continuous eligibility in CHIP.

Twelve-month continuous eligibility can also prevent the potential loss of Medicaid from serving as a disincentive to work. As individuals' incomes increase, they could lose Medicaid eligibility but qualify for exchange coverage that, even when subsidized, requires premiums and cost sharing that can be difficult for families to afford. These financial implications can serve as a disincentive for families to increase their earnings, if those additional earnings are reduced by out-of-pocket premiums and cost sharing. For low-income families, there could also be concerns with churning in and out of exchange coverage and their potential liability to repay premium tax credits.[11] Ensuring that Medicaid policy does not provide a disincentive to work has been a goal of the Congress in enacting many Medicaid provisions, including TMA (GAO 2002, U.S. House of Representatives 1972). Giving states the option that existed prior to the ACA to implement 12-month continuous eligibility for adults in Medicaid would be consistent with this goal.

According to the Congressional Budget Office (CBO) and the ranges of cost estimates it provides to MACPAC, statutorily permitting states to implement 12-month continuous eligibility for adults in Medicaid would increase federal spending in 2015 by $50 million to $250 million. Over the five-year period of 2015 to 2019, this recommendation would increase federal spending by less than $1 billion, the smallest non-zero category used by CBO.

There are many reasons for the relatively small projected federal costs, including potentially low state take-up of the option, since no state has ever implemented 12-month continuous eligibility for adults. Even to the extent that it is implemented, the net federal costs could be limited by the fact that continued Medicaid enrollment resulting from 12-month continuous eligibility would often be replacing other federal spending—such as, for subsidized exchange coverage—thus providing offset savings from any increased federal Medicaid spending.

On the other hand, the Commission acknowledges that states choosing to implement 12-month continuous eligibility could see increased Medicaid spending resulting from enrollees remaining covered for a greater number of months during the year, on average. For example, compared to other states, states that implemented 12-month continuous eligibility between 2008 and 2010 for children in Medicaid experienced 2 percent larger increases in children's average months of enrollment, which could be expected to result in a 2 percent increase in spending on children in Medicaid (Ku et al. 2013). However, some of those costs could be offset by administrative savings of reduced intra-year redeterminations and lower per capita spending from greater stability of coverage.

State projections of the cost of 12-month continuous eligibility have varied widely. The greatest estimated costs were projections by states that had not yet implemented 12-month continuous eligibility (e.g., Colorado Legislative Council 2009).[12] One state that had implemented 12-month continuous eligibility for children noted there was little increased spending as a result and perhaps even some net savings (Barkov and Hale 2013).

Transitional Medical Assistance. As described earlier, Section 1925 TMA provides an additional 6 to 12 months of Medicaid to the lowest-income parents and children who would otherwise lose Medicaid under Section 1931, generally because of an increase in earnings. Like 12-month continuous eligibility, TMA delays churning and, during that time, avoids the concomitant changes in covered benefits, cost sharing, plans, and networks. In 2011, 43 states reported TMA enrollment of over 3.7 million individuals (GAO 2013).

The context for TMA has changed because of the coverage options available under the ACA. Many parents in states implementing the Medicaid expansion will be eligible for the new adult group or subsidized exchange coverage, so TMA may not be as essential in preventing uninsurance as it was in the past. In states that do not expand coverage to the new adult group, however, there is a gap in coverage between states' Section 1931 levels and eligibility for subsidized exchange coverage, which begins at 100 percent FPL for citizens. TMA will be particularly crucial in preventing uninsurance in states that do not expand Medicaid coverage for adults.

As of the publication of this report, Section 1925 TMA funding ends after March 31, 2014. For the past several years, funding for TMA has continued through short-term extensions. Most recently, the Bipartisan Budget Act of 2013 (P.L. 113-67) extended TMA funding by another three months, from December 31, 2013, to March 31, 2014.

If the authorization and funding for TMA is not extended, TMA will not disappear altogether but will revert to its original four-month duration. Four-month TMA has different eligibility policies that have not been in effect since 1990. States would also lose some of the flexibility they currently have under Section 1925 TMA. For example, states may currently require TMA beneficiaries to enroll in employer-sponsored insurance if offered to them. States using this option must pay the enrollees' share of premiums and cost sharing. At least 23 states use this premium assistance option under TMA to purchase employer-sponsored insurance—an option that would disappear if Section 1925 TMA is not renewed (GAO 2012). This option currently provides the opportunity for low-income individuals to transition to employer-sponsored insurance rather than abruptly facing the premiums and cost-sharing requirements that might discourage them from working or working more hours. Thus, reverting to four-month TMA would require states to implement resource-intensive changes, which may be less than ideal as states are making other significant changes to their eligibility systems, and would increase costs—both for states and the federal government.

The Commission's recommendation in its March 2013 report would have ended the sunset date for Section 1925 TMA. The Commission continues to support this recommendation so that states do not face the perennial possibility of reverting to four-month TMA and of needing to modify their eligibility systems to reinstitute TMA policies from 1990. In addition, TMA in its current form also prevents uninsurance, particularly in states not expanding Medicaid to the new adult group. Since non-expansion states will have a gap in eligibility for parents between Medicaid and subsidized exchange coverage, TMA will be critical in those states to reduce churning from Medicaid to uninsurance. The Commission also recognizes that providing incentives to promote increased earnings and employment opportunities for the lowest income Americans is an important goal. TMA has helped many to move on to employment without compromising ongoing health care during the transition.

For providers and health plans, the continuation of 6- to 12-month TMA would reduce the administrative burden associated with individuals moving on and off of Medicaid. Longer tenure by enrollees with the same plan or provider helps ensure that efforts to improve care management and quality are not compromised because of churning. While some churning is inevitable, the Commission's recommendation to eliminate the sunset date for TMA seeks to reduce churning that is disruptive to care delivery.

CBO projects that ending the sunset date for Section 1925 TMA would save the federal government between $1 billion and $5 billion over a five-year period from 2015 to 2019. CBO's current-law assumption is that when 6- to 12-month TMA expires, it will revert to its four-month duration, after which time individuals move to other sources

of coverage or to uninsurance. Under CBO's current-law assumption, the other sources of coverage—for example, subsidized exchange coverage or Medicaid coverage for newly eligible adults currently at the 100 percent federal matching rate—may result in higher federal spending than under regular Medicaid. From the federal perspective, the savings projected by CBO from ending the sunset date on 6- to 12-month TMA result from replacing those more costly sources of coverage with additional months of TMA at the regular Medicaid matching rate. However, if TMA reverts to four months—shortening TMA and allowing individuals to move to subsidized exchange coverage, newly eligible Medicaid, or to uninsurance—states would incur less of an expense than continuing with 6 to 12 months of TMA at the regular Medicaid matching rate.

The second part of the Commission's TMA recommendation in March 2013 was to permit expansion states to opt out of TMA altogether. Because these states have no eligibility gap between Medicaid and subsidized exchange coverage, TMA may no longer be as necessary in these states to prevent uninsurance. Its continuation could create unnecessary confusion and administrative burden for enrollees, state Medicaid and CHIP programs, and exchanges.

For expansion states, opting out of TMA will also address an inequity between those parents and children who are eligible for TMA and those who are not. For example, while very low-income parents and children who are eligible for Medicaid under Section 1931 may qualify for TMA, parents enrolled through the new adult group will not have access to TMA.[13]

The two parts of the Commission's March 2013 TMA recommendation were originally projected by CBO to have little effect on federal spending. However, the same policies are now projected by CBO to increase federal spending by $750 million to $2 billion in 2015 and by $5 billion to $10 billion in the five-year period between 2015 and 2019. The increased estimate results from changes in how CBO projects the federal cost of expansion states opting out of TMA. CBO projects that every expansion state would opt out of TMA, which would result in much higher federal spending as individuals who would otherwise receive TMA at the regular Medicaid matching rate would receive Medicaid as newly eligible adults or would enroll in subsidized exchange coverage, which results in higher federal spending.

The Commission also considered an alternative—allowing expansion states to only opt out of TMA if they replaced it with 12-month continuous eligibility. This alternative would achieve the same purpose—preventing people from forgoing additional income in order to maintain their Medicaid coverage. In addition, the 12-month eligibility period would be more consistent with the annual open enrollment that exists in employer-sponsored insurance and in exchange coverage (MACPAC 2012). Although this approach would be less costly to the federal government than simply allowing expansion states to opt out, the Commission considered but ultimately chose not to recommend that these states be required to adopt 12-month continuous eligibility.

Endnotes

[1] For the remainder of this chapter, childless adults generally refer to individuals age 19–64 who are not pregnant, not eligible for Medicaid on the basis of a disability, and do not have dependent children living in the home.

Individuals could also churn from Medicaid to uninsurance if they are below 400 percent FPL and do not enroll in available employer-sponsored insurance that is considered affordable (i.e., self-only coverage that comprises less than 9.5 percent of income). Having an offer of affordable employer-sponsored insurance disqualifies individuals from receiving premium tax credits for exchange coverage.

[2] Churning can occur for a variety of reasons. Research on churning has historically focused on transitions from Medicaid or CHIP to uninsurance, particularly at enrollees' regular eligibility redetermination. This is generally referred to as administrative churning, where enrollees' coverage terminates because families do not or cannot provide the necessary application or documentation. However, the ACA required states to streamline eligibility determinations and to use existing data wherever possible, in order to minimize the likelihood of administrative churning at redeterminations. A full assessment of the impact of the ACA on administrative churning will not be possible until actual data are available on redeterminations in 2014. This will be an area of interest for the Commission when those data are available.

[3] Other chapters in this report analyze changes in coverage among children and pregnant women in CHIP. Individuals eligible for Medicaid on the basis of being aged or disabled have the highest levels of continuity of coverage (Ku and Steinmetz 2013).

[4] Because of the ACA requirement to count income according to modified adjusted gross income, states will be required to disregard income equal to 5 percent FPL. For this reason, eligibility for the new adult group is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[5] This recommendation also applied to children enrolled in CHIP. Twelve-month continuous eligibility in CHIP is discussed in Chapter 5 of this report.

[6] The eligibility groups in this analysis were aged, blind/disabled, children, and non-elderly adults.

[7] Some states not implementing the expansion to the new adult group cover certain childless adults through Medicaid-funded premium assistance for employer-sponsored insurance or limited-benefit coverage under Section 1115 waivers.

[8] The estimates are of the share of adults under age 65 starting at or below 138 percent FPL who are at a higher-income category at a specific month in the year (at 4 months, at 8 months, and at 12 months). These estimates assess income changes of all adults under age 65, regardless of their source of coverage, their disability, or pregnancy status. The definitions of family and family income are based on U.S. Census Bureau definitions and may produce different estimates than if using tax-filing units and modified adjusted gross income.

[9] Because of TMA, these parents would continue Medicaid coverage for at least six more months.

[10] While this chapter focuses on parents and childless adults, the Commission's recommendation was to enable states to use 12-month continuous eligibility for any population in Medicaid, including adults eligible on the basis of being aged or disabled.

[11] In the ACA as originally enacted, families who were below 400 percent FPL would not be required to repay more than $400 when their actual 2014 tax return was reconciled with their advance premium tax credits (§36B(f)(2)(B) of the Internal Revenue Code as originally enacted in §1401(a) of the ACA). The potential repayment amounts are now much higher, which could increase individuals' reluctance to obtain subsidized exchange coverage. In 2014, families below 200 percent FPL may be required to repay up to $600, families with income of at least 200 percent FPL but below 300 percent FPL may be required to repay up to $1,500, and families with income of at least 300 percent FPL but below 400 percent FPL may be required to repay up to $2,500.

[12] Commissioners noted that if it were uncommon for states to eliminate 12-month continuous eligibility once implemented, then this may indicate that its cost to the state is not substantial. Only one state—Washington—was found to have dropped 12-month continuous eligibility for children in Medicaid. In 2003, Washington eliminated 12-month continuous eligibility along with numerous other changes that, in combination, reduced children's enrollment by 30,000. One large contributor to the reduction may have been requiring redeterminations every 6 months rather than every 12 months. Less than two years later, the state restored 12-month redetermination periods and 12-month continuous eligibility (Center for Children and Families 2009).

[13] TMA is also not available to children enrolled through CHIP and Medicaid's poverty-related pathways, rather than Section 1931.

References

Association for Community Affiliated Plans (ACAP). 2013. *Overlap between Medicaid health plans and QHPs in the marketplaces: An examination.* Washington, DC: ACAP. http://www.communityplans.net/Portals/0/Policy/Medicaid/ACA%20Act/ACAP%20QHP%20Analysis%20Brief.pdf.

Barkov, J., and B. Hale. 2013. Alaska Department of Health and Social Services. E-mails to MACPAC staff. November.

Buettgens, M. 2013. Where Medicaid ends: Churning in health insurance coverage under the ACA. Presentation before the Legislative Summit of the National Conference of State Legislatures, August 14, 2013, Atlanta, GA. http://www.ncsl.org/documents/summit/summit2013/online-resources/MBuettgensLS13.pdf.

Center for Children and Families, Georgetown University Health Policy Institute. 2009. Program design snapshot: 12-month continuous eligibility. http://ccf.georgetown.edu/wp-content/uploads/2012/03/Program-design-12-month-continuous-eligibility.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. State Medicaid and CHIP income eligibility standards effective January 1, 2014. Baltimore, MD: CMS. http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. Letter from Cindy Mann to State Health Officials and State Medicaid Directors regarding "Facilitating Medicaid and CHIP enrollment and renewal in 2014." May 17, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013c. Arkansas Health Care Independence Program (private option). Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013d. Medicaid and the Affordable Care Act: Premium assistance. Baltimore, MD: CMS. http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013e. Questions and answers: Medicaid and the Affordable Care Act. Baltimore, MD: CMS. http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013f. Application for health coverage & help paying costs. Baltimore, MD: CMS. http://marketplace.cms.gov/getofficialresources/publications-and-articles/marketplace-application-for-family.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013g. Section 1115 demonstration program template. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Fillable-1115-Demo-10-12v2.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Frequently asked questions on exchanges, market reforms and Medicaid. Baltimore, MD: CMS. http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf.

Colorado Legislative Council, State of Colorado. 2009. Final fiscal note. Report no. HB09-1293. http://www.leg.state.co.us/clics/clics2009a/csl.nsf/billcontainers/D71C48DD229F80CD872575540079F3A0/$FILE/HB1293_f1.pdf.

Covered California. 2013. Letter from Peter V. Lee to Gary Cohen regarding "Request for approval of bridge program demonstration project." August 20, 2013. http://www.healthexchange.ca.gov/BoardMeetings/Documents/August%2022,%202013/Bridge%20Program%20Letter%20to%20Gary%20Cohen%20(with%20Attachments).pdf.

Fried, B. 2013. Revised SHRP presentation for MACPAC. State Health Access Data Assistance Center (SHADAC). November 8, 2013.

Holahan, J. 2012. *Plan participation in health insurance exchanges: Implications for competition and choice.* Washington, DC: Urban Institute. http://www.urban.org/UploadedPDF/412645-Plan-Participation-in-Health-Insurance-Exchanges.pdf.

Johnson, N. 2013. Apple Health Plus—Washington's churn solution. Presentation before the National Academy for State Health Policy, October 10, 2013, Seattle, WA. http://www.nashpconference.org/wp-content/uploads/2013/presentations/n.johnson.3.churn.pdf.

Ku, L., and E. Steinmetz. 2013. *The continuity of Medicaid coverage: An update*. Washington, DC: Association for Community Affiliated Plans.

Ku, L., E. Steinmetz, and B.K. Bruen. 2013. Continuous-eligibility policies stabilize Medicaid coverage for children and could be extended to adults with similar results. *Health Affairs* 32, no. 9: 1576–1582. http://content.healthaffairs.org/content/32/9/1576.full.pdf.

Ku, L., P. MacTaggart, F. Pervez, et al. 2009. *Improving Medicaid's continuity of coverage and quality of care*. Washington, DC: Association for Community Affiliated Plans. http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_66898AB4-5056-9D20-3D5FC0235271FE99.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. *Report to the Congress on Medicaid and CHIP*. March 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. *Report to the Congress on Medicaid and CHIP*. June 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2012. MACPAC public meeting, November 2012. Washington, DC: MACPAC. http://www.macpac.gov/home/transcripts/MACPAC_2012-11_Transcript.pdf.

Sommers, B., S. Gordon, S. Somers, et al. 2013. Medicaid on the eve of expansion: A survey of state Medicaid officials about the ACA. *Health Affairs Blog*, December 30. http://healthaffairs.org/blog/2013/12/30/medicaid-on-the-eve-of-expansion-a-survey-of-state-medicaid-officials-about-the-aca.

State of Arkansas (Arkansas). 2013a. Arkansas 1115 waiver application. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ar.pdf.

State of Arkansas (Arkansas). 2013b. Arkansas draft 1115 waiver for public comment. https://www.medicaid.state.ar.us/Download/general/comment/InitialHCIWApp.doc.

U.S. Department of Health and Human Services (HHS). 2012. Continuous eligibility for Medicaid and CHIP coverage. Washington, DC: HHS. http://www.insurekidsnow.gov/professionals/eligibility/continuous.html.

U.S. Government Accountability Office (GAO). 2013. *Medicaid: Additional enrollment and expenditure data for the transitional medical assistance program*. Report no. GAO-13-454R. Washington, DC: GAO. http://www.gao.gov/assets/660/653058.pdf.

U.S. Government Accountability Office (GAO). 2012. *Medicaid: Enrollment and expenditures for qualified individual and transitional medical assistance programs*. Report no. GAO-13-177R. Washington, DC: GAO. http://www.gao.gov/assets/660/650816.pdf.

U.S. General Accounting Office (GAO). 2002. *Medicaid: Transitional coverage can help families move from welfare to work*. Report no. GAO-02-679T. Washington, DC: GAO. http://www.gao.gov/assets/110/109281.pdf.

U.S. House of Representatives. 1972. Summary of H.R. 1, the Social Security Amendments of 1972 as approved by the conferees. *Congressional Record* (October 17): 36919.

CHAPTER 3

Issues in Pregnancy Coverage under Medicaid and Exchange Plans

Recommendations

Issues in Pregnancy Coverage under Medicaid and Exchange Plans

3.1 To align coverage for pregnant women, the Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

3.2 The Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of the Treasury should specify that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans.

Key Points

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) will affect women of childbearing age in several ways, including by expanding Medicaid coverage to previously uninsured low-income women at or below 138 percent of the federal poverty level (FPL) in Medicaid-expansion states and by offering subsidized exchange coverage that includes maternity care to previously uninsured women with incomes above 100 percent FPL. This chapter describes how the ACA may affect eligibility and benefits for women eligible for Medicaid coverage for maternity benefits.

- Although states must provide services to all pregnant women at or below 138 percent FPL, they are not required to provide full Medicaid benefits; they may instead limit services to those related to pregnancy. As a result, Medicaid benefits for pregnant women currently differ by eligibility pathway both across and within states, with some pregnant women receiving fewer Medicaid benefits than pregnant women covered through other Medicaid eligibility pathways. The Commission recommends the elimination of coverage restricted to pregnancy-related services only.
- The U.S. Department of the Treasury has determined that most Medicaid coverage—including coverage for pregnant women through the Section 1931 low-income families eligibility pathway—is minimum essential coverage (MEC). However, coverage through pathways that allow states to restrict coverage to pregnancy services only—regardless of whether the state actually limits coverage—is not considered MEC for the purposes of the ACA's individual mandate.
- Because coverage through certain pathways is not considered MEC, women eligible for Medicaid under these pathways who are above 100 percent FPL can have Medicaid coverage, exchange coverage, or both concurrently. This could create issues of coordination of benefits between exchange plans and Medicaid, and potential confusion for women about their different benefit and cost-sharing options.
- If Recommendation 3.1 is adopted, then all Medicaid pregnancy coverage would be MEC. Women with subsidized exchange coverage who become pregnant and who would qualify for Medicaid based on their pregnancy would have to disenroll from exchange coverage and enroll in Medicaid for the duration of their pregnancy and postpartum period. The Commission recommends allowing women with exchange coverage who become eligible for Medicaid based on becoming pregnant to retain exchange coverage to avoid discontinuities in networks and care.

CHAPTER 3

Issues in Pregnancy Coverage under Medicaid and Exchange Plans

Medicaid has long played an important role in financing health care for low-income pregnant women, covering a vulnerable population and promoting healthy birth outcomes. The program covers almost half of all births in the United States (MACPAC 2013a). All states are required to provide pregnancy-related care for women below 138 percent of the federal poverty level (FPL), and all but nine states have extended Medicaid coverage to pregnant women with higher incomes.[1] Among those states, a majority (35 states and the District of Columbia) have raised their eligibility threshold for pregnant women to 190 percent FPL or higher (Appendix Table 3-A-1).

Although states must provide services to all pregnant women at or below 138 percent FPL, they are not required to provide full Medicaid benefits; they may instead limit services to those related to pregnancy.[2, 3] As a result, covered Medicaid benefits for pregnant women differ by eligibility pathway both across and within states, as described below.

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) will affect women of childbearing age in several ways: by expanding Medicaid coverage to previously uninsured low-income women at or below 138 percent FPL in Medicaid expansion states; by offering subsidized exchange coverage that includes maternity care to previously uninsured women with incomes above Medicaid eligibility levels; and by streamlining Medicaid eligibility, which may simplify the application process and increase enrollment rates. These changes will likely increase the number of pregnant women with health insurance.

The new options for coverage of pregnant women may also create challenges and complexities for both states and pregnant women themselves. Two of these challenges are unique to the treatment of pregnant women. First, because pregnancy is a temporary state, coverage that is limited to pregnancy and the postpartum period creates transitional issues for enrollees as they move between different health insurance plans or different

sources of coverage. Such churning among different sources of coverage during pregnancy and the 60 days postpartum is likely to create discontinuities in care, when continuity of care is especially desirable.

Second, because state Medicaid programs are not required to provide full coverage to some pregnant women, women eligible only for pregnancy-related services may receive less generous benefits than do other people in their income group. When Medicaid was expanded to cover pregnant women based solely on their pregnancy status, it provided many pregnant women with coverage that was otherwise unavailable, even though benefits could be limited. Under the ACA, the alternative benefit package offered to the new adult group provides all essential health benefits (including maternity and non-maternity care) to all adults up to 138 percent FPL but excludes pregnant women because they are already eligible for Medicaid. Therefore, pregnant women with coverage limited to pregnancy-related services may now receive fewer benefits than if they were not pregnant.

In addition, subsidized exchange coverage available to individuals between 100 and 400 percent FPL also includes both maternity and non-maternity benefits. This means that higher-income pregnant women with such coverage may receive a broader benefit package than lower-income pregnant women with Medicaid coverage. At the same time, this coverage may come with higher premium and cost-sharing requirements than are typical in Medicaid and may exclude enhanced maternity benefits offered by Medicaid programs.[4, 5]

This chapter describes how the ACA may affect eligibility and benefits for both women at or below 138 percent FPL who may be newly eligible in states expanding their Medicaid programs, and women above 100 percent FPL who may be eligible for subsidized coverage through health insurance exchanges. It also describes certain ACA-related issues that are unique to pregnant women.

The chapter concludes with two recommendations focused on reducing inequities in coverage among pregnant women in different Medicaid eligibility groups. One recommendation would require full Medicaid coverage for women who are eligible through mandatory or optional pregnancy-related pathways. If this recommendation is adopted, the Commission has made a companion recommendation that women enrolled in qualified health plans (QHPs) should be allowed to retain their QHP coverage even if their pregnancy makes them eligible for Medicaid.

Medicaid Eligibility and Benefits for Pregnant Women

States are required to cover all pregnant women below 138 percent FPL, and they have the option of providing coverage to pregnant women above that level. The period of coverage for women eligible for Medicaid on the basis of pregnancy is limited to the duration of the pregnancy and 60 days postpartum.[6, 7]

Currently, there are six possible Medicaid eligibility pathways that cover pregnant women (Table 3-1). Historically, the first pathways that covered pregnant women were limited to those meeting state income and resource standards for the former Aid to Families with Dependent Children (AFDC) program (referred to in this chapter as low-income family-related pathways). These women were eligible for full Medicaid coverage, as were women in three subsequent AFDC-related categories.

When in 1986 Congress added pathways specific to pregnancy—requiring coverage up to 133 percent of poverty for all pregnant women and making it optional over 133 percent FPL—it allowed states to cover only pregnancy-related services (§1902(a)

TABLE 3-1. Benefits under Mandatory and Optional Medicaid Eligibility Pathways for which Pregnancy Status is an Eligibility Factor

Medicaid Eligibility Pathways	Related Sections in the Social Security Act	Coverage May Be Limited to Pregnancy-Related
Mandatory Pathways		
Section 1931 low-income families pathway – Pregnant women who already have children, at or below income level for former Aid to Families with Dependent Children (AFDC) program	1931(b) and (d), 1902(a)(10)(A)(i)(I)	No
Qualified pregnant women and children pathway – Qualified pregnant women who do not already have children, at or below income level for former AFDC program	1902(a)(10)(A)(i)(III)	No
Mandatory poverty-level-related pathway – Pregnant women with income above other mandatory levels but at or below an income level specified in statute (at or above 133 percent of the federal poverty level (FPL))	1902(a)(10)(A)(i)(IV), clause (VII) in the matter following 1902(a)(10)(G)	Yes
Optional Pathways		
Pregnant women who meet former AFDC program financial criteria pathway	1902(a)(10)(A)(ii)(I)	No
Pregnant women who would be eligible for former AFDC program if not institutionalized pathway	1902(a)(10)(A)(ii)(IV)	No
Optional poverty-level-related pathway – Pregnant women above an income level specified in statute (at or above 133 percent FPL)	1902(a)(10)(A)(ii)(IX), clause (VII) in the matter following 1902(a)(10)(G)	Yes

Notes: Amounts indicated here as 133 percent FPL are now equivalent to 138 percent due to application of related income disregard and modified adjusted gross income (MAGI) conversion under the Patient Protection and Affordable Care Act. This table excludes an optional medically needy pathway under which pregnant women with incomes above regular mandatory and optional levels may qualify by incurring medical expenses that reduce their income to a specified limit. Medically needy benefits may be less than full Medicaid but are not limited on the basis of being pregnancy-related. Shaded rows indicate pathways that may restrict benefits to pregnancy-related service coverage only.

Sources: CMS 2012; CMS 2011; Social Security Act.

(10)(A)(i)(IV) of the Social Security Act (the Act)).[8] These two eligibility pathways combined are referred to as poverty-level-related pregnancy pathways in this chapter.

Based on a preliminary analysis, more than 750,000 women currently qualify for Medicaid through poverty-level-related pregnancy pathways, with the percentage of women eligible through a poverty-level-related pregnancy pathway varying by state (MACPAC 2013b). In determining which pregnancy-related pathway a woman should be enrolled in, states consider income, trimester of pregnancy, and linkage to other programs.[9]

Restricting coverage to pregnancy-related services. As of September 2013, at least eight states were reported to cover only pregnancy-related services for most Medicaid-enrolled pregnant women: Alabama, California, Idaho, Indiana, Louisiana, Nevada, New Mexico, and North Carolina.[10] According to preliminary estimates, more than 170,000 women have pregnancy-related coverage in these states (MACPAC 2013b).

Coverage of pregnancy-related services is fairly comprehensive, as the standard is medical necessity for the health of the mother and unborn child (42 CFR 440.210). There is little publicly available information on the extent to which pregnant women are denied care or providers are denied payment when benefits are limited to pregnancy-related services.[11] But advocates have noted instances in which women with Medicaid pregnancy-related service coverage only "could not access treatment for broken bones, osteomyelitis, brain tumor, or heart disease or physical therapy for sciatica or injuries sustained during delivery" (MCHA 2013).

Provider manuals (which describe the rules under which Medicaid claims may be paid in a given state) offer some guidance on how to distinguish between pregnancy-related services and others that are not considered related to the pregnancy. For example, the North Carolina Medicaid provider manual lists services that are considered directly related to pregnancy and adds that pregnancy-related coverage also includes:

> services for conditions that—in the judgment of their physician—may complicate pregnancy. Conditions that may complicate the pregnancy can be further defined as any condition that may be problematic or detrimental to the well-being or health of the mother or the unborn fetus such as undiagnosed syncope [temporary loss of consciousness caused by a fall in blood pressure], excessive nausea and vomiting, anemia, and dental abscesses. (This list is not all-inclusive.)

(North Carolina Medicaid 2011).

It is also not clear how postpartum visits are treated or what conditions are considered pregnancy-related following a pregnancy. Services that are considered pregnancy-related while a woman is pregnant may not be considered pregnancy-related once the pregnancy ends. For example, a California provider manual describes influenza as a non-pregnancy postpartum condition. For non-pregnancy related visits, women may be subject to cost sharing (Medi-Cal 2002).

Enhanced benefits during pregnancy. Regardless of whether they provide full or limited Medicaid coverage for pregnant women, states may also provide services related to the pregnancy that exceed those covered under an alternative benefit plan, a qualified health plan, or other coverage. For example, Louisiana and North Carolina both cover only pregnancy-related services for women eligible through poverty-level-related pathways, but provide enhanced pregnancy-related benefits. Louisiana provides nurse home visits to first-time, low-income mothers and families to improve maternal health, birth outcomes, and parental life course. North Carolina's Baby Love Care Coordination Program extended intensive case management services (including risk assessment, plan of care development, referral to health and support providers, and follow-up) to all Medicaid-enrolled pregnant women (Hill et al. 2009). Several states also offer dental services to pregnant women but not to other adults (MACPAC 2013a).

Changes to Medicaid Coverage in 2014

The ACA created several changes in Medicaid that have implications for coverage of pregnant women. Their experiences will differ depending upon their income, whether their state expands coverage to the new adult group, and whether their state covers full Medicaid benefits or only those services related

to pregnancy. However, one change that will apply across the board is implementation of the new income determination rules that apply to all states and most Medicaid eligibility groups (including pregnant women), as well as the elimination of resource (asset) tests for these groups.

There is another change that affects women above and below 138 percent FPL in both expansion and non-expansion states. In its final rule on eligibility changes mandated by the ACA, the Centers for Medicare & Medicaid Services determined that states opting to limit coverage to pregnancy-related services are required to submit a state plan amendment that explains the state's basis for determining which services are not pregnancy-related and the rationale for not covering them (CMS 2012).

A third change affecting pregnant women both above and below 138 percent FPL is how the U.S. Department of the Treasury (Treasury) has determined whether poverty-level-related pregnancy coverage is minimum essential coverage (MEC). Under the ACA, all individuals are required to have insurance that is considered MEC, or pay a personal responsibility penalty. Individuals with incomes between 100 and 400 percent FPL are eligible for a subsidy to purchase insurance on an exchange. However, if they are eligible for other insurance through an employer or Medicaid that qualifies as MEC, they are not eligible for the subsidy. This creates several important policy issues for pregnant women seeking coverage.

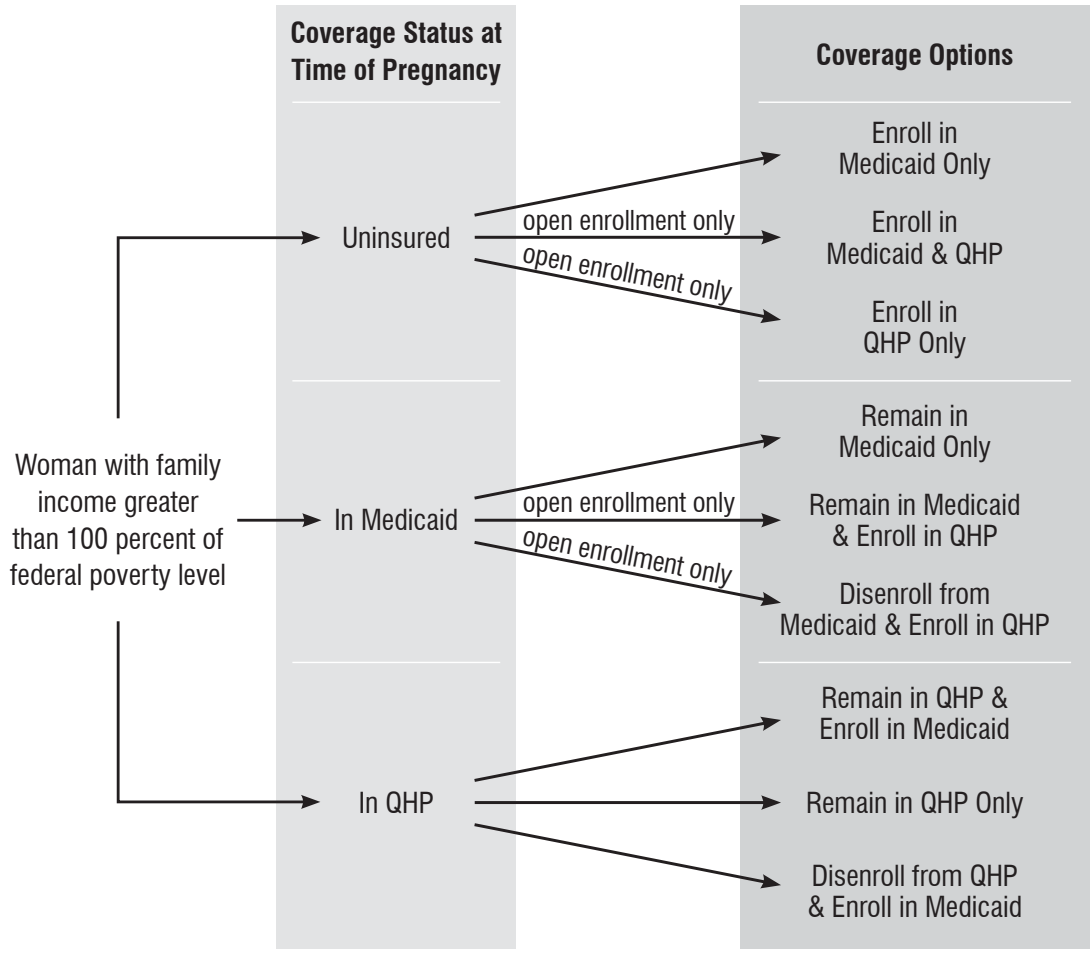
Treasury has determined that most Medicaid coverage, including coverage for pregnant women through the Section 1931 low-income families eligibility pathway, is MEC. However, women who are eligible through a mandatory or optional poverty-level-related pregnancy pathway—regardless of whether the state restricts coverage to pregnancy-related services—do not have MEC for the purposes of the ACA's individual mandate. For Internal Revenue Service purposes, their coverage is not considered to be MEC because states have the ability to limit benefits to those related to the pregnancy, even if they do not do so currently.

This has two implications. First, women with poverty-level-related pregnancy Medicaid coverage are eligible to purchase exchange coverage with premium tax credits and cost-sharing subsidies if their incomes are above 100 percent FPL. Second, if they do not acquire exchange coverage or some other form of MEC in addition to their Medicaid coverage, these women could be subject to the personal responsibility penalty when it is imposed in future years (Treasury 2013).

Because of the ruling that poverty-level-related pregnancy pathway coverage is not MEC, women eligible for Medicaid under these pathways who are above 100 percent FPL can have Medicaid coverage, exchange coverage, or both concurrently (Figure 3-1; Box 3-2). Pregnant women might have compelling reasons to choose any of these options depending on a host of factors such as timing, differences in benefits and out-of-pocket premium and cost-sharing amounts, and what the transitions between Medicaid and exchange coverage might mean in terms of provider networks and family coverage. These issues are discussed further below.

Pregnant women at or below 138 percent FPL. In Medicaid-expansion states, uninsured women at or below 138 percent FPL who are pregnant when they apply for Medicaid are not eligible for the new adult group. They will instead qualify under a mandatory eligibility pathway related to their pregnancy. After two months postpartum, they will no longer be eligible for pregnancy-related coverage and will have to transition to the new adult group or to other coverage for which they are eligible, or to uninsured status. In the states that have opted to cover only pregnancy-related services, this may result in changing benefits (Box 3-1).

FIGURE 3-1. Women in Pregnancy-Related Pathways Over 100 Percent of the Federal Poverty Level (FPL): Coverage Options



Advantages and Disadvantages

Medicaid Only:

- ✓ Limited cost sharing
- ✓ Enhanced maternity benefits
- ✓ Can enroll any time during pregnancy
- ✗ Coverage ends two months post-partum

QHP Only:

- ✓ Coverage does not end after pregnancy
- ✗ Can only enroll during open season
- ✗ More cost sharing
- ✗ No Medicaid enhanced maternity benefits

Medicaid and QHP:

- ✓ Limited cost sharing
- ✓ Enhanced maternity benefits
- ✓ Can enroll any time during pregnancy (Medicaid)
- ✓ Can remain in QHP after pregnancy (if eligible)
- ✗ Coordination of benefits and network issues

Note: QHP is a qualified health plan.

Source: Adapted from presentation by the Medicaid and CHIP Learning Collaborative, November 19, 2013.

BOX 3-1. Example of Medicaid Coverage for a Woman Below 138 Percent of the Federal Poverty Level (FPL) in an Expansion State with Pregnancy-Related Service Coverage Only

Ashley is a healthy 19-year-old who recently graduated from high school. Neither she nor her husband Anthony has health insurance. They have a gross family income of about $14,400 per year, or 125 percent FPL.

In January 2014, Ashley becomes pregnant. Both she and Anthony apply for coverage under the state's Medicaid expansion. Anthony qualifies for the new adult group, which covers the Medicaid alternative benefit package and is equivalent to full Medicaid coverage for all covered services (but not necessarily covering exactly the same services). However, because she is pregnant, Ashley does not qualify for the new adult group coverage and must be enrolled in the state's benefit for pregnant women, which covers only pregnancy-related services. She must pay out of pocket for any service that is not considered pregnancy-related.

Upon the birth of their daughter, Olivia, the baby is enrolled in Medicaid based on Ashley and Anthony's income. Two months later, Ashley's pregnancy coverage ends, but she qualifies for the new adult group with full Medicaid coverage.

BOX 3-2. Example of Coverage for a Woman above 138 Percent of the Federal Poverty Level (FPL) in a State with Medicaid Coverage for Pregnancy-Related Services Only

Karen is a 30-year-old woman with diabetes who is unmarried and works at a retail store that does not offer her health insurance. Her gross income is $21,026 per year, or 183 percent FPL. In January 2014, Karen becomes pregnant and now needs insurance for prenatal care. In her state, the upper cut-off for Medicaid pregnancy-related coverage is 200 percent FPL, but only pregnancy-related services are covered. Because she becomes pregnant during an open enrollment period, she has the option of: 1) enrolling in Medicaid, 2) purchasing subsidized exchange coverage, or 3) both.

Medicaid. If Karen enrolls in Medicaid, she will have no premium and no cost sharing for pregnancy services, but she will have to pay out-of-pocket for any non-pregnancy-related services. Her coverage will end in November, or two months after the birth of her child. After 2014, if she does not purchase exchange or some other coverage during open enrollment, she will have to pay the personal responsibility penalty for not having minimum essential coverage (unless the penalty is waived in the future).

Exchange coverage. If she purchases a silver plan with the second-lowest premium in the exchange, her net annual payment for coverage will be $1,610 after a subsidy. Because her income is below 250 percent FPL, she also qualifies for lower cost sharing in the plan, but costs for pregnancy-related services such as delivery will still be higher than in Medicaid. If Karen became pregnant after March 2014, she would not be able to enroll in exchange coverage until the next enrollment period (unless she had a qualifying life event other than the birth of her child).

Both Medicaid and exchange coverage. If Karen enrolls in both exchange coverage and Medicaid, she will have exchange-based coverage for non-pregnancy related services as well as Medicaid's more generous coverage of pregnancy-related services. She would still pay the subsidized premium for exchange coverage. The state would have to coordinate benefits, with Medicaid being the payer of last resort.

Source: Dollar amounts are based on the Kaiser Family Foundation Subsidy Calculator, which calculates premium assistance amounts for exchange coverage (KFF 2013).

The status of women who become pregnant when already enrolled in Medicaid is less clear. On the one hand, states are not required to track the pregnancy status of women already enrolled through the new adult group. On the other hand, pregnant women are allowed to request that the state move them to a pregnancy-related eligibility group if they want specific benefits that may not be available under the adult group benefit package. Whether this is advantageous would likely depend on the scope of benefits for pregnancy-related coverage in the alternative benefit plan in the state.

In states that are not expanding their Medicaid program to the new adult group, a pregnant woman's Medicaid eligibility will remain largely the same as it was prior to 2014, with the exception of the new income determination rules and the elimination of asset tests.

Pregnant women with incomes above 138 percent FPL. With the expiration of the maintenance of effort (MOE) requirement for adults in 2014, states that currently cover pregnant women above 138 percent FPL have considerable discretion in determining how to cover this population. One caveat is that states that had an income standard above 138 percent FPL in effect for pregnant women in 1989 must keep their higher 1989 standard (§1902(l)(2) of the Act); this long-standing MOE requirement applies to 19 states (NGA 1990).

States have two options for reducing pregnancy-related coverage for women in this income range. First, they can reduce benefits for women eligible through poverty-level-related pregnancy pathways to provide pregnancy-related services only if they are not already doing so. This could affect pregnant women covered under these pathways at all income levels. Alternatively, they can reduce the eligibility level for pregnant women in those pathways to 138 percent FPL (or to their 1989 standard, if higher). Two states—Louisiana and Oklahoma—have rolled back eligibility for pregnant women to 133 percent FPL and will cover pregnant women above that level through the CHIP unborn child option (Table 3-A-1).

If women in states that restrict eligibility do not have another source of coverage, or if they cannot afford an offer of employer-sponsored coverage or coverage offered by an exchange, they may become uninsured.

Interactions between Medicaid and Exchange Coverage for Pregnant Women

The complexity of coverage choices described above highlights the importance of the outreach and education that will be needed to inform pregnant women about their options. Medicaid program staff, exchange staff, and providers may also need education about coordination of benefits and cost sharing for women enrolled in both Medicaid and exchange programs and how to help choose the best source of coverage. Some factors that influence coverage choices between Medicaid and the exchanges are described below.

Timing. Medicaid and exchange coverage have different rules related to when women can enroll and how long coverage will last. Enrollment in the exchange is limited to annual open enrollment periods or to the occurrence of certain qualifying events. The birth of a child is a qualifying life event, but becoming pregnant is not.[12] In contrast, women can enroll in Medicaid at any time they are eligible.

Once enrolled in exchange coverage, a woman retains that coverage for the full year as long as premiums are paid (either through a subsidy or out of pocket). If a woman is enrolled in Medicaid on the basis of pregnancy, she retains that coverage until two months postpartum or until pregnancy ends. Depending on the timing of the pregnancy,

this may result in a loss of Medicaid coverage at any time during the year.

If a woman successfully gives birth, she can immediately enroll in the exchange because the birth of her child is a qualifying life event. If she experiences a miscarriage or terminates her pregnancy, however, this is not a qualifying life event. And because her poverty-level-related pregnancy Medicaid coverage is not MEC, the loss of that coverage also does not count as a qualifying life event. Instead, she would lose Medicaid coverage, and if she is not eligible for Medicaid through another pathway, she would have to wait until the next open enrollment period to sign up for exchange coverage.

Differing benefits. Pregnancy-related services are likely comparable between Medicaid and exchanges in most states, but much is unknown about exactly what services are covered in QHPs and in Medicaid. Exchange plans and state exchanges have some flexibility when it comes to determining what services are covered as part of the required maternity care benefit (and at what cost). Also, as discussed above, it is not evident what Medicaid services are considered pregnancy-related in states that cover only pregnancy-related services or how these benefits would differ from benefits provided under exchange coverage. It is also important to emphasize that, for all pregnancy eligibility pathways, Medicaid may provide enhanced maternity benefits that are not routinely provided by QHPs or employer-sponsored insurance, such as the intensive case management and dental care.[13]

Premiums. Women who qualify for Medicaid through a pregnancy-related pathway do not have to pay premiums for that coverage. For exchange coverage, women may qualify for premium subsidies if they have incomes between 100 and 400 percent FPL, do not have access to affordable employer coverage, and are not eligible for full-benefit Medicaid. However, subsidies may not cover the entire premium, and pregnant women will have to pay an amount that varies by income level. (For example, the amount may be 2 percent of income at 100 percent FPL.)

Cost sharing. Where services are covered by both Medicaid and exchange coverage, Medicaid will generally require lower cost sharing and prohibits it altogether for pregnancy-related care (CMS 2013a). Some prenatal care and essential preventive health benefits are covered with no cost sharing under exchange plans, but cost sharing is allowed for other services, including hospitalization for delivery.[14] Qualifying women with incomes between 100 and 250 percent FPL may be eligible for reductions in their responsibilities for deductibles and copayments.

Churning. With the implementation of the exchanges, women who may have transitioned between Medicaid (with either full benefits or pregnancy-related services only) and uninsured status prior to the ACA may now transition back and forth between Medicaid and exchange coverage (or employer-sponsored coverage)—or being uninsured. Women going through these transitions as their pregnancy status changes could experience disruptions in care. In addition, such churning could be confusing for enrollees and administratively complicated for Medicaid programs, exchanges, and plans.[15]

Coordination of benefits. If women have both pregnancy-related coverage and exchange coverage, Medicaid programs and exchange plans will need to coordinate benefits. Medicaid would be the secondary payer, paying for services not included in a pregnant woman's exchange plan, as well as copayments and deductibles, but not premiums. Because exchange coverage must include coverage of maternity care, the Medicaid program will likely have little payment liability, except for some cost-sharing assistance; any enhanced maternity-related services; and in states offering full benefits,

any additional services covered in a state plan that are not covered in the exchange plans. These might include, for example, non-emergency transportation or similar services that are typically unique to Medicaid. In any case, current law requires that state Medicaid programs must pay the bills and then seek reimbursement from any other coverage, which may be administratively burdensome (§1902(a)(25)(E) of the Act).

Uninsurance. Some women may choose to forgo exchange coverage and be uninsured for reasons including costs. Depending on their income and other circumstances, they may be required to pay the shared responsibility penalty, which may be less than the cost-sharing amounts. Periods of uninsurance for pregnant women are problematic for both the health of the mother and the child because lack of prenatal and other maternity care is associated with poor birth outcomes. Spells of uninsurance are also associated with less care for health risks such as hypertension, obesity, and gynecological problems that can lead to high-cost, adverse birth outcomes (Johnson 2012).

Commission Recommendations

The ACA creates new options for coverage of pregnant women, but also potential challenges and complications. Treasury has determined that coverage through mandatory and optional poverty-level-related pregnancy pathways does not constitute MEC. This means that women who enroll through these pathways can have other coverage and may eventually have to pay a personal responsibility penalty if they do not obtain MEC through some other source. At the same time, one stated goal of the ACA, increasing administrative simplicity by streamlining eligibility, is in effect negated because pregnancy-related pathways are treated differently from other eligibility pathways for tax and penalty purposes.

Two related recommendations would simplify eligibility determinations, reduce inequities in coverage between pregnant women and other enrolled adults, and streamline eligibility while also enabling pregnant women to receive enhanced maternity benefits through Medicaid but retain their exchange coverage if they so choose. The two recommendations that follow are related: Recommendation 3.2 applies only if Recommendation 3.1 is adopted.

Recommendation 3.1

To align coverage for pregnant women, the Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

Rationale

The Commission's recommendation is grounded in three arguments.

First, in order to ensure the best possible pregnancy and birth outcomes, coverage for pregnant women should not be restricted to coverage of only pregnancy-related services. States should also continue to evaluate the best approaches to providing coverage to pregnant women and to ensuring that Medicaid continues to promote healthy pregnancies and births.

Second, removing states' ability to limit coverage to certain services would allow Treasury to classify all pregnant women with Medicaid as having MEC. These women would therefore not be subject to any future personal responsibility penalty. In addition, although the ACA proposes to consolidate the six different Medicaid eligibility pathways for pregnant

women, the fact that the two poverty-related pathways do not lead to MEC means that these two pathways remain separate for tax purposes.

Third, this would prevent states from rolling back benefits in the future. Currently, eight or more states limit benefits for women who qualify on the basis of pregnancy, and additional states may restrict coverage in the future. Rolling back eligibility levels to 138 percent FPL or to the 1989 AFDC level could result in women previously covered by Medicaid with joint federal-state financing now being covered with fully federally funded exchange subsidies.

Women who enter Medicaid through the Section 1931 low-income families pathway are eligible for the full benefit package, including enhanced pregnancy services and non-maternity services with no cost sharing. This recommendation would require that women who enter Medicaid through poverty-level-related pregnancy pathways receive the same benefit package as pregnant women who enter through the Section 1931 low-income families pathway.

Nothing in this recommendation would limit states' ability to provide enhanced pregnancy benefits, designed to improve maternal and birth outcomes, to all pregnant women covered under the state plan. 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 2013a). Others provide targeted case management, medical home programs, and nutrition counseling not available to other Medicaid enrollees (MACPAC 2013a). 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, under the following two conditions:

- These services must be pregnancy-related or related to any other condition which may complicate pregnancy (as defined in 42 CFR 440.210(a)(2)).
- These services must be provided in equal amount, duration, and scope to all pregnant women covered under the state plan (42 CFR 440.250(p)).

Implications

Federal spending. This recommendation would increase federal spending in 2015 by between $50 and $250 million. Over the five-year period from 2015 to 2019, this recommendation would increase federal spending by less than $1 billion. These are the smallest non-zero categories of spending used by the Congressional Budget Office (CBO) when making budget estimates.

States. If states that cover only pregnancy-related services are not providing a large number of services, covering additional medically necessary (but not pregnancy-related) services could raise expenditures. If almost all medically necessary services are in fact provided through these programs, however, expanding coverage to full Medicaid should not add substantial costs to the program. Providing the full benefit package would constitute MEC, and thus prevent pregnant women from having exchange and Medicaid coverage simultaneously. This would reduce the need to coordinate benefits across these programs except as described in the companion Recommendation 3.2, but might increase costs to the extent that Medicaid becomes the primary payer rather than the secondary payer for these services.

Federal government. Eliminating pregnancy-related service coverage only would make fewer women eligible for exchange coverage, which would reduce the amount of subsidies paid by the federal government. At the same time, it would

increase the amount the federal government would pay in Medicaid costs to the extent that these women would begin using services that are not pregnancy-related and previously not covered by Medicaid in some states.

Enrollees. Based on a preliminary analysis, more than 170,000 women currently qualify for Medicaid through a poverty-related pregnancy-related pathway, and the percentage of women eligible through pregnancy-related pathways varies by state (MACPAC 2013b). However, since all states have the option of restricting coverage for women in pregnancy-related pathways, the number of women could increase in the future. This recommendation would prevent this occurrence. Pregnant women with pregnancy-related service coverage only would become eligible for additional (non-pregnancy-related) services not already covered. Pregnancy-related Medicaid coverage would be considered MEC so that women would not have to pay a personal responsibility penalty if it is not waived in the future.

Churning could increase as uninsured eligible pregnant women would be assigned to Medicaid and could not purchase on the exchange until after delivery. Recommendation 3.2 is aimed at reducing this problem. Pregnant enrollees in QHPs would not have to disenroll and enroll in Medicaid (if eligible), could retain their QHP network providers, and could maintain continuous enrollment. If they enrolled in the state Medicaid program as well, they would have reduced cost sharing and potentially enhanced pregnancy benefits.

Providers. Eliminating the ability to limit Medicaid benefits to cover only pregnancy-related services would eliminate the need for providers to determine whether specific services are pregnancy related. They would be able to bill for all Medicaid-covered services provided to pregnant women with Medicaid.

Recommendation 3.2

The Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of the Treasury should specify that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans.

Rationale

Under Recommendation 3.1, all pregnant women who qualify for Medicaid would be eligible for full benefits, which would be MEC. Were Recommendation 3.1 to be adopted, this additional recommendation would allow women already enrolled in QHPs to retain that coverage—and federal subsidies—even if they become eligible for Medicaid under a pregnancy pathway. In the absence of this change, if poverty-level-related pregnancy Medicaid coverage were considered MEC, women in qualified exchange coverage who become pregnant would have to disenroll from their QHPs and enroll in Medicaid. It should be noted that this recommendation is only relevant if states no longer have the option of providing coverage of only pregnancy-related services and if all Medicaid coverage for pregnant women is considered MEC.

By allowing pregnant women to remain in their QHP, churning would be reduced between Medicaid-only and QHP coverage. Medicaid pregnancy-related coverage is limited in duration to a maximum of 11 months (9 months of pregnancy and 2 months postpartum), but QHP coverage is not limited in this way. Therefore, requiring women to disenroll from their QHP solely on the basis of their pregnancy would constitute an unnecessary disruption to their QHP coverage.

While there are advantages and disadvantages to both QHP and Medicaid coverage, and to having both concurrently, a woman should not be involuntarily disenrolled from QHP

coverage solely because she becomes pregnant and therefore becomes eligible for Medicaid. By remaining in QHP coverage, she would retain her current network of providers and would have no disruptions in care between pregnancies, or after delivery. By enrolling concurrently in Medicaid, she could avoid interruptions in QHP coverage and receive cost-sharing assistance from Medicaid. It should be up to each woman to weigh the advantages of switching from QHP to Medicaid coverage, or retaining her QHP coverage.

This recommendation also would align the policy for QHP coverage with current policy for employer-sponsored insurance. Low-income women who have employer-sponsored health insurance do not have to disenroll if they become pregnant and become eligible for Medicaid.

Implications

Federal spending. This recommendation does not change current law or regulation; therefore it has no impact on federal spending relative to the current CBO baseline.

States. Pregnant women with exchange coverage who are also eligible for Medicaid would be allowed to retain their exchange coverage, as is current law. The adoption of Recommendation 3.2 would reduce some of the Medicaid benefit-related costs related to Recommendation 3.1, because exchange coverage would be the primary payer. States might have some additional administrative costs due to the need to coordinate benefits.

Federal government. This recommendation does not change current law or regulation. If Recommendation 3.1 is enacted, Recommendation 3.2 may increase federal spending for women who retain their exchange coverage. Those women would have been disenrolled from their exchange coverage once poverty-level-related Medicaid pregnancy coverage was considered MEC.

Enrollees. Pregnant enrollees in QHPs would not have to disenroll and enroll in Medicaid (if eligible), could retain their QHP network providers, and could maintain continuous enrollment, as they can under current law and regulation.

Providers. Under current law and regulation, providers would have to coordinate benefits for women enrolled in both QHPs and Medicaid. If Recommendation 3.2 were implemented, this would be true for women with both exchange and Medicaid coverage at the time they became pregnant but not for women not enrolled in exchange coverage at the time they become pregnant. If Recommendation 3.2 is adopted, newly pregnant women eligible for Medicaid would receive Medicaid full-benefit coverage only.

Endnotes

[1] As part of the modified adjusted gross income (MAGI)-based eligibility determinations for populations that include pregnant women, states will be required to disregard income equal to 5 percent FPL starting in 2014. For this reason, mandatory income eligibility for pregnant women is often referred to at its effective level of 138 percent FPL, even though federal statute specifies 133 percent FPL. Two additional factors also lead mandatory eligibility levels for pregnant women to exceed 133 percent FPL (or 138 percent FPL, including the mandatory 5 percent of income disregard) and to vary by state. First, as part of the move to MAGI-based eligibility determinations, states were required to convert their eligibility thresholds to account for pre-Patient Protection and Affordable Care Act (ACA) income disregards that had previously increased their effective levels above the 133 percent FPL specified in the statute. Following this conversion (and excluding the mandatory 5 percent of income disregard), only four states remain at 133 percent FPL as of 2014, and the next lowest state is at 139 percent FPL (see Appendix Table 3-A-1). Second, there are 19 states whose pre-ACA mandatory eligibility levels for pregnant women ranged from 150 to 185 percent FPL, due to the fact that they had already expanded to these levels when legislation (P.L. 101-239) was enacted in 1989 to mandate coverage of pregnant women up to at least 133 percent FPL (NGA 1990).

[2] "Full Medicaid benefits" in this chapter refers to the benefits provided to women over the age of 21 with dependents, who have coverage for all mandatory and optional services specified in the state plan amendment, not only those services related to pregnancy.

[3] Specifically, federal law requires that states provide Medicaid coverage to pregnant women whose household income is the higher of 133 percent FPL or the income standard, up to 185 percent FPL, that the state had established as of December 19, 1989, for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so (42 CFR 435.116).

[4] As discussed later in this chapter, a woman who is eligible for Medicaid through a pregnancy-related eligibility pathway and who has income above 100 percent FPL could simultaneously enroll in Medicaid and subsidized exchange coverage, but she would have to pay an exchange premium that varies by income level. (For example, the amount may be 2 percent of income at 100 percent FPL.) In such cases, Medicaid would be the secondary payer after the exchange plan and would provide wrap-around coverage of cost-sharing amounts and Medicaid services not included in the exchange plan.

[5] Immigrants with incomes below 133 percent FPL who would be eligible for Medicaid but for their immigration status are also eligible for advanced premium tax credits.

[6] The postpartum period may vary by state. In some states, it is exactly 60 days from date of birth, in others it is until the end of the month in which the 60th day occurs.

[7] Non-citizen pregnant women who are unauthorized or illegally present, or who are legal immigrants subject to a five-year ban on eligibility—but who otherwise meet all other Medicaid eligibility requirements—are eligible for emergency Medicaid coverage that is limited to labor and delivery services and excludes prenatal or postpartum care. Because these women are not covered by Medicaid for the duration of their pregnancies, the issues raised in this chapter are not directly applicable to these women.

[8] Prior to implementation of the ACA, the threshold was 133 percent FPL with state-specific disregards. After implementation, the threshold is 133 percent FPL with a flat 5 percent income disregard, which is why we refer to it as 138 percent FPL for both periods.

[9] For example, states have the option under Section 1931 406(g)(2) of the Act, as in effect prior to enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) to provide full Medicaid coverage for pregnant women with no dependent children during the third trimester of pregnancy (CMS 2012). States are required to cover "qualified pregnant women" during all trimesters of pregnancy for full Medicaid benefits if they meet the financial eligibility requirements for this group (CMS 2012).

[10] MACPAC analysis of state Medicaid websites and discussions with Medicaid directors in Alabama, Louisiana, Indiana, and New Mexico.

[11] In November 2013, MACPAC staff reached out to Medicaid directors in states identified as providing pregnancy-related service coverage only.

[12] Other qualifying life events include changes in family composition through death, divorce, or adoption; losing minimum essential health coverage through job loss or other events; and several other events (45 CFR 155.420(a)).

[13] See MACPAC's June 2013 *Report to the Congress on Medicaid and CHIP*, Chapter 1, for a detailed description of pregnancy-related eligibility and benefits under the Medicaid program and Medicaid-enhanced maternity services. For example, 35 state Medicaid programs cover prenatal risk assessments, 30 cover home visiting, 28 cover health education, 27 cover nutritional counseling, and 30 cover psychosocial counseling (Hill et al. 2009).

[14] Essential health benefits required with no cost sharing by exchange plans include anemia screening on a routine basis for pregnant women; screening for urinary tract or other infections for pregnant women; counseling about genetic testing for women at higher risk; comprehensive support and counseling from trained providers, as well as breastfeeding supplies for pregnant or nursing women; folic acid supplements for women who may become pregnant; gestational diabetes screening for women 24 to 28 weeks pregnant and for those at high risk for developing gestational diabetes; hepatitis B screening for pregnant women at their first prenatal visit; and Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk (CMS 2011b).

[15] For additional information on churning, see Chapter 2 of this report.

References

Advisory Board Company, The. 2014. Where the states stand on Medicaid expansion. Washington, DC: The Advisory Board Company Daily Briefing, January 24. http://www.advisory.com/Daily-Briefing/Resources/Primers/MedicaidMap.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. Cost sharing out of pocket costs. Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. State Medicaid and CHIP income eligibility standards effective January 1, 2014. Baltimore, MD: CMS. http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid program: Eligibility changes under the Affordable Care Act of 2010. Final rule. *Federal Register* 77, no. 57 (March 23): 17143–17217. http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011a. Medicaid program: Eligibility changes under the Affordable Care Act of 2010. Proposed rule. *Federal Register* 76, no. 159 (August 17): 51148–51199. http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011b. Group health plans and health insurance issuers relating to coverage of preventive services under the Patient Protection and Affordable Care Act. Interim final rules, with request for comments. *Federal Register* 76, no. 149 (August 3): 46621–46625. http://www.gpo.gov/fdsys/pkg/FR-2011-08-03/pdf/2011-19684.pdf.

Hill, I.T., S. Hogan, L. Palmer, et al. 2009. *Medicaid outreach and enrollment for pregnant women: What is the state of the art?* Washington, DC: Urban Institute. http://www.urban.org/UploadedPDF/411898_pregnant_women.pdf.

Johnson, K. 2012. *Addressing women's health needs and improving birth outcomes: Results from a peer-to-peer state Medicaid learning project.* Commonwealth Fund Issue Brief, no. 1629, vol. 21. New York, NY: The Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Aug/1620_Johnson_addressing_womens_htl_needs_improving_birth_ib.pdf.

Kaiser Family Foundation (KFF). 2014. *Status of state action on the Medicaid expansion decision.* Washington, DC: KFF. http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

Kaiser Family Foundation (KFF). 2013. *Subsidy calculator: Premium assistance for coverage in exchanges.* Washington, DC: KFF. http://kff.org/interactive/subsidy-calculator.

Maternal and Child Health Access (MCHA). 2013. MCHA alert, July 23. Los Angeles, CA: MCHA. http://www.mchaccess.org/pdfs/alerts/Regular%20Session%20Memo%20July%2023%202013.pdf.

Medi-Cal, California Department of Health Care Services. 2002. *Pregnancy: Early care and diagnostic services.* Sacramento, CA: Medi-Cal. http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregearly_m00o03.doc.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. *Report to the Congress on Medicaid and CHIP.* June 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. Unpublished analysis of 2008 Medicaid Statistical Information System (MSIS) data. Washington, DC: MACPAC.

National Governors Association (NGA). 2011. *2010 Maternal and child health update: States make progress towards improving systems of care.* Washington, DC: NGA. http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF.

National Governors Association (NGA). 1990. *State coverage of pregnant women and children—January 1990.* Washington, DC: NGA. http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE0190.pdf.

North Carolina Division of Medical Assistance (North Carolina Medicaid). 2011. *Division of Medical Assistance (Obstetrics): Clinical coverage policy no. 1E-5.* http://www.ncdhhs.gov/dma/mp/1E5.pdf.

State Refor(u)m. 2014. Tracking Medicaid expansion decisions: a closer look at legislative activity. Washington, DC: State Refor(u)m. https://www.statereforum.org/node/11675.

U.S. Department of the Treasury (Treasury). 2013. Shared responsibility payment for not maintaining minimum essential coverage. Final regulations. *Federal Register* 78, no. 169 (August 30): 53646–53664. http://www.healthreformgps.org/wp-content/uploads/mec-8-30.pdf.

Chapter 3 Appendix

APPENDIX TABLE 3-A-1. Medicaid Eligibility Levels, Limits on Pregnancy-Related Benefits, Number of Medicaid Births, and Status of Medicaid Expansion

State	Eligibility Level (% FPL) for Medicaid Pregnancy Coverage, January 2014[1]	Limits Benefits for Pregnancy-Related Eligibility Pathways, November 2013[2]	Number of Medicaid Births (2008, 2009 or 2010)	Source of Birth Data	Medicaid Expansion Status, January 2014
Alabama	141	x	27,570	c	No
Alaska	200		5,891	c	No
Arizona	156		84,805	a	Yes
Arkansas	209		37,235	a	Yes
California	208	x	495,252	a	Yes
Colorado	195		60,266	a	Yes
Connecticut	258		14,500	c	Yes
Delaware	209		6,202	c	Yes
District of Columbia	319		NA		Yes
Florida	191		209,525	a	No
Georgia	220		66,607	b	No
Hawaii	191		15,804	a	Yes
Idaho	133	x	9,618	b	No
Illinois	208		157,019	a	Yes
Indiana	208	x	41,793	c	No
Iowa	375		38,043	a	Yes
Kansas	166		38,951	a	No
Kentucky	195		50,343	a	Yes
Louisiana	133	x	37,722	b	No
Maine	209		12,463	a	No
Maryland	259		68,089	a	Yes
Massachusetts	200		71,810	a	Yes
Michigan	195		112,481	a	Yes
Minnesota	278		63,563	a	Yes
Mississippi	194		27,142	b	No

APPENDIX TABLE 3-A-1, Continued

State	Eligibility Level (% FPL) for Medicaid Pregnancy Coverage, January 2014[1]	Limits Benefits for Pregnancy-Related Eligibility Pathways, November 2013[2]	Number of Medicaid Births (2008, 2009 or 2010)	Source of Birth Data	Medicaid Expansion Status, January 2014
Missouri	205		75,278	a	Actively deciding
Montana	159		12,076	c	No
Nebraska	194		25,667	a	No
Nevada	159	x	34,458	a	Yes
New Hampshire	196		3,912	c	Actively deciding
New Jersey	194		103,130	a	Yes
New Mexico	250	x	24,917	a	Yes
New York	218		239,999	a	Yes
North Carolina	196	x	116,184	a	No
North Dakota	147		2,424	b	Yes
Ohio	200		10,391	b	Yes
Oklahoma	133		48,758	a	No
Oregon	185		43,538	a	Yes
Pennsylvania	215		57,371	c	Actively deciding
Rhode Island	190		11,815	a	Yes
South Carolina	194		54,510	a	No
South Dakota	133		4,662	c	No
Tennessee	195		73,816	a	No
Texas	198		369,475	a	No
Utah	139		51,941	a	Actively deciding
Vermont	208		5,630	a	Yes
Virginia	143		28,047	c	Actively deciding
Washington	193		79,463	a	Yes
West Virginia	158		19,753	a	Yes
Wisconsin	301		66,037	a	No
Wyoming	154		6,234	a	No

Notes: FPL is federal poverty level.

[1] Eligibility levels in effect as of January 1, 2014, based on information current as of September 30, 2013, provided to the Centers for Medicare & Medicaid Services (CMS) by states either for purposes of federally facilitated marketplace programming of state-specific Medicaid/State Children's Health Insurance Program rules, through state plan amendments, or by direct request from CMS. These levels are subject to change.

[2] MACPAC identified these states through state Medicaid websites and communication with Medicaid directors in November 2013. There may be additional states that limit services to those that are pregnancy-related for some subset of their pregnant enrollees.

Sources: Eligibility: CMS 2013b.

Medicaid Birth Counts: (a) HealthCare Cost and Utilization Project, Nationwide Inpatient Sample and State Inpatient Databases. Data are for 2010; (b) Medicaid Statistical Information System (MSIS). Data are for 2008; (c) NGA 2011. Data are for 2010. For more information about the data sources and methodologies for counting Medicaid births, see: Medicaid and CHIP Payment and Access Commission. 2013. *Counting the number and percentage of annual births in the Medicaid program at the national, state and sub-state levels.* Washington DC: MACPAC. http://www.macpac.gov/publications.

Medicaid Expansion Status: MACPAC analysis of KFF 2014, The Advisory Board Company 2014, State Refor(u)m 2014, and media accounts.

MACStats: Medicaid and CHIP Program Statistics

MACStats Table of Contents

Overview 64

TABLE 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2013 65

TABLE 2. Medicaid Enrollment by State and Selected Characteristics, FY 2011 (thousands) 66

TABLE 3. CHIP Enrollment by State, FY 2013 68

TABLE 4. Child Enrollment in Medicaid-Financed Coverage by State, and CHIP-Financed Coverage by State and Family Income, FY 2013 70

TABLE 5. Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2013 72

TABLE 6. Medicaid Spending by State, Category, and Source of Funds, FY 2013 (millions) 74

TABLE 7. Total Medicaid Benefit Spending by State and Category, FY 2013 (millions) 76

TABLE 8. CHIP Spending by State, FY 2013 (millions) 78

TABLE 9. Medicaid and CHIP Income Eligibility Levels as a Percentage of the Federal Poverty Level for Children and Pregnant Women by State, January 2014 80

TABLE 10. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-Aged, Non-Disabled, Non-Pregnant Adults by State, January 2014 84

TABLE 11. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Individuals Age 65 and Older and Persons with Disabilities by State, 2014 86

TABLE 12. Mandatory and Optional Medicaid Benefits 88

TABLE 13. Maximum Allowable Medicaid Premiums and Cost Sharing, FY 2014 91

TABLE 14. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, Selected Periods in FY 2011–FY 2015 92

TABLE 15. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, State FY 2012 94

TABLE 16. National Health Expenditures by Type and Payer, 2012 96

TABLE 17. Historical and Projected National Health Expenditures by Payer for Selected Years, 1970–2022 98

TABLE 18. Characteristics of Non-Institutionalized Individuals by Source of Health Insurance, 2013 100

TABLE 19. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2014 105

TABLE 20. Supplemental Payments by State and Category, FY 2013 (millions) 106

TABLE 21. Federal CHIP Allotments, FY 2013 and FY 2014 (millions) 110

TABLE 22. Federal CHIPRA Bonus Payments (millions) 113

TABLE 23. Provider Availability Measures of Access to Care for Medicaid/CHIP Beneficiaries, 2012 . . . 115

TABLE 24. Parent-Reported Measures of Access to Care for Non-Institutionalized Children by Source of Health Insurance, 2011–2012 116

TABLE 25. Parent-Reported Measures of Access to Care for Non-Institutionalized Children with Special Health Care Needs (CSHCN) by Source of Health Insurance, 2009–2012 120

TABLE 26. Measures of Access to Care for Non-Institutionalized Individuals Age 19 to 64 by Source of Health Insurance, 2012 122

TABLE 27. Measures of Access to Care for Non-Institutionalized Medicaid Beneficiaries Age 19 to 64 by Receipt of Supplemental Security Income (SSI), 2009–2011 126

MACStats Appendix 129

MACStats Appendix Table: Index of Access Measures in March 2014 MACStats Tables 23–27 133

Overview

MACStats, a standing section in all Commission reports to the Congress, presents data and information on the Medicaid and CHIP programs that otherwise can be difficult to find and are spread across multiple sources. In this report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, and federal medical assistance percentages (FMAPs). It also details benefits and permissible cost sharing under Medicaid and the dollar amounts of common federal poverty levels (FPLs) used to determine eligibility for Medicaid and CHIP. In addition, it provides information that places these programs in the broader context of state budgets and national health expenditures.

New in this report are five tables presenting access to care measures for individuals with Medicaid/CHIP and other types of coverage. The measures reflect five access domains: provider availability, connection with the health care system, contact with health professionals, timeliness of care, and receipt of appropriate care.

Key points in this report include:

- Total Medicaid spending grew by about 6 percent in fiscal year (FY) 2013, reaching $460.3 billion (Table 6). Total CHIP spending grew by about 8 percent, reaching $13.2 billion (Table 8).
- The estimated number of individuals ever covered by Medicaid remained steady at 72.7 million in FY 2013, compared to 72.2 million in FY 2012 (MACPAC communication with Office of the Actuary, Centers for Medicare & Medicaid Services; includes about one million individuals in the U.S. territories). CHIP enrollment also remained steady at 8.4 million (Table 3).
- Medicaid as a share of state budgets varies depending on how it is measured (Table 15). Looking only at the state-funded portion of state budgets (that is, the portion financed from their own revenues), Medicaid's share was 14.8 percent in state fiscal year (SFY) 2012. After including federal funds in state budgets, a typical practice in other data sources, Medicaid's share was 23.7 percent in SFY 2012.
- The Medicaid and CHIP programs together accounted for 15.5 percent of national health expenditures in calendar year 2012, and their share is projected to reach 17 percent in the next decade (Tables 16 and 17).
- Medicaid and CHIP eligibility levels for most child and adult populations have been converted as of 2014 to reflect the application of uniform modified adjusted gross income (MAGI) rules across states, and half of states are covering a new group of low-income adults (Tables 9 and 10). Eligibility for individuals with disabilities and those age 65 and older was largely unchanged (Table 11).

TABLE 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2013

Medicaid and CHIP Enrollment	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	71.7 million[1]	58.1 million[1]	Not available
CHIP	8.4 million	5.8 million	Not available
Totals for Medicaid and CHIP	80.1 million[1]	63.9 million[1]	52.1 million
U.S. Population	**Census Bureau**		**Survey Data (NHIS)**
	317.1 million	316.1 million	310.2 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	25.3%	20.2%	16.8%

Notes: Excludes U.S. territories. Medicaid and CHIP enrollment numbers obtained from administrative data include individuals who received limited benefits (e.g., emergency services only). Administrative data are estimates for fiscal year (FY) 2013 (October 2012 through September 2013) from the President's budget for FY 2015. By combining administrative totals from Medicaid and CHIP, some individuals may be double-counted if they were enrolled in both programs during the year. Overcounting of enrollees in the administrative data may occur for other reasons—for example, individuals may move and be enrolled in two states' Medicaid programs during the year. National Health Interview Survey (NHIS) data are based on interviews conducted between January and June 2013. NHIS excludes individuals in institutions, such as nursing homes, and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage and respondents are known to underreport Medicaid and CHIP coverage. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of December 2013 (the month 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 2013.

For more detailed discussion of why Medicaid and CHIP enrollment numbers can vary, see Table 1 in MACPAC's March 2012 MACStats. As indicated here, reasons include differences in the sources of data (e.g., administrative records versus interviews), the individuals included in the data (e.g., those receiving full versus limited benefits, those who are living in the community versus an institution such as a nursing home), and the enrollment period examined (e.g., ever during the year versus at a point in time).

1 Excludes about one million individuals in the U.S. territories. All other figures in the table exclude individuals in the U.S. territories, but the number of excluded individuals is not available.

Sources: MACPAC analysis based on the following: MACPAC communication with Office of the Actuary, Centers for Medicare & Medicaid Services; National Center for Health Statistics analysis of NHIS data for MACPAC (see Table 18); CHIP Statistical Enrollment Data (SEDS) data (see Table 3); and Bureau of the Census, *Population estimates, National totals: Vintage 2013*. http://www.census.gov/popest/data/national/totals/2013/index.html.

TABLE 2. Medicaid Enrollment by State and Selected Characteristics, FY 2011 (thousands)

		Basis of Eligibility[1]				Dual Eligible Status[2]					
						All dual-eligible enrollees		Dual-eligible enrollees with full benefits		Dual-eligible enrollees with limited benefits	
State	Total	Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Total	**67,605**	**32,038**	**19,163**	**9,952**	**6,452**	**10,179**	**6,010**	**7,552**	**4,478**	**2,627**	**1,532**
Alabama	**1,061**	539	184	221	118	**212**	117	**97**	51	**115**	66
Alaska	**135**	74	34	18	9	**15**	8	**15**	8	**0**	0
Arizona	**1,283**	571	481	139	91	**148**	86	**118**	64	**30**	22
Arkansas	**693**	357	115	151	71	**128**	68	**70**	42	**58**	27
California	**11,690**	4,563	5,049	1,043	1,034	**1,295**	909	**1,260**	882	**35**	26
Colorado	**762**	437	162	103	60	**94**	55	**69**	42	**25**	13
Connecticut	**785**	317	283	77	107	**155**	103	**83**	48	**72**	55
Delaware	**243**	97	104	26	15	**27**	14	**12**	7	**15**	8
District of Columbia	**232**	82	93	38	19	**23**	15	**16**	10	**7**	5
Florida	**3,983**	2,010	844	622	508	**739**	479	**387**	267	**352**	213
Georgia	**1,953**	1,139	309	322	183	**306**	179	**158**	93	**148**	86
Hawaii	**280**	115	111	28	26	**37**	25	**32**	22	**4**	3
Idaho	**267**	165	39	43	19	**40**	18	**27**	12	**13**	6
Illinois	**2,883**	1,515	816	323	228	**372**	209	**333**	185	**40**	24
Indiana	**1,189**	656	253	188	93	**173**	83	**107**	57	**66**	26
Iowa	**589**	275	186	84	44	**88**	44	**71**	33	**17**	11
Kansas	**416**	236	61	80	39	**72**	36	**49**	26	**23**	10
Kentucky	**937**	449	147	242	99	**195**	98	**113**	58	**82**	40
Louisiana	**1,292**	682	254	238	118	**204**	116	**113**	63	**91**	54
Maine	**435**	129	116	123	67	**104**	62	**59**	27	**45**	35
Maryland	**1,036**	487	319	149	80	**129**	72	**84**	46	**45**	26
Massachusetts	**1,519**	384	633	347	156	**259**	134	**237**	113	**22**	21
Michigan	**2,340**	1,181	637	374	147	**291**	134	**249**	113	**42**	22
Minnesota	**1,106**	460	410	137	99	**149**	79	**135**	70	**15**	9
Mississippi	**781**	406	115	170	90	**162**	90	**84**	49	**78**	41
Missouri	**1,138**	577	239	224	98	**194**	93	**168**	80	**26**	13
Montana	**135**	76	23	23	13	**25**	13	**17**	9	**8**	5
Nebraska	**254**	148	49	41	17	**37**	16	**37**	15	**0**	0
Nevada	**395**	239	76	49	31	**51**	30	**24**	16	**26**	14
New Hampshire	**171**	100	24	31	16	**35**	15	**23**	10	**12**	5

TABLE 2, Continued

State	Total	Basis of Eligibility[1]				Dual Eligible Status[2]					
						All dual-eligible enrollees		Dual-eligible enrollees with full benefits		Dual-eligible enrollees with limited benefits	
		Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
New Jersey	**1,194**	629	216	190	159	**236**	148	**206**	127	**30**	21
New Mexico	**651**	367	168	72	45	**74**	44	**41**	25	**33**	19
New York	**5,790**	2,127	2,321	697	646	**844**	571	**724**	481	**120**	90
North Carolina	**1,948**	1,007	411	341	189	**340**	185	**263**	142	**77**	43
North Dakota	**85**	45	18	12	9	**16**	9	**13**	7	**3**	2
Ohio	**2,339**	1,111	633	401	194	**374**	181	**255**	127	**120**	53
Oklahoma	**907**	492	221	126	68	**124**	65	**101**	53	**23**	12
Oregon	**729**	351	212	103	62	**109**	60	**68**	39	**40**	21
Pennsylvania	**2,529**	1,107	532	638	252	**444**	240	**367**	193	**77**	47
Rhode Island	**199**	90	43	41	26	**41**	23	**35**	19	**6**	4
South Carolina	**961**	477	232	166	87	**163**	87	**140**	74	**23**	13
South Dakota	**132**	77	23	20	13	**22**	13	**14**	8	**8**	4
Tennessee	**1,533**	795	322	270	146	**279**	144	**156**	79	**123**	65
Texas	**5,136**	3,258	717	690	470	**714**	460	**435**	289	**278**	171
Utah	**372**	218	91	45	17	**36**	16	**31**	14	**5**	2
Vermont	**201**	68	85	25	23	**37**	22	**28**	16	**8**	6
Virginia	**1,045**	566	180	186	113	**192**	107	**127**	74	**65**	32
Washington	**1,397**	787	297	212	101	**181**	98	**132**	76	**48**	22
West Virginia	**440**	208	65	124	43	**87**	43	**51**	26	**36**	17
Wisconsin	**1,274**	497	461	169	147	**227**	142	**206**	129	**21**	14
Wyoming	**89**	58	13	12	6	**12**	6	**7**	4	**4**	2

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 CMS Office of the Actuary, 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 Dual-eligible enrollees are covered by both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing.

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

TABLE 3. CHIP Enrollment by State, FY 2013

State	Program Type[1] (as of January 1, 2014)	Children			Adults			Total CHIP Enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Parents	Pregnant women	Total adults enrolled	
Total	–	**2,481,333**	**5,649,460**	**8,130,793**	**209,324**	**10,149**	**219,473**	**8,350,266**
Alabama	Separate	–	113,490	**113,490**	–	–	–	**113,490**
Alaska	Medicaid Expansion	16,566	–	**16,566**	–	–	–	**16,566**
Arizona	Separate	–	80,238	**80,238**	–	–	–	**80,238**
Arkansas	Combination	106,413	2,888	**109,301**	10,425	–	**10,425**	**119,726**
California	Combination	510,424	1,092,859	**1,603,283**	–	–	–	**1,603,283**
Colorado[2, 3]	Combination	–	126,169	**126,169**	–	4,873	**4,873**	**131,042**
Connecticut	Separate	–	18,999	**18,999**	–	–	–	**18,999**
Delaware	Combination	79	13,101	**13,180**	–	–	–	**13,180**
District of Columbia	Medicaid Expansion	9,057	–	**9,057**	–	–	–	**9,057**
Florida	Combination	1,072	472,343	**473,415**	–	–	–	**473,415**
Georgia	Separate	–	269,906	**269,906**	–	–	–	**269,906**
Hawaii	Medicaid Expansion	30,979	–	**30,979**	–	–	–	**30,979**
Idaho[4]	Combination	19,881	25,518	**45,399**	392	–	**392**	**45,791**
Illinois	Combination	162,134	174,963	**337,097**	–	–	–	**337,097**
Indiana	Combination	105,655	46,760	**152,415**	–	–	–	**152,415**
Iowa	Combination	22,159	61,511	**83,670**	–	–	–	**83,670**
Kansas	Separate	–	76,164	**76,164**	–	–	–	**76,164**
Kentucky	Combination	51,391	32,678	**84,069**	–	–	–	**84,069**
Louisiana	Combination	140,876	9,092	**149,968**	–	–	–	**149,968**
Maine	Combination	19,071	10,641	**29,712**	–	–	–	**29,712**
Maryland	Medicaid Expansion	135,454	–	**135,454**	–	–	–	**135,454**
Massachusetts	Combination	69,113	79,606	**148,719**	–	–	–	**148,719**
Michigan	Combination	19,229	70,441	**89,670**	–	–	–	**89,670**
Minnesota	Combination	91	3,744	**3,835**	–	–	–	**3,835**
Mississippi	Separate	–	93,120	**93,120**	–	–	–	**93,120**
Missouri	Combination	55,017	37,901	**92,918**	–	–	–	**92,918**
Montana[3]	Combination	–	31,496	**31,496**	–	–	–	**31,496**
Nebraska	Combination	53,790	1,993	**55,783**	–	–	–	**55,783**
Nevada[3]	Combination	–	20,277	**20,277**	–	–	–	**20,277**
New Hampshire	Medicaid Expansion	19,450	–	**19,450**	–	–	–	**19,450**

TABLE 3, Continued

State	Program Type[1] (as of January 1, 2014)	Children			Adults			Total CHIP Enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Parents	Pregnant women	Total adults enrolled	
New Jersey	Combination	90,512	116,249	**206,761**	183,717	291	**184,008**	**390,769**
New Mexico	Medicaid Expansion	9,368	–	**9,368**	14,790	–	**14,790**	**24,158**
New York[3]	Combination	–	490,114	**490,114**	–	–	–	**490,114**
North Carolina	Combination	81,656	201,916	**283,572**	–	–	–	**283,572**
North Dakota	Combination	2,331	8,950	**11,281**	–	–	–	**11,281**
Ohio	Medicaid Expansion	286,817	–	**286,817**	–	–	–	**286,817**
Oklahoma	Combination	140,373	7,538	**147,911**	–	–	–	**147,911**
Oregon	Separate	–	128,061	**128,061**	–	–	–	**128,061**
Pennsylvania	Separate	–	267,073	**267,073**	–	–	–	**267,073**
Rhode Island	Combination	24,508	2,069	**26,577**	–	349	**349**	**26,926**
South Carolina	Medicaid Expansion	76,191	–	**76,191**	–	–	–	**76,191**
South Dakota	Combination	13,357	4,275	**17,632**	–	–	–	**17,632**
Tennessee	Combination	22,906	83,567	**106,473**	–	–	–	**106,473**
Texas	Separate	–	1,034,613	**1,034,613**	–	–	–	**1,034,613**
Utah	Separate	–	63,001	**63,001**	–	–	–	**63,001**
Vermont	Separate	–	7,393	**7,393**	–	–	–	**7,393**
Virginia	Combination	92,690	104,221	**196,911**	–	4,636	**4,636**	**201,547**
Washington	Separate	–	44,073	**44,073**	–	–	–	**44,073**
West Virginia	Separate	–	37,065	**37,065**	–	–	–	**37,065**
Wisconsin	Combination	92,723	74,569	**167,292**	–	–	–	**167,292**
Wyoming	Separate	–	8,815	**8,815**	–	–	–	**8,815**

Notes: Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half), the individual would only be counted in the most recent category. CHIP-funded coverage of childless adults was prohibited after December 31, 2009. New Jersey and Rhode Island cover targeted low-income pregnant women under a CHIP state plan option; all other CHIP-funded coverage of adults shown in the table was permitted through waivers. Data shown in the 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. In 2014, all states are eligible to receive CHIP funding for at least some Medicaid-enrolled children due to a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid, and a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid eligibility levels by 5 percentage points. See Table 9 for more information.

2 Colorado data are from fiscal year (FY) 2012.

3 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.

4 Data on adults are from FY 2012 for Idaho.

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; for numbers of adults: CMS analysis for MACPAC of SEDS as of February 28, 2014, as reported by states; for CHIP program type: MACPAC analysis of CHIP state plan amendments on the CMS website and CMS, *Children's Health Insurance Program: Plan activity as of January 1, 2014.*

TABLE 4. Child Enrollment in Medicaid-Financed Coverage by State, and CHIP-Financed Coverage by State and Family Income, FY 2013

State	Medicaid-Financed Children[1]	CHIP-Financed Children (Medicaid-expansion and Separate CHIP Coverage)						
		At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		
	All incomes	Number	Percentage	Number	Percentage	Number	Percentage	All incomes
Total	**38,731,044**	**7,223,757**	**88.8%**	**697,169**	**8.6%**	**209,867**	**2.6%**	**8,130,793**
Alabama	**616,718**	91,633	80.7	15,453	13.6	6,404	5.6	**113,490**
Alaska	**86,926**	16,566	100.0	–	–	–	–	**16,566**
Arizona	**913,271**	80,238	100.0	–	–	–	–	**80,238**
Arkansas	**513,534**	109,301	100.0	–	–	–	–	**109,301**
California	**5,318,080**	1,369,661	85.4	223,271	13.9	10,351	0.6	**1,603,283**
Colorado[2]	**484,882**	103,468	82.0	22,701	18.0	–	–	**126,169**
Connecticut	**325,414**	3,577	18.8	9,646	50.8	5,776	30.4	**18,999**
Delaware[3]	**96,916**	13,180	100.0	–	–	–	–	**13,180**
District of Columbia	**91,712**	–	–	9,057	100.0	–	–	**9,057**
Florida	**2,119,324**	473,415	100.0	–	–	–	–	**473,415**
Georgia	**1,162,529**	233,303	86.4	36,603	13.6	–	–	**269,906**
Hawaii	**138,258**	26,375	85.1	3,426	11.1	1,178	3.8	**30,979**
Idaho	**211,607**	45,399	100.0	–	–	–	–	**45,399**
Illinois	**2,352,202**	337,097	100.0	–	–	–	–	**337,097**
Indiana	**701,804**	138,324	90.8	14,091	9.2	–	–	**152,415**
Iowa	**318,377**	69,836	83.5	1,752	2.1	12,082	14.4	**83,670**
Kansas[3]	**237,026**	69,691	91.5	6,473	8.5	–	–	**76,164**
Kentucky	**485,286**	84,069	100.0	–	–	–	–	**84,069**
Louisiana	**670,729**	145,012	96.7	4,956	3.3	–	–	**149,968**
Maine	**175,128**	29,712	100.0	–	–	–	–	**29,712**
Maryland	**490,009**	39,279	29.0	90,793	67.0	5,382	4.0	**135,454**
Massachusetts	**544,851**	117,462	79.0	19,798	13.3	11,459	7.7	**148,719**
Michigan	**1,195,649**	89,670	100.0	–	–	–	–	**89,670**
Minnesota	**505,264**	3,663	95.5	70	1.8	102	2.7	**3,835**
Mississippi	**467,918**	93,120	100.0	–	–	–	–	**93,120**
Missouri	**559,265**	79,904	86.0	9,068	9.8	3,946	4.2	**92,918**
Montana	**83,447**	31,496	100.0	–	–	–	–	**31,496**
Nebraska	**165,038**	55,783	100.0	–	–	–	–	**55,783**
Nevada[3]	**256,109**	20,277	100.0	–	–	–	–	**20,277**

TABLE 4, Continued

State	Medicaid-Financed Children[1]	CHIP-Financed Children (Medicaid-expansion and Separate CHIP Coverage)						
		At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		
	All incomes	Number	Percentage	Number	Percentage	Number	Percentage	All incomes
New Hampshire	**85,562**	7,339	37.7%	7,511	38.6%	4,600	23.7%	**19,450**
New Jersey	**662,198**	157,727	76.3	27,636	13.4	21,398	10.3	**206,761**
New Mexico	**380,290**	4,308	46.0	5,060	54.0	–	–	**9,368**
New York	**2,309,571**	289,919	59.2	104,921	21.4	95,274	19.4	**490,114**
North Carolina[3]	**2,517,188**	283,572	100.0	–	–	–	–	**283,572**
North Dakota	**50,957**	11,281	100.0	–	–	–	–	**11,281**
Ohio	**1,483,176**	286,817	100.0	–	–	–	–	**286,817**
Oklahoma[3]	**558,262**	147,911	100.0	–	–	–	–	**147,911**
Oregon	**401,721**	112,675	88.0	10,556	8.2	4,830	3.8	**128,061**
Pennsylvania	**1,309,862**	225,995	84.6	29,068	10.9	12,010	4.5	**267,073**
Rhode Island	**112,002**	23,304	87.7	3,273	12.3	–	–	**26,577**
South Carolina[3]	**582,293**	76,191	100.0	–	–	–	–	**76,191**
South Dakota[3]	**46,948**	17,632	100.0	–	–	–	–	**17,632**
Tennessee	**790,923**	92,276	86.7	14,197	13.3	–	–	**106,473**
Texas[4]	**3,518,832**	1,034,613	100.0	–	–	–	–	**1,034,613**
Utah	**283,213**	63,001	100.0	–	–	–	–	**63,001**
Vermont	**72,512**	–	–	3,726	50.4	3,667	49.6	**7,393**
Virginia	**648,173**	196,911	100.0	–	–	–	–	**196,911**
Washington	**768,387**	11,934	27.1	20,731	47.0	11,408	25.9	**44,073**
West Virginia	**260,326**	33,924	91.5	3,141	8.5	–	–	**37,065**
Wisconsin	**542,731**	167,101	99.9	191	0.1	–	–	**167,292**
Wyoming	**58,644**	8,815	100.0	–	–	–	–	**8,815**

Notes: Enrollment numbers generally include children ever enrolled during the year, even if for a single month; however, in the event children were in multiple categories during the year (for example, in Medicaid for the first half of the year but in a separate CHIP program for the second half), the child would only be counted in the most recent category. The definition in this table for Medicaid-financed children may differ from that used elsewhere in this report. This table includes children with and without disabilities; in tables using Medicaid eligibility categories, children qualifying on the basis of a disability are counted in the disabled category, not the child category. In 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. For additional information, see MACStats Table 19. Data shown in the table are as of March 4, 2014; states may subsequently revise their current or historical data.

1 MACPAC analysis of Statistical Enrollment Data System (SEDS), as reported by states, found that 99.4 percent of Medicaid-financed children were at or below 200 percent FPL.

2 Colorado data are from fiscal year (FY) 2012.

3 In SEDS, Delaware, Nevada, North Carolina, Oklahoma, South Carolina, and South Dakota reported CHIP enrollees above 200 percent FPL, and Kansas reported CHIP enrollees above 250 percent FPL; however, their CHIP programs are reported to only cover individuals at or below these levels. The numbers here were altered to put all of these enrollees at or below 200 (250 in the case of Kansas) percent FPL.

4 Data on Medicaid-financed children are from FY 2012 for Texas.

Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from CMS as of March 4, 2014.

TABLE 5. Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2013

State	Total[1]	Managed Care		Fee for Service		Primary Care Case Management	
		Number	Percentage	Number	Percentage	Number	Percentage
Total	**5,649,460**	**4,528,414**	**80.2%**	**919,723**	**16.3%**	**201,323**	**3.6%**
Alabama	**113,490**	–	–	113,490	100.0	–	–
Alaska	–	–	–	–	–	–	–
Arizona	**80,238**	75,609	94.2	4,629	5.8	–	–
Arkansas	**2,888**	–	–	2,888	100.0	–	–
California	**1,092,859**	977,885	89.5	114,974	10.5	–	–
Colorado[2]	**126,169**	126,169	100.0	–	–	–	–
Connecticut	**18,999**	–	–	18,999	100.0	–	–
Delaware	**13,101**	12,940	98.8	–	–	161	1.2
District of Columbia	–	–	–	–	–	–	–
Florida	**472,343**	459,381	97.3	5,414	1.1	7,548	1.6
Georgia	**269,906**	255,890	94.8	14,016	5.2	–	–
Hawaii	–	–	–	–	–	–	–
Idaho	**25,518**	–	–	–	–	25,518	100.0
Illinois	**174,963**	6,156	3.5	46,265	26.4	122,542	70.0
Indiana	**46,760**	41,212	88.1	5,548	11.9	–	–
Iowa	**61,511**	61,511	100.0	–	–	–	–
Kansas	**76,164**	76,118	99.9	46	0.1	–	–
Kentucky	**32,678**	32,558	99.6	120	0.4	–	–
Louisiana	**9,092**	1,590	17.5	4,797	52.8	2,705	29.8
Maine	**10,641**	–	–	3,277	30.8	7,364	69.2
Maryland	–	–	–	–	–	–	–
Massachusetts	**79,606**	29,255	36.7	29,053	36.5	21,298	26.8
Michigan	**70,441**	62,895	89.3	7,546	10.7	–	–
Minnesota	**3,744**	3,138	83.8	606	16.2	–	–
Mississippi	**93,120**	93,120	100.0	–	–	–	–
Missouri	**37,901**	14,914	39.3	22,987	60.7	–	–
Montana	**31,496**	–	–	31,496	100.0	–	–
Nebraska	**1993**	–	–	1,993	100.0	–	–

TABLE 5, Continued

State	Total[1]	Managed Care		Fee for Service		Primary Care Case Management	
		Number	Percentage	Number	Percentage	Number	Percentage
Nevada	**20,277**	17,716	87.4%	2,561	12.6%	–	–
New Hampshire	–	–	–	–	–	–	–
New Jersey	**116,249**	113,437	97.6	2,812	2.4	–	–
New Mexico	–	–	–	–	–	–	–
New York	**490,114**	489,456	99.9	658	0.1	–	–
North Carolina	**201,916**	–	–	201,916	100.0	–	–
North Dakota	**8,950**	4,754	53.1	–	–	4,196	46.9%
Ohio	–	–	–	–	–	–	–
Oklahoma	**7,538**	190	2.5	7,348	97.5	–	–
Oregon	**128,061**	14,950	11.7	113,101	88.3	10	0.0
Pennsylvania	**267,073**	267,073	100.0	–	–	–	–
Rhode Island	**2,069**	2,069	100.0	–	–	–	–
South Carolina	–	–	–	–	–	–	–
South Dakota	**4,275**	–	–	1,477	34.5	2,798	65.5
Tennessee	**83,567**	–	–	83,567	100.0	–	–
Texas	**1,034,613**	1,034,613	100.0	–	–	–	–
Utah	**63,001**	63,001	100.0	–	–	–	–
Vermont	**7,393**	–	–	411	5.6	6,982	94.4
Virginia	**104,221**	92,284	88.5	11,937	11.5	–	–
Washington	**44,073**	28,352	64.3	15,520	35.2	201	0.5
West Virginia	**37,065**	–	–	37,065	100.0	–	–
Wisconsin	**74,569**	61,363	82.3	13,206	17.7	–	–
Wyoming	**8,815**	8,815	100.0	–	–	–	–

Notes: Enrollment numbers generally include children ever enrolled during the year, even if for a single month; however, in the event children were in multiple categories during the year (for example, in Medicaid for the first half of the year but in a separate CHIP program for the second half), the child would only be counted in the most recent category. Categorizations of the types of delivery system are based on states' definitions and Statistical Enrollment Data System (SEDS) instructions to states. According to SEDS instructions, managed care includes arrangements under which the state contracts with a health maintenance or health insuring organization to provide a comprehensive set of services; enrollees choose a plan and a primary care provider (PCP) who will be responsible for managing their care. Under fee for service, providers submit claims to the state and are paid a specific amount for each service performed. Under primary care case management, providers are paid generally on a fee-for-service basis, but PCPs are paid an additional flat monthly fee for each patient assigned to them for case management. Data shown in the table are as of March 4, 2014; states may subsequently revise their current or historical data.

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

2 Colorado data are from fiscal year (FY) 2012.

Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from CMS as of March 4, 2014.

TABLE 6. Medicaid Spending by State, Category, and Source of Funds, FY 2013 (millions)

State	Benefits			State Program Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$5,000**	$3,454	$1,546	**$217**	$139	$78	**$5,216**	$3,592	$1,624
Alaska	**1,341**	776	565	**105**	73	33	**1,446**	849	598
Arizona	**8,437**	5,727	2,710	**233**	159	74	**8,670**	5,886	2,784
Arkansas	**4,156**	2,937	1,220	**272**	171	101	**4,428**	3,108	1,320
California	**61,426**	31,501	29,925	**4,631**	2,614	2,017	**66,057**	34,115	31,942
Colorado	**5,048**	2,536	2,512	**267**	167	99	**5,315**	2,703	2,612
Connecticut	**6,415**	3,243	3,172	**308**	177	131	**6,723**	3,420	3,303
Delaware	**1,558**	867	690	**98**	71	27	**1,655**	938	717
District of Columbia	**2,276**	1,592	684	**121**	70	52	**2,397**	1,661	736
Florida	**18,411**	10,742	7,670	**820**	514	306	**19,231**	11,255	7,976
Georgia	**8,888**	5,889	2,999	**471**	307	164	**9,359**	6,196	3,163
Hawaii	**1,586**	825	761	**110**	81	29	**1,697**	907	790
Idaho	**1,642**	1,167	475	**120**	94	25	**1,762**	1,262	500
Illinois	**15,494**	7,834	7,660	**1,039**	658	382	**16,533**	8,492	8,041
Indiana	**7,931**	5,349	2,582	**437**	272	165	**8,367**	5,620	2,747
Iowa	**3,623**	2,186	1,436	**183**	131	52	**3,806**	2,317	1,489
Kansas	**2,545**	1,443	1,102	**176**	114	61	**2,721**	1,557	1,163
Kentucky	**5,726**	4,047	1,680	**209**	148	61	**5,935**	4,195	1,740
Louisiana	**6,889**	4,514	2,375	**293**	188	105	**7,181**	4,701	2,480
Maine	**2,827**	1,778	1,049	**132**	92	41	**2,959**	1,870	1,089
Maryland	**7,688**	3,900	3,788	**365**	224	141	**8,053**	4,124	3,929
Massachusetts	**12,999**	6,520	6,479	**687**	418	270	**13,687**	6,937	6,749
Michigan	**12,308**	8,180	4,129	**662**	413	250	**12,971**	8,593	4,378
Minnesota	**8,781**	4,440	4,342	**563**	327	236	**9,344**	4,766	4,577
Mississippi	**4,709**	3,484	1,224	**171**	121	50	**4,879**	3,605	1,274
Missouri	**8,863**	5,504	3,359	**347**	220	127	**9,210**	5,724	3,486
Montana	**997**	671	325	**78**	53	25	**1,075**	725	350
Nebraska	**1,790**	1,000	790	**116**	79	37	**1,906**	1,079	827
Nevada	**1,797**	1,083	714	**121**	82	39	**1,919**	1,165	754
New Hampshire	**1,189**	603	585	**103**	70	34	**1,292**	673	619
New Jersey	**10,481**	5,259	5,222	**663**	381	282	**11,144**	5,639	5,505
New Mexico	**3,281**	2,303	978	**189**	134	55	**3,470**	2,437	1,033
New York	**52,490**	26,473	26,017	**1,703**	1,037	667	**54,193**	27,510	26,683
North Carolina	**11,722**	7,719	4,003	**741**	493	248	**12,463**	8,212	4,251
North Dakota	**775**	411	365	**61**	41	21	**836**	451	385
Ohio	**16,628**	10,615	6,014	**609**	394	214	**17,237**	11,009	6,228

TABLE 6, Continued

State	Benefits			State Program Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Oklahoma	**$4,482**	$2,916	$1,566	**$270**	$177	$94	**$4,752**	$3,092	$1,660
Oregon	**5,071**	3,185	1,886	**530**	308	221	**5,600**	3,493	2,107
Pennsylvania	**20,922**	11,375	9,548	**777**	476	301	**21,699**	11,850	9,849
Rhode Island	**1,909**	988	921	**109**	73	37	**2,018**	1,061	958
South Carolina	**4,690**	3,317	1,373	**232**	157	75	**4,922**	3,473	1,448
South Dakota	**758**	459	299	**62**	40	22	**820**	499	321
Tennessee	**8,678**	5,784	2,894	**344**	220	124	**9,022**	6,005	3,018
Texas	**27,752**	16,596	11,156	**1,334**	832	502	**29,086**	17,428	11,658
Utah	**2,087**	1,454	633	**142**	92	51	**2,229**	1,546	684
Vermont	**1,452**	816	636	**35**	30	5	**1,487**	846	641
Virginia	**7,218**	3,654	3,565	**387**	257	130	**7,605**	3,911	3,694
Washington	**7,806**	3,915	3,891	**602**	357	244	**8,407**	4,272	4,135
West Virginia	**3,007**	2,169	838	**174**	120	54	**3,181**	2,289	892
Wisconsin	**7,035**	4,222	2,812	**356**	233	123	**7,391**	4,456	2,935
Wyoming	**547**	279	267	**48**	33	15	**595**	312	283
Subtotal (States)	**$431,130**	**$247,698**	**$183,432**	**$22,821**	**$14,128**	**$8,693**	**$453,952**	**$261,826**	**$192,126**
American Samoa	**25**	**14**	11	**1**	**1**	0	**26**	**14**	**11**
Guam	**60**	**33**	27	**3**	**2**	1	**63**	**35**	**28**
Northern Mariana Islands	**31**	**18**	14	**2**	**2**	0	**34**	**20**	**14**
Puerto Rico	**1,837**	**1,011**	827	**107**	**81**	26	**1,944**	**1,091**	**853**
Virgin Islands	**25**	**14**	11	**4**	**2**	1	**29**	**16**	**13**
Subtotal (States & Territories)	**$433,110**	**$248,788**	**$184,322**	**$22,938**	**$14,216**	**$8,722**	**$456,048**	**$263,003**	**$193,045**
State Medicaid Fraud Control Units (MFCUs)	–	–	–	**296**	**222**	74	**296**	**222**	**74**
Medicaid survey and certification of nursing and intermediate care facilities	–	–	–	**307**	**230**	77	**307**	**230**	**77**
Vaccines for Children (VFC) program	–	–	–	–	–	–	**3,607**	**3,607**	**-**
Total	**$433,110**	**$248,788**	**$184,322**	**$23,541**	**$14,668**	**$8,873**	**$460,258**[1]	**$267,063**[1]	**$193,196**

Notes: Total federal spending shown here ($267.063 billion) will differ from total federal outlays shown in fiscal year (FY) 2013 budget documents due to slight differences in the timing of data for the states and the treatment of certain adjustments. Benefits and Administration columns do not sum to Total Medicaid due to the inclusion of VFC in Total Medicaid. Federal spending in the territories is capped; however, they report their total spending regardless of whether they have reached their caps. As a result, federal spending shown here may exceed the amounts actually paid to the territories. State shares for MFCUs and survey and certification are MACPAC estimates based on 75 percent federal match. State-level estimates for these items are available but are not shown here. VFC is authorized in the Medicaid statute but is operated as a separate program; 100 percent federal funding finances the purchase of vaccines for children who are enrolled in Medicaid, uninsured, or privately insured without vaccine coverage. Spending on administration is only for state programs; federal oversight spending is not included. All states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 12, 2014. Figures presented in this table may change if states revise their expenditure data after this date. Zeroes indicate amounts less than $0.5 million that round to zero. Dashes indicate amounts that are true zeroes.

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

Sources: For state and territory spending: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014; for all other (MFCUs, survey and certification, VFC): Centers for Medicare & Medicaid Services (CMS), Fiscal year 2014 justification of estimates for Appropriations Committees, Baltimore, MD, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf.

TABLE 7. Total Medicaid Benefit Spending by State and Category, FY 2013 (millions)

State	Total	Fee for Service									Managed Care and Premium Assistance	Medicare Premiums and Coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			
Alabama	**$5,000**	$1,891	$360	$85	$42	$84	$481	$294	$972	$460	$116	$253	-$39
Alaska	**1,341**	303	106	62	20	185	99	25	160	373	0	23	-16
Arizona	**8,437**	1,467	32	4	5	122	257	5	68	6	6,301	171	-0
Arkansas	**4,156**	990	298	73	19	113	798	159	965	478	19	296	-50
California	**61,426**	16,291	827	402	93	2,720	7,634	740	5,885	8,881	16,162	2,269	-478
Colorado	**5,048**	1,713	358	122	–	131	313	166	695	872	624	100	-44
Connecticut	**6,415**	1,721	314	155	101	241	432	306	1,738	1,351	2	364	-310
Delaware	**1,558**	51	12	33	1	40	64	60	38	101	1,130	34	-5
District of Columbia	**2,276**	359	46	29	2	142	122	61	327	462	702	36	-13
Florida	**18,411**	5,104	1,231	257	40	223	1,585	565	3,299	1,522	3,412	1,324	-150
Georgia	**8,888**	2,199	375	44	35	9	766	239	1,420	907	2,642	324	-73
Hawaii	**1,586**	118	1	20	0	25	4	-0	9	108	1,288	58	-44
Idaho	**1,642**	506	79	0	11	160	215	56	290	266	48	42	-30
Illinois	**15,494**	6,498	813	178	108	323	1,366	374	2,972	1,675	964	388	-165
Indiana	**7,931**	1,858	277	170	10	353	267	349	1,996	935	1,589	163	-37
Iowa	**3,623**	793	196	58	21	71	347	105	910	760	305	142	-86
Kansas	**2,545**	328	47	12	3	13	79	-17	243	422	1,366	83	-33
Kentucky	**5,726**	457	49	2	3	106	314	32	1,055	618	2,970	215	-96
Louisiana	**6,889**	2,202	317	112	–	106	357	182	1,453	843	1,311	265	-258
Maine	**2,827**	997	103	29	49	255	282	57	439	435	5	236	-60
Maryland	**7,688**	993	93	121	18	50	793	132	1,322	1,044	2,965	249	-93
Massachusetts	**12,999**	2,120	337	192	19	322	1,949	241	1,749	2,077	3,741	419	-167
Michigan	**12,308**	1,722	278	81	8	207	167	263	1,798	962	6,491	411	-78
Minnesota	**8,781**	603	177	29	182	39	491	103	998	2,194	3,925	177	-138
Mississippi	**4,709**	1,660	216	6	25	88	386	125	1,123	296	607	204	-28
Missouri	**8,863**	2,981	38	15	11	487	837	655	1,319	1,174	1,116	318	-88
Montana	**997**	268	50	25	16	15	184	31	191	185	7	34	-10
Nebraska	**1,790**	216	38	34	5	72	78	73	434	341	436	107	-43
Nevada	**1,797**	539	98	28	13	17	194	55	254	163	353	110	-26
New Hampshire	**1,189**	156	56	20	12	36	252	33	332	276	0	30	-14
New Jersey	**10,481**	1,740	46	11	3	179	598	66	2,961	1,056	3,616	331	-125
New Mexico	**3,281**	366	51	13	41	35	48	-94	31	325	2,399	80	-14
New York	**52,490**	8,760	346	114	240	1,419	3,199	-1,281	10,670	8,626	21,032	1,296	-1,931
North Carolina	**11,722**	3,461	896	305	86	221	1,227	739	1,660	948	1,948	425	-193
North Dakota	**775**	139	51	11	8	10	41	23	312	173	5	11	-9
Ohio	**16,628**	2,494	339	53	27	54	748	183	3,875	2,317	6,333	381	-175

TABLE 7, Continued

State	Total	Fee for Service									Managed Care and Premium Assistance	Medicare Premiums and Coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			
Oklahoma	**$4,482**	$1,544	$479	$123	$38	$389	$345	$297	$746	$511	$192	$133	-$314
Oregon	**5,071**	348	24	1	23	57	534	66	354	1,159	2,396	148	-40
Pennsylvania	**20,922**	1,726	151	43	4	111	261	-37	4,850	3,217	10,198	567	-169
Rhode Island	**1,909**	351	11	10	1	23	572	1	346	2	564	40	-11
South Carolina	**4,690**	1,156	214	88	26	202	288	74	774	470	1,441	173	-216
South Dakota	**758**	188	62	14	2	90	53	27	167	133	2	28	-8
Tennessee	**8,678**	1,171	27	166	1	42	217	290	284	700	5,478	340	-39
Texas	**27,752**	4,918	1,130	93	240	35	2,855	283	3,565	2,149	12,044	1,025	-587
Utah	**2,087**	458	99	42	3	12	113	46	247	224	848	37	-43
Vermont	**1,452**	44	2	0	0	1	1,361	-67	116	8	3	7	-21
Virginia	**7,218**	1,011	178	139	35	52	980	27	1,292	1,229	2,118	228	-73
Washington	**7,806**	1,033	101	134	38	447	800	40	883	1,553	2,823	319	-366
West Virginia	**3,007**	588	147	56	14	31	242	103	716	572	440	115	-17
Wisconsin	**7,035**	743	57	45	24	296	604	321	1,042	799	2,921	253	-71
Wyoming	**547**	123	48	13	18	28	27	19	135	130	0	13	-8
Subtotal	**$431,130**	**$89,465**	**$11,676**	**$3,872**	**$1,743**	**$10,490**	**$36,229**	**$6,599**	**$69,478**	**$56,488**	**$137,398**	**$14,795**	**-$7,103**
American Samoa	**25**	51	–	–	–	–	-26	1	–	–	–	–	–
Guam	**60**	14	6	1	0	0	23	13	1	0	–	1	–
N. Mariana Islands	**31**	12	–	2	–	6	6	3	–	1	–	0	–
Puerto Rico	**1,837**	–	–	–	–	–	40	–	–	–	1,798	–	–
Virgin Islands	**25**	12	2	0	–	5	1	3	2	–	–	0	–
Total	**$433,110**	**$89,555**	**$11,684**	**$3,875**	**$1,743**	**$10,501**	**$36,273**	**$6,618**	**$69,481**	**$56,489**	**$139,196**	**$14,797**	**-$7,103**
Percent of Total, Exclusive of Collections	–	**20.3%**	**2.7%**	**0.9%**	**0.4%**	**2.4%**	**8.2%**	**1.5%**	**15.8%**	**12.8%**	**31.6%**	**3.4%**	–

Notes: Includes federal and state funds. Service category definitions and spending amounts shown here may differ from other Centers for Medicare & Medicaid Services(CMS) data sources, such as the Medicaid Statistical Information System (MSIS). The specific services included in each category have changed over time and therefore may not be directly comparable to earlier editions of MACStats. LTSS is long-term services and supports. Hospital includes inpatient, outpatient, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments. Physician includes physician and surgical services, both regular payments and those associated with the primary care physician payment increase. Other practitioner includes nurse midwife, nurse practitioner, and other. Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center, and freestanding birth center. Other acute includes lab/X-ray; sterilizations; abortions; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; preventive services with U.S. Preventive Services Task Force (USPSTF) Grade A or B and Advisory Committee on Immunization Practices (ACIP) vaccines; other diagnostic screening and preventive services; school-based services; health home with chronic conditions; tobacco cessation for pregnant women; private duty nursing; case management (excluding primary care case management); rehabilitative services; hospice; and other care not otherwise categorized. Drugs are net of rebates. Institutional LTSS includes nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility. Home and community-based services includes home health, waiver and state plan services, and personal care. Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management (PCCM), employer-sponsored premium assistance programs, and Programs of All-inclusive Care for the Elderly (PACE); comprehensive plans account for about 90 percent of spending in the managed care category. Managed care also includes rebates for drugs provided by managed care plans and managed care payments associated with the primary care physician payment increase, Community First Choice option, and preventive services with USPSTF Grade A or B and ACIP vaccines. Collections includes third-party liability, estate, and other recoveries. All states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 12, 2014. Figures presented in this table may change if states revise their expenditure data after this date. Zeroes indicate amounts less than $0.5 million that round to zero. Dashes indicate amounts that are true zeroes.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

TABLE 8. CHIP Spending by State, FY 2013 (millions)

State	Total CHIP[1]			Benefits						State Program Administration			2105(g) Spending[1]
				Medicaid-expansion CHIP programs			Separate CHIP programs and adult coverage waivers						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
Alabama	**$193.4**	$150.8	$42.6	–	–	–	**$186.5**	$145.4	$41.1	**$6.9**	$5.4	$1.5	–
Alaska	**32.8**	21.3	11.5	**$31.5**	$20.5	$11.0	–	–	–	**1.3**	0.8	0.4	–
Arizona	**73.9**	56.1	17.7	–	–	–	**70.6**	53.7	17.0	**3.3**	2.5	0.8	–
Arkansas	**122.8**	95.4	27.4	**91.1**	72.1	19.0	**26.0**	19.1	6.9	**5.6**	4.1	1.5	–
California	**2,126.8**	1,382.4	744.4	**1,046.9**	680.5	366.4	**985.4**	640.6	344.9	**94.4**	61.4	33.0	–
Colorado	**227.3**	147.7	79.5	**12.1**	7.9	4.2	**205.8**	133.8	72.0	**9.4**	6.1	3.3	–
Connecticut	**28.0**	35.2	-7.2	–	–	–	**25.2**	16.4	8.8	**2.8**	1.8	1.0	$17.0
Delaware	**24.6**	17.0	7.6	**0.3**	0.2	0.1	**21.8**	15.1	6.8	**2.4**	1.7	0.8	–
District of Columbia	**18.4**	14.5	3.9	**18.2**	14.4	3.8	–	–	–	**0.2**	0.1	0.0	–
Florida	**520.7**	367.5	153.2	**3.4**	2.4	1.0	**465.6**	328.6	137.0	**51.7**	36.5	15.2	–
Georgia	**413.3**	313.6	99.7	–	–	–	**383.2**	290.8	92.4	**30.1**	22.9	7.3	–
Hawaii	**40.3**	26.6	13.7	**37.1**	24.4	12.7	–	–	–	**3.2**	2.1	1.1	–
Idaho	**60.7**	48.3	12.4	**23.4**	18.6	4.8	**35.4**	28.1	7.2	**2.0**	1.6	0.4	–
Illinois	**517.7**	336.4	181.3	**148.0**	95.8	52.1	**332.1**	216.1	116.0	**37.6**	24.4	13.1	–
Indiana	**157.4**	121.2	36.2	**102.7**	79.1	23.6	**48.4**	37.2	11.1	**6.4**	4.9	1.5	–
Iowa	**134.2**	96.2	38.0	**29.2**	20.9	8.3	**96.7**	69.3	27.3	**8.3**	5.9	2.3	–
Kansas	**75.5**	52.5	23.0	–	–	–	**69.0**	48.0	21.0	**6.5**	4.5	2.0	–
Kentucky	**184.8**	146.7	38.1	**116.7**	92.6	24.0	**64.6**	51.3	13.3	**3.5**	2.8	0.7	–
Louisiana	**203.3**	148.1	55.2	**172.6**	125.7	46.8	**18.3**	13.3	5.0	**12.5**	9.1	3.4	–
Maine	**37.2**	27.5	9.7	**21.9**	16.2	5.7	**13.8**	10.2	3.6	**1.6**	1.2	0.4	–
Maryland	**258.4**	168.0	90.4	**245.5**	159.5	85.9	–	–	–	**13.0**	8.4	4.5	–
Massachusetts	**573.7**	372.9	200.8	**292.8**	190.3	102.5	**226.6**	147.3	79.3	**54.3**	35.3	19.0	–
Michigan	**147.1**	112.5	34.7	**19.4**	14.8	4.6	**124.4**	95.1	29.3	**3.3**	2.5	0.8	–
Minnesota	**19.5**	32.2	-12.7	**0.1**	0.0	0.0	**19.1**	12.5	6.6	**0.4**	0.3	0.1	19.4
Mississippi	**207.5**	168.9	38.6	–	–	–	**205.2**	167.1	38.2	**2.3**	1.9	0.4	–
Missouri	**170.0**	124.1	45.8	**113.9**	83.1	30.8	**43.8**	32.0	11.7	**12.3**	9.0	3.3	–
Montana	**91.5**	69.7	21.8	**21.6**	16.5	5.1	**65.1**	49.6	15.5	**4.8**	3.6	1.1	–
Nebraska	**70.1**	48.2	21.9	**59.8**	41.1	18.7	**7.1**	4.9	2.2	**3.2**	2.2	1.0	–
Nevada	**37.2**	26.8	10.5	**1.8**	1.3	0.5	**33.2**	23.9	9.3	**2.3**	1.6	0.6	–
New Hampshire	**16.7**	14.9	1.9	**16.3**	10.6	5.7	–	–	–	**0.4**	0.3	0.1	4.0
New Jersey	**958.0**	586.6	371.5	**194.4**	126.4	68.1	**660.3**	397.9	262.4	**103.3**	62.3	41.1	–
New Mexico	**144.9**	110.0	35.0	**67.1**	52.6	14.5	**75.7**	55.8	19.9	**2.1**	1.5	0.5	–

TABLE 8, Continued

State	Total CHIP[1]			Benefits						State Program Administration			2105(g) Spending[1]
				Medicaid-expansion CHIP programs			Separate CHIP programs and adult coverage waivers						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
New York	**$959.9**	$624.0	$335.9	**$291.0**	$189.1	$101.8	**$658.4**	$428.0	$230.4	**$10.5**	$6.8	$3.7	–
North Carolina	**398.0**	302.0	96.1	**78.4**	59.5	18.9	**304.1**	230.7	73.4	**15.5**	11.8	3.8	–
North Dakota	**26.6**	17.7	8.9	**12.0**	8.0	4.0	**13.4**	8.9	4.4	**1.3**	0.8	0.4	–
Ohio	**381.3**	284.1	97.2	**376.4**	280.5	95.9	–	–	–	**4.8**	3.6	1.2	–
Oklahoma	**172.6**	129.1	43.5	**159.0**	119.0	40.1	**9.7**	7.2	2.4	**3.8**	2.9	1.0	–
Oregon	**209.4**	154.3	55.0	–	–	–	**188.4**	138.9	49.5	**20.9**	15.4	5.5	–
Pennsylvania	**428.0**	291.1	136.9	–	–	–	**420.3**	285.9	134.5	**7.7**	5.2	2.4	–
Rhode Island	**81.1**	53.7	27.4	**67.9**	45.0	22.9	**11.1**	7.3	3.8	**2.1**	1.4	0.7	–
South Carolina	**132.5**	105.1	27.4	**120.9**	95.8	25.0	–	–	–	**11.6**	9.2	2.4	–
South Dakota	**24.6**	17.0	7.6	**17.8**	12.3	5.5	**6.4**	4.4	2.0	**0.4**	0.3	0.1	–
Tennessee	**259.6**	198.0	61.6	**43.7**	33.4	10.4	**209.5**	159.8	49.7	**6.4**	4.9	1.5	–
Texas	**1,285.0**	918.8	366.2	**40.4**	28.7	11.7	**1,173.9**	839.5	334.4	**70.7**	50.6	20.1	–
Utah	**68.6**	54.0	14.6	–	–	–	**62.6**	49.3	13.3	**6.0**	4.7	1.3	–
Vermont	**9.0**	13.0	-4.0	–	–	–	**8.3**	5.8	2.6	**0.7**	0.5	0.2	$6.8
Virginia	**301.0**	195.7	105.4	**122.2**	79.4	42.8	**166.3**	108.1	58.2	**12.5**	8.1	4.4	–
Washington	**122.9**	95.5	27.3	**2.2**	1.4	0.8	**116.0**	75.4	40.5	**4.7**	3.1	1.7	15.6
West Virginia	**57.9**	46.5	11.3	–	–	–	**53.4**	43.0	10.5	**4.4**	3.6	0.9	–
Wisconsin	**140.3**	106.2	34.1	**58.7**	42.1	16.6	**69.9**	50.2	19.7	**11.7**	8.4	3.3	5.5
Wyoming	**16.4**	10.7	5.7	–	–	–	**15.7**	10.3	5.5	**0.7**	0.5	0.2	–
Subtotal	**$12,962.4**	**$9,056.2**	**$3,906.2**	**$4,278.4**	**$2,961.8**	**$1,316.6**	**$7,996.2**	**$5,555.6**	**$2,440.6**	**$687.8**	**$470.5**	**$217.3**	**$68.3**
American Samoa	**1.6**	1.3	0.3	**1.6**	1.3	0.3	–	–	–	–	–	–	–
Guam	**6.3**	4.5	1.8	**6.3**	4.5	1.8	–	–	–	–	–	–	–
N. Mariana Islands	**1.1**	0.9	0.1	**1.1**	0.9	0.1	–	–	–	–	–	–	–
Puerto Rico	**194.9**	133.5	61.4	**194.9**	133.5	61.4	–	–	–	–	–	–	–
Virgin Islands	–	–	–	–	–	–	–	–	–	–	–	–	–
Total	**$13,166.3**	**$9,196.5**	**$3,969.8**	**$4,482.3**	**$3,102.0**	**$1,380.3**	**$7,996.2**	**$5,555.6**	**$2,440.6**	**$687.8**	**$470.5**	**$217.3**	**$68.3**

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

1 Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level. Although these are CHIP funds, they effectively reduce state spending on children in Medicaid and do not require a state match within the CHIP program. In cases where the sum of 2105(g) federal CHIP spending (for Medicaid enrollees) and regular federal CHIP spending (for CHIP enrollees) exceeds total spending for CHIP enrollees, states are shown in this table as having negative state CHIP spending (Connecticut, Minnesota, and Vermont).

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

TABLE 9. Medicaid and CHIP Income Eligibility Levels as a Percentage of the Federal Poverty Level for Children and Pregnant Women by State, January 2014

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

	Medicaid Coverage							Separate CHIP Coverage		Medicaid/CHIP Coverage
	Infants under age 1		Age 1 through 5		Age 6 through 18					
State	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2014)	Birth through age 18	Unborn children[3]	Pregnant women and deemed newborns[4]
Alabama	141%	146%	141%	146%	107%	146%	Separate	317%	–	146%
Alaska	159	208	159	208	124	208	Medicaid Expansion	–	–	205
Arizona	147	152	141	146	104	138	Separate	205[5]	–	161
Arkansas	142	216	142	216	107	216	Combination	–	216%	214
California[6]	208	266	142	266	108	266	Combination	321/416[7]	313	213
Colorado	142	147	142	147	108	147	Combination	265	–	200/265
Connecticut	196	201	196	201	196	201	Separate	323	–	263
Delaware	194	217	142	147	110	138	Combination	217	–	217
District of Columbia	206	324	146	324	112	324	Medicaid Expansion	–	–	324
Florida	192	211	140	145	112	138	Combination	215	–	196
Georgia	205	210	149	154	113	138	Separate	252	–	225
Hawaii	191	313	139	313	105	313	Medicaid Expansion	–	–	196
Idaho	142	147	142	147	107	138	Combination	190	–	138
Illinois	142	147	142	147	108	147	Combination	318	205	205
Indiana	157	213	141	163	106	163	Combination	255	–	213
Iowa	240	380	167	172	122	172	Combination	307	–	380
Kansas	166	171	149	154	113	138	Separate	250	–	171
Kentucky	195	200	142	164	109	164	Combination	218	–	200
Louisiana	142	217	142	217	108	217	Combination	255	205	138
Maine	191	196	140	162	132	162	Combination	213	–	214
Maryland	194	322	138	322	109	322	Medicaid Expansion	–	–	264
Massachusetts	185	205	133	155	114	155	Combination	305	205	205

TABLE 9, Continued

State	Medicaid Coverage: Infants under age 1 Medicaid funded[1]	Infants under age 1 CHIP funded[1]	Age 1 through 5 Medicaid funded[1]	Age 1 through 5 CHIP funded[1]	Age 6 through 18 Medicaid funded[1]	Age 6 through 18 CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2014)	Separate CHIP Coverage: Birth through age 18	Separate CHIP Coverage: Unborn children[3]	Medicaid/CHIP Coverage: Pregnant women and deemed newborns[4]
Michigan	195%	200%	143%	165%	109%	165%	Combination	217%	190%	200%
Minnesota	275	288[8]	275	280	275	280	Combination	–	283	283
Mississippi	194	199	143	148	107	138	Separate	214	–	199
Missouri	196	201	148	153	110	153	Combination	305	–	201
Montana	143	148	143	148	109	148	Combination	266	–	162
Nebraska	162	218	147	218	111	218	Combination	–	202	199
Nevada[9]	159	164	159	164	122	138	Combination	205	–	164
New Hampshire	196	323	196	323	196	323	Medicaid Expansion	–	–	201
New Jersey	194	199	142	147	107	147	Combination	355	–	199/205
New Mexico	200	305	200	305	138	245	Medicaid Expansion	–	–	255
New York	196	223	149	154	110	154	Combination	405	–	223
North Carolina	194	215	141	215	107	138	Combination	216	–	201
North Dakota[10]	147	152	147	152	111	138	Combination	175	–	152
Ohio	141	211	141	211	107	211	Medicaid Expansion	–	–	205
Oklahoma	169	210	151	210	115	210	Combination	–	190	138
Oregon	185	190	133	138	133	138	Separate	305	190	190/305
Pennsylvania	215	220	157	162	119	138	Separate	319	–	220
Rhode Island	261	266	261	266	109	266	Combination	–	258	195/258
South Carolina[11]	194	213	143	213	107	213	Medicaid Expansion	–	–	199
South Dakota	177	187	177	187	124	187	Combination	209	–	138
Tennessee[12]	195	200	142	147	109	138	Combination	255	255	200
Texas[13]	198	203	144	149	100	138	Separate	206	205	203
Utah[14]	139	144	139	144	105	138	Separate	205	–	144
Vermont[15]	237	318	237	318	237	318	Separate	317	–	213
Virginia	143	148	143	148	109	148	Combination	205	–	148
Washington	207	212	207	212	207	212	Separate	305	198	198
West Virginia	158	163	141	146	108	138	Separate	305	–	163
Wisconsin	188	306	186	191	101	156	Combination	306	305	306
Wyoming	154	159	154	159	119	138	Separate	205	–	159

TABLE 9, Continued

Notes: In 2014, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $11,670 for an individual and $4,060 for each additional family member. For additional information, see MACStats Table 19. When determining Medicaid and CHIP eligibility prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing. Beginning in 2014, uniform modified adjusted gross income (MAGI) rules must be used to determine Medicaid and CHIP eligibility for most non-disabled children and adults under age 65, including the groups shown in this table. As a result, states are now required to use MAGI-converted eligibility levels that account for the change in income-counting rules. The eligibility levels shown in this table reflect these MAGI-converted levels plus a mandatory income disregard equal to 5 percent FPL that effectively raises eligibility levels by 5 percentage points. Under federal regulations, the 5 percent disregard applies to an individual's determination of eligibility for Medicaid and CHIP overall, rather than for particular eligibility groups within Medicaid or CHIP. All information is based on state decisions as of February 26, 2014.

1 The eligibility levels listed under Medicaid funded are generally the Medicaid eligibility thresholds as of March 31, 1997. Many states had different eligibility levels for children age 6 through 13 and age 14 through 18 in 1997; in such cases, this table shows the 1997 levels for children age 6 through 13. The eligibility levels listed under CHIP funded are the income levels to which Medicaid has expanded with CHIP funding since its creation in 1997. In 2014, all states are eligible to receive CHIP funding for at least some Medicaid-enrolled children due to a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid, and a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid eligibility levels by 5 percentage points. In addition, Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent FPL (see MACStats Table 8 for states that currently claim CHIP funds under this provision).

2 Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches. Although all states will have at least some Medicaid-enrolled children who are eligible for CHIP funding as of 2014 due to the implementation of ACA requirements, 14 states are still categorized as separate programs in this table 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.

3 MAGI-converted eligibility levels for the unborn child option under CHIP were not readily available for Illinois, Louisiana, Massachusetts, Michigan, Oklahoma, Oregon, Tennessee, Texas, and Wisconsin. Converted levels may or may not differ from those shown here, depending in part on whether the state used a gross income counting methodology (similar to MAGI) for determining eligibility prior to 2014.

4 Pregnant women can be covered with Medicaid or CHIP funding. Under CHIP, coverage can be through a state plan option for targeted low-income pregnant women or through a Section 1115 waiver. When two values are shown in this column, the first is for Medicaid and the second is for CHIP.

5 Although Arizona's separate CHIP program up to 200 percent FPL (KidsCare) has been closed to new enrollment since January 2010, thousands of children were added to the state's CHIP-funded coverage through the state's KidsCare II waiver, which was in effect from May 2012 through January 2014.

6 During 2013, California transitioned most of its separate CHIP children into a Medicaid-expansion CHIP program.

7 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.

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

9 Nevada's CHIP-funded Medicaid levels include children who became eligible for Medicaid when the state eliminated the Medicaid asset test.

10 North Dakota's CHIP-funded Medicaid levels include children who became eligible for Medicaid when the state eliminated the Medicaid asset test.

11 South Carolina's CHIP-funded Medicaid levels may include children who will become eligible for Medicaid due to the mandatory elimination of Medicaid asset tests in 2014.

12 Tennessee covers children with CHIP-funded Medicaid, called TennCare Standard, but this Section 1115 waiver is currently capped except for children who roll over from traditional Medicaid. This includes children with a family income above Medicaid income levels, but at or below 216 percent FPL, who are losing TennCare Medicaid eligibility.

13 Texas's CHIP-funded Medicaid levels may include children who will become eligible for Medicaid due to the mandatory elimination of Medicaid asset tests in 2014.

14 Utah's CHIP-funded Medicaid levels may include children who will become eligible for Medicaid due to the mandatory elimination of Medicaid asset tests in 2014.

15 Vermont covers children from 238 percent FPL up to 317 percent FPL with CHIP-funded Medicaid if they have other insurance, and with separate CHIP if they are uninsured.

Sources: MACPAC communication with the Centers for Medicare & Medicaid Services (CMS) and MACPAC analysis of: CMS, *Medicaid moving forward 2014, State-specific documents, MAGI conversion plans* and *SIPP-based MAGI conversion results*. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html; CMS, *State Medicaid and CHIP income eligibility standards effective January 1, 2014 (For MAGI groups, based on state decisions as of February 26, 2014)*; CMS, *Children's Health Insurance Program: Plan activity as of January 1, 2014*; CHIP state plan amendments on the CMS website; and state websites.

TABLE 10. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-Aged, Non-Disabled, Non-Pregnant Adults by State, January 2014

States are required to provide Medicaid coverage for parents (and their dependent children), at a minimum, at their 1996 Aid to Families with Dependent Children eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents (via Section 1931 of the Social Security Act) and other adults under age 65 who are not pregnant, not eligible for Medicare, and have incomes at or below 138 percent of the federal poverty level (via Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act). States may also provide coverage under Section 1115 waivers, which allow them to operate their Medicaid programs without regard to certain statutory requirements. As noted in this table, the covered benefits under these waivers may be more limited than those provided under regular state plan rules and may not be available to all individuals at the income levels shown.

State	Parents of Dependent Children[1]	Other Adults[2]	Medicaid Expansion State[3]
Alabama	18%	–	No
Alaska	136	–[4]	No
Arizona	138	138%	Yes
Arkansas	138	138	Yes
California	138	138	Yes
Colorado	138	138	Yes
Connecticut	201	138	Yes
Delaware	138	138	Yes
District of Columbia	221	215	Yes
Florida	36	–[4]	No
Georgia	41	–	No
Hawaii	138	138	Yes
Idaho	29[5]	–[6]	No
Illinois	138	138	Yes
Indiana	25[5]	–[6]	No
Iowa	138	138	Yes
Kansas	38	–	No
Kentucky	138	138	Yes
Louisiana	24[5]	–[6]	No
Maine	105	–[4, 6]	No
Maryland	138	138	Yes
Massachusetts	138	138[4]	Yes
Michigan	138	138	Yes[7]
Minnesota	205	205	Yes
Mississippi	29	–	No
Missouri	24[5]	–[6]	No
Montana	53	–[6]	No
Nebraska	64	–	No
Nevada	138	138	Yes

TABLE 10, Continued

State	Parents of Dependent Children[1]	Other Adults[2]	Medicaid Expansion State[3]
New Hampshire	75%	–	No
New Jersey	138	138%	Yes
New Mexico	138	138	Yes
New York	138	138[4]	Yes
North Carolina	51	–[4]	No
North Dakota	138	138	Yes
Ohio	138	138	Yes
Oklahoma	48[5]	–[6]	No
Oregon	138	138	Yes
Pennsylvania	38	–[4]	No
Rhode Island	138	138	Yes
South Carolina	67	–	No
South Dakota	64	–	No
Tennessee	111	–	No
Texas	20	–	No
Utah	56[5]	–[6]	No
Vermont	138	138	Yes
Virginia	54	–	No
Washington	138	138	Yes
West Virginia	138	138	Yes
Wisconsin	95[5]	100	No
Wyoming	62	–	No

Notes: In 2014, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $11,670 for an individual and $4,060 for each additional family member. For additional information, see MACStats Table 19. When determining Medicaid and CHIP eligibility prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing. Beginning in 2014, uniform modified adjusted gross income (MAGI) rules must be used to determine Medicaid and CHIP eligibility for most non-disabled children and adults under age 65, including the groups shown in this table. As a result, states are now required to use MAGI-converted eligibility levels that account for the change in income-counting rules. The eligibility levels shown in this table reflect these MAGI-converted levels plus a mandatory income disregard equal to 5 percent FPL that effectively raises eligibility levels by 5 percentage points. Under federal regulations, the 5 percent disregard applies to an individual's determination of eligibility for Medicaid and CHIP overall, rather than for particular eligibility groups within Medicaid or CHIP. All information is based on state decisions as of February 26, 2014.

1 In states that use dollar amounts rather than percentages of the FPL to determine eligibility for parents, those amounts were converted to a percent of the FPL for 2013, and the highest percentage was selected to reflect eligibility level for the group.

2 Includes coverage under the new adult group (Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act) for individuals under age 65 who are not pregnant, not eligible for Medicare, and have incomes at or below 138 percent FPL.

3 Medicaid expansion states are those that have opted to cover adults under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

4 The state covers some 19- and 20-year-olds at income levels not shown in the table: Alaska (129 percent FPL), Florida (31 percent FPL), Maine (156 percent FPL), Massachusetts (150 percent FPL), New York (150 percent FPL), North Carolina (46 percent FPL), and Pennsylvania (33 percent FPL).

5 Reflects parent coverage under the Medicaid state plan. The state has some additional coverage above state plan eligibility standards through a Section 1115 demonstration or a pending demonstration proposal. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap.

6 The state has a Section 1115 demonstration or a pending demonstration proposal that provides Medicaid coverage to some low-income adults. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap.

7 Michigan has a Medicaid expansion as of April 1, 2014.

Source: MACPAC communication with the Centers for Medicare & Medicaid Services (CMS) and MACPAC analysis of CMS, *State Medicaid and CHIP income eligibility standards effective January 1, 2014 (For MAGI groups, based on state decisions as of February 26, 2014).*

TABLE 11. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Individuals Age 65 and Older and Persons with Disabilities by State, 2014

In most states, enrollment in the Supplemental Security Income (SSI) program for individuals age 65 and older and persons with disabilities automatically qualifies them for Medicaid. However, 11 (10 as of June 2014) 209(b) states may use more restrictive criteria than SSI when determining Medicaid eligibility. In all states, additional people with low incomes or high medical expenses may be covered, at the state's option, through poverty level, medically needy, special income level, and other eligibility pathways.

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
Alabama	1634	74%	–	–	–	222%
Alaska[5]	SSI Criteria	59	–	–	–	178
Arizona	1634	74	–	100%	–	222
Arkansas	1634	74	–	80 (Aged only)	11%	222
California	1634	74	–	100	62	–
Colorado	1634	74	–	–	–	222
Connecticut	209(b)	–	63%	–	63	222
Delaware	1634	74	–	–	–	185
District of Columbia	1634	74	–	100	64	222
Florida	1634	74	–	88	19	222
Georgia	1634	74	–	–	33	222
Hawaii	209(b)	–	64	100	42	–
Idaho	SSI Criteria	74	–	–	–	222
Illinois	209(b)	–	100	100	100	–
Indiana[6]	1634	74	–	100	–	222
Iowa	1634	74	–	–	50	222
Kansas	SSI Criteria	74	–	–	49	222
Kentucky	1634	74	–	–	22	222
Louisiana	1634	74	–	74	10	222
Maine	1634	74	–	100	32	222
Maryland	1634	74	–	–	36	222
Massachusetts[7]	1634	74	–	100 (Aged)/133 (Disabled)	54	222
Michigan	1634	74	–	100	42	222
Minnesota	209(b)	–	75	100	75	222
Mississippi	1634	74	–	–	–	222
Missouri	209(b)	–	84	85	84	130
Montana	1634	74	–	–	64	–
Nebraska	SSI Criteria	74	–	100	40	–
Nevada	SSI Criteria	74	–	–	–	222

TABLE 11, Continued

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
New Hampshire	209(b)	–	76%	–	61%	222%
New Jersey	1634	74%	–	100%	38	222
New Mexico	1634	74	–	–	–	222
New York	1634	74	–	83	83	–
North Carolina	1634	74	–	100	25	–
North Dakota	209(b)	–	82	–	82	–
Ohio	209(b)	–	61	–	61	222
Oklahoma	209(b)	–	77	100	77	222
Oregon	SSI Criteria	74	–	–	–	222
Pennsylvania	1634	74	–	100	44	222
Rhode Island	1634	74	–	100	88	222
South Carolina	1634	74	–	100	–	222
South Dakota	1634	74	–	–	–	222
Tennessee	1634	74	–	–	–	222
Texas	1634	74	–	–	–	222
Utah	SSI Criteria	74	–	100	99	222
Vermont	1634	74	–	–	110	222
Virginia	209(b)	–	74	80	46	222
Washington	1634	74	–	–	73	222
West Virginia	1634	74	–	–	21	222
Wisconsin	1634	74	–	–	61	222
Wyoming	1634	74	–	–	–	222

Notes: In 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. For additional information, see MACStats Table 19. Eligibility levels shown here apply to countable income; for some eligibility pathways, states may use various income disregards that result in different amounts of countable income. The eligibility levels listed in this table are for individuals; the eligibility levels for couples differ for certain categories.

1 Both Section 1634 and SSI-criteria states use SSI criteria for Medicaid eligibility. In Section 1634 states, the federal eligibility determination process for SSI automatically qualifies an individual for Medicaid; in SSI-criteria states, individuals must submit information to the state for a separate eligibility determination. Section 209(b) states may use eligibility criteria more restrictive than the SSI program but may not use more restrictive criteria than those in effect in the state on January 1, 1972; if they do not have a separate medically needy standard, they must also allow individuals with higher incomes to spend down to the 209(b) income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes. Indiana is a 209(b) state until June 2014, at which point it will become a 1634 state.

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

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

4 Under the special income level option, states have the option to provide Medicaid benefits to people who require at least 30 days of nursing home or other institutional care and have incomes up to 300 percent of the SSI benefit rate (which is about 222 percent FPL in 2014). The income standard listed in this column may be for institutional services, home and community-based waiver services, or both.

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

6 Indiana is a 209(b) state until June 2014, at which point it will become a 1634 state. The state's poverty level group is also effective as of June 2014.

7 Massachusetts provides medically needy coverage for individuals age 65 and older and those who are eligible on the basis of a disability, but the rules for counting income and spend-down expenses vary for these groups.

Sources: MACPAC analysis of eligibility information from state websites and Medicaid state plans as of February 2014.

TABLE 12. Mandatory and Optional Medicaid Benefits

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

The table on the following page lists mandatory and optional Medicaid benefits that are described in federal statute or regulations. No single source of information currently provides an up-to-date, comprehensive picture of the optional benefits covered by states and the circumstances under which a given benefit is covered. Readers may instead refer to a number of sources including, for example:

- Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, *State Medicaid benefits matrix*, December 2010 and January 2011. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/StateMedicaidBenefitsMatrix042011.zip.
- Kaiser Family Foundation, *Medicaid benefits: Online database*. http://medicaidbenefits.kff.org/.
- Kaiser Commission on Medicaid and the Uninsured, *Coverage of preventive services for adults in Medicaid*, September 2012. http://www.kff.org/medicaid/upload/8359.pdf.
- S. Wilensky, and E. Gray, *Coverage of Medicaid preventive services for adults – A national review*, The George Washington University, November 2012. http://sphhs.gwu.edu/departments/healthpolicy/publications/coverage.pdf.
- Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, *State profiles of mental health and substance abuse services in Medicaid*, January 2005. http://store.samhsa.gov/product/State-Profiles-of-Mental-Health-and-Substance-Abuse-Services-in-Medicaid/NMH05-0202; and SAMHSA, *Behavioral health, United States, 2012*. http://www.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf.
- Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Understanding Medicaid home and community-based services: A primer*, 2010 edition. http://aspe.hhs.gov/daltcp/reports/2010/primer10.pdf.

TABLE 12, Continued

Mandatory Medicaid Benefits

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21 (screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state)
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Laboratory and X-ray services
- Nursing facility services (for ages 21 and over)
- Nurse midwife services (to the extent authorized to practice under state law or regulation)
- Certified pediatric or family nurse practitioner services (to the extent authorized to practice under state law or regulation)
- Rural heath clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Non-emergency transportation to medical care[1]

Optional Medicaid Benefits

- Prescribed drugs
- Intermediate care facility services for individuals with intellectual disabilities
- Clinic services
- Occupational therapy services
- Optometry services
- Physical therapy services
- Targeted case management services
- Prosthetic devices
- Hospice services
- Inpatient psychiatric services for individuals under age 21
- Dental services
- Eyeglasses
- Speech, hearing, and language disorder services
- Inpatient hospital and nursing facility services for individuals age 65 or older in institutions for mental diseases
- Emergency hospital services in a hospital not meeting certain Medicare or Medicaid requirements[2]
- Dentures
- Personal care services
- Private duty nursing services
- Program of All-inclusive Care for the Elderly (PACE) services
- Chiropractic services
- Critical access hospital services
- Respiratory care for ventilator-dependent individuals
- Primary care case management services
- Services furnished in a religious nonmedical health care institution
- Tuberculosis-related services
- Home and community-based services
- Health homes for enrollees with chronic conditions
- Other licensed practitioners' services
- Other diagnostic, screening, preventive, and rehabilitative services

Notes:

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

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

Source: Centers for Medicare & Medicaid Services, Medicaid benefits, as of February 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.

TABLE 13. Maximum Allowable Medicaid Premiums and Cost Sharing, FY 2014

	At or Below 100% FPL	From 100% through 150% FPL	Above 150% FPL
Exemptions from Premiums and Cost Sharing			
Exempt Populations	Populations exempt from most types of cost sharing include most children under age 18, pregnant women, beneficiaries receiving hospice care, certain beneficiaries in institutions such as nursing facilities and intermediate care facilities, American Indians who are furnished a Medicaid item or service through an Indian Health Service provider or through a contract health service referral, and individuals eligible for Medicaid under the Breast and Cervical Cancer Act pathway. Except for certain pregnant women above 150% FPL, these populations are also exempt from premiums.		
Exempt Services	Emergency services, family planning services and supplies, preventive services for children regardless of family income, pregnancy-related services, and services related to provider-preventable conditions are excluded from cost sharing.		
Aggregate Limit on Allowable Premiums and Cost Sharing			
Aggregate limit for all populations	The total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed 5% of the family's monthly or quarterly income.		
Allowable Premiums			
Specified populations	Up to $20 per month for individuals eligible under a medically needy pathway. Sliding scale based on income for individuals eligible under certain disability pathways for children and working adults.		Same as rules at or below 150% FPL for medically needy and disability pathways. Up to 10% of amount by which income exceeds 150% FPL for certain pregnant women.
All other populations	Not permitted		No specific limit
Allowable Cost Sharing			
Outpatient services	Up to $4.00	Up to 10% of the amount the Medicaid agency pays	Up to 20% of the amount the Medicaid agency pays
Inpatient stays	Up to $75.00	Up to 10% of the amount the Medicaid agency pays	Up to 20% of the amount the Medicaid agency pays
Non-emergency use of the emergency department	Up to $8.00		No specific limit
Prescribed drugs	Preferred drugs: Up to $4.00 Non-preferred: Up to $8.00		Preferred drugs: Up to $4.00 Non-preferred: Up to 20% of the amount the Medicaid agency pays

Notes: In 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. FY is fiscal year. For additional information, see MACStats Table 19. Beginning October 1, 2015, maximum allowable cost-sharing amounts will be increased annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). This table does not reflect amounts that states may have implemented under a Section 1115 waiver.

Source: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Medicaid and Children's Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; Exchanges: Eligibility and enrollment; Final rule, *Federal Register* 78 (July 15): 42160, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

TABLE 14. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, Selected Periods in FY 2011–FY 2015

State	FMAPs for Medicaid						E-FMAPs for CHIP			
	First quarter of FY 2011[1]	Fourth quarter of FY 2011[1]	FY 2012	FY 2013	FY 2014[2]	FY 2015[2]	FY 2012	FY 2013	FY 2014	FY 2015
Alabama	78.00%	68.54%	68.62%	68.53%	68.12%	68.99%	78.03%	77.97%	77.68%	78.29%
Alaska	62.46	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Arizona	75.93	65.85	67.30	65.68	67.23	68.46	77.11	75.98	77.06	77.92
Arkansas	81.18	71.37	70.71	70.17	70.10	70.88	79.50	79.12	79.07	79.62
California	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Colorado	61.59	50.00	50.00	50.00	50.00	51.01	65.00	65.00	65.00	65.71
Connecticut	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Delaware	64.38	53.15	54.17	55.67	55.31	53.63	67.92	68.97	68.72	67.54
District of Columbia	79.29	70.00	70.00	70.00	70.00	70.00	79.00	79.00	79.00	79.00
Florida	67.64	55.45	56.04	58.08	58.79	59.72	69.23	70.66	71.15	71.80
Georgia	75.16	65.33	66.16	65.56	65.93	66.94	76.31	75.89	76.15	76.86
Hawaii	67.35	51.79	50.48	51.86	51.85	52.23	65.34	66.30	66.30	66.56
Idaho	79.18	68.85	70.23	71.00	71.64	71.75	79.16	79.70	80.15	80.23
Illinois	61.88	50.20	50.00	50.00	50.00	50.76	65.00	65.00	65.00	65.53
Indiana	76.21	66.52	66.96	67.16	66.92	66.52	76.87	77.01	76.84	76.56
Iowa	72.55	62.63	60.71	59.59	57.93	55.54	72.50	71.71	70.55	68.88
Kansas	69.68	59.05	56.91	56.51	56.91	56.63	69.84	69.56	69.84	69.64
Kentucky	80.61	71.49	71.18	70.55	69.83	69.94	79.83	79.39	78.88	78.96
Louisiana[3]	81.48	68.04	69.78	65.51	62.11	62.05	72.76	72.87	72.69	73.44
Maine	74.86	63.80	63.27	62.57	61.55	61.88	74.29	73.80	73.09	73.32
Maryland	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Massachusetts	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Michigan	75.57	65.79	66.14	66.39	66.32	65.54	76.30	76.47	76.42	75.88
Minnesota	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Mississippi	84.86	74.73	74.18	73.43	73.05	73.58	81.93	81.40	81.14	81.51
Missouri	74.43	63.29	63.45	61.37	62.03	63.45	74.42	72.96	73.42	74.42
Montana	77.99	66.81	66.11	66.00	66.33	65.90	76.28	76.20	76.43	76.13
Nebraska	68.76	58.44	56.64	55.76	54.74	53.27	69.65	69.03	68.32	67.29
Nevada	63.93	51.61	56.20	59.74	63.10	64.36	69.34	71.82	74.17	75.05
New Hampshire	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
New Jersey	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
New Mexico	80.49	69.78	69.36	69.07	69.20	69.65	78.55	78.35	78.44	78.76
New York	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
North Carolina	74.98	64.71	65.28	65.51	65.78	65.88	75.70	75.86	76.05	76.12
North Dakota	69.95	60.35	55.40	52.27	50.00	50.00	68.78	66.59	65.00	65.00
Ohio	73.71	63.69	64.15	63.58	63.02	62.64	74.91	74.51	74.11	73.85

TABLE 14, Continued

State	FMAPs for Medicaid						E-FMAPs for CHIP			
	First quarter of FY 2011[1]	Fourth quarter of FY 2011[1]	FY 2012	FY 2013	FY 2014[2]	FY 2015[2]	FY 2012	FY 2013	FY 2014	FY 2015
Oklahoma	76.73%	64.94%	63.88%	64.00%	64.02%	62.30%	74.72%	74.80%	74.81%	73.61%
Oregon	72.97	62.85	62.91	62.44	63.14	64.06	74.04	73.71	74.20	74.84
Pennsylvania	66.58	55.64	55.07	54.28	53.52	51.82	68.55	68.00	67.46	66.27
Rhode Island	64.22	52.97	52.12	51.26	50.11	50.00	66.48	65.88	65.08	65.00
South Carolina	79.58	70.04	70.24	70.43	70.57	70.64	79.17	79.30	79.40	79.45
South Dakota	70.80	61.25	59.13	56.19	53.54	51.64	71.39	69.33	67.48	66.15
Tennessee	75.62	65.85	66.36	66.13	65.29	64.99	76.45	76.29	75.70	75.49
Texas	70.94	60.56	58.22	59.30	58.69	58.05	70.75	71.51	71.08	70.64
Utah	80.78	71.13	70.99	69.61	70.34	70.56	79.69	78.73	79.24	79.39
Vermont	69.96	58.71	57.58	56.04	55.11	54.01	70.31	69.23	68.58	67.81
Virginia	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Washington	62.94	50.00	50.00	50.00	50.00	50.03	65.00	65.00	65.00	65.02
West Virginia	83.05	73.24	72.62	72.04	71.09	71.35	80.83	80.43	79.76	79.95
Wisconsin	70.63	60.16	60.53	59.74	59.06	58.27	72.37	71.82	71.34	70.79
Wyoming	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
American Samoa	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Guam	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Northern Mariana Islands	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Puerto Rico	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Virgin Islands	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50

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

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

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

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

2 For certain newly eligible individuals under the Medicaid expansion beginning in 2014, there is an increased FMAP (100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and subsequent years). An increased FMAP is also available for certain states that previously expanded eligibility to low-income parents and non-pregnant adults without children prior to enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). (See §§1905(y) and (z) of the Social Security Act.)

3 Louisiana receives a disaster-recovery state FMAP adjustment for the fourth quarter of FY 2011, and FY 2012-FY 2014 (section 1905(aa) of the Social Security Act). P.L. 112-96 and P.L. 112-141 revised the disaster relief formula, effective October 1, 2012. As a result, the FY 2013 disaster-recovery FMAP adjustment for Louisiana that was published in the *Federal Register* on November 30, 2011 has been revised. No state qualifies for a disaster-recovery FMAP adjustment in FY 2015.

Source: *Federal Register* notices from the U.S. Department of Health and Human Services.

TABLE 15. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, State FY 2012

State	Total Budget (Including State and Federal Funds)				State-Funded Budget			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
All states	**$1,644,020**	**23.7%**	**20.0%**	**10.5%**	**$1,127,809**	**14.8%**	**24.1%**	**13.4%**
Alabama	24,178	23.3	20.9	20.1	14,870	12.3	27.5	24.2
Alaska	11,789	11.6	13.4	9.3	8,772	6.5	15.3	10.5
Arizona	28,540	32.0	19.0	13.5	16,241	20.5	26.0	18.8
Arkansas	20,688	21.4	16.3	16.2	14,410	8.9	19.2	23.1
California	199,424	21.6	19.9	7.0	126,361	13.1	26.5	7.2
Colorado	28,777	20.7	25.3	9.0	21,086	16.0	31.4	10.2
Connecticut	27,558	21.4	13.9	10.3	24,927	23.6	13.2	9.9
Delaware	8,942	15.9	24.6	4.5	7,165	8.9	27.3	4.6
District of Columbia[2]	–	–	–	–	–	–	–	–
Florida	62,989	30.6	18.8	7.1	38,374	21.7	25.2	11.3
Georgia	41,127	20.3	24.0	18.7	28,658	9.6	26.6	26.6
Hawaii	11,494	12.3	15.6	11.3	9,562	6.3	15.8	13.3
Idaho	6,267	27.2	25.7	8.1	3,885	16.5	33.9	13.0
Illinois	65,730	19.7	15.8	5.5	46,323	14.6	14.7	7.2
Indiana	26,305	27.3	32.9	6.5	17,033	14.5	43.5	10.0
Iowa	18,940	19.6	16.8	25.0	12,389	13.2	22.1	33.7
Kansas	14,396	18.6	25.8	16.9	10,243	11.5	31.7	17.1
Kentucky	25,649	22.5	19.8	25.7	16,962	10.0	24.5	33.5
Louisiana	27,073	26.7	18.4	9.9	16,457	14.4	23.5	15.3
Maine	8,106	28.8	13.1	3.4	5,457	16.3	19.2	5.0
Maryland	34,877	21.5	19.5	14.5	25,819	14.4	22.6	18.3
Massachusetts	59,271	20.7	10.7	9.3	43,114	12.8	12.0	12.8
Michigan	47,286	26.1	27.2	4.1	29,737	14.0	36.8	6.2
Minnesota	31,329	27.6	23.8	9.7	23,159	18.2	28.8	13.1
Mississippi	18,386	23.4	16.9	16.8	10,441	10.8	22.2	27.8
Missouri	23,364	35.0	22.6	4.7	15,825	24.9	26.5	6.9
Montana	5,919	16.8	15.5	9.8	3,788	8.5	19.6	14.1
Nebraska	9,877	16.7	15.3	23.5	6,889	10.4	16.2	28.1

TABLE 15, Continued

State	Total Budget (Including State and Federal Funds)				State-Funded Budget			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
Nevada	$7,623	25.4%	23.6%	9.7%	$5,069	18.3%	30.5%	14.5%
New Hampshire	4,975	23.9	23.5	2.7	3,325	18.1	29.0	4.0
New Jersey	48,612	21.6	24.7	7.8	37,614	12.9	29.6	10.1
New Mexico	14,164	24.7	19.7	19.3	8,556	12.2	27.7	24.3
New York	133,504	29.4	19.8	7.6	93,193	15.9	23.1	10.6
North Carolina	46,567	24.7	23.2	9.0	32,054	12.4	29.2	13.0
North Dakota	6,027	12.1	13.8	17.7	4,143	7.5	16.3	22.4
Ohio	57,921	24.4	20.6	4.2	44,786	26.1	21.7	5.3
Oklahoma	20,931	23.9	16.5	23.1	14,213	16.3	19.0	30.5
Oregon	27,014	18.2	14.0	2.5	19,261	9.4	16.3	3.2
Pennsylvania	66,948	33.2	18.4	2.8	42,771	23.3	23.1	4.4
Rhode Island	7,907	25.0	14.2	13.2	5,308	17.9	16.7	19.2
South Carolina	22,088	21.7	15.9	21.0	12,804	10.6	21.0	30.7
South Dakota	3,698	20.9	14.3	17.7	2,210	13.0	16.3	25.4
Tennessee	30,419	30.7	17.7	12.8	17,613	18.9	23.3	20.9
Texas	92,963	30.1	28.7	15.8	61,427	19.2	35.5	20.0
Utah	11,822	17.5	24.7	11.9	8,234	8.6	29.7	16.9
Vermont	5,017	25.3	31.1	1.8	3,186	17.3	44.6	2.9
Virginia	43,425	16.2	16.0	13.1	34,213	10.4	16.3	13.1
Washington	34,943	12.1	22.9	17.8	26,894	7.7	26.4	22.8
West Virginia	21,821	12.7	10.8	14.1	17,757	4.4	11.2	15.6
Wisconsin	41,324	16.5	16.7	14.1	30,752	8.9	19.7	12.9
Wyoming	6,026	9.5	3.9	5.5	4,479	6.2	3.1	6.8

Notes: FY is fiscal year. Total budget includes federal and all other funds. State-funded budget includes state general funds, other state funds, and bonds. Medicaid, elementary and secondary education, and higher education represent the largest total budget shares among functions broken out separately by the National Association of State Budget Officers (NASBO). Functions not shown here are transportation, corrections, public assistance, and all other. Medicaid spending amounts exclude administrative costs but include Medicare Part D phased-down state contribution (also referred to as clawback) payments.

1 Total and state-funded budget shares should be viewed with caution because they reflect varying state practices. For example, Connecticut reports all of its Medicaid spending as state-funded spending due to the direct deposit of federal funds into the State Treasury. In addition, some functions—particularly elementary and secondary education—may be partially funded outside of the state budget by local governments.

2 NASBO does not collect information for the District of Columbia.

Sources: National Association of State Budget Officers (NASBO), *State expenditure report: Examining fiscal 2011-2013 state spending,* December 2013. http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202011-2013%20Data%29.pdf.

TABLE 16. National Health Expenditures by Type and Payer, 2012

	Dollars (billions)							
Type of Expenditure	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
National health expenditures	**$2,793.4**	**$421.2**	**$12.6**	**$572.5**	**$917.0**	**$91.1**	**$450.8**	**$328.2**
Hospital	**882.3**	156.4	3.4	239.8	320.9	49.6	82.4	29.8
Physician and clinical	**565.0**	45.6	3.2	128.1	258.3	20.7	54.2	54.9
Dental	**110.9**	7.3	1.3	0.4	53.4	1.3	0.5	46.8
Other professional	**76.4**	4.7	0.2	16.9	28.2	–	6.9	19.4
Home health	**77.8**	28.9	0.0	33.8	5.6	1.0	2.4	6.0
Other non-durable medical products	**53.7**	–	–	3.1	–	–	0.0	50.6
Prescription drugs	**263.3**	19.6	1.5	68.2	117.0	7.7	2.5	46.8
Durable medical equipment	**41.3**	4.6	0.1	8.2	4.7	–	0.6	23.1
Nursing care facilities and continuing care retirement communities	**151.5**	46.3	0.0	34.4	12.0	4.4	11.1	43.3
Other health, residential, and personal care	**138.2**	72.9	0.9	5.1	6.9	3.2	41.7	7.5
Administration	**197.9**	34.9	2.0	34.5	109.9	3.3	13.4	–
Public health activity	**75.0**	–	–	–	–	–	75.0	–
Investment	**160.0**	–	–	–	–	–	160.0	–

TABLE 16, Continued

Type of Expenditure	Total	Share of Total: Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
National health expenditures	**100%**	**15.1%**	**0.5%**	**20.5%**	**32.8%**	**3.3%**	**16.1%**	**11.7%**
Hospital	**100**	17.7	0.4	27.2	36.4	5.6	9.3	3.4
Physician and clinical	**100**	8.1	0.6	22.7	45.7	3.7	9.6	9.7
Dental	**100**	6.6	1.2	0.3	48.1	1.2	0.5	42.2
Other professional	**100**	6.2	0.3	22.2	37.0	–	9.0	25.4
Home health	**100**	37.2	0.0	43.4	7.2	1.3	3.1	7.8
Other non-durable medical products	**100**	–	–	5.8	–	–	0.0	94.2
Prescription drugs	**100**	7.5	0.6	25.9	44.4	2.9	0.9	17.8
Durable medical equipment	**100**	11.1	0.3	19.9	11.4	–	1.4	55.9
Nursing care facilities and continuing care retirement communities	**100**	30.6	0.0	22.7	7.9	2.9	7.3	28.6
Other health, residential, and personal care	**100**	52.7	0.7	3.7	5.0	2.3	30.2	5.5
Administration	**100**	17.6	1.0	17.4	55.5	1.6	6.8	–
Public health activity	**100**	–	–	–	–	–	100.0	–
Investment	**100**	–	–	–	–	–	100.0	–

Notes: Figures for nursing care facilities and continuing retirement communities and other health, residential, and personal care reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40 percent of nursing home expenditures and about three-quarters of other personal health care expenditures. Other professional includes services provided in establishments operated by health practitioners other than physicians and dentists, including those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational, and speech therapists, among others. Other non-durable medical products includes the retail sales of non-prescription drugs and medical sundries. Durable medical equipment includes retail sales of items such as contact lenses, eyeglasses, and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals. Nursing care facilities and continuing care retirement communities includes nursing and rehabilitative services provided in freestanding nursing home facilities that are generally provided for an extended period of time by registered or licensed practical nurses and other staff. Other health, residential, and personal care includes spending for Medicaid home and community-based waivers, care provided in residential facilities for people with intellectual disabilities or mental health and substance abuse disorders, ambulance services, school health, and worksite health care. Administration category includes the administrative cost of health care programs (e.g., Medicare and Medicaid) and the net cost of private health insurance (administrative costs, as well as additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses). Zeroes indicate amounts less than $0.05 billion or 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

1 U.S. Department of Defense and U.S. Department of Veterans' Affairs.

2 Includes all other public and private programs and expenditures except for out-of-pocket amounts.

Sources: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, *National health expenditures by type of service and source of funds: Calendar years 1960-2012,* January 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip. OACT, *National health expenditure accounts: Methodology paper, 2012,* 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf.

TABLE 17. Historical and Projected National Health Expenditures by Payer for Selected Years, 1970–2022

	Dollars						
	Total	Medicaid and CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Historical							
1970	**$75**	$5	$8	$15	$3	$18	$25
1975	**134**	13	16	30	6	30	37
1980	**256**	26	37	69	10	55	58
1985	**445**	41	72	131	15	89	96
1990	**724**	74	110	234	21	146	139
1995	**1,027**	145	184	327	27	198	146
2000	**1,377**	203	225	459	33	255	202
2005	**2,035**	317	340	703	57	351	267
2006	**2,167**	315	404	740	62	369	277
2007	**2,303**	335	433	778	66	397	294
2008	**2,412**	355	468	808	72	408	301
2009	**2,504**	387	500	833	79	405	301
2010	**2,599**	410	520	860	84	420	306
2011	**2,693**	420	546	889	89	433	316
2012	**2,793**	434	572	917	91	451	328
Projected							
2013	**2,915**	450	604	962	101	468	329
2014	**3,093**	503	635	1,036	108	487	324
2015	**3,273**	545	669	1,100	114	511	334
2016	**3,458**	586	715	1,156	122	536	342
2017	**3,660**	622	767	1,215	130	570	356
2018	**3,889**	655	828	1,287	140	609	371
2019	**4,142**	698	886	1,374	149	646	390
2020	**4,416**	747	955	1,459	160	683	412
2021	**4,702**	796	1,029	1,549	171	722	434
2022	**5,009**	847	1,123	1,636	183	761	458

TABLE 17, Continued

	Total	Share of Total					
		Medicaid and CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Historical							
1970	**100%**	7.1%	10.2%	20.6%	4.4%	24.2%	33.4%
1975	**100**	10.1	12.2	22.8	4.5	22.5	28.0
1980	**100**	10.2	14.6	27.0	3.8	21.6	22.8
1985	**100**	9.2	16.2	29.5	3.4	20.1	21.6
1990	**100**	10.2	15.2	32.3	3.0	20.2	19.1
1995	**100**	14.1	17.9	31.8	2.6	19.3	14.2
2000	**100**	14.8	16.3	33.3	2.4	18.5	14.6
2005	**100**	15.6	16.7	34.5	2.8	17.3	13.1
2006	**100**	14.5	18.6	34.2	2.8	17.0	12.8
2007	**100**	14.6	18.8	33.8	2.9	17.3	12.8
2008	**100**	14.7	19.4	33.5	3.0	16.9	12.5
2009	**100**	15.4	20.0	33.3	3.2	16.2	12.0
2010	**100**	15.8	20.0	33.1	3.2	16.1	11.8
2011	**100**	15.6	20.3	33.0	3.3	16.1	11.7
2012	**100**	15.5	20.5	32.8	3.3	16.1	11.7
Projected							
2013	**100**	15.4	20.7	33.0	3.5	16.1	11.3
2014	**100**	16.3	20.5	33.5	3.5	15.8	10.5
2015	**100**	16.7	20.4	33.6	3.5	15.6	10.2
2016	**100**	17.0	20.7	33.4	3.5	15.5	9.9
2017	**100**	17.0	21.0	33.2	3.6	15.6	9.7
2018	**100**	16.8	21.3	33.1	3.6	15.7	9.5
2019	**100**	16.8	21.4	33.2	3.6	15.6	9.4
2020	**100**	16.9	21.6	33.0	3.6	15.5	9.3
2021	**100**	16.9	21.9	32.9	3.6	15.4	9.2
2022	**100**	16.9	22.4	32.7	3.7	15.2	9.1

Notes: Historical data were released in 2014; projected data were released in 2013 and may therefore reflect different assumptions than those used to produce the current historical data.

1 U.S. Department of Defense and U.S. Department of Veterans' Affairs.

2 Includes all other public and private programs and expenditures except for out-of-pocket amounts.

Sources: For historical: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, *National health expenditures by type of service and source of funds: Calendar years 1960–2012*, January 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip. For projected: MACPAC communication with OACT, February 2014, and OACT, *National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1970–2022 in projections format*, September 2013. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe65-22.zip.

TABLE 18. Characteristics of Non-Institutionalized Individuals by Source of Health Insurance, 2013

	All Ages					Age 0–18				
	Total all ages	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 0–18	Private	Medicaid/ CHIP	Medicare	Uninsured
Within Age Group[1]										
Number of People (millions)	**310.2**	185.2	52.1	48.1	45.3	**78.0**	41.5	29.1	0.3	5.9
Share of Population	**100%**	59.7%*	16.8%	15.5%*	14.6%*	**100%**	53.2%*	37.3%	0.4%*	7.5%*
Within Insurance Coverage Type										
Gender (%)										
Male	**48.8***	48.8*	44.4	44.0	54.4*	**51.1**	51.4	50.5	50.0	49.9
Female	**51.2***	51.2*	55.6	56.0	45.6*	**48.9**	48.6	49.5	50.0	50.1
Family Income (%)[2]										
<100% of poverty	**15.1***	3.8*	47.1	11.7*	27.2*	**21.6***	3.1*	47.5	34.1	28.4*
100–199% of poverty	**19.1***	10.7*	32.4	24.5*	33.5	**21.8***	11.2*	35.1	39.1	32.7
200+% of poverty	**65.8***	85.6*	20.5	63.8*	39.3*	**56.6***	85.7*	17.3	26.8	39.0*
Race/Ethnicity (%)										
Hispanic	**17.1***	10.2*	29.3	7.5*	34.5*	**23.8***	12.5*	36.4	40.1	39.8
White, non-Hispanic	**63.2***	72.8*	41.6	78.4*	44.5	**53.5***	68.5*	34.7	29.8	41.3*
Black, non-Hispanic	**12.0***	9.0*	21.1	9.4*	14.3*	**13.8***	9.1*	21.2	26.3	11.7*
Other races and multiple races	**7.7**	7.9	8.0	4.8*	6.8	**8.9**	9.9*	7.7	–[†]	7.2
Health Status (%)										
Excellent or very good	**66.2***	73.5*	59.7	40.7*	57.6	**83.7***	89.9*	75.7	68.9	77.0
Good	**23.6***	20.4*	25.3	32.1*	30.7*	**14.3***	9.2*	20.8	26.1	20.3
Fair or poor	**10.1***	6.1*	15.0	27.2*	11.7*	**2.0***	0.9*	3.5	–[†]	2.7
Place of Residence (%)[3]										
Large MSA	**53.7**	55.1	51.4	47.8	52.5	**53.8**	56.3*	50.6	47.5	52.4
Small MSA	**30.5**	30.5	29.6	30.8	29.7	**30.9**	31.1	30.3	36.9	29.5
Not in MSA	**15.8***	14.4*	19.1	21.4	17.8	**15.3***	12.7*	19.1	–[†]	18.1

TABLE 18, Continued

	Age 19–64					Age 65 and Over				
	Total age 19–64	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 65 and over	Private	Medicaid/ CHIP	Medicare	Uninsured
Within Age Group[1]										
Number of People (millions)	**189.2**	122.0	19.3	7.2	39.0	**43.0**	21.8	3.6	40.5	0.4
Share of Population	**100%**	64.5%*	10.2%	3.8%*	20.6%*	**100%**	50.6%*	8.4%	94.1%*	1.0%*
Within Insurance Coverage Type										
Gender (%)										
Male	**49.0***	48.8*	37.2	45.4*	55.1*	**44.1***	44.0*	33.6	43.6*	48.5*
Female	**51.0***	51.2*	62.8	54.6*	44.9*	**55.9***	56.0*	66.4	56.4*	51.5*
Family Income (%)[2]										
<100% of poverty	**13.8***	4.1*	48.2	30.0*	26.9*	**8.6***	3.2*	37.6	8.2*	32.6
100–199% of poverty	**17.3***	9.5*	28.9	35.7*	33.6*	**22.1***	16.3*	28.5	22.3*	36.1
200+% of poverty	**68.9***	86.4*	22.9	34.3*	39.5*	**69.3***	80.5*	33.9	69.6*	31.3
Race/Ethnicity (%)										
Hispanic	**16.5***	10.6*	20.5	10.3*	33.6*	**7.5***	3.6*	18.9	6.7*	44.7*
White, non-Hispanic	**63.6***	71.7*	49.6	68.1*	45.2*	**79.1***	87.2*	54.0	80.6*	29.6*
Black, non-Hispanic	**12.1***	9.6*	21.7	16.2*	14.7*	**8.4***	5.7*	17.2	8.0*	10.0*
Other races and multiple races	**7.7**	8.1	8.2	5.4*	6.6	**5.0***	3.5*	9.8	4.7*	15.7
Health Status (%)										
Excellent or very good	**63.9***	71.8*	42.4	16.4*	55.0*	**44.8***	51.5*	23.0	44.8*	29.8
Good	**25.4***	22.2*	30.6	28.4	32.2	**32.6**	31.7	32.8	32.8	30.1
Fair or poor	**10.7***	6.0*	27.0	55.2*	12.8*	**22.6***	16.8*	44.2	22.4*	40.1
Place of Residence (%)[3]										
Large MSA	**54.7**	56.4	51.9	44.5*	52.4	**49.3**	45.8*	54.5	48.4	61.0
Small MSA	**30.4**	30.2	29.4	32.5	29.8	**30.1***	31.2*	24.3	30.4*	24.4
Not in MSA	**15.0***	13.4*	18.7	23.0	17.8	**20.6**	23.1	21.2	21.2	14.6

TABLE 18, Continued

Notes:

1 Sum of health insurance coverage types may not add to total for each age group because individuals may have multiple sources of coverage and because not all types of coverage (e.g., military) are displayed. Insurance coverage is measured at the time of the interview. Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care. Medicaid/CHIP also includes persons covered by other public programs, excluding Medicare (e.g., other state-sponsored health plans); nevertheless, as discussed in Table 1, survey data tend to report lower Medicaid/CHIP enrollment than administrative data. Individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid/CHIP, state-sponsored or other government-sponsored health plans, or a 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.

2 For numerous reasons, poverty status shown here may differ from levels calculated by state Medicaid and CHIP programs. While these survey results show coverage as of the time of the survey in 2013, family income is for the prior year, 2012. In 2012, 100 percent of poverty using the U.S. Census Bureau's poverty threshold was $18,284 for a family of three. The poverty threshold differs from the federal poverty guidelines used for Medicaid and CHIP eligibility determinations. (The family income results shown here exclude the 9.9 percent of respondents with unknown poverty status.) In addition, data from surveys such as the National Health Interview Survey tend to include more income and more relatives as part of the family unit, compared to how income is counted for Medicaid and CHIP.

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

† Sample size is not sufficient to support published estimates.

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

Source: National Center for Health Statistics (NCHS) analysis for MACPAC of National Health Interview Survey (NHIS) data, January 2014; the estimates for 2013 are based on data collected from January through June, based on household interviews of a sample of the civilian non-institutionalized population.

TABLE 19. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2014

States		Annual Family size 1	2	3	4	Amount for each additional family member	States		Monthly Family size 1	2	3	4	Amount for each additional family member
Lower 48 states and DC	100% FPL	$11,670	$15,730	$19,790	$23,850	$4,060	Lower 48 states and DC	100% FPL	$973	$1,311	$1,649	$1,988	$338
	133% FPL	15,521	20,921	26,321	31,721	5,400		133% FPL	1,293	1,743	2,193	2,643	450
	138% FPL	16,105	21,707	27,310	32,913	5,603		138% FPL	1,342	1,809	2,276	2,743	467
	150% FPL	17,505	23,595	29,685	35,775	6,090		150% FPL	1,459	1,966	2,474	2,981	508
	185% FPL	21,590	29,101	36,612	44,123	7,511		185% FPL	1,799	2,425	3,051	3,677	626
	200% FPL	23,340	31,460	39,580	47,700	8,120		200% FPL	1,945	2,622	3,298	3,975	677
	250% FPL	29,175	39,325	49,475	59,625	10,150		250% FPL	2,431	3,277	4,123	4,969	846
	300% FPL	35,010	47,190	59,370	71,550	12,180		300% FPL	2,918	3,933	4,948	5,963	1,015
	400% FPL	46,680	62,920	79,160	95,400	16,240		400% FPL	3,890	5,243	6,597	7,950	1,353
Alaska	100% FPL	$14,580	$19,660	$24,740	$29,820	$5,080	Alaska	100% FPL	$1,215	$1,638	$2,062	$2,485	$423
	133% FPL	19,391	26,148	32,904	39,661	6,756		133% FPL	1,616	2,179	2,742	3,305	563
	138% FPL	20,120	27,131	34,141	41,152	7,010		138% FPL	1,677	2,261	2,845	3,429	584
	150% FPL	21,870	29,490	37,110	44,730	7,620		150% FPL	1,823	2,458	3,093	3,728	635
	185% FPL	26,973	36,371	45,769	55,167	9,398		185% FPL	2,248	3,031	3,814	4,597	783
	200% FPL	29,160	39,320	49,480	59,640	10,160		200% FPL	2,430	3,277	4,123	4,970	847
	250% FPL	36,450	49,150	61,850	74,550	12,700		250% FPL	3,038	4,096	5,154	6,213	1,058
	300% FPL	43,740	58,980	74,220	89,460	15,240		300% FPL	3,645	4,915	6,185	7,455	1,270
	400% FPL	58,320	78,640	98,960	119,280	20,320		400% FPL	4,860	6,553	8,247	9,940	1,693
Hawaii	100% FPL	$13,420	$18,090	$22,760	$27,430	$4,670	Hawaii	100% FPL	$1,118	$1,508	$1,897	$2,286	$389
	133% FPL	17,849	24,060	30,271	36,482	6,211		133% FPL	1,487	2,005	2,523	3,040	518
	138% FPL	18,520	24,964	31,409	37,853	6,445		138% FPL	1,543	2,080	2,617	3,154	537
	150% FPL	20,130	27,135	34,140	41,145	7,005		150% FPL	1,678	2,261	2,845	3,429	584
	185% FPL	24,827	33,467	42,106	50,746	8,640		185% FPL	2,069	2,789	3,509	4,229	720
	200% FPL	26,840	36,180	45,520	54,860	9,340		200% FPL	2,237	3,015	3,793	4,572	778
	250% FPL	33,550	45,225	56,900	68,575	11,675		250% FPL	2,796	3,769	4,742	5,715	973
	300% FPL	40,260	54,270	68,280	82,290	14,010		300% FPL	3,355	4,523	5,690	6,858	1,168
	400% FPL	53,680	72,360	91,040	109,720	18,680		400% FPL	4,473	6,030	7,587	9,143	1,557

Notes: The FPLs shown here are based on the U.S. Department of Health and Human Services 2014 federal poverty guidelines. These differ slightly from the U.S. Census Bureau's federal poverty thresholds, which are used mainly for statistical purposes. The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period.

Source: U.S. Department of Health and Human Services (HHS), Annual update of the HHS poverty guidelines, *Federal Register* 78 (January 22): 3593, 2014.

TABLE 20. Supplemental Payments by State and Category, FY 2013 (millions)

State	Inpatient and Outpatient Hospitals[1]				Mental Health Facilities[2]		
	DSH payments	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	DSH payments	Total Medicaid payments	Supplemental payments as % of total
All states	**$13,427.8**	**$20,598.8**	**$89,465.4**	**38.0%**	**$2,949.5**	**$6,524.0**	**45.2%**
Alabama	470.9	343.2	1,891.5	43.0	–	67.5	–
Alaska	7.6	–	302.6	2.5	14.1	32.3	43.7
Arizona	145.1	846.3	1,466.7	67.6	28.0	30.2	92.6
Arkansas	61.0	314.8	990.0	38.0	–	159.9	–
California	2,119.5	5,641.3	16,290.6	47.6	0.2	531.5	0.0
Colorado	194.2	787.1	1,712.8	57.3	–	6.2	–
Connecticut	167.3	95.7	1,721.2	15.3	105.6	179.6	58.8
Delaware	5.2	–	50.8	10.3	5.6	6.5	87.1
District of Columbia	49.9	–	359.3	13.9	6.5	14.0	46.3
Florida	241.9	993.9	5,104.2	24.2	93.1	141.9	65.7
Georgia	430.0	125.2	2,198.9	25.2	–	24.3	–
Hawaii	25.0	81.7	117.9	90.4	–	–	–
Idaho	23.7	35.0	505.7	11.6	–	1.6	–
Illinois	371.6	1,881.9	6,498.3	34.7	75.5	226.7	33.3
Indiana	333.5	201.8	1,858.0	28.8	4.0	50.1	8.0
Iowa	54.6	32.5	792.8	11.0	–	20.5	–
Kansas	51.3	21.8	328.0	22.3	25.3	43.9	57.5
Kentucky	178.9	17.8	456.6	43.1	37.3	44.9	83.2
Louisiana	652.0	918.9	2,202.1	71.3	114.8	117.2	98.0
Maine	–	4.7	997.1	0.5	37.5	99.8	37.6
Maryland	41.9	47.7	993.3	9.0	92.4	184.9	50.0
Massachusetts	–	591.9	2,120.2	27.9	–	109.3	–
Michigan	388.0	622.9	1,722.1	58.7	–	22.6	–
Minnesota	46.1	70.0	603.1	19.3	0.2	86.9	0.2
Mississippi	218.0	490.5	1,660.4	42.7	–	74.2	–
Missouri	496.2	121.6	2,980.5	20.7	207.2	230.4	90.0
Montana	17.7	1.5	268.2	7.2	–	18.1	–
Nebraska	43.7	–	216.1	20.2	1.6	18.9	8.4
Nevada	81.4	120.0	539.1	37.4	–	45.4	–

TABLE 20, Continued

State	Inpatient and Outpatient Hospitals[1]				Mental Health Facilities[2]		
	DSH payments	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	DSH payments	Total Medicaid payments	Supplemental payments as % of total
New Hampshire	$18.6	–	$156.3	11.9%	$22.4	$30.0	74.6%
New Jersey	940.7	$259.1	1,739.5	69.0	357.4	452.5	79.0
New Mexico	25.2	123.1	365.8	40.5	–	2.7	–
New York[5]	2,766.9	-854.7	8,760.0	21.8	656.5	1,129.9	58.1
North Carolina	308.9	1,374.5	3,460.8	48.6	308.5	350.1	88.1
North Dakota	0.5	2.0	138.5	1.8	0.7	7.6	9.8
Ohio[6]	555.7	568.4	2,493.6	45.1	93.4	721.0	13.0
Oklahoma	41.2	442.1	1,544.0	31.3	0.5	72.8	0.7
Oregon	56.6	93.3	348.3	43.0	20.0	23.0	87.0
Pennsylvania	534.5	350.0	1,726.1	51.2	312.6	401.3	77.9
Rhode Island	129.8	11.6	350.7	40.3	–	5.6	–
South Carolina	405.0	108.3	1,156.1	44.4	52.2	102.0	51.1
South Dakota	0.7	2.8	187.7	1.9	0.8	4.0	18.9
Tennessee	80.3	969.5	1,171.3	89.6	–	33.9	–
Texas	106.3	2,014.1	4,918.2	43.1	120.5	141.3	85.3
Utah	27.9	183.4	457.6	46.2	0.9	13.3	7.0
Vermont[5]	37.4	-0.0	44.3	84.5	–	0.0	–
Virginia	179.3	270.6	1,011.0	44.5	7.2	141.9	5.1
Washington	238.6	–	1,033.4	23.1	128.2	153.3	83.6
West Virginia	56.5	229.7	588.2	48.7	18.9	106.9	17.7
Wisconsin	0.6	24.9	743.2	3.4	–	27.9	–
Wyoming	0.5	16.7	122.5	14.0	–	13.4	–

TABLE 20, Continued. Supplemental Payments by State and Category, FY 2013 (millions)

State	Nursing Facilities and ICFs-ID[3]			Physician and Other Practitioners[4]		
	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total
All states	**$2,393.8**	**$62,953.8**	**3.8%**	**$846.3**	**$13,163.5**	**6.4%**
Alabama	–	904.7	–	–	382.3	–
Alaska	–	128.2	–	–	125.7	–
Arizona	2.8	37.3	7.5	–	34.8	–
Arkansas	–	804.6	–	33.3	316.1	10.5
California	290.1	5,353.6	5.4	–	916.5	–
Colorado	91.1	688.3	13.2	14.2	357.7	4.0
Connecticut	–	1,557.9	–	–	414.8	–
Delaware	–	31.6	–	–	12.6	–
District of Columbia	–	312.6	–	–	46.9	–
Florida	11.0	3,156.7	0.3	79.0	1,265.3	6.2
Georgia	144.3	1,395.9	10.3	33.5	409.3	8.2
Hawaii	–	8.8	–	–	1.2	–
Idaho	81.5	288.4	28.3	–	89.9	–
Illinois	–	2,745.0	–	–	894.7	–
Indiana	461.6	1,946.3	23.7	109.9	286.8	38.3
Iowa	–	889.6	–	–	210.0	–
Kansas	2.3	198.6	1.2	15.6	49.9	31.3
Kentucky	0.4	1,010.0	0.0	6.2	50.7	12.3
Louisiana	–	1,336.3	–	42.5	316.7	13.4
Maine	–	339.1	–	–	131.9	–
Maryland	–	1,137.5	–	–	107.6	–
Massachusetts	1.4	1,640.2	0.1	28.0	355.6	7.9
Michigan	339.6	1,775.0	19.1	125.0	283.3	44.1
Minnesota	–	910.6	–	21.7	332.0	6.5
Mississippi	62.5	1,049.0	6.0	–	218.5	–
Missouri	–	1,089.1	–	–	47.9	–
Montana	–	173.1	–	–	65.2	–
Nebraska	–	414.9	–	–	42.3	–
Nevada	–	208.3	–	3.4	109.1	3.1
New Hampshire	–	302.0	–	–	63.2	–
New Jersey	–	2,508.5	–	–	48.2	–
New Mexico	–	28.1	–	14.1	91.1	15.5
New York[5]	172.5	9,540.3	1.8	32.6	585.5	5.6

TABLE 20, Continued

State	Nursing Facilities and ICFs-ID[3]			Physician and Other Practitioners[4]		
	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total
North Carolina	–	$1,309.9	–	$67.3	$912.6	7.4%
North Dakota	$1.7	304.6	0.6%	–	55.2	–
Ohio[6]	-82.1	3,153.6	-2.6	–	365.1	–
Oklahoma	–	673.4	–	0.0	513.9	0.0
Oregon	–	331.3	–	–	45.3	–
Pennsylvania	713.6	4,448.9	16.0	–	153.9	–
Rhode Island	–	339.9	–	–	11.6	–
South Carolina	22.2	671.8	3.3	32.8	237.4	13.8
South Dakota	–	163.1	–	–	64.2	–
Tennessee	–	250.3	–	–	27.7	–
Texas	–	3,424.2	–	83.1	1,358.2	6.1
Utah	5.0	233.7	2.2	27.9	102.0	27.3
Vermont[5]	0.1	116.2	0.1	–	1.9	–
Virginia	4.1	1,149.6	0.4	24.1	213.4	11.3
Washington	–	729.2	–	24.2	138.6	17.5
West Virginia	–	608.7	–	28.0	158.0	17.7
Wisconsin	39.6	1,013.7	3.9	–	78.4	–
Wyoming	28.6	121.4	23.6	–	62.7	–

Notes: Includes federal and state funds. Excludes payments made under managed care arrangements. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; they include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported by states for any given category (e.g., inpatient hospital) sometimes show substantial annual fluctuations. The Centers for Medicare & Medicaid Services (CMS) only began to require separate reporting of non-disproportionate share hospital (DSH) supplemental payments in fiscal year (FY) 2010 and is continuing to work with states to standardize this reporting. As a result, the information presented may not reflect a consistent classification of supplemental payment spending across states. Reporting is expected to improve over time. All states had certified their CMS-64 Finanical Management Report (FMR) submissions as of February 12, 2014. Figures presented in this table may change if states revise their expenditure data after this date. Zeroes indicate amounts less than 0.05 million that round to zero. Dashes indicate amounts that are true zeroes.

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

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

3 Includes nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID). Non-DSH supplemental payments are described in the CMS-64 instructions to states as payments that are made in addition to the standard fee schedule or other standard payment for a given service, including payments made under institutional upper payment limit rules.

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

5 New York and Vermont reported negative non-DSH supplemental payments for inpatient hospitals.

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

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

TABLE 21. Federal CHIP Allotments, FY 2013 and FY 2014 (millions)

State	FY 2013 CHIP Allotments	FY 2014 Allotment Increase Factor	FY 2014 Federal CHIP Allotments
	A	B	C = A x B
Alabama	$162.8	1.0627	$173.1
Alaska	20.6	1.0627	21.8
Arizona	25.4	1.0650	27.0
Arkansas	103.1	1.0636	109.7
California	1,296.0	1.0627	1,377.3
Colorado	131.8	1.0658	140.5
Connecticut	41.3	1.0627	43.9
Delaware	15.7	1.0637	16.7
District of Columbia	14.9	1.0969	16.3
Florida	359.0	1.0647	382.3
Georgia	282.7	1.0642	300.9
Hawaii	25.8	1.0641	27.5
Idaho	36.0	1.0627	38.2
Illinois	275.6	1.0627	292.8
Indiana	144.9	1.0627	153.9
Iowa	92.5	1.0627	98.3
Kansas	55.4	1.0627	58.9
Kentucky	147.9	1.0627	157.2
Louisiana	171.9	1.0643	182.9
Maine	31.5	1.0627	33.5
Maryland	160.5	1.0627	170.5
Massachusetts	330.9	1.0627	351.6
Michigan	54.8	1.0627	58.2
Minnesota	32.1	1.0627	34.1
Mississippi	176.9	1.0627	188.0
Missouri	122.9	1.0627	130.7
Montana	59.4	1.0627	63.1
Nebraska	42.5	1.0666	45.3
Nevada	31.5	1.0650	33.5
New Hampshire	18.2	1.0627	19.3
New Jersey	640.2	1.0627	680.3
New Mexico	124.2	1.0627	132.0
New York	579.8	1.0627	616.1
North Carolina	304.2	1.0642	323.7
North Dakota	17.3	1.0853	18.8
Ohio	336.1	1.0627	357.1

TABLE 21, Continued

State	FY 2013 CHIP Allotments	FY 2014 Allotment Increase Factor	FY 2014 Federal CHIP Allotments
	A	B	C = A x B
Oklahoma	$114.2	1.0678	$121.9
Oregon	143.9	1.0627	152.9
Pennsylvania	305.7	1.0627	324.9
Rhode Island	39.5	1.0627	42.0
South Carolina	98.3	1.0658	104.7
South Dakota	19.4	1.0681	20.8
Tennessee	200.2	1.0635	212.9
Texas	891.5	1.0721	955.8
Utah	62.5	1.0696	66.8
Vermont	13.0	1.0627	13.9
Virginia	186.6	1.0630	198.3
Washington	96.9	1.0654	103.3
West Virginia	48.3	1.0627	51.3
Wisconsin	103.0	1.0627	109.5
Wyoming	10.8	1.0705	11.5
Subtotal	**$8,799.9**		**$9,365.7**
American Samoa	1.3	1.0627	1.4
Guam	4.5	1.0627	4.8
N. Mariana Islands	0.9	1.0627	1.0
Puerto Rico	132.7	1.0627	141.0
Virgin Islands	–	1.0627	–
Total	**$8,939.4**		**$9,513.9**

Notes: For even-numbered years (e.g., fiscal year (FY) 2014), federal CHIP allotments are calculated as the sum of last year's allotment and any shortfall payments (e.g., contingency funds), increased by a state-specific growth factor. In FY 2013, there were no contingency fund payments. For even-numbered years, a state can also have its allotment increased to reflect a CHIP eligibility or benefits expansion; some states have applied for these allotment increases, but the Centers for Medicare & Medicaid Services (CMS) has not named them nor finalized their additional allotment amounts, if any.

Source: MACPAC communication with the Centers for Medicare & Medicaid Services (CMS), February 2014.

TABLE 22. Federal CHIPRA Bonus Payments (millions)

State	FY 2009 CHIPRA bonus payments	FY 2010 CHIPRA bonus payments	FY 2011 CHIPRA bonus payments	FY 2012 CHIPRA bonus payments	Preliminary FY 2013 CHIPRA bonus payments	FY 2013 Outreach and Enrollment Efforts Among 23 States Receiving CHIPRA Bonus Payments							
						12 months of continuous eligibility	Liberalization of asset requirements	Elimination of in-person interview	Joint application and renewal form	Automatic, administrative renewal	Presumptive eligibility	Express Lane	Premium assistance
Total	**$37.1**	**$167.2**	**$303.5**	**$318.3**	**$307.3**	**15**	**22**	**23**	**23**	**17**	**13**	**5**	**5**
AL[1]	1.5	5.7	20.4	15.8	11.5	✓	✓	✓	✓	✓	–	–	–
AK	0.7	4.9	5.7	4.1	2.6	✓	✓	✓	✓	✓	–	–	–
CO	–	18.2	32.9	47.5	58.5	–	✓	✓	✓	✓	✓	✓	✓
CT	–	–	5.2	3.0	1.7	–	✓	✓	✓	✓	✓	–	–
GA	–	–	4.9	2.2	–								
ID	–	0.9	0.5	1.4	5.4	✓	✓	✓	✓	✓	–	–	✓
IL	9.5	15.3	15.3	13.3	6.3	✓	✓	✓	✓	✓	✓	–	–
IA	–	7.7	10.0	11.4	10.6	✓	✓	✓	✓	–	✓	✓	–
KS	1.2	5.5	6.0	12.8	10.9	✓	✓	✓	✓	✓	✓	–	–
LA	1.5	3.7	1.9	–	–								
MD	–	11.4	28.0	37.5	43.5	–	✓	✓	✓	✓	–	✓	–
MI	4.7	8.4	6.9	4.4	1.6	✓	✓	✓	✓	–	✓	–	–
MT	–	–	5.0	7.2	7.0	–	✓	✓	✓	✓	✓	–	–
NJ	3.1	8.8	17.6	24.4	22.4	–	–	✓	✓	✓	✓	✓	–
NM	5.4	9.0	5.2	2.7	1.7	✓	✓	✓	✓	✓	✓	–	–
NC	–	–	11.6	18.6	11.6	✓	✓	✓	✓	✓	–	–	–
ND	–	–	3.2	2.7	1.1	✓	✓	✓	✓	✓	–	–	–
NY[2]	–	–	–	0.6	13.1	✓	✓	✓	✓	–	✓	–	
OH	–	13.1	20.9	19.0	10.8	✓	✓	✓	✓	–	✓	–	–
OK	–	–	0.5	–	–								
OR	1.6	10.6	22.3	25.9	24.4	✓	✓	✓	✓	✓	–	–	–
SC	–	–	2.7	2.9	17.5	✓	✓	✓	✓	–	✓	✓	–
UT	–	–	–	9.9	5.3	–	✓	✓	✓	✓	✓	–	–
VA	–	–	24.6	20.0	18.0	–	✓	✓	✓	✓	–	–	✓
WA	7.9	20.7	19.0	13.8	7.8	✓	✓	✓	✓	–	–	–	✓
WI	–	23.4	33.3	17.1	13.9	–	✓	✓	✓	✓	–	–	✓
WV	–	–	0.1	–	–								

Notes: CHIPRA is the Children's Health Insurance Program Reauthorization Act. Each of these outreach and enrollment efforts is described in MACPAC's March 2011 report (pp. 68–69). Some fiscal year (FY) 2012 bonus payments have been revised based on final enrollment figures.

1 Originally, Alabama's bonus payments were $40 million for FY 2009 and $55 million for FY 2010. A preliminary audit conducted by CMS and the state revealed an error in the state's calculation of qualifying children. For some states, preliminary bonus payments may be revised to reflect final figures showing growth in children's enrollment in Medicaid.

2 New York qualified for FY 2012 bonus payment after reconciliation of final enrollment figures.

Sources: U.S. Department of Health and Human Services (HHS), *CHIPRA performance bonuses: A history (FY 2009 – FY 2013)*, December 2013. http://www.insurekidsnow.gov/professionals/eligibility/pb-2013-chart.pdf; and HHS, *FY 2013 CHIPRA performance bonus awards*. http://www.insurekidsnow.gov/professionals/eligibility/fy2013-pb-table.pdf.

TABLE 23. Provider Availability Measures of Access to Care for Medicaid/CHIP Beneficiaries, 2012

	Measure Number[1]	All Primary Care Physicians[2]	Physicians in Primary Care Specialties	
			General pediatrics	General, family or internal medicine
Provider Availability				
Primary care physician (PCP) is accepting new patients by source of payment[3]	P1			
New Medicaid/CHIP patients		**67.4%**	79.5%^	62.6%^†
New Medicare patients		**75.1***	–[4]	87.5*^
New privately insured patients		**85.2***	94.7*^	81.8*^†
Percentage of the PCP's patient care revenue that comes from Medicaid/CHIP (categories sum to 100%)[5]	P2			
None		**27.3**	19.2^	30.6^†
1 to 9 percent of revenue		**18.5**	10.0^	22.0^†
10 to 25 percent of revenue		**27.5**	20.9^	30.2^†
26 to 50 percent of revenue		**17.9**	27.5^	14.0^†
More than 50 percent of revenue		**8.8**	22.4^	3.2^†

Notes: Data in this table are drawn from the 2012 National Electronic Health Records Survey, a component of the National Ambulatory Medical Care Survey (NAMCS-NEHRS). The 2012 NAMCS-NEHRS draws on a national multistage probability sample of practicing physicians in office-based settings, defined as a physician office where non-federally employed physicians provide direct patient care. This includes community health centers, HMOs, and faculty practices that refer patients to academic health centers and excludes outpatient hospital departments. Physicians in the specialties of anesthesiology, pathology, and radiology are excluded.

* Difference from percentage accepting new Medicaid patients is statistically significant at the 0.01 level.

^ Difference from all primary care physicians (PCPs) is statistically significant at the 0.01 level.

† Difference from PCPs in general pediatrics is statistically significant at the 0.01 level.

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 PCPs include physicians in general pediatrics, general medicine, family medicine, and internal medicine. Obstetrician-gynecologists are not included in the table.

3 Physicians who do not accept any new patients are considered not to be accepting any new Medicaid, Medicare, or privately insured patients.

4 The percentage of pediatricians accepting new Medicare patients is omitted due to very low Medicare participation by this group.

Source: National Center for Health Statistics analysis for MACPAC of the 2012 National Electronic Health Records Survey, a component of the 2012 National Ambulatory Medical Care Survey (NAMCS-NEHRS).

TABLE 24. Parent-Reported Measures of Access to Care for Non-Institutionalized Children by Source of Health Insurance, 2011–2012

	Measure Number[1]	All Children[2]	Children with Selected Sources of Insurance[2,3]		
			Medicaid/ CHIP[4]	Private/ Other[5]	Uninsured[6]
Connection to the health care system (past 12 months)					
Has a usual source of care[8]	S1	**95.4%**	96.8%	98.0%*	65.9%*
Had same usual source of medical care 12 months ago (all children)[8]	S2	**88.8**	90.0	91.9*	64.3*
Has a personal doctor or nurse[7]	S3	**90.3**	87.8	94.5*	64.5*
Access barrier is reason for having no usual source of care[8,9]	S4	**1.4**	0.4	0.2	18.1*
Had trouble finding a doctor[8,10]	S5	**3.7**	4.8	2.2*	4.5
Had usual source of care barrier or trouble finding a doctor[8,11]	S6	**4.9**	5.1	2.4*	20.8*
Receipt of effective care coordination[7,12]	S7				
Parent did not receive all care coordination needed		**14.3**	16.4	12.9	14.6
Parent received all care coordination needed		**27.8**	27.1	29.9*	12.2*
Did not need care coordination		**57.9**	56.5	57.3	73.1*
Contact with health care professionals (past 12 months)					
Had at least one office visit[8,13]	C1	**90.7**	91.6	92.7	63.1*
Saw a general doctor[8]	C2	**81.8**	82.4	84.6*	50.3*
Saw a general doctor, nurse practitioner, PA, midwife, or Ob-Gyn[8,14]	C3	**83.6**	83.7	86.3*	54.5*
Had at least one preventive dental visit (age 2–17)[7]	C4	**80.7**	76.9	86.3*	49.5*
Timeliness of care (past 12 months)					
Delayed medical care due to an access barrier[8,15]	T1	**11.5**	13.4	7.3*	23.6*
Any time when needed health care was delayed or not received[7]	T2				
Medical care		**3.4**	4.4	1.8*	13.2*
Mental health care		**0.8**	1.0	0.7*	1.4
Dental care		**2.6**	3.0	1.7*	10.7*
Vision		**0.9**	1.0	0.5*	4.4*

TABLE 24, Continued

	Measure Number[1]	All Children[2]	Children with Selected Sources of Insurance[2,3]		
			Medicaid/ CHIP[4]	Private/ Other[5]	Uninsured[6]
Unmet need for selected types of care due to cost[8]	T3				
Medical care		**1.8%**	0.9%	0.8%	10.5%*
Mental health care or counseling, age 2–18		**1.0**	0.8	0.7	2.7*
Dental care		**5.6**	4.2	3.2*	21.7*
Prescription drugs		**2.2**	1.9	1.3*	7.2*
Eyeglasses		**2.0**	2.0	1.1*	7.2*
Had problem getting referrals (of children needing referrals)[7]	T4	**20.8**	24.9	15.9*	43.5*
Receipt of appropriate care (past 12 months)					
Doctors and other providers spend enough time with child[7,16]	A1	**77.5**	68.8	85.6*	47.4*
Received at least one preventive medical visit (age 0–17)[8]	A2	**80.2**	82.7	82.1	46.1*
Children age 0–5		**89.7**	88.4	92.8*	62.5*
Children age 6–11		**77.9**	81.2	79.5	45.1*
Children age 12–17		**73.0**	76.2	75.8	40.8*
Received selected EPSDT services (of children needing service)[7,17]	A3				
Vision screening in last 2 years (age 5–17) or ever (age 0–4)		**67.6**	63.4	71.5*	57.6*
Mental health care (children needing mental health care, age 2–17)		**61.1**	59.2	66.1*	41.9*
Therapy services (children with autism or developmental delays)		**87.9**	86.7	90.0	77.7
Received coordinated, ongoing, comprehensive care within a medical home[7]	A4	**54.4**	43.9	64.0*	27.8*
Had at least one hospital emergency room (ER) visit[8]	A5	**18.0**	24.9	13.3*	12.9*
ER visit was related to a serious health problem[18]		**10.0**	13.1	7.9*	5.4*
ER visit was related to an access barrier, not a serious problem[18]		**6.6**	9.8	4.2*	5.5*
Had two or more ER visits[8]	A6	**5.9**	9.9	3.2*	3.8*

TABLE 24, Continued

Notes: Data in this table are drawn from national samples of children based on two different surveys, the 2012 National Health Interview Survey (NHIS) and the 2010–2011 National Survey of Children's Health (NSCH). The NHIS and NSCH apply different sampling methodologies, and data are collected from different time periods. In addition, the surveys have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared. The table is intended to compare populations with different coverage sources within each measure. Responses to access and use questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. As a result, experiences with access barriers and service use in part may be due to periods with other coverage or no coverage in the past year.

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

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 For NHIS measures, the population is children age 0–18 who were insured or uninsured for the entire year. For NSCH measures, the population is all children age 0–17.

3 The population in each column differs somewhat based on the data source, as described in the footnotes on individual columns. Children covered by Medicare (generally children with end-stage renal disease) are not separately shown.

4 For NHIS measures, the Medicaid/CHIP population consists of children age 0–18 with Medicaid/CHIP at the time of interview and is limited to children insured for the entire year, including children who switched coverage sources during the year. For NSCH measures, the Medicaid/CHIP population consists of children age 0–17 with Medicaid/CHIP at the time of interview, including children who were uninsured during the past year. NHIS measures exclude a small number of children with Medicaid/CHIP who are also covered by private, Medicare, or other state-sponsored and government-sponsored insurance at the time of interview, while NSCH measures include any children with Medicaid/CHIP and additional sources of public or private coverage.

5 For NHIS measures, the private/other population is limited to children age 0–18 insured for the entire year and includes children who switched coverage sources during the year, while NSCH measures include children age 0–17 who were uninsured during the past year. The private/other population for NHIS measures consists of children with employer-sponsored insurance, other private plans, and military health plans at the time of the interview and includes children with both private insurance and Medicaid/CHIP or other coverage. For NSCH measures, the privately insured/other population consists of children who were covered by any insurance other than Medicaid/CHIP at the time of the interview. These children primarily have employer-sponsored insurance, other private plans, and military health plans, but this population also includes a small number of children with other state-sponsored or other government-sponsored insurance.

6 For NHIS measures, the uninsured population is children age 0–18 who did not have any health insurance coverage at the time of interview and who were uninsured for the entire year. Children with Indian Health Service coverage only or a private plan that paid for one type of service, such as accidents or dental care, were classified as uninsured. For NSCH measures, the uninsured population is children age 0–17 who did not have any type of health insurance coverage at the time of interview and includes children who had a source of coverage sometime in the past year.

7 Measure is constructed from the 2011–2012 NSCH.

8 Measure is constructed from the 2012 NHIS.

9 Reasons given by those who reported no usual place of care that were classified as access barriers include: too expensive/cost, previous doctor not available, parent does not know where to go, and speaks a different language.

10 Parent reported one of these barriers in the past 12 months: trouble finding a doctor or provider, doctor's office/clinic did not accept child's insurance coverage, or office/clinic did not accept child as a new patient.

11 Reported any experiences captured in measure S4 and S5.

12 Children are classified as needing care coordination if they received two or more services or the parent reported needing care coordination. The criteria for receipt of effective care coordination were that the family received some type of help with care coordination, and the family was very satisfied with doctors' communication with other health care providers, school, and other programs, if those services were needed. The denominator for each statistic is all children.

13 Parents may report encounters with a broad range of health professionals (e.g., speech therapist or social worker) but the question is limited to visits in a doctor's office or clinic.

14 PA is physician assistant. Ob-Gyn is obstetrician-gynecologist, and these visits were limited to females age 15–18.

15 Reasons given for delayed care classified as access barriers include cost, transportation, and provider-related reasons (parent couldn't get an appointment, had to wait too long to see doctor, couldn't go when open, couldn't get through on phone, and parent speaks a different language).

16 Defined as the percentage of children whose parents reported the providers usually or always spend enough time with child.

17 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are a mandatory Medicaid benefit. The denominator for vision screening is all children. The denominator for mental health care is children whose parents report the child needed mental health care. The denominator for therapy services is children with autism or a developmental delay. These measures do not capture children with an undiagnosed need or whose parents are not aware the child needs services.

18 Based on questions about the most recent emergency room (ER) visit. The most recent ER visit is classified as related to a serious health problem if the parent reported that the visit resulted in a hospital admission or reason for the visit was taken by ambulance, advised by doctor to go, or problem too serious for doctor's office/clinic. The ER visit is classified as related to an access barrier if the parent reported that the visit occurred at night or on a weekend, or the reason for the visit was that doctor's office/clinic was closed, excluding visits for a serious health problem. These categories do not capture all visits.

Source: MACPAC analysis of the 2012 National Health Interview Survey (NHIS) and the 2011–2012 National Survey of Children's Health (NSCH).

TABLE 25. Parent-Reported Measures of Access to Care for Non-Institutionalized Children with Special Health Care Needs (CSHCN) by Source of Health Insurance, 2009–2012

	Measure Number[1]	All CSHCN[2]	CSHCN[2] with Selected Sources of Insurance[3]		
			Medicaid/ CHIP[4]	Private/ Other[5]	Uninsured[6]
Connection to the health care system (past 12 months)					
Has a personal doctor or nurse[7]	S3	**92.8%**	90.3%	95.8%*	75.3%*
Receipt of effective care coordination[7,8]	S7				
Parent did not receive all care coordination needed		**33.1**	34.3	32.1	38.2*
Parent received all care coordination needed		**42.9**	41.8	45.5	18.9*
Did not need care coordination		**23.9**	24.0	22.4	42.8*
Family had one or more unmet needs for support services[9,10]	S8	**7.2**	8.8	4.6*	18.1*
Contact with health professionals (past 12 months)					
Had at least one preventive dental visit (age 2–17)[7]	C4	**84.4**	80.1	90.1*	49.7*
Received care from a specialist doctor[9]	C5	**45.6**	40.4	50.0*	31.9*
Timeliness of care (past 12 months)					
Had unmet need for selected types of care[9]	T5				
Specialist care		**4.4**	6.2	2.5*	15.3*
Prescription drugs		**2.6**	3.4	1.4*	15.9*
Mental health care and counseling		**5.6**	7.3	4.0*	14.9*
Non-preventive dental		**5.4**	7.1	3.7*	20.8*
Physical, occupational, or speech therapy		**4.7**	5.1	3.8*	8.0*
Vision care or eyeglasses		**2.1**	2.8	1.3*	8.2*
Had 2 or more unmet needs for 14 specific services[9,11]	T6	**8.8**	11.9	5.3*	33.6*
Receipt of appropriate care (past 12 months)					
Doctors and other providers spend enough time with child[7,12]	A1	**79.7**	74.2	85.8*	54.3*
Had at least one preventive medical visit[9]	A2	**90.4**	91.5	91.1	70.3*
Children less than age 2		**97.8**	97.5	98.3*	–[13]
Children age 2–4		**94.6**	92.9	96.6*	93.5
Children age 5–11		**89.3**	88.1	93.1*	52.6*
Children age 12–17		**90.4**	90.2	90.2	64.5*
Received coordinated, ongoing, comprehensive care within a medical home[9]	A4	**46.8**	40.6	53.2*	25.8*
Had two or more ER visits[9]	A6	**21.6**	33.0	12.8*	23.5*

TABLE 25, Continued

Notes: Data in this table are drawn from national samples of children based on two different surveys, the 2010–2011 National Survey of Children's Health (NSCH) and the 2009–2010 National Survey of Children with Special Health Care Needs (NS-CSHCN). Measures are for children age 0–17, unless otherwise noted. The NSCH and NS-CSHCN apply different methods to sample children, and data are collected from different time periods. In addition, the surveys have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared. The table is intended to compare populations with different coverage sources within each measure. Responses to access and use questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. As a result, experiences with access barriers and service use may be due partly to periods with other coverage or no coverage in the past year. Not separately shown are children covered by Medicare (generally children with end-stage renal disease). See additional notes.

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

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 CSHCN is children with special health care needs. In both the NSCH and NS-CSHCN, CSHCN are identified using a five-item, parent-reported tool that identifies children across the range and diversity of childhood chronic conditions and special needs and who currently experience one or more of five common health consequences due to a physical, mental, behavioral, or other type of health condition lasting or expected to last at least 12 months. See Child and Adolescent Health Measurement Initiative (CAHMI), Fast facts: *Children with special health care needs screener* (Portland, OR: CAHMI, 2007). http://childhealthdata.org/docs/cshcn/cshcn-screener-cahmi-quickguide-pdf.pdf.

3 The population in each column differs somewhat based on the data source. See additional notes for the selected populations.

4 CHIP is State Children's Health Insurance Program. For all measures, the Medicaid/CHIP population is children with Medicaid or CHIP at the time of interview and includes children who were uninsured during the past year or who switched coverage sources during the year. For NSCH measures, Medicaid/CHIP includes a small number of children with additional sources of public or private coverage. For NS-CSHCN measures, Medicaid/CHIP is limited to children with Medicaid or CHIP only at the time of interview and excludes children with additional sources of public or private coverage.

5 For NSCH measures, the private/other population consists of children who were covered by any insurance other than Medicaid/CHIP at the time of the interview. These children primarily have employer-sponsored insurance, other private plans, and military health plans, but this population also includes a small number of children with other state-sponsored or other government-sponsored insurance. For the NS-CHSCN measures, the private/other population is limited to children with private health insurance only, defined as insurance through an employer, purchased directly from an insurance company, or any military health plan. For both NSCH and NS-CSHCN measures, the private/other population includes children insured at the time of interview who were uninsured during the year or who switched coverage sources during the year.

6 For both NSCH and NS-CHSCN measures, the uninsured population consists of children who did not have any health insurance coverage at the time of interview and includes children who had a source of coverage sometime in the past year. For NS-CHSCN measures, parents who indicated the child was insured by a source other than Medicaid/CHIP were asked a follow-up question of whether the insurance covered doctor visits and hospital stays. If not, these children also were classified as uninsured. In addition, the NS-CSHCN instructed parents not to count dental, vision, school, or accident insurance as coverage.

7 Measure is constructed from the 2011–2012 NSCH (see source noted below).

8 Children are defined as needing care coordination if they received two or more services or the parent reported needing care coordination. The criteria for receipt of effective care coordination were that the family received some type of help with care coordination, and the family was very satisfied with doctors' communication with other health care providers, school, and other programs, if those services were needed. The denominator for each statistic is all children.

9 Measure is constructed from the 2009–2010 NS-CSHCN (see source noted below).

10 The family needed one or more family supports (respite care, genetic counseling, or family mental health care or counseling) but did not receive all the help they needed.

11 In addition to the services listed in the table, this includes unmet need for dental, home health care, substance abuse treatment or counseling, durable medical equipment, genetic counseling, and respite care.

12 The percentage of children whose parents reported the providers usually or always spend enough time with child.

13 Data not shown due to small sample size.

Source: MACPAC analysis of the 2011–2012 National Survey of Children's Health (NSCH) and the 2009–2010 National Survey of Children with Special Health Care Needs (NS-CSHCN).

TABLE 26. Measures of Access to Care for Non-Institutionalized Individuals Age 19 to 64 by Source of Health Insurance, 2012

	Measure Number[1]	All Adults[2]	Adults with Selected Sources of Insurance		
			Medicaid[3]	Private[4]	Uninsured[5]
Connection to the health care system (past 12 months)					
Has a usual source of care when sick or needs advice	S9	**79.6%**	87.1%	89.9%*	41.7%*
Access barrier is reason for having no usual source of care[6]	S11	**8.4**	3.1	1.4*	34.5*
Had trouble finding a doctor[7]	S12	**3.1**	4.5	1.5*	6.3*
Had usual source of care barrier or trouble finding a doctor[8]	S13	**13.3**	11.6	5.1*	38.4*
Contact with health professionals (past 12 months)					
Had at least one office visit[9]	C6	**77.5**	84.9	84.7	46.6*
Saw a selected health professional (any setting)[10]					
Saw a nurse practitioner, physician assistant (PA), or midwife	C7	**19.1**	22.3	20.7	9.0*
Saw a medical doctor, nurse practitioner, PA, or midwife[11]	C8	**76.7**	81.7	84.2*	45.7*
Saw a mental health professional (adults with SMI only)[12]	C9	**39.5**	45.9	38.9	24.2*
Saw a dental professional	C10	**61.3**	50.7	74.2*	28.1*
Saw any health professional, excluding dental[13]	C11	**82.4**	88.6	89.1	53.4*
Saw any health professional, including dental[13]	C12	**88.8**	92.8	94.9*	62.3*
Timeliness of care (past 12 months)					
Delayed medical care due to an access barrier (any below)[14]	T7	**21.8**	22.9	14.7*	37.9*
Because of costs		**13.0**	7.9	6.0*	32.4*
Provider-related reasons[14]		**10.3**	14.6	9.5*	8.4*
Did not have transportation		**1.9**	6.0	0.6*	2.5*
Unmet need for selected types of care due to cost	T8				
Medical care		**9.9**	6.1	3.4*	28.1*
Mental health care or counseling		**3.0**	2.2	1.2*	7.1*
Did not take medication as prescribed to save money[15]	T9	**14.3**	12.8	8.0*	28.6*
Had any barriers to finding a doctor, delayed care, or unmet need[16]	T10	**34.1**	33.5	21.8*	65.3*

TABLE 26, Continued

	Measure Number[1]	All Adults[2]	Adults with Selected Sources of Insurance		
			Medicaid[3]	Private[4]	Uninsured[5]
Receipt of appropriate care (past 12 months)					
Received any preventive visit or counseling, all individuals[17]	A7	**84.1%**	89.1%	90.3%	57.3%*
Individuals age 19 to 49		**80.7**	87.8	87.8	54.2*
Individuals age 50 to 64		**91.2**	93.3	94.6	68.0*
Individuals with a chronic condition or pregnant, all ages		**92.7**	96.3	96.0	73.9*
Had cholesterol checked by health professional, all individuals	A8	**57.3**	60.9	64.9*	27.2*
Men age 35 to 64		**65.4**	67.4	73.8*	28.6*
Individuals with health-related risk of heart disease (CHD)[18]		**65.6**	69.2	75.6*	33.3*
All individuals at increased risk of CHD		**63.5**	66.8	72.6*	30.0*
Had a flu shot, all individuals	A9	**31.6**	31.3	37.3*	13.0*
Individuals age 50 to 64		**42.8**	42.6	46.4	19.3*
Individuals with a chronic condition or pregnant		**40.5**	38.8	46.5*	18.5*
All individuals at high-risk of influenza complications[19]		**39.1**	38.1	44.2*	17.4*
Had professional counseling about smoking (current smokers)	A10	**49.2**	59.0	55.0	28.8*
Had any test for colorectal cancer (age 50 to 64)	A11	**22.8**	24.7	25.1	6.3*
Men age 50 to 64		**24.9**	22.1	27.5	5.9*
Women age 50 to 64		**20.9**	26.4	22.8	6.7*
Had Pap smear or test for cervical cancer (women age 21 to 60)	A12	**59.3**	61.6	65.8*	33.6*
Had more than 15 office visits	A13	**5.3**	9.6	5.0*	1.9*
Had at least one hospital emergency room (ER) visit	A14	**18.8**	35.9	14.9*	17.1*
ER visit was related to a serious health problem[20]		**12.1**	23.8	9.7*	8.9*
ER visit was related to an access barrier, not a serious problem[20]		**4.9**	8.7	4.0*	5.0*
Four or more ER visits	A15	**2.0**	7.2	0.8*	2.0*

TABLE 26, Continued

Notes: Measures in this table are based on national samples of adults from the 2012 National Health Interview Survey (NHIS). Measures are for adults age 19–64, unless otherwise noted. The population in this table is limited to individuals insured for the entire year or uninsured for the entire year and excludes individuals insured for only part of the year and uninsured part of the year. Responses to access and use questions are based on the previous 12 months, during which time the individual may have had a different source of coverage than that shown in the table. Not separately shown are individuals covered by Medicare.

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

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 In addition to individuals in the Medicaid, private, and uninsured columns, includes individuals dually covered by Medicare and Medicaid and covered by Medicare only.

3 Medicaid includes a small number of individuals covered by other state-sponsored health plans. Individuals with both Medicaid and Medicare or other public coverage at the time of interview were excluded.

4 Private health insurance coverage includes individuals with employer-sponsored coverage, other private plans, and military health plans at the time of interview and includes individuals with both private insurance and Medicaid/CHIP, Medicare, or other public coverage.

5 Uninsured includes individuals who did not have any health insurance coverage at the time of interview (individuals were also classified 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).

6 Reasons given by those who reported no usual place of care that were classified as access barriers include: too expensive/cost, previous doctor not available, respondent does not know where to go, and respondent speaks a different language.

7 Individual reported one of these barriers in the past 12 months: trouble finding a doctor or provider, doctor's office/clinic did not accept the individual's insurance coverage, or office/clinic did not accept individual as a new patient.

8 Reported any experiences captured in measures S11 and S12.

9 Respondents may report encounters with a broad range of health professionals (e.g., a chiropractor or physical therapist) but the question is limited to visits in a doctor's office or clinic.

10 Respondents may not limit encounters with health professionals to visits in a doctor's office or clinic.

11 Medical doctor includes general doctor, obstetrician-gynecologist, medical specialist, and eye doctor, but excludes other health professionals (e.g., a chiropractor, podiatrist or foot doctor, or physical therapist).

12 SMI is serious mental illness. Individuals were defined as having SMI if they reported a limitation due to a mental health or behavioral problem or received a score over 30 (out of 40) on the Kessler Psychological Distress Scale (K10) in the NHIS. For more information on the Kessler Psychological Distress Scale, see R. Kessler, P. Barker, L. Colpe, et al., Screening for serious mental illness in the general population, *Archives of General Psychiatry* 60, no. 2 (2003): 184–189.

13 C11 is a global measure of professional contact and includes all encounters in C8, all encounters with a mental health professional (not just those in C9 by individuals with SMI), and encounters with other health professionals not counted elsewhere (e.g. chiropractor, podiatrist or foot doctor, or physical therapist). C12 adds to C11 all dental professional visits. Responses to questions about specific types of health professionals may not align with reported office visits in C6 due to differences in question wording, respondent interpretation, and recall.

14 Reasons given for delayed care classified as access barriers include: cost, transportation, and provider-related reasons (respondent couldn't get an appointment, had to wait too long to see doctor, couldn't go when open, couldn't get through on phone, and speaks a different language).

15 Individuals reporting unmet need because of cost for prescription drugs, and individuals who took specific actions to save money on medications (skipped doses, took less medicine, and delayed filling a prescription).

16 Measure T10 is all individuals with an access problem reported in S13 and T7–T9.

17 Includes all preventive services in measures A8–A12 and other services reported in the NHIS: health professional talked to you about diet, blood pressure checked by health professional, and screening for breast cancer. Includes individuals who reported receiving the service, but who are not in a high-risk group or of a recommended age for the service.

18 Individuals of any age or sex reporting hypertension, diabetes, and who currently smoke. See details in MACStats Appendix.

19 Based on common risk factors that can be measured in the NHIS. See details in MACStats Appendix.

20 Based on responses to questions about the most recent emergency room (ER) visit. Most recent ER visit is classified as related to a serious health problem if the individual reported that the visit resulted in a hospital admission, or reason for the visit was either taken by ambulance, advised by doctor to go, or problem too serious for doctor's office/clinic. Visit is classified as related to an access barrier if the individual reported the visit occurred at night or on weekend, or reason for the visit was doctor's office/clinic was closed, and excludes individuals reporting a serious health problem.

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

TABLE 27. Measures of Access to Care for Non-Institutionalized Medicaid Beneficiaries Age 19 to 64 by Receipt of Supplemental Security Income (SSI), 2009–2011

	Measure Number[1]	Adult Medicaid Enrollees by Receipt of SSI	
		Received SSI	Did not receive SSI
Connection to the health care system (past 12 months)			
Has a usual source of care when sick or needs advice	S9	91.0%	87.3%*
Had same usual source of care 12 months ago (all adults)	S10	83.8	81.0
Contact with health care professionals (past 12 months)			
Had at least one office visit[2]	C6	87.9	82.2*
Saw a selected health professional (any setting)[3]			
Saw a nurse practitioner, physician assistant (PA), or midwife	C7	22.8	17.1*
Saw a medical doctor, nurse practitioner, PA, or midwife[4]	C8	86.4	81.1*
Saw a mental health professional	C9	32.9	12.5*
Saw an obstetrician-gynecologist (women)	C13	32.5	49.9*
Saw other specialist, not an obstetrician-gynecologist	C14	36.5	22.0*
Timeliness of care (past 12 months)			
Delayed medical care due to an access barrier (any below)[5]	T7	29.4	21.8*
Because of costs		8.2	7.2
Provider-related reasons[5]		16.6	14.7
Did not have transportation		14.9	5.5*
Unmet need for selected types of care due to cost	T8		
Medical care		6.3	5.7
Mental health care or counseling		4.8	2.8*
Prescription drugs		12.2	9.1*
Dental care		20.0	18.3
Eyeglasses		12.5	9.9*
Receipt of appropriate care (past 12 months)			
Had more than 15 office visits	A13	17.0	8.8*
Four or more hospital emergency room (ER) visits	A15	11.6	5.7*

TABLE 27, Continued

Notes: Measures in this table are based on national samples of adults from the National Health Interview Survey (NHIS) using 2009–2011 data. Measures are for adults age 19–64, unless otherwise noted. All individuals in this table were covered by Medicaid at the time of interview. The population is limited to individuals who were insured for the entire year and includes individuals who switched coverage sources during the year. Medicaid includes a small number of persons covered by other state-sponsored health plans at the time of interview. Individuals with both Medicaid and other coverage (private, Medicare, or other public insurance) at the time of interview were excluded from the table. SSI is Supplemental Security Income. Adults with SSI are individuals with little or no income and assets whose ability to work is limited by a physical or mental disability that can be expected to result in death or last for at least 12 months. The SSI group does not capture all persons with a disability. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different insurance than that shown in the table.

* Difference from adults who received SSI is statistically significant at the 0.05 level.

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 Respondents may report encounters with a broad range of health professionals (e.g., a chiropractor or physical therapist) but the question is limited to visits in a doctor's office or clinic.

3 Respondents may not limit encounters with health professionals to visits in a doctor's office or clinic.

4 Medical doctor includes general doctor, obstetrician-gynecologist, medical specialist, and eye doctor, but excludes other health professionals (e.g., a chiropractor, podiatrist or foot doctor, or physical therapist).

5 Reasons given for delayed care classified as access barriers include cost, transportation, and provider-related reasons (respondent couldn't get an appointment, had to wait too long to see doctor, couldn't go when open, couldn't get through on phone).

Source: MACPAC analysis of three years of pooled 2009–2011 data from the National Health Interview Survey (NHIS).

MACStats Appendix

MACStats Appendix

Five new tables (Tables 23–27) presenting measures of access to care have been added to the March 2014 edition of MACStats. Measures reflect the conceptual framework for access to care that MACPAC first presented in its March 2011 report to Congress, which stresses timely receipt of care in an appropriate setting.[1] Each measure in Tables 23–27 is assigned a measure number that corresponds to a detailed description in the table (MACStats Appendix Table) contained in this appendix.

Access Domains. A total of 54 measures were selected to represent 5 access domains: provider availability, connection to the health care system, contact with health care professionals, timeliness of care, and receipt of appropriate care.

Populations. Table 23 presents data on provider availability for Medicaid/CHIP beneficiaries. Tables 24 and 26 present data for children and adults under age 65, respectively, and compare access measures for these individuals based on insurance status. Table 25 presents data on children with special health care needs (CSHCN) and compares access measures for these children based on insurance status. Table 27 presents data for adult Medicaid beneficiaries under age 65 and compares access measures for these individuals based on receipt of Supplemental Security Income (SSI). The SSI population is comprised of individuals with little or no income and assets whose ability to work is limited by a physical or mental disability that can be expected to result in death or last for at least 12 months. Although this definition does not capture all individuals with disabilities, receipt of SSI is used as a proxy to identify individuals with a diverse range of severe disabilities and complex needs.

Data Sources. Measures are drawn from four federal surveys with the broadest available scope of access measures. The surveys and years of data presented in this report are:

- National Ambulatory Medical Care Survey-National Electronic Health Records Survey (2012 NAMCS-NEHRS);[2]
- National Health Interview Survey (2012 NHIS, and pooled 2009–2011 NHIS data);[3]
- National Survey of Children's Health (2011–2012 NSCH);[4] and
- National Survey of Children with Special Health Care Needs (2009–2010 NS-CSHCN).[5]

Measurement Approach. All measures represent national estimates. The data are drawn from surveys that apply different sampling methods, are collected from different time periods, and have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared.

Limitations. Interpretation of measures should consider the limitations of survey data. Particular weaknesses associated with household survey data include:

- Survey data are based on a respondent's recall of events, which tend to omit some health care encounters documented by other sources such as medical records or administrative data.

- Parents reporting experiences for their children may feel pressure to provide answers that are socially desirable rather than factually accurate.
- Survey data are based on subjective perceptions that might not align with objective criteria (for example, individuals may not be aware of services they or their children need).

Moreover, interpretation of measures should consider the definition of each population and its characteristics:

- Responses about recent experiences with access to care and service use are based on the previous 12 months, during which some individuals had a different source of coverage than that shown in the table.
- Comparison of measures are unadjusted for differences between populations in age, health, income, ethnicity, race, family and household characteristics known to explain much but not all differences in access and use observed between individuals with different insurance experience.[6]
- Finally, measures might be interpreted differently based on the needs of each population. For example, people with severe disabilities need more help with transportation than other individuals, so one might expect that Medicaid beneficiaries receiving SSI would report more problems getting timely care because they did not have transportation.

Endnotes

[1] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP,* March 2011 (Washington, DC: MACPAC, 2011). http://www.macpac.gov/reports.

[2] National Center for Health Statistics, *Ambulatory health care data* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/ahcd/new_ahcd.htm.

[3] National Center for Health Statistics, *National Health Interview Survey: About the National Health Interview Survey* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[4] National Center for Health Statistics, *State and Local Area Telephone Integrated Survey: 2011–2012 National Survey of Children's Health quick facts* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/slaits/nsch.htm.

[5] National Center for Health Statistics, *State and Local Area Telephone Integrated Survey: 2009–2010 National Survey of Children with Special Health Care Needs quick facts and additions* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/slaits/cshcn.htm.

[6] Kenney, G.M., and Coyer, C., *National findings on access to health care and service use for children enrolled in Medicaid or CHIP* (MACPAC Contractor Report No. 1) (Washington, DC: MACPAC, 2012). http://www.macpac.gov/publications; Long, S.K., Stockley, K., Grimm, E., and C. Coyer. *National findings on access to health care and service use for non-elderly adults enrolled in Medicaid* (MACPAC Contractor Report No.2) (Washington, DC: MACPAC, 2012). http://www.macpac.gov/publications.

MACStats APPENDIX TABLE. Index of Access Measures in March 2014 MACStats Tables 23–27

Provider Availability

Measures	Population Subgroups	Data Source	Rationale for Measure Selection
P1. Primary care physician acceptance of new patients by source of payment Percentage of office-based physicians who reported currently accepting new patients into their practice with a type of payment of Medicaid/CHIP, Medicare, and private insurance, respectively.	Pediatricians and other primary care physicians	NAMCS-NEHRS 2012	This measure is one method of identifying physicians participating in Medicaid or CHIP. Change in the proportion accepting new Medicaid/CHIP patients could indicate a change in Medicaid workforce capacity.
P2. Percentage of the primary care physician's patient care revenue that comes from Medicaid/CHIP This measure shows the distribution of responses for Medicaid/CHIP by office-based physicians to the question: "Roughly, what percent of your patient care revenue at the reporting location comes from the following: Medicare? Medicaid/CHIP? Private insurance? All other sources?"	Pediatricians and other primary care physicians	NAMCS-NEHRS 2012	Because many physicians see only a small number of Medicaid or CHIP patients, this alternative measure of physician participation in Medicaid/CHIP is based on the amount of revenue they receive from Medicaid/CHIP. A change in this revenue distribution could indicate a change in Medicaid/CHIP workforce capacity.

Connection to the Health Care System — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
S1. Has a usual source of care when sick or needs advice Percentage of children whose parents report that child had a usual place to go when sick or needs health advice (not the emergency department).	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Having a usual source of care is a common measure of potential access to health care and represents the interim step between provider availability and utilization with potential for timely access.
S2. Had same usual source of medical care 12 months ago Percentage of children whose parents report that child had the same usual place of care 12 months ago. Denominator is all children.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	The foundation of a medical home is having an ongoing source of care. Having an ongoing source of care is Objective AHS-5.2 of Healthy People 2020 (HP2020). The HP2020 target is 100 percent of all children ages 17 and under.[1]
S3. Has a personal doctor or nurse Percentage of children whose parents reported having one or more persons they think of as the child's personal doctor or nurse.	Children and CSHCN[2] with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure is a higher bar for potential access than having a usual source of care. Having a personal doctor or nurse is one of the criteria for receiving care in a medical home. See measure A4.
S4. Access barrier is reason for having no usual source of care Percentage of children whose parents reported child had no usual source of medical care for reasons: too expensive, no insurance, or cost; doesn't know where to go; previous doctor not available/moved; or speaks a different language.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	When children have no usual source of care, primary and preventive care may be missed. Measure is limited to reasons for having no usual source of care that can be affected by health plan supports or other program features. This percentage is expected to be small, but reflects a gap in outreach for children enrolled the full year.
S5. Had trouble finding a doctor Percentage of children whose parents reported one of three barriers during the past 12 months: trouble finding general doctor/provider who would see them; doctor's office/clinic would not accept child as new patient; doctor's office/clinic did not accept child's health care coverage.	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	This is an alternative measure for barriers to access. Problems finding a doctor can be affected by provider behavior, plan recruitment of providers, payment, and other factors.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Connection to the Health Care System — Children, Continued

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
S6. Had usual source of care barrier or trouble finding a doctor Composite of children facing barriers in S4 or S5.	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	This measure captures the extent to which children experience barriers to connecting to the health system across measures.
S7. Receipt of effective care coordination[3] Children were classified as needing care coordination if the child received two or more services or the parent reported they needed help coordinating care.[3] The criteria for "received all care coordination needed" were that the family has some type of help with care coordination and was very satisfied with doctors' communication with other health care providers, school or other programs, if those services were needed. Otherwise children were classified as "did not receive all care coordination needed."	Children and CSHCN with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	Effective care coordination is one component of the medical home summary measure reported as A4. CSHCN often require care coordination among multiple providers. Lack of coordination may result in duplication of services and missed opportunities for better care.
S8. Family had one or more unmet needs for support services Percentage of children whose parents reported that their family needed one or more family supports (respite care, genetic counseling, or family mental health care or counseling) but did not receive them.	CSHCN with Medicaid/CHIP, children with private insurance, uninsured children	NS-CSHCN 2009–2010	These three specific family support services are services a family member of CSHCN might need because of the child's medical, behavioral, or other conditions.

Connection to the Health Care System — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
S9. Has a usual source of care when sick or needs advice Percentage of adults who reported currently having a place they usually go when they are sick or need advice about their health (not the emergency department).	Adults with Medicaid, private insurance, uninsured; Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Having a usual source of care is a common measure of potential access to health care and represents the interim step between provider availability and utilization with potential for timely access.
S10. Had same usual source of medical care 12 months ago Percentage of adults who reported having the same usual place of care 12 months ago.	Medicaid SSI-related and non-SSI-related adults	NHIS 2009–2011	A higher bar for potential access than having a usual source of care, this measure indicates an established relationship with a provider important for patient-centered, quality care.
S11. Access barrier is reason for having no usual source of care Percentage of adults who reported one of the access-related reasons for having no usual place of medical care as listed in S4.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	Problems navigating the provider network, lack of consumer information, language barriers, cost and distance all are barriers to providers with factors that can be addressed by health plan outreach, payment, and other factors.
S12. Had trouble finding a doctor Percentage of adults who reported facing one of three barriers during the past 12 months as listed in S5.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	This is an alternative measure of barriers to access. Trouble finding a doctor can be addressed by provider behavior, health plan recruitment of providers, payment, and other factors.
S13. Had usual source of care barrier or trouble finding doctor Composite of adults who reported barriers in S11 or S12.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	Captures extent to which adults experienced barriers to connecting to the health system across measures.

MACStats APPENDIX TABLE, Continued

Contact with Health Professionals — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
C1. Had at least one office visit Percentage of children whose parent reported they had seen a doctor or other health care professional at a doctor's office, clinic, or other place (not including hospitalization, ER visits, dental visits, or telephone calls) during the past 12 months.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	This measure is commonly used to ascertain a minimal threshold of contact in an office or clinic setting and allows comparison between populations and data sources.
C2. Saw a general doctor Percentage of children whose parent reported they had seen or talked to a general doctor who treats a variety of illnesses (a doctor in general practice, pediatrics, family medicine, or internal medicine) during the past 12 months.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Contact with a general doctor is commonly used to ascertain a minimal threshold of contact with a physician and allows comparison between populations.
C3. Saw a general doctor, nurse practitioner, PA, midwife, or Ob-Gyn Percentage of children whose parent reported the child had seen a general doctor, nurse practitioner, physician assistant (PA), midwife, or obstetrician-gynecologist (Ob-Gyn) during the past 12 months. Ob-Gyn encounters are limited to females age 15–18.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	This measure contributes to the interpretation of C2 by including mid-level clinicians and obstetrician-gynecologists. C3 more accurately gauges primary care contact that Medicaid enrollees may have at community clinics and through reproductive health care for adolescents.
C4. Received at least one preventive dental visit Percentage of children whose parent reported that child had seen a dentist for preventive care, such as check-ups and dental cleanings, during the past 12 months.	Children and CSHCN with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure monitors contact with the oral health care system and also is a measure of receipt of appropriate care. This question is not asked of children in the NHIS.
C5. Received care from a specialist doctor Percentage of CSHCN whose parent reported that child received care from a specialist doctor during the past 12 months.	CSHCN with Medicaid/CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	Specialists can play a critical role in the care of CSHCN.

Contact with Health Professionals — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
C6. Had at least one office visit Percentage of adults who reported seeing a doctor or other health care professional at a doctor's office, clinic, or other place (not including hospitalization, ER visits, dental visits, or telephone calls) during the past 12 months.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure is commonly used to ascertain a minimal threshold of contact in an office or clinic setting and allows comparison between populations and data sources. Survey respondents may recall having an office visit but not know or recall which type of professional they saw.
C7. Saw a nurse practitioner (NP), physician assistant (PA), or midwife Percentage of adults who reported seeing a nurse practitioner, physician assistant, or midwife in any setting during the past 12 months.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	Mid-level clinicians are expected to play a role in expanding access to health care for Medicaid enrollees, yet little is known about the degree to which adults encounter these clinicians.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Contact with Health Professionals — Adults, Continued

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
C8. Saw a medical doctor, nurse practitioner, PA, or midwife Percentage of adults who reported seeing or talking to any of these selected practitioners during the past 12 months: medical doctor, nurse practitioner, physician assistant (PA), midwife, and includes obstetrician-gynecologist, specialist, or eye doctor. For Medicaid adults with and without SSI, obstetrician-gynecologists and other specialists are presented separately in C13 and C14.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure emphasizes contact with a medical doctor or advanced practice clinician in any setting. Counting mid-level clinicians may increase contact levels observed in shortage areas.
C9. Saw a mental health professional (individuals with SMI)[4] Percentage of adults with serious mental illness (SMI) who reported seeing or talking to a mental health professional (psychiatrist, psychologist, psychiatric nurse, or clinical social worker) during the past 12 months.	Adults with Medicaid, private insurance, and uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure monitors contact with the mental health system. The denominator for this measure is based partly on active symptoms and will miss some adults who no longer have symptoms because they are receiving successful treatment.
C10. Saw a dental professional Percentage of adults who reported at least one visit to a dentist, dental specialist, or dental hygienist during the past 12 months.	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	This measure monitors contact with the oral health care system.
C11. Saw any health professional, excluding dental Percentage of adults who reported at least one visit in C8 or reported seeing a mental health professional (not limited to just those with SMI as in C9). The measure also includes encounters with health professionals not captured elsewhere (e.g. chiropractor, podiatrist or foot doctor, or physical therapist).	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Expands C8 to include mental health professionals, a major source of care for adults, and other health professionals to provide a global measure of contact. This percentage may not align with reported office visits in C6 due to differences in question wording, respondent interpretation, and recall.
C12. Saw any health professional, including dental Composite measure of adults with at least one visit in C11 or C10, including visits to a dental professional.	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Much of the difference in contact between Medicaid and private patients is due to dental visits, so the summary measure is reported with and without visits to dental professionals in C12 and C11, respectively. Dental services are an optional Medicaid benefit.
C13. Saw an obstetrician-gynecologist Percentage of Medicaid adults who reported seeing or talking with an obstetrician-gynecologist during the past 12 months. Limited to women.	Medicaid adults with and without SSI	NHIS 2012	This measure is a subset of C8 that highlights specialists, who can play a critical role in the care of individuals with disabilities.
C14. Saw other specialist, not an obstetrician-gynecologist Percentage of Medicaid adults who reported seeing or talking with a specialist other than an obstetrician-gynecologist during the past 12 months.	Medicaid adults with and without SSI	NHIS 2012	This measure is a subset of C8 that highlights specialists, who can play a critical role in the care of individuals with disabilities.

MACStats APPENDIX TABLE, Continued

Timeliness of Care — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
T1. Delayed medical care due to an access barrier Percentage of all children whose parents reported the child needed health care during the past 12 months that was delayed due to a cost barrier, transportation, or provider-related reasons (couldn't get appointment, had to wait too long to see doctor, couldn't go when open or get through on phone, and speaks a different language). Each barrier is separately reported.	Children with Medicaid/ CHIP, private insurance, and uninsured	NHIS 2012	Delayed care is a common measure, but this measure limits the definition to delays for reasons that could reasonably be influenced by providers, health plans, and program services and supports. Delays for reasons that primarily reflect parents' motivation (i.e.,"put it off") are excluded.
T2. Selected types of care were delayed or not received Percentage of all children whose parents reported child needed but delayed or did not receive a service during the past 12 months. Medical care, mental health care, dental care, and vision are separately reported.	Children with Medicaid/ CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure provides information on specific services for which parents are reporting delayed or unmet needs. The measure does not capture reasons for delay or unmet need. Question wording is not comparable to NHIS measure of delayed care (T1).
T3. Unmet need for selected types of care due to cost Percentage of all children whose parents reported a time in the past 12 months when their child needed a service but didn't get it because they couldn't afford it: medical care, mental health care or counseling, dental care, prescription drugs, eyeglasses. Services are separately reported.	Children with Medicaid/ CHIP, private insurance, and uninsured	NHIS 2012	These measures track access to service domains in the mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit for children, but not unmet need due to barriers other than cost that can impact Medicaid disproportionately. Other barriers are presumably captured in measure T2.
T4. Had a problem getting referrals (children needing referrals)[3] Percentage of children whose parents reported that getting referrals was a big or small problem. The denominator of this measure is children whose parents reported that the child needed a referral to see a doctor or receive services during the past 12 months.	Children with Medicaid/ CHIP, private insurance, and uninsured	NSCH 2011–2012	Difficulty getting referrals from primary care providers or health plans can lead to delays obtaining timely diagnosis and treatment critical to child development.
T5. Unmet need for selected types of care Percentage of children whose parents reported needing the service and did not receive all the care needed or received no care. The six types of care are: specialist; prescription drugs; mental health care; non-preventive dental; physical, occupational or speech therapy; vision care or eyeglasses.	CSHCN with Medicaid/ CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	The NS-CSHCN provides measures of unmet need for a wide array of services that are needed by children with severe mobility, cognitive, and sensory disabilities. All of these services fall under the EPSDT benefit. Unmet need for many of these services is not collected in the NHIS or the NSCH.
T6. Had 2 or more unmet needs for 14 specific services In addition to types of care in T5, this measure captures unmet need for dental, mobility aids or devices, communication aids or devices, home health care, substance abuse treatment or counseling, durable medical equipment, genetic counseling, and respite care.	CSHCN with Medicaid/ CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	By measuring unmet need for particular services, this measure helps determine if unmet need is a significant problem for a small proportion of CSHCN with particular service needs.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Timeliness of Care — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
T7. Delayed medical care due to an access barrier Percentage of adults who reported they needed medical care during the past 12 months and that it was delayed because of selected reasons as listed in T1.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Medicaid beneficiaries primarily report barriers to care other than cost. Reasons for these delays are segmented to help identify where in the health care system the barriers exist.
T8. Unmet need for selected types of care due to cost Percentage of adults who reported a time in the past 12 months when they needed a type of care but didn't get it because they couldn't afford it. For all adults, this measure reports on unmet need for medical care and mental health care or counseling. Other services reported for Medicaid adults with and without SSI are dental care, prescription drugs, and eyeglasses.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	These measures track access to two mandatory service groups for adult beneficiaries, but do not capture barriers to service unrelated to cost.
T9. Did not take medication as prescribed to save money Percentage of adults who reported one of the following in past 12 months: unmet need for prescription medicines because of cost; skipped medication doses to save money; took less medicine to save money; or delayed filling a prescription to save money.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	This measure expands the well-known definition of "unmet need for prescriptions due to cost" to include individuals who took specific actions to save money. Some actions, such as "asked for a generic drug" were not included.
T10. Reported any barriers to care, delayed care, or unmet need Composite of adults who reported any barriers in measures in measure S13 (had usual source of care barrier or trouble finding doctor), T7–T9 (delayed care due to an access barrier, unmet need due to cost, reported not taking medication as prescribed to save money).	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Provides a gauge for the overall reach and potential impact of all barriers to timely care in the population. Unmet need for dental care and eyeglasses are excluded due to the very limited Medicaid benefit available.

MACStats APPENDIX TABLE, Continued

Receipt of Appropriate Care — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
A1. Doctors and other providers spend enough time with child Percentage of children whose parents reported doctors or other health care providers usually or always spend enough time with the child.	Children with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	This measure is one of the criteria for receiving care in a medical home.
A2. Received at least one preventive medical visit Percentage of children whose parents reported that child saw a doctor, nurse, or other provider for preventive medical care such as a physical exam or well-child checkup during the past 12 months. Presented for selected age ranges.	Children and CSHCN with Medicaid/CHIP, private insurance, uninsured	NHIS 2012 NSCH 2011–2012	The EPSDT benefit in Medicaid states that children should receive one or more preventive or well-child visits, dependent on the age group. This measure sets a low bar well below the number of preventive visits recommended for 0–3 year olds.
A3. Received selected EPSDT services (children needing services) Among children whose parents reported that their child needed a specific type of EPSDT service, the percentage who received it: mental health services (children age 2–17 with a problem needing treatment), therapy services (children with autism or developmental delay), and vision screening (age 2–17).	Children with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	These measures capture receipt of appropriate care for common EPSDT services. The denominator for each measure is limited to children needing the service based on parent-reported condition and/or eligible for screening based on age.
A4. Received coordinated, ongoing, comprehensive care within a medical home[3, 5] Percentage of children who have met all criteria for receiving care in a medical home based on a series of questions.	CSHCN with Medicaid/CHIP, private insurance, uninsured	NS-CSHCN 2009–2010	This measure reflects a core outcome chosen by the Maternal and Child Health Bureau for the community-based system of services required for all CSHCN under Title V of the Social Security Act.[6] Increasing the proportion of CSHCN receiving care in a medical home is an HP2020 objective. The HP2020 target is 51.8 percent.[7]
A5. Had an ER visit in past 12 months and most recent ER visit was related to a serious health problem or an access barrier Percentage of children whose parents reported the child had an ER visit in the past 12 months, and the most recent ER visit is related to either serious health problem[8] (e.g., admitted to hospital) or an access barrier, excluding serious health problems.	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	ER visits due to access barriers (e.g. doctor's office wasn't open) may reflect poor access to primary care or a need for more education about the importance of using primary care providers when possible, rather than the ER.
A6. Had 2 or more ER visits during the past 12 months Percentage of children whose parents reported that the child went to a hospital ER 2 or more times in past 12 months.	Children and CSHCN with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012 NS-CSHCN 2009–2010	High use of ER services may signify complex health needs, poor access to primary care, or a need for parent education.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Receipt of Appropriate Care — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
A7. Received any preventive visit or counseling Percentage of adult beneficiaries who reported receipt of prevention services, including any service in measures A8–A12, talking with a health professional about diet, having blood pressure checked by health professional, or screening for breast cancer. Includes individuals not in a high-risk group or of a recommended age who received the preventive service.	Adults age 19–49, 50–64, pregnant or have chronic condition with Medicaid, private insurance, and uninsured	NHIS 2012	This measure is a global indicator that adults received some aspect of recommended prevention services. Physicians and patients may prioritize preventive services based on a patient's risk of complications or a patient's health goals and care preferences.
A8. Had cholesterol checked by health professional (at-risk groups) Percentage of adults at high-risk for coronary heart disease who reported having their blood cholesterol checked by a doctor, nurse, or other professional during the past 12 months.	Selected at-risk groups with Medicaid, private insurance, and uninsured	NHIS 2012	The U.S. Preventive Services Task Force (USPSTF) recommends routine screening for men ages 35 and over for lipid disorders, and others at increased risk of coronary heart disease.[9] The HP2020 target for the proportion of adults who have their blood cholesterol checked within preceding 5 years is 82.1 percent.[10]
A9. Had an influenza vaccine or flu shot Percentage of adults who reported having an influenza shot in the past 12 months is presented for all individuals and for three vaccination priority groups whose percentages should be higher as the result of flu shot campaigns.	Selected high-risk groups with Medicaid, private insurance, and uninsured	NHIS 2012	The Centers for Disease Control and Prevention (CDC) recommends annual vaccination of persons at risk of severe complications from influenza. Priority is given to these high-risk groups when supply is short. Vaccination rates of wider populations will fluctuate with supply.[11]
A10. Had professional counseling about smoking (current smokers) Percentage of currently smoking adults who reported that a doctor or other health professional talked to them about their smoking during the past 12 months.	Current smokers with Medicaid, private insurance, and uninsured	NHIS 2012	This measure captures preventive counseling for smoking for a targeted population but will miss persons who reported using tobacco products other than cigarettes or who quit during the past 12 months, possibly as the result of counseling.
A11. Had any test for colorectal cancer (CRC) Percentage of adults who reported having any test done for colon cancer during the past 12 months using a single item. Limited to individuals in the recommended age group 50–64.	Men and women age 50 to 64 with Medicaid, private insurance, and uninsured	NHIS 2012	The HP2020 target for the proportion of adults age 50 to 75 receiving regular CRC screening is 70.5 percent.[12] Because the periodicity of screening recommended by USPSTF has been increased to 5 years,[13] the proportion in annual surveys will be lower than the HP2020 target.
A12. Had Pap smear or test for cervical cancer (women age 21 to 60)[14] Percentage of women who reported having a Pap smear or Pap test during the past 12 months. This measure omits women over age 60 who are least likely to be eligible for screening.	Women age 21–60 with Medicaid, private insurance, and uninsured	NHIS 2012	Because screening is recommended every 3 or 5 years, the proportion in annual surveys will be lower than the HP2020 target (93 percent for women age 21 to 64).[15]
A13. Had more than 15 office visits Percentage of adults who reported more than 15 office visits as defined in C6.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Individuals with over 15 office visits may have very high needs or high use may be a sign of opportunities for improved clinical management.
A14. Had an ER visit in past 12 months and most recent ER visit was related to a serious health problem or an access barrier[8] Percentage of adults as defined in A5.	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	See A5. If physicians are unable to meet demand from the new Medicaid expansion population, ER use related to access problems could increase.
A15. Reported 4 or more ER visits Percentage of adults who reported having gone to a hospital ER 4 or more times in the past 12 months.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	High use of the ER relative to others may signify complex health needs, poor access to primary care, or a need for patient education.

MACStats APPENDIX TABLE, Continued

Notes: NAMCS-NEHRS is the 2012 National Ambulatory Medical Care Survey-National Electronic Health Records Survey. NSCH is the National Survey of Children's Health. NHIS is the National Health Interview Survey. NS-CSHCN is the National Survey of Children with Special Health Care Needs.

HP2020 is Healthy People 2020. SSI is Supplemental Security Income. EPSDT is the Medicaid early and periodic screening, diagnostic, and treatment benefit. USPSTF is the U.S. Preventive Services Task Force. CDC is the Centers for Disease Control and Prevention. ER is hospital emergency room or emergency department.

CSHCN is children with special health care needs.

Recommendations by the USPSTF are based on a rigorous review of existing peer-reviewed evidence; see U.S. Preventive Services Task Force (USPSTF), *About the USPSTF* (Washington, DC: USPSTF). http://www.uspreventiveservicestaskforce.org/about.htm.

Surveys from which the measures are drawn use different methods to sample individuals, and data are collected from different time periods. In addition, the surveys have different questions about health insurance and different reference periods. As a result, the population sampled and subsequently classified as Medicaid, privately insured, or uninsured differs based on the data source. See additional notes in MACStats Tables 23–27 for detailed definitions of populations and insurance coverage.

1 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=AHS-5.2.

2 CSHCN is children with special health care needs. CSHCN are identified in the NSCH and NS-CSHCN using a 5-item, parent-reported tool that identifies children across the range and diversity of childhood chronic conditions and special needs who currently experience 1 or more of 5 common health consequences due to a physical, mental, behavioral, or other type of health condition lasting or expected to last at least 12 months. For more on how children are categorized as CSHCN, see Child and Adolescent Health Measurement Initiative (CAHMI), *Fast facts: Children with special health care needs screener* (Portland, OR: CAHMI, 2007). http://childhealthdata.org/docs/cshcn/cshcn-screener-cahmi-quickguide-pdf.pdf.

3 Measures S7, T4, and A4 are child quality measures developed by the Maternal and Child Health Bureau, Health Resources and Services Administration through the Child & Adolescent Health Measurement Initiative (CAHMI). For details on these measure definitions, see Data Resource Center for Child & Adolescent Health (DRC), CAHMI, *Indicator 4.9d: Medical home component: Effective care coordination.* http://www.nschdata.org/browse/survey/results?q=2512&r=1 [for S7]; DRC, CAMHI, *Problems getting referrals, only children who needed referrals.* http://www.nschdata.org/browse/survey/results?q=2549&r=1 [for T4]; DRC, CAHMI, *Indicator 4.8: Children who receive coordinated, ongoing, comprehensive care within a medical home.* http://www.nschdata.org/browse/survey/results?q=2507&r=1 [for A4].

4 Individuals were defined as having serious mental illness if they reported an activity limitation due to depression, anxiety, or emotional problem; feelings interfered with life a lot in the past 30 days; or received a score of 13 or over (out of 24) on the Kessler Psychological Distress Scale (K6) in the NHIS. See R.C. Kessler, P.R. Barker, L.J. Colpe, et al., Screening for serious mental illness in the general population, *Archives of General Psychiatry* 60, no. 2 (2003): 184–189.

5 NS-CSHCN survey questions from which this measure is constructed are whether the child has a personal doctor or nurse, has a usual source of sick and well-child care, or has no problems obtaining needed referrals; family is satisfied with doctors' communication, or gets help coordinating the child's care if needed; doctor spends enough time with the child, listens carefully to the parent, is sensitive to the family's customs, or provides enough information; and the parent feels like a partner in care.

6 Maternal and Child Health Bureau, *The national survey of children with special health care needs chartbook 2009–2010* (Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services, 2013). http://mchb.hrsa.gov/cshcn0910/.

7 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=MICH-30.2.

8 The ER visit is classified as a serious health problem if it resulted in a hospital admission, a health provider advised the person to go, the problem was too serious for a doctor's office, or they arrived by ambulance. The ER visit is classified as an access-related problem if it happened either at night or on the weekend, or when their doctor's office or clinic was not open, and excludes individuals reporting a serious health problem.

9 M. Helfand, and S. Carson, Screening for lipid disorders in adults: Selective update of 2001 U.S. Preventive Services Task Force review, *Evidence Syntheses* 49 (Rockville, MD: Agency for Healthcare Research and Quality, 2008). http://www.ncbi.nlm.nih.gov/books/NBK33500/.

10 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=HDS-6.

11 Over time and geographically, vaccination rates fluctuate based on supply of the vaccine and flu activity, reducing the utility of monitoring changes for the entire population. When vaccine supply is limited, health professionals are instructed to focus vaccination efforts on older adults and people with conditions that place them at high risk of developing complications from influenza. See L.A. Krosskopf, et al., Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices–United States, 2013–2014, *Morbidity and Mortality Weekly Review* 62, no. RR07 (2013): 1–43. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm?s_cid=rr6207a1_w#PersonsAtRiskMedicalComplicationsAttributableSevereInfluenza.

12 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=C-16.

13 The USPSTF recommends screening adults beginning at age 50 and continuing until age 75 for colorectal cancer using fecal occult blood testing every year, sigmoidoscopy in the past 5 years and blood test in the past 3 years, or colonoscopy in the past 10 years. See U.S. Preventive Services Task Force (USPSTF), *USPSTF A and B Recommendations* (Washington, DC: USPSTF). http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

14 The USPSTF recommends against cervical cancer screening for women who have had a hysterectomy with removal of the cervix and who do not have a history of cervical abnormalities or cancer, but the 2012 NHIS removed the survey item capturing this history. Women over age 60 are not included in measure A12 to minimize overcounting of older women not eligible for screening. The USPSTF recommends screening for cervical cancer in women age 21 to 65 with cytology (Pap smear) every 3 years, and provides an alternative recommendation of screening every 5 years for women age 30 to 65 who want to lengthen the screening interval. See U.S. Preventive Services Task Force (USPSTF), *USPSTF A and B Recommendations* (Washington, DC: USPSTF). http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

15 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=C-15.

Source: MACPAC analysis.

CHAPTER 4

ACA Eligibility Changes: Program Integrity Issues

Key Points

ACA Eligibility Changes: Program Integrity Issues

- The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) mandates many changes to eligibility processes and policies for Medicaid and the State Children's Health Insurance Program (CHIP). While the ACA changes simplify many aspects of these processes, the overall system remains complex to administer.
- The ACA requires states to maximize automation of Medicaid and CHIP applications and gives states broader access to third-party sources of data that will be used to verify eligibility. These changes are intended to help states make eligibility determinations more accurately, more quickly, and at less expense. However, states and the Centers for Medicare & Medicaid Services (CMS) must also ensure that they continue to balance the objectives of access and accuracy.
- CMS has not yet issued updated program integrity rules and procedures that are aligned with the new eligibility rules and that account for the role exchanges will play in determining eligibility. Some policymakers have raised concerns about this lack of guidance, given the potential consequences of eligibility errors.
- Currently, CMS has two specific strategies to promote the accuracy of eligibility decisions made under new rules and to supplement existing safeguards.
    - All states have developed a verification plan that details how the state will implement and comply with new eligibility regulations. These standardized verification plans will serve as the basis for eligibility quality control audits.
    - All states will participate in a pilot program that will generate timely feedback about the accuracy of determinations based on new eligibility rules. States will also identify process improvements where problems are found.
- MACPAC will continue to monitor aspects of ACA implementation that may affect program integrity. This will include examining new approaches to improve the efficiency and effectiveness of eligibility quality control programs and to promote overall program integrity.

CHAPTER 4

ACA Eligibility Changes: Program Integrity Issues

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) mandates many changes to Medicaid and the State Children's Health Insurance Program (CHIP) eligibility processes and policies to reduce complexity and effort on behalf of enrollees and program administrators. These changes affect all states, whether or not they have adopted the Medicaid expansion, and apply to both expansion and existing eligibility groups for children, parents, pregnant women, and non-disabled adults under age 65. At the same time, states must continue to operate legacy systems for determining eligibility for certain other groups, including persons eligible on the basis of age or disability. Thus, while the ACA changes simplify many aspects of the application and renewal process, the overall system remains complex to administer.

These changes are necessary given the increased pressure that Medicaid expansion and enrollment outreach efforts will put on eligibility processes and the desire to align Medicaid with other subsidy programs. In addition, the ACA makes available new resources, such as the federal data services hub, to support eligibility verification. These changes are intended to simplify and streamline enrollment and redetermination processes, increase the share of eligible persons who are able to successfully enroll and retain coverage, and reduce errors associated with administering complex eligibility rules. However, implementing them requires states to invest in additional systems, develop new policies and procedures, and retrain staff. New approaches are being tested to measure the impact these significant policy and procedural changes may have on program integrity.

From the perspective of program integrity, two significant changes include replacing complex income-counting and disregard rules with the streamlined modified adjusted gross income (MAGI) standard, and moving away from in-person and documentation-heavy processes towards online applications and automated third-party data checks. These changes shift much of the burden of demonstrating eligibility from individuals to states and are intended to reduce the number of eligibility errors, including both false

positives (determining a person eligible even though he or she does not meet program standards) and false negatives (denying a person eligibility even though he or she does meet program standards).

The consequences of eligibility errors can be significant: individuals can be enrolled in the wrong program, receive the wrong benefits, be assigned incorrect cost sharing, or be denied enrollment altogether. Errors can also result in states and the federal government making payments for benefits to which people are not entitled or making payments in the wrong amount. Inappropriate denials can result in increases in uncompensated care, avoidance of necessary care, or greater use of state-funded social services. Finally, program assignment errors can have consequences for federal financing, as federal contributions differ for persons who qualify for advanced payment of premium tax credits for qualified health plans, persons who are newly eligible for Medicaid, and persons who qualify for Medicaid under traditional categories.

In rulemaking to implement the ACA Medicaid eligibility provisions, the Centers for Medicare & Medicaid Services (CMS) emphasized the importance of accuracy. CMS stated that program integrity rules and procedures will be aligned with the new eligibility rules and will account for the role exchanges will play in determining eligibility, but deferred additional guidance on these issues (CMS 2012). Some state and federal policymakers have raised concerns about the lack of guidance or clear standards for eligibility program integrity, given the potential consequences of eligibility errors. In addition, a substantial number of eligibility determinations may be made by the federally facilitated exchange, as 11 states have delegated the authority to make Medicaid and CHIP eligibility determinations to the exchange. CMS is now pilot testing processes to measure the errors that occur under new eligibility policies and to identify potential opportunities to reduce errors or improve the measurement process. Results from these pilots will help inform future guidance and rulemaking.

This chapter discusses ACA-related eligibility policy and process changes and considers the impact of these changes on traditional eligibility quality control mechanisms and the potential for eligibility-related errors and fraud. Over the coming year, the Commission will continue its review of Medicaid and CHIP program integrity activities and potential areas for program improvement, focusing on areas where there is overlap and redundancy or where additional guidance would support overall program integrity. As part of this effort, MACPAC will monitor additional eligibility program integrity guidance as it is released by CMS, as well as the initial and ongoing findings from eligibility reviews conducted by all states. This information will be used to further discussion of key policy questions.

Eligibility Policy and Process Issues Post-MAGI

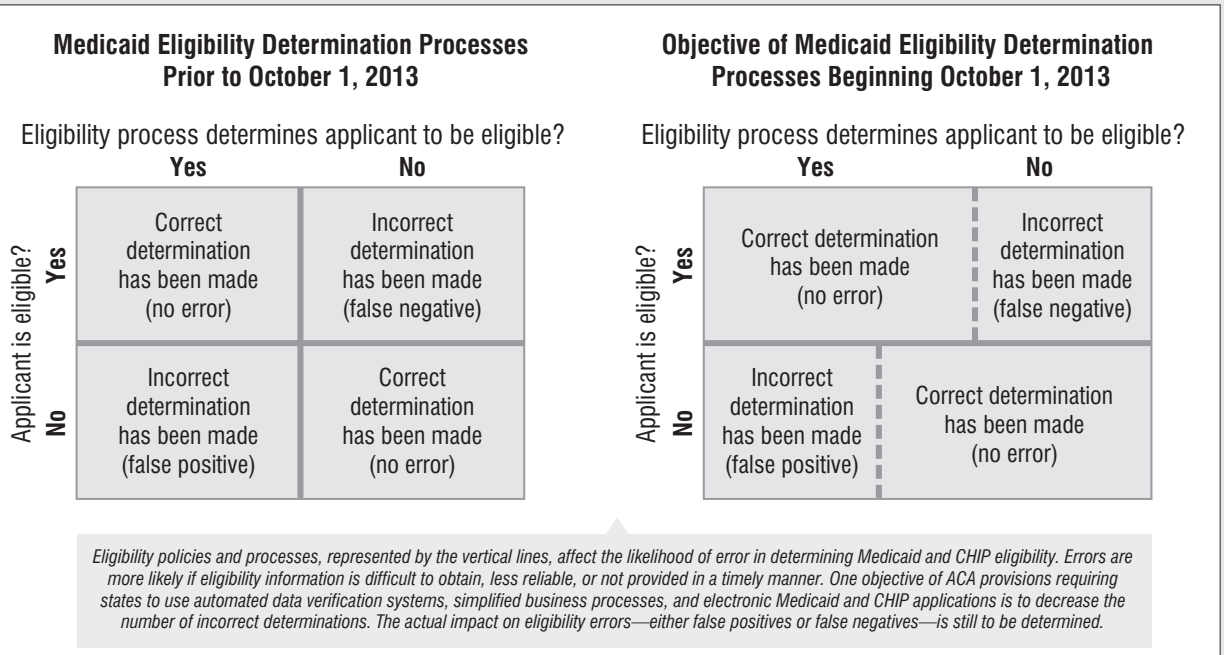
All persons enrolled in Medicaid and CHIP must be initially determined eligible (that is, the state must determine that applicants meet the relevant income and non-financial criteria, such as age, citizenship, disability, and pregnancy) and then have their eligibility periodically redetermined. To minimize errors, states have historically used a variety of methods to validate eligibility information, including in-person interviews, review of paper documentation supplied by applicants, and third-party database checks.

In the late 1990s, out of concern that some eligibility validation processes were creating enrollment delays or resulting in denial of coverage when applicants failed to complete the eligibility process, CMS began encouraging states to accept applicant self-attestation or use third-party sources of information to validate certain documented eligibility criteria, other than citizenship and immigration status (CMS 1998). Many states adopted eligibility simplification strategies for certain types of applicants or specific situations (e.g., paper documentation was required for

the initial application, but the state would use third-party data sources to redetermine eligibility after one year). These changes simplified the eligibility process for applicants and, in some cases, helped decrease administrative burden on states and streamline some state functions. The Congress later codified some of these strategies; for example, in 2009, the Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) allowing states to adopt the Express Lane Eligibility option, which allowed them to use findings from another public agency to assist in determining that a child was eligible for Medicaid or CHIP.

The ACA, enacted in 2010, mandated many additional changes to Medicaid and CHIP eligibility processes and policies to further simplify enrollment and increase the share of eligible persons able to successfully enroll and obtain coverage, as well as to align with the processes and policies used to determine exchange coverage. The ACA requires states to maximize automation and real-time adjudication of Medicaid and CHIP applications through the use of electronic verification policies, simplified business processes, and the use of multiple application channels, including online applications. The ACA also gave states broader access to third-party sources of data and required states to use these sources to verify eligibility whenever possible for most non-disabled adults under age 65 and children, instead of requiring applicants to document their eligibility. When these changes are fully in place, determinations of both eligibility and ineligibility should be made more accurately, more quickly, and at less expense. However, the widespread adoption of new processes to support automation and rapid adjudication will require new strategies to ensure that they effectively balance the objectives of access and accuracy (Figure 4-1).

FIGURE 4-1. Illustrative Impact of Medicaid Eligibility Determination Process Changes on Potential for Eligibility Errors



Eligibility policies and processes, represented by the vertical lines, affect the likelihood of error in determining Medicaid and CHIP eligibility. Errors are more likely if eligibility information is difficult to obtain, less reliable, or not provided in a timely manner. One objective of ACA provisions requiring states to use automated data verification systems, simplified business processes, and electronic Medicaid and CHIP applications is to decrease the number of incorrect determinations. The actual impact on eligibility errors—either false positives or false negatives—is still to be determined.

Source: MACPAC analysis.

Self-reported information and the reasonable compatibility standard. For the first time, Medicaid and CHIP will primarily verify program eligibility through trusted electronic sources instead of paper documentation and accept applicant self-attestation of most elements of eligibility. There has been a longstanding policy allowing states to accept self-reported information in certain circumstances, but, as of January 1, 2014, states are prohibited from requiring applicants to provide documentation unless self-reported information is not reasonably compatible with the information in government databases; exceptions are citizenship and immigration status, which cannot be self-attested (42 CFR 435.945, 435.948, 435.949, 435.952, 457.380, 45 CFR 155.300).[1] States must now compare application information to data available from a number of third-party sources, which they will access via direct linkage to state-based systems or through the federal data services hub. For most eligibility factors, states must establish a reasonable compatibility standard to be used when there is an inconsistency between the information obtained from electronic data sources and the information provided by the applicant. These third-party electronic data sources are expected to provide reliable and timely information on various eligibility factors, but the actual availability of current information to support eligibility determination has not been widely tested. In addition, implementation of these changes requires significant systems changes, development of new interagency agreements, development (or purchase) of new data sources, and retraining for eligibility workers. While these changes are likely to simplify the enrollment process for applicants, the effect on program integrity is yet to be determined.

If an applicant's attestation and data are not within the state-defined threshold for compatibility (e.g., self-reported income is at 125 percent of the federal poverty level (FPL), but the federal data hub indicates that the applicant's income the prior year was at 140 percent FPL), states can only require the individual to provide additional documentation if the information cannot be obtained electronically or if establishing an additional data match would not be effective. A state can rely on an applicant's explanation for a discrepancy (e.g., recent job loss or reduction in hours) without additional documentation. CMS has instructed states that they must compare the administrative costs associated with data matching to the administrative costs related to relying on paper documentation before requesting additional documentation. States must also consider the impact on program integrity, in terms of the potential for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage (42 CFR 435.952, 42 CFR 457.380).

State Medicaid and CHIP programs have greater flexibility in this area than does the federal exchange to determine eligibility for premium subsidies for persons with incomes too high for Medicaid or CHIP. For the exchanges, the reasonable compatibility threshold has been set at 10 percent, so if an applicant's self-reported income is 10 percent less than data matches indicate, the federal exchange must request a reasonable explanation for the discrepancy from the applicant, try to verify the self-reported information using additional federal sources, or request additional documentation. State-based exchanges can determine a broader standard of reasonable compatibility or choose to limit requests for additional documentation to a statistically valid sample of applications (45 CFR 155.315).

Post-enrollment verification. To further support the goal of real-time eligibility determinations, states may use post-enrollment verification processes to validate application information. States have the option to determine a Medicaid or CHIP applicant eligible based on self-reported eligibility information, then verify as needed through matching to electronic data sources after the determination is made (42

CFR 435.952). A state can determine a threshold for reasonable compatibility and consider an applicant's attestation to be verified if the data obtained post enrollment are within the state's established threshold for compatibility. If post-enrollment data checks indicate a significant discrepancy, the state will contact the applicant to obtain additional information and then terminate benefits (with appropriate advance notice) if supporting evidence is not provided within appropriate timeframes. Like other changes to the processes for verifying application information, the impact and potential risks of these new processes require close monitoring.

Administrative renewal. New policies for periodic renewals are also intended to minimize the burden on program enrollees but should be carefully monitored to measure the impact on program integrity. The eligibility of Medicaid and CHIP enrollees must be redetermined once every 12 months. State agencies must use available information, such as third-party databases and information otherwise known to the state, to facilitate the annual redetermination process. If the state is unable to complete the renewal process based on available data, it must provide the enrollee with a pre-populated enrollment form and at least 30 days to respond with any necessary information. The state must also provide a 90-day grace period, in which an enrollee who has missed the 12-month renewal date can renew without a new application (42 CFR 435.916, 457.343, 45 CFR 155.335).

Administrative renewal has been used in the past by some states and has been shown to increase retention without raising the eligibility error rate (CMS 2013a). However, similar to the other changes described above, these procedures have not been used on a wide scale and will require the development of new systems and additional training for eligibility workers. The potential effect on program integrity has not been precisely determined.

The impact of new administrative renewal policies is also complicated by ACA-mandated changes to redetermination timeframes. Before the ACA, states were required to redetermine eligibility for Medicaid and CHIP enrollees at least once every 12 months, but many states chose to conduct renewals more frequently (on a quarterly or semiannual basis). States may no longer require midyear status reporting; redeterminations will be conducted at 12-month intervals. While Medicaid enrollees are required to report changes in circumstances that may affect continued eligibility, the elimination of midyear reporting in some states may result in some people maintaining enrollment for longer periods of time after an unreported change, as well as some people whose circumstances do not change and who maintain enrollment longer.

Coordination with exchanges. Coordination and sharing of eligibility information among Medicaid, CHIP, and the exchanges is an important component of new eligibility policy, and ensuring the accuracy of this information sharing is likewise an important aspect of eligibility program integrity efforts. The ACA establishes exchanges to purchase insurance coverage for persons without access to affordable employer-sponsored coverage. If individuals with incomes between 100 percent and 400 percent FPL obtain coverage through an exchange, they may qualify for premium tax credits. Some persons who apply for premium subsidies may have income low enough to qualify for Medicaid or CHIP in their state. For this reason, the ACA explicitly requires Medicaid and CHIP to coordinate with the exchange in each state to ensure that eligible applicants are enrolled in the appropriate program and to make coordinated decisions wherever possible.

States must share information about persons determined ineligible for Medicaid and CHIP with the exchange and accept information from the exchange to make a final determination of eligibility for Medicaid and CHIP. States can

also delegate authority for making Medicaid and CHIP eligibility determinations to the exchange; as of October 2013, 11 states (out of 34 using the federally facilitated exchange) have wholly or partially delegated the authority to make Medicaid or CHIP eligibility determinations to the federally facilitated exchange (CMS 2013b); for applicants in other states, the federally facilitated exchange assesses Medicaid or CHIP eligibility but does not make a determination. Federal rules require states to have written agreements with federal or state agencies that will determine Medicaid eligibility on behalf of the Medicaid agency, while allowing states to retain oversight responsibilities for all decisions (42 CFR 431.10, 42 CFR 431.11). CMS is testing procedures to review Medicaid and CHIP eligibility determinations made by state or federal exchanges, as described in more detail below, but the impacts of these changes on program integrity are yet to be determined.

Strategies to Support Program Integrity

The ACA does not change current law regarding enrollee fraud. Applicants are required to accurately and fully report information needed to establish eligibility and sign applications (in writing or electronically) under penalty of perjury (42 CFR 435.907). States must ensure that only eligible persons receive benefits and implement necessary verification procedures to promote program integrity (42 CFR 435.940). However, the adoption of new processes to support automation and real-time eligibility adjudication, as described above, requires additional strategies to ensure that eligibility determinations are being made correctly. CMS has implemented two strategies to support the development of appropriate methods to ensure the accuracy of eligibility decisions made under new rules. These strategies will supplement existing safeguards.

Verification plans. States now have more flexibility in establishing verification procedures for various factors of eligibility (e.g., income, residency, age, household composition). For example, states can choose to accept self-attestation of information without additional verification (if the information is reasonably compatible with other data sources) or they can choose to verify elements of eligibility after enrollment. In addition to establishing a reasonable compatibility standard, states must also determine which third-party data sources will be used at the time of application at renewal, or for post-enrollment verification.

To catalog these state choices, states must develop a verification plan and submit it to CMS, which will then assess the plan for compliance with the new eligibility regulations. In early 2013, states submitted verification plans for individuals whose eligibility is based on MAGI, using a template provided by CMS (CMS 2013c). CMS has published completed verification plans on its website and released summary information on the plans. For example, as of October 2013, 5 states had indicated that they would accept self-attestation of income at application (without further information from the individual), and 10 states indicated they would accept self-attestation of income with post-eligibility verification. Most eligibility rules for non-MAGI groups (e.g., persons who qualify for Medicaid on the basis of disability) have not changed, so CMS plans to issue guidance on verification plans for these groups at a future date. The verification plan will serve as the basis for eligibility quality control audits, as discussed below (42 CFR 435.945, 42 CFR 457.380).

Retrospective eligibility quality control programs. Given the widespread changes being implemented in Medicaid and CHIP eligibility policies and processes, CMS has temporarily replaced broad-based retrospective eligibility quality control programs with pilot programs.[2] These pilot programs are intended to provide rapid

feedback to inform improvements for fiscal year (FY) 2014 through FY 2016, but will not support program-wide estimates of eligibility errors.

To help ensure that Medicaid and CHIP eligibles are enrolled in the appropriate program and receive the benefits and cost-sharing support to which they are entitled, and to help reduce the rate of eligibility errors that cause improper payments, states conduct in-depth retrospective reviews of a sample of eligibility decisions, measuring the extent to which errors occur and identifying process mistakes for corrective action. (Note that these reviews are different from the limited post-enrollment verifications described above.) As discussed in MACPAC's June 2013 report to the Congress, states must conduct two different types of retrospective reviews of eligibility determinations: Medicaid Eligibility Quality Control (MEQC) reviews and Payment Error Rate Measurement (PERM) reviews (MACPAC 2013). The rules for these two federally required programs overlap and do not align well with each other, which creates burdens for states and the federal government. The rules have also not been aligned with the significant changes in eligibility policies and processes required by the ACA.

In recognition of the challenges states will face in implementing all of the ACA-mandated eligibility policy and process changes for Medicaid and CHIP and the need to update program integrity guidance, CMS is implementing a new 50-state pilot program strategy that will replace PERM and MEQC for federal FY 2014 through FY 2016 (CMS 2013d).[3] These pilots will be designed to provide states and CMS with timely feedback about the accuracy of determinations based on new eligibility rules and help support the development of improvements or corrections where problems are found. The initial pilot in each state will focus on MAGI-based determinations and will require all states to sample, review, and report on 200 Medicaid and CHIP cases determined eligible or denied between October 1, 2013, and March 31, 2014, and to report findings by June 2014. All states will participate each year (whether or not other components are being measured for PERM) and will conduct four pilots over the three fiscal years.

The Medicaid and CHIP eligibility review pilots will be designed to provide programmatic assessments of the performance of new processes and systems to adjudicate eligibility decisions, identify strengths and weaknesses in operations and systems that can lead to errors, and test the effectiveness of corrections and improvements. The pilots will also inform CMS' approach to rulemaking that it will undertake prior to the resumption of the PERM eligibility measurement component in 2017 (CMS 2013d). In particular, the rapid nature of the pilots may help CMS determine how to incorporate strong feedback loops that support real-time intervention into the design of the permanent Medicaid eligibility quality control program.

Policy Considerations

Over the past 20 years, states and the federal government have taken incremental steps to simplify and streamline the Medicaid eligibility determination process.[4] The changes mandated by the ACA complete the de-linking of Medicaid from public assistance programs begun in 1996 and create a new, separate system for enrolling many low-income persons in health care coverage.[5] While traditional eligibility policies and procedures required applicants to demonstrate their eligibility, the ACA-mandated changes shift much of that responsibility to the states and federal government, while providing them with new tools to automate the verification process. Implementation of these changes has required that states and the federal government redesign business operations and systems, and has created new interactions between state and federal agencies. The goals

of these changes are to simplify and streamline the enrollment and renewal processes, increase the share of eligible persons who are able to successfully enroll in and retain coverage, and reduce errors associated with administering complex eligibility rules. As these changes are implemented over the next year, it will be important for policymakers to measure the extent to which these goals are being met.

Policymakers will be interested in monitoring three aspects of the implementation that will affect program integrity. First, as responsibility for the accuracy of eligibility information shifts more to the states and to centralized systems, it will be important to monitor the extent to which these data sources and systems are able to provide sufficient, timely, and reliable information for states to make accurate eligibility determinations. In addition, as the ACA places Medicaid in a continuum of coverage that includes exchange-based coverage and premium tax credits, it will also be important to evaluate the accuracy and efficiency of program assignments and handoffs among programs. Finally, while the ACA simplifies the Medicaid and CHIP eligibility determination process in many ways, it also introduces new complexities that may affect program integrity, such as the addition of an alternative Medicaid benefit package for some enrollees that complicates the assignment process, as well as different federal financial match rates for different eligibility categories. States and the federal government must measure the extent to which these types of errors occur and their causes in order to inform and prioritize improvements. The eligibility review pilots that replace PERM and MEQC for FY 2014 through FY 2016 will provide critical information on both the performance of new processes and systems and the effectiveness of corrections and improvements.

The three-year pilot period will also provide an opportunity to revisit the overall eligibility program integrity framework and adapt it to better reflect the new system, which includes multiple access points and a continuum of coverage across programs. For example, traditional eligibility quality control programs have focused solely on individual programs at the state level, and states are required to repay the federal government for costs incurred by ineligible persons, even if the person would have qualified for another program. As the ACA supports a continuum of coverage that includes Medicaid, CHIP, and subsidies for coverage purchased through the exchanges, policymakers should reconsider how to evaluate errors in assignment across programs. Similarly, because MEQC and PERM focus on state actions, they exclude from review enrollees whose eligibility is based on an outside determination, such as persons eligible on the basis of disability in states that accept disability determinations from the Social Security Administration (SSA) (42 CFR 431.812, 42 CFR 431.978). Similar to the SSA decisions in some states, exchanges now provide an outside but overlapping eligibility pathway that will need to be assessed. Policymakers should consider these exclusions and processes in counting errors. Processes will also need to be developed to measure and attribute eligibility errors made by the state and federally facilitated exchange or resulting from any incorrect data accessed through the federal data services hub.

The ACA has transformed the rules and business processes associated with eligibility determinations, but it did not make corresponding changes in program integrity standards and processes to reflect the new eligibility paradigm. This creates a need to examine the standards and processes for measuring the accuracy of these determinations and to develop new approaches that reflect the current policy environment. Policymakers can use the next three years to consider novel approaches that improve the efficiency and effectiveness of eligibility quality control programs and promote overall program integrity.

Endnotes

[1] Federal regulations provide an explicit threshold for reasonable compatibility for evaluating income information provided on an application for coverage through the exchange. (Annual income within 10 percent of the income reported on prior tax data must be accepted without further verification.)

[2] Medicaid programs are required to participate in two retrospective eligibility quality control programs, as described in 42 CFR 431 Subparts P and Q.

[3] PERM managed care and fee-for-service reviews will continue in federal FY 2014, FY 2015, and FY 2016. CMS will continue to report annual Medicaid and CHIP improper payment rates based on payment data and an estimated eligibility component based on historical data.

[4] The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) required that individuals applying for Medicaid present proof of citizenship and identity. The Congress revised this requirement in 2009, allowing states to verify citizenship directly with the Social Security Administration.

[5] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193), which replaced the Aid to Families with Dependent Children program with the Temporary Assistance to Needy Families program, also severed the link between welfare and Medicaid such that receipt of cash assistance no longer automatically qualified a family for Medicaid coverage. The ACA changes some eligibility policies and procedures but does not create a separate system for determining Medicaid eligibility for persons eligible on the basis of age, blindness, or disability.

References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. *Simplified, real-time verification issue brief*. MAC Learning Collaboratives Issue Brief, April 2013. Baltimore, MD: CMS. http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Downloads/Realtimebrief.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. Medicaid and CHIP marketplace interactions. Baltimore, MD: CMS. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-and-the-Marketplace/medicaid-chip-marketplace-interactions.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013c. *MAGI-based eligibility verification plans.* CMCS Informational Bulletin, February 21, 2013. Baltimore, MD: CMS. http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-02-21-13.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013d. Letter from Deborah Taylor and Cindy Mann to State Health Officials and State Medicaid Directors regarding "Payment error rate measurement (PERM) eligibility reviews, Medicaid Eligibility Quality Control (MEQC) Program, and development of an interim approach for assessing payment error for eligibility." August 15, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-005.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid programs: Eligibility changes under the Affordable Care Act of 2010. Final rule. *Federal Register* 77, no. 57 (March 23): 17143–17217. http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 1998. Letter from Nancy-Ann Min DeParle and Claude Earl Fox to State Health Officials regarding "Children's Health Insurance Program outreach and enrollment." January 23, 1998. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho012398.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013. *Report to the Congress on Medicaid and CHIP.* June 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

CHAPTER 5

Children's Coverage under CHIP and Exchange Plans

Recommendations

Children's Coverage under CHIP and Exchange Plans

5.1 To reduce complexity and to promote continuity of coverage for children, the Congress should eliminate waiting periods for the State Children's Health Insurance Program (CHIP).

5.2 In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums.

Key Points

- The establishment of health insurance exchanges and subsidized coverage for individuals between 100 percent and 400 percent of the federal poverty level (FPL)—a population that substantially overlaps with the income levels of many children covered by CHIP—creates a new context for considering CHIP's role within the broader health care system. In this chapter, we begin to sketch out a vision for what CHIP coverage might look like beyond fiscal year 2015, but also offer recommendations to improve CHIP as it currently exists.
- Eliminating CHIP waiting periods reduces uninsurance and improves stability of coverage while reducing administrative burden on states, plans, and enrollees. Moreover, waiting periods have not been shown to be particularly effective in reducing crowd-out over the years. The Commission's recommendation on eliminating CHIP waiting periods enhances program simplification and promotes coordinated policies across public programs.
- The Commission also recommends that the Congress eliminate CHIP premiums for families with incomes below 150 percent FPL. Such a policy would reduce uninsurance for a particularly price-sensitive group of enrollees and align CHIP and Medicaid policy on premiums. The recommendation would also eliminate premium stacking—the combined burden of both CHIP and exchange coverage premiums—for the lowest-income families.

CHAPTER 5

Children's Coverage under CHIP and Exchange Plans

Since its creation in 1997, the State Children's Health Insurance Program (CHIP) has focused the attention of state and federal policymakers on children's coverage, and in particular on expanding eligibility and enrollment of children in CHIP and Medicaid. The number and share of children who are uninsured have declined substantially over the past 16 years, as children have gained CHIP and Medicaid coverage.[1] CHIP and Medicaid have promoted access to care for many more children who would otherwise face significant challenges obtaining needed care.

The Congress has revisited CHIP several times over the years. In 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) made significant changes to strengthen CHIP and extended federal CHIP allotments through fiscal year (FY) 2013. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) made additional changes to CHIP the following year, including a shift to the use of modified adjusted gross income (MAGI) for eligibility determinations and the movement of certain children from separate CHIP programs into CHIP-funded Medicaid. While policymakers raised questions as to whether CHIP should continue, or whether CHIP-eligible children should be enrolled in the health insurance exchanges, the ACA ultimately contained provisions to extend federal CHIP allotments by two years, through FY 2015. The ACA also requires states to maintain children's eligibility levels through FY 2019, as long as federal CHIP allotments to states are sufficient, leaving open the question of CHIP's long-term future in the new health insurance landscape.

The establishment of health insurance exchanges and subsidized coverage for individuals between 100 percent and 400 percent of the federal poverty level (FPL)—a population that substantially overlaps with the income levels of many children covered by CHIP—creates a new context for considering CHIP's role within the broader health care system. The ACA required states to move children in separate CHIP coverage with family incomes below 138 percent FPL into Medicaid (with CHIP funding), leaving up for discussion the disposition

long-term future of those with higher incomes remaining in separate CHIP programs.[2]

This moment presents an opportunity for policymakers to consider a long-term vision, not just for CHIP, but for coverage of lower-income children more broadly. In this chapter, we begin to sketch out a vision for what such coverage might look like beyond FY 2015. While the Commission plans to develop this vision further in its June 2014 report, this report focuses on some short-term changes to align the program with long-term goals. The chapter begins with background information on the program to help orient the reader to the discussion of near-term policy changes and long-term goals. The chapter concludes with two Commission recommendations pertaining to CHIP—that the Congress should provide that children in CHIP not be subject to waiting periods, and that children with family incomes below 150 percent FPL ($29,685 in annual income for a family of three) not be subject to CHIP premiums. The Commission approved these recommendations to promote simplicity, program coordination, and affordability and continuity of coverage for children.

Key Features of CHIP Today

CHIP is a joint federal-state program that provides coverage primarily to uninsured children in families whose incomes are too high to qualify for Medicaid (MACPAC 2013a). CHIP is smaller than Medicaid both in terms of covered individuals (8.4 million versus an estimated 71.7 million in FY 2013) and total spending ($13.2 billion versus $460.3 billion in FY 2013, including both federal and state dollars).[3] As with Medicaid, CHIP is administered by states within federal rules, and states receive federal matching funds for program spending. CHIP, however, differs from Medicaid in a variety of ways.

Program design. CHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid with its own branding, or as a combination of both approaches. For example, some states use a Medicaid-expansion CHIP program to cover younger or lower-income children and a separate CHIP program for others. When states use a Medicaid-expansion CHIP program, federal Medicaid rules generally apply. Separate CHIP programs generally operate under a separate set of federal rules that allow states to design benefit packages that look more like commercial insurance than Medicaid. In 2014, 8 states and 5 territories ran CHIP as a Medicaid expansion, 14 states operated separate CHIP programs, and 29 states operated a combination program (MACStats Table 9). Although all states are eligible to receive CHIP funding for at least some Medicaid enrolled children 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 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 income disregard equal to 5 percent FPL that effectively raises Medicaid (and CHIP) eligibility levels by 5 percentage points.

Entitlement. While individuals who meet eligibility criteria for Medicaid (including Medicaid-expansion CHIP programs) are entitled to Medicaid coverage, there is no individual entitlement to coverage in separate CHIP programs. Under a maintenance of effort (MOE) provision in the ACA that applies to children through FY 2019, states may generally not reduce eligibility levels or institute new CHIP enrollment caps as long as federal CHIP funding is available. As discussed later in this chapter, states may continue to impose existing waiting periods in separate CHIP programs. Neither waiting periods nor enrollment caps are permitted in Medicaid without a waiver.

Eligibility levels. CHIP was designed to provide health insurance to low-income uninsured children above 1997 Medicaid eligibility levels and has also been used to fund coverage of pregnant women and other adults on a limited basis. While Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no mandatory income level up to which CHIP programs must extend coverage. Under the ACA, however, states must maintain their 2010 eligibility levels for children in both Medicaid and CHIP through FY 2019. States' upper limits for children's CHIP eligibility range from 175 percent to 405 percent FPL (MACStats Table 9). Although many states offer CHIP coverage at higher income levels (generally with 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 (MACStats Table 4).

Benefit packages. States with separate CHIP programs have greater flexibility around the design of their benefit packages than is permitted in Medicaid. Separate CHIP program benefits may be more similar to those offered in the commercial health insurance market and are not required to include the full array of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services mandated for children in Medicaid. However, 13 separate CHIP programs cover EPSDT benefits (Touschner 2014). CHIP programs may charge premiums for coverage and may also require enrollees to pay higher cost sharing than is allowed in Medicaid.

Federal funding. Regardless of whether states implement CHIP through a Medicaid expansion, a separate CHIP program, or a combination of both, states' CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's. CHIP's enhanced federal medical assistance percentage (E-FMAP) varies by state, ranging from 65 percent to 81 percent, compared to 50 percent to 73 percent for children in Medicaid (MACStats Table 14). Unlike Medicaid, federal CHIP funding is capped (MACStats Table 21).

Weighing the Future of CHIP

At its core, the debate on the future of CHIP weighs the benefits of continuing a uniquely child-focused effort versus integrating children into Medicaid, exchange, or other existing coverage. At the time CHIP was enacted in 1997, it was designed to reach children above Medicaid eligibility levels for whom other coverage options might be unavailable or unaffordable. Today, many CHIP children have parents who are eligible for subsidized exchange coverage.

Because exchange coverage is new, and because CHIP and Medicaid programs are also implementing multiple provisions of the ACA, children's experiences in these various sources of coverage may evolve through 2014 and beyond. The Commission recognizes the importance of maintaining CHIP while exchanges get off the ground and children's experience with exchange coverage is assessed. It also views the impending exhaustion of federal CHIP funding as an opportunity to think broadly about how best to meet the needs of lower-income children in the new landscape of coverage.

The Commission's vision for the future of children's coverage is one that reflects lessons learned from CHIP. Regardless of the form such coverage takes, it should follow CHIP's lead in limiting premiums and cost sharing to affordable levels. In assessing affordability, the interactions between families' costs for CHIP and subsidized exchange coverage should be taken into account. Coverage should also include certain pediatric benefits that are appropriate to the specific needs of children, with networks that ensure access to the

health care providers who can meet those needs. In addition, to the extent that there is an ongoing role in the future for states in serving children currently covered by CHIP, it may be desirable to maintain some degree of state flexibility in program design.

While the recommendations in this chapter focus on areas for improvement in the near term, here we provide a brief preview of issues under consideration for MACPAC's June 2014 report that will address the future of CHIP beyond FY 2015.

Flexibility in program design. Separate CHIP programs are able to operate with benefit packages, cost sharing, and administrative structures that are distinct from and offer more state flexibility than Medicaid. Over time, however, certain flexibilities afforded to separate CHIP programs have narrowed for a variety of reasons. Some outreach and enrollment techniques that began as experiments in individual states were subsequently identified as best practices and are now required in all states in both CHIP and Medicaid.[4] Other policies have been limited at the federal level as well. For example, beginning with the enactment of the ACA, separate CHIP programs cannot cap enrollment unless they will otherwise exhaust all available federal CHIP funds.

While CHIP was initially implemented with no minimum or maximum levels of eligibility, the ACA has limited states' ability to alter their CHIP income-eligibility levels. The ACA's MOE requirement has limited states' flexibility to reduce children's eligibility levels through FY 2019.[5] The ACA's MAGI requirement has eliminated the ability of all but a few states to expand CHIP income-eligibility levels.[6]

Availability and take-up of coverage. Even with the availability of subsidized exchange coverage, the absence of CHIP would cause some children to become uninsured. For example, due to higher premiums and cost sharing for exchange coverage relative to CHIP, some parents could be deterred from enrolling their formerly CHIP-eligible children (and themselves) in such coverage.

Moreover, many children in the income range now covered by CHIP would be ineligible for subsidized exchange coverage because a parent is offered employer-sponsored insurance that is considered affordable. Under the ACA, employer-sponsored insurance is considered affordable if employees' out-of-pocket premiums for self-only coverage comprise less than 9.5 percent of family income. This policy is sometimes referred to as the family glitch because the cost of coverage for the entire family is not considered. In the absence of CHIP, this affordability test could contribute to many formerly CHIP-eligible children moving to uninsurance if families find that employer-sponsored insurance and unsubsidized exchange coverage are too expensive. Approximately 1.9 million children, one-third of CHIP-financed children, would be ineligible for subsidized exchange coverage because a parent is offered and enrolled in employer-sponsored insurance that is considered affordable (GAO 2012).

However, the impact of CHIP is not limited to such direct effects. CHIP has also played additional roles by encouraging coverage through outreach, enrollment, and marketing efforts aimed at increasing awareness of and reducing stigma associated with public insurance more generally. The ongoing need for these efforts may be reduced, however, as millions of additional people are enrolled in publicly subsidized coverage beginning in 2014, making such coverage more mainstream.

Affordability. CHIP programs generally require higher out-of-pocket premiums and cost sharing than Medicaid but lower amounts than subsidized exchange plans, an issue that must be addressed in any consideration of future coverage for the children currently served by CHIP. The core issue with regard to affordability is the reasonable level

of contribution that may be expected on the part of a child's family toward the cost of care without becoming a financial obstacle that impedes access to and use of appropriate care. For children in CHIP programs that impose premiums or cost sharing, the aggregate amount is limited to 5 percent of a family's income—although states' cost-sharing levels are typically well below those levels.[7]

However, because the calculation of family premiums is not coordinated across CHIP and exchanges, certain families may pay combined CHIP and exchange premiums in 2014 that exceed the amount they would have paid if CHIP did not exist and children were instead enrolled in their parents' exchange coverage.

Premiums are not the only factor in determining affordability; cost sharing for services can also be a source of significant cost differences between programs. In exchange plans, individuals with incomes at or below 250 percent FPL are eligible for cost-sharing subsidies. Even with these subsidies, exchange coverage requires far more service-related cost sharing than CHIP, particularly for enrollees above 150 percent FPL (Watson Wyatt Worldwide 2009).[8]

Covered benefits. The breadth and depth of CHIP's benefit package relative to Medicaid and the exchanges is an important issue that raises larger questions of access to appropriate care for all children in the future, regardless of their coverage source. In the case of Medicaid-expansion CHIP programs, CHIP-funded children receive the same benefit package as Medicaid-funded children, including comprehensive EPSDT services that were designed to emphasize pediatric care and to ensure coverage of dental and other optional services that are not always offered to adults in Medicaid. Separate CHIP programs must cover certain benefits, including dental, but are not required to include EPSDT services. At least a quarter of separate CHIP programs have elected coverage that is similar to Medicaid, while others have benefits that more closely mirror commercial coverage (Touschner 2014). In an analysis of five states, separate CHIP programs offered benefit packages that were generally comparable to the benchmarks chosen for exchange plans (GAO 2013). However, additional analyses are needed to assess other states and to compare CHIP benefit packages to actual exchange plans, rather than to just the state's benchmark benefit package.

Provider networks. One argument for retaining the current structure of CHIP is the notion that the program offers provider networks that are designed to meet the specific needs of children. Some directors of separate CHIP programs also point out that their networks include more providers than Medicaid (Caldwell 2013a). However, there is little systematic information available that would allow comparisons among Medicaid, CHIP, and exchange networks, either in terms of their composition or capacity. With regard to exchange coverage, current federal standards provide substantial flexibility to states with little specific guidance on pediatric provider networks.

Continuity of coverage. While separate CHIP coverage may have certain advantages over Medicaid and exchange coverage, some of these programs cover a relatively small wedge of children in between the larger population of lower-income children served by Medicaid and the potentially larger population of higher-income children covered in the exchanges. This creates challenges for the continuity of coverage.

Large variation exists by state in the number of transitions between Medicaid and CHIP programs—often referred to as churning (Czajka 2012). Research has found that the primary predictor of a state's churning was the size of its CHIP program—that is, if its CHIP program covered a relatively narrow income band, children in that CHIP program were more likely to

transition between sources of coverage (Czajka 2013). Although there are strategies available under CHIP to mitigate such churning (see, for example, the discussion of continuous eligibility and eliminating waiting periods in this chapter), the very existence of an additional program like CHIP means that there are more boundaries for churning between programs that may lead to periods of uninsurance or discontinuity of care.[9]

Financing. If CHIP funding is exhausted, the financial impact on states will differ based on the type of program they operate. Should CHIP funding run out in FY 2016, the federal financing for children in Medicaid-expansion CHIP programs will revert to Medicaid funding at the regular federal medical assistance percentage (FMAP), which will increase states' financial burden for covering these children. On the other hand, states with separate CHIP programs will see many of these children go to exchange coverage, where subsidies are 100 percent federally financed. Although an MOE requirement exists for children's Medicaid and CHIP eligibility through FY 2019, separate CHIP programs may limit their enrollment based on the availability of federal CHIP funds.

While the federal cost of CHIP's continuation was a major legislative issue for reauthorization in 2009, it may be less of an issue in the future because of the assumptions used by the Congressional Budget Office (CBO). In 2009, CBO assumed that extending CHIP would increase federal spending because many children who would otherwise be uninsured would enroll in CHIP coverage. However, if CHIP allotments are not extended past FY 2015, CBO assumes that the bulk of enrollees would receive federally funded coverage from other sources—primarily through exchanges and Medicaid. Since an extension of CHIP would replace other forms of federally subsidized coverage, federal cost estimates of extending CHIP may not be as large as one might expect.

Timing of federal and state action. The absence of new federal CHIP allotments beyond FY 2015 (which runs through September 2015) will be a major concern for state fiscal year (SFY) 2016 budgets, which run from July 2015 through June 2016 in all but Alabama, Michigan, New York, and Texas (NCSL 2012). Although states will continue to spend from their leftover CHIP allotments in FY 2016, a scheduled E-FMAP increase of 23 percentage points will cause them to exhaust those funds more quickly. Most states will begin their SFY 2016 budget planning processes in earnest during the fall of 2014 and will continue into the first half of 2015. To provide some degree of certainty during this period, the Congress would need to enact legislation that, at a minimum, addresses CHIP funding through June 2016.

Issues for CHIP in the Near Term

The Commission's vision for children's coverage and the future of CHIP beyond FY 2015 will be further developed in MACPAC's June 2014 report. This report makes specific policy recommendations intended to better align the program with Medicaid and exchange coverage in the near term. The two recommendations are that the Congress should provide that children in CHIP not be subject to waiting periods, and that children with family incomes below 150 percent FPL not be subject to CHIP premiums. These changes are consistent with longer-term goals for children's coverage that include both continuity and affordability.

Promoting continuity of children's coverage in CHIP

Changes in insurance coverage can result in lapses in care, discontinuity in providers, and administrative burden for individuals, health plans, and public

programs (MACPAC 2013b). Implementation of the ACA affects how these changes might occur and how widespread they might be.[10]

Exchange coverage introduces an additional source of coverage to the mix when considering how children are likely to transition in and out of CHIP and other coverage. At the same time, ACA policies to simplify renewals may reduce administrative churning at the time of CHIP enrollees' regular redeterminations.

The Commission's March 2013 report described the ability of 12-month continuous eligibility policies to reduce churning, particularly among children (MACPAC 2013b). By waiving the requirement that families report changes in income between their annual redeterminations, 12-month continuous eligibility can increase continuity of coverage, lower use of more expensive care, and reduce states' administrative burden in processing this information outside of their regular eligibility cycle. No explicit statutory authority exists to provide 12-month continuous eligibility for children in CHIP, although such authority exists for children in Medicaid. Nevertheless, 28 of the 38 separate CHIP programs used 12-month continuous eligibility in January 2013 (Heberlein et al. 2013). While the Centers for Medicare & Medicaid Services (CMS) proposed regulations in January 2013 to permit 12-month continuous eligibility in CHIP, the final regulation in July 2013 did not include that provision. CMS informed state health officials that 12-month continuous eligibility continues to be available as a CHIP state plan option (CMS 2013a).

To assure states that this option would continue, the Commission recommended in March 2013 that the Congress authorize 12-month continuous eligibility statutorily in CHIP, parallel to the current option for children in Medicaid. In this report, the Commission reiterates its support for the recommendation in the March 2013 report. Adoption of this recommendation would formalize states' ability to provide 12-month continuous eligibility for children in CHIP, as is currently in use by most states. The CBO projects no cost for making 12-month continuous eligibility a statutory option in CHIP, because it merely formalizes a state plan option that is currently in place.

The remainder of this section discusses CHIP waiting periods and their effect on the stability of coverage in CHIP, and includes the Commission's recommendation that the Congress end the use of CHIP waiting periods. CHIP waiting periods—the length of time that some states require children be without employer-sponsored insurance before enrolling in CHIP—reflect the initial design of the CHIP program and concerns that public coverage would crowd out private coverage. During the CHIP waiting period, many children are now eligible for exchange coverage (although not all children will be eligible for subsidies or be enrolled). After the CHIP waiting period has been satisfied, they will be eligible for CHIP, not exchange coverage. Thus, CHIP waiting periods will require children to churn between exchange coverage (or uninsurance) and CHIP, which leads to administrative burden and expenses for families, states, providers, and plans, with the potential for delays in children's coverage and care.

Use of waiting periods. State CHIP programs are required to have methods in place to prevent the substitution of public coverage for private coverage, often referred to as crowd-out. One strategy to reduce crowd-out is built into CHIP eligibility—that to qualify for CHIP, children cannot be enrolled in employer-based coverage. States have flexibility to adopt additional measures to limit crowd-out, including CHIP waiting periods.

Under new regulations effective January 1, 2014, CHIP waiting periods cannot exceed 90 days (42 CFR 457.805(b)(1)). Previously, CHIP waiting periods could be as long as 12 months. In reducing the CHIP waiting period to 90 days, CMS pointed out that CHIP should not permit waiting periods longer than

those that apply in private plans, which the ACA limited to 90 days beginning in 2014 (HHS 2013).

The new regulations also instituted multiple federal exemptions to CHIP waiting periods, some of which were already in use by many state CHIP programs (42 CFR 457.805(b)(3)). Children may be exempted from the waiting period if any of the following applies:

- the additional out-of-pocket premium to add the child to an employer plan exceeds 5 percent of income;
- a parent is eligible for subsidized exchange coverage because the premium for the parent's self-only employer-sponsored coverage exceeds 9.5 percent of income;
- the total out-of-pocket premium for employer-sponsored family coverage exceeds 9.5 percent of income;
- the employer stopped offering coverage of dependents (or any coverage);
- a change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (regardless of potential eligibility for COBRA coverage);
- the child has special health care needs; or
- the child lost coverage due to the death or divorce of a parent.

Twenty-one states currently have CHIP waiting periods, a reduction from 37 states with waiting periods in 2013 (Table 5-1). Another seven have reduced their waiting periods to 90 days or less to comply with the new CHIP regulations. In 2013, eight states reported waiting periods as their only crowd-out policy (Arizona, Arkansas, Georgia, Kentucky, Maryland, South Dakota, Virginia, and Wyoming); Kentucky and Maryland have since eliminated waiting periods.[11]

While CHIP waiting periods have been long-standing practice, waiting periods are not permitted in Medicaid or in exchange coverage.[12] In fact, individuals may be enrolled in both Medicaid and employer-sponsored insurance, in which case employer-sponsored insurance serves as first payer. In exchange coverage, the key mechanism to prevent crowd-out is to make individuals ineligible for subsidies if they are offered employer-sponsored insurance that is considered affordable.

Children affected by CHIP waiting periods. Relatively few children eligible for CHIP are subject to states' CHIP waiting periods, because only a small proportion of uninsured children had employer-sponsored insurance in the prior three months. To be eligible for CHIP, children must be uninsured, and only 4.6 percent of uninsured children with family incomes between 125 percent and 199 percent FPL had employer-sponsored coverage three months beforehand (Figure 5-1).[13]

Even fewer children will be subject to CHIP waiting periods because of the new federal exemptions. Existing data do not permit analyses of the share of children who might qualify for the numerous exemptions to CHIP waiting periods. However, at least half of children potentially subject to a CHIP waiting period are likely to be exempt due to the high out-of-pocket costs associated with employer-sponsored insurance. The median out-of-pocket premium for employer-sponsored family coverage in 2012 was $3,700, which would be 9.7 percent of the income of a family of three at 200 percent FPL (AHRQ 2013). Since family contributions exceeding 9.5 percent of income are an exception to CHIP waiting periods, this one exemption alone could apply to over half of the potentially affected families. Some of the remaining families may face little or no premium for their employer-based coverage; for families with lower required contributions, many face no employee contribution for family coverage

TABLE 5-1. CHIP Waiting Periods by State (Months)

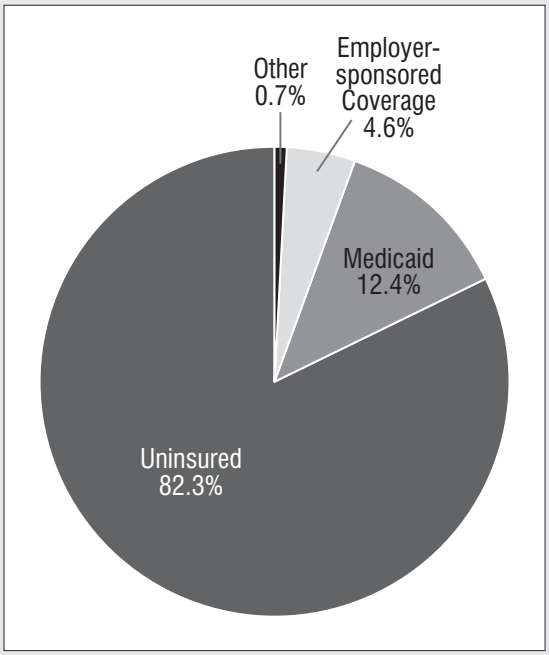
State	January 2013	January 2014	Exempt Groups Based on Income
Alabama	3	–	–
Arizona	3	3	–
Arkansas	6	3	–
California	3	–	–
Colorado	3	–	–
Connecticut	2	–	–
Delaware	6	–	–
Florida	2	2	–
Georgia	6	2	–
Idaho	6	–	–
Indiana	3	3	–
Iowa	1	1	Individuals below 200% FPL
Kansas	8	3	Individuals below 200% FPL
Kentucky	6	–	–
Louisiana	12	3	Individuals below 200% FPL
Maine	3	3	–
Maryland	6	–	–
Massachusetts	6	–	Individuals below 200% FPL
Michigan	6	3	–
Missouri	6	6[1]	Individuals below 150% FPL
Montana	3	3	–
Nevada	6	–	–
New Jersey	3	3	–
New Mexico	6	–	Individuals below 185% FPL
New York	6	3	Individuals below 250% FPL
North Dakota	6	3	–
Oregon	2	–	–
Pennsylvania	6	–	Individuals below 200% FPL
South Dakota	3	3	–
Tennessee	3	–	–
Texas	3	3	–
Utah	3	3	–
Virginia	4	4[1]	–
Washington	4	–	–
West Virginia	3	–	–
Wisconsin	3	3	Individuals below 150% FPL
Wyoming	1	1	–

Notes: FPL is federal poverty level. This table includes only states that had a waiting period in January 2013; all other states had no waiting periods at that time. Dashes in the January 2014 column indicate there was no waiting period. Dashes in the Exempt Groups column indicate that no individuals are exempt from the waiting period based solely on income. For states that provided exemptions from the waiting periods in 2013 that will maintain waiting periods in 2014 (IA, KS, LA, MO, NY, WI), the exemptions will apply to the same individuals in 2014.

[1] As of January 2014, the state legislature had not yet reduced its CHIP waiting period to three months.

Sources: For January 2013: Heberlein et al. 2013. For January 2014: personal communication by MACPAC staff and Center for Children and Families at Georgetown University with state CHIP officials, October–November 2013.

FIGURE 5-1. Source of Health Insurance in September for Children between 125 Percent and 199 Percent Federal Poverty Level (FPL) Who Were Uninsured in December



Source: Analysis for MACPAC by Social & Scientific Systems of 2009–2011 data from the Medical Expenditure Panel Survey (MEPS).

(generally in small firms) and are less likely to seek CHIP coverage for their children.[14]

Churning due to CHIP waiting periods. In the 21 states continuing to use CHIP waiting periods in 2014, many affected children will churn back and forth between exchanges and CHIP for their coverage, or remain uninsured during this period. For those children who enroll in an exchange plan during the waiting period, the child must be moved to CHIP once the waiting period has been satisfied. Other children—for example, those in families who do not enroll in exchange coverage, with its required premiums—would likely be uninsured for the duration of the CHIP waiting period.

This churning risks disruptions in children's coverage and in their continuity of care, particularly in the 20 waiting-period states using the federally facilitated exchange (CMS 2013b).[15] Because of the complexity and state variation around CHIP waiting periods, the federally facilitated exchange does not determine children's eligibility for CHIP in most of these states (HHS 2013). Instead, the federally facilitated exchange assesses whether a child is eligible for CHIP and, if potentially subject to a waiting period, transfers the case to the state CHIP program to determine whether or not an exemption applies. The CHIP agency must inform the exchange if a child is subject to a waiting period so the child can receive subsidized exchange coverage, if eligible, for the duration of the waiting period.[16]

Health plans have also noted the negative effects of churning associated with CHIP waiting periods. Regarding the now-eliminated waiting period for West Virginia CHIP (WVCHIP), the president of the state's largest insurer, Highmark West Virginia, wrote that:

> continuation of a waiting period requirement could be cumbersome to our potential customers seeking to enroll, and administratively burdensome to both the Marketplace and WVCHIP's application and eligibility systems. Delayed access to services for children as well as disruptions of coverage that could result in some cases could also be a potential outcome. The waiting period may have served a meaningful purpose in the earlier days of WVCHIP's existence. But given the changes to occur as of January 2014, if the WVCHIP Board were to act to eliminate the waiting period at this juncture, this would not pose a significant issue for us (Highmark West Virginia 2013).

Commission Recommendation

Recommendation 5.1

To reduce complexity and to promote continuity of coverage for children, the Congress should eliminate waiting periods for CHIP.

Rationale

The Commission focused on four primary reasons to eliminate CHIP waiting periods. First, eliminating CHIP waiting periods will reduce uninsurance and improve the stability of coverage. Waiting periods cause children to move between 90 days or less of enrollment in exchange coverage, or uninsurance, before being eligible for CHIP. Second, eliminating CHIP waiting periods will reduce administrative burden and complexity for families, states, health plans, and providers as children move from short-term exchange coverage to CHIP. Because most of the states with CHIP waiting periods rely on the federally facilitated exchange, which is generally not able to do CHIP determinations where waiting periods exist, CHIP waiting periods are a barrier to streamlined, coordinated eligibility determinations (HHS 2013).

Third, although CHIP waiting periods were instituted to deter crowd-out, it is not clear that they have been effective in doing so. The limited research on CHIP waiting periods has reached contradictory conclusions, primarily driven by the different sources of data used by the researchers.[17] In addition, the potential pool of children who might be targeted by this strategy is small. As described earlier, estimates suggest that only a small percentage of uninsured children in the CHIP income range had employer-sponsored coverage in the prior 90 days.

Fourth, eliminating CHIP waiting periods is consistent with the Commission's desire to have more simplified and coordinated policies across various programs. Since neither exchanges nor Medicaid require waiting periods, eliminating CHIP waiting periods would make CHIP consistent with exchanges and Medicaid in this regard.[18]

Congressional action to end CHIP waiting periods would be consistent with the trend in state actions on this policy. Of the 37 states that began 2013 with CHIP waiting periods, 16 eliminated those waiting periods by 2014. States have eliminated their CHIP waiting periods because of the resulting short-term transitions between exchange coverage and CHIP, the additional administrative burden on states, and the new federal regulations that exempt most children who would otherwise face a CHIP waiting period (Caldwell 2013a).

Implications

Federal spending. This recommendation would increase federal spending in 2015 by $50 million to $250 million, based on ranges provided by CBO. Over the five-year period of 2015 to 2019, this recommendation would increase federal spending by less than $1 billion. These represent net federal costs, reflecting not only increased federal CHIP spending, but also reduced federal spending for exchange subsidies.

States. Ending the use of CHIP waiting periods would simplify eligibility and reduce the administrative burden associated with determining which children may be subject to CHIP waiting periods (as well as the federal and state exemptions). This would enable states to use the federally facilitated exchange for CHIP determinations, if they so choose. In states currently using CHIP waiting periods, eliminating the waiting periods could increase state CHIP spending resulting from the additional months of CHIP coverage. However, at least one state predicted little additional cost from

eliminating the CHIP waiting period, considering the administrative cost and burden of administering the policy and the relatively low number of children who would gain additional coverage (Caldwell 2013b).

Enrollees. Because the majority of the children seemingly subject to a CHIP waiting period are likely exempt, the primary impact of eliminating the waiting period would be relieving families of the administrative burden of verifying their exemption and avoiding any associated delays in coverage. For children who are not currently exempt, eliminating CHIP waiting periods would reduce the risk that children subject to a waiting period may go uninsured if families do not enroll their children in exchange coverage or if the transition from exchange to CHIP coverage is not implemented correctly.

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

CHIP premiums

Separate CHIP programs may charge premiums and cost sharing, while Medicaid—including Medicaid-expansion CHIP programs—generally may not. Although some limited authority exists to charge small premiums in Medicaid, federal law generally prohibits premiums in Medicaid for children and for individuals with income below 150 percent FPL ($29,685 for a family of three).

When CHIP was originally enacted, the ability to charge premiums and cost sharing was a key component of the flexibility states were provided as they expanded eligibility to children above Medicaid levels. CHIP premiums were originally authorized to ensure that relatively higher-income families contributed their fair share toward their children's coverage and to prevent crowd-out of employer-sponsored insurance. Some reconsideration of the role of CHIP premiums, particularly for the lowest-income families, may be merited due to their effect on increasing uninsurance and their interaction with exchange premiums and other ACA policies. On the other hand, the Commission recognizes that efforts to reduce uninsurance are undermined if substantial crowd-out occurs.

The use of CHIP premiums is fairly widespread. Based on policies in place in January 2013 (Heberlein et al. 2013), MACPAC estimates that approximately 44 percent of CHIP-funded children (3.4 million) faced premiums in 33 states. In states charging CHIP premiums, the combination, or stacking, of both CHIP and exchange premiums could be substantial for families. While CHIP and exchange coverage each has separate statutory limits on premiums based on family income, neither takes into account the effect of premiums required by the other. With more than 3 million children facing CHIP premiums, many families will be subject to premium stacking if they purchase coverage on the exchange in addition to enrolling their children in CHIP.

This section begins with a review of states' current use of CHIP premiums, followed by a description of premium levels for subsidized exchange coverage. We then illustrate how premium stacking could affect families, depending on their income and state. The final part of this chapter describes the Commission's recommendation to eliminate CHIP premiums for families below 150 percent FPL, to align with Medicaid's premium policy.

Current use of CHIP premiums. In January 2013, 33 states charged premiums for children enrolled in CHIP-financed coverage; no premiums were charged in the other 17 states and the District of Columbia (Table 5-2). Those monthly premiums for children up to 251 percent FPL varied from $4 to more than $50, depending on the state and

TABLE 5-2. Premium and Enrollment Fee Requirements for Children in CHIP-Funded Coverage as of January 2013

State	Income at Which CHIP Funding Begins (% FPL)	Income at Which CHIP Premiums Begin (% FPL)	Upper Income Eligibility Level for Children's CHIP-Funded Coverage (% FPL)
Alabama	101%	101%	300%
Arizona	101	101	200
California	101	101	250/300[1]
Colorado	101	151	250
Connecticut	186	235	300
Delaware	101	101	200
Florida[2]	101	101	200
Georgia[3]	101	101	235
Idaho	101	133	185
Illinois	101	151	200
Indiana	101	150	250
Iowa	101	150	300
Kansas	101	151	232
Louisiana	101	201	250
Maine	126	151	200
Maryland	186	200	300
Massachusetts	115	150	300
Michigan	101	151	200
Missouri	101	150	300
Nevada[4]	101	36	200
New Jersey	101	201	350
New York	101	160	400
North Carolina	101	151	200
Oregon	101	201	300
Pennsylvania	101	201	300
Rhode Island	101	150	250
Texas	101	151	200
Utah	101	101	200
Vermont	226	226	300
Washington	201	201	300
West Virginia	101	201	300
Wisconsin[5]	101	200	300

Notes: Some states have changed policies with regard to premiums in CHIP since January 2013. For example, 6- to 18-year-olds between 100 and 138 percent of the federal poverty level (FPL) must be enrolled in Medicaid-expansion CHIP rather than separate CHIP programs, as of January 1, 2014, and therefore are not subject to premiums. Table excludes premiums for Medicaid-funded children in Minnesota and Vermont.

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

[2] Florida operates two CHIP-funded separate programs. Healthy Kids covers children age 5 through 19, as well as younger siblings in some locations. MediKids covers children age 1 through 4. Children in MediKids pay premiums, while children in Healthy Kids pay premiums and copayments.

[3] Children under age six in Georgia are exempt from CHIP premiums.

[4] In Nevada, although Medicaid covers children in families with income up to 100 percent or 133 percent FPL, some children with lower incomes may qualify for CHIP depending on the source of income and family composition. Such families with incomes at or above 36 percent of the FPL are required to pay premiums.

[5] In Wisconsin, infants covered in Medicaid between 200 percent and 300 percent of the FPL would be subject to premiums.

Source: MACPAC analysis of Heberlein et al. 2013.

TABLE 5-3. Premiums for CHIP-Financed Children at Selected Income Levels for States Charging CHIP Premiums as of January 2013

State	Effective Amount Per Child[1] at: 101% FPL	151% FPL	201% FPL	251% FPL	301% FPL	351% FPL
Monthly Payments						
Arizona	$10	$40	$50	N/A	N/A	N/A
California[2]	4/7	13/16	21/24	$21/24	N/A	N/A
Connecticut	–	–	–	30	$30	N/A
Delaware[3]	10	15	25	N/A	N/A	N/A
Florida	15	20	20	N/A	N/A	N/A
Georgia	10	20	29	N/A	N/A	N/A
Idaho	–	15	N/A	N/A	N/A	N/A
Illinois	–	15	15	N/A	N/A	N/A
Indiana	–	22	42	53	N/A	N/A
Iowa	–	10	20	20	20	N/A
Kansas	–	20	50	N/A	N/A	N/A
Louisiana[4]	–	–	50	50	N/A	N/A
Maine	–	8	32	N/A	N/A	N/A
Maryland[4]	–	–	50	63	63	N/A
Massachusetts	–	12	20	28	28	N/A
Michigan[4]	–	10	10	N/A	N/A	N/A
Missouri	–	13	43	105	N/A	N/A
New Jersey	–	–	41.50	83	134.50	$134.50
New York	–	–	9	30	45	60
Oregon[5]	–	–	28.50	43	43	N/A
Pennsylvania[5]	–	–	48	67	N/A	N/A
Rhode Island[4]	–	61	92	92	N/A	N/A
Vermont[6]	–	–	–	20/60	20/60	N/A
Washington	–	–	20	30	30	N/A
West Virginia	–	–	35	35	N/A	N/A
Wisconsin	–	–	10	34	97	N/A
Quarterly Payments						
Nevada[4]	$25	$50	$80	N/A	N/A	N/A
Utah[4]	30	75	75	N/A	N/A	N/A
Annual Payments						
Alabama[7]	$52	$104	$104	$104	$104	N/A
Colorado	–	25	25	75	N/A	N/A
North Carolina	–	50	50	N/A	N/A	N/A
Texas	–	35	50	N/A	N/A	N/A

Notes: For states with eligibility levels ending at 200 percent of the federal poverty level (FPL), the highest premiums are shown in the column for 201 percent FPL; this approach also applies to the columns for 251 percent FPL, 301 percent FPL, and 351 percent FPL. Dashes represent states with no premium and/or where children are enrolled in Medicaid. N/A represents states that do not extend CHIP eligibility to children at that income level. Some states have changed policies with regard to premiums in CHIP since January 2013. For example, 6- to 18-year-olds between 100 and 138 percent FPL must be enrolled in Medicaid-expansion CHIP rather than separate CHIP programs, as of January 1, 2014, and therefore are not subject to premiums. Table excludes premiums for Medicaid-funded children in Minnesota and Vermont. The following states had no premiums or enrollment fees: AK, AR, DC, HI, KY, MN, MS, MT, NE, NH, NM, ND, OH, OK, SC, SD, TN, VA, and WY.

[1] Family caps may apply.

[2] Premiums in California depend on whether the child is enrolled in a community provider plan. The first figure applies to children enrolled in a community provider plan; the second applies to those who are not.

[3] In Delaware, premiums are per family per month regardless of the number of eligible children. Delaware has an incentive system for premiums where families can pay three months and get one premium-free month, pay six months and get two premium-free months, and pay nine months and get three premium-free months.

[4] In Louisiana, Maryland, Michigan, Rhode Island, Nevada, and Utah, premiums are family-based, not costs per child.

[5] In Oregon and Pennsylvania, premiums vary by plan. The average amount is shown.

[6] In Vermont, premiums are for all children in the family, not costs per child. For those above 225 percent FPL, the monthly charge is $20 if the family has other health insurance and $60 if there is no other health insurance.

[7] Alabama's premium is an annual fee and is not required before a child enrolls in coverage.

Source: MACPAC analysis of Heberlein et al. 2013.

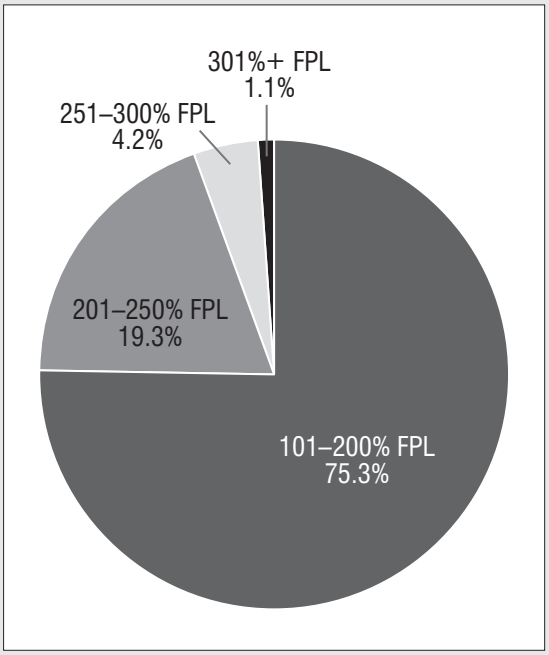
income level (Table 5-3). For a family of three at 251 percent FPL ($49,673 per year) with two children, CHIP premiums of $50 per month per child ($1,200 per year) would amount to 2.4 percent of family income.[19] A family's total out-of-pocket costs in CHIP—premiums as well as cost sharing—may not exceed 5 percent of family income.

Although states may not charge premiums to Medicaid enrollees below 150 FPL, separate CHIP programs may do so. As of January 2013, several states reported charging CHIP premiums below 150 percent FPL—Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, and Utah (Table 5-2). Since then, California has changed most of its CHIP program to a Medicaid-expansion program and has eliminated premiums below 150 percent FPL, which could reduce the number of children in that state subject to CHIP premiums by nearly 500,000 children (CMS 2012).[20]

Based on the state policies reported as of January 2013 (Heberlein et al. 2013), a MACPAC analysis of FY 2012 CHIP Statistical Enrollment Data System (SEDS) estimated that approximately 44 percent of CHIP-financed children—3.4 million—were subject to CHIP premiums. The vast majority of these children were in families whose incomes fell between 101 percent and 200 percent FPL (Figure 5-2).[21] Excluding California, an estimated 371,000 children were estimated to be subject to CHIP premiums below 150 percent FPL, according to MACPAC analyses of FY 2012 CHIP enrollment data in eight states: Alabama, Arizona, Delaware, Florida, Georgia, Idaho, Nevada, and Utah.[22]

The ACA is reducing the number of children below 150 percent FPL subject to CHIP premiums from 371,000 to approximately 110,000. This is occurring because of two ACA policies. First, 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs will transition to Medicaid-expansion CHIP programs. These children will no longer be charged premiums, because Medicaid does not permit premiums below 150 percent FPL. This will decrease the number of children below 150 percent FPL who may be charged CHIP premiums in eight states by approximately 216,000.

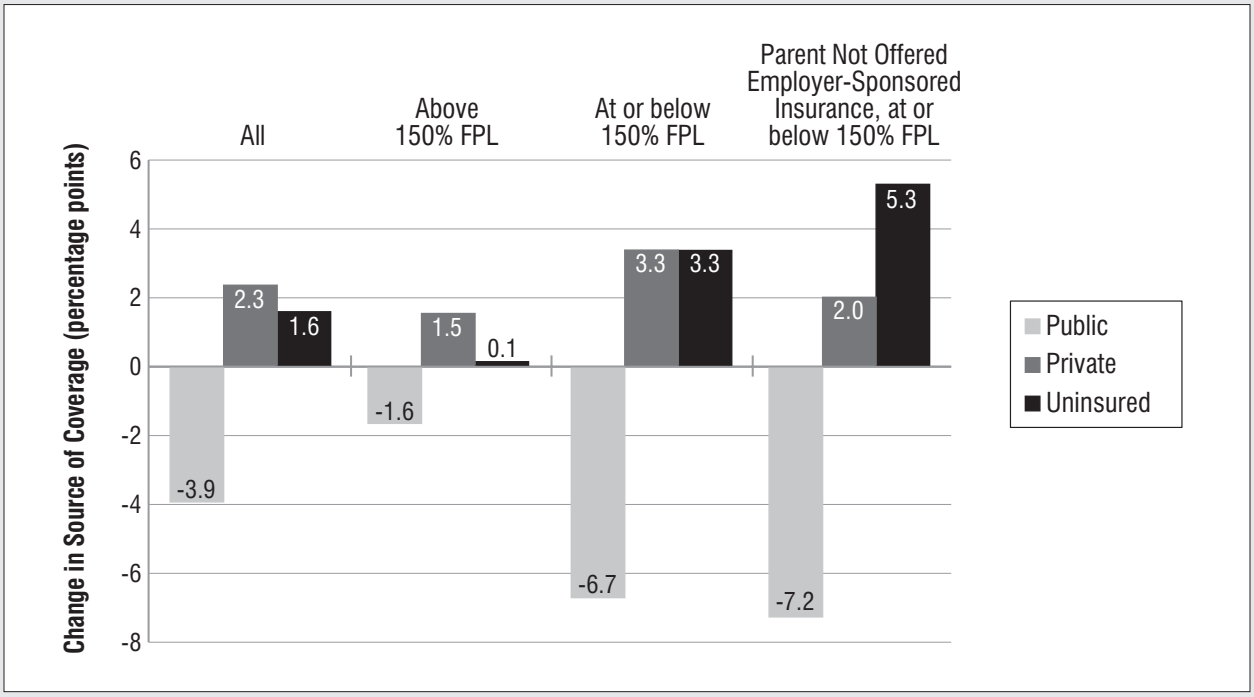
FIGURE 5-2. Estimated Distribution of CHIP-Enrolled Children Charged CHIP Premiums, by Federal Poverty Level (FPL)



Sources: MACPAC analysis of FY 2012 CHIP Statistical Enrollment Data System (SEDS) and state policies reported in Heberlein et al. 2013.

Second, the number of children subject to CHIP premiums below 150 percent FPL will also be reduced by the move to counting family income according to MAGI. Because MAGI requires disregarding an additional 5 percentage points of the FPL when determining if children are eligible for Medicaid and CHIP, in most states, Medicaid will effectively extend eligibility for children to 138 percent FPL rather than 133 percent FPL. This will reduce the number of children potentially subject to CHIP premiums in these eight states by another 46,000.

FIGURE 5-3. Simulated Effect of $120 Increase in Annual Premiums on Medicaid and CHIP Children above 100 Percent Federal Poverty Level (FPL)



Note: Components may not add to total due to rounding.

Source: Abdus et al. 2013.

TABLE 5-4. Examples of the Impact of Combined CHIP and Exchange Premiums for a Family of Three with Two CHIP-Enrolled Children

Federal Poverty Level	Annual income	Annual Exchange Out-of-Pocket Premiums		Monthly CHIP Out-of-Pocket Premiums Per Child	Annual CHIP Out-of-Pocket Premiums		Combined Annual Exchange and CHIP Out-of Pocket Premiums	
		Dollars	Percent of income		Dollars	Percent of income	Dollars	Percent of income
151%	$29,490	$1,193	4.05%	$20	$480	1.6%	$1,673	5.7%
201%	39,255	2,487	6.34	30	720	1.8	3,207	8.2
251%	49,020	3,960	8.08	30	720	1.5	4,680	9.5
301%	58,785	5,585	9.50	100	2,400	4.1	7,985	13.6

Note: Components may not add to total due to rounding. The CHIP premiums illustrated here are designed to represent typical premiums between the lowest and highest amounts in use by states. The exchange premiums are based on the maximum allowable premiums for the second lowest-cost silver plans for individuals eligible for subsidies based on 2013 FPLs, which apply for determining eligibility for subsidized exchange coverage in 2014. The exchange out-of-pocket premium shows the maximum permitted for subsidy-eligible individuals. However, if the total premium for the second lowest-cost exchange plan is less than the amount shown, then the family would pay that lower amount and receive no premium tax credit.

Source: MACPAC analysis of Heberlein et al. 2013.

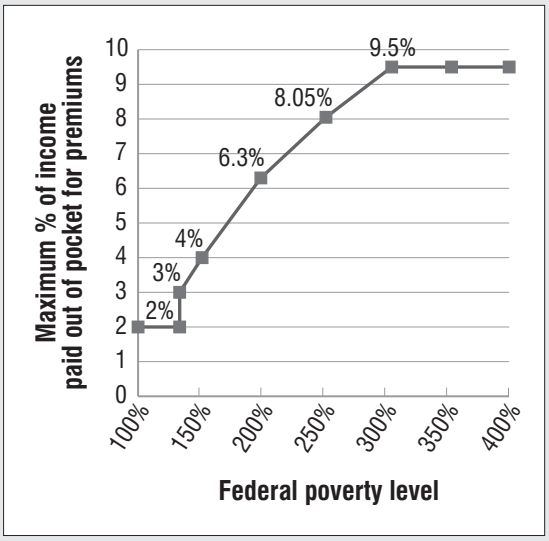
While CHIP premiums below 150 percent FPL may prevent crowd-out of employer-sponsored insurance, they also increase children's uninsurance (Abdus et al. 2013, Herndon et al. 2008). For example, increasing CHIP premiums by $120 annually—including going from no CHIP premium to $120 per year—for children at or below 150 percent FPL would decrease public coverage by 6.7 percentage points, increase private coverage by 3.3 percentage points, and increase uninsurance by 3.3 percentage points (Figure 5-3). For families in this income range who are not offered job-based coverage, the impact of premiums increasing uninsurance is even larger, and the reduction in private coverage is smaller (Abdus et al. 2013). For children above 150 percent FPL, the effect of premiums in increasing uninsurance is much smaller (Figure 5-3).[23]

CHIP–exchange premium stacking. Parents of some CHIP-enrolled children will be eligible for subsidized exchange coverage, for which they will generally pay some out-of-pocket premiums. The amount they pay will vary by income, family size, the plan in which they enroll, and the area in which they live. Exchange plans vary by actuarial value (i.e., the percentage of health care costs paid by the plan), with plans generally classified into four categories—bronze, silver, gold, and platinum.[24] The amount of the premium tax credit is tied to the silver plan with the second-lowest premium in every area, for which families' contribution ranges from 2 percent of income (for those below 133 percent FPL) to 9.5 percent of income (for those between 300 percent and 400 percent FPL) (Figure 5-4).[25] (See Appendix Table 5-A-1 for additional examples of premiums in different geographic areas.)

The combination of premiums for both CHIP and exchange coverage could be substantial for some families (Table 5-4). For example, 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 for the benchmark plan to 4 percent of her income, or $1,193. Her children would be required to enroll in CHIP, not the exchange. In a state charging $20 per child per month for CHIP coverage, the additional cost for this coverage would be an additional 1.6 percent of her income. In total, she would be paying 5.6 percent of her income for insurance coverage, more than contemplated by the limits established in the ACA.

The Commission discussed CHIP-exchange premium stacking and the financial hardship that could result for families. The Commission considered ways to mitigate premium stacking, with consideration of how costs associated with addressing the issue could be split between states and the federal government. No clear consensus was reached for the best approach. The Commission will continue to monitor this issue and assess possible policy options.

FIGURE 5-4. Percent of Income for Out-of-Pocket Premiums for Subsidized Exchange Coverage in the Second Lowest-Cost Silver Plan, by Federal Poverty Level (FPL)



Source: MACPAC analysis.

Commission Recommendation

Recommendation 5.2

In order to align premium policies in separate CHIP programs with premium policies in Medicaid, the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums.

Rationale

Eliminating CHIP premiums for families with incomes under 150 percent FPL will reduce uninsurance and align CHIP premium policies with Medicaid policies for lower-income children. Compared to higher-income enrollees, children in families below 150 percent FPL are much more price sensitive and less likely to take up CHIP coverage when a premium is required (Abdus et al. 2013, Herndon et al. 2008). The CHIP premiums charged in this income range, generally less than $10 per month (Table 5-3), are so small that they would not represent a significant revenue loss to states if they were eliminated—especially as this also removes states' burden in collecting and administering these premiums (Kenney et al. 2007). Ending these CHIP premiums would also address some CHIP-exchange premium stacking for the lowest-income CHIP enrollees, limiting family insurance costs to the amounts set out in the ACA. This recommendation does not call for any change to CHIP's premium policies for families above 150 percent FPL, the income range for the vast majority of CHIP enrollees subject to premiums.

As described in this chapter, while CHIP premiums are widely used, only eight states continue to charge CHIP premiums below 150 percent FPL.[26] Because of ACA changes effective in 2014, the income band for premiums under 150 percent FPL in separate CHIP programs is narrowed down to the income range of 139 to 150 percent FPL, with the number of children potentially facing CHIP premiums below 150 percent FPL reduced to approximately 110,000.

Implications

Federal spending. CHIP matching funds would be available for any increase in state CHIP spending due to loss of premiums or increased enrollment, up to the point at which states have expended their allotments. This recommendation would increase federal spending by less than $50 million in 2015 and by less than $1 billion over the five-year period of 2015 to 2019. These are the smallest non-zero ranges provided by CBO.

States. Eight states charge premiums below 150 percent FPL in their separate CHIP programs. Because of the ACA, the number of children subject to CHIP premiums below 150 percent FPL is shrinking considerably in 2014—to a narrow window between 139 and 150 percent FPL. Ending the use of CHIP premiums would affect state spending in three ways. First, states would lose a small amount of revenue from premiums currently paid by families under 150 percent FPL. Second, states would likely see administrative savings associated with no longer collecting these CHIP premiums. The amount of revenue from CHIP premiums obtained from families below 150 percent FPL is relatively small compared to the administrative costs they create (Kenney et al. 2007). Third, some increased CHIP spending would result from increased enrollment, from children otherwise prevented from enrolling by the premiums.

Enrollees. If states no longer charged CHIP premiums below 150 percent FPL, an estimated 110,000 children would be exempted from CHIP premiums, based on FY 2012 data. As a result of ending these premiums, additional children might also enroll in CHIP, reducing uninsurance but also

private coverage (Abdus et al. 2013, Herndon et al. 2008).

Plans. Plans would no longer have to obtain premiums from newly exempted families, which would reduce administrative burden and increase enrollee retention. Ending CHIP premiums for families below 150 percent FPL might also increase CHIP enrollment in the eight affected states.

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

Endnotes

[1] For a more in-depth discussion on the impact of CHIP on children's uninsurance, see "Impact of CHIP" in Chapter 3 of MACPAC's January 2013 publication entitled *Overview of Medicaid and CHIP*. See also Martinez and Cohen 2013.

[2] Because of the ACA requirement to count income according to MAGI, states will be required to disregard income equal to 5 percent FPL. For this reason, Medicaid eligibility for children (and other groups) is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[3] Medicaid figure excludes about 1 million individuals in U.S. territories. See MACStats Tables 3 and 8 for state-by-state information on CHIP enrollment and spending.

[4] Through FY 2013, states could receive CHIPRA bonus payments for implementing five of eight particular outreach activities. Four of those eight are now required for children's eligibility in Medicaid and CHIP: no asset test, no requirement for an in-person interview, use of the same application and renewal forms in both Medicaid and CHIP, and administrative renewal based on information available to the state.

[5] In addition, CMS issued guidance that states would also be in violation of the MOE if they increased premiums considerably or if they imposed premiums for the first time on existing eligibility groups (CMS 2011).

[6] While the federal CHIP statute limits states' upper-income eligibility levels to 200 percent FPL, or, if higher, 50 percentage points above states' pre-CHIP Medicaid levels, states were permitted to count applicants' income so they could effectively expand eligibility to any income level (HCFA 2001). MAGI eliminated that income-counting flexibility. Unless states obtain federally approved waivers, the original statutory limitation at 200 percent FPL, or 50 percentage points above their 1997 Medicaid levels for children, holds for 2014 forward. (States that expanded prior to 2014 and the implementation of MAGI are grandfathered.)

[7] Cost sharing is also limited by other federal CHIP policies. For example, federal law prohibits states from charging cost sharing for preventive or pregnancy-related services.

[8] Cost-sharing subsidies are given in terms of a plan's actuarial value. Actuarial values estimate the percentage of covered expenses that are paid for by the plan, with the remaining percentage paid for by the enrollee as cost sharing. Actuarial values are calculated as averages for an entire population. In exchange plans, qualifying individuals up to 150 percent FPL are eligible for plans with an actuarial value of 94 percent (i.e., cost sharing equal to 6 percent on average across all enrollees and services). The subsidy decreases as family income rises. Actuarial values are 87 percent for those above 150 percent FPL but at or below 200 percent FPL, and 73 percent for those above 200 percent FPL but at or below 250 percent FPL (§1402(c)(2) of the ACA). An analysis of 16 separate CHIP programs estimated their actuarial values as all above 95 percent FPL—at 175 percent FPL and 225 percent FPL (Watson Wyatt Worldwide 2009). West Virginia was included in the original analysis, but its results are not included here because it has since reduced its CHIP cost sharing, which would increase its actuarial value (MACPAC 2013c).

[9] To minimize burden on individuals and ensure that eligibility is determined promptly, state CHIP agencies must have agreements with Medicaid and exchanges to share application information and maintain proper oversight of determinations made by the other program (42 CFR 457.348).

[10] Research on churning has historically focused on transitions from Medicaid or CHIP to uninsurance, particularly at children's regular eligibility redetermination. The main emphasis of that prior research was on what is called administrative churning, where children's coverage terminates because families do not or cannot provide the necessary application or documentation. However, the ACA required states to streamline eligibility determinations and to use existing data wherever possible, in order to minimize the likelihood of administrative churning at redeterminations. Assessing the impact of the ACA on administrative churning and children's coverage will not be possible until actual enrollment data are available, and this will be an area of interest to the Commission when those data are available.

[11] In addition, 8 reported cost sharing, 28 monitoring, and 8 with some other activity. These data are from the federal CHIP Annual Reporting Template System (CARTS). All states are asked to complete Section IIIB, which pertains to "substitution of coverage (crowd-out)." After noting whether or not there are "substitution prevention policies in place," states answering in the affirmative must check one or more of the following: imposing waiting periods between terminating private coverage and enrolling in CHIP, imposing cost sharing in approximation to the cost of private coverage, monitoring health insurance status at the time of application, and "Other, please explain."

[12] States may be able to implement waiting periods in Medicaid with a federally approved waiver. However, waiting periods under these Medicaid waivers are generally limited to populations not otherwise entitled to Medicaid.

[13] Among uninsured children with incomes between 200 and 399 percent FPL, 9.2 percent had employer-sponsored insurance three months beforehand, 83.9 percent were uninsured, 5.3 percent had Medicaid, and 1.6 percent had other coverage. These estimates are derived from analysis of the Medicaid Expenditure Panel Survey for uninsured children based on pooled data from December of 2009, 2010, and 2011, along with information on these children's health insurance three months prior. MACPAC explored using administrative data for this analysis. The best candidate for information on CHIP waiting periods among administrative data sources was the CARTS. However, MACPAC staff assessed the information reported by states through CARTS on CHIP waiting periods and on applicants' prior employer-sponsored insurance, and the data do not appear usable. For example, states are required to report the percentage of children subject to a CHIP waiting period and exempt from a CHIP waiting period. By state, the percentages ranged from 0 percent to 100 percent.

[14] While survey estimates indicate that relatively few uninsured children had employer-sponsored insurance three months beforehand, they do not shed light on the effectiveness of CHIP waiting periods in deterring crowd-out. The primary purpose of CHIP waiting periods is not to force uninsured children to go without coverage, but to deter parents from dropping their children's employer-sponsored insurance in favor of CHIP coverage that is less expensive to the family and more costly to the federal and state governments. However, no available sources of data ask parents whether they continued their children's enrollment in employer-sponsored insurance because of the waiting periods required in CHIP.

[15] New York is the only state continuing to use CHIP waiting periods that is not using the federally facilitated exchange; New York's exchange is a state-based model. The other 20 states shown in Table 5-1 as having CHIP waiting periods in 2014 use the federally facilitated exchange—either exclusively or in partnership with the state.

[16] Five of the states shown in Table 5-1 as having CHIP waiting periods in 2014 are both using the federally facilitated exchange and permitting the exchange to perform eligibility determinations for Medicaid and, in some cases, CHIP. In three of those states (Louisiana, Texas, and Wisconsin), the federally facilitated exchange is performing Medicaid and CHIP determinations "temporarily as a mitigation strategy" (CMS 2013b). In Wyoming, the federally facilitated exchange is performing Medicaid determinations, but not CHIP determinations. The fifth state, Montana, appears to have a permanent arrangement for the federally facilitated exchange to perform both Medicaid and CHIP determinations (CMS 2013b).

[17] CMS called the evidence base on crowd-out generally "robust but inconclusive" (HHS 2013). On CHIP waiting periods in particular, there are two studies that analyzed the effects of CHIP waiting periods on crowd-out. One found that CHIP waiting periods reduced crowd-out (LoSasso and Buchmueller 2004). The second found "there is certainly no reason to conclude that waiting periods are lowering the crowd-out rate" (Gruber and Simon 2007). In a follow-up analysis, LoSasso and Buchmueller used the data used in their research but applied the approach by Gruber and Simon and continued to find evidence that waiting periods reduce crowd-out; thus, the main difference between the results appears to be the dataset used (Gruber and Simon 2007). LoSasso and Buchmueller used the Current Population Survey, while Gruber and Simon used the Survey of Income and Program Participation—both surveys administered by the U.S. Census Bureau.

[18] Waiting periods are not unprecedented in federal health insurance programs. For most individuals, there is a 24-month waiting period for Medicare after an individual qualifies for Social Security Disability Insurance.

[19] While most states charge CHIP premiums on a monthly basis, some apply premiums (or enrollment fees) on a quarterly or annual basis (Table 5-3). Some also cap the family amount of CHIP premiums.

[20] According to California's approved waiver documentation, for children who have family income between 151 percent and 250 percent FPL, monthly CHIP premiums will be $13 for one child, $26 for two children, and $39 for three or more children. This waiver allowed California to transition its CHIP-enrolled children from a separate CHIP program to a Medicaid-expansion CHIP program while permitting premiums for those children above 150 percent FPL. In addition, families who pay three months of premiums in advance will receive the fourth consecutive month with no premium required. Families paying by means of electronic funds transfer, including credit card payment, will receive a 25 percent discount (CMS 2012).

[21] The SEDS income categories do not allow breaking down the 101 percent to 200 percent FPL range into smaller groups. The large percentage of CHIP-enrolled children charged premiums who are between 101 and 200 percent FPL is reflective of CHIP enrollment overall. Approximately 89 percent of CHIP-enrolled children are below 200 percent FPL.

[22] California was not included because the state has stopped charging CHIP premiums below 150 percent FPL.

[23] For children above 150 percent FPL, a $120 annual CHIP premium increase would decrease public coverage by 1.6 percentage points, increase private coverage by 1.5 percentage points, and increase uninsurance by 0.1 percentage points (Abdus et al. 2013).

[24] The actuarial values are 60 percent for bronze plans, 70 percent for silver plans, 80 percent for gold plans, and 90 percent for platinum plans. For certain individuals under age 30, catastrophic plans are also available through exchanges.

[25] No credit is available if the premium for the second lowest-cost silver plan is less than the amount individuals are required to pay out of pocket. If a credit is available, the family's choice of plan will affect the out-of-pocket costs they pay. For families who choose lower-cost plans (e.g., bronze plans or the lowest-cost silver plan), the premium tax credit may cover a greater portion of the premium. If families choose more expensive plans (e.g., gold or platinum plans), they will be responsible for the difference. However, cost-sharing reductions for families below 250 percent FPL are only available if the family chooses a silver plan. Families will also have to pay separate premiums and cost sharing for exchange-based stand-alone dental plans, in states where offered.

[26] Alabama, Arizona, Delaware, Florida, Georgia, Idaho, Nevada, and Utah.

References

Abdus, S., J. Hudson, S.C. Hill, and T. Selden. 2013. Children's insurance coverage: Evidence from the Medical Expenditure Panel Survey (MEPS). Presentation before the Association for Public Policy Analysis & Management, November 9, 2013, Washington, DC; follow-up with slightly revised numbers from authors, December 13, 2013.

Agency for Healthcare Research and Quality (AHRQ). 2013. Table I.G.2(2012). Employee contribution distributions (in dollars) for employees enrolled in single, employee-plus-one, and family coverage at the 10th, 25th, 50th (median), 75th, and 90th percentiles at private-sector establishments that offer health insurance by firm size: United States, 2012. Rockville, MD: AHRQ. http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tig2.pdf.

Caldwell, C. 2013a. Presentation before the Medicaid and CHIP Payment and Access Commission, November 14, 2013, Washington, DC. http://www.macpac.gov/home/transcripts/MACPAC_2013-11_Transcript.pdf.

Caldwell, C., Alabama Department of Public Health. 2013b. E-mail to MACPAC staff, December 4.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. Letter from Cindy Mann to State Health Officials and State Medicaid Directors regarding "Facilitating Medicaid and CHIP enrollment and renewal in 2014." May 17, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. Medicaid and CHIP marketplace interactions. Baltimore, MD: CMS. http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-and-the-Marketplace/medicaid-chip-marketplace-interactions.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. *Centers for Medicare & Medicaid Services special terms and conditions: California bridge to reform demonstration.* Baltimore, MD: CMS. http://www.dhcs.ca.gov/provgovpart/Documents/1115amendapprovallet12312012.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2011. Letter from Cindy Mann to State Health Officials regarding "Maintenance of effort." February 25, 2011. http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf.

Czajka, J.L., Mathematica Policy Research. 2013. E-mail to MACPAC staff, February 15.

Czajka, J.L. 2012. *Movement of children between Medicaid and CHIP, 2005–2007*. MAX Medicaid Policy Brief, no. 4. Princeton, NJ: Mathematica Policy Research, Inc. http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/Medicaid_and_CHIP_Transitions.pdf.

Gruber, J., and K. Simon. 2007. *Crowd-out ten years later: Have recent public insurance expansions crowded out private health insurance?* NBER Working Paper, no. 12858. Cambridge, MA: National Bureau of Economic Research. http://www.nber.org/papers/w12858.pdf.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 2001. Medicaid program; Change in application of federal financial participation limits. Final rule. *Federal Register* 66, no. 8 (January 11): 2316–2322.

Heberlein, M., T. Brooks, J. Alker, et al. 2013. *Getting into gear for 2014: Findings from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP,* 2012–2013. Washington, DC: Kaiser Family Foundation. http://www.kff.org/medicaid/upload/8401.pdf.

Herndon, J.B., W.B. Vogel, R.L. Bucciarelli, and E.A. Shenkman. 2008. The effect of premium changes on SCHIP enrollment duration. *Health Services Research* 43(2): 458–477.

Highmark West Virginia. 2013. Letter from J. Fred Earley, II, president, to Sharon L. Carte, executive director of West Virginia Children's Health Insurance Program. August 6, 2013.

Kaiser Family Foundation (KFF). 2013. Subsidy calculator: Premium assistance for coverage in exchanges. Washington, DC: KFF. http://kff.org/interactive/subsidy-calculator/.

Kenney, G., J. Marton, J. McFeeters, and J. Costich. 2007. Assessing potential enrollment and budgetary effects of SCHIP premiums: Findings from Arizona and Kentucky. *Health Services Research* 42 (6 Pt 2): 2354–2372.

LoSasso, A., and T. Buchmueller. 2004. The effect of the State Children's Health Insurance Program on health insurance coverage. *Journal of Health Economics* 23(5): 1059–1082.

Martinez, M.E., and R.A. Cohen. 2013. *Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2013*. Hyattsville, MD: National Center for Health Statistics. http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201312.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013a. *Overview of Medicaid and CHIP*. January 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013b. *Report to the Congress on Medicaid and CHIP*. March 2013. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2013c. Public meeting, November 2013. Washington, DC: MACPAC. http://www.macpac.gov/home/transcripts/MACPAC_2013-11_Transcript.pdf.

National Conference of State Legislatures (NCSL). 2012. Quick reference fiscal table. Washington, DC: NCSL. http://www.ncsl.org/research/fiscal-policy/basic-information-about-which-states-have-major-ta.aspx#fyrs.

Touschner, J. 2014. Separate CHIP benefits and cost sharing. Presentation before the Medicaid and CHIP Payment and Access Commission, January 23, 2014, Washington, DC. http://www.macpac.gov/home/2014-01/2014JanuarySession3aTouschner.pdf.

U.S. Department of Health and Human Services (HHS). 2013. Medicaid and Children's Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; exchanges: eligibility and enrollment. Final rule. *Federal Register* 78, no. 135 (July 15): 42180.

U.S. Government Accountability Office (GAO). 2013. *Children's health insurance: Information on coverage of services, costs to consumers, and access to care in CHIP and other sources of insurance*. Report no. GAO-14-40. Washington, DC: GAO. http://www.gao.gov/assets/660/659180.pdf.

U.S. Government Accountability Office (GAO). 2012. *Children's health insurance: Opportunities exist for improved access to affordable insurance*. Report no. GAO-12-648. Washington, DC: GAO. http://www.gao.gov/assets/600/591797.pdf.

Watson Wyatt Worldwide. 2009. *Implications of health care reform for children currently enrolled in CHIP programs*. Washington, DC: First Focus. http://www.firstfocus.net/library/reports/implications-health-care-reform-children-currently-inrolled-chip-programs.

Chapter 5 Appendix

APPENDIX TABLE 5-A-1. Examples of Premiums and Cost Sharing (Out-of-Pocket Maximum) for a Family of Three with Two Adults (Age 40) and One Child in the Silver Plan with the Second-Lowest Premium

	150 Percent FPL	200 Percent FPL	300 Percent FPL	350 Percent FPL
Household income	$29,295	$39,060	$58,590	$68,355
Maximum premium as a percent of income	4%	6.3%	9.5%	9.5%
Enrollee premium responsibility	$1,172	$2,461	$5,566	$6,494
Out-of-pocket maximum for services	4,500	10,400	12,700	12,700
Tax Credits in Selected Locations				
Little Rock, Arkansas ($9,174 total premium)	$8,002	$6,713	$3,607	$2,680
Sacramento, California ($8,090 total premium)	6,918	5,629	2,524	1,596
Tallahassee, Florida ($8,791 total premium)	7,620	6,331	3,225	2,298
Atlanta, Georgia ($7,506 total premium)	6,334	5,045	1,940	1,012
Indianapolis, Indiana ($10,202 total premium)	9,030	7,741	4,636	3,708
Augusta, Maine ($9,583 total premium)	8,411	7,122	4,017	3,089
Albany, New York ($11,699 total premium)	10,527	9,238	6,133	5,206
Bismarck, North Dakota ($8,602 total premium)	7,430	6,141	3,036	2,108
Columbus, Ohio ($7,578 total premium)	6,406	5,117	2,012	1,084
Austin, Texas ($7,478 total premium)	6,306	5,017	1,912	984
Charleston, West Virginia ($8,642 total premium)	7,470	6,181	3,076	2,148

Note: FPL is federal poverty level. Because exchange coverage uses the prior year's FPL, this table reflects the 2013 FPLs.
Source: KFF 2013.

CHAPTER 6

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

Recommendations

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

6.1 As a first step toward improving transparency and facilitating understanding of Medicaid payments, the Secretary should collect and make publicly available non-DSH (UPL) supplemental payment data at the provider level in a standard format that enables analysis.

Key Points

- Non-disproportionate share hospital (non-DSH) supplemental payments, also known as upper payment limit (UPL) payments, account for more than 20 percent of total Medicaid fee-for-service payments to hospitals nationally and more than 50 percent in some states.
- These payments are not reported to the federal government at the provider level in a readily usable format, and, therefore, it is often not possible to determine total payment to individual providers or the effect of these payments on policy objectives such as efficiency, quality, and access to necessary services.
- MACPAC conducted an analysis of five state Medicaid programs, using data supplied by the states. The analysis shows that:
  - Lump-sum supplemental payments can be a significant source of Medicaid payments, particularly to hospitals.
  - Net Medicaid payments are effectively reduced by the health care related taxes that providers pay.
  - Without data on both health care related taxes and supplemental payments, it is not possible to meaningfully analyze Medicaid payments at either the provider or state level.
- Provider-level non-DSH supplemental payment data would provide greater transparency to Medicaid payments, support program integrity efforts, and facilitate Medicaid payment analysis, including assessments of Medicaid payment adequacy and analysis of the relationship between payment and desired outcomes.

CHAPTER 6

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

The Medicaid program is a major purchaser of health care services, accounting for about $431 billion in benefit spending (not including the territories) in fiscal year (FY) 2013 and representing about 15 percent of national health care spending (OACT 2013). Of this, 65 percent was for fee-for-service (FFS) payments from state Medicaid agencies to providers (MACStats Table 7). Federal statute requires that these Medicaid payments be consistent with efficiency, economy, quality, and access and that they safeguard against unnecessary utilization (§1902(a)(30)(A) of the Social Security Act (the Act)). Federal statute also provides states with considerable flexibility in determining both provider payments and methods for financing their share of Medicaid spending.[1]

The Commission is charged with examining all aspects of Medicaid payment and the relationships among payment, access, and quality of care. Therefore, it has begun to take a closer look at states' payments to providers and their methods for determining them. In MACPAC's March 2012 report to the Congress, the Commission provided an overview of state approaches to financing their share of Medicaid expenditures and began to explore the interaction between non-federal financing and provider payment policies (MACPAC 2012). In that report, the Commission made two observations. First, statutorily authorized financing approaches, such as health care related taxes, are important to states' ability to finance their Medicaid programs. Second, lump-sum supplemental payments are often a large component of overall provider payments. At the same time, the Commission highlighted that the lack of data regarding states' use of health care related taxes and supplemental payments makes it difficult to analyze Medicaid payments at the federal level.

Over the past year, the Commission continued its examination of the role of non-federal financing approaches and supplemental payments in the Medicaid program,

working directly with five states to better understand Medicaid payments to hospitals and nursing facilities. This analysis confirmed that supplemental payments play an especially important role in Medicaid payment to providers, and that incomplete Medicaid payment and financing data limit policymakers' ability to fully understand spending in the program. For example, in working with state-specific data, we found that supplemental payments can account for more than half of total payments to providers. For this reason, the Commission is now recommending that the Secretary of the U.S. Department of Health and Human Services (HHS) collect certain supplemental payment data at the provider level and make those data publicly available.

For purposes of Medicaid policy analysis as well as oversight and program integrity, federal and state Medicaid policymakers should fully understand what the program is purchasing, and for what amount. The wide variation in state payment and financing methods, combined with limitations in the payment and financing data reported to the federal government, make it difficult to analyze payment and financing both within and across states. Other health care payers, including Medicare, commonly conduct assessments of payment adequacy and compare payment levels across providers and geographic areas. In the Medicaid program, however, despite the fact that the federal government is responsible for the majority of Medicaid spending, existing federal

BOX 6-1. Glossary of Key Terms

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

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

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

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

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

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

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

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

data sources are not sufficient for comparable analyses of the effects of state payment methods and rates on policy goals such as efficiency, quality, and access to necessary services. This is of particular importance at a time of growing interest in payment reforms that incentivize greater value in the delivery of health services and, thus, a need for data to both design and evaluate these approaches.

This chapter begins with background information regarding supplemental payments and health care related taxes and then describes the Commission's analysis of state-supplied data in detail. It then raises several policy questions about the balance between providing flexibility to states in designing payment and financing methods and offering accountability to the federal government for how Medicaid dollars are used. The chapter concludes with discussion of the Commission's recommendation for improved federal collection of provider-level supplemental payment data as an important first step toward greater understanding of Medicaid payments to providers, and the need for continued examination of related issues, including states' approaches to financing their programs.

Background

The federal Medicaid statute affords states considerable flexibility both in how they finance their Medicaid programs and in how they pay providers. Both health care related taxes and supplemental payments are allowable under federal Medicaid requirements and both are used by the vast majority of states.[2] However, as the Commission previously noted, there is little systemic information on how such taxes and payments flow through the system, making it difficult to assess Medicaid payments within and across states.

Supplemental payments

Some states make payments to providers above what they pay for individual services through Medicaid provider rates. These additional payments fall into two categories:

- disproportionate share hospital (DSH) payments to hospitals serving low-income patient populations, which accounted for about $16 billion (including federal matching funds) in FY 2013; and
- upper payment limit (UPL) supplemental payments, which comprise the difference between total base Medicaid payments for services and the maximum payment level allowed under the regulatory UPL for those services. States reported about $24 billion (including federal matching funds) in these payments in FY 2013.

DSH payments. Medicaid DSH payments are statutorily required payments to hospitals serving low-income patient populations. They are intended to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients. In FY 2013, Medicaid DSH payments accounted for about $16 billion total (including federal matching funds). Each state is allotted DSH funding according to a statutory formula, generally based on historical DSH spending levels increased to account for inflation (§1923(f)(3)(B) of the Act). Approximately $11.5 billion in federal funds were allotted to states for DSH in FY 2013, and state allotments ranged from about $10 million or less in four states (WY, DE, ND, and HI) to over $1 billion in three states (CA, NY, and TX) (CMS 2013a).

In 2010, with the passage of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), the Congress reduced state DSH allotments from FY 2014 to FY 2020 to account for the decrease in uncompensated care anticipated

under the health insurance coverage expansions to begin in 2014. The onset of the reduction was later delayed to FY 2016, and the reduction was extended to FY 2023 in the Bipartisan Budget Act of 2013 (P.L. 113-67).

State distribution of Medicaid DSH funding to hospitals is subject to two rules. First, hospitals meeting specified minimum criteria must be included in the distribution. Second, federal statute limits the amount of DSH payments that a state can make to any single hospital (§1923(g) of the Act). In general, DSH payments may not exceed a hospital's uncompensated costs of providing inpatient and outpatient hospital services to Medicaid and uninsured patients, known as the hospital-specific DSH limit.[3] Within these limitations, states have broad flexibility in determining which hospitals receive DSH payments and how the payments are calculated. This flexibility results in significant variation across states, with some providing DSH payments to relatively few hospitals and others providing DSH payments to nearly all of the hospitals in a state (Mitchell 2012).

Non-DSH supplemental payments. Federal regulations, first promulgated in 1981, prohibit federal financial participation (FFP) for Medicaid FFS payments in excess of an upper payment limit, intended to prevent Medicaid from paying more than Medicare would pay for the same services. Rather than applying a UPL on a claim-by-claim basis, however, the regulations limit the aggregate amount of Medicaid payments that a state can make to a class of providers.[4] The institutions subject to the UPL requirement are hospitals (separated into inpatient services and outpatient services), nursing facilities, intermediate care facilities for persons with intellectual disabilities (ICFs/ID), and freestanding non-hospital clinics. Separate UPLs apply to three separate ownership categories (governmentally operated, non-state governmentally operated, and private) for each provider type.

When FFS Medicaid rates result in aggregate provider payments that are lower than the UPL, some states make supplemental payments (UPL payments) to providers. In determining whether and how much money to allocate to UPL payments, states start by calculating the difference between the UPL for services provided by a class of institutions and the aggregate amount Medicaid paid for those services under FFS. States then target the amount of the difference—or some portion of it—to a subgroup of institutions, allocating it among eligible institutions based on state-defined criteria that sometimes, but not always, include Medicaid days, visits, or discharges.

Hospitals receive the large majority of supplemental payments (Table 6-1). Such payments may be an especially important source of revenue for hospitals that serve a significant proportion of Medicaid enrollees and uninsured individuals. Some states also make supplemental payments to physicians, typically those employed by state university hospitals. Although there is not a federal regulation that establishes a UPL for such non-institutional providers, the Centers for Medicare & Medicaid Services (CMS) has indicated that Medicare rates and average commercial rates for physician services may be used as upper limits (CMS 2013b).

UPL payments are subject to the same broad federal requirements as most Medicaid payments. If a state makes UPL payments, the payment methodology must be documented in the Medicaid state plan, subject to CMS approval. UPL payments are not required to be tied to specific policy objectives in the same manner as, for example, DSH payments are tied to uncompensated care. However, CMS has indicated that, as part of an oversight initiative that began in 2003, state plans must demonstrate a link between supplemental payments and general Medicaid purposes (GAO

2008). In response to comments on changes in the UPL regulations in 2001, CMS specifically stated that the UPL for institutional payments applies only to FFS payments, and that managed care payments are subject to separate regulatory requirements (HCFA 2001) (Box 6-2).

TABLE 6-1. Upper Payment Limit (UPL) Supplemental Payments Reported on CMS-64, Fiscal Year 2013 (Millions)

Provider Type	UPL Payments	Total Medicaid Payments (including DSH)	Percent of Total Medicaid Payments (including DSH)
Hospitals (inpatient and outpatient)	$20,598.8	$89,465.4	23%
Nursing Facilities/ Intermediate Care Facilities for Persons with Intellectual Disabilities	$2,393.8	$62,953.8	4%
Physicians and Other Practitioners	$846.3	$13,163.5	6%

Source: MACStats, Table 20.

BOX 6-2. The Interaction between Upper Payment Limits (UPLs) and Medicaid Managed Care

The ability to make UPL supplemental payment policies has important implications for states' decisions regarding the use of Medicaid managed care (MACPAC 2012, MACPAC 2011). Since UPLs are computed based only on fee-for-service (FFS) days in a hospital or other institutional setting, transitioning populations from FFS to managed care means fewer FFS days and lower potential UPL supplemental payments.

As states increasingly turn to managed care delivery models for broader groups of Medicaid enrollees, FFS payments for acute and long-term care services are declining, along with the amount of UPL supplemental payments that states may make to providers. If the shift in inpatient days from FFS to managed care is large enough in a particular state, the loss of federal matching dollars for UPL payments may outweigh the savings the state realizes through managed care. Furthermore, since higher-cost populations, such as individuals with disabilities, account for a significant share of hospital days, transitioning these populations into managed care has the most significant effect on the UPL.

States' decisions to implement or expand Medicaid managed care have been influenced by the potential loss in federal matching dollars for supplemental payments. Some of these states (e.g., California, Florida, Texas) have received Section 1115 demonstration waiver authority to allow for the continued use of supplemental payments while expanding the use of Medicaid managed care. In the 1115 waivers that have been approved by the Centers for Medicare & Medicaid Services, states' supplemental payments have been contingent upon additional requirements that do not typically apply to FFS UPL payments. For example, payments from uncompensated care pools created under the waivers may not exceed the cost of uncompensated care as defined for disproportionate share hospital payments, while payments from delivery system reform incentive pools have been contingent upon providers' achieving metrics related to delivery system improvements.

While the mechanisms for targeting providers vary by state, UPL payments are generally allocated to providers based on their relative number of Medicaid days or discharges or as an equal share of a fixed amount (Bachrach and Dutton 2011). These payments are not subject to provider-specific limits and, therefore, individual providers may receive more than their reported Medicaid costs as long as the aggregate payments to all providers in their class do not exceed the aggregate UPL.[5]

Health care related taxes

States generate their share of Medicaid spending through a combination of sources, including state general revenue, contributions from local governments (including providers operated by local governments), and other revenue sources such as health care related taxes. As long as a state operates its program within federal requirements, it is entitled to receive federal matching funds toward allowable state expenditures.

According to a recent survey, every state but Alaska has at least one health care related tax in place as of state fiscal year (SFY) 2014 (Smith et al. 2013). In general, health care related taxes (sometimes referred to as provider taxes, fees, or assessments) are defined by federal statute as taxes of which at least 85 percent of the tax burden falls on health care providers (§1903(w)(3)(A) of the Act).[6] The statute includes several other requirements, including that such taxes be broad-based and uniform and that providers cannot be held harmless through increased Medicaid payments.[7]

These taxes are commonly used by states to:

- fund the non-federal share of supplemental Medicaid payments for the classes of providers that pay the tax;
- increase or avert reductions in Medicaid rates; and
- finance other areas of the Medicaid program, including enrollment expansions.

Federal regulations specify that states may assess health care related taxes on 18 separate provider classes (42 CFR 433.56). They are most commonly assessed on nursing facilities (44 states), hospitals (40 states), ICFs/ID (37 states), and managed care organizations (12 states) (Smith et al. 2013). Use of health care related taxes has increased over the past decade, likely due, at least in part, to declines in other state revenues during a period of economic downturn. In 2008, 18 states had a hospital tax, compared to 40 states in state fiscal year (SFY) 2014.

The total amount of non-federal Medicaid share raised through health care related taxes and other local government contributions known as intergovernmental transfers (IGTs) and certified public expenditures (CPEs) was estimated to be about $41 billion in SFY 2012, accounting for about 24 percent of non-federal Medicaid spending (NASBO 2012). While the total amount of health care related tax revenue is uncertain, those states that reported revenue on the CMS-64 reported $23.0 billion for FY 2013.[8] A recent survey asked all states to estimate the proportion of their non-federal Medicaid share that is financed through provider taxes. Among the 30 states that responded, estimates ranged from less than one-half of 1 percent to slightly more than 40 percent (Smith et al. 2013).

Insufficient data on health care related taxes and supplemental payments complicate Medicaid payment analysis

All health care payers should know what they pay, to whom, and for what. This information allows payers to assess whether payments are set at appropriate levels and to evaluate the effects of payment on the delivery of services, including, for example, effects on service integration, enrollee access, and quality. For the Medicaid program, the primary statutory obligation is to assure consistency with efficiency, economy, quality,

and access to care. At the federal level, this has historically been addressed through review of payment methods outlined in Medicaid state plans and through enforcement of aggregate UPLs.

Analyzing whether Medicaid payments are consistent with efficiency, economy, quality, access, and appropriate utilization requires an understanding of net Medicaid payment—the amount of Medicaid payment that providers receive, including both claims-based and supplemental payments, less the amount that providers contribute toward the non-federal share of Medicaid expenditures. Currently, however, there are insufficient data at the federal level to determine provider-specific net Medicaid payments and by extension, the relationship of payment to program objectives. This is because neither UPL supplemental payment data nor data regarding provider-contributed non-federal Medicaid share (e.g., health care related taxes, IGTs, CPEs) are reported to the federal government at the provider level in a readily usable format.

Supplemental payment data. States are required to submit claims-level Medicaid data to the federal government each quarter. However, because supplemental payments are typically paid in lump sums, they are not included on claims. As of FY 2010, states are required to report the aggregate amount of UPL supplemental payments on the CMS-64, but not the providers that receive them nor their specific amounts. Thus, it is not possible to determine or compare the total amount of Medicaid payments to individual providers nor what those payments are for.

In March 2013, CMS issued guidance in a State Medicaid Director letter requiring states to demonstrate their compliance with UPL requirements annually, including provider-level reporting of non-DSH supplemental payments (CMS 2013c). Beginning in 2013, states must submit these UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. Beginning in 2014, states will also be required to submit annual UPL demonstrations for clinics, physician services (for states that make targeted physician supplemental payments), ICFs/ID, private residential treatment facilities, and institutes for mental disease.

The UPL demonstration data will be collected by CMS regional offices and maintained separately from other Medicaid payment data. At this time they are not required to be submitted in a standardized format and are not expected to be available for analysis outside of CMS. While these data will allow CMS to assure compliance with UPL regulations and may provide them with an improved understanding of total Medicaid payments at the provider level, it may not be possible for analysts to combine these supplemental payment data with claims-based data, such as those in the Medicaid Statistical Information System (MSIS), to obtain complete and consistent total Medicaid payments by provider.

Since MACPAC first discussed this issue in its March 2012 report, the U.S. Government Accountability Office (GAO) has also reported that federal Medicaid payment data sources provide incomplete and inconsistent information regarding program expenditures (GAO 2012a). The GAO further recommended that:

- CMS issue guidance to states on permissible methods for calculation of non-DSH supplemental payments;
- CMS issue facility-specific reporting requirements for non-DSH supplemental payments as is required for DSH;[9] and
- non-DSH supplemental payments be subject to an annual independent audit as is the case for DSH (GAO 2012b).

In response, CMS agreed about the need to improve reporting and oversight of non-DSH supplemental payments and noted that supplemental payments

are subject to CMS' oversight through the state plan amendment (SPA) process. CMS also indicated that it was scrutinizing supplemental payment methods in approved SPAs and identifying states that are not reporting aggregate supplemental payment amounts on the CMS-64.

Health care related taxes. There are no consistent reliable national data on health care related tax rates and amounts of revenue generated at either the provider or state level. Health care related taxes effectively reduce the amount of Medicaid payment actually received by providers. Therefore, if health care related tax revenue is used to finance provider payments, it may be misleading to compare these payments to those that are not financed, in any part, by these taxes.

Health care related taxes and supplemental payments often, but not always, go hand in hand. In many cases, health care related taxes are used as the source of non-federal financing for supplemental payments to the providers that pay them. At the same time, health care related taxes can also be used to finance claims-based payments to these providers or to finance other types of state Medicaid spending or other state activities. Supplemental payments may also be financed through other sources of non-federal share (e.g., general revenue, IGTs, or CPEs). Unless specified by state law or policy documentation, it can be difficult to know the types and amounts of Medicaid payments that are financed through particular types of revenue (e.g., health care related taxes and IGTs).

Understanding Medicaid Payments to Hospitals and Nursing Facilities: State Analysis

MACPAC conducted an analysis of five state Medicaid programs, using data supplied by the states, to demonstrate the effects of provider-contributed financing (such as health care related taxes) and supplemental payments on net Medicaid payments to hospitals and nursing facilities. MACPAC asked selected states to participate in this study based on a number of factors, including their use of supplemental payments and health care related taxes, the size of the state, and geographic region. Provider-specific payment and financing data were requested and interviews were conducted with Medicaid officials in each of the states to better understand their payment and financing policies and to provide context for the data.

The analysis focused on FFS payments for hospital and nursing facility services but did not examine managed care arrangements. It included hospitals and nursing facilities because both are frequently subject to health care related taxes (40 states impose a hospital tax, 44 states impose a nursing facility tax, and 39 states impose both (Smith et al. 2013)), and both are subject to UPLs. All five states agreed to participate anonymously in order to allow MACPAC to analyze actual state data without drawing policy conclusions specific to individual state programs. The five states selected used a variety of rate-setting practices, supplemental payment approaches, and non-federal financing sources.

Methods

Interviews with state officials. Interviews were conducted with Medicaid officials in each of the five study states in order to better understand each state's payment and financing methodologies. Interviews focused specifically on the following topics:

- rate-setting methodologies for inpatient hospital services, outpatient hospital services, and nursing facilities;
- health care related taxes assessed on inpatient hospital services, outpatient hospital services, and nursing facilities, including the amount and basis of the tax and the use of revenue generated;

- IGTs or CPEs used by the state to finance the state matching share for hospital and nursing facility services;
- payments made to hospitals and nursing facilities outside the rate itself, including DSH and non-DSH supplemental payments;
- anticipated policy developments regarding provider payments and financing approaches; and
- state-specific issues that led to current payment and financing policies and perspectives on the strengths and weaknesses of their approach.

Data. States supplied provider-specific payment and financing data for dates of service July 1, 2011, to June 30, 2012, including data related to:

- Medicaid claims;[10]
- supplemental payments, as well as the intended purpose of the supplemental payments;
- non-federal Medicaid share contributed by providers, including through health care related taxes, IGTs, and CPEs;
- provider characteristics, including ownership type (state, non-state public, private for-profit, private non-profit) and urban and rural designation;
- provider cost data; and
- supplemental documentation regarding payment and financing policies and data.

Four of the five states were able to provide the requested data for analysis of the effect of supplemental payments and non-federal financing on net provider payment. These data, along with hospital and nursing facility Medicare cost reports collected for this study, were also used to estimate payment-to-cost ratios for providers in each of the four states. Data were analyzed as reported by the states; no attempts were made to audit or independently verify the information.

Metrics for state comparison. A primary goal of this project was to illustrate the difference between claims-based Medicaid payment and net Medicaid payment, which takes into account both supplemental payments and the provider-contributed non-federal share. The following metrics were determined to be most appropriate for comparison of net payments across states:

- hospitals: payment per unduplicated recipient served for inpatient and outpatient services combined;[11] and
- nursing facilities: payment per resident day.

For both hospitals and nursing facilities, payment-to-cost ratios were also estimated with and without supplemental payments, in order to illustrate the extent to which this measure is affected by supplemental payments.

This project focused solely on Medicaid payments and associated Medicaid costs (as estimated using Medicare cost reports). Unless otherwise noted, results are presented for total payment excluding DSH payments. This is because DSH payments are intended to account for both unpaid Medicaid costs and the costs of serving the uninsured. For this project, it was not possible to identify the portion of DSH payments attributable to unpaid Medicaid costs and, therefore, including them would have included payment for, at least in part, the costs of services to the uninsured.

Limitations of the data and associated metrics. MACPAC selected a small number of states because of the considerable effort required to obtain and understand each state's data. The results, therefore, are illustrative but may not be generalizable across all state Medicaid programs. Also, the data themselves have a number of limitations, including:

- inconsistency between claims and cost report time periods;

- inability to standardize payments for case mix; and
- uncertainty regarding reliability and consistency of cost reporting (e.g., whether or not health care related taxes are included).[12]

There are also other differences among state Medicaid programs that affect net FFS provider payments in the aggregate and per recipient, per discharge (for inpatient hospital), per visit (for outpatient hospital) and per day (for nursing facility). These include, for example, state eligibility levels for Medicaid and the acuity and service use of the enrolled population. States with higher acuity enrollees might be reasonably expected to spend more per person for hospital services than states with a higher proportion of enrollees with fewer health care needs. Payments might also be affected by the extent to which enrollees are enrolled in Medicaid managed care plans and the types of utilization controls that a state has in place (e.g., cost sharing, prior authorization, service limits), among other factors.

Finally, it is important to mention that MACPAC originally assumed that the entire amount of health care related taxes could be subtracted from Medicaid payments for the purpose of estimating net Medicaid payments. Health care related taxes are generally used to support Medicaid expenditures and, therefore, for this project we chose to subtract the full amount contributed by providers from their total Medicaid payments. However, as discussed previously, it is not necessarily the case that such taxes are used entirely to finance payments back to the contributing providers. Thus, it is not possible to determine the portion of Medicaid payments to providers that are financed with health care related taxes. This is one reason why the Commission is choosing to focus its recommendation on non-DSH supplemental payments and intends to continue to examine health care related taxes in the future.

State payment and financing policies

Payment methodologies. Four of the five states selected for this analysis make payments to hospitals for inpatient services using a diagnosis-related group (DRG)-based methodology (as do 35 states nationally (Xerox 2013)). DRG-based methodologies typically pay hospitals a per discharge amount based on the diagnoses that are the reason for the hospital stay. The fifth state currently makes a tiered per diem payment but is contemplating conversion to DRGs (Table 6-2). Each DRG system, however, had numerous state-specific features (Box 6-3).

For outpatient services, the five study states used a variety of payment methodologies, including calculating payment based on a hospital's cost-to-charge ratio, fee schedules, and ambulatory classification groups (Table 6-2). This appears consistent with the variation at the national level, with 15 states using ambulatory care groups, 13 using fee schedules, and 23 paying based on providers' reported costs, typically via cost-to-charge ratio (Xerox 2013).

Nursing facility payment systems were similar across the study states. Each calculates per diem rates based on reported costs, and each adjusts the direct care and nursing components of the rate based on patient acuity. However, there were significant differences among the states, for example, in the ceilings applied to each of the cost centers, the use of cost settlement, definitions of allowable costs, the manner of paying for capital expenses, and the number of acuity groups used for adjustment (Table 6-3).

Non-federal financing. All five states collect health care related taxes from nursing facilities, and four collect health care related taxes from hospitals. In addition, in several of the states, publicly owned and operated providers contribute non-federal Medicaid share through IGTs, and others certify

TABLE 6-2. Summary of Hospital Payment and Financing in Study States

State	Inpatient	Outpatient	Financing	Non-Disproportionate Share Hospital Supplemental Payments
One	Diagnosis-related group (DRG)	Combination of cost-to-charge ratio (CCR) and fee schedule	Health care related tax on both inpatient and outpatient charges; limited use of certified public expenditures (CPE)	UPL payments, including some based on quality incentives
Two	DRG	Combination of fees and ambulatory care groups	Health care related tax on both inpatient and outpatient gross receipts; limited use of intergovernmental transfers (IGTs)	UPL payments, payments for graduate medical education (GME), and for safety-net tertiary and rural providers
Three	Provider-specific rate per discharge, adjusted using DRGs	Ambulatory care groups	Health care related tax on net operating revenue	Limited supplemental payments for graduate medical education
Four	Tiered per diem	Combination of fees, ambulatory care groups, and CCR	Significant use of both IGTs and CPEs by public providers	UPL payments, payments for GME, behavioral health services, and services to low-income individuals
Five	DRG	Ambulatory care groups	Health care related tax per day; CPEs	Variety of payments, including those for high Medicaid volume, safety net providers, tertiary care, and trauma centers, among others

Notes: Identifies the most prominent base payment methodology, but there are commonly exceptions for particular types of providers (e.g., psychiatric hospitals, critical access hospitals) and services (e.g., neonatal intensive care units). UPL payments refers to non-disproportionate share hospital supplemental payments for which state officials did not identify specific purposes.

Source: Burns & Associates analysis for MACPAC.

their direct spending on Medicaid services as eligible for federal match through CPEs.

States reported a variety of uses for health care related tax revenue (Table 6-4). These ranged from very broad—such as general Medicaid financing—to specifically targeted purposes such as supporting mental health capacity in emergency departments. The proportion of tax revenue that is used for each of the purposes is not known. As mentioned previously, for the purposes of this analysis, MACPAC assumed that the entire amount of health care related taxes paid could be subtracted from Medicaid payments in order to estimate net Medicaid payments.

BOX 6-3. State-Specific Features of Diagnosis-Related Group (DRG) Hospital Payment Methods in Study States

Policy Features

- Payment for readmissions (e.g., within 7, 10, or 30 days)
- Certain hospitals excluded from DRG methodology
- Treatment of out-of-state hospitals
- Payment for transfers among hospitals or distinct units
- Payment for short stay or same-day discharges
- Payment for psychiatric services
- Payment for substance abuse services
- Payment for rehabilitation services
- Payment for transplants
- Payment for nursery and neonatal intensive care unit

Technical Features

- Type of DRG grouper and included updates
- Basis of relative weights (e.g., costs based on claims or charges)
- Peer groups
- Frequency of rebasing
- Inflation indices and timing
- Source of average cost per discharge (e.g., claims or cost reports)
- Treatment of capital expenses
- Treatment of graduate medical education
- Outlier criteria and payment
- Special pricing for specific DRGs

Source: Burns & Associates analysis for MACPAC.

TABLE 6-3. Summary of Nursing Facility Payment and Financing in Study States

State	Method	Financing	Supplemental Payments
One	Prospective per diem with case mix adjustment	Health care related tax per non-Medicare day calculated monthly; public facilities use certified public expenditures (CPEs)	Upper payment limit (UPL) payments, including for quality incentives and treating complex patients
Two	Prospective per diem with case mix adjustment	Health care related tax on gross receipts; limited use of CPEs by state-owned facilities	None
Three	Prospective per diem with case mix adjustment	Health care related tax on net operating revenue; limited use of CPEs.	None
Four	Prospective per diem with case mix adjustment	Health care related tax per bed day	None
Five	Prospective per diem with case mix adjustment	Health care related tax per patient day; CPEs	None

Note: UPL payments refers to non-DSH supplemental payments for which state officials did not identify specific purposes.
Source: Burns & Associates analysis for MACPAC.

TABLE 6-4. Uses of Health Care Related Taxes in Study States

Hospital Tax	Nursing Facility Tax
Payment rate increases (or avoidance of payment reductions) Upper payment limit supplemental payments General Medicaid program financing Quality incentives	
Eligibility expansion	Pay-for-performance
Support emergency department mental health capacity	Payments for high resident acuity
Support inpatient psychiatric capacity	Payments for residents with mental illness, dementia, or brain injury
Support hospitals with high Medicaid utilization	Change management

Source: Burns & Associates analysis for MACPAC.

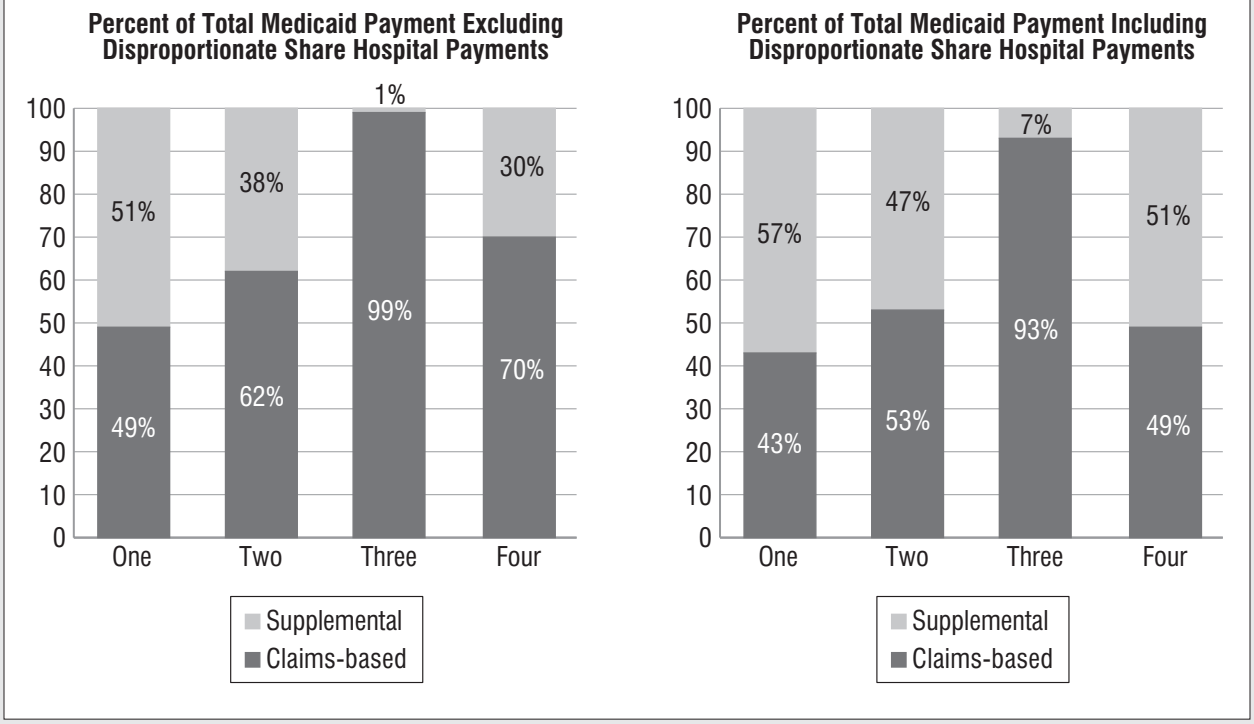
Findings

In each of the states that were able to provide data, net payments to hospitals and nursing facilities were substantially different from payments based on claims alone. In three of the four states studied, supplemental payments represent a large portion of total Medicaid payment (Figure 6-1). For example, even when DSH payments are excluded, non-DSH supplemental payments account for between 30 and 51 percent of total Medicaid payment in three of the four states.

These results show why both health care related taxes and supplemental payments are important to Medicaid payment analysis. In State Three, for example, non-DSH supplemental payments are only about 1 percent of total FFS Medicaid payment. As a result, claims-based payment metrics should be reasonably reflective of the actual amount that hospitals receive from Medicaid. However, after accounting for the non-federal share that hospitals contribute through a health care related tax, the net Medicaid payment to State Three hospitals is only 89 percent of that which is indicated by claims data (Table 6-5). In State Two, however, both supplemental payments and health care related taxes play important roles. Claims-based payments represent only about 62 percent of total payments to hospitals and, because hospitals in State Two also contribute a large amount of non-federal share, net payment is only about 77 percent of the total payment.

Both supplemental payments and provider-contributed financing also have significant effects on comparative analyses of Medicaid payments in the examined states (Table 6-5). Based on claims data alone, State Three paid nearly $3,300 per recipient served by hospitals, a figure that is $400 higher than State Two and approximately double the amounts paid by States One and Four. After including supplemental payments, however, State Three is only the third-highest payer and pays about $1,400 less per recipient than State Two. After accounting for non-federal share contributed by the hospitals, the picture changes yet again. Hospitals in States One and Two contribute more than $1,000 in health care related taxes per

FIGURE 6-1. Proportion of Claims-Based and Supplemental Payments to Hospitals in Each Study State, Including and Excluding DSH Payments (SFY 2012)



Source: Burns & Associates analysis for MACPAC.

recipient served, while State Three's hospitals are taxed at a rate of about $367 per recipient. State Four does not have a health care related tax on hospitals, but government-owned providers contribute non-federal share through IGTs and CPEs. While significant differences remain among the states after accounting for these financing arrangements, the differences in Medicaid payment across states are somewhat moderated.

For nursing facilities, only State One makes supplemental payments. Thus, for the other three states, total Medicaid payments are identical to claims-based payments. All four states, however, assess health care related taxes on nursing facilities, resulting in net Medicaid payments that are 9 to 17 percent lower than total payments (Table 6-6).

Cost coverage of hospitals and nursing facilities. The ratio of payment to cost is a common measure of payment adequacy, allowing policymakers to consider payment levels relative to the cost of providing care. For this analysis, payment-to-cost ratios were estimated with and without non-DSH supplemental payments to demonstrate the effect that these payments can have on results. It is important to note that payment-to-cost ratios depend heavily on the method used to determine provider costs. Furthermore, reported costs may or may not reflect efficient service delivery. Thus, while payment-to-cost ratios are a useful benchmark, they alone may not be sufficient to fully assess the appropriateness of payment. Because of the data limitations described previously, as well as the use of Medicare cost reports to estimate Medicaid costs, this analysis was not intended as an assessment of payment adequacy in

TABLE 6-5. Comparison among Average Claims-Based, Total, and Net Medicaid Payment to Hospitals across Four Study States (SFY 2012)

	State			
	One	Two	Three	Four
Claims payment per recipient	$1,886	$2,878	$3,278	$1,512
Supplemental payment per recipient	1,985	1,799	36	652
Total payment per recipient	3,872	4,677	3,315	2,165
Claims payment as a percent of total payment	48.7%	61.5%	98.9%	69.9%
Health care related tax paid per recipient	$1,542	$1,044	$367	$0
Intergovernmental transfers/certified public expenditures paid per recipient	18	16	0	208
Net payment per recipient	2,311	3,618	2,948	1,957
Difference between total payment and net payment	1,560	1,059	367	208
Net payment as a percent of total payment	59.7%	77.3%	88.9%	90.4%

Source: Burns & Associates analysis for MACPAC.

TABLE 6-6. Comparison among Claims-Based, Total, and Net Medicaid Payment to Nursing Facilities across Four Study States (SFY 2012)

	State			
	One	Two	Three	Four
Claims payment per diem	$77	$203	$90	$126
Supplemental payment per diem	12	0	0	0
Total payment per diem	88	203	90	126
Claims payment as a percent of total payment	86.8%	100%	100%	100%
Health care related tax paid per diem	$6	$17	$14	$11
Intergovernmental transfers/certified public expenditures paid per diem	2	3	0	0
Net payment per recipient	81	183	75	115
Difference between total payment and net payment	8	20	15	11
Net payment as a percent of total payment	91.4%	90.0%	83.6%	91.3%

Source: Burns & Associates analysis for MACPAC.

TABLE 6-7. Medicaid Payment to Cost Ratios with and without Supplemental Payments (SFY 2012) across Four Study States

	Payment-to-Cost Ratio (Claims-Based Payment)				Payment-to-Cost Ratio (Total Payment)			
	State One	State Two	State Three	State Four	State One	State Two	State Three	State Four
Hospitals	40%	49%	117%	60%	83%	80%	118%	86%
Nursing facilities	98	92	77	79	113	92	77	79

Note: Medicaid costs include both the cost of Medicaid services (using the claims provided by the states and hospital-specific cost-to-charge ratios (CCRs) calculated using Medicare cost report data), as well as any non-federal Medicaid share contributed by the provider. When establishing a CCR, the actual assignment of costs can vary and lead to different results. For example a total facility CCR, revenue center-specific CCRs, or different CCRs for inpatient and outpatient services, among others, all may lead to different results. Therefore, the cost coverage values shown in this table should be considered estimates due to the variability in the costing methodologies that can be employed. SFY is state fiscal year.

Source: Burns & Associates analysis for MACPAC.

the participating states and should not be considered reflective of Medicaid payment adequacy in general.

For hospitals in the study states, the estimated payment-to-cost ratio can differ dramatically depending on whether supplemental payments are included (Table 6-7). The three states that make supplemental payments to hospitals had estimated payment-to-cost ratios of 40, 49, and 60 percent based on claims payments alone. Including supplemental payments, these same states were estimated to cover 83, 80, and 86 percent of their hospitals' Medicaid costs—ratios that are far more similar than claims-based payments alone would suggest. Cost coverage in State Three, which generally does not make lump-sum supplemental payments, does not change when supplemental payments are included, yet remains the highest of the four states by far.

Unlike for hospitals, cost coverage for nursing facilities generally did not vary when including supplemental payments. As discussed earlier, only State One makes lump-sum supplemental payments to nursing facilities, accounting for the significant increase in cost coverage when such payments are included (Table 6-7).

Interpreting the results

This analysis helps illustrate several of the issues MACPAC has raised previously:

- Lump-sum supplemental payments can be a significant source of Medicaid payments, particularly to hospitals.
- Net Medicaid payments are effectively reduced by the health care related taxes that providers pay.
- Without data on both health care related taxes and supplemental payments, it is not possible to meaningfully compare Medicaid payments across providers and states.

The results confirmed that supplemental payments can have a significant effect on total Medicaid payment. For three of the four states that provided data, supplemental payments are a large source of Medicaid revenue for hospitals and contribute greatly to the proportion of estimated costs that are covered, particularly when base payment rates may be relatively low. This analysis also demonstrated that provider-contributed financing, such as health care related taxes, has significant effects on the net amount of Medicaid payments

that providers receive. Yet uncertainty regarding the ultimate use of tax revenue by the state makes the relationship between health care related taxes and provider payment less clear.

Despite the apparent importance of non-DSH supplemental payments and health care related taxes in Medicaid payment, our ability to conduct analyses that take these factors into account is hampered by lack of data. CMS does not routinely collect health care related tax data at the provider level, and provider-level supplemental payment data are collected only for DSH audit and UPL compliance purposes in formats that cannot be readily combined with claims-based payment data for analysis. While states are required to report Medicaid provider payments to MSIS (§1903(r)(1)(F) of the Act), payment data that are not claims-based, including most supplemental payments, are often not included. Even when working directly with the state Medicaid programs that agreed to participate, multiple data limitations left MACPAC unable to conclusively determine net Medicaid payments to individual providers.

Policy implications. As with most Medicaid payments, states have considerable flexibility in establishing UPL payment methodologies. UPL payments are typically made in lump-sum amounts and distributed among a group of providers based on the volume of Medicaid services that they provide. However, because provider-level data regarding these payments are generally not available, we cannot assess their effects on policy goals such as efficiency, quality, and access to necessary services. For example, without knowing the full amount of Medicaid payments to individual providers, we cannot evaluate the relationship between their Medicaid payment and the cost of providing services to Medicaid enrollees.

While states' methods for distributing UPL payments are subject to CMS approval, their use (beyond supplementing payment rates) and effectiveness in promoting program objectives can be difficult to discern. Since its inception, the Medicaid statute has allowed states the flexibility to adapt their financing and payment approaches to meet changing needs and program objectives. Moreover, the reasons for individual state approaches may stem from a variety of factors, including their historic approaches to health care delivery, local health care markets, state politics, and budget conditions. However, the state-level characteristics that drive each state's policies, and the effect of these policies on the Medicaid program, are not always well understood. Further, without a detailed understanding of each state's distribution methods, it is difficult to identify the services and enrollees with which these payments are associated, an issue that takes on greater importance now that different federal matching rates apply to different enrollees.

A primary goal of Medicaid payment policy is to assure sufficient access to high quality health care services while guarding against unnecessary expenditures. In pursuit of that goal, states have adopted a wide variety of approaches to both financing the payments and determining how they are distributed. For example, among the study states, two of the four that provided data use a DRG-based inpatient hospital payment methodology, but at least half of their total hospital payments are made as lump-sum supplemental payments. The one study state that does not have a health care related tax on hospitals makes significant use of IGTs and CPEs, pays for inpatient hospital services based on per diem rates, and still makes a large amount of supplemental payments. Another state pays hospitals based on a per discharge rate, assesses a health care related tax on hospitals, and makes almost no supplemental payments.

While the results indicate that these state policies have a profound effect on the net amount of Medicaid payment that providers receive, they provide little insight into the specific reasons

for these policies or the effect that they have on provider incentives, enrollee access to needed services, or states' ability to develop new approaches. It is possible, for example, that the effect of payment policies intended to promote certain outcomes (e.g., using DRGs to encourage inpatient hospital efficiency) may be muted by providers' ability to access supplemental payments. On the other hand, the supplemental payments themselves may promote improved access. Without knowing which providers receive these payments, and the payment amounts, these effects cannot be measured. In recent years, states have undertaken payment reforms designed to encourage providers to produce desired outcomes rather than service volume—including the use of bundled payments, shared savings, and non-payment for services deemed inefficient. As states increasingly pursue these types of reforms, it will be even more important to understand the role of non-DSH supplemental payments and the effects that they have on provider incentives.

Participating state officials indicated a number of ways in which some supplemental payments were associated with policy objectives, such as rewarding quality outcomes and promoting access to particular types of specialty care that are important to Medicaid enrollees. However, the analysis did not attempt to identify the extent to which supplemental payments were associated with specific objectives or the extent to which they may help achieve them. Regardless, after accounting for both supplemental payments and health care related taxes, net Medicaid payments still varied dramatically among states and providers. While the analysis did not attempt to account for known differences among study states (e.g., geographic variation in input costs, or eligibility levels), such characteristics may not explain the full amount of the differences in net payment percent that were observed among the study states.

The results of this analysis, while illustrative, are not conclusive. For example, estimates of cost coverage among the study states suggest that net Medicaid payments are generally within about 20 percent of estimated costs, though the extent to which costs appear to be covered differs significantly. While supplemental payments are a significant component of total payments in several of the states, they do not appear to result in very high payment levels relative to cost. In the three states that make supplemental payments to hospitals, including these payments still results in estimated payment-to-cost ratios of less than 90 percent. However, because data regarding their use are generally not available at the federal level, without other sources of these data it is not possible to determine what Medicaid pays to individual providers, nor for what types of services or enrollees. It is also not possible to determine the effect that payment policies, including supplemental payments, have on access to services. MACPAC is charged with assessing the link between Medicaid payment and enrollee access to services. Without the information required to determine net payment, this is far more difficult to accomplish.

Commission Recommendation

Recommendation 6.1

As a first step toward improving transparency and facilitating understanding of Medicaid payments, the Secretary should collect and make publicly available non-DSH (UPL) supplemental payment data at the provider level in a standard format that enables analysis.

Rationale

For purposes of Medicaid policy analysis as well as oversight and program integrity, federal

and state Medicaid policymakers should fully understand what the program is purchasing and for what amount. Non-DSH supplemental payments account for more than 20 percent of total Medicaid FFS payments to hospitals nationally and more than 50 percent in some states (MACStats Table 20). Even so, non-DSH supplemental payments are not reported to the federal government at the provider level in a readily usable format, and, therefore, it is often not possible to determine total payment to individual providers or the effect of these payments on policy objectives. While the Commission discussed a range of options related to non-DSH supplemental payments, including requiring supplemental payments to be tied to measurable outcomes or requiring all payments to be claims-based, ultimately the Commission agreed that obtaining provider-level supplemental payment data was an essential first step toward understanding the role of these payments in the Medicaid program. Health care related taxes have also been shown to play an important role in net Medicaid payments, and data regarding their use are also unavailable; however, their direct relationship to provider payments is less clear and thus requires further examination.

The federal government has historically financed about 57 percent of national Medicaid expenditures, and this percentage is expected to increase as a result of the ACA. It is reasonable, therefore, to expect federal interest in overseeing and understanding states' use of Medicaid funds and the extent to which state policies are consistent with statutory requirements. At the same time, the program is largely administered at the state level with broad federal oversight. This relationship has always raised questions regarding the federal government's role in overseeing payment policy and its need to be able to analyze and compare data at the state and provider level, rather than simply assuring compliance with broad parameters such as aggregate UPLs. Federal policymakers must remain sensitive both to the administrative effort required for states to provide, and for the federal government to collect, various sources of administrative data and to preserving the flexibility that the Medicaid statute affords to states.

Health care policymakers commonly assess provider payments for their consistency with efficiency and economy and their effect on enrollees' access to services. Potential analyses of these issues in the Medicaid program will often be incomplete—and possibly misleading—without the inclusion of provider-level data on UPL payments.

Payment and access to care. In the Medicaid program, the wide variation in state Medicaid payment methods, combined with limitations in the supplemental payment data reported to the federal government, make it difficult to analyze both the adequacy and effects of payment both within and across states. MACPAC is charged with assessing the link between Medicaid payment and enrollee access to services, and might wish, for example, to examine whether higher payment relative to cost is related to higher Medicaid utilization. Without the information required to determine total Medicaid payment, however, this cannot be done.

Efficiency and economy. At the same time, the lack of data on payment levels hinders the ability to evaluate the efficiency and economy of state Medicaid programs. For example, provider margins are typically considered as part of assessments of payment adequacy, but without total payments, this is not possible.[13] Further, states themselves frequently attempt to benchmark their Medicaid payment rates against those of other states but have to rely on rough estimates for comparison due to a lack of consistent and complete Medicaid payment data. A number of states are pursuing value-based approaches to Medicaid payment and may be increasingly seeking to tie payment to policy objectives, yet existing data sources cannot be used to determine the extent to which such payments are made, or their effects on program objectives.

Provider-level non-DSH supplemental payment data would provide greater transparency to Medicaid payments, support program integrity efforts, and facilitate Medicaid payment analysis, including assessments of Medicaid payment adequacy and analysis of the relationship between payment and desired outcomes (e.g., efficiency, quality, access). For these reasons, the GAO recommended that CMS issue facility-specific reporting requirements for non-DSH supplemental payments and that such payments should be subject to an annual independent audit (GAO 2012b). CMS has not generally collected non-DSH supplemental payment data at the individual provider level in a standard format. In response to an earlier GAO report, CMS indicated that, while requiring provider-specific reporting of supplemental payments through the same system as the CMS-64 was not feasible, they could request provider-specific data as back-up during their review of state expenditure reports (GAO 2008). However, it does not appear that these data have been routinely collected, and, if they have, they have not been made publicly available for analysis.

In March 2013, CMS issued guidance in a State Medicaid Director letter requiring states to demonstrate their compliance with UPL requirements annually, including provider-level reporting of non-DSH supplemental payments (CMS 2013c). Beginning in 2013, states must submit these UPL demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. Beginning in 2014 states will also be required to submit annual UPL demonstrations for clinics, physician services (for states that make targeted physician supplemental payments), ICFs/ID, private residential treatment facilities, and institutes for mental disease. While these data will provide CMS with an improved understanding of total Medicaid payments at the provider level and allow them to assure compliance with UPL regulations, they are not required to be submitted in a standardized format at this time and are not expected to be available for analysis outside of CMS regional offices.

Options for data collection. Transparency and improved understanding of Medicaid payments ultimately depend on data being both standardized and available in a format that makes it suitable for analysis. For example, payment data should be available for each provider and should include data elements, such as provider identification numbers, that will allow analysis of payments based on different provider characteristics, such as location, ownership, and role in serving low-income populations. Data should also indicate the time period for which payments were made.

One option for data collection could be to develop standardized templates for the submission of UPL compliance data. CMS could also consider collecting these data through the MSIS. MSIS is a federal data source compiled by CMS that contains detailed demographic, enrollment, and claims data that are required to be reported by all states. As discussed previously, states are required to report Medicaid provider payments to MSIS. However, payment data that are not claims-based, including most supplemental payments, are often not included, and CMS has not emphasized their inclusion. Therefore, while the MSIS is intended to facilitate national and cross-state examinations of the Medicaid program, data regarding total Medicaid payments may not be complete.

A review of MSIS data from FY 2008–2010 confirmed that most states do not appear to include supplemental payments of the type discussed in this chapter in their submissions.[14] Further, the CMS MSIS State Data Characteristics/Anomalies Report includes very few entries related to state reporting of supplemental payments (CMS 2013d). Enforcing the collection of supplemental payment data through the MSIS would enhance the system's analytic utility, both for payment analyses and program integrity purposes, by including the total amount of Medicaid payments made to a common

set of providers for a common time period (e.g., total Medicaid inpatient hospital payments for FY 2013). Further, including supplemental payment data would allow for greater continuity between MSIS data and state-reported Medicaid expenditure data on the CMS-64. Supplemental payment data were identified as a major component of the discrepancy between the two systems in a recent GAO report on the subject (GAO 2012a).

MSIS currently has the capability to accept records for supplemental payments, mitigating any potential federal administrative burden (CMS 2012). Also, the Commission has previously reported on a CMS effort to expand and enhance MSIS—an initiative known as the Transformed Medicaid Statistical Information System (T-MSIS). CMS has added the submission of T-MSIS data as a condition for enhanced federal match for systems upgrades, and data specifications for T-MSIS include values to specifically identify supplemental payments for inpatient and outpatient hospitals and for nursing facilities. CMS has indicated that it is implementing T-MSIS with states on a rolling basis and expects monthly submissions from all states by July 2014 (CMS 2013e). It remains to be seen, however, whether CMS will enforce the requirement to submit supplemental data through T-MSIS.

In January 2014, CMS issued a solicitation seeking support for oversight of Medicaid DSH and UPL payments (CMS 2014). While the solicitation does not indicate plans for making data publicly available, specific tasks include:

- the compilation of a database to enable analysis of DSH and UPL payments at both aggregate and provider-specific levels;
- analysis of supplemental payments at national, regional, state, and provider-specific levels; and,
- an assessment of the utility of T-MSIS data in assisting CMS in oversight and analysis of state UPL submissions and Medicaid DSH payments.

Improved collection of non-DSH supplemental payment data is a reasonable first step. However, there are many other factors related to variation in states' Medicaid payments, including differences in the methodologies used to determine them, as well as the role of states' approaches to Medicaid financing. With so much variation, and a lack of complete and consistent data at the federal level, it remains difficult to assess the extent to which individual state approaches are more or less effective at fulfilling the program's objectives. Moving forward, the Commission intends to continue to examine the many factors involved in Medicaid payment, as well as their effects.

Implications

Federal spending. The Congressional Budget Office has estimated that this recommendation will not affect federal Medicaid spending. Depending on the method of collection, it could result in increased administrative effort for development of reporting standards, required changes to information technology systems, and making the data publicly available, but these activities are not expected to result in increased spending.

States. Reporting of provider-specific supplemental payments could result in some increased administrative effort by the states. However, because the payments are calculated in accordance with the Medicaid state plan and paid to enrolled Medicaid providers, states should already have records for them and reporting should not be excessively burdensome.

Providers and enrollees. State reporting of provider-level supplemental payment data would not have a direct effect on Medicaid payments to providers or on services provided to Medicaid enrollees. Over time, however, increased transparency could lead to modifications in state payment methodologies.

Endnotes

[1] The non-federal share of Medicaid spending has historically averaged about 43 percent.

[2] See Chapter 3 of MACPAC's March 2012 *Report to the Congress on Medicaid and CHIP* for a full discussion of how states finance their share of Medicaid expenditures, including the use of health care related taxes and their use of supplemental payments to certain providers.

[3] Total annual uncompensated care costs are defined in federal regulation as "the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental or enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services" (42 CFR 447.299).

[4] The federal government first promulgated regulations prohibiting FFP for Medicaid payments in excess of what would have been paid under Medicare payment principles in September of 1981 (HCFA 1981). For the current UPL regulations, see 42 CFR 447.272(b) (defining UPLs for inpatient care); 42 CFR 447.321(b) (defining UPLs for outpatient care); 42 CFR 447.257 (establishing that FFP is not available for state expenditures in excess of the UPLs for inpatient care); and 42 CFR 447.304 (establishing that FFP is not available for state expenditures in excess of the UPLs for outpatient care).

[5] However, payments for inpatient hospital services may not exceed a provider's customary charges to the general public for the services (42 CFR 447.271).

[6] Specifically, the term "health care related tax" means a tax that is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or is not limited to such items or services but provides for treatment of individuals or entities providing or paying for such items or services that is different from the treatment provided to other individuals or entities. A tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

[7] Providers that pay a health care related tax cannot be "held harmless" through any direct or indirect payment, offset, or waiver that directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount. Three tests are used to determine whether a hold-harmless arrangement exists: (1) a non-Medicaid payment to the providers is correlated to the tax amount, (2) any portion of Medicaid payments varies solely based on the tax amount, and (3) providers are directly or indirectly guaranteed to be held harmless. An indirect guarantee exists if 75 percent or more of the providers paying the tax receive 75 percent or more of their total tax costs back through enhanced Medicaid payments or other state payments. If the tax amount falls within the so-called safe harbor of 6 percent of net patient revenue, however, the tax is permissible under this test (42 CFR 433.68(f)).

[8] States report revenue from health care related taxes in Section 64.11 of their CMS-64 Quarterly Expenditure Reports. Reporting of tax collection amounts does not automatically generate a Medicaid expenditure claim for FFP, and this information is used solely for informational purposes.

[9] The guidance that CMS issued in March 2013 requiring states to submit annual UPL demonstrations, including provider-specific non-DSH supplemental payment data, may address the second recommendation.

[10] States were asked to advise if date-of-service data were not substantially complete. This appears to have been the case for one state (State Two). In the case of State Two, date-of-payment claims data were substituted as a result.

[11] Payment per claim and payment per visit were also considered, but variations in state payment policies limit the comparability of these metrics. Separate metrics for inpatient and outpatient were also considered, but states were not always able to separate supplemental payments between inpatient and outpatient.

[12] For this project, it was assumed that health care related taxes were not included in the hospital and the nursing facility costs extracted from Medicare cost reports. Some of the study states make it explicit that taxes are not allowable costs for either nursing facilities or hospitals. Per diem taxes for nursing facilities, for example, typically exclude Medicare days and consequently would not be an allowable cost on the Medicare cost report. While health care related taxes are an allowable cost under Medicare, they are required to be net of any offsetting payments.

[13] For fiscal years beginning on or after May 1, 2010, the Medicare cost report for hospitals (CMS-2552-10) was redesigned to include additional Medicaid payment information. Specifically, Worksheet S-10 now requires that hospitals report their total amount of Medicaid revenue, including DSH and non-DSH supplemental payments, as well as Medicaid charges, which are multiplied by the hospital's cost-to-charge ratio (CCR) to calculate Medicaid costs. Instructions indicate the Medicaid revenue should be "net of associated provider taxes or assessments" (CMS 2013f). While these data may allow for estimates of Medicaid margins for hospitals, limitations include the applicability of the CCR to Medicaid costs, the fact that revenue may not be reported net of IGTs and CPEs, and the fact that DSH payments are not reported separately from other Medicaid revenue.

[14] MSIS claims records contain several fields, including claim type and claim adjustment indicator, that may be used to identify supplemental payments. Two relevant claim types described in MSIS documentation include: (1) service tracking (also referred to as gross adjustment) claims (TYPE-OF-CLAIM=4) used for special purposes, such as tracking individual services covered in a lump-sum billing or for all non-claims based service expenditures such as DSH payments, drug rebates, and year-end settlements, and (2) supplemental payment claims (TYPE-OF-CLAIM=5) used to identify payments above a capitation fee or above negotiated rate. Additionally, claims of any type (service tracking, supplemental, or other) may be categorized as gross adjustments (ADJUSTMENT-INDICATOR=5) when they reflect an aggregate claim, such as one paid at a provider level rather than a patient encounter level.

To determine whether states appear to be reporting supplemental payments, MACPAC analyzed FY 2008–2010 MSIS claims counts and payment amounts by state, claim type, adjustment indicator, type of service, and whether claims could be linked to individual enrollees. The analysis showed that MSIS includes a variety of claims flagged as supplemental payments, but only a small number of states appear to include the aggregate, lump-sum type discussed in this chapter. These cannot be separated into DSH and non-DSH amounts. The vast majority of MSIS claims with at least one of the supplemental payment values described above had a TYPE-OF-CLAIM value of 5, had payment amounts less than $1,000, and could be linked to individual enrollees; as such, they were not of interest for this analysis.

To the extent supplemental payment data of the type discussed in this chapter are reported, they represent a small number of claims and are most likely to be reported as gross adjustment claims (TYPE-OF-CLAIM value of 4, often with an ADJUSTMENT-INDICATOR value of 5 as well) that have large payment amounts and cannot be linked to individual enrollees. For FY 2010, 6,037 claims had a paid amount of $100,000 or more and were not linked to an actual Medicaid enrollee. Of these, 5,527 (92 percent) were gross adjustments. The most common types of service among these claims were inpatient hospitals and nursing facilities, also the most likely to receive supplemental payments. However, while it appears that most supplemental payments of the type discussed in this chapter have these characteristics when they are reported in MSIS, only 16 states reported any inpatient hospital or nursing facility claims with these characteristics in FY 2010 (compared to 35 that reported making supplemental payments on the CMS-64).

On the other hand the vast majority of MSIS claims reported as gross adjustments do not appear to be supplemental payments of the type discussed in this chapter. In FY 2010, about half of these claims had negative or zero payment amounts and, among those with positive payments, 96 percent had payment amounts of less than $1,000. Further, claims with these characteristics were identified for 28 different types of service, most of which are not typically associated with supplemental payments of the type discussed in this chapter. Because states appear to use the gross adjustment category for more than one purpose, we cannot definitively identify specific types of supplemental payments in MSIS.

References

Bachrach, D., and M. Dutton. 2011. *Medicaid supplemental payments: Where do they fit in payment reform?* Hamilton, NJ: Center for Health Care Strategies, Inc. http://www.chcs.org/usr_doc/Medicaidsupplementalpaymentbrief.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Solicitation Number APP140426, "Medicaid Upper Payment Limit and Disproportionate Share Hospital Demonstration." January 23, 2014.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013a. Medicaid program: Disproportionate share hospital allotments and institutions for mental diseases, disproportionate share hospital limits for FY 2012, and preliminary FY 2013 disproportionate share hospital allotments and limits. Notice. *Federal Register* 78, no. 144 (July 26): 45217–45231. http://www.gpo.gov/fdsys/pkg/FR-2013-07-26/pdf/2013-17965.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013b. *Medicaid qualified practitioner services—methodologies for enhanced payment made to physicians and practitioners associated with academic medical centers and safety net hospitals and upper payment calculation.* Baltimore, MD: CMS. http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/UPL-Instructions-Qualified-Practitioner-Services-Replacement-New.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013c. Letter from Cindy Mann to State Medicaid Directors regarding "Federal and state oversight of Medicaid expenditures." March 18, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013d. MSIS state data characteristics/anomalies report. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013e. Letter from Cindy Mann to State Medicaid Directors regarding "Transformed Medicaid Statistical Information System (T-MSIS) data." August 23, 2013. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013f. Part 2, Chapter 40, Revision 3. In *Provider reimbursement manual.* Baltimore, MD: CMS. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/P152_40.zip.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. *Medicaid and CHIP Statistical Information System (MSIS) file specs and data dictionary.* Baltimore, MD: CMS. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MSIS/Downloads/msis-data-dictionary.pdf.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 2001. Medicaid program: Revision to Medicaid upper payment limit requirements for hospital services, nursing facility services, intermediate care facility services for the mentally retarded, and clinic services. Final rule. *Federal Register* 66, no. 9 (January 12): 3148–3177.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 1981. Medicaid program: Payment for long-term care facility services and inpatient hospital services. Interim final rule with comment period. *Federal Register* 46, no. 189 (September 30): 47964–47973.

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

Medicaid and CHIP Payment and Access Commission (MACPAC). 2011. *Report to the Congress: The evolution of managed care in Medicaid.* June 2011. Washington, DC: MACPAC. http://www.macpac.gov/reports.

Mitchell, A. 2012. *Medicaid disproportionate share hospital payments.* Washington DC: Congressional Research Service. http://www.fas.org/sgp/crs/misc/R42865.pdf.

National Association of State Budget Officers (NASBO). 2012. *State expenditure report: Examining fiscal 2010–2012 state spending.* Washington, DC: NASBO. http://www.nasbo.org/publications-data/state-expenditure-report.

Office of the Actuary (OACT), Centers for Medicare & Medicaid Services (CMS). U.S. Department of Health and Human Services. 2013. *National health expenditure projections, 2012–2022.* Baltimore, MD: CMS. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf.

Smith, V.K., K. Gifford, E. Ellis, et al. 2013. *Medicaid in a historic time of transformation: Results from a 50-state Medicaid budget survey for state fiscal years 2013 and 2014*. Washington, DC: Kaiser Family Foundation. http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf.

U.S. Government Accountability Office (GAO). 2012a. *Medicaid data sets provide inconsistent picture of expenditures*. Report no. GAO-13-47. Washington, DC: GAO. http://www.gao.gov/products/GAO-13-47.

U.S. Government Accountability Office (GAO). 2012b. *More transparency of and accountability for supplemental payments are needed*. Report no. GAO-13-48. Washington, DC: GAO. http://www.gao.gov/products/GAO-13-48.

U.S. Government Accountability Office (GAO). 2008. *CMS needs more information on the billions of dollars spent on supplemental payments*. Report no. GAO-08-614. Washington, DC: GAO. http://www.gao.gov/products/GAO-08-614.

Xerox Corporation. 2013. Government healthcare solutions, payment method development: Overview of hospital finances nationwide. Unpublished Presentation. Norwalk, CT: Xerox Corporation.

Appendix

Acronym List

ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act
ACAP	Association for Community Affiliated Plans
ACIP	Advisory Committee on Immunization Practices
AFDC	Aid to Families with Dependent Children
AHRQ	Agency for Healthcare Research and Quality
APS	Annual Person Summary
BHP	Basic Health Program
CAHMI	Child and Adolescent Health Measurement Initiative
CARTS	CHIP Annual Reporting Template System
CBO	Congressional Budget Office
CCR	Cost-to-Charge Ratio
CDC	U.S. Centers for Disease Control and Prevention
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPE	Certified Public Expenditure
CPI-U	Consumer Price Index for All Urban Consumers
CSHCN	Children with Special Health Care Needs
CY	Calendar Year
DRG	Diagnosis-Related Group
DSH	Disproportionate Share Hospital
E-FMAP	Enhanced Federal Medical Assistance Percentage
EHB	Essential Health Benefit
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
FFP	Federal Financial Participation
FFS	Fee for Service
FMAP	Federal Medical Assistance Percentage
FMR	Financial Management Report

FPL	Federal Poverty Level
FY	Fiscal Year
GAO	U.S. Government Accountability Office
HCBS	Home and Community-Based Services
HCFA	Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
HP20	Healthy People 2020
HRET	Health Research and Educational Trust
ICF/ID	Intermediate Care Facility for Persons with Intellectual Disabilities
IGT	Intergovernmental Transfer
IRC	Internal Revenue Code
KCMU	Kaiser Commission on Medicaid and the Uninsured
KFF	Kaiser Family Foundation
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MBES/CBES	Medicaid and CHIP Budget Expenditure System
MCHA	Maternal and Child Health Access
MCO	Managed Care Organization
MEC	Minimum Essential Coverage
MEPS	Medical Expenditure Panel Survey
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Control Units
MOE	Maintenance of Effort
MSA	Metropolitan Statistical Area
MSIS	Medicaid Statistical Information System
NAMCS	National Ambulatory Medical Care Survey
NASBO	National Association of State Budget Officers
NCSL	National Conference of State Legislatures
NEHRS	National Electronic Health Records Survey
NGA	National Governors Association
NHE	National Health Expenditures
NHIS	National Health Interview Survey
NSCH	National Survey of Children's Health
NS-CSHCN	National Survey of Children with Special Health Care Needs
OACT	Office of the Actuary
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider

PERM	Payment Error Rate Measurement Program
QHP	Qualified Health Plan
SEDS	Statistical Enrollment Data System
SFY	State Fiscal Year
SHADAC	State Health Access Data Assistance Center
SHOP	Small Business Health Options Program
SIPP	Survey of Income and Program Participation
SMI	Serious Mental Illness
SPA	State Plan Amendment
SSA	U.S. Social Security Administration
SSI	Supplemental Security Income
TMA	Transitional Medical Assistance
T-MSIS	Transformed Medicaid Statistical Information System
UPL	Upper Payment Limit
USPSTF	U.S. Preventive Services Task Force
VFC	Vaccines for Children
WVCHIP	West Virginia Children's Health Insurance Program

Authorizing Language from the Social Security Act (42 U.S.C. 1396)

MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as 'MACPAC').

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.— Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Commission Votes on Recommendations

In its authorizing language in the Social Security Act (42 U.S.C. 1396), the Congress required MACPAC to review Medicaid and CHIP program policies and to make recommendations 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 recommendations included in this report and the corresponding voting record below, fulfill this mandate.

Issues in Pregnancy Coverage under the Affordable Care Act

3.1 To align coverage for pregnant women, Congress should require that states provide the same benefits to pregnant women who are eligible for Medicaid on the basis of their pregnancy that are furnished to women whose Medicaid eligibility is based on their status as parents of dependent children.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martínez Rogers, Moore, Riley, Rosenbaum, Rowland, Smith, Sundwall

Not Present: Checkett,* Waldren

3.2 The Secretaries of Health and Human Services and Treasury should specify that pregnancy-related Medicaid coverage does not constitute minimum essential coverage in cases involving women enrolled in qualified health plans.

15	Yes
0	No
0	Not Voting
2	Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martínez Rogers, Moore, Riley, Rosenbaum, Rowland, Smith, Sundwall

Not Present: Checkett,* Waldren

Children's Coverage under CHIP and Exchange Plans

5.1 To reduce complexity and to promote continuity of coverage for children, the Congress should eliminate waiting periods for CHIP.

15 Yes
0 No
0 Not Voting
2 Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martínez Rogers, Moore, Riley, Rosenbaum, Rowland, Smith, Sundwall

Not Present: Checkett,* Waldren

5.2 In order to align premium policies in separate CHIP programs with premiums policies in Medicaid, the Congress should provide that children with family incomes below 150 percent FPL not be subject to CHIP premiums.

15 Yes
0 No
0 Not Voting
2 Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martínez Rogers, Moore, Riley, Rosenbaum, Rowland, Smith, Sundwall

Not Present: Checkett,* Waldren

Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments

6.1 As a first step toward improving transparency and facilitating understanding of Medicaid payments, the Secretary should collect and make publicly available non-DSH (UPL) supplemental payment data at the provider level in a standard format that enables analysis.

15 Yes
0 No
0 Not Voting
2 Not Present

Yes: Carte, Chambers, Cohen, Edelstein, Gabow, Gray, Henning, Hoyt, Martínez Rogers, Moore, Riley, Rosenbaum, Rowland, Smith, Sundwall

Not Present: Checkett,* Waldren

*Commissioner Checkett expressed support for the recommendation in writing based on her involvement in Commission deliberations.

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 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 365,000 Medicaid, State Children's Health Insurance Program (CHIP), and Medicare Advantage Special Needs Plan 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 4.3 million individuals and families who receive their care through Medicaid, CHIP, Medicare Advantage, and other government-funded programs in 15 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. Prior to CalOptima, Mr. Chambers spent over 27 years working for the Centers for Medicare & Medicaid Services (CMS). He served as the director of the Family and Children's Health Programs Group, responsible for national policy and operational direction of Medicaid and CHIP. While at CMS, 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 the Washington, DC office. He received his bachelor's degree 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 as well as the chief executive officer of Missouri Care, a managed Medicaid health plan owned by University of Missouri—Columbia Health Care, one of the largest safety net hospital systems in the state. For eight years, Ms. Checkett served as the director of the Missouri Division of Medical Services (Medicaid), during which time she was the chair of the National Association of State Medicaid Directors and a member of the National Governors Association Medicaid Improvements Working Group. She served as chair of the advisory board for the Center for Health Care Strategies, a non-profit health policy resource center dedicated to improving health care quality for low-income children and adults. Ms. Checkett also served as chair of the National Advisory Committee for Covering Kids, a Robert Wood Johnson Foundation program fostering outreach and eligibility simplification efforts for Medicaid and CHIP beneficiaries. She received a master of public administration from the University of

Missouri—Columbia and a master of social work from The University of Texas at Austin.

Andrea Cohen, J.D., is the director of health services in the New York City Office of the Mayor, where she coordinates and develops strategies to improve public health and health care services for New Yorkers. She serves on the board of the Primary Care Development Corporation and represents the deputy mayor for health and human services on the board of the Health and Hospitals Corporation, the largest public hospital system in the country. From 2005 to 2009, Ms. Cohen was counsel with Manatt, Phelps & Phillips, LLP, where she advised clients on issues relating to Medicare, Medicaid, and other public health insurance programs. Prior professional positions include senior policy counsel at the Medicare Rights Center, health and oversight counsel for the U.S. Senate Committee on Finance, and attorney with the U.S. Department of Justice. She received her law degree from the Columbia University School of Law.

Burton L. Edelstein, D.D.S., M.P.H., is a board-certified pediatric dentist and professor of dentistry and 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 to 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, 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 Toyota Production Systems in health care.

Herman Gray, M.D., M.B.A., is chief executive officer of Detroit Medical Center Children's Hospital of Michigan (CHM) and vice president of pediatric health services for Tenet Health System. At CHM, Dr. Gray served previously as

pediatrics vice chief for education, chief of staff, and chief operating officer and president. He also served as associate dean for graduate medical education (GME) and vice president for GME at Wayne State University School of Medicine and the Detroit Medical Center. Dr. Gray has also served as the chief medical consultant for the Michigan Department of Public Health Division of Children's Special Health Care Services and as vice president and medical director of clinical affairs for Blue Care Network. During the 1980s, he pursued private medical practice in Detroit. Dr. Gray serves on the boards of trustees for the Children's Hospital Association and the Skillman Foundation. He received his medical degree from the University of Michigan in Ann Arbor and a master of business administration from the University of Tennessee.

Denise Henning, C.N.M., M.S.N., is 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 and chair of the business section of the American College of Nurse-Midwives. She received her master of science in nurse midwifery from the University of Florida in Jacksonville and her bachelor of science in nursing from the University of Florida in Gainesville. 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, and

was the first distinguished visiting fellow and lecturer in state health policy at The George Washington University, following her tenure as director of the Maine Governor's Office of Health Policy and Finance. She was a principal architect of the Dirigo Health Reform Act of 2003, which was enacted to increase access, reduce costs, and improve quality of health care in Maine. Ms. Riley previously served as executive director of the National Academy for State Health Policy and as president of its corporate board. Under four Maine governors, she held appointed positions, including executive director of the Maine Committee on Aging, director of the Bureau of Maine's Elderly, associate deputy commissioner of health and medical services, and director of the Bureau of Medical Services responsible for the Medicaid program and health planning and licensure. Ms. Riley served on Maine's Commission on Children's Health, which planned the S-CHIP 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 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 support group for women transitioning from prison back into society and 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 is the former president of the National Association of Hispanic Nurses. She received a master of science in psychiatric nursing from the UT Health Science Center at San Antonio and her doctorate in cultural foundations in education from The University of Texas at Austin.

Sara Rosenbaum, J.D., is founding chair of the Department of Health Policy and the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University School of Public Health and Health Services. 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., has served as chair of MACPAC since the Commission was formed in December 2009. She is the executive vice president of the Henry J. Kaiser Family Foundation and

the executive director of the Kaiser Commission on Medicaid and the Uninsured. She is also an adjunct professor in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. Dr. Rowland has directed the Kaiser Commission since 1991 and has overseen the foundation's health policy work on Medicaid, Medicare, private insurance, HIV, women's health, and disparities since 1993. She is a noted authority on health policy, Medicare and Medicaid, and health care for low-income and disadvantaged populations, and frequently testifies as an expert witness before the U.S. Congress on health policy issues. Dr. Rowland, a nationally recognized expert with a distinguished career in public policy and research, focusing on health insurance coverage, access to care, and health care financing for low-income, elderly, and disabled populations, has published widely on these subjects. She is an elected member of the IOM, a founding member of the National Academy for Social Insurance, and past president and fellow of the Association for Health Services Research (now AcademyHealth). Dr. Rowland holds a bachelor's degree from Wellesley College, a master of public administration from the University of California at Los Angeles, and a doctor of science in health policy and management from The Johns Hopkins University.

Robin Smith and her husband Doug have been foster and adoptive parents for many children covered by Medicaid, including 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 senior advisor for research. 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.

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 in the U.S. Department of Health and Human Services (HHS) Office of the Secretary 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.

Benjamin Finder, M.P.H., is a senior analyst. His work focuses on benefits and payment policy. Prior to joining MACPAC, he served as an associate director in the Health Care Policy and Research Administration at the District of Columbia Department of Health Care Finance, and as an analyst at the Henry J. Kaiser Family Foundation. Mr. Finder holds a master of public health from The George Washington University, where he concentrated in health policy and health economics.

Moira Forbes, M.B.A., is director of payment and program integrity, 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 director of data development and analysis. 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.

Benjamin Granata is a finance and budget specialist. His work focuses on reviewing financial documents to ensure completeness and accuracy for processing and recording in the financial systems. Mr. Granata graduated from Towson University with a bachelor's degree in business administration, specializing in project management.

Lindsay Hebert, M.S.P.H., is special assistant to the executive director. Previously, she was a research assistant at The Johns Hopkins School of Medicine, focusing on patient safety initiatives in the department of pediatric oncology. Prior to that, she was a project coordinator in the pediatric intensive care unit at The Johns Hopkins Hospital. Ms. Hebert holds a master of science in public health from the Johns Hopkins Bloomberg School of Public Health and a bachelor of arts from the University of Florida.

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.

Molly McGinn-Shapiro, M.P.P., is a senior analyst. Her work focuses on issues related to LTSS and individuals dually eligible for Medicaid and Medicare. Previously, she was the special assistant to the executive vice president of the Henry J. Kaiser Family Foundation and to the executive director of the Kaiser Commission on Medicaid and the Uninsured. Ms. McGinn-Shapiro holds a master of public policy from Georgetown University's Georgetown Public Policy Institute.

Chinonye Onwunli Onwuka, M.P.H., M.S., is a senior analyst. Her work focuses on Medicaid and CHIP data analysis. Prior to joining MACPAC she worked as a senior government analyst at Florida's Agency for Health Care Administration in Medicaid program analysis, where she analyzed Medicaid expenditures for the agency and state legislature. Prior to that, she worked as a research analyst studying policy diffusion across states and as an adjunct professor at Florida State University. Ms. Onwuka holds a bachelor of science in psychology and a master of science in political science with a concentration in policy analysis from Florida State University. She also holds a master of public health with a concentration in health policy from the University of South Florida.

Saumil Parikh, M.B.A., is an information technology (IT) specialist. Previously, he was a network/system administrator at CBH Health. Prior to that, he was an IT support specialist at Emergent Biosolutions, focusing on IT system administration, user support, network support, general projects, and team leadership. He also worked in a similar role as an IT associate at Vesta, Inc. Mr. Parikh holds a master of business administration in information systems and a bachelor of arts in computer networking from Strayer University.

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.

Chris Peterson, M.P.P., is director of eligibility, enrollment, and benefits. Prior to joining MACPAC, he was a specialist in health care financing at the Congressional Research Service, where he worked on major health legislation. Prior to that, he worked for the Agency for Healthcare Research and Quality and the National Bipartisan Commission on the Future of Medicare. Mr. Peterson has a master of public policy from Georgetown University's Georgetown Public Policy Institute and a bachelor of science in mathematics from Missouri Western State University.

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.

Anna Sommers, Ph.D., M.S., M.P.Aff., is director of access and quality. 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.

Mary Ellen Stahlman, M.H.S.A., is senior advisor to the executive director. In addition to managing MACPAC's congressional affairs, she assists in directing MACPAC's policy agenda and in editing and producing the Commission's reports to the Congress. Previously, she held positions at the National Health Policy Forum, focusing on

Medicare issues, including private plans and the Medicare drug benefit. She served at CMS and its predecessor agency—the Health Care Financing Administration—for 18 years, including as deputy director of policy. Ms. Stahlman received a master of health services administration from The George Washington University and a bachelor of arts from Bates College.

James Teisl, M.P.H., is a principal analyst focused on issues related to Medicaid payment and financing. Previously, he was a senior consultant with The Lewin Group and has also worked for the Greater New York Hospital Association and the Ohio Medicaid program. Mr. Teisl received a master of public health from the Johns Hopkins Bloomberg School of Public Health.

Ricardo Villeta, M.B.A., is deputy director of operations, finance, and management with overall responsibility for management of the MACPAC budget and resources. Mr. Villeta directs all operations related to financial management and budget, procurement, human resources, information technology, and contracting. Previously, he was the senior vice president and chief management officer for the Academy for Educational Development, a private, non-profit educational organization that provided training, education, and technical assistance throughout the United States and in more than 50 countries. Mr. Villeta holds a master of business administration from The George Washington University and a bachelor of science from Georgetown University.

Eileen Wilkie is the administrative officer and is responsible for human resources, office maintenance, and coordinating travel and Commission meetings. Previously, she held similar roles at National Public Radio and the National Endowment for Democracy. Ms. Wilkie has a bachelor of science in political science from the University of Notre Dame.

MACPAC

Medicaid and CHIP Payment and Access Commission

Printed on recycled material

www.MACPAC.gov
(202) 350-2000