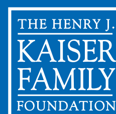
MEDICAID

A PRIMER

2010



THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

MEDICAID
A PRIMER

Key Information on Our Nation's Health Coverage Program for Low-Income People

June 2010

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

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Over its nearly 45-year history, the Medicaid program has grown increasingly integral to our health care system. Today, it is a primary source of coverage, access, health care financing, and innovation in health care delivery. During the recession, the program has provided a coverage safety-net for millions of Americans, especially children, who would otherwise have joined the uninsured. Under health reform, Medicaid assumes even greater importance as it becomes the national coverage mechanism for low-income people in the new plan for near-universal coverage. With this expanded role for Medicaid on the horizon, basic information about the program is a key resource.

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Medicaid is the nation's publicly funded health coverage program for low-income Americans. Medicaid covers health and long-term care services for specified categories of low-income people currently, but it will be expanded in 2014 to reach nearly everyone under age 65 with income up to 133% of the poverty level. Medicaid fills large gaps in our health insurance system, finances the lion's share of long-term care, and provides core support for the health centers and safety-net hospitals that serve the nation's uninsured and millions of others. Within broad federal guidelines, states design their own Medicaid programs.

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Medicaid covers nearly 60 million low-income Americans, including children and parents, people with severe disabilities, and low-income, elderly and disabled Medicare beneficiaries known as "dual eligibles." Medicaid is expected to reach another 16 million people over the first five years of health reform, when a national expansion of the program takes place. Most Medicaid beneficiaries have no access to or cannot afford employer-based or individual insurance in the private market. For dual eligibles, Medicaid supplements Medicare, covering services that Medicare excludes or limits – especially, long-term care – and paying Medicare's premiums and cost-sharing.

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Medicaid covers a broad range of health and long-term care services, but program benefits vary by state. Medicaid covers comprehensive services for children. It also covers services that most private insurers and Medicare exclude or limit, including long-term care, mental health care, and services and supports needed by people with disabilities. Transportation, translation, and other services help lower access barriers that many in the low-income population face. Medicaid enrollees obtain most services from providers and managed care plans in the private sector.

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Medicaid spending on services totaled about $339 billion in 2008. Two-thirds of Medicaid benefit spending is attributable to seniors and people with disabilities. Although beneficiaries in these two groups make up just a quarter of all Medicaid enrollees, their extensive needs for health and long-term care translate into high costs to the program. While aggregate Medicaid costs are high, Medicaid's administrative costs are low and Medicaid acute care spending per capita has been rising more slowly than private insurance premiums.

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Medicaid financing is a federal-state partnership in which the federal government matches state Medicaid spending. Under normal rules, the federal match rate is at least 50% in every state but higher in poorer states, reaching 76% in the poorest state, and the federal share of Medicaid spending overall is 57%. In 2008, states on average spent about 16% of their general funds on Medicaid, and Medicaid accounted for about 7% of total federal outlays. In 2009, Congress enacted a temporary increase in federal Medicaid funding to ease recessionary pressures on states and preserve coverage, and currently the federal government funds about 66% of Medicaid spending. Under health reform, the federal-state financing partnership that supports Medicaid will continue. However, the federal government will finance the lion's share – an estimated 96% -- of the cost of the new Medicaid coverage stemming from health reform over the first decade.

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A major expansion of the Medicaid program is integral to the national coverage framework established by the health reform law. In the new system, Medicaid will provide the foundation for coverage of the low-income population. Current restrictions on eligibility for non-elderly adults will be removed so that nearly everyone under age 65 with income below a national floor will be eligible. Millions of the uninsured will gain Medicaid coverage as a result, and the federal government will finance the vast majority of increased coverage over the next decade. To prepare Medicaid for its broader, national role, the reform law strengthens the program through provisions and investments to simplify Medicaid enrollment, improve Medicaid access and quality of care, ensure coordination with the new insurance exchanges, and achieve other goals of reform.

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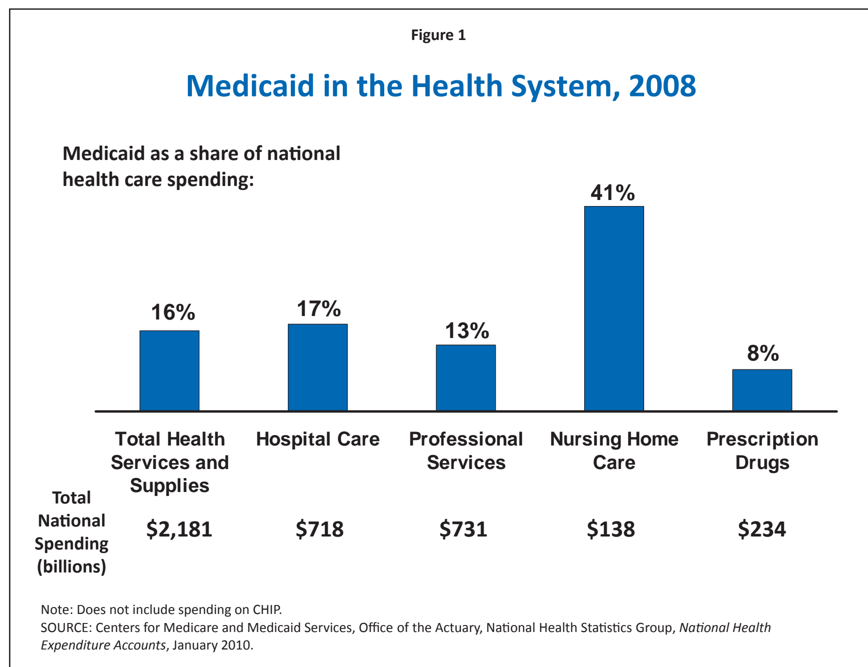
INTRODUCTION

No major health program or issue can be considered today outside the context of the nation's new health care reform law, known as the "Affordable Care Act."* The health reform law, the most significant social legislation in the U.S. since 1965, seeks to eliminate large and growing gaps in health insurance by increasing access to affordable coverage and instituting a new legal obligation on the part of individuals to obtain it. To accomplish this reform, the law creates a national framework for near-universal coverage and also outlines a comprehensive set of strategies to improve care and contain costs. Integral to the coverage framework laid out in the reform law is a dramatic expansion of the Medicaid program; half the expected gains in coverage due to health reform will be achieved through this expansion.



The reliance on Medicaid as a platform for wider coverage of the low-income uninsured has a long history. Established in 1965 as part of President Johnson's "Great Society," Medicaid was originally conceived as a health coverage supplement only for those receiving cash welfare assistance. Overtime, Congress has expanded Medicaid substantially to fill growing coverage gaps left by the private insurance system. Many states have expanded eligibility for the program further and Medicaid has been the cornerstone of all state-level initiatives to broaden coverage of the uninsured. In 2007, Medicaid covered health and long-term care services for nearly 60 million people, including more than 1 in 4 children and many of the sickest and poorest in our nation. During the economic recession, Medicaid has provided a safety-net of coverage for millions more Americans affected by loss of work or declining income. Medicaid now provides benefits to more people than any other public or private insurance program, including Medicare.

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* Health reform was enacted in two separate pieces of legislation. President Obama signed the Patient Protection and Affordable Care Act (P.L. 111-148) into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), signed on March 30, 2010, includes changes to new law.

As a mainstay of coverage in the U.S., Medicaid is also a core source of health care financing – it funds almost a sixth of total national spending on personal health care (Figure 1). Medicaid is the main payer of nursing home care and long-term care services overall; it is also the largest source of public funding for mental health care. Health centers and safety-net hospitals that serve low-income and uninsured people rely heavily on Medicaid revenues. Medicaid is an engine in state and local economies, too, supporting millions of jobs.

Looking ahead to the even larger role Medicaid will soon play under health care reform, understanding the program and how it fits into our health care system takes on additional importance. The purpose of this primer is to provide that foundation by explaining the basics of Medicaid and providing key information about the program today.

WHAT IS MEDICAID?

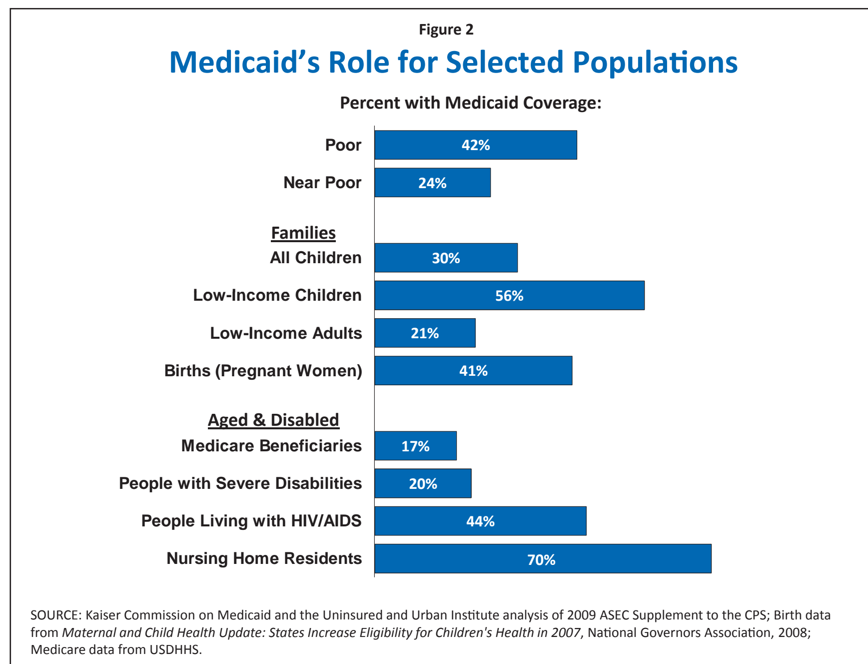
Medicaid is a public health insurance program that fills important gaps in our system today – gaps in coverage, long-term care, and financing for the safety-net delivery system. Under health reform, Medicaid's role in health coverage and financing will increase substantially. A significant expansion of Medicaid, which will extend health coverage to millions more low-income people, is the foundation of the national coverage system established by the new law. The federal government will finance the lion's share of the cost of the new coverage. States will continue to shape their own programs, but Medicaid eligibility will be simplified to support coordination between Medicaid and subsidized coverage offered in the new insurance exchanges.

What is Medicaid?

Medicaid is the nation's publicly financed health and long-term care coverage program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is an entitlement program that was initially established to provide medical assistance to individuals and families receiving cash assistance, or "welfare." Over the years, Congress has incrementally expanded Medicaid eligibility to reach more Americans living below or near poverty, regardless of their welfare eligibility. Today, Medicaid covers a broad low-income population, including parents and children in both working and jobless families, individuals with diverse physical and mental conditions and disabilities, and seniors. Medicaid's beneficiaries include many of the poorest and sickest people in the nation.

What is Medicaid's role in the U.S. health care system?

Medicaid fills large gaps in our health insurance system. Medicaid provides health coverage for millions of low-income children and families who lack access to the private health insurance system that covers most Americans. The program also provides coverage for millions of people with chronic illnesses or disabilities who are excluded from private insurance or for whom such insurance, which is designed for a generally healthy population, is inadequate. Finally, Medicaid provides extra help for millions of low-income Medicare enrollees known as "dual eligibles," assisting them with Medicare premiums and cost-sharing and covering key services, especially long-term care, that Medicare limits or excludes. Medicaid is the nation's largest source of coverage for long-term care, covering more than two-thirds of all nursing home residents. (Figure 2)

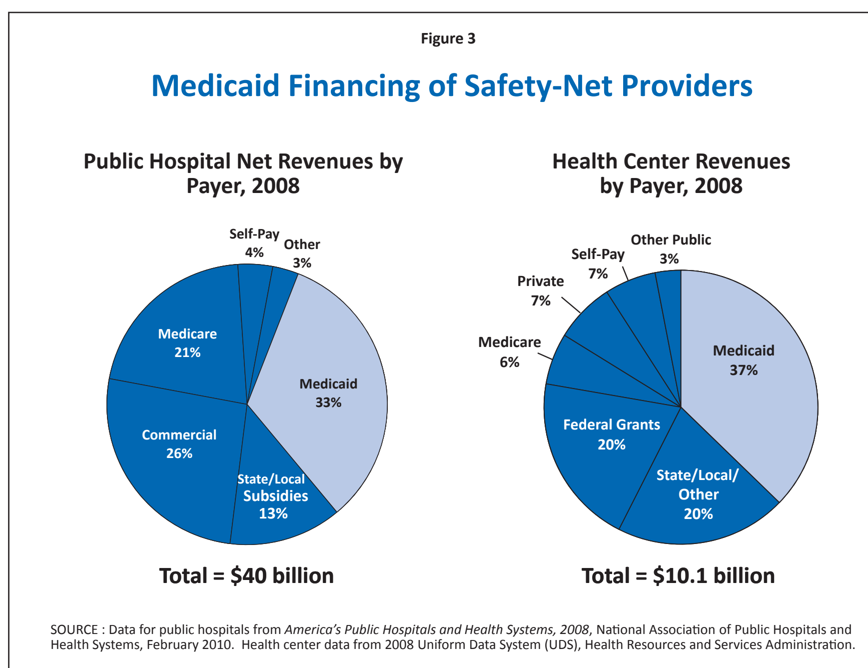


By design, Medicaid expands to cover more people during economic downturns. Because eligibility for Medicaid is tied to having low income, and enrollment cannot be limited or waiting lists kept, the program operates as a safety-net. During economic recessions like the current one, when job loss causes workers and their families to lose health coverage and income, more people become eligible for Medicaid and the program expands to cover many of them, offsetting losses of private health insurance and mitigating increases in the number of uninsured.

It is estimated that for every one percentage point increase in the unemployment rate, Medicaid enrollment grows by 1 million.[1] Medicaid enrollment growth has been accelerating in each six-month period since the recession began in December 2007. The largest six-month Medicaid enrollment increase on record occurred from December 2008 to June 2009, when 2.1 million additional individuals obtained Medicaid coverage. Between June 2008 and June 2009, enrollment rose by nearly 3.3 million, or 7.5%.

Medicaid is the main source of long-term care coverage and financing in the U.S. Over 10 million Americans, including about 6 million elderly and 4 million children and working-age adults, need long-term services and supports.[2] Medicaid covers about 7 of every 10 nursing home residents and finances over 40% of nursing home spending and long-term care spending overall.[3] More than half of all Medicaid long-term care spending is for institutional care, but a growing share – 41% in 2006, up from 30% in 2000 and 13% in 1990 – is attributable to home and community-based services.[4]

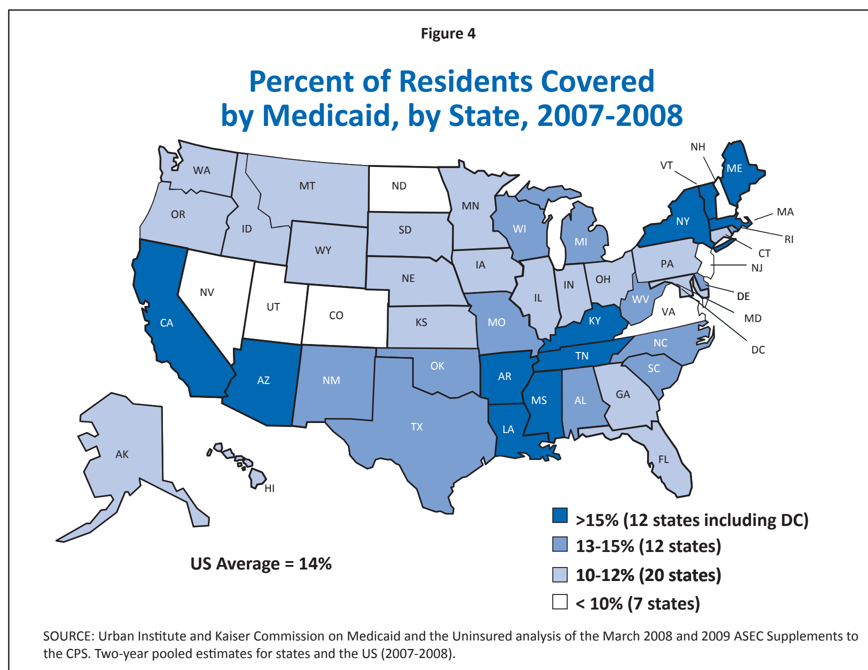
Medicaid funding supports the safety-net institutions that provide health care to low-income and uninsured people (Figure 3)**.** Medicaid provides 33% of public hospitals' net revenues. Medicaid payments provide an even larger share of health centers' total operating revenues (37%) and is their largest source of third-party payment.[5]



How is Medicaid structured?

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid. States are entitled to these federal matching dollars and there is no cap on funding. This financing model supports the federal entitlement to coverage and allows federal funds to flow to states based on actual need. Through the matching arrangement, the federal government and the states share the cost of the program.

The states administer Medicaid within broad federal guidelines and state programs vary widely. State agencies administer Medicaid subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). State participation in Medicaid is voluntary but all states participate. Federal law outlines basic minimum requirements that all state Medicaid programs must meet. However, states have broad authority to define eligibility, benefits, provider payment, delivery systems, and other aspects of their programs. As a result, Medicaid operates as more than 50 distinct programs – one in each state, the District of Columbia, and each of the Territories. Due to wide programmatic variation and demographic differences across the country, the proportion of the population covered by Medicaid varies from state to state, ranging from 8% in New Hampshire and Nevada to 22% in the District of Columbia (Figure 4).



***States can seek federal waivers to operate their Medicaid programs outside of federal guidelines*.** Section 1115 of the Social Security Act gives the HHS Secretary authority to waive statutory and regulatory provisions of health and welfare programs, including Medicaid, for demonstration purposes. States can apply for Section 1115 waivers to operate their Medicaid programs outside regular federal rules. Some states have used waivers to expand Medicaid eligibility and to adopt new models of coverage and health care delivery for the low-income population.

***Medicaid's structure enables the program to adapt and evolve*.** The combination of the federal entitlement to Medicaid for all individuals who qualify, broad state flexibility in program design, and guaranteed federal matching funds has enabled Medicaid to respond to economic and demographic changes, and to address emergent needs – for example, by expanding during economic downturns and providing a coverage safety-net for many affected by the HIV/AIDS pandemic. In addition, as a major source of health care financing, Medicaid has leveraged improvements in health care, including new approaches to care coordination and management, as well as wider adoption of community-based alternatives to institutional long-term care.

WHO IS COVERED BY MEDICAID?

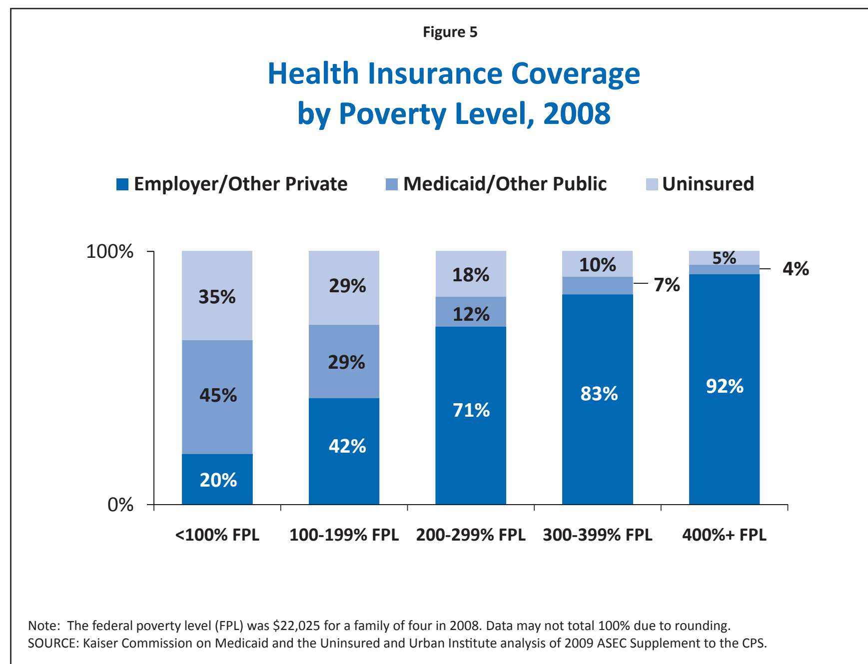
By design, Medicaid covers low-income and high-need populations. Medicaid plays an especially large role in covering children and pregnant women. It also covers millions of low-income Medicare beneficiaries and individuals with disabilities and chronic conditions. Currently, nearly all low-income children can qualify for Medicaid or the Children's Health Insurance Program. But Medicaid eligibility for low-income parents is far more limited and varies widely by state, and federal law categorically excludes adults without dependent children. Under health reform, "who is covered" will change dramatically. The new law simplifies and broadens Medicaid eligibility for the under-65 population by eliminating categorical criteria and establishing a national income eligibility floor at 133% of the poverty level. These reforms of Medicaid eligibility fit Medicaid into the national health coverage framework structured by the new law, establishing the program as the coverage pathway for low-income people.

What is Medicaid's coverage role?

Medicaid covers 45% of all poor Americans – those with income below the federal poverty level (FPL), which was $22,025 for a family of four in 2008* (Figure 5). Medicaid also covers more than one-quarter of near-poor Americans, those between 100% and 200% FPL. Most of the low-income individuals Medicaid covers are in working families but lack access to job-based health insurance or cannot afford the premiums. Most cannot obtain individual (non-group) health insurance either, because they cannot afford it or because they are excluded based on their health status or conditions. Overall, Medicaid beneficiaries are much poorer and in markedly worse health than low-income people with private insurance.

Figure 5

Health Insurance Coverage by Poverty Level, 2008



Note: The federal poverty level (FPL) was $22,025 for a family of four in 2008. Data may not total 100% due to rounding.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of 2009 ASEC Supplement to the CPS.

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* $22,025 for a family of four is the 2008 poverty threshold published by the U.S. Census Bureau. Depending on the context, this *Primer* also sometimes uses the poverty guidelines issued by the U.S. Department of Health and Human Services.

Who can qualify for Medicaid?

Under current law, to qualify for Medicaid, a person must meet financial criteria and also belong to one of the groups that are "categorically" eligible for the program. Federal law requires states to cover certain "mandatory" groups in order to receive any federal matching funds. The mandatory groups are pregnant women and children under age 6 with family income below 133% FPL; children age 6 to 18 below 100% FPL; parents below states' July 1996 welfare eligibility levels (often below 50% FPL); and most elderly and persons with disabilities who receive Supplemental Security Income (SSI), a program for which income eligibility equates to 75% FPL for an individual. States have broad flexibility to determine their own methods for counting income and they may also impose an asset test. Nearly all state Medicaid programs have eliminated the asset test for children, but about half require an asset test for parents; almost every state applies an asset test in determining Medicaid eligibility for the elderly and people with disabilities.

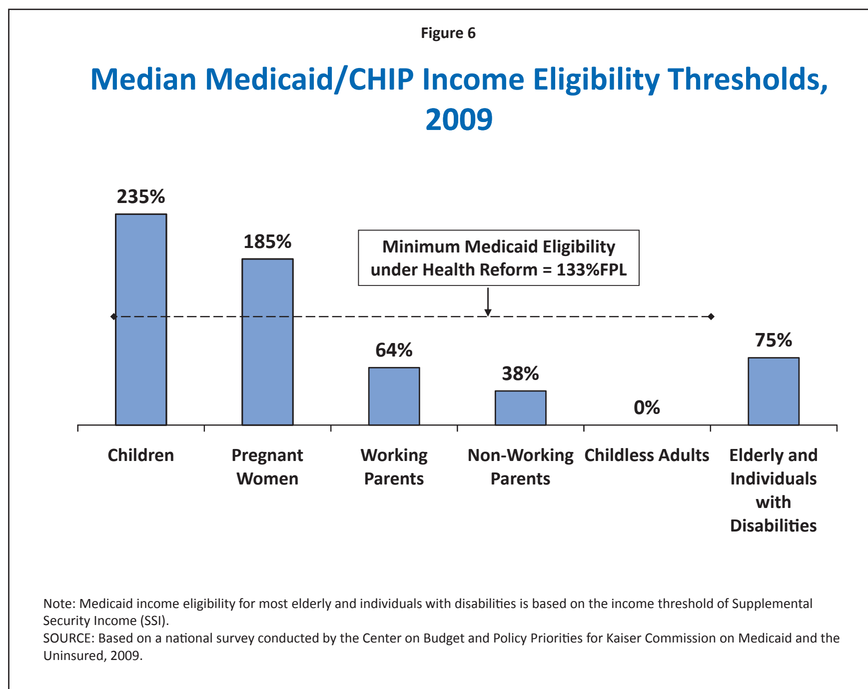
Under the new health reform law, nearly everyone under age 65 – regardless of category – with income below a national "floor" will be eligible for Medicaid, making Medicaid the coverage pathway for many more low-income Americans. Historically, non-elderly adults without dependent children, no matter how poor they are, have been categorically excluded from Medicaid by federal law unless they are disabled or pregnant. States have been able to receive federal Medicaid funds to cover these adults only if they obtained a federal waiver; alternatively, states could use state-only dollars. The new health reform law ends the categorical exclusion of these adults as of 2014, expanding Medicaid eligibility nationally to reach adults under age 65 (both parents and those without dependent children) up to 133% FPL; an enhanced federal match rate applies for adults newly eligible for Medicaid as a result. Health reform did not change Medicaid eligibility for the elderly and people with disabilities.

States have the option to cover or phase-in coverage of the new eligibility group beginning April 1, 2010, rather than waiting until 2014. States (including those that have been covering childless adults in Medicaid with state-only dollars) can receive federal Medicaid matching funds for people in the new eligibility group. States' regular federal match rate applies for this group until 2014, when the enhanced federal match rate takes effect.

Medicaid eligibility is limited to American citizens and certain lawfully residing immigrants. Only American citizens and specific categories of lawfully residing immigrants can qualify for Medicaid. The Personal Responsibility and Work Opportunity Reconciliation Act, enacted in 1996, barred most lawfully residing immigrants from Medicaid during their first five years in the U.S., except for emergency treatment.[6] Some states have used state-only funds to cover these legal immigrants during the five-year ban. Recently, Congress gave states the option to receive federal Medicaid matching funds for lawfully residing immigrant children and pregnant women during their first five years in the U.S.[7] At this writing, 18 states including the District of Columbia had adopted the option to cover immigrant children, pregnant women, or both, without the five-year wait. The health reform law does not change any of the rules regarding immigrants' eligibility for Medicaid.

Documentation of citizenship and identity is required. Since July 1, 2006, most U.S. citizens applying for Medicaid coverage for the first time must, under federal law, document their citizenship and identity by submitting a passport or a combination of a birth certificate and an identity document.[8] (Previously, many states accepted applicants' self-declaration of citizenship under penalty of perjury.) Nearly all elderly individuals and people with disabilities are exempt from the citizenship documentation requirement, as are newborns whose deliveries were paid for by Medicaid. As of January 1, 2010, states have the option to satisfy the documentation requirement by conducting a data match with the Social Security Administration's database, using social security numbers, to verify U.S. citizenship. Almost half the states are now using or testing this data-match option.

States have broad discretion to expand Medicaid eligibility beyond federal minimum standards to cover additional "optional" groups. Optional eligibility groups include, among others: pregnant women, children, and parents with income exceeding the mandatory thresholds; elderly and disabled individuals up to 100% FPL; working disabled individuals up to 250% FPL; persons residing in nursing facilities with income below 300% of the SSI standard; individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers; and the "medically needy," individuals who cannot meet the financial criteria but have high health expenses relative to their income, and who belong to one of the categorically eligible groups. Between Medicaid expansions for children and coverage under the Children's Health Insurance Program (CHIP), most states cover all children below 200% FPL. States have also expanded Medicaid to adult optional groups, but much less extensively, and Medicaid adult eligibility above federal minimum levels varies widely from state to state. (Figure 6)



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

Who is covered currently?

Over 46 million low-income children and parents, the majority of them in working families, rely on Medicaid. Medicaid is the largest source of health insurance for American children. In 2007, about 29 million children – over one-quarter of all children and more than half of low-income children – were enrolled in the program at some point during the year.[9] CHIP builds on Medicaid, covering more than 7 million children in families whose incomes are too high to qualify for Medicaid.[10] Medicaid covers close to 15 million low-income, non-elderly adults, primarily parents in working families. Most children and families covered by Medicaid would be uninsured without it as they lack access to private insurance.

Medicaid covers 8.8 million non-elderly people with disabilities, including 4 million children. Medicaid provides health and long-term care coverage for people with diverse physical and mental disabilities and chronic illnesses. Often, these individuals cannot obtain coverage in the private market or the coverage available to them falls short of their health care needs. Medicaid enables people with disabilities to gain access to a fuller range of the services they need, helping to maximize their independence and, in the case of some disabled adults, supporting their participation in the workforce. Medicaid covers a large majority of all poor children with disabilities.

Medicaid is a key source of coverage for pregnant women. Most states have expanded coverage of pregnant women beyond the federal minimum income eligibility level of 133% FPL. Sixteen states cover pregnant women up to 185% FPL and another 24 states provide eligibility at higher income levels. Medicaid improves access to prenatal care and neonatal intensive care for low-income pregnant women and their babies, helping to improve maternal health and reduce infant mortality, low-weight births, and avoidable birth defects. Medicaid funds approximately four of every ten births in the U.S. and is the largest source of public funding for family planning.[11]

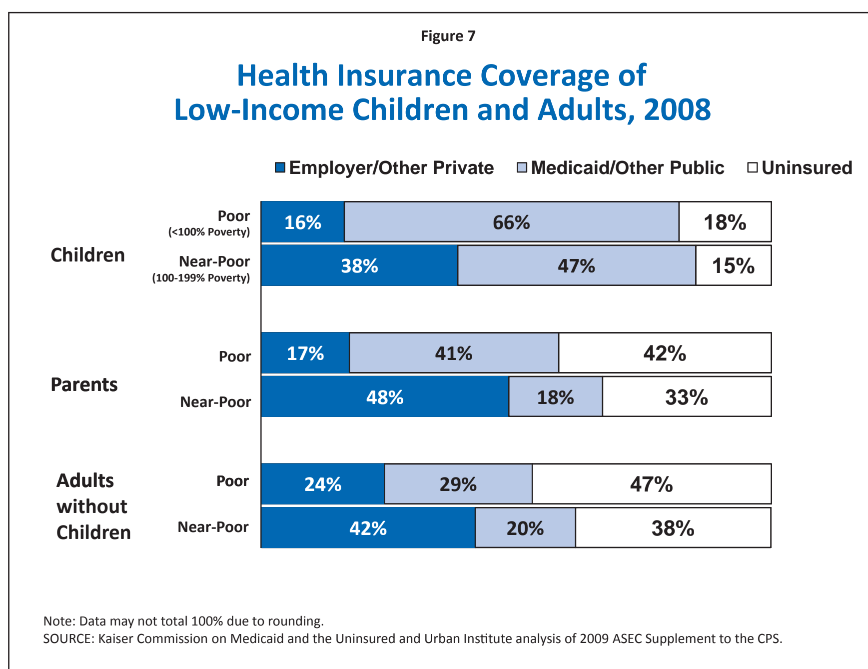
Medicaid provides assistance for more than 8 million low-income Medicare beneficiaries. The federal *Medicare* program provides health insurance 47 million Americans, including 39 million seniors and 8 million non-elderly individuals with permanent disabilities. About 1 in 6 Medicare beneficiaries, based on their low income, are also covered by Medicaid and are known as "dual eligibles." Dual eligibles are much poorer and in worse health compared with other Medicare enrollees. Medicaid assists dual eligibles with Medicare premiums and cost-sharing and covers important services that Medicare limits or does not cover, especially long-term care. In 2005, dual eligibles accounted for 18% of Medicaid enrollees but 46% of all Medicaid spending for services. Until a prescription drug benefit was added to Medicare in 2006, Medicaid covered prescription drugs for dual eligibles and paid nearly 40% of their total health care costs.

Medicaid is viewed favorably both by the general public and by those with experience in the program. A large majority of Americans view Medicaid as a very important program and would be willing to enroll in the program if they needed health care and qualified. Over half of adults have received Medicaid benefits themselves or have a friend or family member who has benefited from Medicaid.[12] Findings from surveys and focus group studies show a high degree of satisfaction with Medicaid among families with program experience.[13] They value both the breadth of Medicaid's benefits and the affordability of the coverage.

Who is left out of Medicaid?

Not all low-income Americans can currently qualify for Medicaid. Although Medicaid covers millions of poor and near-poor Americans, income and categorical restrictions currently exclude millions of low-income people – mostly adults. Due to these restrictions, which the new health reform law redresses, low-income adults today are much more likely than low-income children to be uninsured, as outlined more fully below.

Parents. While all poor children are eligible for Medicaid, many of their parents are not because most states have much stricter income eligibility for parents than for children. As of December 2009, 34 states set income eligibility for working parents at a level below 100% FPL, and half of those states set their levels below 50% FPL. In 29 states, a parent in a family of three working full-time at the state's minimum wage could not qualify for Medicaid.[14] Because their eligibility for Medicaid is so much more limited than children's, parents who are below or near the poverty level are more than twice as likely to be uninsured as children in the same income stratum (Figure 7). Health reform extends Medicaid eligibility, nationally, to nearly everyone under age 65 with income up to 133% FPL, closing the coverage gap that many low-income parents currently face.



Adults without dependent children. Until health reform was enacted, federal law categorically excluded most adults without dependent children from Medicaid. States were precluded from receiving federal Medicaid matching funds for such adults – no matter how poor – unless they were pregnant or severely disabled. About half the states have federal waivers and/or use state-only funds to provide some kind of coverage to childless adults. Only five of these states provide Medicaid or Medicaid-like benefits; most provide more limited benefits or cover childless adults through workplace coverage under certain conditions.[15] In 2008, over 40% of low-income adults without children were uninsured, and these adults accounted for more than one-third of the 46 million non-elderly Americans who lacked insurance.[16] The national Medicaid expansion under health reform does away with the exclusion of childless adults and covers those with income up to 133%FPL. As mentioned previously, states have the option to implement this expansion immediately, rather than waiting until 2014 when the expansion is required.

Immigrants. In most states, lawfully residing immigrants are ineligible for Medicaid for their first five years in the U.S. While states can opt to cover legal immigrant pregnant women and children without a wait, most have not, and other legal immigrants remain barred from Medicaid for their first five years here. Federal law prohibits undocumented immigrants from enrolling in Medicaid. Medicaid payments may be made for undocumented immigrants only for emergency services and only if they would otherwise qualify for Medicaid. These rules do not change under health reform.

State-to-state variation in eligibility leads to marked inequities in low-income adults' access to Medicaid coverage. Because of state variation in Medicaid income eligibility levels and other state policy choices, adults at a given income level – even below the poverty level – may be eligible for Medicaid in one state but ineligible in another. In 2009, eligibility thresholds for working parents ranged from 17% FPL in Arkansas to 215% FPL in Minnesota (Figure 8). Twenty-five states including the District of Columbia had federal waivers or used state-only funds to provide Medicaid coverage to childless adults.[17] Due to federal minimum standards, Medicaid income eligibility levels for pregnant women and children are somewhat uniform, but other low-income adults' access to Medicaid coverage varies widely across the states.

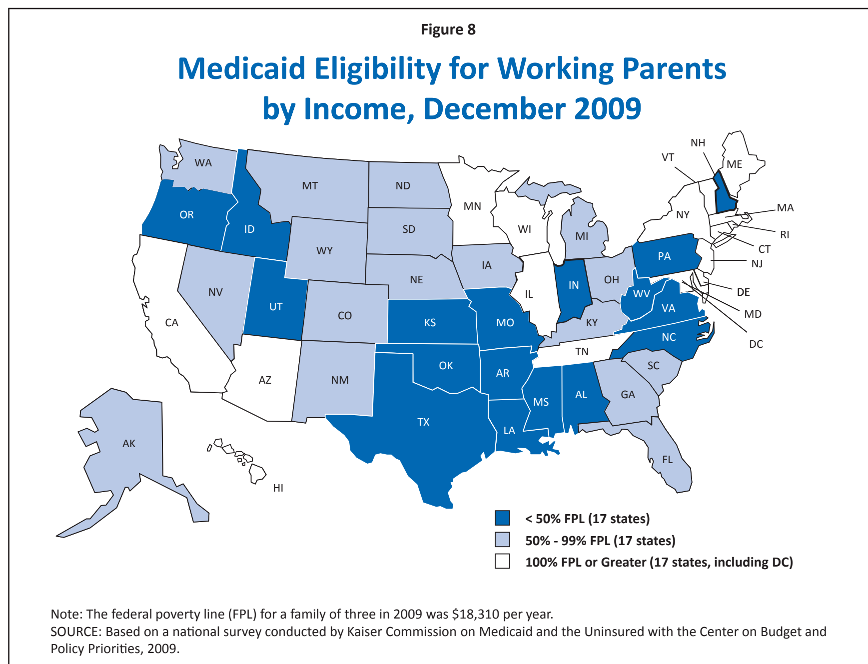


Figure 8

Medicaid Eligibility for Working Parents by Income, December 2009

Note: The federal poverty line (FPL) for a family of three in 2009 was $18,310 per year.
SOURCE: Based on a national survey conducted by Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 2009.

Can Medicaid cover more of the uninsured?

Many people who are eligible for Medicaid are not enrolled. Participation in Medicaid is high compared with other voluntary programs. Yet many who could gain coverage under the program are not enrolled. Over 70% of uninsured children are potentially eligible for Medicaid or CHIP but not enrolled. Some low-income families are not aware of the programs or do not believe their children qualify. In addition, although important improvements have been made over the last decade, mostly for children, burdensome enrollment and renewal requirements still pose major obstacles to participation. Responding to evidence that citizenship documentation requirements have imposed a further burden on U.S. citizens who are eligible for Medicaid and impeded their participation, Congress enacted changes to ease the impact.[18]

States that meet performance goals related to enrolling Medicaid-eligible children can qualify for federal bonus payments. The Children's Health Insurance Program Reauthorization Act (CHIPRA), enacted in February 2009, provided for federal performance bonuses to be paid to states that both implement an array of policies to encourage enrollment and retention of children in Medicaid and CHIP and achieve child enrollment in Medicaid that exceeds targets specified in the law. The more children a state enrolls above the target, the larger the federal bonus payment to the state. The intent of the bonuses is to promote and reward increased enrollment of children who are eligible for Medicaid but uninsured. In December 2009, HHS awarded nine states $72.6 million in performance bonuses.

"Churning" in Medicaid interrupts coverage and care and contributes to the number of Americans without insurance. Documentation and other administrative requirements cause many eligible children and families to lose their Medicaid coverage at renewal time. This "churning" – people cycling on and off the program – disrupts coverage and care and leads to uninsured spells. Many states, when fiscally strong, have stepped up their Medicaid outreach, simplified enrollment and renewal, and taken other actions to promote participation. However, when faced with difficult budget pressures, states have often reduced their efforts or even reinstated barriers that dampen participation in an attempt to control costs.

For health reform to achieve its coverage goals, effective Medicaid outreach and easy enrollment and renewal procedures will be needed. The potential of health reform to cover millions of low-income, uninsured individuals and families is contingent on improving participation in Medicaid. Particular efforts will be needed to reach childless adults, who are new to Medicaid, to introduce the program to them and motivate them to participate. Research shows that easy procedures for enrolling in and renewing Medicaid coverage are also necessary to convert eligibility to participation.

WHAT SERVICES DOES MEDICAID COVER?

Medicaid covers a broad array of health and long-term care services, including many services not typically covered by private insurance. Cost-sharing is tightly restricted to minimize financial barriers to access for the low-income people Medicaid serves. The benefit package for children is comprehensive. Federal law gives states more latitude in defining the benefit package for adults. Under health reform, individuals newly eligible for Medicaid generally will receive "benchmark" or "benchmark-equivalent" benefits, which must include at least the "essential health benefits" required of coverage in the new exchanges. The health reform law offers financial incentives to states to increase access to preventive care in Medicaid and to provide "health home" services to better coordinate care for people with chronic conditions. The law also increases states' opportunities to expand access to home and community-based long-term services and gives states financial incentives to further shift their Medicaid long-term services to non-institutional settings. A new Medicaid and CHIP Payment and Access Commission (MACPAC) is charged with assessing a broad set of access issues.

What does the Medicaid benefit package include?

Because Medicaid enrollees have diverse and often extensive needs, Medicaid benefits include a broad range of health and long-term care services. Medicaid covers parents and children, pregnant women, people with physical and mental disabilities and chronic diseases of all kinds, and seniors. To address the wide-ranging health needs of its diverse enrollees and their limited ability to afford care out-of-pocket, Medicaid benefits include the health services typically covered by private insurance, but also many additional services, such as dental and vision care, transportation and translation services, and long-term care services and supports. Some covered benefits, such as services provided by federally qualified health centers, reflect the special role that certain institutions and other providers play in furnishing care to the low-income population. States use numerous tools to manage utilization, such as prior authorization and case management.

State Medicaid programs must cover "mandatory services" specified in federal law in order to receive any federal matching funds. Most Medicaid beneficiaries are entitled to receive the mandatory services listed below. Medicaid services are covered subject to medical necessity, as determined by the state Medicaid program or a managed care plan that is under contract to the state.

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

States are also permitted to cover many important services that federal law designates as "optional." Many of these optional services are particularly vital for persons with chronic conditions or disabilities and the elderly. Prescription drugs (which all states cover), personal care services, and rehabilitation services are just three examples. The inclusion of many of these services in state Medicaid programs despite their "optional" designation in federal statute is evidence that, as a practical matter, they are often considered essential. Nonetheless, when states are under severe budget strains, such as in the current economic recession, "optional" benefits like dental services for adults are particularly vulnerable to cuts. Close to one-third of Medicaid spending is estimated to be attributable to optional services.[19]

Commonly offered optional services include:

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

How are Medicaid benefits different from typical private health benefits?

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

The concept of medical necessity in EPSDT is expansive, consistent with an emphasis in Medicaid on promoting children's healthy development and maximizing their health and function. Further, the limits that states may impose on services for adults cannot be applied to children. In principle at least, EPSDT represents a uniform and comprehensive federal benefit package for low-income children.

In addition to acute health services, Medicaid covers a wide range of long-term services and supports that Medicare and most private insurance exclude or narrowly limit. Medicaid long-term care services include comprehensive services provided in nursing homes and intermediate care facilities for the mentally retarded (ICF-MR), as well as a wide range of services and supports needed by people, young and old, to live independently in the community – home health care, personal care, medical equipment, rehabilitative therapy, adult day care, case management, respite for caregivers, and other services. Because Medicare and private insurers provide little coverage of long-term care, Medicaid is by far the largest source of assistance for these costly services. Driven partly by the Supreme Court's *Olmstead* decision concerning the civil rights of people with disabilities in public programs, both federal and state Medicaid policy have increasingly supported home and community-based alternatives to institutional long-term care.

Health care reform creates new opportunities and incentives for states to balance their Medicaid long-term care delivery systems by expanding access to home and community-based services. The new law expands states' current Medicaid options to provide home and community-based benefits, both enlarging the scope of services covered and broadening financial and functional eligibility criteria to expand access to these benefits. The law also provides increased financial incentives for states that further shift their Medicaid long-term services to non-institutional settings.

Separate from Medicaid, the health reform law establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS). The program will be financed through payroll deductions; all working-age adults will be enrolled automatically unless they opt out. Subject to a five-year vesting period, CLASS will provide cash benefits to individuals with functional limitations for non-medical services and supports necessary to maintain community residence.

The broad array of services Medicaid covers is particularly important for the care of low-income people with chronic illnesses and disabilities, who include pre-term babies, individuals with mental illness, people living with HIV/AIDS, and many with Alzheimer's disease. Another distinctive purpose of Medicaid's is to provide access to care for people with disabilities and complex conditions, who often have extensive needs for both acute care and long-term services. Medicaid's coverage of services needed especially by such individuals, such as case management, dental care, mental and behavioral health services, rehabilitation services, personal care, and nursing facility and home health care, is a defining aspect of the program. Millions of Americans with diverse disabilities and needs depend on Medicaid. Medicaid is the single largest public payer of mental health care in our system.[20] It is also the nation's largest source of coverage for people with HIV, covering about 40% of those estimated to be receiving care for disease.[21]

How do states define their Medicaid benefit packages?

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

States can offer more limited "benchmark" benefits to some groups. In the Deficit Reduction Act of 2005, Congress changed the law to permit states to provide some groups with more limited benefits modeled on specified "benchmark" plans, and to offer different benefits to different enrollees.[22] States providing benchmark or benchmark-equivalent coverage must provide EPSDT "wraparound" coverage for children. Most groups are exempt from benchmark coverage, including mandatory pregnant women and parents, individuals with severe disabilities, individuals who are medically frail or have special needs, dual eligibles, people with long-term care needs, and specified other groups. Few states have used the new authority. Four states have provided different tiers of benefit packages for different groups, two of them limiting or granting access to certain benefits based on enrollees' health behaviors.[*] Four other states have used the authority to enhance Medicaid coverage for specified populations.

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

States can impose premiums and cost-sharing in Medicaid subject to some federal limitations. In 2005, Congress loosened longstanding rules that sharply restricted states' use of premiums and cost-sharing in Medicaid. Premiums remain prohibited for most children and adults below 150% FPL. However, for most children and adults with income above 150% FPL, premiums as well as cost-sharing up to 20% of the cost of the service are now permitted.

For most services, cost-sharing is largely prohibited for mandatory children and it is limited to nominal levels for adults below 100% FPL. For other children and adults up to 150% FPL, cost-sharing is limited to 10% of the cost of the service. Total cost-sharing and premiums cannot exceed 5% of family income for any family, and cost-sharing for preventive care is prohibited for children at all income levels. Finally, the 2005 rules also give states the option to terminate Medicaid coverage if premiums are not paid and, except for mandatory children and adults under 100%FPL, to grant health care providers the right to deny care if Medicaid patients do not pay their cost-sharing charges.[23]

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[*] Recent federal regulations further delineate the scope of state flexibility regarding benchmark packages. To comply with these rules, one of the states that restricted benefits (WV) has discontinued doing so; other states may also have to reexamine their benchmark policies in light of the new rules.

Under health reform, adults newly eligible for Medicaid will receive a benchmark benefit package, or broader benefits if a state elects. Beginning January 1, 2014, newly-eligible Medicaid adults, unless they belong to one of the exempt groups mentioned above, will receive benchmark or benchmark-equivalent coverage. The reform law establishes a new minimum standard for benchmark benefits, requiring that they include at least the "essential health benefits" required of health plans in the new insurance exchanges. These benchmark benefits may be more limited than states' current Medicaid benefits, but states retain the flexibility to provide more comprehensive or full Medicaid benefits to new eligibles.

How do Medicaid enrollees receive services?

Although Medicaid is publicly financed, the program purchases health services primarily in the private sector. Medicaid is a publicly financed health coverage program, but it is not a government-run care delivery system. On the contrary, the Medicaid program generally procures services for its beneficiaries in the private health care market. States pay health care providers for services furnished to their Medicaid beneficiaries. Medicaid programs purchase services on a fee-for-service basis, or by paying premiums to managed care plans under contracts, or by using a combination of both approaches.

Managed care is the most common health care delivery system in Medicaid. In 2008, about 70% of Medicaid enrollees received some or all of their services through managed care arrangements (Figure 9). The two main models of managed care in Medicaid are managed care organizations (MCO) and primary care case management (PCCM). MCOs are paid on a capitation basis and assume the financial risk for comprehensive Medicaid services or a defined set of services (e.g., ambulatory care, dental services). In PCCM, the primary care provider receives a small fee per person per month to provide basic care and coordinate specialist care and other needed services, which are usually paid fee-for-service.

Healthy children and families make up the lion's share of Medicaid managed care enrollees, but many states are now enrolling more complex populations, including children and adults with disabilities and chronic illnesses and dual eligibles, in managed care arrangements. Several states are applying managed care principles to long-term care; new initiatives include projects that integrate acute and long-term care within MCO delivery systems.[24]

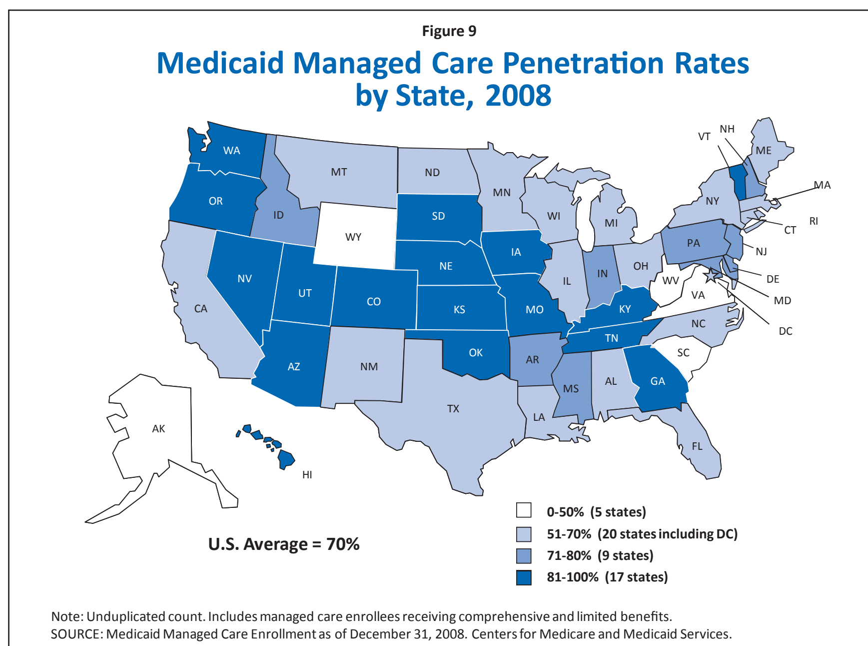


Figure 9

Medicaid Managed Care Penetration Rates by State, 2008

Note: Unduplicated count. Includes managed care enrollees receiving comprehensive and limited benefits.
SOURCE: Medicaid Managed Care Enrollment as of December 31, 2008. Centers for Medicare and Medicaid Services.

States are using a variety of approaches to balance their long-term care delivery systems in favor of community settings. As the demand for long-term services in the community is growing, efforts to make Medicaid benefits more flexible and allow consumer involvement in determining and managing services are expanding across the states. Many states allow some form of consumer direction of personal assistance services, giving the Medicaid beneficiary more control over hiring, scheduling, and paying personal care attendants. Under health reform, states have increased opportunities to expand access to home and community-based services, and the law extends an existing demonstration program that provides states with enhanced federal matching funds for each Medicaid beneficiary they transition from an institution to the community.

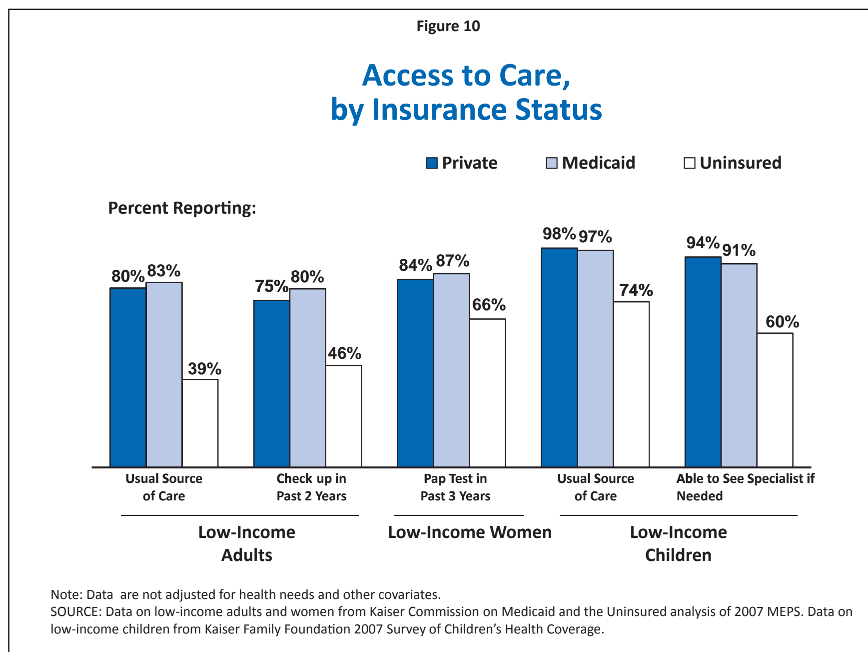
States have built delivery systems designed to serve the Medicaid population. Whether they use managed care, fee-for-service, or a combination of strategies, many states have developed strong care delivery networks that rely heavily on community health centers and other safety-net providers located in the communities where low-income people reside. These providers are often uniquely prepared and competent to address diverse low-income populations' needs for services and supports.

New models of care are emerging in Medicaid. Many states are building into their PCCM programs features to enhance the coordination and management of care for enrollees with chronic illnesses and disabilities. Some disease and care management programs are targeted to people with specific conditions, and others target individuals with multiple conditions. A number of states are structuring payment strategies and incentives to support the "patient-centered medical home" model for Medicaid beneficiaries. This model emphasizes continuous and comprehensive care, care teams directed by a personal physician, and care for all stages of life. It also seeks to enhance access through expanded hours and other improvements. Information technology and quality improvement activities promote quality and safety.

How is access to care in Medicaid?

Medicaid increases access to care and limits out-of-pocket burdens for low-income people. Children and adults enrolled in Medicaid have much better access to care than the uninsured, and pregnant women covered by Medicaid obtain more timely and adequate prenatal care than their low-income, uninsured counterparts.[25 26] On key measures of access to preventive and primary care, Medicaid enrollees fare as well as people with private health insurance (Figure 10).[27 28 29] In addition, Medicaid's strict limits on cost-sharing help to ensure that, for the low-income and high-need population the program serves, cost is not an obstacle to obtaining care.[30] Research shows that Medicaid beneficiaries are substantially less likely to face high financial burdens for health care than low-income people with private insurance.[31]

Figure 10



Note: Data are not adjusted for health needs and other covariates.
SOURCE: Data on low-income adults and women from Kaiser Commission on Medicaid and the Uninsured analysis of 2007 MEPS. Data on low-income children from Kaiser Family Foundation 2007 Survey of Children's Health Coverage.

System-wide problems with access to care are amplified in Medicaid. Shortages and inadequacies in the distribution of certain providers and specialists have contributed to access problems in the private and public sectors alike, but low provider payment and participation rates compound these problems in Medicaid (Figure 11). Gaps in access to specialist and dental care in Medicaid are a major concern. In provider surveys and other research, low provider payment and administrative burden consistently emerge as leading barriers to provider acceptance of Medicaid.[32] Also, providers often do not locate in low-income neighborhoods, creating time, distance, and cost barriers to access for people living in these communities.

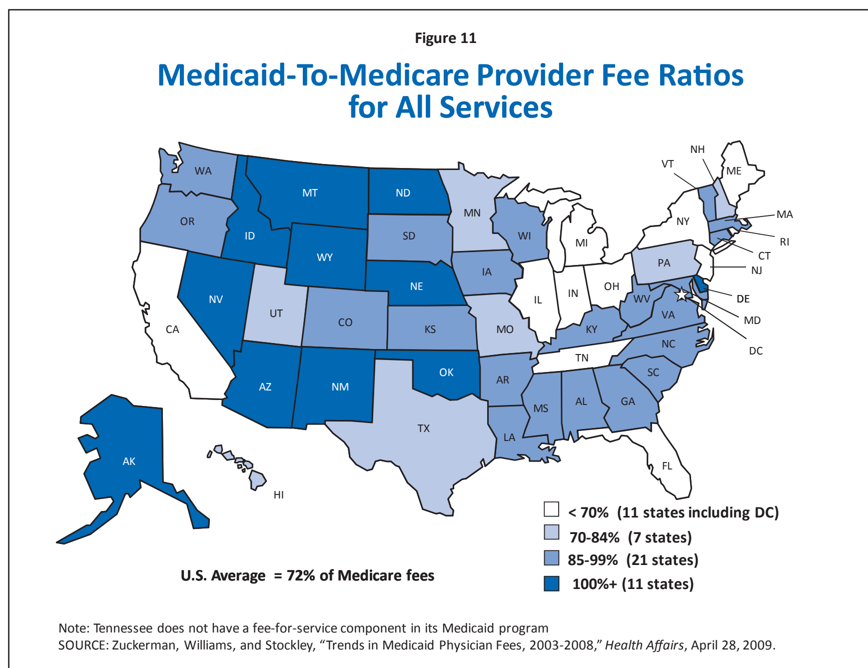


Figure 11

Medicaid-To-Medicare Provider Fee Ratios for All Services

Note: Tennessee does not have a fee-for-service component in its Medicaid program
SOURCE: Zuckerman, Williams, and Stockley, "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, April 28, 2009.

Provider participation and systems of care affect access. A number of states have achieved gains in provider participation in Medicaid following increases in provider payment and increased provider outreach and support.[33] MCOs have the potential to structure and deliver a network of providers to Medicaid beneficiaries who, on their own in a fee-for-service environment, might have difficulty identifying providers willing to serve them. At the same time, access in managed care arrangements depends on provider networks that are adequate to meet the needs of Medicaid enrollees and mechanisms that connect enrollees with timely and appropriate care.

To help boost access to primary care in Medicaid, the health reform law requires states to pay the Medicare payment rate for primary care services furnished by primary care physicians in 2013 and 2014 and provides full federal funding for this increase. The law also funded the recently-established Medicaid and CHIP Payment and Access Commission (MACPAC), which is charged with monitoring access in the two programs, identifying gaps, and making recommendations concerning payment and access issues.

How does Medicaid monitor and promote quality?

States use a variety of data and payment strategies to improve quality in Medicaid. Increasingly, states are using standardized data to benchmark and improve the quality of care provided by managed care programs and other medical providers. Most states require MCOs serving Medicaid enrollees to provide data on specified utilization and performance measures (from the Healthcare Effectiveness Data and Information Set (HEDIS)), and most also use the patient satisfaction surveys (Consumer Assessment of Healthcare Providers and Systems (CAHPS)) in MCOs as a quality gauge; a smaller number of states do so in PCCM and fee-for-service. More and more states are publicly reporting the quality data they collect, both to help beneficiaries choose plans based on quality considerations and to drive improvements in provider performance. A growing number of states require or reward MCOs that are accredited by a recognized standard-setting organization. Finally, pay-for-performance (P4P) systems in most states financially reward high performance by MCOs and/or physicians, hospitals, nursing homes, and other providers.[34]

States are using health information technology (HIT) in a variety of ways to improve quality and safety in Medicaid. Medicaid programs in most states are participating in electronic prescribing and electronic health record (EHR) or electronic medical record (EMR) initiatives to promote better coordination of care. Some states are using Medicaid claims data to design evidence-based recommendations for care; some are facilitating data-sharing among agencies and providers that care for children.[35] HHS is developing a core set of children's healthcare quality measures for children enrolled in Medicaid or CHIP that will be useful in state efforts to evaluate the "meaningful use" of HIT, a criterion for qualifying for new HIT payment incentives to providers (described below).

Substantial new federal investments are likely to foster increased HIT initiatives in Medicaid. ARRA provided $21.6 billion in Medicaid funding to encourage physicians, hospitals, and other health care providers to adopt and "meaningfully use" certified EHRs. Illustrations of meaningful use include use for electronic prescribing, electronic exchange of health information to improve quality of care, and reporting on clinical quality measures. Full federal funding is initially available for Medicaid incentive payments to eligible providers to help offset the costs of purchasing, implementing, operating, maintaining, and using the technology, training, and other costs. Generally, to qualify for incentive payments, providers must serve a minimum level of Medicaid and other low-income patients. ARRA also provides 90% federal funding for states to administer the EHR incentives, including actions to encourage adoption of EHR and track meaningful use. The HIT investments are estimated to generate $12 billion in savings attributable to improved quality, care coordination, and reductions in medical errors and duplicative care. Complementing the funds for HIT incentive payments are two competitive grant programs for states, one to enable states to make loans to providers for technology purchasing and training, and another for states to facilitate and expand electronic exchange of health information among organizations.[36]

HOW MUCH DOES MEDICAID COST?

In 2008, Medicaid spending totaled about $339 billion. Spending is distributed across a broad array of health and long-term care services. Medicaid spending is high because of the extensive health needs of many of its beneficiaries. The top 5% percent of spenders in Medicaid account for nearly 60% of total spending. Also, close to half of Medicaid spending is attributable to low-income Medicare beneficiaries who also qualify for Medicaid. Total Medicaid spending will rise under health reform as millions of people become eligible for the program. The Congressional Budget Office projects that the expansion will cost states $20 billion over the next decade, an increase of 1.25 percent over what they would otherwise have spent; the federal government will finance 96% of the cost of the coverage expansion over the ten years.

What does Medicaid cost currently?

In 2008, total federal and state Medicaid spending on services was nearly $339 billion (Figure 12*)*. Over 60% of spending was attributable to acute care, including payments to managed care plans. More than a third (34%) of spending went toward long-term care. Medicaid administrative costs were 5% (not shown).

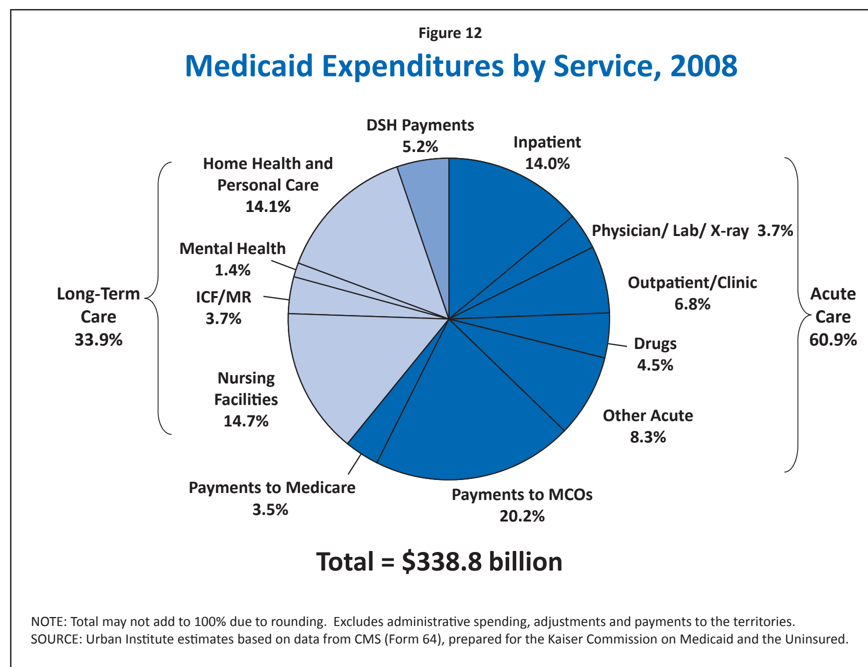


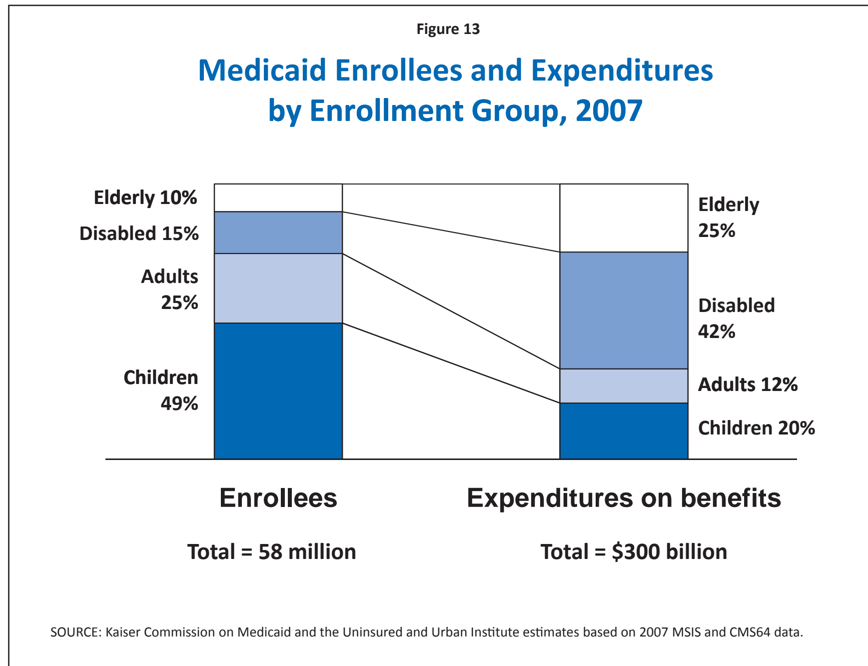
Figure 12
Medicaid Expenditures by Service, 2008

NOTE: Total may not add to 100% due to rounding. Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

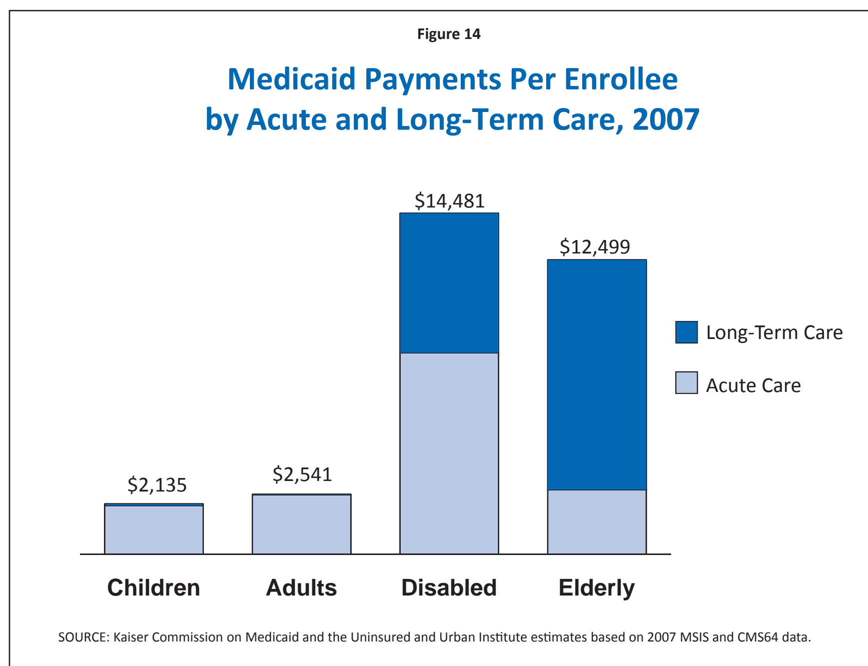
Medicaid makes special payments to hospitals that serve a disproportionate share of low-income and uninsured patients. About 5% of Medicaid spending is attributable to supplemental payments to hospitals that serve a disproportionate share of low-income and uninsured patients, known as "DSH." DSH payments help to support the safety-net hospitals that provide substantial uncompensated care.

What drives Medicaid spending?

Children and their parents make up the majority of Medicaid enrollees, but most Medicaid spending is attributable to the elderly and people with disabilities. Children, parents, and pregnant women make up three-quarters of the Medicaid population but account for only about a third (32%) of Medicaid spending. The elderly and disabled make up one-quarter of the Medicaid population but account for roughly two-thirds of spending. (Figure 13)



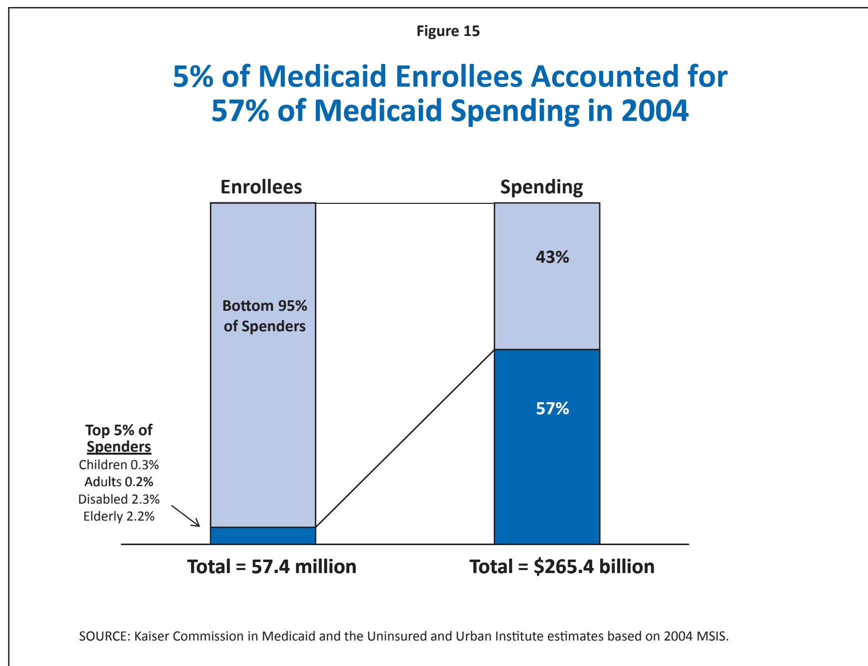
Medicaid spending per enrollee varies sharply by eligibility group. In 2007, the per capita cost for children covered by Medicaid was about $2,100, compared to $2,500 per adult, $14,500 per disabled enrollee and $12,500 per elderly enrollee (Figure 14). Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of both acute and long-term care services.



More than 45% of all Medicaid spending for medical services is attributable to dual eligibles. In 2005, dual eligibles – low-income individuals who are enrolled in both Medicare and Medicaid – made up 18% of the Medicaid population, but accounted for 46% of Medicaid spending. More than half of Medicaid spending for dual eligibles is for long-term care services. Until 2006, Medicaid provided prescription drug coverage for dual eligibles because Medicare did not include a drug benefit. Beginning January 2006, Medicare covers prescription drugs under the new Part D, but states make a monthly "clawback" payment to the federal government to help finance the benefit. The payments roughly reflect what states would have spent if they continued to pay for outpatient prescription drugs through Medicaid on behalf of their dual eligibles. In 2006, state clawback payments totaled $6.6 billion.

Desirable coordination between Medicare and Medicaid benefits and integration of acute and long-term care for dual eligibles has long been a policy goal. To support improved coordination of care for dual eligibles, as well as better-coordinated payment, the health reform law established a federal Coordinated Health Care Office within CMS.

The five percent of Medicaid beneficiaries with the highest costs account for over half of all Medicaid spending. Medicaid spending is highly skewed; a very small group of high-cost enrollees accounts for a large share of Medicaid spending. In 2004, the 1% of Medicaid enrollees with the highest health and long-term care costs accounted for one-quarter of Medicaid spending, and the highest-cost 5% of enrollees accounted for 57% of all program spending (Figure 15). This pattern, in which the high costs of a small share of enrollees drive total spending, holds in each of Medicaid's four major eligibility groups.



Under health reform, a new Center for Medicare and Medicaid Innovation is established within CMS. The Center is charged with testing, evaluating, and expanding innovative service delivery and payment models in Medicare, Medicaid, and CHIP to foster patient-centered care and improve quality while reducing spending.

Along with the health needs of the Medicaid population, growth in Medicaid enrollment and rising health care costs are major drivers of Medicaid costs. Between 2000 and 2007, Medicaid enrollment increased from 31.8 million to 42.3 million, or at an average annual rate of 4.2 percent.[37] Between June 2008 and June 2009, in the midst of the current recession, enrollment grew by 3.3 million, or 7.5%. Several factors fuel Medicaid enrollment. When state economies are strong, states seeking to broaden coverage may expand Medicaid eligibility. In economic recessions, job loss and resulting losses of job-based insurance and declining income cause more people to qualify for Medicaid. Ongoing erosion in employer-sponsored insurance contributes as well. Medicaid spending trends also reflect health care cost inflation, a systemic problem that drives health spending across our entire system.

How effectively is Medicaid spending managed?

Medicaid is a low-cost program when the health needs of its beneficiaries are taken into account. Medicaid spending is high primarily because of the high-need people Medicaid serves. Medicaid enrollees overall are in significantly worse health than the low-income, privately insured population. When health status differences are controlled to make the Medicaid and low-income, privately insured populations more comparable, per capita spending for both adults and children is lower in Medicaid than under private insurance. Medicaid's lower spending levels are due mostly to its lower provider payment rates; differences in access to specialists and expensive technology for those in fair or poor health may also be a factor.[38]

Medicaid spending per capita has not risen faster than private health spending per capita. On a per capita basis, Medicaid acute care spending has been growing at the same rate as private health spending and less than monthly premiums for private insurance (Figure 16). From 2000 to 2008, the increase in acute care spending per Medicaid enrollee averaged 5% per year, as did growth in per capita private health care spending. Over the same period, monthly premiums for job-based coverage for an individual rose 8% per year on average.

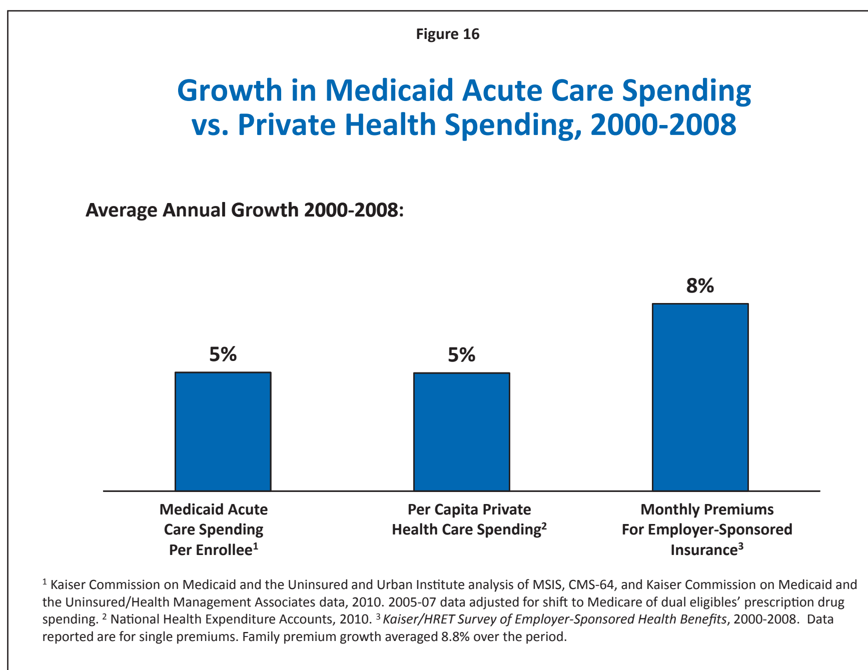


Figure 16

Growth in Medicaid Acute Care Spending vs. Private Health Spending, 2000-2008

[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of MSIS, CMS-64, and Kaiser Commission on Medicaid and the Uninsured/Health Management Associates data, 2010. 2005-07 data adjusted for shift to Medicare of dual eligibles' prescription drug spending. [2] National Health Expenditure Accounts, 2010. [3] *Kaiser/HRET Survey of Employer-Sponsored Health Benefits*, 2000-2008. Data reported are for single premiums. Family premium growth averaged 8.8% over the period.

Program management tools at the federal and state level help to ensure proper payment and improve Medicaid's efficiency. In 2006, Congress established a federal Medicaid Integrity Program (MIP) within CMS and provided substantial resources annually for audits, identification of fraud and abuse and other overpayments, education regarding program integrity and quality of care, and other purposes.[39] Most operational program integrity responsibilities rest with the states, but the MIP greatly enlarged the federal government's commitment to and CMS' accountability for sound and efficient management of the Medicaid program.

A separate mechanism for ensuring Medicaid (and CHIP) integrity is the Payment Error Rate Measurement Program (PERM). Under this initiative, a random sample of claims (both fee-for-service and managed care) and eligibility determinations are reviewed in a third of the states each year to determine error rates. Errors include payments that should not have been made or were made in the wrong amount, and also payments that were incorrectly denied. CMS calculates state and national error rates and reports to HHS and the Office of Management and Budget. States must submit a corrective plan to CMS and reimburse the federal government for its share of any overpayments.

HOW IS MEDICAID FINANCED?

Medicaid is financed through a federal-state partnership in which the federal government matches each state's spending based on a statutory formula. Under the normal formula, the federal government funds about 57% of all Medicaid spending, but with a temporary increase in the federal match rate to provide fiscal relief to states during the recession, the overall federal share is 66%. Under health care reform, the federal-state partnership in financing Medicaid will continue. However, the federal government will finance the full cost of the new coverage in the first three years of reform and the lion's share in subsequent years.

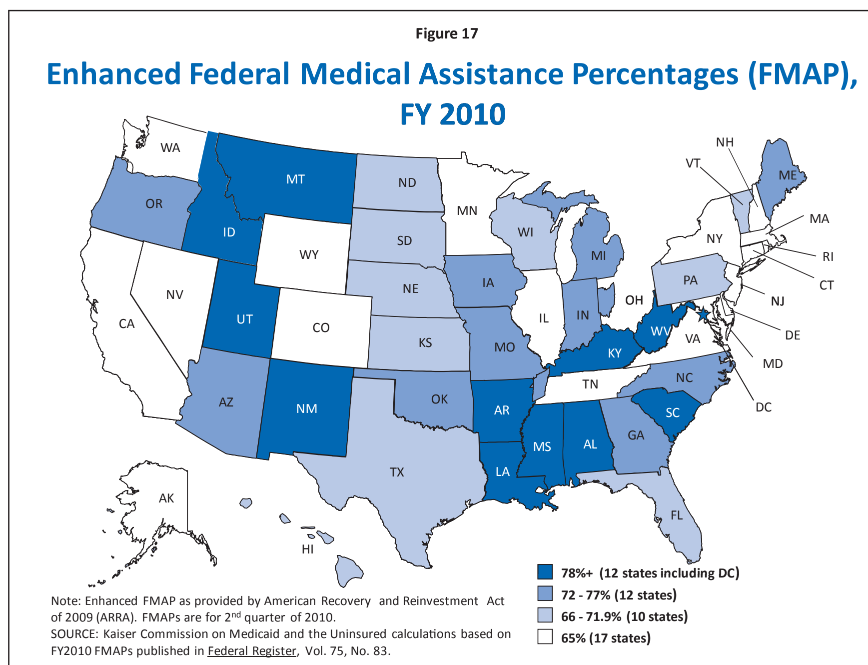
Who pays for Medicaid?

Medicaid is financed through a partnership between the federal government and the states. The federal government matches state spending on Medicaid. The federal match rate is known as the Federal Medical Assistance Percentage, or FMAP, and it varies based on state per capita income relative to the national average. The FMAP is at least 50% in every state. It is higher in relatively poor states, reaching 76% in the poorest state, Mississippi (Figure 17). The federal match rate for most Medicaid administrative costs is 50%. Federal matching dollars are guaranteed and flow to states based on need (as reflected by state spending), rather than on the basis of a pre-set formula or projected need. Overall, the federal government funds about 57% of Medicaid spending.

The American Recovery and Reinvestment Act (ARRA), enacted in February 2009 to boost the ailing economy, provided for a temporary increase in the FMAP. This federal relief supports the states in a period when they are facing rising Medicaid enrollment but are least able to afford it. With the ARRA adjustment, the FMAP for fiscal year 2010 ranges from 56% to 85%. The FMAP enhancement increases federal Medicaid spending by about $87 billion over the period October 1, 2008 through December 31, 2010, and increases the federal share of total Medicaid spending from 57% to 66%.[40] The enhanced FMAP rates will expire at the end of 2010, unless extended by Congress.

Figure 17

Enhanced Federal Medical Assistance Percentages (FMAP), FY 2010



Note: Enhanced FMAP as provided by American Recovery and Reinvestment Act of 2009 (ARRA). FMAPs are for 2nd quarter of 2010.
SOURCE: Kaiser Commission on Medicaid and the Uninsured calculations based on FY2010 FMAPs published in Federal Register, Vol. 75, No. 83.

Medicaid is a major source of federal revenue to the states. At the same time that Medicaid is a major spending program, it is also the largest source of federal revenue to the states. Federal Medicaid dollars are the single largest source of federal grant support to states, accounting for an estimated 44% of all federal grants to states in 2008.[41] Medicaid currently accounts for about 7% of federal budget outlays.[42]

States commit substantial funds to Medicaid. On average, states spend about 16% of their general funds on Medicaid, making it the second largest item in most states' general fund budgets, following spending for elementary and secondary education, which represented 35% of state general fund spending in 2008.[43] Medicaid spending pressures are a perennial issue at the state level. This is so because states have limited fiscal capacity to meet the many competing demands they face and must balance their budgets. State budget pressures intensify during economic downturns, when state revenues decline just as enrollment in Medicaid and other assistance programs is growing.

Medicaid is a major engine in state economies. Economic research shows that state Medicaid spending has a "multiplier effect" as the money injected into the state economy through the program generates successive rounds of earning and purchasing by businesses and residents. This economic activity supports jobs and yields additional income and state tax revenues. Compared with other state spending, Medicaid spending is especially beneficial because it also triggers an infusion of new federal dollars into the state economy, intensifying the multiplier effect.[44]

How well does Medicaid's financing structure support the program?

Medicaid's financing structure gives states flexibility to respond to changing and emerging needs and supports state efforts to expand coverage to the uninsured. When states spend their dollars on Medicaid, federal matching dollars follow. The matching system increases states' capacity to respond to changes in needs, economic conditions, and demographics, and to disasters and epidemics. Guaranteed federal matching payments provide an incentive to states to invest in health care and discourage them from reducing coverage. At the same time, states' incentives to control their costs constrain state Medicaid spending, and thus, federal Medicaid spending as well.

Federal matching rates are based on lagged data that may not reflect current economic conditions. The FMAP formula that determines the federal share of Medicaid spending in each state is based on the relationship between the state's per capita income and the national average. However, because the income data used in the FMAP formula are lagged, a state's match rate may reflect economic conditions that differ dramatically from current conditions. For example, in an economic downturn, some states may actually receive a reduced federal match because the data used in the FMAP calculation reflect a different set of economic circumstances.

The current financing system for Medicaid does not adequately account for the "countercyclical" nature of the program. By design, during economic downturns such as the current recession, when people lose their jobs and their health coverage and income decline, Medicaid expands. However, economic downturns also cause state tax revenues to shrink, reducing state capacity to afford increased enrollment just when it is most likely to occur. The current FMAP formula, which uses lagged data and is based solely on per capita income, does not provide an effective "countercyclical" adjustment to increase federal assistance to states during economic downturns. The temporary increase in the FMAP provided by ARRA was a legislative response to this problem. In effect, the FMAP increase *is* a countercyclical adjustment that boosts the federal share of Medicaid costs temporarily, while states are crunched between rising demands for Medicaid coverage and dwindling coffers due to the recession. As a condition of receiving the enhanced federal match, states cannot reduce Medicaid eligibility or use more restrictive rules for determining eligibility. Similar to relief provided in 2003 during the last economic decline, the ARRA FMAP increase has been instrumental in helping states to avoid additional and deeper reductions in their Medicaid programs, address budget shortfalls, and preserve coverage.

Under health reform, the federal government will finance the vast majority of the costs of new Medicaid coverage. The federal-state financing partnership that supports the current Medicaid program will continue under health reform. However, the cost of the new Medicaid coverage stemming from health reform will be fully financed by the federal government in the first three years of reform (2014-2016); in subsequent years, the federal government will continue to finance the lion's share, phasing down to 90% in 2020 and thereafter. Overall, federal funds will finance 96% of the cost of the Medicaid expansion over the first decade.

HOW DOES HEALTH REFORM RESHAPE MEDICAID FOR THE FUTURE?

The Affordable Care Act establishes a national framework for near-universal health coverage. Under the law, beginning in 2014, a new individual mandate will require most individuals to obtain coverage. At the same time, access to affordable health coverage will be improved through a significant expansion of the Medicaid program, the creation of new health insurance exchanges, and reforms of the private health insurance market. The major expansion of Medicaid and health reform's reliance on the program as the foundation for coverage of low-income people give Medicaid both a much larger and a distinctively national coverage role going forward.

- ***Medicaid eligibility reform.*** Under health reform, Medicaid eligibility for people under age 65 will be based solely on income. With categorical restrictions abolished for this population, Medicaid coverage will be extended to millions more low-income people, including both parents and adults without dependent children. In addition, a national Medicaid eligibility floor will apply, all states will count income using a specified, uniform method, and there will be no asset test. As a result of these provisions, nearly everyone under age 65 with income below 133% of the poverty level will qualify for Medicaid, significantly reducing uninsurance and state variation in coverage. These changes define Medicaid as the national coverage pathway for low-income individuals and families; they also introduce a degree of standardization in eligibility across state Medicaid programs to permit necessary coordination between Medicaid and the health insurance exchanges in the new national system.

- ***Simplified enrollment.*** The simplified, uniform methods for determining Medicaid eligibility help set the stage for simplified Medicaid enrollment procedures. Further, the new law requires that states streamline and coordinate their Medicaid and exchange enrollment systems in a "no wrong door" approach, to promote coverage, minimize the burden on people seeking coverage, and ensure their enrollment in the appropriate program. Additional requirements, investments, and incentives in the law push toward increased use of automation and technology in Medicaid to optimize participation and stable coverage.

- ***Improved access to care.*** The law includes an array of measures to increase physician participation and access to care in Medicaid, especially primary care. Full federal financing is provided to raise Medicaid payment rates for primary care to Medicare levels in 2013 and 2014. The law also gives states financial incentives to cover preventive care for adults in Medicaid. Other provisions seek to correct shortcomings in the healthcare workforce that hit underserved communities especially hard. The newly created Medicaid and CHIP Payment and Access Commission (MACPAC) is charged to assess access issues broadly. Innovation in service delivery is another focus of the law. For example, the law includes financial incentives for states to provide "health home" services to better coordinate care for Medicaid enrollees with chronic conditions, and new options to increase access to community-based long-term care. Also, a new federal office is established to coordinate care and financing for dual eligibles.

- ***Financing***. About 16 million more people are projected to gain Medicaid or CHIP coverage by 2019 due to the expansion of Medicaid eligibility and increased participation that is expected as the public responds to health reform. The Congressional Budget Office estimates that the federal government will finance about 96% of the coverage increases associated with reform between 2010 and 2019 ($434 billion), and states will contribute 4% ($20 billion).

As the nation prepares to implement health reform, understanding Medicaid is more important than ever. Key information about how the program operates and fits into our system today can help to ground policymakers and the interested public, orienting them to Medicaid's current scope and role, while providing perspective on how health reform reshapes the program for the future, preparing it for the central role it is to play in the national plan for covering our people.

Endnotes

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TABLES

Table 1: Medicaid Expenditures by Type of Service, FFY 2008

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Table 3: Medicaid Enrollment by Group, FFY 2007

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Table 6: Medicaid Income Eligibility as a Percent of Federal Poverty Level (FPL), 2009

Table 1

Medicaid Expenditures by Type of Service, FFY 2008

	Expenditures (in millions)						
	Total	Acute Care*		Long-Term Care*		DSH Payments	
State	$	$	%	$	%	$	%
United States	**$338,791**	**$206,256**	**61%**	**$114,797**	**34%**	**$17,739**	**5%**
Alabama	4,078	2,292	56%	1,358	33%	428	11%
Alaska	890	533	60%	342	38%	16	2%
Arizona**	7,506	5,594	75%	1,797	24%	115	2%
Arkansas	3,287	2,074	63%	1,167	36%	46	1%
California	38,748	24,125	62%	12,457	32%	2,166	6%
Colorado	3,169	1,832	58%	1,171	37%	166	5%
Connecticut	4,544	1,878	41%	2,384	52%	281	6%
Delaware	1,102	755	68%	342	31%	6	1%
District of Columbia	1,446	980	68%	396	27%	70	5%
Florida	14,691	10,054	68%	4,305	29%	331	2%
Georgia	7,338	5,056	69%	1,881	26%	401	5%
Hawaii	1,207	770	64%	406	34%	31	3%
Idaho	1,207	771	64%	414	34%	22	2%
Illinois	11,602	8,289	71%	3,119	27%	194	2%
Indiana	6,151	3,607	59%	1,966	32%	578	9%
Iowa	2,844	1,501	53%	1,293	45%	50	2%
Kansas	2,274	1,268	56%	926	41%	81	4%
Kentucky	4,809	3,246	68%	1,367	28%	196	4%
Louisiana	6,068	3,218	53%	1,885	31%	965	16%
Maine	2,253	1,451	64%	752	33%	50	2%
Maryland	5,701	3,585	63%	2,005	35%	111	2%
Massachusetts	10,822	7,670	71%	3,152	29%	0	0%
Michigan	9,847	7,042	72%	2,319	24%	486	5%
Minnesota	6,978	3,882	56%	2,956	42%	139	2%
Mississippi	3,812	2,401	63%	1,215	32%	195	5%
Missouri	7,090	4,620	65%	1,800	25%	670	9%
Montana	776	432	56%	329	42%	15	2%
Nebraska	1,588	861	54%	701	44%	27	2%
Nevada	1,317	836	63%	398	30%	83	6%
New Hampshire	1,257	495	39%	539	43%	223	18%
New Jersey	9,425	4,189	44%	3,709	39%	1,527	16%
New Mexico	3,045	2,245	74%	801	26%	-1	0%
New York	47,618	24,284	51%	20,324	43%	3,011	6%
North Carolina	10,162	6,680	66%	3,065	30%	417	4%
North Dakota	534	191	36%	342	64%	1	0%
Ohio	13,054	7,044	54%	5,371	41%	639	5%
Oklahoma	3,539	2,231	63%	1,257	36%	51	1%
Oregon	3,220	1,961	61%	1,187	37%	73	2%
Pennsylvania	16,300	8,916	55%	6,586	40%	798	5%
Rhode Island	1,834	1,025	56%	581	32%	228	12%
South Carolina	4,437	2,863	65%	1,132	26%	442	10%
South Dakota	656	382	58%	272	41%	1	0%
Tennessee	7,176	5,080	71%	1,930	27%	165	2%
Texas	21,461	14,827	69%	5,176	24%	1,459	7%
Utah	1,517	1,099	72%	398	26%	20	1%
Vermont	973	545	56%	392	40%	36	4%
Virginia	5,384	3,094	57%	2,117	39%	173	3%
Washington	6,293	3,894	62%	2,073	33%	326	5%
West Virginia	2,278	1,299	57%	906	40%	73	3%
Wisconsin	4,989	3,034	61%	1,800	36%	156	3%
Wyoming	493	257	52%	236	48%	0	0%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64).
Note: Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total Medicaid spending including these additional items was $352.1 billion in FFY 2008. Figures may not sum to totals due to rounding.
* Acute care services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, family planning, dental, vision, other practitioners'' care, payments to managed care organizations, and payments to Medicare.
** Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services.
"DSH" refers to disproportionate share hospital payments.

Table 2

Federal Medical Assistance Percentages, FY 2006-2010

State	FY 2006	FY 2007	FY 2008	FY 2009*	FY 2010*	Federal Funds Sent to State for Each Dollar in State Medicaid Spending, FY 2010
Alabama	69.5%	68.9%	67.6%	77.5%	77.5%	$3.45
Alaska	57.6%	57.6%	52.5%	61.1%	62.5%	$1.66
Arizona	67.0%	66.5%	66.2%	75.9%	75.9%	$3.15
Arkansas	73.8%	73.4%	72.9%	80.5%	81.2%	$4.31
California	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Colorado	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Connecticut	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Delaware	50.1%	50.0%	50.0%	61.6%	61.8%	$1.62
District of Columbia	70.0%	70.0%	70.0%	79.3%	79.3%	$3.83
Florida	58.9%	58.8%	56.8%	67.6%	67.6%	$2.09
Georgia	60.6%	62.0%	63.1%	74.4%	75.0%	$2.99
Hawaii	58.8%	57.6%	56.5%	67.4%	67.4%	$2.06
Idaho	69.9%	70.4%	69.9%	79.2%	79.2%	$3.80
Illinois	50.0%	50.0%	50.0%	61.9%	61.9%	$1.62
Indiana	63.0%	62.6%	62.7%	74.2%	75.7%	$3.11
Iowa	63.6%	62.0%	61.7%	70.7%	72.6%	$2.64
Kansas	60.4%	60.3%	59.4%	69.4%	69.7%	$2.30
Kentucky	69.3%	69.6%	69.8%	79.4%	80.1%	$4.04
Louisiana	69.8%	69.7%	72.5%	80.8%	81.5%	$4.40
Maine	62.9%	63.3%	63.3%	74.4%	74.9%	$2.98
Maryland	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Massachusetts	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Michigan	56.6%	56.4%	58.1%	70.7%	73.3%	$2.74
Minnesota	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Mississippi	76.0%	75.9%	76.3%	84.2%	84.9%	$5.61
Missouri	61.9%	61.6%	62.4%	73.3%	74.4%	$2.91
Montana	70.5%	69.1%	68.5%	77.1%	78.0%	$3.54
Nebraska	59.7%	57.9%	58.0%	67.8%	68.8%	$2.20
Nevada	54.8%	53.9%	52.6%	63.9%	63.9%	$1.77
New Hampshire	50.0%	50.0%	50.0%	60.2%	61.6%	$1.60
New Jersey	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
New Mexico	71.2%	71.9%	71.0%	79.4%	80.5%	$4.13
New York	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
North Carolina	63.5%	64.5%	64.1%	74.5%	75.0%	$3.00
North Dakota	65.9%	64.7%	63.8%	70.0%	70.0%	$2.33
Ohio	59.9%	59.7%	60.8%	72.3%	73.5%	$2.77
Oklahoma	67.9%	68.1%	67.1%	75.8%	76.7%	$3.30
Oregon	61.6%	61.1%	60.9%	72.6%	72.9%	$2.69
Pennsylvania	55.1%	54.4%	54.1%	65.6%	65.9%	$1.93
Rhode Island	54.5%	52.4%	52.5%	63.9%	63.9%	$1.77
South Carolina	69.3%	69.5%	69.8%	79.4%	79.6%	$3.90
South Dakota	65.1%	62.9%	60.0%	70.6%	70.8%	$2.42
Tennessee	64.0%	63.7%	63.7%	74.2%	75.4%	$3.06
Texas	60.7%	60.8%	60.5%	69.9%	70.9%	$2.44
Utah	70.8%	70.1%	71.6%	80.0%	80.8%	$4.20
Vermont	58.5%	58.9%	59.0%	70.0%	70.0%	$2.33
Virginia	50.0%	50.0%	50.0%	61.6%	61.6%	$1.60
Washington	50.0%	50.1%	51.5%	62.9%	62.9%	$1.70
West Virginia	73.0%	72.8%	74.3%	83.1%	83.1%	$4.90
Wisconsin	57.7%	57.5%	57.6%	69.9%	70.6%	$2.40
Wyoming	54.2%	52.9%	50.0%	58.8%	61.6%	$1.60

Source: Kaiser Commission on Medicaid and the Uninsured calculations based on FFY 2006-2009 FMAPs as published in the Federal Register as follows:
FY 2006 FMAP Vol. 69, No. 226, pp. 68370-28373; FY 2007 FMAP Vol. 70, No. 229, pp. 71856-71857; FY 2008 FMAP Vol. 71, No. 230, pp. 69209-6921
FY 2009 FMAP Vol. 74, No. 234, pp. 64697-64700; FY 2010 FMAP Vol . 75, No. 83, pp. 22807-22809

Note: FY2006 and FY2007 for Alaska are from Federal Register, May 15, 2006 (Vol. 71, No. 93), pp. 28041-28042. FY 2009 and FY2010 FMAPs relfect additional federal Medicaid funding available through the American Recover and Reinvestment Act (ARRA) of 2009, P.L. 111-5.

* FY 2009 FMAPs are for the 4th Quarter of that fiscal year, and FY2010 FMAPs are for the 2nd Quarter of 2010.

Table 3

Medicaid Enrollment by Group, FFY 2007

	Enrollment (rounded to nearest 100)								
	Total	**Aged**		**Disabled**		**Adult**		**Children**	
State	Number	Number	%	Number	%	Number	%	Number	%
United States	**58,106,000**	**5,934,900**	**10%**	**8,789,500**	**15%**	**14,627,000**	**25%**	**28,754,500**	**49%**
Alabama	918,800	124,800	14%	194,500	21%	158,400	17%	441,100	48%
Alaska	120,800	8,500	7%	14,900	12%	24,500	20%	72,900	60%
Arizona	1,455,800	90,700	6%	137,900	9%	545,700	37%	681,400	47%
Arkansas	692,300	64,800	9%	120,200	17%	133,700	19%	373,700	54%
California	10,511,100	952,500	9%	964,300	9%	4,318,100	41%	4,276,200	41%
Colorado	553,800	48,300	9%	76,700	14%	98,900	18%	329,800	60%
Connecticut	530,300	65,700	12%	68,200	13%	116,900	22%	279,500	53%
Delaware	184,900	13,900	8%	22,300	12%	69,600	38%	79,100	43%
District of Columbia	164,900	14,600	9%	33,200	20%	40,200	24%	76,900	47%
Florida	2,842,400	399,500	14%	469,400	17%	514,100	18%	1,459,400	51%
Georgia	1,685,000	166,000	10%	258,400	15%	276,800	16%	983,800	58%
Hawaii	216,600	22,900	11%	25,100	12%	72,800	34%	95,800	44%
Idaho	212,500	16,200	8%	35,900	17%	28,600	13%	131,800	62%
Illinois	2,322,500	219,300	9%	292,700	13%	498,700	21%	1,311,800	56%
Indiana	1,022,700	82,100	8%	151,600	15%	189,900	19%	599,200	59%
Iowa	470,000	42,500	9%	72,000	15%	130,600	28%	225,000	48%
Kansas	352,900	35,500	10%	64,100	18%	53,000	15%	200,300	57%
Kentucky	833,900	95,900	12%	215,500	26%	132,200	16%	390,300	47%
Louisiana	1,096,500	112,200	10%	199,000	18%	163,200	15%	622,200	57%
Maine	350,100	55,400	16%	61,500	18%	107,600	31%	125,600	36%
Maryland	753,100	72,500	10%	128,000	17%	168,100	22%	384,600	51%
Massachusetts	1,402,500	157,900	11%	425,500	30%	366,500	26%	452,600	32%
Michigan	1,855,500	136,400	7%	306,800	17%	378,200	20%	1,034,000	56%
Minnesota	785,600	93,500	12%	114,200	15%	187,500	24%	390,500	50%
Mississippi	750,400	93,200	12%	157,300	21%	123,900	17%	376,100	50%
Missouri	1,001,800	94,100	9%	177,500	18%	178,000	18%	552,200	55%
Montana	110,800	10,500	9%	19,600	18%	19,900	18%	60,800	55%
Nebraska	240,900	24,200	10%	34,200	14%	39,400	16%	143,100	59%
Nevada	247,000	24,200	10%	37,300	15%	48,100	19%	137,500	56%
New Hampshire	143,500	14,700	10%	23,000	16%	18,900	13%	86,900	61%
New Jersey	954,000	146,200	15%	162,500	17%	135,900	14%	509,300	53%
New Mexico	501,300	35,000	7%	57,100	11%	106,800	21%	302,400	60%
New York	4,954,600	555,700	11%	635,300	13%	1,805,200	36%	1,958,400	40%
North Carolina	1,645,900	182,900	11%	286,600	17%	311,400	19%	864,900	53%
North Dakota	69,400	9,300	13%	10,600	15%	14,600	21%	35,000	50%
Ohio	2,067,300	177,800	9%	358,300	17%	476,300	23%	1,055,000	51%
Oklahoma	719,200	66,200	9%	104,400	15%	121,100	17%	427,400	59%
Oregon	512,600	51,500	10%	82,200	16%	112,900	22%	266,000	52%
Pennsylvania	2,090,200	233,300	11%	510,700	24%	387,800	19%	958,400	46%
Rhode Island	195,400	24,700	13%	40,600	21%	39,500	20%	90,600	46%
South Carolina	891,600	84,400	9%	142,300	16%	207,200	23%	457,600	51%
South Dakota	122,700	12,500	10%	16,600	14%	20,200	16%	73,400	60%
Tennessee	1,447,100	149,500	10%	296,200	20%	288,100	20%	713,300	49%
Texas	4,170,100	428,900	10%	535,700	13%	526,900	13%	2,678,600	64%
Utah	291,000	15,200	5%	35,900	12%	79,900	27%	160,000	55%
Vermont	157,600	19,900	13%	21,500	14%	50,400	32%	65,900	42%
Virginia	863,300	103,500	12%	156,900	18%	134,500	16%	468,400	54%
Washington	1,163,300	86,900	7%	173,700	15%	269,700	23%	633,000	54%
West Virginia	392,300	40,200	10%	109,000	28%	57,000	15%	186,100	47%
Wisconsin	990,000	153,300	15%	142,700	14%	268,200	27%	425,800	43%
Wyoming	78,100	5,500	7%	9,800	13%	11,600	15%	51,100	65%

Note: Totals may not sum due to rounding.

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2007 MSIS, 2010.

Table 4

Medicaid Payments by Group, FFY 2007

State	Total	Aged		Disabled		Adult		Children	
	Payments (in millions)								
	$	$	%	$	%	$	%	$	%
United States	**$300,001**	**$74,180**	**25%**	**$127,278**	**42%**	**$37,166**	**12%**	**$61,378**	**20%**
Alabama	$3,625	$1,066	29%	$1,338	37%	$271	7%	$951	26%
Alaska	$944	$163	17%	$346	37%	$125	13%	$311	33%
Arizona	$6,331	$315	5%	$1,500	24%	$1,727	27%	$2,788	44%
Arkansas	$2,904	$818	28%	$1,266	44%	$131	5%	$690	24%
California	$33,301	$9,017	27%	$13,921	42%	$4,185	13%	$6,178	19%
Colorado	$2,733	$725	27%	$1,185	43%	$255	9%	$568	21%
Connecticut	$3,901	$1,413	36%	$1,477	38%	$306	8%	$706	18%
Delaware	$1,002	$213	21%	$358	36%	$255	25%	$176	18%
District of Columbia	$1,308	$280	21%	$640	49%	$177	14%	$211	16%
Florida	$12,753	$3,375	26%	$5,481	43%	$1,467	12%	$2,429	19%
Georgia	$6,559	$1,204	18%	$2,342	36%	$1,044	16%	$1,968	30%
Hawaii	$1,065	$259	24%	$363	34%	$241	23%	$202	19%
Idaho	$1,082	$201	19%	$548	51%	$105	10%	$228	21%
Illinois	$12,510	$2,098	17%	$5,382	43%	$1,617	13%	$3,413	27%
Indiana	$4,766	$1,006	21%	$2,082	44%	$539	11%	$1,138	24%
Iowa	$2,422	$585	24%	$1,207	50%	$253	10%	$377	16%
Kansas	$2,088	$502	24%	$987	47%	$152	7%	$447	21%
Kentucky	$4,373	$892	20%	$2,038	47%	$506	12%	$936	21%
Louisiana	$4,448	$850	19%	$2,324	52%	$532	12%	$741	17%
Maine	$1,930	$553	29%	$865	45%	$174	9%	$339	18%
Maryland	$5,227	$1,181	23%	$2,510	48%	$541	10%	$996	19%
Massachusetts	$10,505	$2,853	27%	$4,528	43%	$1,285	12%	$1,839	18%
Michigan	$8,646	$2,286	26%	$3,535	41%	$1,148	13%	$1,677	19%
Minnesota	$6,049	$1,510	25%	$2,915	48%	$564	9%	$1,060	18%
Mississippi	$3,062	$852	28%	$1,287	42%	$299	10%	$624	20%
Missouri	$5,780	$1,218	21%	$2,412	42%	$600	10%	$1,550	27%
Montana	$707	$225	32%	$266	38%	$71	10%	$146	21%
Nebraska	$1,460	$378	26%	$611	42%	$103	7%	$369	25%
Nevada	$1,133	$228	20%	$533	47%	$105	9%	$266	24%
New Hampshire	$971	$263	27%	$404	42%	$60	6%	$245	25%
New Jersey	$7,454	$2,349	32%	$3,345	45%	$586	8%	$1,174	16%
New Mexico	$2,563	$400	16%	$998	39%	$358	14%	$806	31%
New York	$41,869	$12,314	29%	$17,930	43%	$7,035	17%	$4,590	11%
North Carolina	$9,329	$1,785	19%	$4,280	46%	$1,079	12%	$2,184	23%
North Dakota	$506	$182	36%	$214	42%	$43	8%	$67	13%
Ohio	$11,951	$3,216	27%	$5,616	47%	$1,354	11%	$1,764	15%
Oklahoma	$3,305	$647	20%	$1,367	41%	$329	10%	$962	29%
Oregon	$2,789	$742	27%	$1,062	38%	$437	16%	$548	20%
Pennsylvania	$14,963	$4,830	32%	$6,264	42%	$1,324	9%	$2,545	17%
Rhode Island	$1,719	$424	25%	$821	48%	$153	9%	$321	19%
South Carolina	$3,697	$810	22%	$1,494	40%	$461	12%	$932	25%
South Dakota	$610	$143	23%	$239	39%	$68	11%	$160	26%
Tennessee	$6,954	$1,200	17%	$3,029	44%	$1,180	17%	$1,545	22%
Texas	$18,996	$3,619	19%	$7,271	38%	$1,678	9%	$6,429	34%
Utah	$1,378	$166	12%	$587	43%	$235	17%	$390	28%
Vermont	$850	$244	29%	$354	42%	$107	13%	$146	17%
Virginia	$4,682	$1,179	25%	$2,161	46%	$398	9%	$944	20%
Washington	$5,427	$1,210	22%	$2,258	42%	$739	14%	$1,220	22%
West Virginia	$2,138	$481	22%	$1,066	50%	$155	7%	$437	20%
Wisconsin	$4,803	$1,613	34%	$2,080	43%	$569	12%	$540	11%
Wyoming	$434	$98	23%	$194	45%	$39	9%	$104	24%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2007 MSIS and CMS-64 reports, 2010.

Table 5

Medicaid Payments Per Enrollee by Group, FFY 2007

State	Payments per Enrollee				
	Total	Aged	Disabled	Adult	Children
United States	**$5,163**	**$12,499**	**$14,481**	**$2,541**	**$2,135**
Alabama	$3,945	$8,538	$6,879	$1,709	$2,155
Alaska	$7,815	$19,143	$23,194	$5,108	$4,261
Arizona	$4,348	$3,473	$10,880	$3,164	$4,092
Arkansas	$4,195	$12,617	$10,529	$982	$1,846
California	$3,168	$9,467	$14,437	$969	$1,445
Colorado	$4,935	$15,003	$15,447	$2,583	$1,723
Connecticut	$7,357	$21,507	$21,650	$2,615	$2,527
Delaware	$5,421	$15,350	$16,041	$3,667	$2,225
District of Columbia	$7,932	$19,188	$19,289	$4,396	$2,740
Florida	$4,487	$8,449	$11,677	$2,854	$1,665
Georgia	$3,892	$7,254	$9,065	$3,773	$2,000
Hawaii	$4,918	$11,307	$14,472	$3,308	$2,111
Idaho	$5,091	$12,391	$15,273	$3,678	$1,728
Illinois	$5,386	$9,567	$18,386	$3,242	$2,602
Indiana	$4,660	$12,255	$13,736	$2,839	$1,899
Iowa	$5,154	$13,771	$16,758	$1,941	$1,675
Kansas	$5,916	$14,128	$15,396	$2,861	$2,234
Kentucky	$5,244	$9,303	$9,456	$3,831	$2,399
Louisiana	$4,056	$7,577	$11,678	$3,262	$1,192
Maine	$5,514	$9,976	$14,062	$1,618	$2,698
Maryland	$6,941	$16,289	$19,606	$3,216	$2,590
Massachusetts	$7,490	$18,069	$10,641	$3,506	$4,064
Michigan	$4,660	$16,762	$11,521	$3,036	$1,622
Minnesota	$7,700	$16,153	$25,525	$3,008	$2,714
Mississippi	$4,080	$9,146	$8,181	$2,410	$1,659
Missouri	$5,769	$12,947	$13,586	$3,370	$2,807
Montana	$6,385	$21,385	$13,578	$3,544	$2,406
Nebraska	$6,062	$15,620	$17,854	$2,604	$2,579
Nevada	$4,586	$9,438	$14,279	$2,192	$1,938
New Hampshire	$6,769	$17,905	$17,550	$3,165	$2,816
New Jersey	$7,814	$16,069	$20,584	$4,312	$2,305
New Mexico	$5,112	$11,443	$17,481	$3,356	$2,664
New York	$8,450	$22,159	$28,223	$3,897	$2,344
North Carolina	$5,668	$9,758	$14,935	$3,466	$2,525
North Dakota	$7,288	$19,572	$20,194	$2,940	$1,908
Ohio	$5,781	$18,087	$15,674	$2,844	$1,672
Oklahoma	$4,595	$9,772	$13,093	$2,716	$2,251
Oregon	$5,441	$14,407	$12,914	$3,873	$2,061
Pennsylvania	$7,159	$20,702	$12,266	$3,414	$2,656
Rhode Island	$8,796	$17,171	$20,220	$3,869	$3,542
South Carolina	$4,146	$9,594	$10,500	$2,224	$2,036
South Dakota	$4,972	$11,415	$14,413	$3,367	$2,182
Tennessee	$4,805	$8,026	$10,226	$4,097	$2,165
Texas	$4,555	$8,437	$13,572	$3,185	$2,400
Utah	$4,737	$10,952	$16,364	$2,940	$2,434
Vermont	$5,394	$12,246	$16,453	$2,124	$2,209
Virginia	$5,424	$11,388	$13,775	$2,962	$2,015
Washington	$4,665	$13,919	$12,999	$2,741	$1,927
West Virginia	$5,450	$11,961	$9,777	$2,713	$2,348
Wisconsin	$4,851	$10,523	$14,574	$2,123	$1,269
Wyoming	$5,561	$17,805	$19,762	$3,326	$2,038

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2007 MSIS and CMS-64 reports, 2010.

Note: Data in this table do not include spending when the service or basis of eligibility of the enrollee is unknown; national per capita spending amounts shown elsewhere in this report are adjusted to include this unknown spending and differ slightly from the totals shown here.

Table 6

Medicaid Income Eligibility as a Percent of Federal Poverty Level (FPL), 2009

State	Infants	Children 1-5	Children 6-19	Pregnant Women	Working Parents*	Childless Adults*
Alabama	133%	133%	100%	133%	24%	NA
Alaska	175%	175%	175%	175%	81%	NA
Arizona	140%	133%	100%	150%	106%	110%
Arkansas	200%	200%	200%	200%	17%	NA
California	200%	133%	100%	200%	106%	NA
Colorado	133%	133%	100%	200%	66%	NA
Connecticut	185%	185%	185%	250%	191%	NA
Delaware	200%	133%	100%	200%	121%	110%
District of Columbia	300%	300%	300%	300%	207%	NA
Florida	200%	133%	100%	185%	53%	NA
Georgia	200%	133%	100%	200%	50%	NA
Hawaii	300%	300%	300%	185%	100%	100% (closed)
Idaho	133%	133%	133%	133%	27%	NA
Illinois	200%	133%	133%	200%	185%	NA
Indiana	200%	150%	150%	200%	25%	NA
Iowa	300%	133%	133%	300%	83%	NA
Kansas	150%	133%	100%	150%	32%	NA
Kentucky	185%	150%	150%	185%	62%	NA
Louisiana	200%	200%	200%	200%	25%	NA
Maine	200%	150%	150%	200%	206%	NA
Maryland	300%	300%	300%	250%	116%	NA
Massachusetts	200%	150%	150%	200%	133%	NA
Michigan	185%	150%	150%	185%	64%	NA
Minnesota	280%	275%	275%	275%	215%	NA
Mississippi	185%	133%	100%	185%	44%	NA
Missouri	185%	150%	150%	185%	25%	NA
Montana	133%	133%	133%	150%	56%	NA
Nebraska	200%	200%	200%	185%	58%	NA
Nevada	133%	133%	100%	185%	88%	NA
New Hampshire	300%	185%	185%	185%	49%	NA
New Jersey	200%	133%	133%	200%	200%	NA
New Mexico	235%	235%	235%	235%	67%	NA
New York	200%	133%	100%	200%	150%	100%
North Carolina	200%	200%	100%	185%	49%	NA
North Dakota	133%	133%	100%	133%	59%	NA
Ohio	200%	200%	200%	200%	90%	NA
Oklahoma	185%	185%	185%	185%	47%	NA
Oregon	133%	133%	100%	185%	40%	NA
Pennsylvania	185%	133%	100%	185%	34%	NA
Rhode Island	250%	250%	250%	250%	181%	NA
South Carolina	185%	150%	150%	185%	89%	NA
South Dakota	140%	140%	140%	133%	52%	NA
Tennessee	185%	133%	100%	250%	129%	NA
Texas	185%	133%	100%	185%	26%	NA
Utah	133%	133%	100%	133%	44%	NA
Vermont	300%	300%	300%	200%	191%	160%
Virginia	133%	133%	133%	200%	29%	NA
Washington	200%	200%	200%	185%	74%	NA
West Virginia	150%	133%	100%	150%	33%	NA
Wisconsin	300%	300%	300%	300%	200%	NA
Wyoming	133%	133%	100%	133%	52%	NA

Source: *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009* . Data based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, December 2009. Available at http://www.kff.org/medicaid/kcmu120809pkg.cfm. See note below for source of parents and childless adult eligibility levels

* Eligibility for Medicaid or Medicaid Look-Alike coverage. For eligibility levels for programs offering more limited coverage or premium assistance, please see *Where Are States Today: Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults* , Kaiser Commission on Medicaid and the Uninsured analysis of state policies through program websites and contacts with state officials, December 2009. Available at: http://www.kff.org/medicaid/upload/7993.pdf.

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Medicaid Beneficiaries and Access to Care
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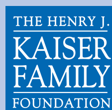

THE KAISER COMMISSION ON
Medicaid and the Uninsured

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

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