

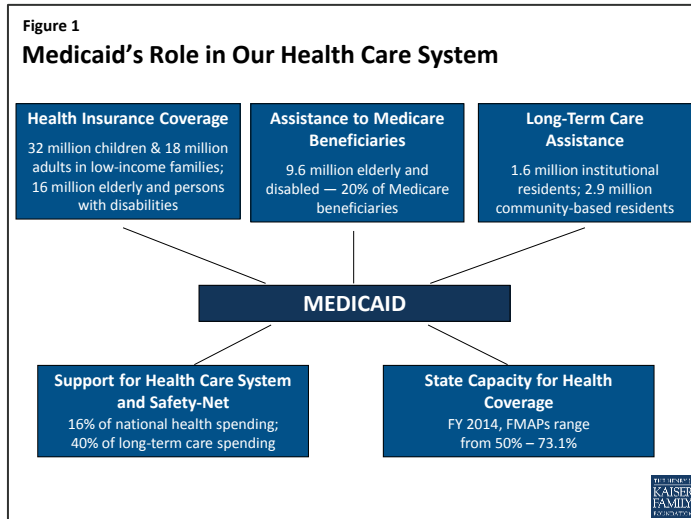
June 2014 | Fact Sheet

Medicaid Moving Forward

Medicaid is the nation's main public health insurance program for people with low incomes and the single largest source of health coverage in the U.S. At last count, Medicaid covered over 66 million Americans – more than 1 in every 5 – at some point during the year. Medicaid is administered by the states within broad federal requirements, and states and the federal government finance the program jointly. Medicaid plays many roles in our health care system (Figure 1). Medicaid coverage facilitates access to care for beneficiaries, connecting many with managed care plans and their networks of providers, covering a broad range of benefits, and limiting out-of-pocket medical costs. As a major payer, Medicaid is a core source of financing for safety-net hospitals and health centers that serve low-income communities, including many of the uninsured. It is also the main source of coverage and financing for nursing home and community-based long-term care. Altogether, Medicaid finances 16% of total personal health spending in the U.S.

The Affordable Care Act (ACA), enacted on March 23, 2010, expanded the Medicaid program significantly as part of a broader plan to cover millions of uninsured Americans.¹ Specifically, the ACA expanded Medicaid eligibility to reach nearly all non-elderly adults with incomes at or below 138% of the federal poverty level (FPL) – about \$16,105 for an individual in 2014 – establishing a new coverage pathway for millions of uninsured adults who were previously excluded from the program, effective January 1, 2014. The law also provided for 100% federal funding of the expansion through 2016, declining gradually to 90% in 2020 and future years. However, the Supreme Court ruling on the ACA in June 2012 effectively made the Medicaid expansion optional for states, and many states, to date, have elected to forgo the expansion.

In addition to expanding Medicaid, the ACA also made other significant changes that improve the program in all states, regardless of whether or not they implement the Medicaid expansion. The law required that states simplify and modernize their enrollment processes and create a new coordinated enrollment system for Medicaid, the Children's Health Insurance Program (CHIP), and coverage through the new Marketplaces. The ACA also established an array of new authorities and funding opportunities for delivery system and payment reform initiatives in Medicare, Medicaid, and CHIP, designed to promote better models of care and cost-effective care, particularly for those with high needs and high costs. Further, the law provided new options and incentives to states to rebalance their Medicaid long-term care programs in favor of community-based services and supports rather than institutional care. These new opportunities and mechanisms have accelerated



innovation already taking place in many Medicaid programs. Because Medicaid covers many of the highest-need populations in the nation, states have unique financial and policy leverage to reform the systems of care that serve them.

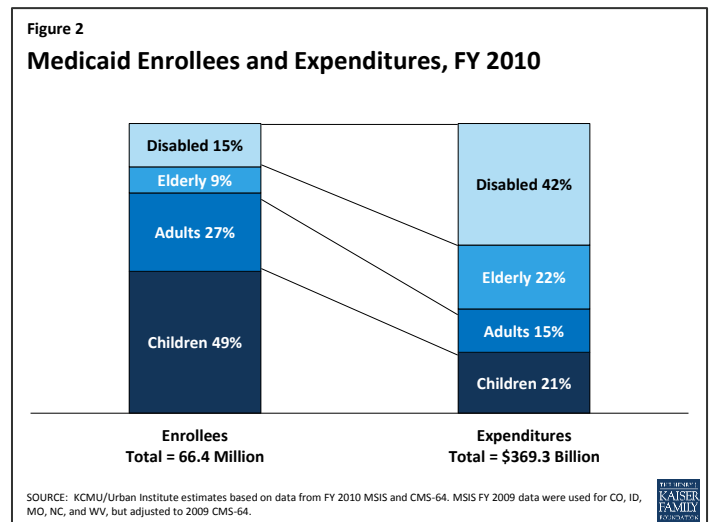
Between action in many states to strengthen the Medicaid program and far-reaching ACA provisions in key Medicaid domains, the Medicaid program is in a period of historic transformation. While data and analysis on the impact of the changes underway will take time to materialize, this fact sheet provides a current profile of Medicaid and highlights developments in the program unfolding at the federal and state level.

Who does Medicaid cover?

Before the enactment of the ACA, federal law provided federal funding for Medicaid only for specified categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with disabilities, and people age 65 and older. In FY 2010, the most current year for which national data are available, about three-quarters of all Medicaid beneficiaries were children and non-elderly, non-disabled adults (primarily, working parents), and the elderly and younger people with disabilities accounted for the remaining one-quarter (Figure 2).

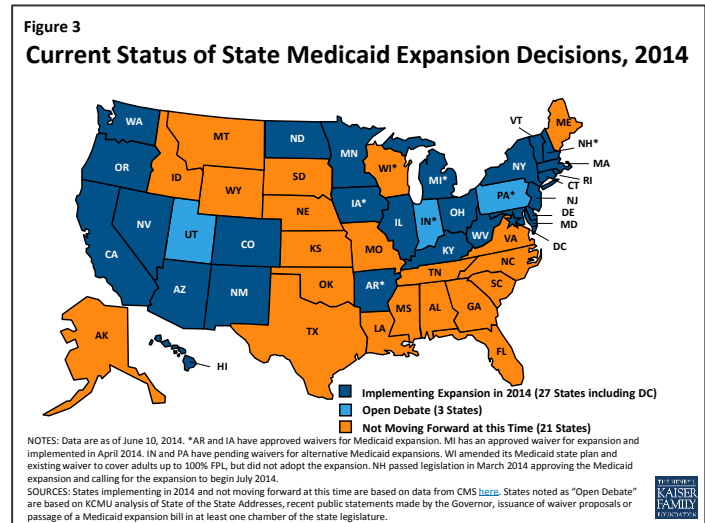
State Medicaid programs must cover people in the federally specified groups with income levels up to federal mandatory minimum thresholds, and states have the option to expand coverage to individuals at higher income levels. Many states have taken up options to expand coverage for children. To illustrate, the federal minimum income eligibility threshold for children age 6-18 is 100% FPL (\$19,790 for a family of three in 2014), but, as of April 1, 2014, 29 states (including DC) covered children in families with income up to at least 250% FPL under Medicaid or CHIP; 19 of these states covered children with income up to at least 300% FPL. Together, Medicaid and CHIP cover more than 1 in every 3 children, and the programs cover a larger share of low-income children and children of color. In June 2013, over 28 million children were enrolled in Medicaid and 5.7 million were enrolled in CHIP.²

Historically, Medicaid eligibility for adults has been much more limited than eligibility for children. In 2013, prior to the ACA expansion of Medicaid to non-elderly adults up to 138% FPL, the median income eligibility threshold for working parents was 61% FPL and, in most states, other non-elderly adults without dependent children (“childless adults”) were not eligible regardless of how low their income.³ Income eligibility thresholds have generally been higher for the elderly and people with disabilities. States generally must provide Medicaid automatically to seniors and people with disabilities who receive Supplemental Security Income (SSI) benefits, for which the federal benefit rate is 74% FPL.⁴ All states have the option to cover additional elderly individuals and people with disabilities with higher incomes or high medical expenses relative to their income.⁵ Further, although the ACA did not change eligibility for these groups, some adults with disabilities at higher income levels will qualify for Medicaid in states that implement the ACA Medicaid expansion, discussed below.

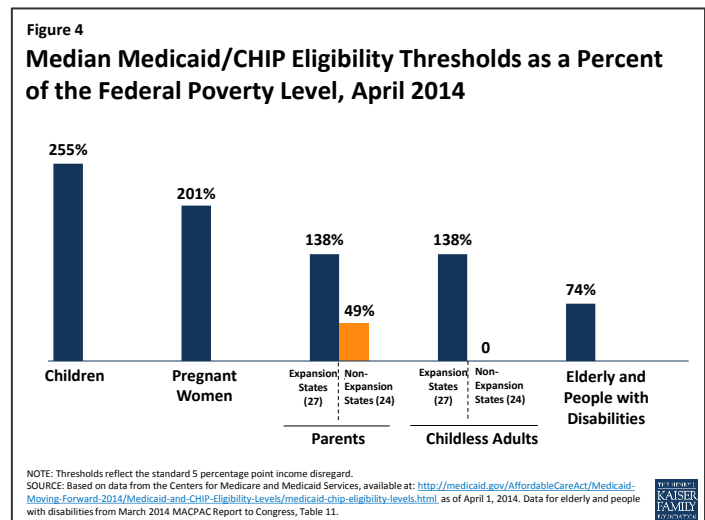


In FY 2010, 14% of all Medicaid enrollees – more than 9 million – were “dual eligible” seniors and younger persons with disabilities who are also covered by Medicare. Dual eligible beneficiaries are very poor and many have high health and long-term care needs. Medicaid assists them with their Medicare premiums and cost-sharing, and covers full Medicaid benefits for a large majority of them – most importantly, long-term services and supports, for which Medicare coverage is very limited.

Key ACA reforms. As enacted, the ACA expanded Medicaid to nearly all adults under age 65 with income at or below 138% FPL, effective January 1, 2014. However, as noted, the Supreme Court ruling on the ACA effectively made implementation of the expansion a state choice. As of June 2014, 27 states, including DC, were expanding Medicaid, three states were actively debating the issue, and 21 states were not moving forward (Figure 3). States can decide to implement the Medicaid expansion at any time. Regardless of whether they expand Medicaid or not, all states are required to establish streamlined, coordinated, and automated Medicaid eligibility and enrollment systems to facilitate enrollment in Medicaid and promote continuity of coverage.



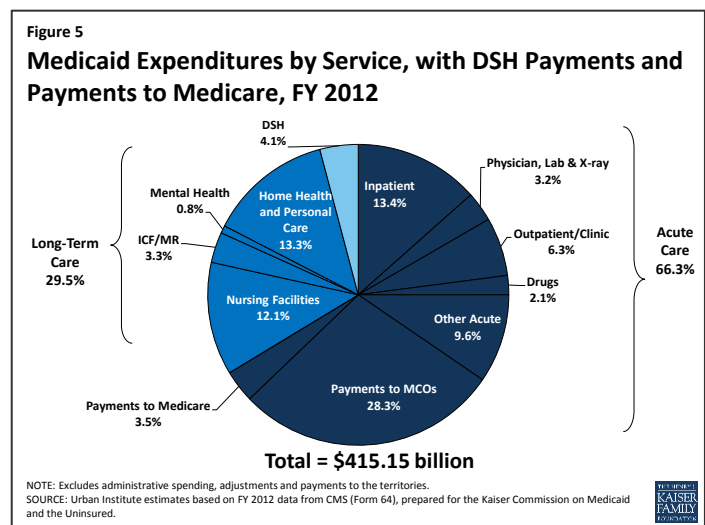
States' Medicaid expansion decisions have major implications for low-income non-elderly adults. In the 27 states that are moving forward with the expansion, the median eligibility threshold for parents rose from 106% FPL in 2013 to 138% FPL in 2014. By contrast, in the 24 non-expansion states, the median threshold for parents is 49% FPL (Figure 4); in 20 of these states, the eligibility level is lower than the poverty level, including 12 states where the threshold is lower than 50% FPL. Similarly, the eligibility threshold for childless adults is now 138% FPL in the expansion states, while these adults remain ineligible for Medicaid in the non-expansion states at any income level, except in Wisconsin, which covers childless adults up to 100% FPL under a waiver.⁶ In the states not currently expanding Medicaid, nearly 5 million uninsured non-elderly adults with incomes above the states' limited eligibility levels but below 100% FPL fall into a coverage gap; they cannot qualify for Medicaid because their income exceeds their state's eligibility cutoff, but they do not earn enough to qualify for federal subsidies to purchase coverage through the Marketplaces – these subsidies begin at 100% FPL. An additional 2.8 million adults with incomes between 100% and 138% FPL who would have been eligible for Medicaid under the expansion, may be eligible for premium subsidies to purchase coverage through Marketplace (although the open enrollment period for 2014 is now closed).⁷



Under the ACA, the gains in Medicaid and CHIP coverage of children that have been achieved over time are protected, as states are required to maintain eligibility thresholds for children that are at least equal to those they had in place when the law was enacted, through September 30, 2019. The law also established a uniform minimum Medicaid eligibility level of 138% FPL for all children up to age 19. As of 2014, states must provide Medicaid coverage to children aging out of foster care, up to age 26. Finally, the ACA extends CHIP funding through 2015, and includes a provision that would increase federal matching rates under CHIP by 23 percentage points during the period FY 2016-2019 if the Congress extends funding beyond 2015.⁸

What services does Medicaid cover?

Medicaid covers a diverse array of services to meet the diverse needs of the populations it serves (Figure 5). In addition to acute health care services, Medicaid covers a broad spectrum of long-term services and supports that Medicare and most private insurance plans exclude or tightly limit. Premiums are prohibited and cost-sharing is limited for Medicaid beneficiaries at or below 150% FPL, with stronger limits for pregnant women, children, and adults below 100% FPL. Emergency services, family planning services and supplies, preventive services for children, and tobacco cessation services for pregnant women are exempt from cost-sharing. Total premiums and cost-sharing for a family cannot exceed 5% of the family's income on a quarterly or monthly basis.⁹



Under federal law, states must cover the following “mandatory” services for people who qualify for Medicaid under pre-ACA eligibility groups, subject to medical necessity:

- inpatient and outpatient hospital services;
- physician, midwife, and nurse practitioner services;
- early and periodic screening, diagnosis, and treatment (EPSDT) for children up to age 21;
- laboratory and x-ray services;
- family planning services and supplies;
- federally qualified health center (FQHC) and rural health clinic (RHC) services;
- freestanding birth center services (added by ACA);
- nursing facility (NF) services for individuals age 21+;
- home health services for individuals entitled to NF care;
- tobacco cessation counseling and pharmacotherapy for pregnant women (added by ACA); and
- non-emergency transportation to medical care

Many states also cover services that federal law designates as optional for adults, including prescription drugs (all states), dental care, durable medical equipment, and personal care services. Under EPSDT, children up to age 21 are entitled to all medically necessary Medicaid services, including those considered optional for adults, most notably, prescription drugs and dental care.

As mentioned above, Medicaid’s mandatory benefits include NF services for those age 21 or older and home health services for individuals who meet NF level-of-care criteria. States also cover many optional home and community-based (HCBS) long-term services and supports through their state plans, or provide HCBS under several different HCBS waivers or “section 1115” demonstration waivers.¹⁰ HCBS include targeted case management, personal care services, family and caregiver training and support; rehabilitative services, housing coordination to help individuals locate and obtain community housing; and a diversity of other services. Medicaid is the principal payer for institutional and community-based long-term care in the U.S., financing 40% of total spending in this area.¹¹

Historically, states have generally been required to provide the same Medicaid benefits to all beneficiaries statewide. However, legislation enacted in 2006 gave states limited flexibility to provide “benchmark” benefits to some Medicaid beneficiaries based on one of three commercial insurance plans specified in the law or a benefit package determined appropriate by the HHS Secretary. Few states have actually used the benchmark authority. States also have the ability to use Medicaid dollars to purchase private coverage on behalf of Medicaid beneficiaries who have access to employer-sponsored health insurance, an approach known as “premium assistance.” States must generally provide wrap-around services and cost-sharing protection to fill in any gaps between the private coverage and Medicaid.

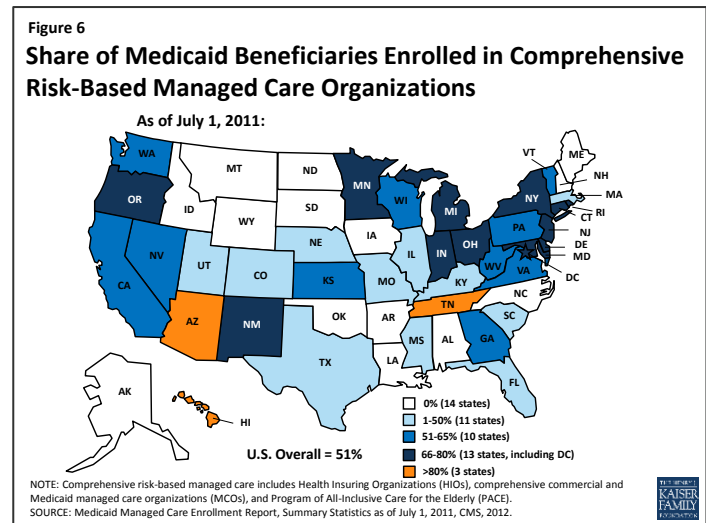
Key ACA reforms. Most adults in the new Medicaid expansion group will receive “Alternative Benefit Plans” (ABPs), which is the new term for the Medicaid benchmark options just mentioned. Notably, all ABPs must include the same ten “essential health benefit” (EHB) categories established by the ACA that Marketplace health plans must include. In addition, ABPs must provide parity between physical health and mental health/substance use disorder services, offer the full range of EHB preventive services, and cover family planning services and supplies, FQHC and RHC services, and non-emergency medical transportation. Adult dental benefits are not included among the ten EHB categories. Compared to traditional Medicaid benefits for adults, ABPs based on commercial products may provide broader coverage of some services (e.g., behavioral health care, preventive care) and narrower coverage of other services (e.g., prescription drugs, long-term services). All but a few states plan to align their ABP with their traditional Medicaid benefit package for adults. Certain populations are exempt from enrollment in ABPs and can choose instead to have access to all traditional state plan adult Medicaid benefits. The exempt groups include people with disabilities, dual eligible beneficiaries, and medically frail individuals, among others.

In July 2013, CMS issued revised regulations on Medicaid premiums and cost-sharing. The new rule establishes a uniform maximum copayment amount of \$4 for outpatient services and \$75 per inpatient admission for those with income below 100% FPL. It also permits states to charge these individuals up to \$8 for non-preferred drugs and non-emergency use of the emergency department; states can charge higher cost-sharing amounts for some services to those with income above 100% FPL, within federally specified parameters. The prohibition against premiums for those at or below 150% FPL, the cost-sharing exemptions mentioned earlier, and the 5% aggregate cap on premiums and cost-sharing remain in place.

How do Medicaid beneficiaries get care?

Most Medicaid beneficiaries obtain their care from private office-based physicians and other health professionals. Safety-net health centers and hospitals also play a major role in serving the Medicaid population.

Over half of Medicaid beneficiaries nationally – mostly, children and parents – are enrolled in comprehensive managed care organizations (MCO) that contract with states on a capitation, or risk, basis to deliver Medicaid services (Figure 6). This share is growing as states expand managed care to include higher-need Medicaid populations, such as people with disabilities and dual eligible beneficiaries, as well as Medicaid expansion adults. A smaller but still significant number of beneficiaries are enrolled in Primary Care Case Management (PCCM) programs, in which states continue to pay fee-for-service but also pay primary care providers a small monthly fee to coordinate care for their Medicaid patients. Historically, many states have kept Medicaid provider payment rates low as a cost-containment strategy. Risk-based managed care and PCCM programs can be understood, in part, as vehicles for establishing networks of providers and garnering greater access to care.



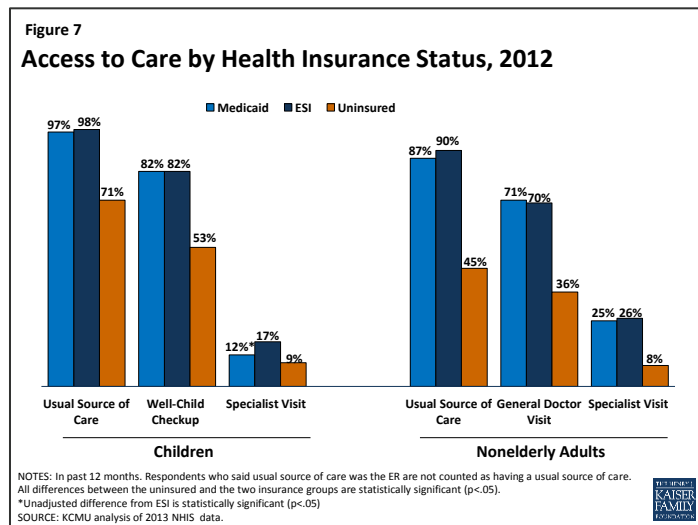
On the long-term care front, over the last several decades, states have been working to rebalance their systems by devoting a greater proportion of spending to HCBS instead of institutional care. While the majority of Medicaid long-term care spending still goes toward institutional care, the share of Medicaid long-term care spending on HCBS continues to increase. In FY 2011, HCBS accounted for 45% of total Medicaid long-term care spending, up from 32% in FY 2002.¹²

Key ACA reforms. The ACA includes a range of new investments, demonstrations, and authorities designed to leverage Medicaid and other public insurance programs to drive reforms in health care delivery and financing. These provisions have accelerated ongoing innovation in Medicaid programs, including state implementation of models (e.g., patient-centered medical homes, accountable care arrangements) that involve a more central role for preventive and primary care, increased care coordination for beneficiaries with complex needs, and incentives for performance. States are combining and integrating these approaches in different ways with their underlying systems for organizing and financing care in Medicaid. The ACA also provides states with new and expanded opportunities, as well as enhanced federal financing, to improve access to and delivery of Medicaid long-term services and supports, and to incentivize states to devote a greater share of their long-term care spending to home and community-based services rather than institutional care. Nearly every state (47 states and DC) has taken steps forward on at least one of six key Medicaid LTSS options contained in the ACA, with many states pursuing multiple options.¹³

How is access to care in Medicaid?

Medicaid beneficiaries fare much better than the uninsured on diverse measures of access to care, utilization, unmet need, and financial protection. The vast majority of Medicaid beneficiaries have a usual source of care, compared to sizeable shares of the uninsured who do not (Figure 7). Medicaid also lowers financial barriers to care and limits out-of-pocket costs, and Medicaid beneficiaries are much less likely than the uninsured to report unmet health care needs.^{14 15 16 17}

Moreover, both children and adults with Medicaid coverage have rates of access to and use of primary and preventive care comparable to the rates for those with employer-sponsored insurance (ESI). When demographic, health status, and socioeconomic differences between the two insured populations are controlled, the shares with any office or doctor visit are similar, as are the shares with any specialist visit.¹⁸ Likewise, controlling for these differences, the shares of children with unmet needs for medical care, dental care, or prescription drugs due to costs are similar between the Medicaid and privately insured groups, and rates of unmet needs due to costs are similar or lower among adults with Medicaid compared to adults with ESI.

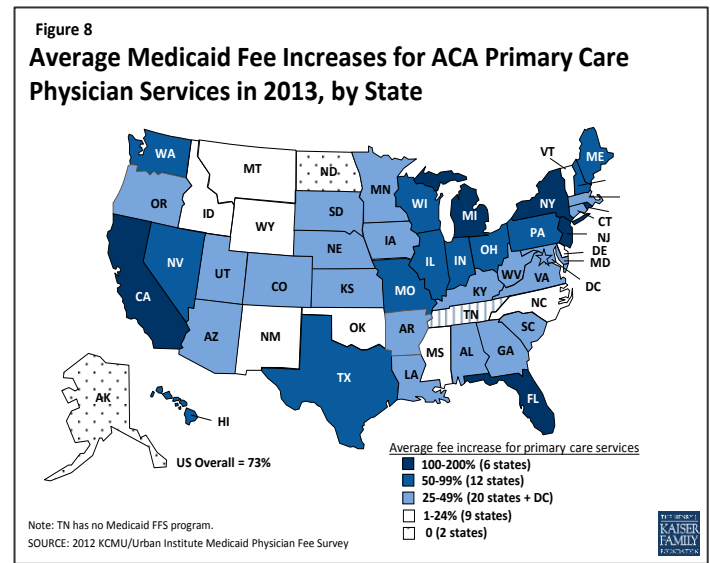


Still, there are important areas of concern regarding access in Medicaid. Physician surveys consistently show that low fee-for-service payment rates in Medicaid discourage physician participation in the program, and low physician participation exacerbates the impact of gaps in the supply and distribution of physicians, which tend to be more acute in low-income communities. According to a report by the General Accountability Office, 38 states reported that they experienced challenges securing sufficient provider participation in Medicaid, with the leading reasons being overall provider shortages and low Medicaid payment rates.¹⁹ As mentioned earlier, states are relying to a large and growing extent on risk-based managed care plans to deliver services to Medicaid beneficiaries. States pay contracted plans a monthly premium, or “capitation” rate, for each enrolled Medicaid beneficiary, and the plans are responsible for providing all the services covered under their Medicaid contract and for establishing adequate provider networks. It is managed care plans – not states – that set the payment rates for physicians and other providers in their networks. Thus, the adequacy of provider payment rates in Medicaid is increasingly a matter of managed care plans’ payment policies. However, state and federal enforcement of network adequacy standards is important to ensure access to care for Medicaid beneficiaries enrolled in managed care.

Research evidence regarding the adequacy of access to specialist care in Medicaid is mixed. Inadequate access to behavioral health care, including both mental health and substance abuse treatment services, is a particular concern because of the high prevalence of behavioral health conditions among Medicaid beneficiaries. For the many Medicaid beneficiaries who have behavioral and physical health comorbidities, lack of access to behavioral health care can adversely affect management of their physical health conditions as well. Low participation in Medicaid by psychiatrists²⁰ and shortages of substance abuse treatment providers²¹ both represent challenges to ensuring access to behavioral health services. Access to dental care among Medicaid beneficiaries has also emerged as a major issue. Although Medicaid provides comprehensive dental benefits for children under EPSDT, use of recommended dental care among children falls well short of benchmarks. Adult access to dental care in Medicaid is an even more significant problem. Medicaid coverage of dental care for adults is a state option, and many states only cover dental care for pain relief or emergency care for injuries, trauma, or extractions; many also impose tight dollar caps on adult dental benefits.²² In general, less provider

willingness to accept new Medicaid patients than new privately insured patients, limited access to after-hours care, and lack of transportation have emerged as barriers to access for Medicaid enrollees.

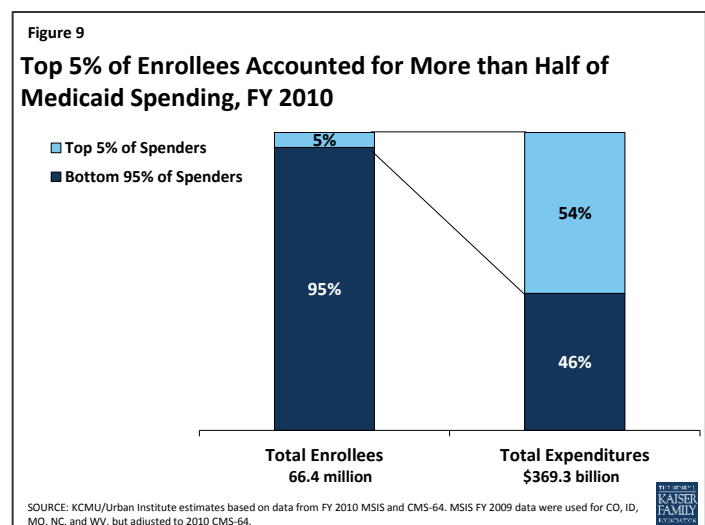
Key ACA reforms. The ACA made a number of significant investments designed to expand access to care in Medicaid as the program expands. One key provision raised Medicaid payment rates for most primary care physician services to Medicare fee levels in 2013 and 2014, financing the increase with federal dollars. This change translated into an overall average increase of 73% in Medicaid payment rates for the affected primary care physician services (Figure 8). The law also funded a vast expansion of community health centers and the health care workforce that staffs them. These investments are enabling health centers to expand the scope of services they provide, and are expected to double health centers' patient capacity in the next five years.



How much does Medicaid cost and how is it financed?

In FY 2012, Medicaid spending on services totaled about \$415 billion, as shown earlier in Figure 5. Administrative costs (not shown) accounted for 5% of overall program spending. Two-thirds of all spending on services was attributable to acute care and about 30% was associated with long-term care. Supplemental payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients, known as “DSH,” accounted for about 4% of spending, and Medicaid payments for Medicare premiums and cost-sharing on behalf of dual eligible beneficiaries totaled 3.5%.

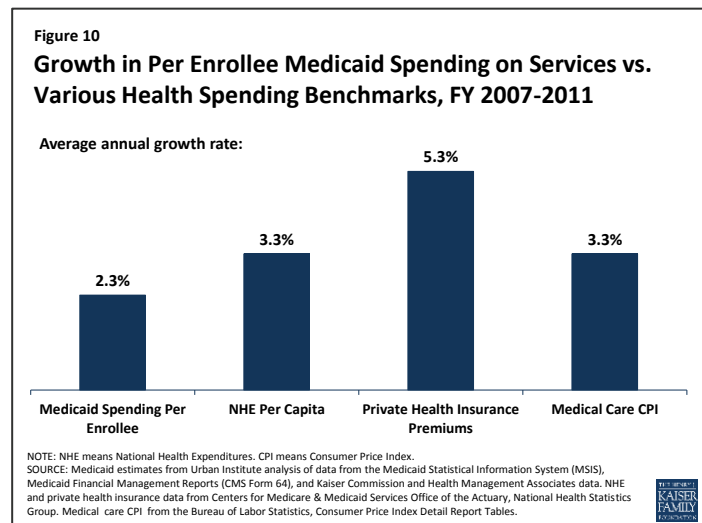
Referring back to Figure 4, nearly two-thirds of Medicaid spending for services is attributable to the elderly and persons with disabilities, who make up just one-quarter of all Medicaid enrollees. Dual eligible beneficiaries alone account for almost 40% of all spending, driven largely by spending for long-term care, for which Medicare benefits are limited. The 5% of Medicaid beneficiaries with the highest costs drive nearly half of all Medicaid spending (Figure 9). Their high costs are attributable to their extensive needs for acute care, long-term care, or often both.



Medicaid spending is driven by multiple factors including the number and mix of enrollees, underlying medical cost inflation, health care utilization, and state policy choices regarding benefits, provider payment rates, and other program factors. During economic downturns, enrollment in Medicaid grows, increasing program

spending at the same time that state tax revenues are declining. Frequently, states under recessionary pressures have sought to reduce Medicaid spending growth through actions such as cutting provider payment rates or reducing benefits. Increasingly, however, states are undertaking more fundamental transformation of their Medicaid payment and delivery systems both to control costs and to improve care, particularly for high-cost populations. Over the period FY 2007-2011, total Medicaid spending for services grew by nearly 7%, but spending per Medicaid enrollee grew by only about 2% – less than the rate of growth in both national health spending per capita and private health insurance premiums, and less than the underlying rate of growth in medical costs (Figure 10).²³

States and the federal government share the cost of Medicaid. The federal government matches state Medicaid spending for beneficiaries eligible for Medicaid under pre-ACA law at least dollar for dollar, according to a formula contained in federal statute. The federal match rate, known as the Federal Medical Assistance Percentage, or FMAP, varies based on state per capita income. In FY 2015, which began October 1, 2014, the FMAP ranges from the federal floor of 50% to 73.6% in the poorest state today, Mississippi.²⁴ In 2012, the federal share of total national Medicaid spending was about 57%.²⁵



Key ACA reforms. The expansion of Medicaid in the states moving forward, and greater participation in Medicaid nationwide due to increased outreach and simplified application and enrollment processes will lead (as intended) to increased enrollment in Medicaid in the coming years and, in turn, to higher total Medicaid spending. The federal government will finance the vast majority of the new costs associated with the Medicaid expansion to adults – the federal match for newly eligible Medicaid adults is 100% in 2014, 2015, and 2016, phasing down gradually to 90% in 2020 and future years. In addition, the ACA provides enhanced federal financing for an array of investments that all states can make, including health home programs for people with chronic conditions, options to expand access to HCBS, and state coverage of all EHB adult preventive services without cost-sharing. Whether they expand Medicaid or not, states will see new state Medicaid costs related to increased participation in Medicaid (at the regular federal match rate) and, in the case of states expanding Medicaid, the relatively small state match for expansion adults after 2016. However, many states moving forward expect offsets or net savings as Medicaid expands, due to reduced state spending for uncompensated care and state-funded mental health and other programs, broader economic effects of the Medicaid expansion, such as increased jobs, income and state tax revenues, and other impacts. States that do not expand Medicaid will still see increased Medicaid costs due to increased participation among individuals who are eligible under pre-ACA law, but will forgo the substantial federal funding provided with expanded coverage.

Looking Ahead

Already an integral source of coverage and access for low-income people, including many individuals with complex health needs, and many with long-term care needs, Medicaid's role is growing further as the ACA Medicaid expansion and other Medicaid reforms take hold. It will be important to track and assess how the program evolves under the ACA and in response to innovation at the state, health plan, and provider level. The unprecedented transformation and experimentation now underway in Medicaid provides an opportunity to identify successful models of enrollment and retention, robust access to care, person-centered and coordinated care, and alignment of financial incentives with performance goals, all of which can benefit Medicaid programs and the millions of people they serve.

¹ The health reform law also provided for new health insurance Marketplaces and premium subsidies for individuals with income between 100% and 400% FPL.

² Vernon Smith et al., *Medicaid Enrollment: June 2013 Data Snapshot and CHIP Enrollment: June 2013 Data Snapshot* (Kaiser Family Foundation, January 2014), <http://kff.org/medicaid/issue-brief/medicaid-enrollment-june-2013-data-snapshot/> and <http://kff.org/medicaid/issue-brief/chip-enrollment-june-2013-data-snapshot/>

³ *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of January 1, 2014* (Kaiser Family Foundation, January 2014), <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>

⁴ States that elect the "209(b)" option are permitted to use financial eligibility standards that are more restrictive than federal SSI rules. However, these states must allow SSI beneficiaries to establish Medicaid eligibility through a "spend-down" by deducting their out-of-pocket medical expenses from their income. See <http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities/> for a more detailed discussion.

⁵ *March 2014 Report to the Congress on Medicaid and CHIP* (Medicaid and CHIP Payment and Access Commission (MACPAC), March 2014). See Table 11.

⁶ *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of April 1, 2014* (Kaiser Family Foundation, June 2014), <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>

⁷ *A Closer Look at the Impact of State Decisions Not to Expand Medicaid on Coverage for Uninsured Adults* (Kaiser Family Foundation, April 2014), <http://kff.org/medicaid/fact-sheet/a-closer-look-at-the-impact-of-state-decisions-not-to-expand-medicaid-on-coverage-for-uninsured-adults/>

⁸ Robin Rudowitz et al., *Children's Health Coverage: Medicaid, CHIP and the ACA* (Kaiser Family Foundation, March 2013), <http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/>

⁹ *Medicaid: A Primer* (Kaiser Family Foundation, March 2013), <http://kff.org/medicaid/issue-brief/medicaid-a-primer/>

¹⁰ *Medicaid Home and Community-Based Services Programs: 2010 Data Update* (Kaiser Family Foundation, March 2014), <http://kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/>

¹¹ KCMU estimates based on 2012 CMS National Health Expenditure Accounts data, available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

¹² KCMU and Urban Institute analysis of Centers for Medicare & Medicaid Services (CMS)-64 data.

¹³ Molly O'Malley Watts et al., *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options* (Kaiser Family Foundation, April 2013), <http://kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/>

¹⁴ Teresa A. Coughlin et al., *What Difference Does Medicaid Make?* (Kaiser Family Foundation, May 2013), <http://kff.org/medicaid/issue-brief/what-difference-does-medicaid-make-assessing-cost-effectiveness-access-and-financial-protection-under-medicaid-for-low-income-adults/>

¹⁵ Genevieve Kenney and Christine Coyer, *National Findings on Access to Health Care and Service Use for Children Enrolled in Medicaid*, MACPAC Contractor Report No. 1, March 2012.

¹⁶ Sharon Long et al., *National Findings on Access to Health Care and Service Use for Non-elderly Adults Enrolled in Medicaid*, MACPAC Contractor Report No. 2, June 2012.

¹⁷ *2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP*, U.S. Department of Health and Human Services, December 2012, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf>.

¹⁸ Coughlin et al., Kenney and Coyer, and Long et al., op. cit.

¹⁹ *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, General Accountability Office, November 2012, <http://www.gao.gov/products/GAO-13-55>

²⁰ Andrew Bindman, Andrew Chu, and Kevin Grumbach. *Physician Participation in Medi-Cal, 2008*, California Healthcare Foundation, July 2010, <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PhysicianParticipationMediCal2008.pdf>

²¹ *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issue*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, January 24, 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>

²² *Medicaid Benefits: Dental Services* (Kaiser Family Foundation), <http://kff.org/medicaid/state-indicator/dental-services/>

²³ Rachel Garfield and Katherine Young, *Enrollment-Driven Expenditure Growth: Medicaid Spending During the Economic Downturn, FY 2007-2011* (Kaiser Family Foundation, April 2013), <http://kff.org/medicaid/report/enrollment-driven-expenditure-growth-medicaid-spending-during/>

²⁴ *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier* (Kaiser Family Foundation, 2014), <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/#note-1>

²⁵ *Federal and State Share of Medicaid Spending* (Kaiser Family Foundation, 2012), <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>