

Unsettling Scores

A Ranking of State Medicaid Programs

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TABLE OF CONTENTS

Executive Summary	5
I. Introduction	7
Scope and purpose of the current report.....	8
Organization of the report.....	9
II. Methods.....	11
Basic guidelines.....	11
Scoring process.....	12
Limitations	13
III. Eligibility	15
Mandatory groups.....	15
Optional groups	16
Findings.....	18
IV. Scope of Services	21
Subcategories of service	21
Measuring scope of service.....	22
Findings.....	23
V. Quality of Care	27
Markers of quality	27
Findings.....	28
VI. Provider Reimbursement	31
Medicaid financing.....	31
Findings.....	32
VII. National Results.....	35
Overview.....	35
In short.....	38
VIII. State-by-State Reports	51
Alabama	52
Alaska.....	53
Arizona	54
Arkansas.....	56
California	57
Colorado	58
Connecticut.....	59
Delaware	60
District of Columbia	61
Florida.....	62
Georgia.....	63
Hawaii	64
Idaho.....	65
Illinois.....	67
Indiana.....	68
Iowa	69
Kansas.....	70
Kentucky.....	71
Louisiana	72
Maine.....	73
Maryland.....	74
Massachusetts.....	75
Michigan	76
Minnesota	77
Mississippi	78
Missouri	79
Montana.....	80
Nebraska	81
Nevada	82
New Hampshire	83

New Jersey	84
New Mexico	85
New York	86
North Carolina	87
North Dakota	88
Ohio	89
Oklahoma	90
Oregon.....	91
Pennsylvania	93
Rhode Island	94
South Carolina.....	95
South Dakota.....	96
Tennessee.....	97
Texas.....	98
Utah	99
Vermont.....	100
Virginia.....	101
Washington.....	102
West Virginia	103
Wisconsin	104
Wyoming.....	105
IX. Conclusions	107
Appendix.....	111
Scoring Protocol.....	111
Eligibility.....	111
Scope of Services.....	114
Services defined by type or target group	114
Women's services.....	119
Services delivered by specific providers.....	120
Rehabilitation services.....	122
Devices and equipment	123
Drugs	125
Transportation	126
Quality of Care.....	126
Reimbursement	129
Ranking weights	133
Glossary	135
Bibliography	139

Tables and Figures

Table 1. Ranking of state Medicaid programs, eligibility	19
Table 2. Ranking of state Medicaid programs, scope of services	24
Table 3. Ranking of state Medicaid programs, quality of care	29
Table 4. Ranking of state Medicaid programs, reimbursement.....	Error! Bookmark not defined.
Table 5. Summary of state Medicaid program scores.....	35
Table 6. Overall ranking of state Medicaid programs.....	36
Table 7. Scores and ranks for state Medicaid programs in each category and overall, by state in alphabetical order	40
Figure 1. Overall ranking of state Medicaid programs, total points scored in all categories	41
Figure 2. Total scores of state Medicaid programs in all categories, by state in alphabetical order	42
Figure 3. Ranking of state Medicaid programs, total points scored in eligibility	43
Figure 4. State Medicaid program scores in eligibility, by state in alphabetical order	44

Figure 5. Ranking of state Medicaid programs, total points scored in scope of services.....	45
Figure 6. State Medicaid program scores in scope of services, by state in alphabetical order	46
Figure 7. Ranking of state Medicaid programs, total points scored in quality of care	47
Figure 8. State Medicaid program scores in quality of care, by state in alphabetical order	48
Figure 9. Ranking of state Medicaid programs, total points scored in reimbursement.....	49
Figure 10. State Medicaid program scores in reimbursement, by state in alphabetical order.....	50
Appendix Table 1. Relative weight by category	133
Appendix Table 2. Eligibility relative weights.....	133
Appendix Table 3. Scope of services relative weights, by indicator	133
Appendix Table 4. Quality of care relative weights	134
Appendix Table 5. Reimbursement relative weights	134

Executive Summary

Enacted over 40 years ago, Medicaid has evolved with changing demographic, technological, and health needs; political priorities; and fiscal realities. The program has been called many things: the cornerstone of the nation's health system, a safety net for the neediest, a workhorse that goes into action when help is needed, and an inflexible and flawed system, among others.

Whatever its shortcomings, Medicaid continues to grow, reflecting and refracting many of the trends affecting health care as a whole. At present, the program

- covers approximately 55 million Americans;
- accounts for one out of every five health care dollars spent in the nation;
- pays for 41 percent of all U.S. births and 50 percent of all long-term care costs;
- supports tens of thousands of health care providers throughout the country; and
- represents the largest source of federal grant support to states.

Purpose and scope of study

While there are abundant data on Medicaid, these tend to avoid making value judgments. This report therefore seeks to fill the existing gap. We feel that it is not enough to say “this is the way things are;” instead, we should assess and say “this is the way things should be.”

Almost 20 years ago, the Public Citizen Health Research Group published a report on Medicaid, *Poor Medicine for Poor People*, ranking state Medicaid programs. The current report seeks to update that report. But because programmatic mandates have changed and states now have considerably more latitude in how they run their programs, the indicators are different, as are the sources of data. As a result, there is greater variety among states, as well as greater differences within states.

Each state program has been evaluated in terms of four categories: eligibility, scope of services, quality of care, and reimbursement. These were in turn measured by 55 indicators, and the resulting scores were weighted according to the relative value given to each category by experts. The ranking system gives a state a score for each category as well as an overall score.

Major findings

Nationally, the state Medicaid programs are severely challenged: even the best state scores only 645.9 points on a scale of 1000. And the worst state rates a score of only 317.8, i.e., less than a third of the total maximum points.

The state-by-state breakdowns reveal marked disparities between and among states. The top 10 states, ranking #1 to #10, tend to cluster in the Northeast but also include three states in the Midwest and two in the Northwest. The following states occupy the first 10 ranks, in descending order: Massachusetts, Nebraska, Vermont, Alaska, Wisconsin, Rhode Island, Minnesota, New York, Washington, and New Hampshire.

The 10 most deficient state programs have overall scores ranging from between 317.8 and 379.1 of the total 1000 points. The worst, in order from 50th to 41st, are in Mississippi, Idaho, Texas, Oklahoma, South Dakota, Indiana, South Carolina, Colorado, Alabama, and Missouri.

The overall score of top-ranked Massachusetts is more than twice that of bottom-ranked Mississippi. A breakdown of scores by category further highlights the existing disparities: the scores vary 2.5-fold for scope of services, and more than threefold for eligibility. In the remaining two categories, which have fewer indicators and are therefore more volatile, variations among states are even more dramatic: in quality of care, the difference is more than 17-fold; in reimbursement, it is more than 20-fold.

The overall ranks are followed by state-specific summaries with the breakdown of scores by category. This allows states to pinpoint their areas of weakness, and to more successfully target their interventions. It also highlights states that have achieved success in one or more areas and can therefore serve as models for other jurisdictions.

I. Introduction

Medicaid has been called many things:

- the cornerstone of the nation's diverse and complex system of financing health and long-term services;¹
- a safety net for those who need assistance with health care;²
- a workhorse, expected to aid populations when no other source will help;³
- an amalgamation of responses to different problems over 40 years;⁴
- a surprisingly flexible program;⁵ and
- a rigidly inflexible and inefficient system that is not financially sustainable.⁶

Whatever the prevailing contradictory views of the system and its operation, there is consensus that the program has an “overwhelming level of diversity and complexity.”⁷ Lofty in its goals but often miserly in its actual impact on people, Medicaid mirrors changing economic circumstances, conflicting political pressures, and fluctuating demographic and medical needs. A complicated partnership between states and the federal government has yielded more than 50 different programs, each with its own distinctive features and idiosyncrasies. Indeed, state variation in eligibility, covered care, program administration, and reimbursement for services is now the rule rather than the exception.⁸ These allowable state-by-state variations are a major weakness in Medicaid.

Twenty years ago, Public Citizen Health Research Group conducted a comprehensive state-by-state assessment of the Medicaid Program. That report ranked all states on the basis of five criteria: eligibility, services, provider availability, quality, and reimbursement, each of which was measured through an array of operational indicators. Public Citizen's 1987 report was used by states to examine their status vis-à-vis other states and the nation as a whole. The report prompted states to confront their deficiencies and improve their programs. It also provided leverage to those states that were getting less than their fair share in federal funds or had not fared well in the monies allocated by their state legislatures. In addition, the report underscored the disparities that exist among states, thereby revealing the significant differences in access to care that Americans face simply because of where they happen to live.

The current report seeks to update, though not replicate, the previous one. An update is particularly timely and necessary because many changes have taken place over the course of two decades. Much federal legislation has either focused directly on Medicaid or enacted changes in other health and welfare services that have had important implications for Medicaid. These changes have affected each of the five criteria that we focused on in the previous report, as well as some of the indicators that were used to measure them. Furthermore, Medicaid has come of age. As the program enters its fifth decade, it is going

1 Jeffrey S Crowley and Molly O'Malley, *Profiles of Medicaid's High Cost Populations*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. December 2006:1.

2 Crowley and O'Malley, *Profiles*: 4.

3 Alan Weil, “There's Something About Medicaid”. *Health Affairs*. 22 (1) (Jan-Feb 2003): 15.

4 Medicaid Commission. Final Report and Recommendations presented to Secretary Michael O. Leavitt, December 29, 2006: 5.

5 Alliance for Health Reform. *Covering Health Issues 2006*. Chapter 6: Medicaid: 79.

6 Quote from HHS Secretary Mike Leavitt. U.S. Department of Health and Human Services. News release: HHS Secretary Leavitt Establishes Commission to Work on Strengthening and Sustaining Medicaid. May 20, 2005. See <http://www.hhs.gov/news/press/2005pres/20050520.html>.

7 Jean Hearne. *Medicaid Eligibility for Adults and Children*, Congressional Research Service, The Library of Congress, CRS Report for Congress. August 3, 2005: CRS-27.

8 Jean Hearne. *Medicaid Issues for the 109th Congress*. Congressional Research Service, The Library of Congress. CRS Report for Congress. Updated April 10, 2006: CRS-1.

through a programmatic “midlife crisis.” It is not surprising that the program’s advocates as well as its critics are taking stock of where the program is at present in order to point out areas where changes are needed. Although much of the concern revolves around program costs, we feel that this focus fails to address more fundamental aspects of the program, including equity in access to care and the quality of services rendered.

In 2005, U.S. Department of Health and Human Services (DHHS) Secretary Michael Leavitt declared that the program was no longer meeting its potential. He named a bipartisan commission to plan for an improved Medicaid that would “provide quality health care in a financially sustainable way.”⁹ The commission was charged with preparing two reports. The first, which was submitted September 2005, outlined recommendations for Medicaid to achieve \$10 billion in savings over the next five years. The second, submitted December 29, 2006, sought to address the following issues:

- How to expand coverage to more Americans while being fiscally responsible;
- Ways to provide long-term care to those who need it;
- A review of eligibility, benefits design, and delivery; and
- Improved quality of care, choice, and beneficiary satisfaction.

Scope and purpose of the current report

This report neither substitutes nor supplements the reports prepared by the federally-mandated commission. Its principal audience includes policymakers as well as advocates and individual consumers. Nevertheless, it does not consider issues related to political appeal or cost-effectiveness as much as it addresses the scope of the program, its access to those in need, and its monitoring of the services delivered. Like its predecessor, this report tries to answer the question: “If I were a poor, sick person, in which state would I have the best chance of becoming eligible for Medicaid and getting comprehensive, quality health care?” The evaluation criteria and the indicators used to measure them therefore reflect the consumer’s perspective and aim to answer the following questions:

1. Am I eligible to receive Medicaid services in this state? Given the variety of pathways to determine eligibility, this is not an easy question to answer. An extensive list of requirements may enter the decision. Criteria for eligibility include the following: age, income, citizenship status, assets, work status, marital status, enrollment in school, medical condition, and improvement potential, among others. The permutations and combinations of eligibility requirements make for a complicated patchwork of enrollees. As a result, a “protected” population in one state may very well be entirely expendable in another.

2. If I am eligible, does this state cover the particular services I need? While there are certain services that all states cover, there are more than 30 optional services that may be included in a state’s offerings. And some of these may be covered only when given by certain providers; have limitations in terms of populations covered, frequency, duration, and scope; require cost-sharing; or may be provided only under certain conditions.

3. If the services are covered, will they be of adequate quality? Although Medicaid programs generate an inordinate number of statistics, and information technology has

⁹ U.S. Department of Health and Human Services, News Release: HHS Secretary Leavitt Establishes Commission to Work on Strengthening and Sustaining Medicaid. May 20, 2005. See <http://www.hhs.gov/news/press/2005pres/20050520.html>.

greatly facilitated the collection and analysis of data, most states lack reliable, measurable criteria to assess the quality of care they provide, or even to establish profiles of who is getting what care, when, and at what cost. Instead, the focus has been on billing and fraud detection. As a result, data on quality are very spotty. Unlike Medicare data, which are collected centrally and processed nationally, information on Medicaid depends on the capabilities and priorities of each state. As a result, much of the information may not be comparable across jurisdictions, and state initiatives cannot be properly evaluated.

4. Will the state pay for my services in a way that encourages access, equity, and quality? States have been experimenting with ways to expand their coverage while keeping costs down and increasing efficiency. In some cases, these objectives are at cross-purposes, and involve trade-offs that are not always explicit to the consumer. As more and more states have been granted waivers from the originally mandated services, they have been given greater leeway in coverage, reimbursement policies, and organization of services. An increasing proportion of Medicaid beneficiaries is now enrolled in managed care. And more states are experimenting with cost-sharing, ostensibly as a way of making consumers more “prudent purchasers” of health care.

There are relatively few indicators for quality of care and reimbursement, but we have used those that reflect both a commitment to patient care and an interest in treating Medicaid providers equitably vis-à-vis practitioners who serve other populations.

Organization of the report

The report is organized by topic as well as by state. Following a chapter on Methods (II), Chapters III through VI focus on one of the four questions listed above, which correspond to the four categories we examined: eligibility, scope of services, quality of care, and provider reimbursement. In each case we present the state scores and rankings for the specific category, thus allowing comparisons among and between states. These are followed by a chapter on national results (VII), a summary of both the overall scores and the category-specific ranks. Chapter VIII presents state-by-state data, highlighting each state’s scores and ranks. Chapter IX summarizes our main conclusions.

II. Methods

Our study assesses four aspects of the Medicaid program: eligibility, scope of services, quality of care, and reimbursement. Each of these categories is measured through different indicators. The choice of indicators is understandably contingent upon the availability of data. We therefore relied on data that are routinely collected and published, broken down by state. For each of the categories studied, we took what are basically qualitative characteristics and transformed them into quantitative values. This allowed us to give each state specific points for each indicator, depending on its performance for those indicators. These scores allow us to rank all states except Tennessee¹⁰, both by category and as a whole. States can then be compared to each other, as well as compared against the maximum possible number of points for each category.

Basic guidelines

Certain principles underlie the selection of indicators, their interpretation, and the points assigned to them. While the Scoring Protocol included in the Appendix describes each indicator and the unadjusted points assigned to it, there were general principles governing the assignment of points, and these cut across categories and indicators. Our scoring methodology is based on the following guidelines:

1. No state gets extra points for merely following the law and doing what is federally mandated. That is taken as a “floor” from which extras are measured.
2. States that are doing less than what is required or that deviate from a desirable norm may have points deducted. For example, states are penalized for limiting services that are considered desirable or for falling short of indexes that are considered essential to quality of care. Because these items tend to involve judgment calls, we have made our values explicit whenever this is the case.
3. In scoring each indicator, we have taken the state-by-state distribution into account. As a result, with only one exception,¹¹ even the most stringent indicators are met by at least one state. The top values are therefore not unreachable targets but rather feasible objectives for states that are committed to meeting the needs of their Medicaid beneficiaries.
4. Because we believe that access to health care should be based on need rather than on ability to pay, we reward those states that have lowered financial barriers to care. Conversely, we penalize those that use cost-sharing and other similar means to restrict access. This is based on extensive research which shows that “while cost-sharing may be viewed as a tool to promote cost-consciousness in the general population, out-of-pocket burdens may impose substantial financial barriers to health care access for low-

¹⁰ TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

¹¹ The exception to this is sickle cell services, which no state has made explicitly available under its Medicaid coverage. Sickle cell services were added as an optional Medicaid service through legislation enacted as part of the JOBS Act of 2004. Although no state has availed itself of these services, we have included them in our scoring scheme because they represent a novel attempt in using Medicaid to address race-based health disparities.

income people.”¹² Consequently, cost-sharing may result in the postponement of treatment of illness when it is most amenable to successful intervention.

5. In some cases, we have used accepted benchmarks for care as the standard of choice.¹³ Only those programs that meet these benchmarks are credited with extra points.
6. States that have expanded the usual offerings or that show innovation in their concern with the scope or quality of care are rewarded for their promising efforts.
7. In the area of quality, we look at both systems for monitoring quality and actual outcomes. Indicators on monitoring include activities to assess services and correct any deficiencies found. Outcomes reflect improvements in actual health status, or actions that further desirable policy objectives.
8. In each case, we have used the most recent information available that includes all states. We have therefore relied primarily on data from 2004 or more recent years, and have not used any data from earlier than 2000.

Scoring process

The scores on which our rankings are based began with the four categories assessed—eligibility, scope of services, quality of care, and reimbursement. Each of these categories was broken down into a number of indicators, which ranged from three to 36 per category. In some cases, the indicators were composites and were further broken down, as indicated in the Scoring Protocol in the Appendix.

The indicators were evaluated by an expert on Medicaid, who suggested adding, eliminating, or combining certain indicators. Each indicator was given a maximum number of points, ranging between one and 11. These points were considered “raw scores” which were then adjusted to reflect their relative value.

To determine the relative weight of each category and indicator, two other recognized experts in the field of Medicaid were consulted. They were asked to distribute 100 points among the four categories. The mean of the points assigned to each category was then computed, and divided by 100 to determine the relative weights. The relative weights for the four categories are as follows:

Eligibility	.35
Scope of services	.20
Quality of care	.20
Reimbursement	.25

The same experts were asked to further distribute 100 points among the indicators in each of the categories, and these values were also averaged, then divided by 100. A listing of all category and indicator weights can be found in the Appendix.

The final score for each indicator for each state was therefore the fraction of the total maximum points obtained by the state for each given indicator, multiplied by both the

¹² Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy*. November 2006: 19.

¹³ For example, this is the case for hours of nursing care per nursing home resident.

category weight and the weight assigned to each individual indicator. Because the resulting numbers were very small, these products were then multiplied by 1000. As a result, all scores are based on a theoretical total of 1000 points overall.

The scores for each indicator within a category were then added, the sum being the score for that particular category. The sum of the scores for all four categories constitutes the overall score for each state.

Because the data were entered into a spreadsheet, the computation of the adjusted scores allowed for aggregations of indicators within a given category. The final scores were then sorted by order of magnitude, thereby allowing rankings by category and overall.

In a few cases of three categories (scope of services, quality of care, reimbursement) and overall, two or more states had the same score and therefore shared a rank. In these cases, the subsequent ranks were adjusted so that there were as many ranks as programs scored. For example, two states tied for 5th place received the same rank, 5th, but the rank following that was 7th rather than 6th.

The many indicators used and the weighting of the raw scores yielded final scores that were rounded off to one decimal point. This is not intended to overstate the degree of precision, but rather to allow us to draw distinctions among state programs. We have therefore emphasized how states rank generally with respect to each other instead of focusing on any differences that may distinguish, say, a state ranking #22 from one ranking #23 overall as well as in any one category.

The detailed Scoring Protocol (including the definition, rationale, and source of each indicator and its components) is described in the Appendix.

Limitations

The Medicaid Program has been called “resilient” because it is constantly re-inventing itself to meet new circumstances. One scholar has indicated that Medicaid’s infrastructure provides “a base from which almost any health matter can be addressed.”¹⁴ Despite its deficiencies, the program has been responsive to new technologies (e.g., drugs and devices), emerging disease entities (e.g., HIV/AIDS), natural events (Hurricane Katrina), ideological trends (assumption of personal responsibility, lifestyle modifications), and modalities of care (managed care). To take a snapshot in time of the program is therefore to miss some of the changes and adaptations that are occurring continually. This is particularly the case at present, when many states are looking to modify their programs or significantly alter their involvement in health care delivery.

Several states (including California, Massachusetts, New Jersey, New York, and Vermont) are seeking to reduce or even eliminate the number of uninsured within their jurisdictions. Others (including West Virginia, Florida, and Kentucky) are incorporating incentives for health-seeking behaviors among their enrollees. Yet others are modifying the way care is given and the incentives for participation in the program. Because of the fact that we were dealing with a moving target, we had to establish a cut-off point beyond which no new data would be incorporated. This was January 15, 2006. Any time-limited data will therefore not capture the current fluidity in the state policy arena.

14 Alan Weil, “There’s Something About Medicaid”: 24.

A second limitation of our study refers to the need for comparability between and among states. The efforts of those states that have attempted to “break the mold” in covering their Medicaid-eligible population may therefore not be fully represented in our scoring protocols. This limitation is also tied into a significant constraint: the availability of data. Large-scale data collection efforts require consistency in definitions. As a result, some of the variations that occur from state to state may not be fully evident in tables that adopt a uniform system of coding and description.¹⁵

Because our rankings entail an analysis of secondary sources, they rely on data collected for different purposes and at varying points in time. We have relied primarily on the online data on Medicaid made available through the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured. In some cases, these data have been supplemented with other sources, as indicated in the Scoring Protocol. Moreover, when the data for a particular state were not available on the Kaiser database, we consulted directly with the state, thus filling in gaps to complete the national picture.

The data on provider reimbursement are limited by the fact that they reflect only those Medicaid payments that are made under fee-for-service systems. While all states other than Tennessee have a fee-for-service component, this is limited in states that have adopted capitated systems under managed care. At present, more than 60 percent of all Medicaid enrollees in the United States are enrolled in managed care.¹⁶ When the data are broken down by state, the proportion varies between zero and 100 percent.¹⁷ Our indicators on provider reimbursement thus have greater validity and reliability for those states that rely more on fee-for-service and have a lower proportion of users enrolled in managed care. Because the indicators do not apply to Tennessee, we have not computed a score for this state under the reimbursement category. This omission precludes the state being ranked with the other states in this category, and therefore in the overall category as well. As a result, the overall ranks and those in reimbursement range between one and 50 rather than between one and 51.

15 For example, a source may indicate that a given state provides a specific service to the “medically needy,” but states may have different definitions of who constitute the “medically needy” and may offer different service packages to different segments of the population. Additionally, expansion populations that are covered through approved waivers are not captured in the data.

16 Kaiser Family Foundation. Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of June 30, 2005. See <http://www.statehealthfacts.org>.

17 Kaiser Family Foundation. Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of June 30, 2005. See <http://www.statehealthfacts.org>.

III. Eligibility

Consumers who want to know if they are eligible for Medicaid have to work their way through a complicated list of demographic categories to see if they qualify under any of these. Indeed, federal law describes more than 50 eligibility pathways.¹⁸ Many demographic variables—e.g., age, sex, marital status, family composition, income, disability, and disease—help define current eligibility criteria.

In keeping with the program’s labyrinthine complexity, there are some populations that **must** be covered by all states, and there are others who **may** be covered as well. To add another layer of confusion, not everyone is covered under the same circumstances, nor for the same services.

While Medicaid is more frequently known as a “program for the poor,” and the program has always targeted low-income individuals, not all the poor are eligible and not all the eligible are poor.¹⁹ To be covered, the poor must meet **financial requirements** (regarding income, assets, and expenses) as well as **categorical requirements** (regarding age, family circumstances, employment status, blindness, disability, and other factors). These requirements exclude many people from Medicaid. Indeed, it is estimated that approximately 60 percent of poor Americans are not covered by Medicaid.²⁰

The Medicaid program varies greatly from state to state. Eligibility rules vary from one state to another, although there are guidelines that govern local options. While federal regulations require all states to cover certain groups and limit the additional groups that states may cover, each state can elect to include other groups falling somewhere between the federal “floor” and “ceiling.” As a result of these differences among states, the same person may be eligible in one state but ineligible in another. Moreover, many states have taken advantage of Medicaid “waivers” which exempt them from eligibility and coverage requirements as long as they are budget-neutral and do not cost the federal government more than prior coverage.

Mandatory groups

When first enacted, Medicaid was linked to beneficiaries of the federally-assisted income maintenance program Aid to Families with Dependent Children (AFDC). After 1972, the program also included those covered by Supplemental Security Income (SSI), a program which provides cash assistance to help aged, blind, and disabled people who have little or no income. Since then, changes in Medicaid and SSI have created additional groups of beneficiaries whose financial eligibility is based solely on income and resources rather than on cash assistance.²¹ The inclusion of these “poverty-related” groups expanded Medicaid to include pregnant women and children by separating Medicaid eligibility from receipt of AFDC. At present, these groups represent a growing proportion of Medicaid beneficiaries, accounting for over one-quarter of the total.²²

As a result of these and other changes, all states must provide Medicaid coverage to the following eligibility groups:

18 Hearne, *Medicaid Eligibility for Adults and Children*: CRS-26.

19 Hearne, *Medicaid Eligibility for Adults and Children*: CRS-i.

20 Kaiser Family Foundation. The Kaiser Commission on Medicaid and the Uninsured. Who Needs Medicaid? April 2006: 2. <http://www.kff.org/kmcu>.

21 Health Care Financing Administration, U.S. Department of Health and Human Services. *A Profile of Medicaid: 2000 Chartbook*: 7.

22 U.S. DHHS, *A Profile of Medicaid: 2000*: 24.

AFDC-eligible individuals as of July 16, 1996: States must provide Medicaid to individuals who qualified for AFDC as of that date.

Poverty-related groups: States must cover all pregnant women and children below age 6 with incomes up to 133 percent of the federal poverty level (FPL).

All children born after September 30, 1983 with incomes up to 100 percent FPL. This requirement covers poor children under the age of 19.

Current and some former recipients of SSI: Despite this requirement, states may use more restrictive eligibility standards for Medicaid than those used for SSI if states were using those standards prior to the enactment of SSI in 1972.

Foster care and adoption assistance: States must cover all recipients of foster care and adoption assistance under Title IV-E of the Social Security Act.

Certain Medicare beneficiaries: All Medicare beneficiaries with incomes below the poverty level are eligible for Medicaid assistance to pay for Medicare premiums, deductibles and cost-sharing. In addition, individuals at the lowest income levels are entitled to full Medicaid benefits, which provide “Medigap” services (i.e., services not covered by Medicare). The latter individuals are most often referred to as “dual eligibles.”

The determination of Medicaid eligibility is two-tiered: First, individuals must fall within one of the previously listed “categorical” groups. Once the individual is found to meet the categorical restrictions, financial tests are applied.²³ States have some latitude concerning the latter, which further adds to the administrative complexity of the program and to the inter-state variation. While states have limited flexibility to modify income standards, they have greater discretion concerning how “countable income” is defined. By excluding certain types of income from their definitions of “countable income,” states can liberalize their eligibility criteria without violating income standards. The following are among the “income disregards” that can be excluded from countable income: a certain portion of earned income during the first few months of employment, a given dollar amount as a child care allowance, and a set amount for married couples.²⁴

Optional groups

States can provide Medicaid coverage to other groups. These optional groups fall within the mandated defined categories, but the financial eligibility standards are more liberally defined. Optional eligibility groups include:

Poverty-related groups: States may choose to cover pregnant women and infants with family incomes up to 185 percent of the FPL.

Medically needy: States may choose to cover individuals who do not meet the financial standards for program benefits but fit into one of the mandated groups and have income and resources within special “medically needy” limits established by the state. Individuals whose resources are above the “medically needy” standards may qualify by “spending down”—i.e., incurring medical bills that reduce their income and/or resources to the necessary level.

²³ Hearne, *Medicaid Eligibility for Adults and Children*: CRS-2.

²⁴ Hearne, *Medicaid Eligibility for Adults and Children*: CRS-8, 9.

Recipients of state supplementary payments: States may opt to include individuals who do not receive SSI but qualify for other state cash payments.

Long-term care: States may cover residents in medical institutions or those receiving certain long-term care services in community settings if their incomes are less than 300 percent of the SSI payment level.

Working disabled: States have the option of covering those who are disabled (as defined in Social Security Administration guidelines) but who do not qualify for Medicaid under any statutory provision due to their income. States opting to cover this group may also cover those who lose their Medicaid eligibility as a result of losing SSI due to medical improvement.

Persons with specific diseases: Persons with specific medical diagnoses may be covered by Medicaid under certain conditions. All states and the District of Columbia have chosen to cover women who need treatment for breast or cervical cancer if they are under 65, uninsured, and otherwise not eligible for Medicaid. Benefits are limited to the period during which treatment is provided.²⁵

A total of 13 states and the District of Columbia cover persons with tuberculosis (TB) who are uninsured, but coverage is limited to services related to the treatment of TB.

Some parents of disabled children: The Deficit Reduction Act of 2005 provides states the option of allowing parents of disabled children to “buy in” to the Medicaid program if they have a family income below 300 percent of the federal poverty level. This option is subject to a premium.

Other groups: States may extend eligibility beyond these groups. The use of specific waivers allows states to diverge from certain provisions of the Medicaid Act. Waivers granted under Section 1915(b) of the Social Security Act are called “freedom of choice” waivers because they permit a state to limit the providers of Medicaid services and require beneficiaries to obtain services through a managed care organization.²⁶ Section 1115(a) of the Social Security Act provides even greater leeway to the states. That legislation allows states to carry out experimental, pilot, or demonstration projects that, in the judgment of the Secretary of DHHS, are likely to assist in promoting the objectives of the Act, including those of the Medicaid statute.²⁷ These waivers permit a state to alter the scope of services and to expand eligibility to persons who would not otherwise be eligible for the Medicaid program. Using section 1115 waivers, states can adopt less restrictive methodologies for calculating income and resources. This discretion allows states to institute broader coverage, and hence has the potential to address the needs of otherwise uninsured populations. But the waivers also allow states to reduce benefits, increase cost sharing, and cap enrollment for some beneficiaries. Projects authorized under Section 1115 are usually approved for a five-year period and may be extended under certain circumstances. Demonstration projects must be *budget neutral* over their life. Several states have used the authority conferred under Section 1115 to launch “health care reform demonstrations” that include restructuring the delivery of services.²⁸

Medicaid coverage is very much in a state of flux as a result of these waivers. In fiscal year 2007, 12 states reported planning to implement new Section 1115 waivers. These vary by size

²⁵ Hearne, *Medicaid Eligibility for Adults and Children*: CRS-25.

²⁶ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community: A Handbook*. January 2005: 103.

²⁷ U.S. Department of Health and Human Services, *Using Medicaid to Support Working Age Adults*: 106.

²⁸ U.S. Department of Health and Human Services, *Using Medicaid to Support Working Age Adults*: 108.

and scope, and hence by expected impact. Moreover, they are designed to meet different objectives, the three top goals being increasing private or employer-based coverage, encouraging personal responsibility, and expanding eligibility.²⁹ The state-specific information that is part of this report will describe some of the initiatives that are now in effect or under consideration.

In addition, states are addressing a Medicaid law that went into effect on July 1, 2006, restricting benefits to those who can provide proof of citizenship. This measure, which was part of the Deficit Reduction Act of 2005, requires that beneficiaries and applicants to Medicaid present a birth certificate, passport, or another form of identification in order to apply. This documentation replaces the previous requirement that applicants to Medicaid attest in writing that they are citizens, under penalty of perjury.³⁰

The legislation has both ideological and fiscal roots. Originally designed to prevent undocumented immigrants from gaining access to care, the measure was also touted as a cost-saving device, estimated to save the federal government some \$220 million over five years and \$735 million over 10 years.³¹ The Congressional Budget Office calculates that Medicaid enrollment will decrease by 35,000 because of loss of coverage, and some states are already feeling the effects of the new requirements.

Findings

Given the multiple pathways into Medicaid, states exhibit much variety in how they score in the eligibility category. Of the four categories examined, eligibility is the one weighted most heavily, accounting for 350 of the total 1000 points. States that rank high in this category are therefore more likely to score high overall.

Rhode Island, the highest-ranking state in eligibility, earned a total score of 296.8, while Indiana, with a score of 90.6, had the lowest eligibility value. There is therefore a more than threefold difference between the two ends of the eligibility spectrum.

In addition to Rhode Island, the other states ranking among the “Top 10” in terms of eligibility include, in descending order of rank:

Vermont	283.7 points
New York	264.8 points
Washington	260.9 points
California	258.9 points
Minnesota	254.5 points
District of Columbia	248.5 points
Massachusetts	247.6 points
Wisconsin	246.6 points
Hawaii	245.0 points

29 Vernon Smith, et al. *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2006: 48.

30 The only states that do not allow the self-declaration option are Montana, New Hampshire, New York, and Georgia. “New Requirements for Citizen Documentation in Medicaid.” *Medicaid Facts*, Kaiser Commission on Medicaid and the Uninsured. Kaiser Family Foundation, June 2006.

31 “Class-Action Suit Medicaid Over Proof-of-Citizenship Law to be Filed.” *Kaiser Daily Health Policy Report*. June 28, 2006. http://www.kaisernetwork.org/Daily_reports.

Given the high relative weight of this category, it is not surprising that seven of these 10 states are also among the “Top 10” overall.

The 10 states with the lowest ranks in eligibility are:

Indiana	90.6 points
Alabama	91.6 points
Mississippi	92.6 points
Arizona	95.5 points
South Dakota	101.1 points
Nevada	108.5 points
Texas	110.3 points
Idaho	117.1 points
Delaware	127.1 points
Virginia	131.0 points

As with their higher-ranked counterparts, most of these states (Indiana, Alabama, Mississippi, South Dakota, Texas, and Idaho) are also among the 10 programs with the worst scores overall.

Eligibility indicators regarding children [extending services to children above the federal poverty level, and coverage under the State Children’s Health Insurance Program (SCHIP)] accounted for 24.8 percent of the 350 possible points under eligibility. Eligibility for women’s services (care provided to pregnant women and services provided to those with breast/cervical cancer) accounted for an additional 16.8 percent of the total points. Coverage of these children and women’s groups thus accounted for 41.5 percent of all points in the eligibility category. Looked at another way, these two categories of indicators accounted for 14.5 percent of all points for all categories. It is therefore useful to see how those states with the highest and lowest rankings in eligibility treated these two important groups.

For the two children’s and the two

Table 1. Ranking of state Medicaid programs, eligibility
Sorted alphabetically by state (left) and by rank (right)

	Score	Rank		Score	Rank
Alabama	91.6	50	Rhode Island	296.8	1
Alaska	159.3	33	Vermont	283.7	2
Arizona	95.5	48	New York	264.8	3
Arkansas	190.0	23	Washington	260.9	4
California	258.9	5	California	258.9	5
Colorado	131.8	41	Minnesota	254.5	6
Connecticut	218.7	14	District of Columbia	248.5	7
Delaware	127.1	43	Massachusetts	247.6	8
District of Columbia	248.5	7	Wisconsin	246.6	9
Florida	182.4	27	Hawaii	245.0	10
Georgia	190.9	22	Louisiana	228.7	11
Hawaii	245.0	10	Maryland	226.4	12
Idaho	117.1	44	Nebraska	220.1	13
Illinois	143.6	36	Connecticut	218.7	14
Indiana	90.6	51	Michigan	217.0	15
Iowa	186.0	25	New Jersey	216.8	16
Kansas	183.0	26	New Hampshire	211.3	17
Kentucky	162.8	30	Maine	210.0	18
Louisiana	228.7	11	Oregon	204.9	19
Maine	210.0	18	Pennsylvania	198.3	20
Maryland	226.4	12	Oklahoma	193.3	21
Massachusetts	247.6	8	Georgia	190.9	22
Michigan	217.0	15	Arkansas	190.0	23
Minnesota	254.5	6	North Carolina	188.9	24
Mississippi	92.6	49	Iowa	186.0	25
Missouri	141.8	37	Kansas	183.0	26
Montana	159.7	32	Florida	182.4	27
Nebraska	220.1	13	Tennessee	175.2	28
Nevada	108.5	46	Utah	167.4	29
New Hampshire	211.3	17	Kentucky	162.8	30
New Jersey	216.8	16	New Mexico	160.1	31
New Mexico	160.1	31	Montana	159.7	32
New York	264.8	3	Alaska	159.3	33
North Carolina	188.9	24	West Virginia	157.5	34
North Dakota	139.8	38	Ohio	144.9	35
Ohio	144.9	35	Illinois	143.6	36
Oklahoma	193.3	21	Missouri	141.8	37
Oregon	204.9	19	North Dakota	139.8	38
Pennsylvania	198.3	20	Wyoming	133.7	39
Rhode Island	296.8	1	South Carolina	132.7	40
South Carolina	132.7	40	Colorado	131.8	41
South Dakota	101.1	47	Virginia	131.0	42
Tennessee	175.2	28	Delaware	127.1	43
Texas	110.3	45	Idaho	117.1	44
Utah	167.4	29	Texas	110.3	45
Vermont	283.7	2	Nevada	108.5	46
Virginia	131.0	42	South Dakota	101.1	47
Washington	260.9	4	Arizona	95.5	48
West Virginia	157.5	34	Mississippi	92.6	49
Wisconsin	246.6	9	Alabama	91.6	50
Wyoming	133.7	39	Indiana	90.6	51
Total Possible	350.0		Total Possible	350.0	

women's eligibility subcategories described above, the five states with the lowest eligibility ranks had the following scores out of a possible 145.3 points:

South Dakota	24.6 points
Alabama	30.4 points
Arizona	34.2 points
Indiana	60.0 points
Mississippi	61.9 points

Conversely, the five states with the highest eligibility rankings had the following scores for these children's and women's subcategories:

Rhode Island	115.7 points
Vermont	115.3 points
Washington	79.8 points
New York	75.4 points
California	69.5 points

As the above breakdown shows, there is no overlap between the top and bottom five states in their scores for these populations. The state with the fewest points, South Dakota (with 24.6 points), has only 21.3 percent as many points as Rhode Island, the state with the most points for eligibility for children's/women's services.

Ultimately, eligibility is the most important category. If a person is deemed ineligible for Medicaid, it matters little what services are available, how good they are, or how equitably the providers are paid. Yet widely divergent eligibility requirements continue to plague the Medicaid program. For example, a pregnant woman in family of three needs to have an annual income of less than \$22,128 in order to qualify for Medicaid in Wyoming, while her Minnesota counterpart can be covered with an income of up to \$45,650. Similarly, an infant's family's income would have to be less than \$22,128 in Virginia for the baby to be covered, but less than \$49,800 in Missouri. These are disparities that reflect local political decisions but have a ripple effect throughout the Medicaid program, undermining the very concepts of "one nation," equal opportunity, and equal protection.

IV. Scope of Services

Scope of services is the category exhibiting the most variety, complexity, and nuances. Over time, states have modified the optional services they provide under Medicaid in response to need, federal financial incentives, and political imperatives.

Subcategories of service

Because this category has the largest number of indicators, we have grouped them into seven major, mutually-exclusive subcategories:

- Services by type or target group
- Women's services
- Services delivered by specific providers
- Rehabilitation services
- Devices and equipment
- Drugs
- Transportation

Most of these are in turn broken down into a number of discrete services, which were scored using different point values and weights before being reaggregated into the seven categories.

Services by type or target group

This broad category includes the following 16 subcategories: targeted case management; free-standing ambulatory surgery; diagnostic, screening, and preventive services; home and community-based services; home health services; hospice care; in-patient psychiatric services for those under 21; in-patient institutions for mental diseases and other institutions for mental diseases for those 65 and over; intermediate care facility services for persons with mental retardation; nursing facility services other than for mental diseases; Program of All-Inclusive Care for the Elderly (PACE); personal care services; sickle cell services; private duty nursing services; rehabilitation services for those with mental illness and substance abuse; and tobacco-dependence treatments.

Women's services

These services relate to pregnancy and reproductive health and are reimbursed at a higher matching federal rate. States therefore have an added incentive to cover them, and most do. Nevertheless, some are more generous than others in their coverage, and this is reflected in their scores.

Services delivered by specific providers

These include non-physician providers who provide a wide range of primary and specialized services to Medicaid beneficiaries. These providers agree to "accept assignment," which means that they accept the state's payment as payment in full for the services rendered and cannot bill the patient for an additional amount. Because some of the services under this rubric are quite broad, states may choose to impose restrictions by type of patient or service, or limit the duration or frequency of the service provided. In many cases, these services are provided as part of an institutional stay.

Services in this category include the following: chiropractor services, dental services, nurse anesthetist services, nurse practitioner services, optometrist services, podiatrist services, and psychologist services.

Rehabilitation services

These services include the following: occupational therapy; physical therapy; and speech, hearing, and language services. They are subject to much variation, and are often limited by type of beneficiary, trigger condition, rehabilitation potential, frequency and duration of service, and other variables.

Devices and equipment

This category comprises dentures; eyeglasses; hearing aids; medical equipment and supplies; and prosthetic and orthotic devices.

Drugs

While drugs are a covered service, they are subject to restrictions that vary by state. Our indicators take this into account, reflecting the variations in scope that emerge even within covered services.

Transportation

Here, we are including this service only for states that include it under their State Medicaid Plan. Some states include this as an administrative expense, and are not represented here.

Measuring scope of service

In general, we are ranking states only in terms of the non-mandated services they provide. Most of the services listed above are optional. In the case of mandated services, we have taken into account only those characteristics that affect scope and that exceed or refine the mandated minimum levels. Over time, optional services have increased their share of Medicaid expenditures. In 1998, for example, Medicaid spending on optional services accounted for 65 percent of the total spent by the federal and state governments.³²

Rankings are based on the following criteria:

Coverage: States offering an optional service receive credit in their scores, regardless of how limited the scope or how restricted the eligible population. The total number of points, however, may reflect the scope of service, as indicated below.

Population covered: Some states cover only the categorically needy, while others extend services to the medically needy as well. The latter receive more points than the former in our scoring scheme.

Comprehensiveness: In general, the wider the scope of services, the higher the score. Limitations in terms of amount, frequency or duration will be taken into account in applying this criterion.

32 Andy Schneider, et al. *The Medicaid Resource Book*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, July 2002: 55.

Lack of a financial barrier: Services that do not depend on cost-sharing on the part of the consumer are rewarded in our rankings. When co-pays are required, a distinction may be made between a nominal fee that is unlikely to deter access to services, and a more significant amount that may constitute a barrier to prompt care.

The rationale for the indicator and the way in which each indicator was scored is described in detail in the Scoring Protocol included in the Appendix. Our scoring in this category leans toward the conservative, and we assign points to any state reporting that it covers a given service. In practice, however, the service may be seriously curtailed by the fact that: it is not available everywhere within the state; there may not be sufficient practitioners to provide the service promptly and effectively; or Medicaid providers offering the service may have capped their clientele and may not be taking new Medicaid patients.

Findings

Table 2 and Figure 5 present all states and their ranks with respect to scope of services. The range in scores runs from top-ranked New York (with 168.3 points or 84.2 percent of the total score) to Mississippi (with 66.8 points or 33.4 percent): a more than 2.5-fold difference. The average score is 117.7, or 58.9 percent of the total points.

The “Top 10” Medicaid programs in terms of scope of services are as follows:

New York	168.3 points
Minnesota	158.1 points
Oregon	155.0 points
Washington	145.8 points
Illinois	145.1 points
North Dakota	145.1 points
Maine	142.6 points
Arizona	142.5 points
Tennessee	141.6 points
California	141.0 points

Because this was by far the category with the most indicators, the states’ overall scores tend to be evenly distributed throughout the spectrum, with only one tie among states (between North Dakota and Illinois, who share the 5th rank). Although the two top-ranked states in scope of services—New York and Minnesota—rank among the top 10 overall, only one other state (Washington) also falls within both the overall and the category-specific top 10 ranks.

The following 10 states place at the bottom in scope of services, ranking from 51st to 42nd:

Mississippi	66.8 points
Oklahoma	71.7 points
Alabama	71.9 points
Georgia	76.3 points
Wyoming	81.9 points
South Carolina	82.9 points
Delaware	86.2 points
Idaho	91.6 points
Arkansas	94.4 points
Connecticut	98.9 points

Table 2. Ranking of state Medicaid programs, scope of services
Sorted alphabetically by state (left) and by rank (right)

	Score	Rank		Score	Rank
Alabama	71.9	49	New York	168.3	1
Alaska	105.1	33	Minnesota	158.1	2
Arizona	142.5	8	Oregon	155.0	3
Arkansas	94.4	43	Washington	145.8	4
California	141.0	10	Illinois	145.1	5
Colorado	100.6	40	North Dakota	145.1	5
Connecticut	98.9	42	Maine	142.6	7
Delaware	86.2	45	Arizona	142.5	8
District of Columbia	116.3	27	Tennessee	141.6	9
Florida	103.5	35	California	141.0	10
Georgia	76.3	48	Nebraska	138.8	11
Hawaii	135.1	16	Massachusetts	138.5	12
Idaho	91.6	44	New Hampshire	136.8	13
Illinois	145.1	5	Wisconsin	136.7	14
Indiana	111.6	31	Montana	135.8	15
Iowa	120.7	25	Hawaii	135.1	16
Kansas	131.2	19	Rhode Island	134.7	17
Kentucky	104.8	34	Utah	132.8	18
Louisiana	118.2	26	Kansas	131.2	19
Maine	142.6	7	West Virginia	128.4	20
Maryland	125.4	23	Vermont	128.2	21
Massachusetts	138.5	12	New Jersey	126.6	22
Michigan	124.3	24	Maryland	125.4	23
Minnesota	158.1	2	Michigan	124.3	24
Mississippi	66.8	51	Iowa	120.7	25
Missouri	102.1	39	Louisiana	118.2	26
Montana	135.8	15	District of Columbia	116.3	27
Nebraska	138.8	11	Pennsylvania	115.1	28
Nevada	102.8	36	New Mexico	113.6	29
New Hampshire	136.8	13	Ohio	112.5	30
New Jersey	126.6	22	Indiana	111.6	31
New Mexico	113.6	29	North Carolina	108.2	32
New York	168.3	1	Alaska	105.1	33
North Carolina	108.2	32	Kentucky	104.8	34
North Dakota	145.1	5	Florida	103.5	35
Ohio	112.5	30	Nevada	102.8	36
Oklahoma	71.7	50	South Dakota	102.5	37
Oregon	155.0	3	Virginia	102.4	38
Pennsylvania	115.1	28	Missouri	102.1	39
Rhode Island	134.7	17	Colorado	100.6	40
South Carolina	82.9	46	Texas	100.3	41
South Dakota	102.5	37	Connecticut	98.9	42
Tennessee	141.6	9	Arkansas	94.4	43
Texas	100.3	41	Idaho	91.6	44
Utah	132.8	18	Delaware	86.2	45
Vermont	128.2	21	South Carolina	82.9	46
Virginia	102.4	38	Wyoming	81.9	47
Washington	145.8	4	Georgia	76.3	48
West Virginia	128.4	20	Alabama	71.9	49
Wisconsin	136.7	14	Oklahoma	71.7	50
Wyoming	81.9	47	Mississippi	66.8	51
Total Possible	200.0		Total Possible	200.0	

Although this category is not weighted as heavily as eligibility in our adjusted scores, it nevertheless reflects overall program performance, and half of the states ranking in the bottom 10 in scope of services also rank at the bottom in the overall score. These states are Mississippi, Oklahoma, Alabama, South Carolina, and Idaho.

When services are broken down by type of care, it becomes evident that different states have different priorities in deciding the package of services they offer their Medicaid populations.

With respect to **services by type or target group**, the following states rank in the top five, in descending order:

New York	73.9 points
Oregon	68.4 points
Maryland	65.0 points
Rhode Island	63.7 points
Michigan	62.9 points
Tennessee	62.9 points

The bottom rankings in **services by type or target group** are occupied by:

Georgia	30.0 points
Wyoming	30.0 points
Mississippi	30.9 points
Delaware	34.5 points
Alabama	34.7 points
Oklahoma	34.7 points

In terms of **women's services**, the following five states occupy the top ranks:

California	14.6 points
Minnesota	14.6 points
New York	14.6 points
Vermont	14.6 points
Maryland	13.5 points

The bottom rankings in **women's services** are occupied by:

Idaho	2.8 points
South Dakota	2.8 points
Utah	3.3 points
Nevada	3.8 points
North Dakota	3.8 points
Wyoming	3.8 points

In **provider-specific services**, the following states earn the top ranks:

West Virginia	31.2 points
Minnesota	30.4 points
Arizona	29.3 points
Iowa	29.1 points
New Jersey	28.6 points
North Dakota	28.6 points

The bottom rankings in **provider-specific services** are occupied by:

Alabama	10.2 points
Delaware	11.7 points
Alaska	11.8 points
Nevada	12.8 points
Georgia	13.8 points

In **devices and equipment**, the top rankings are occupied by:

New York	32.2 points
Rhode Island	32.2 points
Oregon	30.8 points
New Jersey	29.9 points
Illinois	29.9 points
North Dakota	29.9 points

The bottom rankings of **devices and equipment** are occupied by:

Delaware	9.7 points
Mississippi	9.7 points
Oklahoma	9.7 points
Texas	10.6 points
Maryland	12.4 points
West Virginia	12.4 points

Of all the categories, scope of services presents the most options for the states. Services cover the lifespan (from prenatal care to hospice), involve a broad range of facilities and providers, and can expand or contract as a function of need and budgetary possibilities. Even when two states offer the same package of services, they can do so under very different conditions. States can impose cost-sharing, or limit the frequency, duration, or amount of service provided

to a given beneficiary. For this reason, this is the category with the most indicators and the most finely-calibrated scores.

V. Quality of Care

Given the large number of beneficiaries and the expenses involved in the program, Medicaid is under pressure to prove that it can deliver quality care. Up to now, however, the focus on quality has been primarily on avoiding fraud. Some states appeal to consumers to be careful about divulging their Medicaid card number, and urge their beneficiaries to avoid seeking medical care they do not need. For their part, Medicaid providers are told to watch for “upcoding” of procedures (billing for a more complex and costly procedure than what was actually delivered); to monitor attempts to “unbundle” a single medical event into its component parts in order to increase the fees; to be cautious of cost reports that do not reflect hours worked; and to be suspicious of anyone getting excess prescriptions that they may be reselling.³³

While these measures may be necessary to protect the fiscal integrity of the program, they are not directly related to the quality of care. In fact, because Medicaid comprises more than 50 different programs, there are no overall indicators of quality that all states maintain. Our comparisons are therefore based on measures that serve as markers of quality.

Markers of quality

The data on quality vary a great deal and are a lot more complete for some services, such as nursing home care. Because this type of care was notoriously and dangerously neglected for many years, it has been subjected to greater oversight and more complete data collection. Since 1987, the Centers for Medicare and Medicaid Services (CMS) has defined the protocol that all states must use to survey their nursing care facilities and report their findings.

In cases such as nursing home care or services for children, where a significant proportion of a given service or target population is covered by Medicaid, we have used the quality indicators available for each state for all patient populations as a proxy for quality of care for the service covered by Medicaid. While these data have the limitation of not being specific enough, they provide a close approximation of the quality available to Medicaid recipients.

In the case of nursing home care, the rationale for using statewide data, even when not Medicaid-specific, includes the following:

- The overwhelming majority of nursing homes (93.9 percent) accept Medicaid patients.³⁴
- In 2003, the most recent year for which data are available, Medicaid paid for 46 percent of all nursing home expenditures, and this proportion is likely to have increased since then. An additional 12 percent was paid for by Medicare.³⁵
- Because nursing home care is so expensive, 56 percent of nursing home residents eventually “spend down” their resources and qualify for help from Medicaid.³⁶

33 One example of this is the brochure put out by Florida’s Agency for Health Care Administration, Medicaid Program Integrity: “Why You Should Be Worried About Medicaid Fraud.”

34 Charlene Harrington, Helen Carillo, and Courtney LaCava. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1999 Through 2005*. Department of Social and Behavioral Sciences, University of California, San Francisco. September 2006.

35 Paying for Nursing Home Care: Asset Transfer and Qualifying for Medicaid. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, January 2006.

36 Paying for Nursing Home Care: Asset Transfer and Qualifying for Medicaid. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, January 2006.

In the case of services for children, the rationale is that Medicaid covers a significant portion of their medical care: the program covers more than one in four children in this country.³⁷ Moreover, what is adopted as the standard of care under Medicaid is often reflective of what providers do for the pediatric population as a whole, regardless of payer. Additionally, this is one of the few populations for which data on results are available.

The indicators used under the quality of care category cover structure, process, and outcomes.³⁸ Indicators of structure include those ingredients or elements that facilitate or promote quality of care. Process measures include whether proper procedures were used in delivering care. Outcome measures include both improvements in health status and the avoidance of adverse results.

Findings

In part because states have not been held accountable for the quality of their Medicaid programs, they earn the lowest scores in this category. The median score for this category is a meager 28.2 percent of 200 points.

Because states have so many deficiencies in this area, even those ranking at the top have low scores, boosted only by the fact that many others do even worse in this category.

The following states score in the “Top 10” in this category:

Massachusetts	143.0 points
Rhode Island	109.0 points
Ohio	106.7 points
Florida	106.4 points
Nebraska	105.4 points
Kentucky	105.1 points
Alabama	97.1 points
Alaska	95.5 points
Virginia	94.0 points
Maine	92.7 points

The 10 states with the lowest scores all earn less than 12 percent of the maximum points in this category. They are as follows, ranking between #51 and #42:

Idaho	-4.4 points
Oklahoma	-3.8 points
Nevada	8.4 points
Louisiana	10.2 points
Kansas	18.0 points
Maryland	18.8 points
Arkansas	19.5 points
South Carolina	20.1 points
Georgia	22.4 points
Colorado	22.4 points

37 Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. *Health Coverage for Low-Income Children*. September 2004.

38 This framework, now widely adopted, was established by Avedis Donabedian.

Unlike the previous two categories, quality of care shows a very broad spread in scores, with a more than 17-fold difference between the states with the highest and lowest positive scores (Massachusetts, with 143.0 points; Nevada, with 8.4 points).

To a large extent, much of the difference can be accounted for by differences in the quality of their nursing home facilities. Because some of the indicators used rely on evidence-based benchmarks for adequacy in nursing home care, states that fall short of the acceptable minimum standards earn negative points. As a result, quality of care is the only category in which two states (Oklahoma and Idaho) have negative scores.

The distribution of scores has two “tails” representing statistical outliers on either side of the spectrum: one state that scores considerably higher than the rest, and the two that are at the very bottom, with negative scores. When these three states are omitted, the differences in scores are significantly reduced, although they still vary by a very large factor of 13.0.

Despite its top rank, Massachusetts earns only 71.5 percent of the total points in this category. It is followed at a distance by Rhode Island, with only 54.5 percent of the total points.

These findings suggest that “quality control” needs to be drastically redefined within the Medicaid program. At present, the term is used to refer to the CMS’ statutory responsibility to monitor state and local Medicaid eligibility determinations. However, the sifting and sorting of people to see if they are indeed eligible for services is more of an accounting procedure than a quality assessment process. Accountability therefore needs to supplement the current emphasis on accounting. Only then will the public be served and the government be assured that it is getting value for the monies invested in the program.

Table 3. Ranking of state Medicaid programs, quality of care
Sorted alphabetically by state (left) and by rank (right)

	Score	Rank		Score	Rank
Alabama	97.1	7	Massachusetts	143.0	1
Alaska	95.5	8	Rhode Island	109.0	2
Arizona	52.5	30	Ohio	106.7	3
Arkansas	19.5	45	Florida	106.4	4
California	50.4	33	Nebraska	105.4	5
Colorado	22.4	42	Kentucky	105.1	6
Connecticut	43.7	36	Alabama	97.1	7
Delaware	63.1	23	Alaska	95.5	8
District of Columbia	29.4	41	Virginia	94.0	9
Florida	106.4	4	Maine	92.7	10
Georgia	22.4	42	Tennessee	85.7	11
Hawaii	66.7	22	New Hampshire	84.4	12
Idaho	-4.4	51	New York	83.1	13
Illinois	71.4	16	Utah	80.5	14
Indiana	71.4	16	Montana	72.4	15
Iowa	43.4	37	Wisconsin	71.4	16
Kansas	18.0	47	Illinois	71.4	16
Kentucky	105.1	6	Indiana	71.4	16
Louisiana	10.2	48	North Carolina	69.1	19
Maine	92.7	10	Missouri	68.3	20
Maryland	18.8	46	Vermont	67.8	21
Massachusetts	143.0	1	Hawaii	66.7	22
Michigan	55.1	27	Delaware	63.1	23
Minnesota	50.7	32	Wyoming	62.1	24
Mississippi	58.2	25	Mississippi	58.2	25
Missouri	68.3	20	Pennsylvania	56.4	26
Montana	72.4	15	Michigan	55.1	27
Nebraska	105.4	5	New Jersey	55.1	27
Nevada	8.4	49	North Dakota	53.9	29
New Hampshire	84.4	12	Arizona	52.5	30
New Jersey	55.1	27	Oregon	51.7	31
New Mexico	32.8	39	Minnesota	50.7	32
New York	83.1	13	California	50.4	33
North Carolina	69.1	19	West Virginia	48.1	34
North Dakota	53.9	29	Texas	45.5	35
Ohio	106.7	3	Connecticut	43.7	36
Oklahoma	-3.8	50	Iowa	43.4	37
Oregon	51.7	31	South Dakota	37.7	38
Pennsylvania	56.4	26	New Mexico	32.8	39
Rhode Island	109.0	2	Washington	31.7	40
South Carolina	20.1	44	District of Columbia	29.4	41
South Dakota	37.7	38	Georgia	22.4	42
Tennessee	85.7	11	Colorado	22.4	42
Texas	45.5	35	South Carolina	20.1	44
Utah	80.5	14	Arkansas	19.5	45
Vermont	67.8	21	Maryland	18.8	46
Virginia	94.0	9	Kansas	18.0	47
Washington	31.7	40	Louisiana	10.2	48
West Virginia	48.1	34	Nevada	8.4	49
Wisconsin	71.4	16	Oklahoma	-3.8	50
Wyoming	62.1	24	Idaho	-4.4	51
Total Possible	200.0		Total Possible	200.0	

VI. Provider Reimbursement

Medicaid is financed by the states and the federal government. Federal funding for the program comes from general revenues. As an entitlement program, Medicaid's federal spending levels are pegged to the number of people participating in the program and the services provided; spending is therefore open-ended and subject to fluctuations that are difficult to budget. As costs have risen over time, the program has become an important arena in which issues related to resource allocation have played out.

Even when states may be reluctant to commit an increasing share of their revenues to the program, the political and economic reality is that they need to leverage their share of the costs to maximize what they get from the federal government. The stakes for all participants are high. At present, Medicaid:

- covers over 55 million Americans;³⁹
- is a major budget item for the states, averaging 16 percent of all state spending;⁴⁰
- represents the largest source of federal grant support to states;⁴¹
- accounts for eight percent of all federal spending⁴² and one of every five health care dollars spent in the U.S.;⁴³
- is the nation's main source of coverage for long-term care;⁴⁴
- supports tens of thousands of health care providers throughout the country; and
- has a significant multiplier effect on the U.S. economy as a whole.⁴⁵

It is therefore not surprising that the financing of Medicaid is a topic that is often debated, defused, reframed, or circumvented, depending on who is affected and who is doing the debating.

Medicaid financing

The federal government contributes between 50 percent and 76 percent of the payments for services provided under each state Medicaid program.⁴⁶ This contribution, known as the Federal Matching Assistance Percentage (FMAP), varies from state to state and from year to year because it is based on the average per capita income in each state. States with lower per capita incomes receive a higher federal matching rate. The federal matching rate for administrative costs is uniform for all states and is generally 50 percent.

Although the sliding FMAP was intended to have a redistributive effect and therefore sought to reduce disparities between states, it does this only partially because of the constraints imposed by the statutory minimum FMAP. The funding formula is also problematic for additional reasons.⁴⁷ First, the cost of coverage is substantial for both federal and state

39 Smith, et al. *Low Medicaid Spending Growth*: 10.

40 Kaiser Family Foundation. Kaiser Commission on Medicaid and the Uninsured. *The Role of Medicaid in State Economies: A Look at the Research*. April 2004.

41 Kaiser Family Foundation. *The Role of Medicaid in State Economies*.

42 Alliance of Community Health Plans. *The Federal Budget Environment Aug. 2006. Key Issues in Health Care Policy*. <http://www.achp.org/library/download.asp?id=6795>.

43 Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. Diane Rowland. *Medicaid: The Basics*. KaiserEDU.org. June 2005.

44 Smith, et al. *Low Medicaid Spending Growth*: 11.

45 Kaiser Family Foundation. *The Role of Medicaid in State Economies*: 2-3.

46 There are some exceptions to this: For example, family planning services receive a larger federal match.

47 Victoria Wachino, Andy Schneider, and David Rousseau. *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. January 2004. www.kff.org/kmcu.

governments, and is difficult to predict. In addition, Medicaid's matching payments do not automatically adjust to changing economic conditions. The program's scope may therefore be forced to contract during an economic downturn, thus having a negative effect on both the beneficiaries and those who are newly uninsured.

Furthermore, states have used "Medicaid maximization" or "revenue enhancement" strategies to increase federal spending in the program; in some cases, these payments may constitute up to one-sixth of a state's Medicaid expenditures.⁴⁸ Because the monies obtained through such strategies enter the states' coffers without earmarking, they are often used for purposes unrelated to the population and services for which Medicaid was created. As a result, these strategies have been the target of measures to insure greater accountability. These measures have included legislation, regulation, greater federal oversight, and moral suasion. Changes in intergovernmental transfer rules would reduce federal payments to states by almost \$24 billion over 10 years.⁴⁹ States are therefore poised to adjust to a significant shortfall in federal revenues, and many are restructuring their services in anticipation of lost funds.

Few indicators relate directly to reimbursement. We have therefore relied on those that cover three aspects of Medicaid finances: payments per enrollee, by demographic group; physician fees; and Medicaid fees compared to Medicare fees. Because the data on fees are restricted to payments made under fee-for-service and do not reflect payments made to managed care organizations, they capture a decreasing proportion of Medicaid enrollees, particularly in some states where a vast majority of program beneficiaries are in managed care. Nevertheless, fee-for-service reimbursement rates also have an impact on what managed care organization rates pay physicians, as many states peg their capitation rates to what they pay under fee-for-service.⁵⁰ Because TennCare, Tennessee's Medicaid program, does not use fee-for-service, that program has not been included in our calculations under reimbursement.

Findings

Of the four categories examined, reimbursement is the one with the fewest indicators. It is therefore subject to much fluctuation between and among states. At the same time, it is the "lumpiest" category, with several states sharing the same rank in some cases.

States have wide discretionary authority concerning the methods and amounts of fees.⁵¹ Medicaid fees have lagged in comparison with other physician fees, including those paid under Medicare, and many states face physicians who are reluctant to see Medicaid patients or who place limits on the number or proportion of Medicaid patients in their practices, thus closing off options for new entrants. Physician reimbursement is therefore a proxy for access to care, as research has shown that acceptance of new Medicaid patients is higher in states that have higher Medicaid fees relative to Medicare than in states with lower Medicaid fees.⁵²

Unlike the fairly even distribution of scores that characterizes some of the other categories assessed in this report, reimbursement has states with very high and very low scores. At the high end is Alaska, which pays Medicaid providers much more than the national average in

48 In New Hampshire, for example, "enhanced revenues" account for 17.7 percent of all Medicaid expenditures. Cindy Mann. *Financing Under Federal Medicaid Section 1115 Waivers: Federal Policy and Implications for New Hampshire*. Prepared for the Endowment for Health, September 9, 2004. Health Policy Institute, Georgetown University: 6-7.

49 Mann, *Financing Under Federal Medicaid Section 1115 Waivers*: 7.

50 Stephen Zuckerman, et al. Changes in Medicaid Physician Fees: Implications for Physician Participation. *Health Affairs*. 23 (June 2004): W4-374.

51 Zuckerman, Changes in Medicaid: W4-374.

52 Zuckerman, Changes in Medicaid: W4-381.

order to attract and retain them. As a result, Alaska earns the maximum number of points allotted to this category, 250 points, the only case in which a state does so.

The other states within the top 10 ranks are the following:

Delaware	200.4 points
Nevada	185.3 points
Arizona	184.2 points
Nebraska	161.3 points
Wyoming	160.1 points
Iowa	160.1 points
Maryland	152.7 points
Wisconsin	152.0 points
Montana	144.6 points
Connecticut	144.6 points

At the other end of the scoring scale, the states occupying the bottom 10 ranks in reimbursement are the following:

New Jersey	12.2 points
New York	44.0 points
Rhode Island	59.5 points
Missouri	66.9 points
Pennsylvania	68.0 points
District of Columbia	68.8 points
Florida	75.4 points
California	75.4 points
Oklahoma	75.4 points
Texas	79.5 points
Illinois	79.5 points
Michigan	79.5 points
Maine	83.1 points
Indiana	83.5 points

Because New Jersey ranks so low, the scores between the highest- and the lowest-ranking states vary 20.5-fold. But even when the two states representing the extreme values are omitted, the difference in scores between the second-highest state (Delaware) and the next-to-last state is still approximately 4.5-fold.

These are differences that make a difference. States have understandably attempted to keep their Medicaid costs low by paying providers lower fees, and

Table 4. Ranking of state Medicaid programs, reimbursement*

Sorted alphabetically by state (left) and by rank (right)

	Score	Rank*		Score	Rank*
Alabama	115.7	25	Alaska	250.0	1
Alaska	250.0	1	Delaware	200.4	2
Arizona	184.2	4	Nevada	185.3	3
Arkansas	111.7	26	Arizona	184.2	4
California	75.4	42	Nebraska	161.3	5
Colorado	120.9	21	Wyoming	160.1	6
Connecticut	144.6	10	Iowa	160.1	6
Delaware	200.4	2	Maryland	152.7	8
District of Columbia	68.8	45	Wisconsin	152.0	9
Florida	75.4	42	Montana	144.6	10
Georgia	136.5	15	Connecticut	144.6	10
Hawaii	100.2	30	North Carolina	140.5	12
Idaho	120.9	21	West Virginia	140.5	12
Illinois	79.5	39	New Mexico	140.5	12
Indiana	83.5	37	Vermont	136.5	15
Iowa	160.1	6	Georgia	136.5	15
Kansas	100.2	30	Oregon	132.4	17
Kentucky	123.9	20	South Carolina	128.3	18
Louisiana	100.2	30	Minnesota	127.9	19
Maine	83.1	38	Kentucky	123.9	20
Maryland	152.7	8	Colorado	120.9	21
Massachusetts	116.9	23	Idaho	120.9	21
Michigan	79.5	39	Massachusetts	116.9	23
Minnesota	127.9	19	New Hampshire	116.5	24
Mississippi	100.2	30	Alabama	115.7	25
Missouri	66.9	47	Washington	111.7	26
Montana	144.6	10	Arkansas	111.7	26
Nebraska	161.3	5	South Dakota	111.3	28
Nevada	185.3	3	North Dakota	104.3	29
New Hampshire	116.5	24	Utah	100.2	30
New Jersey	12.2	50	Hawaii	100.2	30
New Mexico	140.5	12	Mississippi	100.2	30
New York	44.0	49	Kansas	100.2	30
North Carolina	140.5	12	Louisiana	100.2	30
North Dakota	104.3	29	Virginia	96.1	35
Ohio	87.6	36	Ohio	87.6	36
Oklahoma	75.4	42	Indiana	83.5	37
Oregon	132.4	17	Maine	83.1	38
Pennsylvania	68.0	46	Illinois	79.5	39
Rhode Island	59.5	48	Michigan	79.5	39
South Carolina	128.3	18	Texas	79.5	39
South Dakota	111.3	28	Florida	75.4	42
Texas	79.5	39	California	75.4	42
Utah	100.2	30	Oklahoma	75.4	42
Vermont	136.5	15	District of Columbia	68.8	45
Virginia	96.1	35	Pennsylvania	68.0	46
Washington	111.7	26	Missouri	66.9	47
West Virginia	140.5	12	Rhode Island	59.5	48
Wisconsin	152.0	9	New York	44.0	49
Wyoming	160.1	6	New Jersey	12.2	50
Total Possible	250.0		Total Possible	250.0	

* TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

this has had an impact on access to care. Low payment rates deter physician participation in the program, or lead providers to cap their Medicaid clientele. This is especially the case among physicians in solo practice or working in small groups.⁵³ As a result, an increasing proportion of Medicaid patients are relying on physicians who practice in larger groups, hospitals, or community health centers.

⁵³ Peter J. Cunningham and Jessica H. May. *Medicaid Patients Increasingly Concentrated Among Physicians*. Tracking Report No. 16, Center for the Study of Health System Change, August 2006.

VII. National Results

Overview

As summarized in the table below, the state Medicaid programs show much variation between and within the categories assessed.

Table 5. Summary of state Medicaid program scores				
Category	Total Possible	Range of Scores	Mean Score	Median Score
Eligibility	350	Highest: 296.8 Lowest: 90.6	181.4 (51.8%)	183 (52.3%)
Scope of Services	200	Highest: 168.3 Lowest: 66.8	117.7 (58.9%)	118.2 (59.1%)
Quality of Care	200	Highest: 143.0 Lowest: -4.4	58.8 (29.4%)	56.4 (28.2%)
Reimbursement	250	Highest: 250 Lowest: 12.2	115.3 (46.1%)	113.7 (45.5%)
Overall	1000	Highest: 645.9 Lowest: 317.8	472.3 (47.2%)	471.1 (47.1%)

Almost all state Medicaid programs are doing poorly in meeting all of their basic objectives.

The best overall score is only 645.9 (64.6 percent) and the average score is 472.3 out of 1000 points. The median overall score of 471.1 means that half of all states have scores lower than this. Further, 31 states have scores of less than 500 (50 percent of possible points).

Highlighting the problem of very widespread and uneven performance is the fact that a total of 30 states (over one-half of states) were in the bottom 10 in one or more of the four categories. These 30 states include: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Idaho, Illinois, Indiana, Kansas, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Jersey, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Virginia, and Wyoming.

The 10 highest-scoring states earn between 645.9 and 548.9 points of the maximum 1000.

The following states occupy the first 10 ranks, in descending order: Massachusetts (645.9), Nebraska (625.5), Vermont (616.1), Alaska (609.9), Wisconsin (606.8), Rhode Island (600.0), Minnesota (591.2), New York (560.2), Washington (550.0), and New Hampshire (548.9).

The 10 most deficient state programs have overall scores ranging from 317.8 to 379.1 of the total 1000 points.

The worst programs, in order from 50th to 41st, are in Mississippi (317.8), Idaho (325.2), Texas (335.5), Oklahoma (336.7), South Dakota (352.6), Indiana (357.2), South Carolina (364.0), Colorado (375.7), Alabama (376.3), and Missouri (379.1).

Even the top-ranking programs fall short in some categories and have ample room for improvement.

When the data are broken down by category, there are gaps between the scores of even those at the top and the maximum scores. For example, in eligibility, Rhode Island, the highest-ranking state in that category, earns only 84.8 percent of the maximum points in that category. Similarly, in scope of services, the state ranked first, New York, gets 84.2 percent of the total points in that category. In quality of care, even the best-scoring state, Massachusetts,

Table 6. Overall ranking of state Medicaid programs*

Sorted alphabetically by state (left) and by rank (right)

	Score	Rank*		Score	Rank*
Alabama	376.3	42	Massachusetts	645.9	1
Alaska	609.9	4	Nebraska	625.5	2
Arizona	474.5	24	Vermont	616.1	3
Arkansas	415.7	38	Alaska	609.9	4
California	525.7	14	Wisconsin	606.8	5
Colorado	375.7	43	Rhode Island	600.0	6
Connecticut	505.8	19	Minnesota	591.2	7
Delaware	476.8	22	New York	560.2	8
District of Columbia	462.9	27	Washington	550.0	9
Florida	467.7	26	New Hampshire	548.9	10
Georgia	426.1	36	Hawaii	547.1	11
Hawaii	547.1	11	Oregon	544.0	12
Idaho	325.2	49	Maine	528.4	13
Illinois	439.6	32	California	525.7	14
Indiana	357.2	45	Maryland	523.3	15
Iowa	510.2	17	Montana	512.5	16
Kansas	432.4	35	Iowa	510.2	17
Kentucky	496.6	20	North Carolina	506.6	18
Louisiana	457.3	28	Connecticut	505.8	19
Maine	528.4	13	Kentucky	496.6	20
Maryland	523.3	15	Utah	480.9	21
Massachusetts	645.9	1	Delaware	476.8	22
Michigan	475.8	23	Michigan	475.8	23
Minnesota	591.2	7	Arizona	474.5	24
Mississippi	317.8	50	West Virginia	474.4	25
Missouri	379.1	41	Florida	467.7	26
Montana	512.5	16	District of Columbia	462.9	27
Nebraska	625.5	2	Louisiana	457.3	28
Nevada	405.0	40	Ohio	451.7	29
New Hampshire	548.9	10	New Mexico	447.0	30
New Jersey	410.7	39	North Dakota	443.2	31
New Mexico	447.0	30	Illinois	439.6	32
New York	560.2	8	Pennsylvania	437.8	33
North Carolina	506.6	18	Wyoming	437.8	33
North Dakota	443.2	31	Kansas	432.4	35
Ohio	451.7	29	Georgia	426.1	36
Oklahoma	336.7	47	Virginia	423.5	37
Oregon	544.0	12	Arkansas	415.7	38
Pennsylvania	437.8	33	New Jersey	410.7	39
Rhode Island	600.0	6	Nevada	405.0	40
South Carolina	364.0	44	Missouri	379.1	41
South Dakota	352.6	46	Alabama	376.3	42
Texas	335.5	48	Colorado	375.7	43
Utah	480.9	21	South Carolina	364.0	44
Vermont	616.1	3	Indiana	357.2	45
Virginia	423.5	37	South Dakota	352.6	46
Washington	550.0	9	Oklahoma	336.7	47
West Virginia	474.4	25	Texas	335.5	48
Wisconsin	606.8	5	Idaho	325.2	49
Wyoming	437.8	33	Mississippi	317.8	50
Total Possible	1000.0		Total Possible	1000.0	

* TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

receives a modest 71.5 percent of the total. Reimbursement is the only area in which one state, Alaska, gets the maximum number of points. This can be attributed to the fact that the state pays its Medicaid providers much more than the rest of the country in order to attract and retain practitioners. This is a clear anomaly, as suggested by the fact that the second-ranking state in this category earns only 80.2 percent of the total points and the average for the other 48 states was only 44.3 percent of the total.

Emphasizing the spotty performance of some of the top-ranking states is the fact that two states in the “Top 10” overall, New York and Rhode Island, were in the bottom 10 in one of the four categories; both states had poor reimbursement policies. This poor showing confirms that even the states with the most resources, best intentions, and higher overall scores are failing in one or more of the categories we examined: eligibility, scope of services, quality, and reimbursement.

Quality of care is the category in which states earn the lowest scores.

The absence of national benchmarks and uniform data collection and reporting systems makes quality difficult to assess across states. As a result, states are in the anomalous position of having much data, but limited information and practically no intelligence that can be used in decision-making.

There are marked inter-state differences, with some categories showing greater disparities than others.

Because uniform federal guidelines have been undermined by waivers and the federal financial matching formula does not fully make up for differences in the resources each state devotes to Medicaid, disparities between states are quite dramatic. Not surprisingly, the gradients between the best and worst Medicaid programs can be quite steep. For example:

- the difference in overall scores between the highest- and the lowest-ranking states is twofold (Massachusetts with 645.9 points, Mississippi with 317.8 points);
- the difference in scores between the highest- and lowest-ranking states in the eligibility category is 3.3-fold (Rhode Island with 296.8 points, Indiana with 90.6 points);
- the difference in scores between the highest- and lowest-ranking states in the scope of services category is 2.5-fold (New York with 168.3, Mississippi with 66.8 points);
- the difference in scores between the highest- and lowest-ranking states with positive scores in the quality of care category is more than 17-fold (Massachusetts with 143.0 points, Nevada with 8.4);
- the difference in scores between the highest- and lowest-ranking states in the reimbursement category is more than 20-fold (Alaska with 250 points, New Jersey with 12.2 points). Even when the two extremes, which are statistical outliers, are omitted, the difference in scores between the second-scoring state (Delaware) and the state ranked #49 (New York) is still more than 4.5-fold.

There is significant intra-state variation in scores, with only a handful of states ranking consistently (i.e., within 15 ranks) across categories.

Some states have made a conscious decision to trade off populations covered for breadth of services, or vice-versa. In other cases, the variation reflects the result of many discrete decisions, each one a response to a time-bound, local situation. Only four states—Nebraska, New Hampshire, Texas, and Wisconsin—show overall consistency (placing within 15 ranks) across all four categories. Interestingly, three of these (Nebraska, New Hampshire, and Wisconsin) rank in the “Top 10,” which indicates that some succeed in all or most categories, without making significant trade-offs that weaken the program.

The 10 best states and the 10 worst states tend to cluster geographically.

Half of those that rank in the top 10 are in the Northeast: Massachusetts, Vermont, Rhode Island, New York, and New Hampshire. Another three—Nebraska, Wisconsin, and Minnesota—are in the Midwest. An additional two are in the Northwest: Washington and Alaska. The 10 worst states also show a geographic pattern, with three of them in the South (Mississippi, South Carolina, and Alabama) and four in the south central part of the country: Colorado, Texas, Oklahoma, and Missouri.

States whose Medicaid programs rank the lowest also tend to fare poorly in overall health rankings.

In order to test if our Medicaid rankings were in any way associated with the national health rankings published in *America's Health Rankings*⁵⁴, we computed Spearman's correlation coefficient. The resulting measure showed an association between the two ranks [ρ (a measurement of correlation) = .5480] and it is highly significant ($p < .0001$). Thus the states whose Medicaid programs rank the lowest also tend to have the worst health indicators overall.

States' ranks tend to correlate with median household income.

The programs that do better are those in states that have higher overall median household incomes. Conversely, those states whose median household income is low tend to have lower-ranking Medicaid programs. The Spearman's correlation coefficient in this case showed a correspondence between the two rankings ($\rho = .4480$, $p < .0012$). Unfortunately, this means

54 United Health Foundation, Partnership for Prevention, American Public Health Association. *America's Health Rankings: A Call to Action for People and Their Communities*. 2006 edition: 15.

that the poorest states, which have the most need for the program, have the worst services, the Medicaid version of what has been codified as the “inverse care law” which says that “the more you need, the less you get.”⁵⁵

Although the federal matching formula is designed to mitigate existing inequalities, it does this only to an extent. All states receive at least a 50 percent match, and those with lower per capita incomes receive a larger percentage. In fiscal year 2007, the Federal Matching Assistance Percentage (FMAP) for Medicaid ranged from 50.0 percent (in 12 states) to 75.9 percent (for Mississippi).⁵⁶ While the 12 states that are at the 50 percent FMAP get a federal dollar for every state dollar they spend on the program, those that have a higher FMAP get more. Mississippi, for example, receives approximately \$3.00 from the federal government for every state dollar it devotes to Medicaid. If Mississippi chooses to reduce its Medicaid expenditures, it also forgoes its corresponding share of the federal match. Reducing its Medicaid spending by \$1 will therefore “cost” Mississippi the \$3 in matching funds and result in a total reduction of \$4 in its Medicaid budget.⁵⁷ The political and financial stakes in the program are therefore higher for the poorer states. But these states also have competing needs, and health spending may be sacrificed to other pressing priorities.

Specific populations fare much better in some states than others.

Moreover, even within a given state, those with certain characteristics or conditions are likely to be more successful than others in gaining access to care. Therefore the question, “As a Medicaid enrollee, where am I most likely to gain access to the most comprehensive and best care?” can only be answered by, “It depends.” The answer is contingent on the patient’s demographic characteristics and medical requirements. For example, a woman in need of reproductive services is clearly at an advantage in four states—California, Minnesota, New York, and Vermont—all of which offer more expansive coverage with fewer restrictions than the rest of the nation. Conversely, she would do well to avoid seeking care in South Dakota, Idaho, and Utah, where there may be eligibility restrictions, limited services, or others barriers to care.

Similarly, patients who need devices and equipment are better off in New York or Rhode Island, while those requiring rehabilitation services (e.g., a stroke victim or someone recovering from an accident) are likely to be more successful in getting comprehensive care in New York or Tennessee.

In short

In summary, this evaluation of Medicaid demonstrates a bleak picture for millions of people in many states.

The first barrier, eligibility, is difficult to get past for millions of uninsured people. The wide variation in eligibility scores, more than threefold between the best and worst states, reflects this, as does the fact that 23 states had eligibility scores less than 50 percent of the total possible (350 points), thus keeping people out who would be eligible were they to live in certain other states.

55 J. Tudor Hart, “The Inverse Care Law,” *Lancet*, 27 February 1971.

56 Kaiser Family Foundation Online Database. Federal Matching Rate (FMAP) for Medicaid and Multiplier, FY2007. <http://www.statehealthfacts.org>.

57 Victoria Wachino, Andy Schneider, and David Rousseau: *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*, Kaiser Commission on Medicaid and the Uninsured Policy Brief, January 2004: 4.

But even for those eligible for Medicaid, the scope of services is extremely uneven. In addition to the 2.5-fold difference between the best and worst states, 10 states had scope of services scores of less than 50 percent of the possible 200 points.

Similarly, even if people are eligible for Medicaid in their state and the program provides those services needed by particular patients, the miserly reimbursement policies in many states make it less likely that they will be able to find a physician who can provide these services. There was a 20.5-fold difference between the best and the worst scores on reimbursement; in this important category, 31 states had scores that were less than 50 percent of the total possible 250 points.

Despite limitations on measuring more indicators of quality because such data are not uniformly collected, this category demonstrated very poor results for almost all states. With a maximum score of 200 points in this category, only six states had scores of more than 50 percent of this point total and 18 states had scores of less than 25 percent of 200 points.

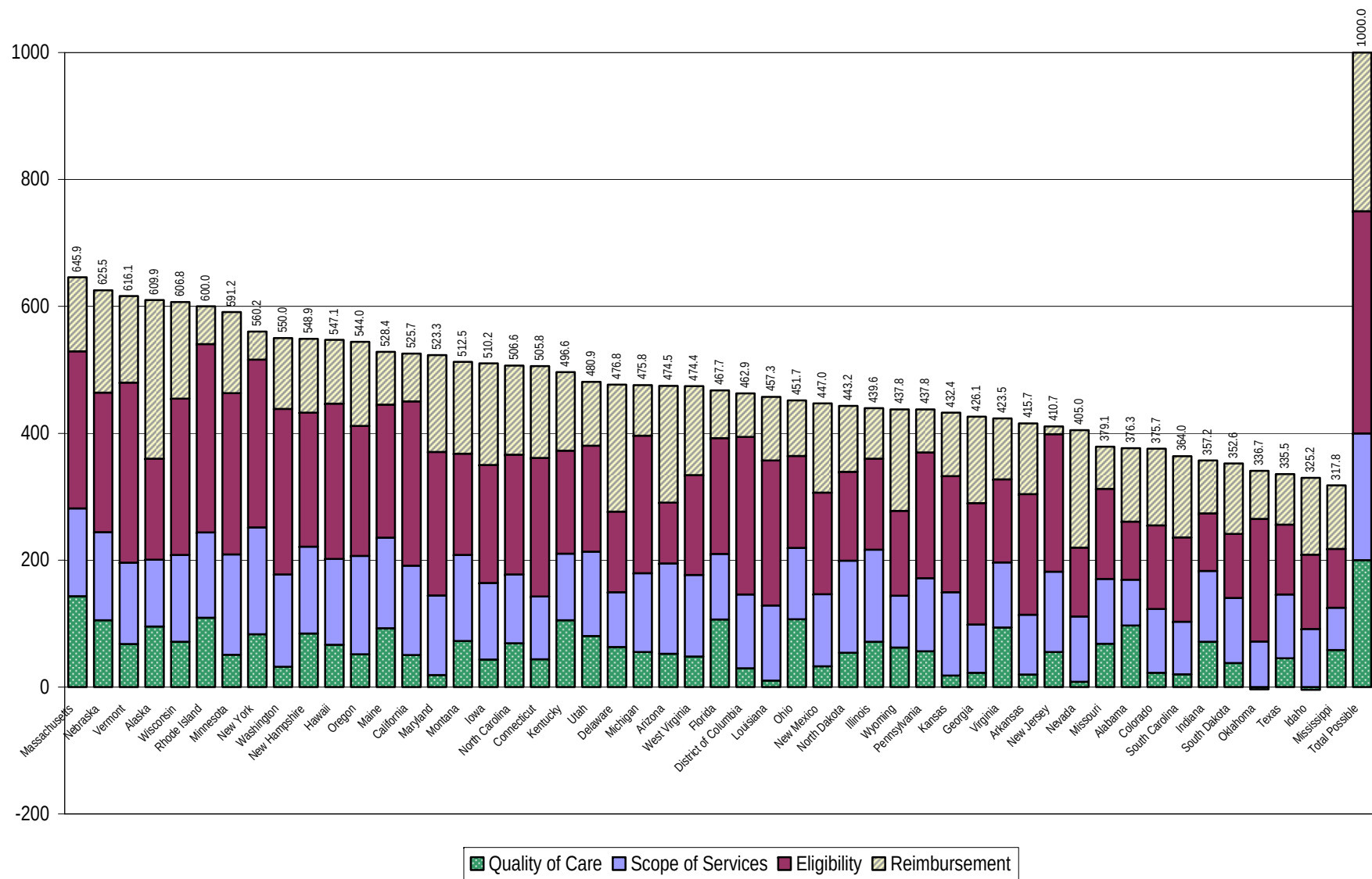
Overall, and in many ways, Medicaid is failing to deliver care to millions of people desperately in need of good quality health services.

Table 7. Scores and ranks for state Medicaid programs in each category and overall, by state in alphabetical order

	Eligibility		Scope of Services		Quality of Care		Reimbursement		Overall	
	Score	Rank	Score	Rank	Score	Rank	Score	Rank*	Score	Rank*
Alabama	91.6	50	71.9	49	97.1	7	115.7	25	376.3	42
Alaska	159.3	33	105.1	33	95.5	8	250.0	1	609.9	4
Arizona	95.5	48	142.5	8	52.5	30	184.2	4	474.5	24
Arkansas	190.0	23	94.4	43	19.5	45	111.7	26	415.7	38
California	258.9	5	141.0	10	50.4	33	75.4	42	525.7	14
Colorado	131.8	41	100.6	40	22.4	42	120.9	21	375.7	43
Connecticut	218.7	14	98.9	42	43.7	36	144.6	10	505.8	19
Delaware	127.1	43	86.2	45	63.1	23	200.4	2	476.8	22
District of Columbia	248.5	7	116.3	27	29.4	41	68.8	45	462.9	27
Florida	182.4	27	103.5	35	106.4	4	75.4	42	467.7	26
Georgia	190.9	22	76.3	48	22.4	42	136.5	15	426.1	36
Hawaii	245.0	10	135.1	16	66.7	22	100.2	30	547.1	11
Idaho	117.1	44	91.6	44	-4.4	51	120.9	21	325.2	49
Illinois	143.6	36	145.1	5	71.4	16	79.5	39	439.6	32
Indiana	90.6	51	111.6	31	71.4	16	83.5	37	357.2	45
Iowa	186.0	25	120.7	25	43.4	37	160.1	6	510.2	17
Kansas	183.0	26	131.2	19	18.0	47	100.2	30	432.4	35
Kentucky	162.8	30	104.8	34	105.1	6	123.9	20	496.6	20
Louisiana	228.7	11	118.2	26	10.2	48	100.2	30	457.3	28
Maine	210.0	18	142.6	7	92.7	10	83.1	38	528.4	13
Maryland	226.4	12	125.4	23	18.8	46	152.7	8	523.3	15
Massachusetts	247.6	8	138.5	12	143.0	1	116.9	23	645.9	1
Michigan	217.0	15	124.3	24	55.1	27	79.5	39	475.8	23
Minnesota	254.5	6	158.1	2	50.7	32	127.9	19	591.2	7
Mississippi	92.6	49	66.8	51	58.2	25	100.2	30	317.8	50
Missouri	141.8	37	102.1	39	68.3	20	66.9	47	379.1	41
Montana	159.7	32	135.8	15	72.4	15	144.6	10	512.5	16
Nebraska	220.1	13	138.8	11	105.4	5	161.3	5	625.5	2
Nevada	108.5	46	102.8	36	8.4	49	185.3	3	405.0	40
New Hampshire	211.3	17	136.8	13	84.4	12	116.5	24	548.9	10
New Jersey	216.8	16	126.6	22	55.1	27	12.2	50	410.7	39
New Mexico	160.1	31	113.6	29	32.8	39	140.5	12	447.0	30
New York	264.8	3	168.3	1	83.1	13	44.0	49	560.2	8
North Carolina	188.9	24	108.2	32	69.1	19	140.5	12	506.6	18
North Dakota	139.8	38	145.1	5	53.9	29	104.3	29	443.2	31
Ohio	144.9	35	112.5	30	106.7	3	87.6	36	451.7	29
Oklahoma	193.3	21	71.7	50	-3.8	50	75.4	42	336.7	47
Oregon	204.9	19	155.0	3	51.7	31	132.4	17	544.0	12
Pennsylvania	198.3	20	115.1	28	56.4	26	68.0	46	437.8	33
Rhode Island	296.8	1	134.7	17	109.0	2	59.5	48	600.0	6
South Carolina	132.7	40	82.9	46	20.1	44	128.3	18	364.0	44
South Dakota	101.1	47	102.5	37	37.7	38	111.3	28	352.6	46
Tennessee	175.2	28	141.6	9	85.7	11	NA*	NA*	NA*	NA*
Texas	110.3	45	100.3	41	45.5	35	79.5	39	335.5	48
Utah	167.4	29	132.8	18	80.5	14	100.2	30	480.9	21
Vermont	283.7	2	128.2	21	67.8	21	136.5	15	616.1	3
Virginia	131.0	42	102.4	38	94.0	9	96.1	35	423.5	37
Washington	260.9	4	145.8	4	31.7	40	111.7	26	550.0	9
West Virginia	157.5	34	128.4	20	48.1	34	140.5	12	474.4	25
Wisconsin	246.6	9	136.7	14	71.4	16	152.0	9	606.8	5
Wyoming	133.7	39	81.9	47	62.1	24	160.1	6	437.8	33
Total Possible	350.0		200.0		200.0		250.0		1000.0	

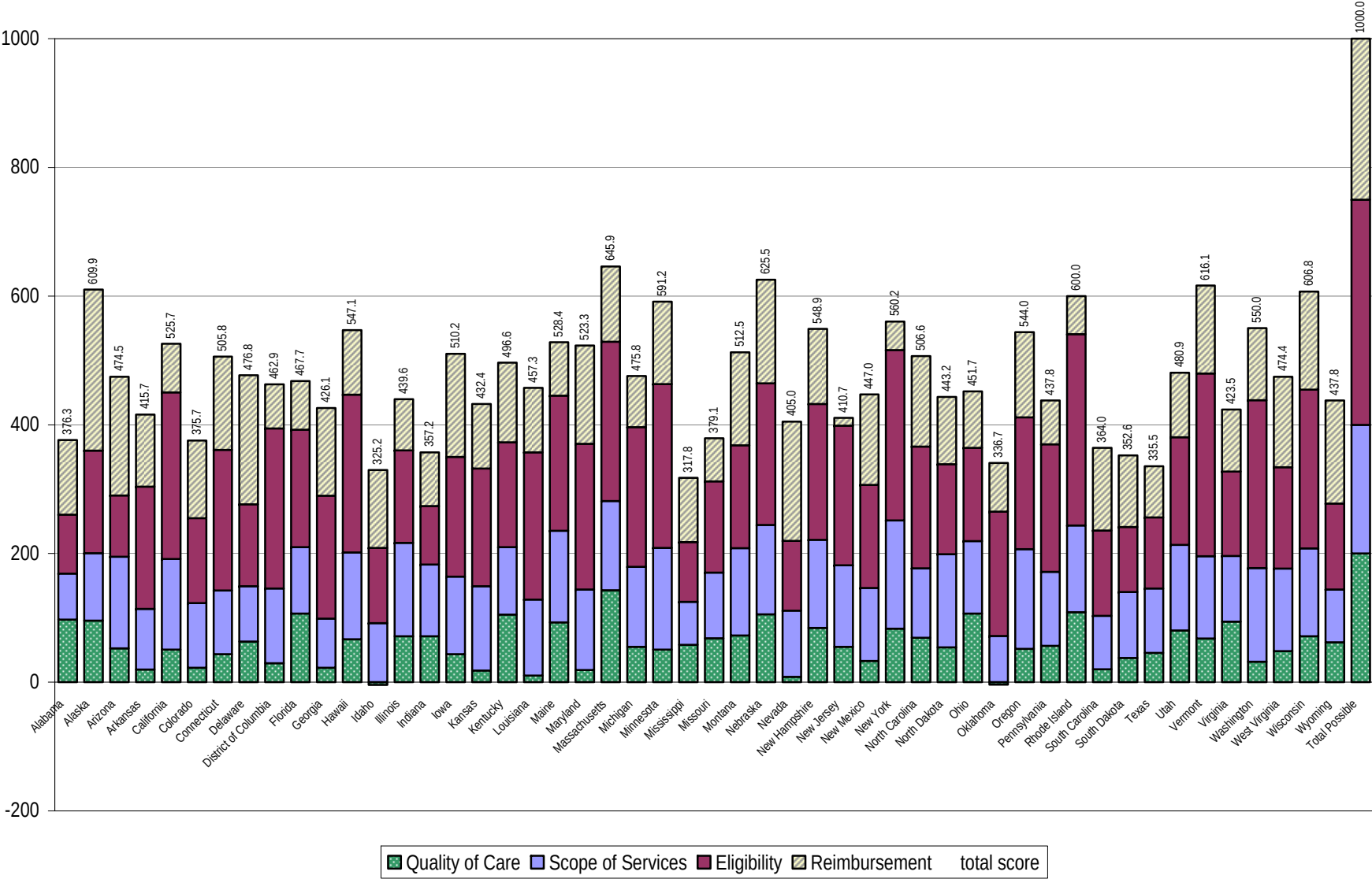
* TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score. Therefore, the reimbursement and overall categories are ranked one through 50 instead of one through 51.

Figure 1. Overall ranking of state Medicaid programs, total points scored in all categories*



*TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

Figure 2. Total scores of state Medicaid programs in all categories, by state in alphabetical order*



*TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

Figure 3. Ranking of state Medicaid programs, total points scored in eligibility

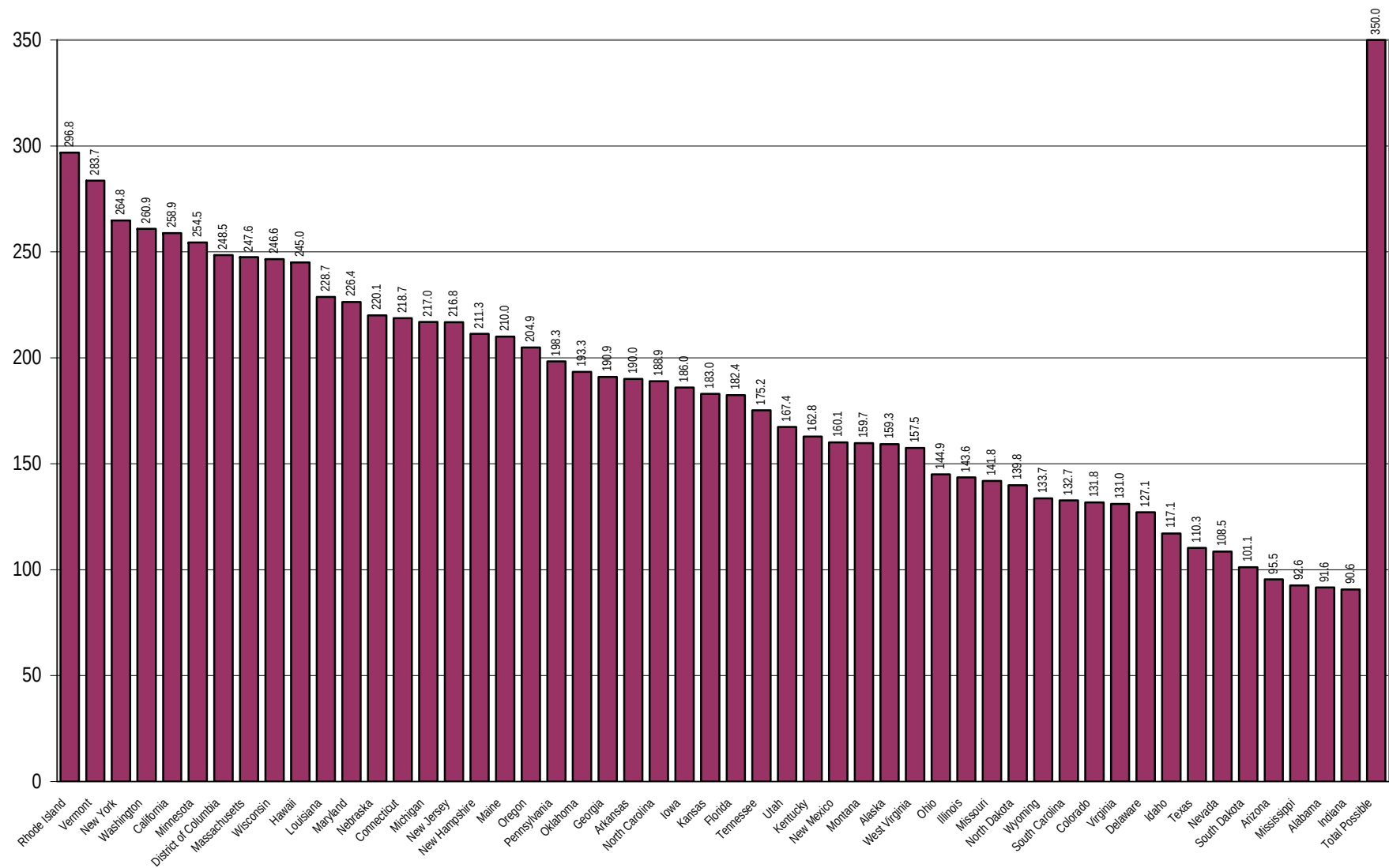


Figure 4. State Medicaid program scores in eligibility, by state in alphabetical order

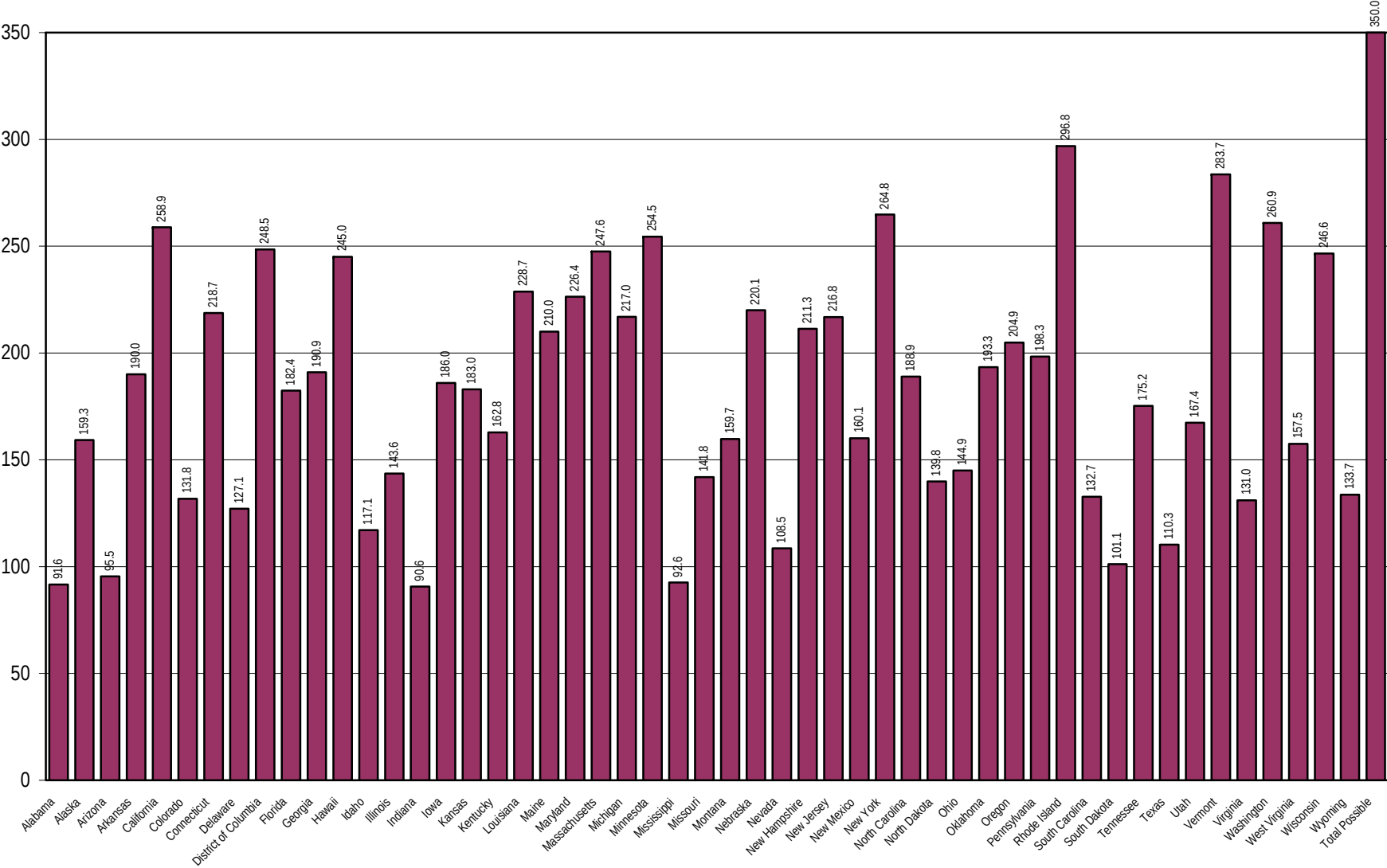


Figure 5. Ranking of state Medicaid programs, total points scored in scope of services

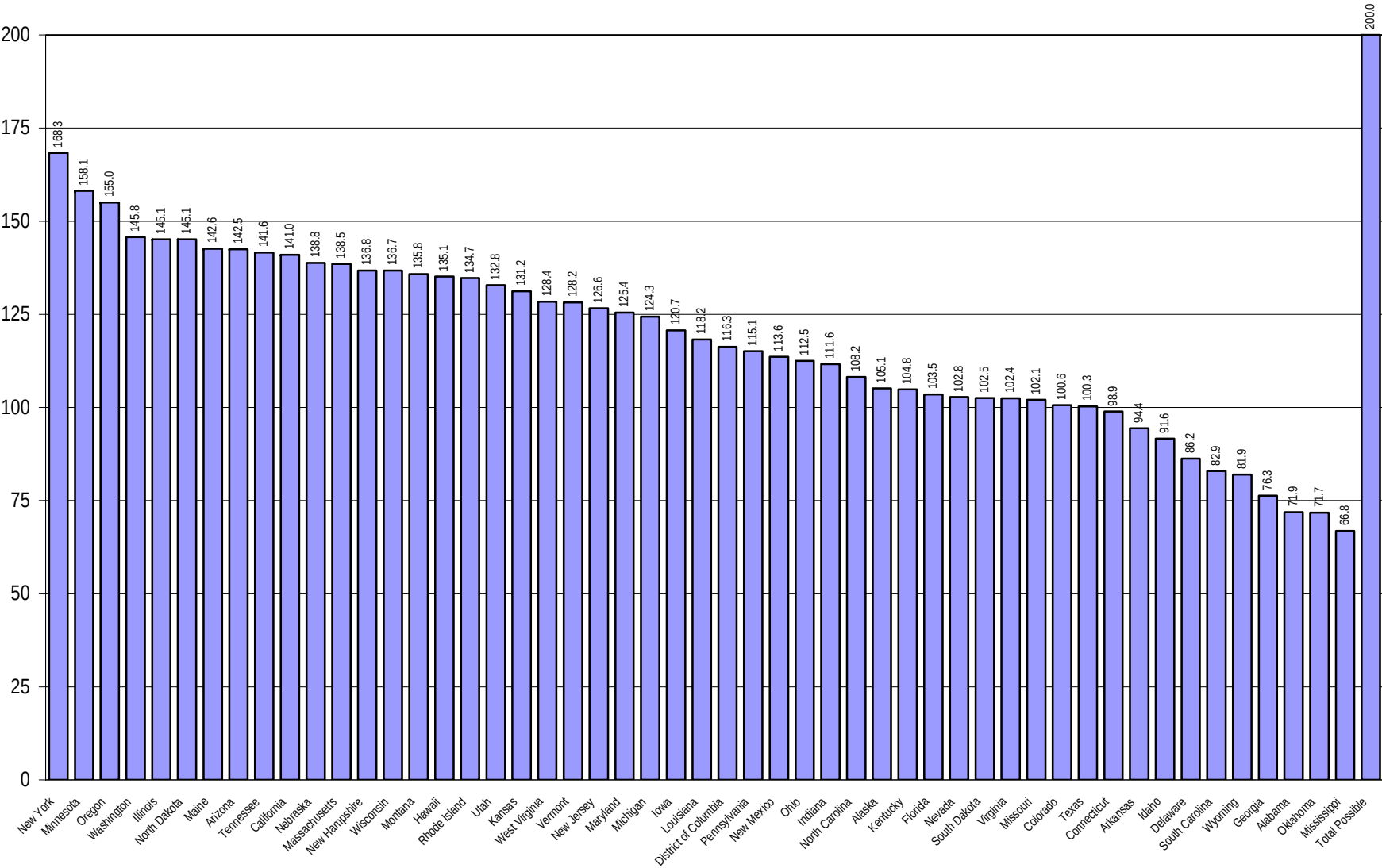


Figure 6. State Medicaid program scores in scope of services, by state in alphabetical order

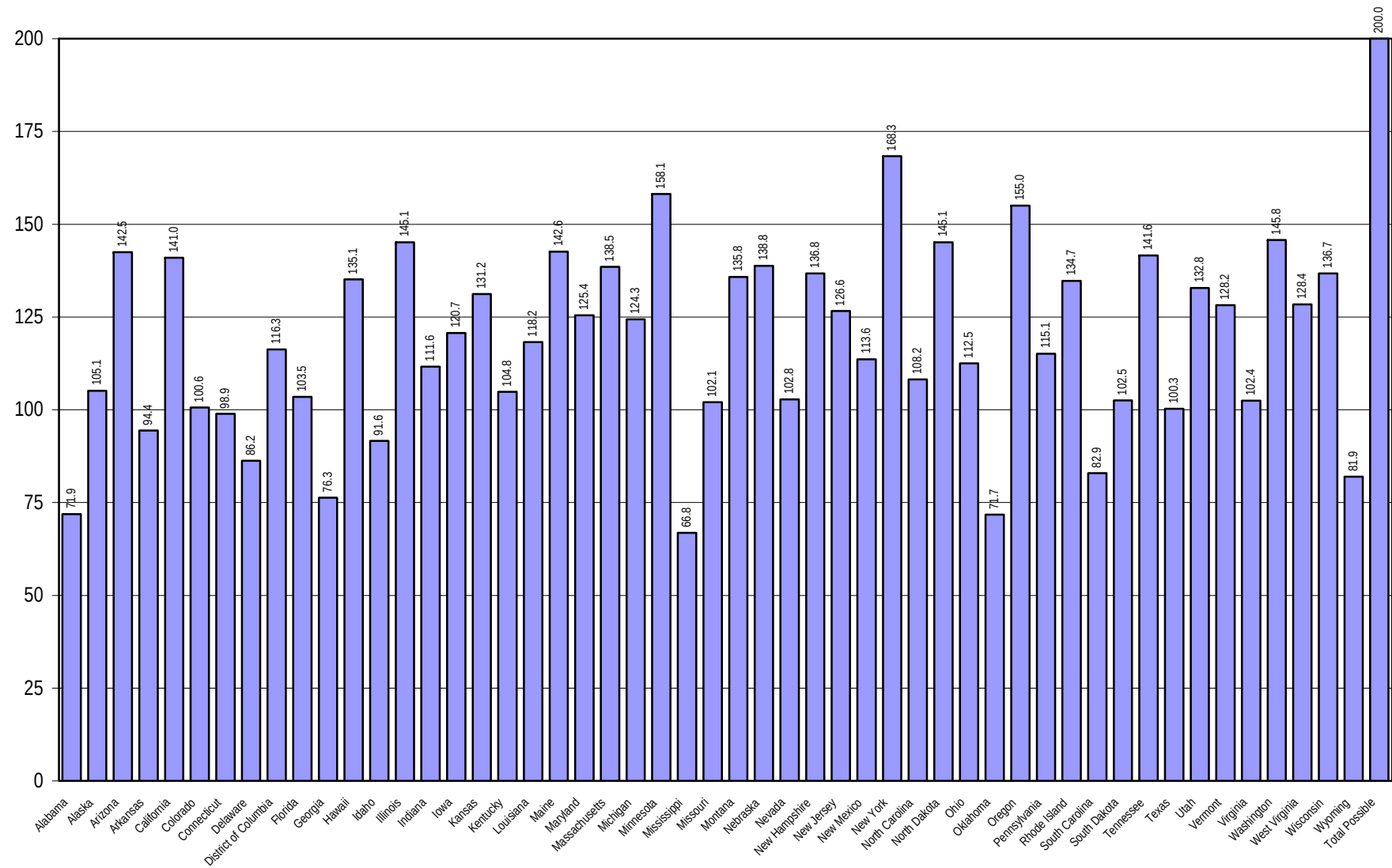


Figure 7. Ranking of state Medicaid programs, total points scored in quality of care

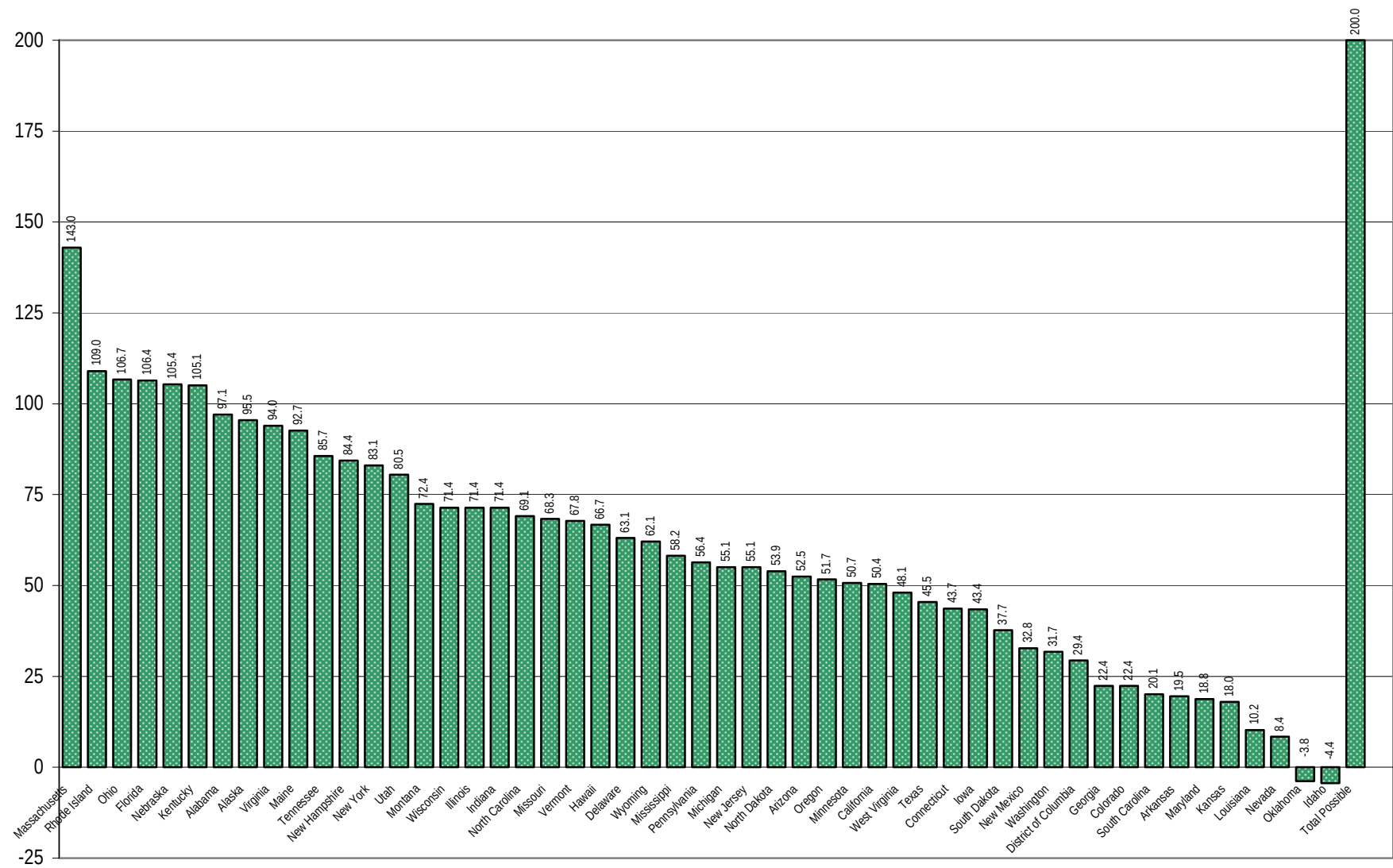


Figure 8. State Medicaid program scores in quality of care, by state in alphabetical order

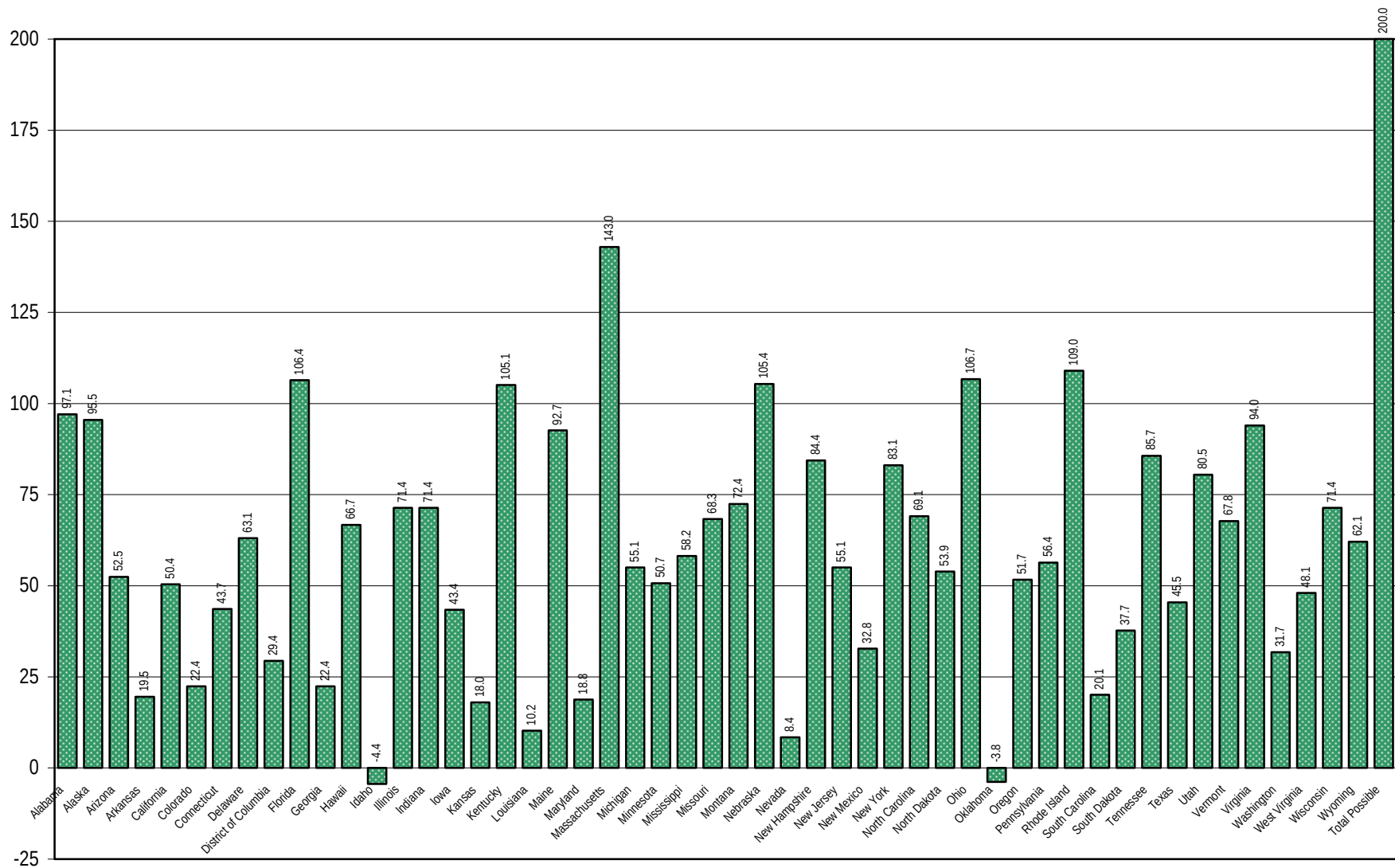
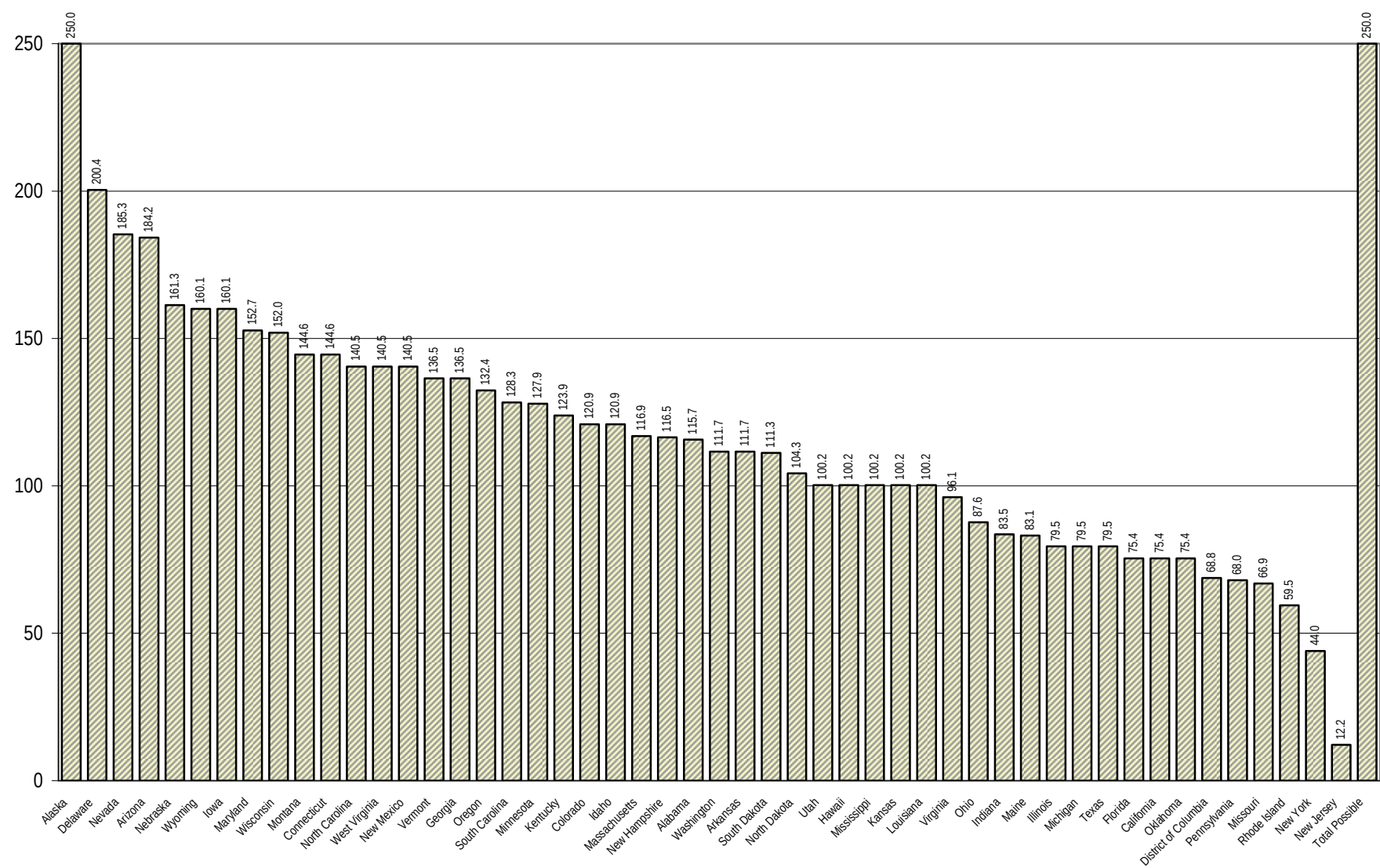
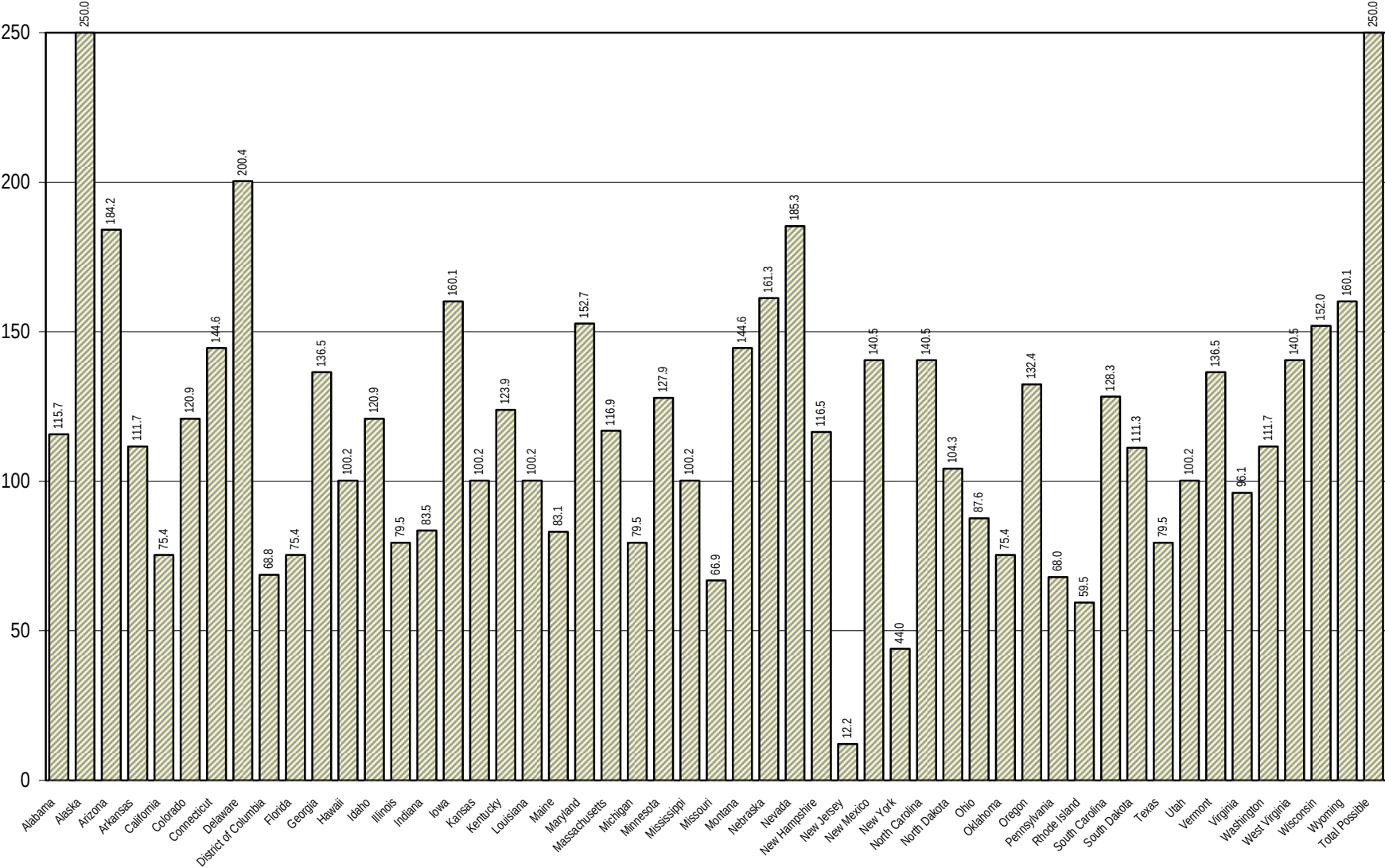


Figure 9. Ranking of state Medicaid programs, total points scored in reimbursement*



*TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

Figure 10. State Medicaid program scores in reimbursement, by state in alphabetical order*



*TennCare does not pay its providers by fee-for-service, so Tennessee does not have reimbursement indicators that are comparable to the rest of the nation. The state thus lacks a reimbursement score and an overall score.

VIII. State-by-State Reports

Individual state reports are presented in alphabetical order starting on the following page.

Alabama

Overall Score:*	376.3 37.6% of 1000 points
Scores by Category:	
Eligibility	91.6 26.2% of 350 points
Scope of Services	71.9 36.0% of 200 points
Quality of Care	97.1 48.6% of 200 points
Reimbursement	115.7 46.3% of 250 points
Overall Rank:	42

Alabama's Medicaid program ranks 42nd overall, brought down by its placement among the bottom three states in two of the four categories, eligibility and scope of services. These two categories are both affected by the state's failure to cover those who are made poor by their extreme medical expenses, known as the medically needy.

In terms of **Eligibility**, Alabama ranks next-to-last; its score in that category is just 26.2 percent of the total possible points. This score reflects the state's exclusion of the medically needy, the state's tendency to cover only those with the mandated lowest income levels, its exclusion of tuberculosis patients, and eligibility restrictions in its State Children's Health Insurance Program (SCHIP). This poor showing in eligibility in Alabama means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria.

Alabama is also very deficient with respect to its **Scope of Services**, ranking 3rd from

the bottom (49th). This reflects the state's failure to cover a number of services, such as chiropractor services; dental services; occupational, physical, and speech therapy; dentures; hearing aids; diagnostic, screening and preventive services; personal care services; and private duty nursing. This poor showing in scope of services means that even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

In terms of **Quality of Care**, however, Alabama does better than most states. Although it ranks 7th in that category, a score of only 48.6 percent of possible points suggests that the state could still do a better job of monitoring the services it provides.

Given its limited population coverage and shallow service offerings, it is not surprising that Alabama's Medicaid payments per enrollee are low; indeed, the state ranks close to the bottom in this indicator. However, Alabama pays its Medicaid physicians more than the national average, and has adjusted its fee schedule to provide incentives for given services (e.g., obstetric care). The state also reimburses providers in rural areas at a higher rate. The combined effect of these measures is reflected in its **Reimbursement** scores, in which Alabama occupies a middle rung (ranking 25th).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Alaska

Overall Score:*	609.9 61.0% of 1000 points
Scores by Category:	
Eligibility	159.3 45.5% of 350 points
Scope of Services	105.1 52.6% of 200 points
Quality of Care	95.5 47.8% of 200 points
Reimbursement	250.0 100% of 250 points
Overall Rank:	4

Alaska receives a total score of 609.9, for an overall ranking of 4th. This final score, however, masks much divergence in the different categories. More than most other states, Alaska's scores are very uneven; the Medicaid program receives two high scores and two low scores in the four categories.

The state limits its coverage to the categorically needy, thus losing points in both eligibility and scope of services. In the **Eligibility** category, the state receives only 45.5 percent of the possible number of points. In addition to excluding the medically needy, Alaska does not cover State Children's Health Insurance Program (SCHIP) parents, and research has shown that coverage of parents enhances access to care for their children. These exclusions cost the program points, and the state ranks 33rd in this category.

Similarly, Alaska's Medicaid program is deficient in terms of its **Scope of Services**, where it earns only 52.6 percent of the maximum value and also ranks 33rd. In most cases, this reflects coverage limitations rather than outright exclusions.

In the area of **Quality of Care**, Alaska receives less than half the maximum possible score. Nevertheless, because almost all states are deficient in this area, Alaska ranks 8th.

Alaska's location, climate, and sparse population present unique challenges to service providers. Transportation to health care assumes great importance, and the state of Alaska has contracted with air carriers to transport Medicaid recipients to services in other communities, including other states and Canada. In addition, the state pays markedly higher fees to its health providers as incentives to recruit and retain them.

As a result, Alaska occupies the top rank in the **Reimbursement** category. Indeed, it has the distinction of being the only state which gets the maximum score in any of the four categories assessed. At present, Alaska is one of 10 states whose Medicaid fees are more than 125 percent the national average; Alaska's overall fees are 228 percent higher than the national average, and are particularly high for primary care (250 percent). Additionally, by raising the fees it pays primary providers, Alaska has more than closed the gap between its Medicaid and Medicare fees. The Medicaid-to-Medicare fee index is 1.37, in contrast to the inequitable national index (.69).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Arizona

Overall Score:*	474.5[†] 47.5% of 1000 points
Scores by Category:	
Eligibility	95.5 27.3% of 350 points
Scope of Services	142.5 71.3% of 200 points
Quality of Care	52.5 26.3% of 200 points
Reimbursement	184.2 73.7% of 250 points
Overall Rank:	24

The last state to begin its Medicaid program, Arizona presents some difficulties in nationwide comparisons. Nevertheless, we obtained state-specific data to supplement the information in national databases, and were able to assess the state in terms of all indicators. Arizona currently ranks 24th in terms of the four categories examined.

Arizona's Medicaid program operates under a 1115 Waiver, which allows the state to have a managed care system through which all Medicaid members enroll in a contracted health plan. The state's Medicaid program, which is known as the Arizona Health Care Cost Containment System (AHCCCS), pays each of eight plans a set fee per member per month. Each plan therefore assumes the financial risk of providing all covered services for its enrolled Medicaid beneficiaries.

In addition to its prepaid per capita payments, AHCCCS has adopted a number of mechanisms to control costs since it was enacted in 1981. These mechanisms

include the use of primary care physicians as gatekeepers, competitive bidding processes, cost-sharing, and limitations on freedom of choice.

In terms of **Eligibility**, Arizona ranks 48th (4th from the bottom) and this is a major reason why its overall score is not higher. Its low score in this category is explained by the state's low Federal Poverty Level caps, which exclude those with slightly higher incomes even though many other states provide such coverage. Moreover, the state does not cover certain categories, such as tuberculosis patients or the medically needy (those who have too much income to qualify but also have very high medical expenses) that many other states cover. This poor showing in eligibility in Arizona means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria.

With respect to **Scope of Services**, Arizona ranks a respectable 8th in the nation, which suggests that it at least provides a relatively comprehensive array of services to the selected populations that meet the state's overly-stringent eligibility policies.

Quality of Care, in which Arizona occupies the 30th rank, is clearly a deficient area. Indicators related to nursing homes were primarily responsible for the state's poor showing in this category. In addition, the state has a poor record in childhood immunization.

The state's overall rank is clearly raised by its **Reimbursement** indicators. In this category, Arizona ranks 4th. This is entirely the result of its policies to make Medicaid competitive with other payers, which have allowed the state to pay its providers not only higher fees than the national average but also very close

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The four category scores may not add up to the overall score due to the rounding of numbers.

to what Medicare providers receive, even though most states pay their Medicaid providers significantly less.

Arkansas

Overall Score:*	415.7[†] 41.6% of 1000 points
Scores by Category:	
Eligibility	190.0 54.3% of 350 points
Scope of Services	94.4 47.2% of 200 points
Quality of Care	19.5 9.8% of 200 points
Reimbursement	111.7 44.7% of 250 points
Overall Rank:	38

Arkansas's Medicaid program scores range widely by category. The state ranks among the bottom 10 in two of the categories assessed.

In terms of **Eligibility**, Arkansas ranks 23rd. Despite its extension of coverage to those whose higher-than-standard incomes are offset by extreme medical expenses (the medically needy), it has stringent requirements for coverage, which cost it points in the final score. While the state has a Medicaid waiver to create a "Safety Net Benefits Program" to cover uninsured workers, it is not at all clear that this will expand eligibility significantly. Because the plan has limited benefits and includes deductibles and cost-sharing, its attractiveness to employees is still untested. Moreover, the plan is optional rather than mandated for employers, who must meet specific guidelines to participate.

The score for **Scope of Services** reflects the fact that the state has significant gaps, particularly with respect to rehabilitation

services, which are not covered. Other uncovered care includes services provided by psychologists; dental care; and diagnostic, screening, and preventive services. As a result, its final score is 47.2 percent of the total in this category (ranking 43rd). This poor showing in scope of services means that even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

With respect to **Quality of Care**, the state occupies a low rung, being ranked 45th, or 7th from the bottom. This is accounted for by the low quality of its nursing home services and its poor showing in terms of health outcomes, such as childhood immunizations and mental health care.

In the **Reimbursement** category, Arkansas is ranked in the middle (26th). It spends fewer dollars per enrollee in its Medicaid program than do most states, but pays its physicians slightly more than the national average. It has also maintained near-parity with Medicare fees, thus avoiding the reimbursement gap that afflicts most states.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The four category scores may not add up to the overall score due to the rounding of numbers.

California

Overall Score:*	525.7 52.6% of 1000 points
Scores by Category:	
Eligibility	258.9 74.0% of 350 points
Scope of Services	141.0 70.5% of 200 points
Quality of Care	50.4 25.2% of 200 points
Reimbursement	75.4 30.2% of 250 points
Overall Rank:	14

Medi-Cal, California's Medicaid program, is in transition as the state looks to expand coverage to children and the uninsured. With one-fifth of the population currently uncovered—a higher proportion than most other states—health has become a top political priority in the state, and California is proposing to extend near-universal coverage to its inhabitants.

At present, Medi-Cal covers the medically needy as well as the categorically needy, and has a relatively liberal threshold for eligibility (i.e., is more generous) for the latter. As a result, the state program ranks 5th in **Eligibility**.

The score for **Scope of Services** represents 70.5 percent of the maximum total; the state ranks 10th in this category. Its comprehensive offerings in women's services, rehabilitation services, and transportation contribute to its rank in this category.

The state's overall score is pulled down by California's poor showing in the remaining two categories. In **Quality of Care**, Medi-Cal

ranks 33rd, largely as a result of its poor performance in monitoring the quality of nursing home care. Additionally, the state has a low rate of childhood immunization.

The state also earns low scores in **Reimbursement**. In fact, it ranks 42nd in this category. California pays little to cover its different demographic groups, and is similarly miserly towards its providers. Medi-Cal not only pays its Medicaid providers less than the average for the nation, it also pays them significantly less than it does their Medicare counterparts. It is therefore not surprising that Medi-Cal's low reimbursement rates have long been a source of acrimony and political debate. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Colorado

Overall Score:*	375.7 37.6% of 1000 points
Scores by Category:	
Eligibility	131.8 37.7% of 350 points
Scope of Services	100.6 50.3% of 200 points
Quality of Care	22.4 11.2% of 200 points
Reimbursement	120.9 48.4% of 250 points
Overall Rank:	43

Colorado ranks 43rd overall and places in the bottom quarter of all categories except one.

The Medicaid program does not cover those who are poor because of high medical bills, known as the medically needy. Moreover, in most cases it restricts coverage to only the poorest segments of the population, excluding many who cannot afford private insurance. These factors contribute heavily to its low rank within **Eligibility**, where it places 41st.

Its low rank, #40, under **Scope of Services** reflects the exclusion of the medically needy as well as certain gaps and limitations. The state's Medicaid program also excludes a number of services, such as dental care; psychologists' services; dentures; hearing aids; and personal care services. In addition, many services have co-pays or other limitations, features that also deduct points from their scores.

In the area of **Quality of Care**, in which it ranks 42nd, the state gets negative points for its deficiencies in nursing home care. In

addition, the state has a poor record in childhood immunization.

Reimbursement is the one category in which Colorado occupies a middle rank (#21) rather than placing in the bottom quarter. The state has a slightly higher-than-national Medicaid fee index, indicating that it pays its providers similarly to the rest of the country. Nevertheless, Colorado pays its Medicaid providers less than their Medicare counterparts within the state, the Medicaid-to-Medicare fee index being .74 for all services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Connecticut

Overall Score:*	505.8[†] 50.6% of 1000 points
Scores by Category:	
Eligibility	218.7 62.5% of 350 points
Scope of Services	98.9 49.5% of 200 points
Quality of Care	43.7 21.9% of 200 points
Reimbursement	144.6 57.8% of 250 points
Overall Rank:	19

With an overall rank of 19th, Connecticut's Medicaid program varies noticeably in how it places by category.

In terms of **Eligibility**, Connecticut covers the medically needy as well as the categorically needy. But it has modest levels of Federal Poverty Level limits for the categorically needy, thus excluding some segments of the population covered by other states. It also excludes State Children's Health Insurance Program (SCHIP) parents, and research has shown that children's access to care is enhanced when their parents are also covered. It ranks 14th in this category.

The score for **Scope of Services** represents half of the total possible points in this category, and the state ranks a poor 42nd in this category. Connecticut has practically no co-payments, but offers a limited package. The state Medicaid program excludes a number of services, i.e., care provided by freestanding ambulatory surgery centers; mental health and substance abuse rehabilitation services;

services provided by nurse anesthetists, chiropractors, and podiatrists; rehabilitation services (physical therapy, occupational therapy, speech/hearing/language therapy); and eyeglasses. Yet another gap concerns community-based care: hospice care, personal care services, and private duty nursing are all excluded. This poor showing in scope of services means that even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

Connecticut scores poorly in the **Quality of Care** category, largely because of significant deficiencies reflected in the indicators for nursing home care. It ranks 36th in this category.

In the **Reimbursement** category, Connecticut ranks 10th. Although it spends a fair amount of money per enrollee, its scores suggest that it is not obtaining value for money in terms of overall coverage and performance. While its Medicaid fee index is higher than the national level, this is offset in part by the gap between its Medicaid and Medicare fees (the ratio is .83), which is further accentuated in the area of primary care (.74).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The four category scores may not add up to the overall score due to the rounding of numbers.

Delaware

Overall Score:*	476.8 47.7% of 1000 points
Scores by Category:	
Eligibility	127.1 36.6% of 350 points
Scope of Services	86.2 43.1% of 200 points
Quality of Care	63.1 31.6% of 200 points
Reimbursement	200.4 80.2% of 250 points
Overall Rank:	22

Delaware's Medicaid program shows wide variation from one category to another, with individual scores ranging across ranks from #2 to #45. It ranks among the bottom 10 in two of the four categories.

Because in many cases Delaware limits its coverage to the minimum income levels required by law (e.g., children with incomes at or below 133 percent of the Federal Poverty Level), it ranks 43rd in terms of **Eligibility**. Its score is only 36.6 percent of the possible maximum value in this category. This poor showing in eligibility in Delaware means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria.

The score for **Scope of Services** is affected by some of these restrictions, and is also very low: 45th. Delaware's Medicaid program excludes services provided by certain providers (chiropractors, nurse anesthetists, dentists, psychologists); certain products and devices (dentures, eyeglasses, hearing aids); diagnostic,

screening, and preventive services; targeted case management; and personal care services. Each of these exclusions results in deducted points, adding up to a score of 43.1 percent of the total possible. This poor showing in scope of services means that, even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

With respect to **Quality of Care**, Delaware ranks 23rd. It is hurt by mediocre scores across the board, and by its especially poor performance in nursing home care, where it earns negative points.

The state fares well in the **Reimbursement** category, where it ranks 2nd overall. This is accounted for by its higher-than-average physician fee index, particularly in primary care. Furthermore, unlike most other states, Delaware pays its Medicaid providers higher fees than those paid by Medicare. The state's Medicaid-to-Medicare fee index is 1.01, in contrast to the inequitable national index (.69).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

District of Columbia

Overall Score:*	462.9[†] 46.3% of 1000 points
Scores by Category:	
Eligibility	248.5 71.0% of 350 points
Scope of Services	116.3 58.2% of 200 points
Quality of Care	29.4 14.7% of 200 points
Reimbursement	68.8 27.5% of 250 points
Overall Rank:	27

The Medicaid program is particularly important in the District of Columbia because this is the jurisdiction with one of the highest proportions of program enrollees: more than one in five (21.2 percent) of the population is covered by Medicaid.

The District of Columbia shows wide differences in scores by category, with ranks ranging from 7th to 45th.

The District of Columbia ranks 7th in **Eligibility**, the only category in which it appears among the “Top 10” nationally. This reflects in part the District’s relative generosity in covering vulnerable groups, including childless adults with incomes at or below 50 percent of the Federal Poverty Level, and those who spend an inordinate amount of their income on medical care.

The District ranks 27th in the **Scope of Services** category. Although DC covers a wide range of services without imposing barriers or deterrents, it fails to cover

services provided by certain types of practitioners (e.g., dentists, nurse anesthetists, chiropractors, psychologists). It also excludes rehabilitation services, such as occupational therapy and services for speech, hearing, and language disorders.

With respect to **Quality of Care**, DC ranks 41st. Its score represents less than 15 percent of the total possible number of points, largely because of the points deducted for deficiencies in nursing home care. A recent District Inspector General report emphasized the need for greater use of home care services, a change that would decrease the total number of nursing home residents. This would reduce nursing home care costs and could improve nursing home care by increasing the number of nursing care hours per resident for the institutionalized.

The District has adopted performance measures to assess health outcomes under different Medicaid initiatives, a step that should improve quality of care.

In the **Reimbursement** category, DC receives a very low score, placing it 45th nationally. It not only pays its Medicaid providers less than the national average (i.e., the Medicaid fee index is .78), it also pays them a fraction of what Medicare providers receive, the Medicaid-to-Medicare fee index being a meager .52. This differential is exacerbated in the area of primary care, where Medicaid providers get paid 35 cents for every dollar that Medicare providers receive for comparable service. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

* For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The four category scores may not add up to the overall score due to the rounding of numbers.

Florida

Overall Score:*	467.7 46.8% of 1000 points
Scores by Category:	
Eligibility	182.4 52.1% of 350 points
Scope of Services	103.5 51.8% of 200 points
Quality of Care	106.4 53.2% of 200 points
Reimbursement	75.4 30.2% of 250 points
Overall Rank:	26

Florida's Medicaid program is 4th in enrollment numbers and 5th in spending, and the state is under pressure to control both. In 2005 Florida received a Section 1115 waiver which allows the state to waive compliance with many requirements of the Medicaid statute. Through this provision, Florida is piloting a new approach in two counties: it is testing a defined-contribution program in which the state allots each enrollee a set premium rather than a given benefits package. Enrollees are thus allowed to choose among different coverage options, and are at risk for payments beyond the set contribution. Beneficiaries are also able to opt out of Medicaid and use their premiums to obtain other coverage. The data and scores included here, however, reflect the situation prior to the change, which is still evolving and far from statewide as this is written.

In terms of **Eligibility**, Florida earns points by covering individuals that have very high medical expenses but would otherwise have too much income to qualify. But it loses points for its restricted definition of who constitute the poor, with low Federal Poverty Levels required for some

populations. As a result, the state earns a rank of 27th in this area.

The score for **Scope of Services** is only 51.8 percent of the total maximum, placing Florida in 35th place nationally. This poor showing reflects the state's non-coverage of a number of services, including dental care and rehabilitation services. The current waiver gives plans new authority to determine the amount, scope, and duration of almost all benefits (including those previously mandated), and plans may therefore have an incentive to stint on care.

In terms of **Quality of Care**, however, Florida ranks 4th. With a population that is disproportionately elderly, the state has a creditable track record in monitoring nursing home care, and this is reflected in its quality of care indicators.

In the **Reimbursement** category, Florida ranks 42nd. Although it has a Medicaid fee index of .95, thus paying providers close to the national average, its Medicaid fees lag far behind those paid to Medicare providers. The Medicaid-to-Medicare fee index is only .65, lower than the national one (.69). The gap is exacerbated for primary care (.60). Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Georgia

Overall Score:*	426.1 42.6% of 1000 points
Scores by Category:	
Eligibility	190.9 54.5% of 350 points
Scope of Services	76.3 38.2% of 200 points
Quality of Care	22.4 11.2% of 200 points
Reimbursement	136.5 54.6% of 250 points
Overall Rank:	36

Georgia covers those whose higher-than-standard income is offset by inordinate medical bills, and therefore gets additional points for both eligibility and scope of services. These points are not enough to compensate for deficiencies in other areas, though. Georgia ranks in the bottom 10 for two of the four categories, which contributes to its overall rank of #36.

Georgia's Medicaid program provides services only to the very poor in most cases, leaving slightly higher-income individuals without coverage. This is reflected in its mediocre rank of 22nd in **Eligibility**. In 2006 Georgia enacted rules requiring beneficiaries to provide proof of income and citizenship, thereby more stringently enforcing eligibility requirements. As a result, 5.3 percent of the state's Medicaid beneficiaries lost benefits, a fact that is not reflected in the current scores.

The score for **Scope of Services** is only 38.2 percent of the total maximum, and Georgia ranks 4th from the bottom (#48) in this category. The state excludes many services

from coverage such as services provided by nurse anesthetists, chiropractors, and psychologists; physical therapy and other rehabilitation services; dentures; hearing aids; some home health services, e.g., personal care, private duty nursing; and certain types of institutional care for those under 21 or over 65. This poor showing in scope of services means that even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

With respect to **Quality of Care**, the state Medicaid program ranks 42nd, largely by accruing negative points in nursing home care.

In the **Reimbursement** category, the state is hurt by its low per person expenditures on children and the elderly. But the state pays its Medicaid providers more than the national average, although less than their Medicare counterparts earn. The Medicaid-to-Medicare fee index for Georgia is .81, somewhat higher than the national index (.69). Georgia ranks #15 in this category.

* For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Hawaii

Overall Score:*	547.1[†] 54.7% of 1000 points
Scores by Category:	
Eligibility	245.0 70.0% of 350 points
Scope of Services	135.1 67.6% of 200 points
Quality of Care	66.7 33.4% of 200 points
Reimbursement	100.2 40.1% of 250 points
Overall Rank:	11

In the **Reimbursement** category, the state ranks very low relative to its overall score: it is 30th, because its higher-than-average payments to Medicaid providers are nevertheless lower than comparable Medicare fees.

Hawaii's overall rank masks wide disparities in how its Medicaid program ranks in terms of the different categories.

In terms of **Eligibility**, the state ranks 10th. It not only covers the medically needy in addition to the categorically needy, but it also has generous definitions for who qualifies in terms of the Federal Poverty Level.

The score for **Scope of Services** is 67.6 percent of the total number of points, giving the state a rank of 16th in this category. The state does not cover certain provider-specific services (e.g., nurse anesthetists, chiropractors); dentures; personal care services and private duty nursing; and institutional care for those 65 and over suffering from mental illness.

With respect to **Quality of Care**, Hawaii occupies the 22nd rank, largely because of a mediocre showing in terms of nursing home care and low childhood immunization rates.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Idaho

Overall Score:*	325.2 32.5% of 1000 points
Scores by Category:	
Eligibility	117.1 33.5% of 350 points
Scope of Services	91.6 45.8% of 200 points
Quality of Care	-4.4 None of 200 points
Reimbursement	120.9 48.4% of 250 points
Overall Rank:	49

Idaho's Medicaid program ranks next-to-last in its overall score, and is among the bottom 10 states in three of the four individual categories.

In terms of **Eligibility**, Idaho's Medicaid program ranks 44th. It loses points for its failure to cover those who are poor as a result of high medical expenses, the medically needy. Moreover, Idaho restricts its coverage of pregnant women to the lowest mandated poverty level, and does not cover other populations (e.g., tuberculosis patients, parents of children who are covered by SCHIP, the State Children's Health Insurance Program). This poor showing in eligibility in Idaho means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria.

The score for **Scope of Services** is 45.8 percent of the maximum, and Idaho ranks 44th in this category. In addition to losing points for not covering the medically needy, the state is penalized for imposing

restrictions and limitations on most services. This poor showing in scope of services means that, even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

In the area of **Quality of Care**, Idaho has the dubious distinction of occupying the lowest rung, #51. It is one of only two states to lack a Medicaid Fraud Control Unit. Moreover, it has serious deficiencies in nursing home care, earning it a negative score in two indicators.

The **Reimbursement** category is the only one in which the state scores in the top half, ranking #21. It treats its Medicaid providers rather equitably vis-à-vis their Medicare counterparts.

Given its dismal track record to date, it is therefore not surprising that the state is currently in the process of drastically modifying its Medicaid program. Changes approved in mid-2006 modify practically all key aspects of the state's program. The more than 50 Medicaid eligibility categories and the array of services have been reduced to three benefit packages designed to meet the needs of different groups. The Benchmark Basic program is for low-income health children and adults. The Enhanced Benchmark program covers the elderly and those with disabilities or special needs, and will include long-term and institutional care. A third program is for the "dual eligibles," those covered by both Medicaid and Medicare.

To determine who belongs in which program, the state will conduct health risk assessments of all enrollees. Other changes include the imposition of co-payments, a pay-for-performance program in community health centers, incentives to promote private

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

financing options, and personal “health accounts” through which participants get credit for practicing good health behaviors. We are skeptical as to whether these new measures will meet their goals without forcing the most needy to forgo services.

Illinois

Overall Score:*	439.6 44.0% of 1000 points
Scores by Category:	
Eligibility	143.6 41.0% of 350 points
Scope of Services	145.1 72.6% of 200 points
Quality of Care	71.4 35.7% of 200 points
Reimbursement	79.5 31.8% of 250 points
Overall Rank:	32

Like other states, Illinois's Medicaid program has opted to expand the scope of its services, trading off some other aspects of the program, including the population covered.

Although the state provides coverage to those whose higher-than-standard income is offset by inordinate medical costs (i.e., the medically needy, a group sometimes excluded from coverage by other states), it gets only 41 percent of the maximum value and ranks 36th in **Eligibility** because in most cases it restricts services to those at the lowest poverty levels. Still, the program covers State Children's Health Insurance Program (SCHIP) parents, a measure that has been found to enhance access of services to children.

The score for **Scope of Services** is markedly higher, giving the state 72.6 percent of the total maximum in the category and earning Illinois a "Top 10" spot in this category. The state ranks 5th in this area, because it has few exclusions and covers the medically needy as well.

The state also does relatively well in terms of **Quality of Care**, ranking 16th in this area. Illinois does better than the national average in terms of nursing home care, its indicators in this subcategory contributing to its favorable rank.

In the **Reimbursement** category, the state ties with two other states for the 39th rank. It spends less on Medicaid services per person than the national average, especially in services to the elderly. Moreover, it pays its Medicaid providers less than the mean for the nation overall, and has a significant gap between what it pays its Medicaid providers and what it pays Medicare doctors. The Medicaid-to-Medicare fee index is .63 (versus .69 nationally) and is particularly low with respect to primary care, where it is a meager .54.

* For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Indiana

Overall Score:*	357.2[†] 35.7% of 1000 points
Scores by Category:	
Eligibility	90.6 25.9% of 350 points
Scope of Services	111.6 55.8% of 200 points
Quality of Care	71.4 36.0% of 200 points
Reimbursement	83.5 33.4% of 250 points
Overall Rank:	45

Indiana shows great fluctuations in its Medicaid program scores from one category to another. While it ranks 45th overall, its rankings by category range from 16th to 51st.

The state Medicaid program excludes those made poor by extreme medical expenses, the medically needy, and therefore loses points in **Eligibility**. In addition, Indiana has very low cut-offs in terms of poverty level, thereby restricting services to only the neediest. These and other limitations deduct points from the score, leaving Indiana in the bottom rank (51st) in this category. This poor showing in eligibility in Indiana means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria. Because this is the category with the highest relative value, this score strongly reduces the state's overall score as well.

The score for **Scope of Services** is

55.8 percent of the total in that category, placing Indiana 31st nationally. While the state excludes few services, and women's services is the only subcategory that receives less than half of the total possible points, the state's Medicaid program imposes co-pays and other limitations which deduct points from the total.

Interestingly, although **Quality of Care** is the category in which otherwise comprehensive and inclusive state Medicaid programs fall short, this is where Indiana's Medicaid program fares best, earning a rank of 16th. The state gets points for its nursing home indicators, and these are consistent with its other scores in that category.

In the **Reimbursement** category, Indiana occupies the 37th rank.

The state loses points for mediocre expenditures per enrollee, and sub-par payment of Medicaid providers, specifically for gynecological services. In addition, Indiana's Medicaid-to-Medicare fee index is .68, indicating that Medicaid providers earn significantly less than their Medicare counterparts. This in turn restricts access to care, reducing the number of providers that accept Medicaid patients.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Iowa

Overall Score:*	510.2 51.0% of 1000 points
Scores by Category:	
Eligibility	186.0 53.1% of 350 points
Scope of Services	120.7 60.4% of 200 points
Quality of Care	43.4 21.7% of 200 points
Reimbursement	160.1 64.0% of 250 points
Overall Rank:	17

The **Reimbursement** category is the only one in which Iowa's program places in the top 10, ranking #6. This reflects the state's commitment of resources to the program as well as its equitable payment of Medicaid providers. The state pays its Medicaid physicians more than the national average and close to parity with Medicare doctors, thus enhancing access to Medicaid beneficiaries.

While Iowa ranks #17 overall, its individual ranks by category range from 6th to 37th.

In terms of **Eligibility**, the state's Medicaid program ranks 25th. Although Iowa covers the medically needy as well as the mandated categorical groups, it imposes restrictions in terms of income levels for both groups and these cost the state points in this area.

Under **Scope of Services**, Iowa also ranks 25th. In this category it earns 60.4 percent of the total points. This reflects the state's lack of coverage of certain services, including diagnostic, screening, and preventive services; personal care services; and private duty nursing services. Moreover, some of the covered services have cost-sharing and coverage limitations that deduct points from their final scores.

Like many other Medicaid programs, Iowa's is deficient in monitoring the **Quality of Care** and earns a rank of #37. Nursing home deficiencies and low childhood immunization rates cost the state points here, lowering the score in this category.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Kansas

Overall Score:*	432.4 <i>43.2% of 1000 points</i>
Scores by Category:	
Eligibility	183.0 <i>52.3% of 350 points</i>
Scope of Services	131.2 <i>65.6% of 200 points</i>
Quality of Care	18.0 <i>9.0% of 200 points</i>
Reimbursement	100.2 <i>40.1% of 250 points</i>
Overall Rank:	35

Kansas ranks in the bottom half in three of the four categories assessed.

The state's Medicaid program places 26th in terms of **Eligibility**. While the state covers those whose higher-than-standard income is offset by extreme medical costs, an option that earns the program extra points, it has stringent income requirements in terms of Federal Poverty Levels that restrict the number of potential beneficiaries. Additionally, the state's Medicaid program lost more than six percent of its enrollees in 2006, when the state enacted a new requirement requiring applicants to provide proof of citizenship.

The score for **Scope of Services** represents 65.6 percent of the maximum value and places Kansas in 19th place in that category. The Medicaid program covers practically all services, with the exception of a few such as diagnostic, screening, and preventive services, and private duty nursing. Nevertheless, the state is hurt by its reliance on enrollee co-payments and the imposition of other limitations.

Moreover, it loses points for its restrictions on women's services.

Kansas' final score is significantly lowered by its deficiencies in **Quality of Care**, where it ranks 47th. This low placement is largely attributable to Kansas' inadequate staffing patterns and other deficiencies in nursing home care.

In the **Reimbursement** category, Kansas' program ranks 30th for its limited per capita investment in children and its low payments to primary care providers. The Medicaid-to-Medicare fee index is only .63 in primary care.

* For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Kentucky

Overall Score:*	496.6 49.7% of 1000 points
Scores by Category:	
Eligibility	162.8 46.5% of 350 points
Scope of Services	104.8 52.4% of 200 points
Quality of Care	105.1 52.5% of 200 points
Reimbursement	123.9 49.6% of 250 points
Overall Rank:	20

Like several other states, Kentucky is in the process of adopting a number of changes aimed at improving health status and controlling costs. Its Medicaid program is currently in transition toward a system that will enroll most of its current Medicaid population into four targeted benefit plans, each of which has different eligibility requirements, service packages, and benefit limitations.

The new program, parts of which began in June 2006, imposes new cost-sharing requirements on most beneficiaries. It also stresses healthy behaviors and includes incentives that “reward” those who adhere to a disease management program. Because these measures are still in the process of being implemented, our scores do not reflect the effect of these changes, some of which may restrict access to care through the imposition of co-payments.

Kentucky’s Medicaid program ranks 20th overall but shows great variability in its ranks by category. In terms of **Eligibility**, the program ranks 30th, largely because of its stringent income restrictions for some

beneficiaries and its limitations in the State Children’s Health Insurance Program (SCHIP), which is designed to provide coverage for children whose parents do not qualify for Medicaid but cannot afford private health insurance.

The score for **Scope of Services** is 52.4 percent of the total value, placing Kentucky in the 34th rank. The state gains points by extending coverage to individuals that have very high medical expenses but would otherwise have too much income to qualify. However, it imposes some limitations to all eligible groups and excludes certain services altogether. The latter include psychologist services, rehabilitation services, products and devices, personal care services, and private duty nursing services. The state has points deducted primarily in three subcategories: women’s services, devices and appliances, and rehabilitation services.

The state, however, is among the top 10 scorers in the **Quality of Care** category. Kentucky’s program ranks 6th nationally, largely because of its creditable performance in staffing its nursing homes.

In the **Reimbursement** category, Kentucky’s rank, 20th, mirrors its overall position. While the state’s Medicaid fees are close to the national average, the Medicaid-to-Medicare fee index is .76, indicating a gap that costs the state points in its score.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Louisiana

Overall Score:*	457.3 45.7% of 1000 points
Scores by Category:	
Eligibility	228.7 65.3% of 350 points
Scope of Services	118.2 59.1% of 200 points
Quality of Care	10.2 5.1% of 200 points
Reimbursement	100.2 40.1% of 250 points
Overall Rank:	28

Louisiana's Medicaid program was severely tested following hurricanes Katrina and Rita, which devastated great swaths of the coastal areas and displaced hundreds of thousands of persons, many of whom were vulnerable and in need of health care. The hurricanes also destroyed part of the state's medical infrastructure, especially in New Orleans, leading to the closure of several hospitals and the relocation of many health providers, including more than 3,000 physicians.

Given the breadth and depth of this upheaval, it is not surprising that an already frayed health safety net was unable to meet the needs of the many who were left without homes, jobs, or access to their usual sources of care. Although a Medicaid waiver gave hurricane survivors temporary coverage in other states, and federal funds were appropriated to cover needy populations and reimburse providers for uncompensated care costs, these were stopgap measures rather than long-term solutions to a dire situation.

Many months after the storms, Louisiana continues to rebuild its health care system,

seeking to restore access to care at the same time that it improves the network of services with an emphasis on primary care and more extensive insurance coverage. The following scores thus reflect a situation and a population that is in a state of flux and facing major changes over the next years.

In terms of **Eligibility**, Louisiana ranks relatively high, #11, and receives 65.3 percent of the total value. This can be attributed to the state's generous thresholds of eligibility for most categories, and its extension of coverage to the medically needy, which are individuals who have both a higher income than traditional Medicaid recipients and inordinately high medical expenses.

Louisiana's category-specific scores are lower in the other areas. The state ranks #26 in **Scope of Services**. Although the state covers most services, it imposes limitations in terms of amount, duration, frequency, or type of service in many areas. Moreover, it does not cover some services at all, such as physical or occupational therapy, some devices (eyeglasses, hearing aids), or private duty nursing.

Quality of Care is by far the most deficient area. Here, Louisiana ranks 48th, a score that significantly lowers its overall rank. This reflects the state's dismal performance in monitoring its nursing home services as well as the state's poor rate of childhood immunizations.

In the **Reimbursement** category, Louisiana ranks 29th. It is close to the national average both in payment to Medicaid providers and in how Medicaid fees compare to those paid to Medicare providers.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Maine

Overall Score:*	528.4 52.8% of 1000 points
Scores by Category:	
Eligibility	210.0 60.0% of 350 points
Scope of Services	142.6 71.3% of 200 points
Quality of Care	92.7 46.4% of 200 points
Reimbursement	83.1 33.2% of 250 points
Overall Rank:	13

Maine's Medicaid program covers 29 percent of the state's population and accounts for 27 percent of the state's budget. Although it ranks among the "Top 10" in two of the four categories, the program falls significantly short in a third category.

In terms of **Eligibility**, the state ranks 18th with 60 percent of the maximum value for this category. Maine's Medicaid program covers both the categorically and the medically needy and has generous limits in terms of income levels, but loses points for its failure to cover tuberculosis patients and for some limitations in its State Children's Health Insurance Program (SCHIP) program. It does not cover SCHIP parents, and research has shown that such coverage enhances access to care for their children.

Maine ranks a respectable 7th in the **Scope of Services** category. It covers almost all optional services, imposing only minor limitations, if any.

With respect to **Quality of Care**, the state ranks 10th. Its placement among the top 10 is the result of its success in providing nursing home residents adequate nursing hours.

But Maine's Medicaid program is sorely wanting in the **Reimbursement** category, in which it ranks 38th. Physician payment is deficient in all areas of care, and the state pays its providers at some of the lowest rates in the nation. The Medicaid-to-Medicare fee index is .65, and is lower in the area of primary care (.54).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Maryland

Overall Score:*	523.3 52.3% of 1000 points
Scores by Category:	
Eligibility	226.4 64.7% of 350 points
Scope of Services	125.4 62.7% of 200 points
Quality of Care	18.8 9.4% of 200 points
Reimbursement	152.7 61.1% of 250 points
Overall Rank:	15

Following Massachusetts' lead, Maryland is studying the possibility of requiring residents to purchase health insurance. Under the proposed system, employers would pay most of the costs, and the state would subsidize low-income workers. While the contours and merits of the plan are being debated, a second proposal seeks to increase cigarette taxes, using the funds generated to expand Medicaid coverage to more low-income adults and to subsidize small businesses that cannot cover their employees.

At present, Maryland gets 64.7 percent of the total points and ranks 12th nationally in terms of **Eligibility**. The state's Medicaid program covers the medically needy, and has generous income limits in its coverage.

The score for **Scope of Services** is 62.7 percent of the total, placing Maryland 23rd nationally in this category. The state has apparently opted to cover more people for fewer services, which explains the disparity in rankings between the categories of eligibility and scope of services. Maryland covers no rehabilitation services

(occupational therapy, physical therapy, speech/hearing) or most devices (dentures, eyeglasses, hearing aids). These exclusions, together with limitations in the coverage of drugs, cost it points in coverage of services.

But it is in the area of **Quality of Care** that the state suffers the most. It lacks mandatory reporting requirements for medical errors, has a poor track record in monitoring the quality of nursing home care, and shows deficient performance in terms of health outcomes. It is therefore not surprising that the state ranks 46th in terms of quality of care.

In **Reimbursement**, the state ranks 8th. Maryland's Medicaid program spends 44.2 percent more per capita than the nation as a whole, and this difference is reflected in all the demographic groups it covers (particularly adults). Nevertheless, the state could reduce the gap between its Medicaid and Medicare fees. The Medicaid-to-Medicare fee index is .80, higher than the national index (.69) but still significant.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Massachusetts

Overall Score:*	645.9[†] 64.6% of 1000 points
Scores by Category:	
Eligibility	247.6 70.7% of 350 points
Scope of Services	138.5 69.3% of 200 points
Quality of Care	143.0 71.5% of 200 points
Reimbursement	116.9 46.8% of 250 points
Overall Rank:	1

Probably more than any other state, Massachusetts will be facing changes in its health delivery system in the coming months. In 2006 the state enacted legislation requiring that all residents purchase health insurance and most employers contribute or face penalties. The plan, which is scheduled to be in place by July 2007, has been hailed for not only addressing the issue of the uninsured, but for having secured strong bipartisan support. Enrollment in the plan began last October, and the process is being closely followed by other states seeking to make a dent in their rates of uninsured and provide more comprehensive coverage for their populations. In order to succeed, the plan must juggle adequate coverage and affordability in the available plans. We are skeptical that the state will be able to do this. Because it does not intend to set premiums, deductibles, or co-payments, Massachusetts may end up promoting options that provide only shallow coverage at affordable rates, or more comprehensive services that few can afford.

At present, although Massachusetts ranks #1 overall, its overall score is only 64.6 percent of the total 1000 points in our assessment protocol. The state is among the top 10 in two of the categories, but ranks #23 in a third.

The state ranks 8th in **Eligibility**. The state covers most categories of eligible populations, although it has lower federal poverty level cutoffs than other states for children and thus loses points in several indicators. The new legislation expands Medicaid coverage for state residents, and the Massachusetts plan has obtained a federal waiver which will also increase its federal funding for this purpose.

Massachusetts ranks #12 in **Scope of Services**. Although the state covers the medically needy and offers almost all services, one notable exclusion is diagnostic, screening, and preventive services.

Massachusetts ranks #1 nationally in **Quality of Care**, an outcome accomplishment that is in part a function of the inadequacies of other states. Nevertheless, the state does a creditable job in terms of monitoring structures and producing satisfactory health outcomes. But it still has room for improvement in upgrading its nursing home services.

Massachusetts receives its lowest rank in the **Reimbursement** category, where it places #23. Despite the state's reputation as a big spender and strong imposer of taxes, Massachusetts' Medicaid providers do not have parity with their Medicare counterparts. This could deter some providers from participating in the Medicaid program or opening their practices to new Medicaid beneficiaries.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Michigan

Overall Score:*	475.8[†] 47.6% of 1000 points
Scores by Category:	
Eligibility	217.0 62.0% of 350 points
Scope of Services	124.3 62.2% of 200 points
Quality of Care	55.1 27.6% of 200 points
Reimbursement	79.5 31.8% of 250 points
Overall Rank:	23

Unlike most states, Michigan's Medicaid program is consistently mediocre in its scores across categories, showing neither remarkable accomplishments nor serious lags compared to the rest of the states.

The state's highest rank is in the **Eligibility** category, in which it places 15th. Michigan covers individuals that have very high medical expenses but would otherwise have too much income to qualify. However, it has a relatively low Federal Poverty Level ceiling for children, leaving those with slightly higher income without coverage, and does not cover disease-specific groups—two exclusions that cost Michigan points.

The score for **Scope of Services** is 62.2 percent of the total value, placing the state in the 24th rank. Major exclusions are psychologist services, rehabilitation services (e.g., occupational therapy, physical therapy, speech/hearing therapy); dentures; and diagnostic, screening, and preventive services. In terms of subcategories, the state loses significant

points in women's services and rehabilitation.

With respect to **Quality of Care**, Michigan ties with New Jersey at #27. While it receives perfect scores in infant immunizations and childhood mental health care, two health outcomes that gauge quality, it does not have mandatory reporting requirements and is deficient in the quality of its nursing home services.

The state ranks the lowest in the **Reimbursement** category, where it places #39 (a rank it shares with Illinois and Texas). Michigan spends limited funds per child covered by Medicaid, and pays lower fees than the national average in gynecological and other services. Additionally, the state pays its Medicaid providers significantly less than their Medicare counterparts, the Medicaid-to-Medicare fee index being .62 overall.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Minnesota

Overall Score:*	591.2 <i>59.1% of 1000 points</i>
Scores by Category:	
Eligibility	254.5 <i>72.7% of 350 points</i>
Scope of Services	158.1 <i>79.1% of 200 points</i>
Quality of Care	50.7 <i>25.4% of 200 points</i>
Reimbursement	127.9 <i>51.2% of 250 points</i>
Overall Rank:	7

Minnesota ranks #7 overall. It earns “Top 10” ranks in two of the four categories, but has mediocre or poor showings in the other two.

In terms of **Eligibility**, Minnesota ranks 6th. It covers all groups and has adopted generous Federal Poverty Level thresholds for its populations. Moreover, it covers State Children’s Health Insurance Program (SCHIP) parents, a measure that has been found to enhance access to care for their children.

In the **Scope of Services** category, the state is surpassed only by New York. The #2 rank is earned by Minnesota’s generous Federal Poverty Levels for coverage, and its limited reliance on cost-sharing. Minnesota is one of four states that rank #1 in the subcategory of women’s services.

With respect to **Quality of Care**, Minnesota ranks a very disappointing #32. Although the state is a recognized leader in patient safety and has an impressive Adverse Health Events Reporting Law holding hospitals accountable for their actions,

apparently the same concern does not extend towards nursing home services, where the state’s indicators are clearly wanting.

In the **Reimbursement** category, Minnesota ranks 19th. This reflects the fact that it does not spend much per capita on children, and that it pays primary care providers significantly less than their Medicare counterparts receive.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Mississippi

Overall Score:*	317.8 31.8% of 1000 points
Scores by Category:	
Eligibility	92.6 26.5% of 350 points
Scope of Services	66.8 33.4% of 200 points
Quality of Care	58.2 29.1% of 200 points
Reimbursement	100.2 40.1% of 250 points
Overall Rank:	51

Twenty years ago, Mississippi ranked last among all the Medicaid programs. The passage of time and the hurricane gusts of Katrina, alas, have not benefited the state, which once again ranks last. In two of the categories which, combined, account for 55 percent of the total score, Mississippi's Medicaid program ranks among the bottom three.

The state ranks 49th in **Eligibility**. This reflects its restriction of services to those at the lowest mandated poverty level in most cases, leaving out many who cannot afford private health insurance, and its exclusion of those who are poor due to extreme health care costs, the medically needy. This poor showing in eligibility in Mississippi means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria.

The score for **Scope of Services** is the lowest in the nation and represents only 33.4 percent of the total value. This reflects not only the exclusion of some services

(e.g., psychologist services, dentures, hearing aids, prosthetic and orthotic devices, among others) but also the fact that the state has limitations in terms of amount, type, duration, and frequency of services, all of which cost points in the final score. The state scores particularly poorly in the subcategories of devices and equipment and rehabilitation. This poor showing in scope of services means that, even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

In the remaining two categories, Mississippi's Medicaid program fares considerably better.

In terms of **Quality of Care**, it ranks 25th. This reflects a better-than-average performance in staffing and monitoring nursing care, indicators in which many other state programs are quite deficient.

In the **Reimbursement** category, Mississippi is tied with four other states in the 30th rank. Despite its obvious deficiencies in covering a population in need, Mississippi does a creditable job in paying its providers in comparison with both national standards and their Medicare counterparts. Nevertheless, it loses points in this category because it provides low provider payments for gynecological services and spends less than average on care per enrollee.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Missouri

Overall Score:*	379.1 37.9% of 1000 points
Scores by Category:	
Eligibility	141.8 40.5% of 350 points
Scope of Services	102.1 51.1% of 200 points
Quality of Care	68.3 34.2% of 200 points
Reimbursement	66.9 26.8% of 250 points
Overall Rank:	41

Missouri is taking advantage of the fact that its Medicaid program is up for reauthorization this year to restructure its services, emphasizing prevention and personal responsibility. The recommendations that have emerged to date have been politically controversial, and are therefore likely to be heavily debated. As Missouri considers options to make a dent in the number of uninsured and how best to deliver services to its population, we hope the “Show Me” State will consider the deficiencies outlined in this report and how best to address them.

Missouri ranks 37th in the **Eligibility** category, which reflects the exclusion of the medically needy (those made poor due to high medical expenses) and limitations on extending services to the aged, blind, and disabled. Recent data not reflected in our report would probably exacerbate the state’s poor showing in this area, because some 100,000 beneficiaries were cut off from the program in 2005, when the governor cut Medicaid spending in order to avoid raising taxes.

The score for **Scope of Services** represents 51.1 percent of the maximum value. Missouri ranks 39th in this category. In addition to the exclusion of the medically needy, major service exclusions are: diagnostic, screening, and preventive services; private duty nursing; and non-emergency medical transportation.

In the **Quality of Care** category, Missouri achieved its best showing with a rank of 20th. Although this is in part attributable to the fact that many otherwise strong states score poorly in this area, thereby lowering the bar for everyone, Missouri does a better-than-average job of monitoring its services. Nevertheless, it does poorly in childhood immunizations.

In the **Reimbursement** category, Missouri ranks 47th. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services. Not surprisingly, one of the recommendations currently being reviewed as part of the proposal to restructure the program involves increasing the physician reimbursement rate.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Montana

Overall Score:*	512.5 51.3% of 1000 points
Scores by Category:	
Eligibility	159.7 45.6% of 350 points
Scope of Services	135.8 67.9% of 200 points
Quality of Care	72.4 36.2% of 200 points
Reimbursement	144.6 57.8% of 250 points
Overall Rank:	16

Montana's program also does well in the **Reimbursement** category, in which it ranks 10th. With a Medicaid population of only 80,000, Montana has been able to spend more than the national average for most enrolled populations. In addition, the state pays its providers better than the national average and has narrowed the gap between Medicaid and Medicare payments, although there is still a differential in the area of primary care.

Although Montana ranks 16th overall, it ranks considerably lower in terms of **Eligibility**, where it is 32nd. This is entirely the result of the state's very strict policies for coverage: in a majority of cases it limits services only to those who are at the lowest Federal Poverty Level, thereby excluding other poor and near-poor.

The score for **Scope of Services** is 67.9 percent of the total value, placing the state in the 15th rank. At present, Montana has two tiers of health care, full and basic, with different service packages provided to different populations.

With respect to **Quality of Care**, the state ranks 15th. Its creditable rank in this area is explained by the fact that Montana's program has avoided having negative points in indicators related to nursing home care, a feature that it shares with only six other programs. The state has therefore done a better job than most of monitoring its services in this area, and this is reflected in its scores.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Nebraska

Overall Score:*	625.5[†] 62.6% of 1000 points
Scores by Category:	
Eligibility	220.1 62.9% of 350 points
Scope of Services	138.8 69.4% of 200 points
Quality of Care	105.4 52.7% of 200 points
Reimbursement	161.3 64.5% of 250 points
Overall Rank:	2

Nebraska ranks 2nd overall, second only to Massachusetts in the nation. Indeed, it ranks among the top 13 in each of the four categories, which not even Massachusetts can boast. Its consistency should be recognized, especially as many states achieve high scores in one category only at the expense of another.

In terms of **Eligibility**, Nebraska's Medicaid program ranks 13th. Although it does not cover TB patients or State Children's Health Insurance Program (SCHIP) parents, the program has adopted relatively generous Federal Poverty Level requirements for eligibility.

The state ranks 11th in its score for **Scope of Services**. Nebraska covers a broad array of services, includes the medically needy across-the-board, and has few limitations and cost-sharing. Women's services is one area where the program is limited, and it receives only 34.8 percent of the total value in that subcategory.

With respect to **Quality of Care**, Nebraska ranks 5th. It does adequately in nursing home care, an area in which most states do abysmally. Moreover, it earns points for its favorable record in childhood immunization and services to children in need of mental health care.

In the **Reimbursement** category, Nebraska also ranks 5th. The state's Medicaid program spends more than the national per capita average in every demographic category; in addition, it is close to parity with Medicare in its payments to Medicaid providers, except in the area of primary care, in which the Medicaid-to-Medicare ratio is .78.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The addition of the four category scores may not total the overall score due to rounding.

Nevada

Overall Score:*	405.0 40.5% of 1000 points
Scores by Category:	
Eligibility	108.5 31.0% of 350 points
Scope of Services	102.8 51.4% of 200 points
Quality of Care	8.4 4.2% of 200 points
Reimbursement	185.3 74.1% of 250 points
Overall Rank:	40

The fastest-growing and most transient state, Nevada faces particular challenges in delivering health services to vulnerable populations. Ranking 40th nationwide, Nevada's Medicaid program barely avoids falling into the bottom 10 states in terms of the scope and functioning of its Medicaid program. It ranks among the bottom five in two areas. In only one category—reimbursement—can it boast a high rank.

The state ranks 46th in **Eligibility**, with only 31 percent of the total maximum score. This reflects the fact that Nevada largely limits itself to covering those at the mandated lowest income levels, with little or no leeway given to any demographic group. Moreover, the state does not cover the medically needy (those made poor due to extremely high medical bills), tuberculosis patients, or parents of children covered by the State Children's Health Insurance Program (SCHIP); these exclusions cost it points. This poor showing in eligibility in Nevada means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered

in a state with more lenient eligibility criteria.

The score for **Scope of Services** is 51.4 percent of the total maximum score in that area, placing the state in the 36th rank. While some states have opted to cover fewer persons with more comprehensive services, Nevada loses points not so much through the outright exclusion of services (although it fails to cover some services, such as chiropractor, podiatrist, psychologist, and private duty nursing services) but rather by imposing limitations in terms of frequency, type, or amount of care. It is also hurt by its low scores in the subcategories of women's services and provider-specific services.

With respect to **Quality of Care**, the state ranks 49th. It is very deficient in its nursing home care, and fails to meet adequate benchmarks in providing childhood immunizations.

Only in the **Reimbursement** category does Nevada have a good record, ranking 3rd and earning 74.1 percent of the total points in this category. The state's Medicaid program spends more per enrollee than the national average for adults, but less for both children and the elderly. It pays its providers noticeably more than the national average and maintains its fees close to parity with those received by Medicare providers.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

New Hampshire

Overall Score:*	548.9[†] 54.9% of 1000 points
Scores by Category:	
Eligibility	211.3 60.4% of 350 points
Scope of Services	136.8 68.4% of 200 points
Quality of Care	84.4 42.2% of 200 points
Reimbursement	116.5 46.6% of 250 points
Overall Rank:	10

New Hampshire's Medicaid program is in the "Top 10," occupying the last rank among these selected best. The state shows unusual consistency across categories, ranking between 12th and 24th in all four areas.

The state ranks 17th in **Eligibility**, with approximately 60 percent of the total maximum score in that category. It earns points for covering the medically needy, but these are partly offset by the exclusion of tuberculosis patients and State Children's Health Insurance Program (SCHIP) parents. Coverage of the latter has been shown to enhance access to care for their children.

In **Scope of Services**, New Hampshire ranks 13th. Although it excludes some types of care (e.g., freestanding ambulatory surgery, nurse anesthetist services, dentures, hospice care, and non-emergency medical transportation), it has practically no cost-sharing, which earns the program extra points.

In **Quality of Care**, the state ranks a consistent 12th. New Hampshire does a better job than most other states in monitoring the performance of its nursing homes, but falls short in the area of childhood immunization.

It is the **Reimbursement** category where the state's Medicaid program ranks the lowest of any of the four categories, placing 24th. Indeed, reimbursement issues have been a source of complaint among providers. While the state pays physicians slightly above the national average, it is below parity in what it pays Medicaid doctors compared to their Medicare counterparts, and the disparities cut across all services.

* For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

[†] The individual category scores may not add up to the overall score due to the rounding of numbers.

New Jersey

Overall Score:*	410.7 41.1% of 1000 points
Scores by Category:	
Eligibility	216.8 61.9% of 350 points
Scope of Services	126.6 63.3% of 200 points
Quality of Care	55.1 27.6% of 200 points
Reimbursement	12.2 4.9% of 250 points
Overall Rank:	39

It is in the **Reimbursement** category that New Jersey really suffers. Here, the state ranks last, the result of extremely low payments to physicians compared not only to the rest of the country but also to what Medicare physicians get. The Medicaid-to-Medicare index is a mere .35 overall, and dips to .31 in obstetric care. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

New Jersey's Medicaid program ranks between 16th and 50th, depending on category.

In **Eligibility**, the state's Medicaid program occupies the 16th rank. Although New Jersey covers the medically needy (those made poor because of high medical expenses), it provides them with a more restricted service package, excluding a number of services or limiting these to certain eligibility categories (e.g., pregnant women, children).

Moreover, the state fails to cover some services, such as rehabilitation services and private duty nursing. These exclusions are reflected in the **Scope of Services** category, where New Jersey's program ranks 22nd with 63.3 percent of the total score.

The state ranks 27th in **Quality of Care** and gets only 27.6 percent of the possible points in that area. New Jersey has deficiencies in nursing care staffing and other indicators related to nursing homes. It is also deficient in childhood immunization rates.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

New Mexico

Overall Score:*	447.0 44.7% of 1000 points
Scores by Category:	
Eligibility	160.1 45.7% of 350 points
Scope of Services	113.6 56.8% of 200 points
Quality of Care	32.8 16.4% of 200 points
Reimbursement	140.5 56.2% of 250 points
Overall Rank:	30

A poor state with a high percentage of uninsured adults, New Mexico does not cover those whose higher-than-standard incomes are significantly offset by inordinate medical bills.

With a score that represents only 45.7 percent of the total possible value, New Mexico occupies the 31st rank in **Eligibility**. In October 2006, the current income limit for a family of three was only 30 percent of the Federal Poverty Level, or \$4,700 annually, and the state sought to ease its eligibility rules and expand the eligible population.

In an attempt to extend coverage to uninsured low-income workers, the state has a Medicaid waiver which went into effect in mid-2005. This provides managed care coverage for uninsured, unemployed adults with incomes up to 200 percent of the Federal Poverty Level. Although it serves a different population, the plan's eligibility criteria and reporting requirements mirror Medicaid's. Nevertheless, the "extension" plan has more restricted benefits and higher co-payments.

The Medicaid program's score for **Scope of Services** is 56.8 percent of the total, and places New Mexico 29th nationwide. Although the state loses points for not covering the medically needy, a group of people whose higher-than-standard income is offset by extreme medical expenses, it gains points by offering comprehensive services. There are a few exclusions, including diagnostic, screening, and preventive services and private duty nursing.

Quality of Care is the category where New Mexico ranks lowest, earning a meager 16.4 percent of the total score. This places the state in the 39th rank in that area, largely because of deficiencies in nursing home care.

In the **Reimbursement** category, the state ranks a creditable 12th, sharing that rung with North Carolina and West Virginia. The state spends close to the national average per Medicaid enrollee. Moreover, it pays its Medicaid providers only slightly less for their services than what physicians earn under Medicare, a benchmark only a minority of other states meet.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

New York

Overall Score:*	560.2 56.0% of 1000 points
Scores by Category:	
Eligibility	264.8 75.7% of 350 points
Scope of Services	168.3 84.2% of 200 points
Quality of Care	83.1 41.6% of 200 points
Reimbursement	44.0 17.6% of 250 points
Overall Rank:	8

The size of its population and the number and importance of its medical institutions make New York a bellwether state in health trends. With almost three million enrollees, Medicaid has a strong multiplier effect throughout the economy and is therefore important financially and politically as well as in terms of health.

The state's Medicaid program currently ranks 8th nationwide. In fact, New York ranks at or close to the top in three of the four categories, its final placement being lowered only by its very poor showing in the remaining category.

In **Eligibility**, the state ranks 3rd, reflecting its relative generosity in establishing high Federal Poverty Level thresholds for its enrollees. In addition, New York covers the medically needy.

New York ranks 1st in **Scope of Services**. It excludes only a few services (e.g., chiropractor and podiatrist services, nurse anesthetists) and imposes limited or no cost-sharing on most its services. Because of its comprehensive offerings, the state

earns the maximum number of points in rehabilitation services, devices and equipment, and transportation.

With respect to **Quality of Care**, New York ranks 13th. It loses points in nursing home care, and in childhood immunization.

These generally favorable scores are somewhat offset by the state's extremely poor performance in the **Reimbursement** category, where it places an anomalous 49th. While the state spends generously on a per capita basis for most demographic groups, it has failed to keep up with national physician payments. It therefore has a Medicaid fee index of only .70, and its fees pay Medicaid providers only 45 cents for every dollar paid to their Medicare counterparts. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

At present, New York is greatly modifying its entire health system, shrinking its hospital component while increasing the use of managed care plans and curtailing its current drug expenditures. The federal government is providing the state with \$1.5 billion over 5 years to stabilize the existing hospitals and ease their transition into a new system. In exchange for this sum, the state has agreed to curb Medicaid costs and strengthen its fraud detection and recovery efforts. It will be interesting to see how the state will achieve this without jeopardizing its strengths in the Medicaid program or lagging further in provider reimbursement.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

North Carolina

Overall Score:*	506.6† 50.7% of 1000 points
Scores by Category:	
Eligibility	188.9 54.0% of 350 points
Scope of Services	108.2 54.1% of 200 points
Quality of Care	69.1 34.6% of 200 points
Reimbursement	140.5 56.2% of 250 points
Overall Rank:	18

points primarily because of its inadequate nursing home care.

In the **Reimbursement** category, however, the state ranks a respectable 12th. It matches the national average in its per capita spending, and, with a Medicaid-to-Medicare index of .97, has narrowed the gap between what providers are paid for caring for Medicaid enrollees and what Medicare physicians earn.

Like most states, North Carolina shows marked disparities in the rankings of its Medicaid program by category. Its individual rankings range from 12th to 32nd and the state ranks 18th overall.

The state ranks 24th with respect to **Eligibility**. It covers the medically needy and allows income levels higher than the mandated Federal Poverty Level requirement for some categories. However, it loses points for its scant State Children's Health Insurance Program (SCHIP) coverage.

The score for **Scope of Services** is a low 54.1 percent of the maximum total, placing the state in 32nd place. This reflects deficiencies in services to women, no coverage of rehabilitation services, and limitations on devices and equipment and drugs.

With respect to **Quality of Care**, in which the state places 19th, North Carolina loses

* For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

North Dakota

Overall Score:*	443.2[†] 44.3% of 1000 points
Scores by Category:	
Eligibility	139.8 39.9% of 350 points
Scope of Services	145.1 72.6% of 200 points
Quality of Care	53.9 27.0% of 200 points
Reimbursement	104.3 41.7% of 250 points
Overall Rank:	31

North Dakota's Medicaid program is a clear example of a state trading off the number of people covered for a more comprehensive service package. The state offers a comprehensive array of services, but then restricts eligibility by income so that relatively few can get access to care. As a result, the rankings of its Medicaid program range widely: from #5 in scope of services to #38 in eligibility.

The program restricts **Eligibility** to the mandated minimums, thus excluding many of the near-poor. North Dakota also fails to include those getting state supplemental payments and parents whose children are covered by the State Children's Health Insurance Program (SCHIP), even though research has shown that children have greater access to care when their parents are also covered. All of these exclusions result in deducted points.

The score for **Scope of Services** is 72.6 percent of the total, which is high compared to the rest of the states. The breadth of offerings earns North Dakota's

program a rank among the "Top 10" in this category, placing #5.

With respect to **Quality of Care**, North Dakota ranks 29th, losing points for not having a Medicaid Fraud Control Unit (one of only two states so lacking) and for deficiencies in nursing home care.

The state also occupies a middle rank in the **Reimbursement** category, placing 29th. It pays its Medicaid providers more than the national mean and is close to parity in paying Medicaid physicians what Medicare doctors earn.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Ohio

Overall Score:*	451.7 <i>45.2% of 1000 points</i>
Scores by Category:	
Eligibility	144.9 <i>41.4% of 350 points</i>
Scope of Services	112.5 <i>56.3% of 200 points</i>
Quality of Care	106.7 <i>53.4% of 200 points</i>
Reimbursement	87.6 <i>35.0% of 250 points</i>
Overall Rank:	29

Like other states, Ohio shows marked differences in its scores by category. While it ranks in the bottom half in three of the four areas, it ranks 3rd in the remaining category.

In terms of **Eligibility**, the state ranks 35th and earns 41.4 percent of the maximum value, largely as a result of its exclusion of individuals whose higher-than-standard income is offset by extreme medical expenses and its failure to cover those receiving state supplemental payments.

Similarly, Ohio ranks a poor 30th in **Scope of Services**. In that category, Ohio receives 56.3 percent of the total value, losing significant points in the areas of women's services and provider-specific services in particular.

These low scores are partly offset by Ohio's creditable performance in **Quality of Care**, where the state's Medicaid Program ranks 3rd nationally. Unlike the vast majority of states, Ohio avoids earning negative points in nursing home care, an accomplishment that strengthens its position in this area in

general. Ohio Medicaid is the leading payer of nursing facilities in the state, accounting for 70 percent of all expenditures (versus 63 percent nationally). While other health providers in the state faced rate reductions in recent years, long-term care facilities were not targeted, thereby allowing Ohio to favor nursing home care in the allocation of resources.

With respect to **Reimbursement**, Ohio ranks 36th. Although it pays its Medicaid providers close to the national mean, its fees are lower than those paid to Medicare physicians, the overall ratio between the two being .68.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Oklahoma

Overall Score:*	336.7[†] 33.7% of 1000 points
Scores by Category:	
Eligibility	193.3 55.2% of 350 points
Scope of Services	71.7 35.9% of 200 points
Quality of Care	-3.8 None of 200 points
Reimbursement	75.4 30.2% of 250 points
Overall Rank:	47

Oklahoma's Medicaid program is one of the 10 worst programs in the country. It places among the bottom 10 states in three of the four categories assessed, and ranks 47th nationally.

Eligibility is where the state does best, earning 55.2 percent of the total maximum points and ranking 21st. It appears that the state has opted to cover more persons while providing them fewer services. While Oklahoma excludes those who are poor due to high medical expenses, the medically needy, and parents of children who are covered by the State Children's Health Insurance Program (SCHIP), it has more inclusive Federal Poverty Level thresholds than are legally required, thus expanding the pool of beneficiaries.

In **Scope of Services**, however, the state fails abysmally, ranking 50th with only 35.9 percent of the total points. It is particularly deficient in services by type and/or target population (e.g., hospice care, private duty nursing services), rehabilitation services, and devices and equipment. This poor

showing in scope of services means that, even if people qualify for the program, they may not have access to many services provided to Medicaid recipients in states with a broader benefits package.

Similarly, Oklahoma ranks at the near-bottom in **Quality of Care**, earning a rank of 50th. The state is one of two in this category whose total score has a negative sign. This is the result of inadequate staffing and monitoring of nursing home care, and poor performance in outcomes associated with child health.

Oklahoma pays its Medicaid providers less than the national average and less than Medicare providers make, thereby earning only 30.2 percent of the value assigned to the **Reimbursement** category. It ranks 42nd in this area. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Oregon

Overall Score:*	544.0 54.4% of 1000 points
Scores by Category:	
Eligibility	204.9 58.5% of 350 points
Scope of Services	155.0 77.5% of 200 points
Quality of Care	51.7 25.9% of 200 points
Reimbursement	132.4 53.0% of 250 points
Overall Rank:	12

In 1989, Oregon proposed health reforms that focused on expanding Medicaid to include a wider population by covering fewer services. The plan, which was not approved until 1993, offered recipients a basic package of services based on a prioritized list that ranked treatments in terms of clinical effectiveness and net benefits.

Depending on how generous the state was and how much it wanted to spend on Medicaid, Oregon's legislature drew a line on the list, paying only for services above the line. Hailed as a pioneer for its experiment in health care rationing, the Oregon Health Plan (OHP) nevertheless failed to inspire other states to follow suit.

In 2002, the state moved to expand coverage again through a two-tier plan of services. The first package would cover those categorically eligible (e.g., children, the aged, individuals with disabilities) for Medicaid with the services on the prioritized list. The second package, which introduced cost-sharing and premium requirements, covered an expansion population with a reduced benefit package estimated at 78

percent of the value of the first package. Oregon's Medicaid waiver allowed the state to cap enrollment in the second package or adopt a lower poverty level for eligibility.

Although the state was able to attract the anticipated expansion population when it went into effect, cost-sharing had a devastating effect over time, and the second package lost 53 percent of its enrollees within a year. The state's Medicaid program therefore both covered fewer persons and offered more limited services, a situation from which it is now trying to rebound.

This history makes the Oregon Plan unique, and the state can be considered a statistical outlier that might not appear to lend itself easily to national rankings. Still, it is precisely because of its unusual and novel features that the OHP's performance should be assessed vis-à-vis the other states.

With 58.5 percent of the total score in **Eligibility**, Oregon places 19th in that category. Thus, despite its original rationale, the OHP has fallen short of many other states in the goal of covering more of the uninsured.

With respect to **Scope of Services**, however, the OHP ranks 3rd. Although its initial aim was to limit services to pairs of conditions and treatments of proven safety and efficacy, and these pairs are subject to biannual review, the service package compares favorably with that offered by almost all other Medicaid programs. In fact, the state constantly feels pressured to move the bar on its list of services, thus providing more comprehensive coverage to its eligible population. As a result, Oregon is surpassed only by New York in the subcategory "Services by type or target population," which accounts for nearly half its points in the scope of services category.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Oregon's overall rank is significantly lowered by its poor showing in **Quality of Care**, in which it places #31. This is due primarily to inadequacies in nursing home care, and a low rate of childhood immunizations.

In the **Reimbursement** category, Oregon spends less per enrollee than the national average in every demographic group except children. It also has Medicaid fees that are lower than those for Medicare. But because most states are far from parity in this area, Oregon occupies the 17th rank in this category.

Pennsylvania

Overall Score:*	437.8 43.8% of 1000 points
Scores by Category:	
Eligibility	198.3 56.7% of 350 points
Scope of Services	115.1 57.6% of 200 points
Quality of Care	56.4 28.2% of 200 points
Reimbursement	68.0 27.2% of 250 points
Overall Rank:	33

Health care has been a hot political issue in Pennsylvania. This is not surprising given the state's deficient Medicaid program: it ranks 33rd nationwide, a rank it shares with Wyoming. Known as a state where the role of government has traditionally been limited to encouraging private sector actions, Pennsylvania is nonetheless intent on expanding coverage for children through a "Cover All Kids" Initiative.

Although the state's Medicaid program earns its highest rank (20th) in **Eligibility**, it nevertheless excludes certain populations and has low Federal Poverty Levels for some eligible groups, leaving those with slightly higher income without coverage.

In **Scope of Services**, Pennsylvania ranks 28th. It scores poorly in the subcategories of women's services, rehabilitation, and devices and equipment. It therefore earns only 57.6 percent of the maximum value in this category.

The state's middle rank (26th) with respect to **Quality of Care** reflects its erratic scores in nursing home services. While

Pennsylvania does all right in the indicators related to staffing, it does poorly in type and numbers of deficiencies. The state also loses points for its low childhood immunization rate. It earns only 28.2 percent of the total points in this category.

In the **Reimbursement** category, Pennsylvania is among the bottom 10 states, having earned a reputation for miserliness. A study published in 1996 found that a hospital treating a Medicaid enrollee in the state received only 79 percent of the cost of care. This disadvantage continues at present with respect to doctors. Pennsylvania pays its Medicaid physicians markedly less than the national mean and less than what Medicare providers in the state earn for comparable services. The Medicaid-to-Medicare fee index shows that Medicaid doctors receive only 52 cents for every dollar that Medicare providers earn in Pennsylvania; in primary care that figure is even lower at 43 cents. Pennsylvania therefore ranks 46th in the reimbursement category. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Rhode Island

Overall Score:*	600.0 60.0% of 1000 points
Scores by Category:	
Eligibility	296.8 84.8% of 350 points
Scope of Services	134.7 67.4% of 200 points
Quality of Care	109.0 54.5% of 200 points
Reimbursement	59.5 23.8% of 250 points
Overall Rank:	6

Probably no state better illustrates the variability of Medicaid programs *within* states than Rhode Island. Its scores run the gamut from the top two in two categories to close to the bottom in a third category. Nevertheless, because the state's Medicaid Program ranks first in the category with the greatest weight—eligibility—its overall score places it 6th overall.

Rhode Island is expansive in terms of population coverage, which assures it the 1st rank in **Eligibility**. In addition to covering the medically needy and other optional groups, the state has generous Federal Poverty Level requirements, covering the near poor. For example, while the national eligibility cap by annual income is \$10,849 for working parents, the corresponding figure for Rhode Island is \$31,790. Rhode Island covers State Children's Health Insurance Program (SCHIP) parents, a measure that has been found to enhance their children's access to care.

The state's expanded eligibility requirements are somewhat offset by the

fact that its **Scope of Services** has exclusions that cost it points: in this area, Rhode Island ranks 17th, with 67.4 percent of the maximum score. The state's Medicaid program skimps on women's services, rehabilitation services, and devices and equipment.

With respect to **Quality of Care**, the state ranks 2nd. Even with negative points in two indicators, the state manages to score higher than all other states except Massachusetts, which it follows at a considerable distance (obtaining 54.5 percent of the total value in this category, versus Massachusetts' 71.5 percent).

Rhode Island's Medicaid program, however, fails to make the grade in the **Reimbursement** category, where it places a poor 48th. The state stints on provider payments, paying physicians not only significantly less than the national average (the Medicaid fee index is .62), but also significantly less than what Medicare providers earn (the Medicaid-to-Medicare fee index being a meager .42 overall). Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

South Carolina

Overall Score:*	364.0 36.4% of 1000 points
Scores by Category:	
Eligibility	132.7 37.9% of 350 points
Scope of Services	82.9 41.5% of 200 points
Quality of Care	20.1 10.1% of 200 points
Reimbursement	128.3 51.3% of 250 points
Overall Rank:	44

South Carolina's rank of 44th reflects a Medicaid program that is extremely deficient in all areas except one, and ranks among the 10 worst in the country overall.

With respect to **Eligibility**, the state excludes those who are poor due to high medical expenses, the medically needy, and does not extend coverage above the mandated minimum Federal Poverty Level for the elderly, blind and disabled. Were it not for its relatively favorable showing in the State Children's Health Insurance Program (SCHIP) program, the state would place at a lower rank than its current one (40th) in this category.

South Carolina's rank for **Scope of Services** is 46th. The state loses significant points in the areas of women's services, provider-specific services (e.g., psychologist services), drugs, and services by type or population group (e.g., private duty nursing services, smoking cessation treatments). The program also excludes rehabilitation services altogether. This poor showing in scope of services means that, even if people qualify for the program, they may not have

access to many services provided to Medicaid recipients in states with a broader benefits package.

South Carolina not only provides shallow coverage for limited numbers of people, but it also fails in **Quality of Care**. It earns negative points in nursing home care, with scores that lower its relative rank in this category to 44th.

Given its limitations in eligibility and services, it is not surprising that South Carolina's Medicaid program spends frugally on a per enrollee basis for all population groups. Nevertheless, the state exceeds the national mean in Medicaid payments to physicians, and is closer to parity with Medicare providers than is the nation as a whole. This earns South Carolina points in the **Reimbursement** category, where it ranks 18th.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

South Dakota

Overall Score:*	352.6 35.3% of 1000 points
Scores by Category:	
Eligibility	101.1 28.9% of 350 points
Scope of Services	102.5 51.3% of 200 points
Quality of Care	37.7 18.9% of 200 points
Reimbursement	111.3 44.5% of 250 points
Overall Rank:	46

South Dakota's Medicaid program ranks between 28th and 47th in the four categories.

In most cases, South Dakota extends coverage to as few populations as possible, ranking a poor 47th in **Eligibility**. The state's Medicaid program adheres closely to the federal minimums in terms of Federal Poverty Levels for almost all populations, leaving out many who cannot afford private health insurance. It also excludes the medically needy, those who are poor due to high medical expenses. This poor showing in eligibility in South Dakota means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria. Because eligibility has the heaviest weight among the four categories assessed in this report, South Dakota's poor showing in this area pulls down its overall score, placing it among the bottom five states nationwide.

South Dakota also ranks a poor 37th in **Scope of Services**. It loses an especially

large number of points in women's services, provider-specific services, and drugs.

With respect to **Quality of Care**, South Dakota's Medicaid program ranks 38th with less than 19 percent of the maximum value in this category. It is particularly deficient in nursing home care, where it earns negative points. This area is not expected to improve in the near future: a 2006 study found that several nursing homes had already closed because of inadequate funding, with additional closings expected in the future. The study also found that half the homes were understaffed.

In the **Reimbursement** category, South Dakota does somewhat better, placing 28th nationwide. Its Medicaid program spends just above the national average per enrollee, and provider payments are close to the national mean. While Medicaid providers in South Dakota earn less than their Medicare counterparts, the state's Medicaid-to-Medicare fee index is somewhat higher than that for the country as a whole (.83 versus .69).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Tennessee

Overall Score:*	NA†
Scores by Category:	
Eligibility	175.2 50.1% of 350 points
Scope of Services	141.6 70.8% of 200 points
Quality of Care	85.7 42.9% of 200 points

When Tennessee launched TennCare in 1994, the program was hailed as a progressive move to expand coverage to populations in need. The plan offered a multi-tiered selection of managed care programs to nearly 1.5 million persons, many of whom were previously uninsured. Intending to test the viability of combining managed care with expanded coverage, the plan held the hope of extending services to some who were uninsurable because of severe illness, and to the “working poor” who lacked employer-sponsored coverage.

But the program has had an uneven career, suffered many setbacks, and been the target of several protracted lawsuits.

In 2005, the state announced a major overhaul, including drastic cuts that restricted eligibility and eliminated benefits to an estimated 170,000 TennCare enrollees. Since then, the state has proposed five programs intended to fill gaps in health coverage. Like many other states, Tennessee is modifying its Medicaid program in an attempt to address both political pressures and fiscal realities. The following rankings therefore reflect both

TennCare’s checkered past and current struggles.

TennCare’s initial aims have been traded off, with services available to fewer people. In **Eligibility**, Tennessee therefore earns only half the maximum number of points, ranking 28th nationwide.

Limited population coverage, however, is somewhat offset by the program’s comprehensive services. Although it loses points in the subcategories of women’s services, and devices and equipment, Tennessee does well in the other services. As a result, the state ranks 9th in **Scope of Services**.

Similarly, the state does well in **Quality of Care**, occupying the 11th rank nationwide. Tennessee does not perform well in monitoring the quality of nursing home care, but gets the maximum score in outcomes related to child health.

Reimbursement presents an anomalous situation for this state. Tennessee spends less on a per-enrollee basis than the national average for most demographic groups. But because Tennessee is the only state that does not have a fee-for-service component in its Medicaid program, it cannot compare its Medicaid provider payments with the rest of the nation. As a result, there is no way to rank the state in this category, which means that the rest of the Medicaid programs are ranked one through 50 in reimbursement, in contrast to one through 51 in the remaining three categories. Tennessee is therefore also omitted from the overall rankings.

*For a graphic depiction of how the state ranks nationally in three categories, see Figures 3-8.

† Since Tennessee does not have any practitioners paid under fee-for-service, it lacks indicators for the reimbursement category. Because of the lack of comparability with other states, there is no way to rank this state in terms of reimbursement. It is also impossible to compute an overall score for Tennessee.

Texas

Overall Score:*	335.5[†] 33.6% of 1000 points
Scores by Category:	
Eligibility	110.3 31.5% of 350 points
Scope of Services	100.3 50.2% of 200 points
Quality of Care	45.5 22.8% of 200 points
Reimbursement	79.5 31.8% of 250 points
Overall Rank:	48

Placing in the bottom 10 in two categories, including the one with the heaviest weight, Texas ranks a poor 48th overall. In fact, it is the only state that places consistently at the bottom, all its category-specific ranks ranging within 10 ranks.

Unlike other states that have made a policy decision to cover more persons for fewer services, or vice-versa, Texas ranks extremely low in both eligibility and scope of services.

With respect to **Eligibility**, Texas tends to adhere closely to the minimum Federal Poverty Levels, for which it earns no points since the mandatory minimums leave many who cannot afford private health insurance without healthcare. This poor showing in eligibility in Texas means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria. These constraints place the state's Medicaid program in the 45th rank for eligibility.

In **Scope of Services**, the Medicaid program skimps on women's services, services by type or population (e.g., institutional care for youth and the elderly, private duty nursing services), and devices and equipment. It therefore ranks 41st in this category.

Texas does somewhat better in **Quality of Care**, although it earns only approximately 23 percent of the maximum score. Because this is a category in which even the state that ranks 1st scores only 71.5 percent of the points, Texas ranks 35th in this area.

Texas ranks 39th in **Reimbursement**, with 31.8 percent of the maximum score in that category. The state spends less than the national average per enrollee, and pays its providers less than the national average for primary care and gynecological services. Its Medicaid-to-Medicare fee index is equal to that for the nation overall (.69), indicating that Medicaid physicians earn less than their Medicare counterparts both nationwide and in Texas. Even if people are eligible for Medicaid and the services they need are covered, the stingy reimbursement policy makes it less likely that all patients will be able to get these services.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The sum of the four category scores may not total the overall score due to rounding of numbers.

Utah

Overall Score:*	480.9 48.1% of 1000 points
Scores by Category:	
Eligibility	167.4 47.8% of 350 points
Scope of Services	132.8 66.4% of 200 points
Quality of Care	80.5 40.3% of 200 points
Reimbursement	100.2 40.1% of 250 points
Overall Rank:	21

A relatively healthy state with a small Medicaid population, Utah places in the middle ranks in most categories. In 2002, Utah received a Medicaid waiver which led to a rethinking of the program. Faced with a choice of covering fewer people with full benefits versus increasing the number of enrollees and providing them with limited benefits, the state opted to provide “less to more.” The current ranks therefore reflect the results of this policy decision to date, although the “more” to whom services are provided still excludes many.

In **Eligibility**, Utah ranks 29th with 47.8 percent of the maximum score. The state loses points because it limits its services to the very poor in most cases, leaving slightly higher-income individuals without coverage. In addition, Utah does not cover parents of children who are covered by the State Children’s Health Insurance Program (SCHIP), even though research has shown that children have greater access to care when their parents are also covered.

In terms of **Scope of Services**, Utah loses points for its limitations in women’s services and drugs, placing 18th nationwide.

With respect to **Quality of Care**, Utah does well in most indicators, including nursing care, where most states lose a significant number of points. It therefore ranks 14th in this area.

In the **Reimbursement** category, the state shares the 30th rank with four other states. It spends less per enrollee than the country as a whole. While Utah’s Medicaid program pays providers slightly more than the national mean, it pays them less than their Medicare counterparts.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Vermont

Overall Score:*	616.1† 61.6% of 1000 points
Scores by Category:	
Eligibility	283.7 81.1% of 350 points
Scope of Services	128.2 64.1% of 200 points
Quality of Care	67.8 33.9% of 200 points
Reimbursement	136.5 54.6% of 250 points
Overall Rank:	3

With relatively broad coverage and a high income cap for Medicaid eligibility, Vermont has been at the forefront of expansive policies to reduce the number of uninsured. In 2006, the state won approval of a Medicaid waiver which made Vermont the only state in the nation with a fixed dollar limit on the amount of federal funding available for its Medicaid program. In exchange for this, the state can use the funds to cover its own non-Medicaid health programs. The waiver also allows Vermont to waive federal requirements concerning benefits, cost-sharing, and eligibility. Because of the state's prior experiences and largesse, however, there are indications that the waiver will not siphon off resources from the Medicaid population for the benefit of other groups and services. In addition, the state is changing its delivery system to stress disease management. Primary care providers will be paid to orchestrate care for those with chronic conditions, a measure that seeks to reduce the need for higher-cost urgent care. Although the state's unique circumstances preclude this experience being easily replicated in other

states, the Vermont model is being watched closely by policymakers throughout the nation.

Vermont ranks 2nd in **Eligibility**, earning 81.1 percent of the maximum score and boosting its overall rank to 3rd place nationally. Nevertheless, it does not cover State Children's Health Insurance Program (SCHIP) parents, and research has shown that children have better access to care when their parents are also covered.

In terms of **Scope of Services**, Vermont loses points for its imposition of certain limitations and its failure to cover inpatient, institutional care for mental illness for those 65 and older, certain rehabilitation services, and ambulatory surgery, personal care services, and chiropractic services. The state therefore ranks only 21st in this category.

With respect to **Quality of Care**, the state earns only 33.9 percent of the total score, placing 21st. It is hurt by its poor showing in nursing home care.

In the **Reimbursement** category, the state ranks 15th. Vermont's Medicaid program spends slightly less than the national average on a per capita basis. Its Medicaid fee index reflects the fact that the state pays its providers more than the national mean. Nevertheless, Medicaid providers earn less than their Medicare counterparts, particularly in the area of primary care, where the ratio is .64.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The sum of the four category scores may not total the overall score due to rounding of numbers.

Virginia

Overall Score:*	423.5 42.4% of 1000 points
Scores by Category:	
Eligibility	131.0 37.4% of 350 points
Scope of Services	102.4 51.2% of 200 points
Quality of Care	94.0 47.0% of 200 points
Reimbursement	96.1 38.4% of 250 points
Overall Rank:	37

Virginia's Medicaid program shows much variation in how it stacks up by category, with ranks ranging from 9th to 42nd.

Virginia places lowest in **Eligibility**, where it ranks 42nd. This poor performance is largely the result of low Federal Poverty Level caps for different populations, leaving those with slightly higher income without coverage, as well as the exclusion of some groups (e.g., tuberculosis patients, parents of children who are covered by SCHIP, the State Children's Health Insurance Program). This poor showing in eligibility in Virginia means that large numbers of people are excluded from Medicaid just because of where they happen to live, and they would be covered in a state with more lenient eligibility criteria.

Similarly, Virginia ranks among the bottom half of all states in **Scope of Services**, where it places 38th with less than 52 percent of the maximum score. It loses significant points in several key subcategories of services: services by type and/or population group (e.g., case management, private duty nursing

services), women's services, provider-specific services (e.g., chiropractor services), rehabilitation, and devices and equipment (e.g., eyeglasses, hearing aids).

With respect to **Quality of Care**, however, Virginia ranks among the "Top 10," placing 9th in this category. Compared with the rest of the states, Virginia does relatively well in indicators of nursing home care and childhood immunizations.

The state places in the middle rungs in terms of **Reimbursement**. It spends below the mean per enrollee for two of the three demographic groups scored. While Virginia's Medicaid payments to providers are somewhat higher than the national average, the state lags in what it pays Medicaid physicians vis-à-vis their Medicare counterparts. The Medicaid-to-Medicare ratio is .77.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

Washington

Overall Score:*	550.0[†] <i>55.0% of 1000 points</i>
Scores by Category:	
Eligibility	260.9 <i>74.5% of 350 points</i>
Scope of Services	145.8 <i>72.9% of 200 points</i>
Quality of Care	31.7 <i>15.9% of 200 points</i>
Reimbursement	111.7 <i>44.7% of 250 points</i>
Overall Rank:	9

Although a “Top 10” overall, Washington’s Medicaid program has very disparate scores: it ranks close to the top nationwide in two categories, placing 4th in each, but falls markedly with respect to the remaining two.

In **Eligibility**, Washington’s expansive policies and high Federal Poverty Level thresholds earn its Medicaid program points in all indicators except those associated with SCHIP, the State Children’s Health Insurance Program. It therefore ranks 4th and receives 74.5 percent of the maximum score in this category.

With respect to **Scope of Services**, the state similarly places among the top ranks. Although losing points in rehabilitation services, it does well in all other major subcategories and earns 72.9 percent of the total number of points in that category. It ranks 4th in that category.

In **Quality of Care**, however, Washington places a poor 40th, with only 15.9 percent of the maximum score. It is particularly

inadequate in nursing home care, where it shows a high number of deficiencies.

In the **Reimbursement** category, the state’s program is in the middle, ranking 26th. Despite its broad scope of services, the state spends rather frugally per Medicaid enrollee in all groups but one. It therefore spends less than 70 percent the overall national average per capita expense per enrollee. Although the state pays its Medicaid providers more than the national average, there is still a gap between its physician fees and those paid to Medicare practitioners, the ratio between the two being .87.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

West Virginia

Overall Score:*	474.4[†] 47.4% of 1000 points
Scores by Category:	
Eligibility	157.5 45.0% of 350 points
Scope of Services	128.4 64.2% of 200 points
Quality of Care	48.1 24.1% of 200 points
Reimbursement	140.5 56.2% of 250 points
Overall Rank:	25

West Virginia's Medicaid program occupies a middle rung nationwide and reflects the wide intra-state variation among scoring categories that characterizes most programs. At present, the state is transitioning into a new benefit package for children and parents. This is being tested in a few counties.

Under the new system, parents sign a member agreement to access certain services and providers, and managed care plans monitor and report patients' progress in meeting the agreed-upon responsibilities. Parents will choose between a "basic" plan and an "enhanced" plan, access to the latter being contingent on compliance with specific health-seeking behaviors such as adhering to a schedule of visits or participating in wellness programs. Conversely, enrollees could pay a penalty for filling a brand drug when a generic was available or for improper use of the emergency room. The changes have been criticized by some for their "blame-the-victim" features, but are expected to

enhance coordination of care, control costs, and promote prevention.

In **Eligibility**, the state ranks 34th, losing points for its strict adherence to the low mandated Federal Poverty Levels needed to qualify for services, which leaves some of the poor and near-poor without coverage. In addition, West Virginia excludes certain population groups (e.g., tuberculosis patients, parents of children who are covered by the State Children's Health Insurance Program (SCHIP)) that some other states cover.

In **Scope of Services**, it ranks 20th, with few noticeable exclusions except in devices and equipment. This is expected to change under the new system: Some adults will lose non-mandatory benefits because the basic plan is more limited than that now in effect.

With respect to **Quality of Care**, West Virginia is hurt by its poor performance in nursing home services and childhood immunizations. It therefore earns only 24.1 percent of the maximum score in this category, in which it ranks 34th.

It is under **Reimbursement** that West Virginia gets its best relative score: it ranks 12th. The state spends more per enrollee than the national average for the population groups included in our report. Moreover, not only does the state pay its Medicaid providers more than the national average, its fees for Medicaid providers are also closer to parity with Medicare fees than is the case for the country as a whole.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Wisconsin

Overall Score:*	606.8[†] 60.7% of 1000 points
Scores by Category:	
Eligibility	246.6 70.5% of 350 points
Scope of Services	136.7 68.4% of 200 points
Quality of Care	71.4 35.7% of 200 points
Reimbursement	152.0 60.8% of 250 points
Overall Rank:	5

Wisconsin's Medicaid program is unusually consistent across the board. Its ranks by category fall within a narrow range, and the program places 5th overall.

The program ranks among the "Top 10" in **Eligibility**, the result of its generous Federal Poverty Level requirements and coverage of the medically needy. It covers State Children's Health Insurance Program (SCHIP) parents, which researchers have found enhances access for children, who are the primary target of the program.

With respect to **Scope of Services**, Wisconsin's program ranks 14th. It covers all services other than diagnostic, preventive and screening services. In some subcategories, however, it loses points because of limitations that may deter access to care. This is particularly the case in women's services and provider-specific services.

Wisconsin ties with two other states in the 16th rank in **Quality of Care**, where it earns

only 35.7 percent of the maximum score. Like many other states, Wisconsin has deficiencies in nursing home care.

In the **Reimbursement** category, in which it ranks 9th, Wisconsin's program has managed to contain per capita payments per enrollee, paying close to the national mean while offering more comprehensive coverage. The state's Medicaid fees are also higher than the average, and exceed parity in the areas of ob/gyn and other care. Its Medicaid-to-Medicare fee index is lowered by the gap in primary care fees (a ratio of .73), bringing down the overall index to .87 (versus .69 for the U.S. as a whole).

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

† The individual category scores may not add up to the overall score due to the rounding of numbers.

Wyoming

Overall Score:*	437.8 43.8% of 1000 points
Scores by Category:	
Eligibility	133.7 38.2% of 350 points
Scope of Services	81.9 41.0% of 200 points
Quality of Care	62.1 31.1% of 200 points
Reimbursement	160.1 64.0% of 250 points
Overall Rank:	33

Wyoming's Medicaid program shows large fluctuations by category. While placing 33rd nationwide, a rank it shares with Pennsylvania, its category-specific ranks range from 6th to 47th.

In **Eligibility**, the state ranks 39th because it restricts services for children and pregnant women to those with very low income levels, and it excludes two important categories of people that other states cover: the medically needy and parents of children who are covered by the State Children's Health Insurance Program (SCHIP). These exclusions cost the program points.

The program's lowest rank is in **Scope of Services**, where Wyoming earns 41.0 percent of the total score and ranks 47th. The state is particularly deficient in the following subcategories: services by type and/or demographic group, provider-specific services, and devices and equipment (e.g., dentures, hearing aids). This poor showing in scope of services means that, even if people qualify for the program, they may not have access to many

services provided to Medicaid recipients in states with a broader benefits package.

With respect to **Quality of Care**, Wyoming ranks in the middle. Because this is the category in which most states are deficient, even a low score can result in a middle rank, as is the case with Wyoming. Although it earns only 31.1 percent of the maximum value in this category, it places 24th nationwide.

In **Reimbursement**, however, the state's Medicaid program places a surprising 6th. This can be attributed to the fact that, despite its limited coverage of both persons and services (or perhaps *because* of this), the state pays its Medicaid providers significantly more than the national average and at parity with their Medicare counterparts.

*For a graphic depiction of how the state ranks nationally, both overall and by category, see Figures 1-10.

IX. Conclusions

We have titled our report *Unsettling Scores* because it is indeed disturbing that, after more than four decades, the Medicaid program has clearly failed to achieve its objectives and to therefore fully meet the needs of those it serves or is supposed to serve.

Our findings make it clear that there are large numbers of people who need to be, but are not, eligible; need to have access to a wider scope of services; need to benefit from better quality health care; or need to have access to more providers than are available because state reimbursement policies make their participation difficult if not impossible. Yet these critically needed additions are “voluntary” on the part of states rather than mandated nationally. The fact that many states have chosen to go beyond the federal legal requirements suggests that they are responding to constituent needs and public pressures, and that the “floor” of mandated Medicaid coverage is clearly inadequate. Because the federal requirements are so lacking, if someone happens to live in the “wrong” state—one that does not provide optimally in all four of these categories—they will be denied needed care.

No state could be described as having an excellent Medicaid program, as the highest-ranking state earned only 64.6 percent of the total points. In addition, the median or midpoint in the range of scores was 47.1 percent of the total. And 30 states, including some of the largest in the country, were among the 10 lowest-ranking states in one or more of the four categories we examined.

The partnership between the federal government and the states has been fraught with tension as a result of the federal desire for national standards and the states’ clamor for greater discretion.⁵⁸ In recent years, the states have prevailed, often to the detriment of patients. Federal guidelines, established to insure some basic level of uniformity and equity across states, have been largely eroded. At present, the system of waivers has given states dangerously great latitude in deciding whom they cover, what package of services they offer, and how and how much they pay providers.

Yet neither of the two partners is satisfied with the results. The federal government feels that the program is too costly, and states still chafe under what they feel is a federal straitjacket that limits their choices. The issue of Medicaid funding is a constant source of tension between the states and the federal government. States may want greater decision-making latitude, but they are reluctant to accept the possibility of greater state financial risk that goes with greater autonomy. The states have an interest in maximizing the number of federal dollars they can draw down; for its part, the federal government tries to shift a greater proportion of costs to the states. And the uneasy partnership between the two levels of government is likely to become increasingly tense as both attempt to address the rising number of uninsured and a growing aging population requiring more costly long-term care.

Much of the current debate has focused on the program’s sustainability. But more important is the question of whether the program, as it currently operates, is worth sustaining. Each of the categories we have examined pose problems that require attention at the national level and cannot be solved on a state-by-state basis.

⁵⁸ Michael S. Sparer, *Medicaid and the Limits of State Health Reform*. (Philadelphia: Temple University Press, 1996): 183.

Medicaid has been called a vestige of the “poor laws” because it attempts to cover the “deserving poor,” systematically excluding those that do not meet specific criteria. **Eligibility** is uneven and complicated. Even when some populations are eligible, inadequate outreach and complicated enrollment procedures leave many out: an estimated 20 to 35 percent of those who are eligible are not enrolled in state Medicaid programs.⁵⁹ Eligibility policies therefore represent only the more obvious and visible aspect of gaining access to care. Even the states with the best eligibility policies do not fully measure up in our rankings. And there are five states that earn scores of less than 30 percent of the total, thereby excluding many by design.

Scope of services is similarly varied, the spectrum of scores in this category varying 2.5-fold between the most expansive and the most restricted program. Bare-bones Medicaid programs leave too many services out. While some states exclude some services altogether, others use subtler means to whittle away at services so that many are unable to get them. State Medicaid programs may only provide certain services to given segments of the population; or require some type of cost-sharing; or provide care only under specific conditions; or restrict the care to only some procedures; or limit the duration, frequency, or amount of service covered. The result is that, in many states, beneficiaries have to make their way through a thicket of restrictions to identify the services to which they are entitled. And, sadly, their efforts may very well end with exclusion.

Quality of care is an area in which even the best are found wanting, and in which scores vary more than 17-fold from the highest to the lowest positive-ranking state. Of the four categories examined in this report, it is the one with the most glaring deficiencies. The lack of oversight on the part of the state and federal governments is reflected in the paucity of consistent and reliable indicators. As a result, it is difficult to verify whether the states and the federal government are spending wisely and allocating their resources where they do the most good. And **Reimbursement**, which is one of many arenas in which the continuing debate plays out, reinforces the role of Medicaid as a stepchild, unable to pay its providers at parity with its more affluent sibling, Medicare.

Yet Medicaid is the largest single health program in the United States and its replacement has to do more than correct its more salient deficiencies. At the same time, as Michael Sparer has pointed out, the program must recognize that there are some decisions that have to be made on a national level. These include a mandate of universal health insurance, a basic benefits package, and a financial framework for how the monies are to be raised, and how costs are to be contained.⁶⁰

At present, many states are taking measures to recast their Medicaid programs. Some are attempting to make a dent in the number of uninsured by loosening eligibility requirements and allowing a greater proportion of the population or their employers to buy into the program by paying a sliding-fee premium. Others are changing the way care is organized, requiring all beneficiaries to have a “medical home” through which services are orchestrated. Many states are focusing on cost-containment through different approaches. One is experimenting with a “fixed contribution” that caps the amount available for each covered person. Several are focusing on the four percent of “high users” that account for approximately 50 percent of all Medicaid expenses.⁶¹ This in turn requires adopting disease-management strategies, diverting those in nursing homes to less expensive modalities, and promoting behaviors to insure

59 Hearne, *Medicaid Eligibility for Adults and Children*: CRS-30.

60 Sparer, *Medicaid and the Limits*: 199.

61 Smith et al. *Low Medicaid Spending Growth*: 11.

greater compliance with preventive practices and treatment regimes. Yet these approaches can only exacerbate the differences in state programs and thwart any attempt to create a universal program in which coverage is equitable, comprehensive, and portable across state lines.

Given the current concern with health disparities, it is surprising that so little attention has been paid to the fact that, for many Medicaid beneficiaries, the care they get is largely a function of where they live. Geography is therefore one of the determinants of who gets what, when, where, how, and at what cost. The differences in state Medicaid program scores represent inequities in health care rather than desirable diversity. Programs need to be made more standard, more uniform, and more accountable if the many state programs that are now failing are to realistically aspire to the achievements of a select few.

Appendix: Scoring Protocol

Eligibility

1. Children

States are required to cover all children in families with incomes equal to or less than 100% of the federal poverty level (FPL). They must also cover those under age 6 who are in families with income equal to or below 133% of FPL. Many states have chosen to go beyond that minimum, extending coverage to older age groups and raising the threshold income level for eligibility. Because state largesse varies by age group, and data are thus available by specific ages, the indicators have been broken down for three different demographic groups: infants under the age of 1, children 1-5, and those ages 6-19.

Points assigned to this indicator are as follows: **9 Total Possible**

a. Infants 0-1

FPL 300+	3
FPL 200-299	2
FPL 150-199	1
FPL under 150	0

b. Children 1-5

FPL 300+	3
FPL 200-299	2
FPL 150-199	1
FPL under 150	0

c. Children 6-19

FPL 300+	3
FPL 200-299	2
FPL 150-199	1
FPL under 150	0

Source: KFF/KCMU Medicaid Database. Income Eligibility Levels for Children's Regular Medicaid by Annual Incomes and as a Percent of Federal Poverty Level (FPL), 2005.

2. Pregnant Women

States are required to cover pregnant women with family incomes equal to or below 133% of FPL. Women who qualify through this pathway are limited to services related to pregnancy and complications of the pregnancy. Eligibility is time-limited and extends to 60 days after labor.

Many states have chosen to extend eligibility beyond the statutory ceiling. These are therefore awarded extra points under our scoring protocol, reflecting research that shows that children experience better access and use of health care when adults in their families are also covered.ⁱ Additionally, some states do not require an asset test for pregnancy coverage. An asset tests counts the resources that applicant may have available to them beyond their earnings and income, up to a fixed dollar limit. The higher the asset limit, the higher the points given to a particular program.

Points assigned to this indicator are as follows: **5 Total Possible**

a.	FPL 250+	3
	FPL 200-249	2
	FPL 150-199	1
	FPL under 150	0

b. No asset test

Yes	2
Over \$5000	1
\$5000 and under	0

Sources: KFF/KCMU Medicaid Database. Income Eligibility Levels for Pregnant Women Applying for Medicaid by Annual Income and as a Percent of Federal Poverty Level (FPL), 2005; and No Asset Tests Required Under Medicaid for Pregnant Women, 2005.

ⁱ Ku L. Broadus M. The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms, Center on Budget and Policy Priorities, 2000.

3. Medically Needy

The term medically needy refers to an optional group made up of individuals who qualify for coverage because of high medical expenses, most often hospital and nursing home care. These individuals meet Medicaid's categorical requirements (i.e., they are children or parents or individuals with disabilities) whose income is too high to enable them to qualify as "categorically needy." The "medically needy" are eligible because they have "spent down" as a result of their medical expenditures. Not all states cover the medically needy, and those that do tend to offer them a more restricted package of services than is provided to the categorically needy. Coverage differentials are reflected under scope of services, and are scored as such.

Points assigned to this indicator are as follows: **11 Total Possible**

a. Overall coverage	
Yes	5
No	0
b. Eligibility standards for Individuals	
FPL 71%+	3
FPL 51-70%	2
FPL 31-50%	1
FPL under 30%	0
c. Couples	
FPL 71%+	3
FPL 51-70%	2
FPL 31-50%	1
FPL under 30%	0

Source: KFF/ KCMU Medicaid Database. Medically Needy Eligibility as a Percent of Federal Poverty Level, 2001.

4. Aged, Disabled, Blind

This eligibility group reflects Medicaid's history: the program was originally tied to the Supplemental Security Income (SSI) Program, which provides cash assistance to aged, blind, or disabled individuals who meet income and resource requirements. In order to qualify as having a disability, an individual must have a severe "medically determinable physical or mental impairment" and be unable to engage in any "substantial gainful activity." "Blindness" is defined as having 20/200 vision or less with the use of a correcting lens in the individual's better eye; or having tunnel vision of 20 degrees or less. Eligibility for the aged is income- and resource-based. Some of the aged are eligible for the full Medicaid benefits package offered in their state, plus assistance with Medicare premiums and cost-sharing. Others are covered only for the costs of Medicare premiums and cost-sharing.

A group of 11 states retains stricter-than-SSI aged and disabled eligibility rules, including lower income and/or assets levels, less generous income disregards, and more stringent disability rules than SSI. These states are referred to as "209(b) states" for the section of Public Law 92-603 (1972) that authorized that option. Because these states restrict access to care to a particularly vulnerable population, they have a point deducted from their scores for the indicator covering SSI [4 (c) below]. The score under that indicator reflects that deduction.

Points assigned to this indicator are as follows: **6 Total Possible**

a. Coverage	
Yes	2
No	0
b. State supplemental payments	
FPL 100%+	2
FPL under 100%	1
No coverage	0
c. SSI	
FPL 50%+	2
FPL under 50%	1
No coverage	0

Sources: KFF/ KCMU Medicaid Database. Income Eligibility Levels for Other Medicaid Enrollment Groups as a Percent of Federal Poverty Level, and Medicaid Coverage Expansions for State Supplementary Payment Recipients. SSI data for Mississippi computed from eligibility levels indicated in: <http://www.aapd-dc.org/News/Katrina/MississippiLevelsChart.pdf>.

5. Breast and Cervical Cancer

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave states the option of providing full Medicaid benefits to uninsured women under 65 who were diagnosed with cervical or breast cancer through the Center for Disease

Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program. Coverage extends through the duration of treatment. The eligibility pathways have three different options. Option 1 covers any women screened by a provider in the CDC screening network. Option 2 includes any women screened by a non-CDC network provider who receives some CDC funds to support screening services. Option 3 includes any women screened by a provider the state decides to consider part of the CDC screening network. These options are additive, with some states offering two or all three. States are assigned points depending on the options they provide: the broader the coverage, the higher the score.

Presumptive eligibility allows women who appear to be eligible for Medicaid to enroll in the program on a temporary basis and receive services and ultimately be reimbursed for services while their Medicaid applications are being processed. Because this allows for prompt treatment, states that allow this are rewarded in our scoring scheme.

Points assigned to this indicator are as follows: **6 Total Possible**

a. Option 3	2
Option 2	1
Option 1	1
Options 1+2	2
Options 1+3	3
Options 2+3	3
Opts. 1+2+3	4

b. Presumptive eligibility

Yes	2
No	1

Source: KFF/KCMU Medicaid Database. Medicaid Breast and Cervical Cancer Treatment Coverage Expansions, 2002.

6. Tuberculosis Patients

The Omnibus Reconciliation Act of 1993 amended the Social Security Act to give states the option of extending Medicaid eligibility to low-income individuals infected with tuberculosis, while limiting their coverage to tuberculosis-related services.

Points assigned to this indicator are as follows: **1 Total Possible**

Yes	1
No	0

Source: Hearne J. Medicaid Eligibility for Adults and Children, August 3, 2005. CRS Report for Congress. Congressional Research Service, The Library of Congress: CRS-25. The data come from CMS Publication, CMS-11024-03.

7. State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) was enacted in 1997 to cover low-income children who did not otherwise qualify for Medicaid. Although this is an optional entitlement, all states have SCHIPs. We have therefore focused on program characteristics that foster or hinder access to care.

Points assigned to this indicator are as follows: **11 Total Possible**

- a. **Cost-sharing.** Because states have different ways of incorporating cost-sharing into the program and there is a lot of variation among states, we have assumed a modal family of two children in a family with FPL of 150% to compute a monthly payment (i.e., if there is an enrollment fee/child rather than a monthly premium, we have divided this by 12 in order to make it comparable).

No cost-sharing	4
Payment of under \$5/month	3
Payment of \$5-\$15/month	2
Payment of \$15.01 to \$25/month	1
Payment of over \$25/month	0

- b. **Length of time a child is required to be uninsured prior to enrolling in coverage.** Some states stipulate the number of months that a child must be insured before he or she can be covered by SCHIP. This provision is designed to avoid 'crowd-out,'ⁱⁱ and hence protect the private insurance market. Requiring a lengthy waiting period prior to enrollment increases a child's vulnerability, and sends the erroneous message that breaks in coverage are acceptable.

ⁱⁱ "Crowd out" is defined as a phenomenon whereby the extension of a public program may prompt some to drop their insurance coverage to take advantage of the public subsidy.

None	4
1 month	3
2-3 months	2
4 or more months	1

- c. Coverage of parents.** Recent research has shown that children have greater access to care when their parents are also covered. Moreover, states that have expanded Medicaid coverage for low-income parents have had greater gains in enrollment among eligible children than those that have not extended coverage to their parents.ⁱⁱⁱ We are therefore rewarding states that cover parents.

Cover parents	2
Do not cover any parents	0

- d. Seamlessness with Medicaid.** Programs that are integrated with Medicaid are more easily administered and avoid gaps in coverage. They are therefore preferable to separate programs.

Integrated with Medicaid	1
Separate from Medicaid	0

Sources: KFF/ KCMU. SCHIP Enrollment in 50 States. December 2004 Data Update. September 2005: 17-19; Bansack CA and Raphael S. The Effects of State Policy Design Features on Take Up and Crowd Out Rates for the State Children's Health Insurance Program. Discussion Paper 05-02: 47; Center on Budget and Policy Priorities, Coverage of Parents Helps Children, Too. October 20, 2006. Data for (a) for Texas based on KFF/KCMU. Dunkelberg A and Molly O'Malley. Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts. July 2004: 7.

Scope of Services

SERVICES DEFINED BY TYPE OR TARGET GROUP

Of the four categories we have focused on, scope of services is the most challenging to assess and score. States have wide discretion in terms of what services they offer, and there are many varieties of a given service. This allows states to make modifications and adjustments. This area is not only a moving target, constantly changing with fiscal incentives or constraints, but it also implies eligibility: a given package of services may be offered to one group (e.g., the categorically needy) and not to another (e.g., the medically needy). Additionally, even within a given rubric, different packages of services may be made available to varied population subgroups. Distinctions among states, or changes that occur over time within a given state, can be quite nuanced: for example, a state can drastically reduce the number of hours a particular therapy is covered, and this may not be reflected in the data.

For many of the services that follow, "scope of services" is defined in terms of both the population(s) covered and the comprehensiveness of the offering. In the case of the former, we have given higher scores to those that cover a wider population. States providing different service packages to different populations are scored for the lowest or most restricted array of services which they cover under Medicaid.

1. Targeted Case Management

This service, which is not offered by all states, seeks to assist beneficiaries in gaining and coordinating access to medical, social, and educational care and other services appropriate to their needs. It is intended for non-institutionalized patients, and may be integrated as part of another covered service. It may be provided by Medicaid agency staff through utilization review, prior approval or other administrative activities, or by appropriately qualified case managers. Most states provide this service to at least one group. Several states offer targeted case management to a number of different groups who meet specific criteria such as age, multiplicity of diagnoses, disease category, severity of condition, perceived risk for given conditions (abuse, exposure to lead), language difficulty, refugee status, etc. This service uses a variety of payment modalities and has been criticized for being used as a catchall for services that do not fit under other rubrics.

Points assigned to this indicator are: **4 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. Covered, no limitations	2
Covered, with limitations with respect to population served, quantity, duration and/or frequency of service	1
Not covered	0

ⁱⁱⁱ Center on Budget and Policy Priorities. "Coverage of Parents Helps Children, Too." October 20, 2006.

Source: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits: Online Database (hereafter shortened as KFF/KCMU Medicaid Database), Benefits by Service: Targeted Case Management (October 2004).

2. Free-standing Ambulatory Surgery.

These are services furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Services are provided by or under the direction of a physician or dentist. They may cover birthing centers or dialysis centers, depending on the state.

Points assigned to this indicator are: **4 Total Possible**

- a. **Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.
 - Covered, no co-pay 2
 - Covered, with co-pay 1
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Clinic Services, by an organized facility of clinic not part of a hospital: Freestanding Ambulatory Surgery Center (October 2004).

3. Diagnostic, Screening and Preventive Services

Even when these do not appear as an option offered by a given state, some of these services are covered through other providers, such as physicians. **Diagnostic services** include medical procedures or supplies recommended by a physician or other licensed health practitioner to identify the existence, nature, or extent of a suspected illness, injury, or other health deviation in an individual (e.g., radiological and laboratory tests). **Screening services** involve the use of standardized tests given under medical direction in the mass examination of a designated population without prior evidence of disease to detect certain conditions or diseases or those at risk for certain conditions or diseases. **Preventive services** are those provided by a physician or other health practitioners to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and efficiency (e.g., mammography, annual gynecological exams, and immunizations).

Points assigned to this indicator are as follows: **5 Total Possible**

- a. **Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.
 - Covered in full 3
 - Covered with limitations in terms of population, scope of services, frequency, but no co-pays 2
 - Covered with co-pays 1
 - Not covered 0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Diagnostic, Screening and Preventive Services (October 2004).

4. Home and Community-Based Services

Through waivers, states are able to provide beneficiaries who meet requirements for admission into an institutional setting with services and supports that allow them to stay in their homes or a community-based setting and maintain their independence and their ties to family and friends. A state may elect to restrict these services to different demographic groups, conditions, or types of care.

Points assigned to this indicator are as follows: **10 Total Possible**

- a. **Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b. The populations served vary by state, and there are currently eight groups that encompass those served. These include the following: acquired or traumatic brain injury; aged; autistic; developmentally disabled/mentally retarded; HIV/AIDS; medically fragile and/or technology dependent; mentally ill; physically or otherwise disabled. Our scoring protocol gives one point to each of the groups covered.

Source: KFF/KCMU Medicaid Database. Benefits by Service: Home and Community-Based Services Waiver (October 2004).

5. Home Health Services

Home health services are provided to beneficiaries within their homes as part of a physician-ordered written plan of care. Services include visits by an RN or credentialed home health aide employed by a home health agency, as well as medical supplies, equipment, and appliances required by the beneficiary and suitable for use in the home.

Points assigned to this indicator are as follows: **4 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. Covered with no co-pay or limitation	
Co-pay, no limitations	2
No co-pay, limitations	1
Co-pay and limitations	0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Home Health Services Waiver (October 2004).

6. Hospice Care

This service is offered by most states. In providing this service, they are required to adhere to most requirements of the Medicare program for the same type of service. They must therefore offer at least 210 days of coverage and must use the same reimbursement methodology used by Medicare. This is based on four levels of care: routine home care, continuous home care, in-patient respite care, and general in-patient care.

Points assigned to this indicator are as follows: **4 Total Possible**

a. Population covered	
CN and MN	2
CN	1
Not covered	0
b. Coverage without limitations	
Coverage with limitations	2
Not covered	1
	0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Hospice Care (October 2004).

7. In-patient Psychiatric Services, Under Age 21

These services may be provided in freestanding psychiatric hospitals or in dedicated units in a general hospital. Admissions often require prior approval and may require period recertification of a beneficiary's continuing need for care.

Points assigned to this service are as follows: **4 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
No coverage	0
b. Covered without limitations	
Co-pay, no limitations or	2
no co-pay, some limitations	1
Not covered	0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Inpatient Psychiatric Services, under age 21 (October 2004).

8. In-patient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Illness, 65+

This indicator includes in-patient institutions for mental illness, and other institutions with at least 16 beds for persons diagnosed with a mental condition who are 65 years old and over. Patients may take occasional leave from these facilities, and some states are paid to hold or save a bed during these leaves.

Points assigned to this service are as follows: **5 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. No co-pay or limitations	3
Co-pay, no limitations	2
No co-pay, some limitations	2
Co-pay, limitations	1
Not covered	0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Inpatient Hospital, Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Diseases, age 65 and older (October 2004).

9. Intermediate Care Facility Services for Persons with Mental Retardation

These facilities include diagnosis, treatment, and rehabilitation for persons who are developmentally disabled or have related conditions. Some states allow such institutions to hold a bed for a patient on temporary leave or in transition to a community setting.

Points assigned to this service are as follows: **3 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. Coverage without limitations	1
Coverage with limitations	0
<i>(All states cover this service).</i>	

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Intermediate Care Facility Services for the Mentally Retarded (October 2004).

10. Nursing Facility Services other than for Mental Illness

These services are covered by all states, although they require some form of approval and/or periodic recertification of continued need. Most states allow payment for this service, more generally known as nursing home care, to hold or save a bed during a resident's brief hospitalization or for therapeutic leaves of absence to visit family or friends.

Points assigned to this service are as follows: **3 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
b. Coverage without limitations	1
Coverage with limitations	0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Nursing Facility Services, other than in an Institution for Mental Diseases (October 2004).

11. Program of All-Inclusive Care for the Elderly (PACE)

A PACE is based on a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE sites provide a variety of long-term care services in an adult health care setting, supplemented with in-home and referral services as necessary. Participants in this program must be at least 55 years old and be certified by the state as eligible for nursing facility care but able to live safely in the community. Services include prescription drugs, and hospital and nursing facility care. In addition, primary care, social services, therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals are provided at the adult day health center. Each PACE site serves a limited number of patients, usually under 200. Although this is a "boutique" service, we have given points to states that are pioneering in offering this type of comprehensive care.

Points assigned to this service are as follows: **3 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. Have a program	1
Do not have a program	0

Sources: KFF/KCMU Database. Benefits by Service: Program of All-Inclusive Care for the Elderly (October 2004); and <http://www.cms.hhs.gov/PACE> (updated 6/17/06).

12. Personal Care Services

This indicator includes an array of human assistance care provided to beneficiaries with disabilities and chronic conditions of all ages. They are an alternative to institutionalization, and include help with activities of daily living (e.g., eating, drinking, bathing, dressing, toileting, grooming, transferring and mobility) as well as other supportive services, including light housework, laundry, meal preparation and grocery shopping, and transportation.

Points assigned to this service are as follows: **5 Total Possible**

a. Population covered		
CN and MN		2
CN only		1
Not covered		0
b. No co-pay or limitations		
No co-pay, limitations		2
Co-pay, limitations		1
Not covered		0
<i>(No state has co-pay, no limitations).</i>		

Sources: KFF/KCMU Medicaid Database. Benefits by Service: Personal Care Services (October 2004).

13. Sickle Cell Services

Sickle cell services were added as an optional Medicaid service through legislation enacted as part of the JOBS Act of 2004. Covered services and treatment include chronic blood transfusions to prevent stroke; genetic counseling and testing; and other treatment and services to prevent stroke. Although no state has availed itself of these services, we have included them in our scoring scheme because they represent a novel attempt in using Medicaid to address race-based health disparities.

Points assigned to these services are as follows: **1 Total Possible**

Covered	1
Not covered	0

Source: Gerald Zellinger, Center for Medicaid and Medicare Services, personal communication, December 12, 2006.

14. Private Duty Nursing Services

Private duty nursing services are provided for those who require more individual and continuous care than is available from a visiting home health agency or routinely provided by the nursing staff of a hospital or skilled nursing facility. Typically, beneficiaries of this service depend on technology to assist with essential functions, such as mechanical ventilation or assisted respiration, frequent oral or tracheotomy suctioning, or nasogastric feeding or medication.

Points assigned to these services are as follows: **5 Total Possible**

a. Population covered		
CN and MN		2
CN only		1
Not covered		0
b. No co-pay or limitations		
Co-pay, no limitations or		3
no co-pay, limitations		2
Co-pay, limitations		1
Not covered		0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Private Duty Nursing Services (October 2004).

15. Rehabilitation Services: Mental Health and Substance Abuse

These services include any medical or remedial services recommended by a physician or other licensed health practitioner for maximum reduction of physical or mental disability and restoration of beneficiaries to their best possible functional level. These services may overlap or be subsumed under other rubrics, e.g., psychologist services. Rehabilitation services for mental health and substance abuse include assessment and counseling; partial hospitalization programs of structured group activities; and intensive therapy, skill training, and other community support services for beneficiaries who are difficult to engage in treatment.

Points assigned to these services are as follows: **5 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. No co-pay or limitations	3
Co-pay, no coverage limitations	
or no co-pay, with limitations	2
Co-pay, limitations	1
Not covered	0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: Rehabilitation Services: Mental Health and Substance Abuse (October 2004).

16. Tobacco-dependence Treatments

These treatments include individual, group, and telephone counseling, as well as pharmacotherapy. CDC data from 2000 indicate that 36% of Medicaid beneficiaries smoke, a prevalence 50% higher than that for the overall U.S. population.^{iv} One of the 2010 national health objectives is thus to provide nicotine-dependence treatment under Medicaid in the 50 states and DC.

Not every state provides this service, and some provide more varied and comprehensive treatment options than others. Our scoring system reflects this, giving more points to those with a broader array of services.

Points assigned to these services are as follows: **3 Total Possible**

Five or more treatments covered	3
2-4 treatments covered	2
1 treatment covered	1
Not covered	0

Sources: KFF. www.statehealthfacts.org State Medicaid Coverage of Tobacco Dependence Treatments, 2003; and Centers for Disease Control and Prevention. State Medicaid Coverage for Tobacco-Dependence Treatments—United States, 1998 and 2000. *Morbidity and Mortality Weekly Report*. Vol. 50, No. 44. November 9, 2001: 981.

WOMEN'S SERVICES

These services are grouped together because they all relate to family planning and are reimbursed at a higher matching federal rate: the government matches the cost of all family planning services and supplies at 90% for all states. States therefore have an added incentive for covering these under Medicaid.

17. Income Eligibility for Pregnant Women

Women are disproportionately represented among the poor, and are therefore more dependent on Medicaid as their health safety net.

The points assigned to this indicator are as follows: **3 Total Possible**

200% and over	3
150%-199% FPL	2
133%-149% FPL	1

Source: KFF. www.statehealthfacts.org. Income Eligibility Levels for Pregnant Women Applying for Medicaid by Annual Income and as a Percent of the Federal Poverty Level (FPL), 2005.

18. Abortions

In certain circumstances, abortions must be covered under Medicaid. Most states adhere to the federal standard stipulated in the Hyde Amendment. This bans state use of federal Medicaid dollars to pay for abortions except in cases involving life endangerment, rape and incest, and other stipulated exceptions. Some states, however, use their own funds to cover other medically necessary abortions, usually defined as those to protect the mental or physical health of the women, under Medicaid. Those that exceed the federal minimum requirements and provide broader coverage are therefore rewarded for their enhanced scope of services and their willingness to commit resources for this purpose.

Points assigned to this indicator are as follows: **1 Total Possible**

Exceed federal minimum requirements	
Yes	1

^{iv} Centers for Disease Control and Prevention. State Medicaid Coverage for Tobacco-Dependence Treatment—United States, 1998 and 2000. *MMWR*. Vol. 50/No. 44. November 9, 2001: 979-982.

No

0

Source: KFF. www.statehealthfacts.org State Funding of Abortions Under Medicaid, as of June 1, 2006.

19. Contraceptives

Contraceptives include different offerings that affect the scope of services provided. There are therefore eight items that are subsumed under this indicator, each of which has a discrete score which is then added to constitute the total for the indicator.

Although items **a**, **b**, **c**, and **d** (see below) are not specific to Medicaid beneficiaries, they illustrate the statewide constraints (or lack thereof) under which health providers operate and thus affect Medicaid patients.

The points assigned to this indicator are as follows: **9 Total Possible**[▼]

a.	Coverage	
	Mandates comprehensive coverage	2
	Partial mandate	1
	No mandate	0
b.	Drugs and devices	
	Yes	1
	No	0
c.	Allows refusal of employers or insurers to provide service	
	Yes	-2
	No	0
d.	Allows individual providers to refuse providing a specific service. This includes three services: abortion, contraception, sterilization. For each of these:	
	Yes	0
	No	1
e.	Expanded eligibility	
	(1) Has secured waiver to cover services	
	Yes	1
	No	0
	(2) Includes men	
	Yes	1
	No	0
	(3) Limited to 19+	
	Yes	0
	No	1

Source for **a-c** above: KFF. State Mandated Benefits: Contraceptives, as of June 1, 2006. Source for **d**: KFF. States That Allow Individual Providers to Refuse Women's Health Services, as of June 1, 2006. Both sources are available at www.statehealthfacts.org. Source for **e**: KFF. States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid, as of June 1, 2006. www.statehealthfacts.org.

SERVICES DELIVERED BY SPECIFIC PROVIDERS

20. Chiropractor Services

These services are most often limited to manual manipulation of the spine to treat a subluxation demonstrated by x-ray.

Points assigned to this indicator are as follows: **5 Total Possible**

a.	Population covered	
	CN and MN	2
	CN only	1
	Covering only one categorical group or not covered	0
b.	Coverage with no co-pay	3
	Co-pay or limitations	2
	Co-pay and limitations	1

[▼] This indicator is a composite of several items, one of which includes negative points. But because the number of points were added prior to weighting, and all states earned positive points for the indicator as a whole, the final raw score for this indicator was positive and treated as such.

Not covered

0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Chiropractor Services (October 2004).

21. Dental Services

Dental services include prophylaxis and treatment, although not all states offer dental services and there are a number of limitations which states have imposed on coverage. Services may be restricted by age group, type of eligibility under Medicaid, types of service, and frequency of treatment. In addition, some states require prior approval for expensive or extensive procedures such as multiple extractions, root canals, and crowns.

Points assigned to this indicator are as follows: **8 Total Possible**

a. Populations covered

CN and MN	2
CN only	1
No coverage	0

b. Cost-sharing

No co-pay	3
Co-pay of under \$7/visit	2
Co-pay of \$7 and over/visit	1

c. Service Scope

No limitations or minor limitations (includes prevention and restorative services)	3
Limited to trauma or ER	1
No coverage	0

Source: KFF/ KMCU Medicaid Database. Benefits by Service: Dental Services (October 2004).

22. Nurse Anesthetist Services

These services include providing anesthesia and related services during surgical procedures, most often under the direction or supervision of a physician. In some cases, a small co-pay is required (\$4 or less). Because the main distinction concerns who is covered, states receive points for this rather than for whether or not they impose cost-sharing.

The points assigned to this indicator are as follows: **2 Total Possible**

Population covered

CN and MN	2
CN only	1
Not covered	0

Source: KFF/ KMCU Medicaid Database. Benefits by Service: Certified Registered Nurse Anesthetist Services (October 2004).

23. Nurse Practitioner Services

This indicator refers to those services for which nurse practitioners can bill directly. This can vary greatly from one state to another, depending on licensure and scope of practice requirements.

Points assigned to this indicator are as follows: **5 Total Possible**

a. Population covered

CN and MN	2
CN only	1
Not covered	0

b. Services

No co-pay, no limitations	3
Co-pay, no limitations or limitations, no co-pay	2
Co-pay and limitations	1
Not covered	0

Source: KFF/ KMCU Medicaid Database. Benefits by Service: Nurse Practitioner Services (October 2004).

24. Optometrist Services

Optometrist Services are those in which beneficiaries undergo a refractive exam for eyeglasses. All states cover this service but there are restrictions by populations covered, frequency of service, and cost-sharing; some states also require prior approval for coverage of this service.

Points assigned to this indicator are as follows: **4 Total Possible**

- a. Population covered**
 - CN and MN 2
 - CN only 1
- b.**
 - No co-pays or limitations 2
 - Co-pays, no limitations or no co-pays, some limitations 1
 - Co-pays and limitations 0

Source: KFF/KMCU Medicaid Database. Benefits by Service: Optometrists Services (October 2004).

25. Podiatrist Services

These services provide care of the feet and can prevent complications from certain conditions such as diabetes. They are therefore not only clinically necessary but also cost-effective. States often require cost-sharing, usually a co-pay that varies between \$.50 and \$4.00 per visit. Some states impose other limitations on these services; these include restrictions on frequency and type of service, prior condition, or site of service. Yet another limitation involves requiring prior approval. For purposes of our scoring, we consider any limitation a restriction, and deduct points for this.

Points assigned to this indicator are as follows: **5 Total Possible**

- a. Populations covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.**
 - No co-pay or limitations 3
 - Co-pay, no limitations or No co-pay, some limitations 2
 - Co-pay and limitations 1
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Services (October 2004).

26. Psychologist Services

Psychologist services reflected in our scores are those for which states allow psychologists to bill directly for services rendered to adult Medicaid beneficiaries who are not also covered by Medicare. Some states have imposed co-pays ranging between \$.50 and \$7.00 per visit. More serious limitations refer to type of service covered, and that is what we have based our scores on.

Points assigned to this indicator are as follows: **4 Total Possible**

- a. Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.**
 - Testing, evaluation and treatment 2
 - Testing only or evaluation only 1
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Psychologist Services (October 2004).

REHABILITATION SERVICES

27. Occupational Therapy Services

Occupational therapy services are provided in different settings such as hospitals and nursing facilities and are billed by these providers as the employers of occupational therapists. Services considered here for purposes of our scoring are limited to those where states have opted to allow occupational therapists to bill directly for services rendered to adult Medicaid beneficiaries who are not also covered by Medicare. Services may be limited by type of population, type or

frequency of service, patient's rehabilitation potential, and other factors. In addition, prior requirement and a co-pay may be required. For our purposes, any such restriction is counted as a limitation on coverage and is thus scored.

Points assigned to this population are as follows: **5 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b.	
Covered, without co-pay or limitation of any kind	3
Co-pays and/or limitations	2
Not covered	0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Occupational Therapy Services (October 2004).

28. Physical Therapy Services

These services are provided in different settings such as hospitals and nursing facilities and are billed by these providers as the employers of physical therapists. Services considered in our scores are limited to those where states have opted to allow physical therapists to bill directly for services provided to adult Medicaid beneficiaries who are not also covered by Medicare. Services are limited by type of beneficiary, trigger condition, patient's rehabilitation potential, and frequency or duration of service. Other restrictions include cost-sharing and the requirement of prior approval. Any of these is considered a limitation for purposes of our score.

Points assigned to this indicator are as follows: **5 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b.	
Covered, without co-pay or limitation of any kind	3
Co-pays and/or limitations	2
Not covered	0

Source: KFF/KCMU Medicaid Database. Physical Therapy Services (October 2004).

29. Speech, Hearing and Language Services

These services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist and audiologist. These services may be provided at different institutional settings, in which case the provider bills directly for those services. Services included in our scores are limited to those where states have opted to allow speech pathologists and audiologists to bill directly for services provided to Medicaid beneficiaries not also covered by Medicare. Services may be provided to certain populations only, and this is reflected in indicator **a** below. In addition, the scope of services may be limited by the imposition of certain requirements, including cost-sharing, and prior approval and by restrictions by type, frequency and duration of service, condition of patient, or trigger event. Any of these is considered a limitation in our scores.

Points assigned to this indicator are as follows: **5 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b.	
Covered, without co-pay or limitation	3
Co-pay and/or limitations	2
Not covered	0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Services for Speech, Hearing and Language Disorders (October 2004).

DEVICES AND EQUIPMENT

30. Dentures

Coverage for dentures varies greatly from state to state. Some limit coverage to certain populations (e.g., pregnant women) and specific conditions. Services may also be limited by type, scope, and/or frequency. A few states also impose cost-sharing or cap the service at a given dollar figure.

Points assigned to this indicator are as follows: **5 Total Possible**

- a. Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.**
 - Covered, no co-pay or limitations 3
 - Co-pay and/or limitations 2
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Dentures (October 2004).

31. Eyeglasses

Because eyeglasses are mandated for children, the scope of services listed here refers to adult benefits. Most states cover eyeglasses, but all have established limits in terms of frequency of service or condition. Some also have co-pays, but these are nominal (between \$.50 and \$3.00 per pair of glasses) and are therefore not factored into our scores. For purposes of scoring the scope of this service we have defined “minor limitations” as providing one pair of glasses every one or two years. States providing this service less frequently, or imposing other restrictions in terms of type or severity of condition, are considered as having “significant limitations” and are scored accordingly.

Points assigned to this indicator are as follows: **5 Total Possible**

- a. Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.**
 - Covered with minor limitations 3
 - Covered with significant limitations 2
 - Not covered 0

Source: KFF/KMCU Medicaid Database. Benefits by Service: Eyeglasses (October 2004).

32. Hearing Aids

Hearing aids are covered by most states, but almost all impose some type of limitation. The latter can take several forms, including cost-sharing, coverage only beyond a predetermined level of hearing loss, type and frequency of service or adjustment, and type of hearing aid covered. In some cases, states require prior approval before covering the service. Although some states have cost-sharing, co-pays do not exceed \$3 and are therefore not considered onerous enough to constitute a deterrent to service; they are therefore not factored into our scoring scale.

Points assigned to this indicator are as follows: **5 Total Possible**

- a. Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.**
 - Covered without limitations 3
 - Covered with adjustments every 2 years or more often 2
 - Covered with adjustments less often than every 2 years 1
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Hearing Aids (October 2004).

33. Medical Equipment and Supplies

These are covered by all but one state. This service includes medical equipment and supplies suitable for use in the home as an alternative to institutionalization and is most often prescribed by a physician or other licensed health practitioner. Some states limit coverage by demographic group, type or cost of equipment, frequency of replacement, or number of pieces of equipment. Some impose cost-sharing, but this is not scored as a significant limitation unless it exceeds \$5 per piece of equipment or over five percent of the cost of the same. Similarly, although most states require prior approval, this is seen as a desirable quality control measure rather than an artificially-established deterrent to service.

Points assigned to this indicator are as follows: **5 Total Possible**

- a. Population covered**
 - CN and MN 2
 - CN only 1
 - Not covered 0
- b.** Covered without limitations or with minor limitations (as defined above) 3
 - Covered with significant limitations 2
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Medical Equipment and Supplies (October 2004).

34. Prosthetic and Orthotic Devices

These include replacement, corrective, or supportive devices prescribed by a physician or other licensed health practitioner to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed part of the body. Most states require prior authorization, but this is seen as a measure to ensure medical necessity and appropriate utilization rather than a limitation. States that do so are not penalized for this. At the same time, states impose limitations such as co-pays, or limit their coverage to only certain devices or appliances, or certain physical conditions. They may also cap coverage at a specified dollar amount. States imposing any of these limitations receive a lower score than those that do not.

Points assigned to this indicator are as follows: **5 Total Possible**

- a. Population covered**
 - CN and CM 2
 - CN only 1
 - Not covered 0
- b.** Covered with no cost-sharing or limitations 3
 - Covered with cost-sharing and/or limitations 2
 - Not covered 0

Source: KFF/KCMU Medicaid Database. Benefits by Service: Prosthetic and Orthotic Devices (October 2004).

DRUGS

35. Drugs

Drugs are covered, but subject to restrictions that vary by state. The variations include whether or not Medicaid programs rely on Preferred Drug Lists, cover over-the-counter (OTC) drugs (and, if so, what categories they cover), have cost-sharing, incorporate incentives to encourage the use of lower-cost generic drugs, and/or require prior authorization for certain types of drugs. While some of these measures are aimed primarily at controlling costs, they may also have salutary benefits by restricting the indiscriminate use of potentially dangerous medications.

Because there is much variability in the coverage of OTC drugs, we have adjusted the scores to reflect this. There are eight categories of OTC drugs, depending on their use. These comprise the following: allergy, asthma, and sinus; analgesics; cough and cold; smoking deterrents; digestive products (non-H2 antagonists); H2 antagonists; feminine products; and topical products. We have scored states according to the scope of their coverage.

Points assigned to this indicator are as follows: **11 Total Possible**

- a. Have Preferred Drug List**
 - Yes 5
 - No 0
- b. Cover OTC drugs**
 - Fully cover 5 or more of 8 categories of drugs 2
 - Fully cover 1-4 of the categories 1
 - Cover some categories only with restrictions or do not cover 0
- c. Prior authorization required**
 - Yes 1
 - No 0
- d. Generic utilization rate: Percentage of prescriptions dispensed that are generic**

55 and over	2
50 - 54	1
49 and under	0
e. Cost-sharing required	
Yes	0
No	1

Sources: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. Crowley, Ashner, and Elam. State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, October 2005; National Pharmaceutical Council. Pharmaceutical Benefits Under State Medical Assistance Programs, 2005-2006, 2006; see <http://www.npcnow.org/resources/PharmBenefitsMedicaid.asp>. Data for indicator **d** are based on Department of Health and Human Services, Office of the Inspector General. Generic Drug Utilization in State Medicaid Programs. OEI-05-05-00360. July 2006, Table 2: Generic Drug Utilization in State Medicaid Programs, 2004: 19-20. Data for Arizona for are based on Testimony of Anthony D. Rogers, Director, Arizona Health Care Cost Containment System Before the Committee on Energy and Commerce Subcommittee on Health. "Medicaid Prescription Drugs: Examining Options for Payment Reform," June 22, 2005. <http://energycommerce.house.gov/108/Hearings/065222005hearing1554/Rodgers.pdf>

TRANSPORTATION

36. Non-Emergency Medical Transportation

This service is covered by most states to enable Medicaid beneficiaries to obtain care from local providers as well as from tertiary centers distant from their homes. States have the option of providing this as a State Plan service or as an administrative expense and are eligible for federal matching funds under either of these options. Here, we include only those states that offer this service as part of their State Plan. States may require some measure of cost-sharing or impose some limitation in terms of cost, frequency, or miles. Most states that offer this service require prior approval. Our scoring scale penalizes states for cost-sharing and other limitations but excludes prior approval as a limitation because it ensures greater accountability.

Points assigned to this indicator are as follows: **4 Total Possible**

a. Population covered	
CN and MN	2
CN only	1
Not covered	0
b. Covered without limitations or co-pay	
Covered without limitations or co-pay	2
Covered with limitations and/or co-pay	1
Not covered	0

Source: KFF/ KCMU Medicaid Database. Benefits by Service: non-Emergency Medical Transportation Services (October 2004).

Quality of Care

When the Public Citizen Health Research Group first ranked state Medicaid programs almost two decades ago, data on the quality of care were described as being "virtually nonexistent."^{vi} The situation has improved only marginally since then. Despite frequent calls for greater accountability and the increasing ubiquity of information technology to collect and analyze data, quality review by the Federal government or state Medicaid programs is uneven at best. The data reflected in this protocol therefore include the few indicators that shed light on aspects of quality. Because we included only those measures that: (1) were available for all or most states, and (2) were deemed valid and reliable by experts, we have nine indicators that reflect some measure of quality control, are markers for quality care, or suggest favorable health outcomes.

1. Mandatory Quality Reporting Requirements in Place

A minority of states require institutions, whatever their auspices, to report medical errors of different types. These can include medication errors, as well as adverse/sentinel events that result in injury. Medication errors include omissions (failure to administer an ordered medication dose), quantity errors (related to the dose, strength, or quantity of drug prescribed), and errors caused by a medication not having been authorized by the prescriber. An adverse event is an injury caused by or associated with medical management that results in death or measurable disability.

While there is no assurance that the information provided in mandatory reports will result in intelligence that can be used to improve care, we nevertheless see this requirement as a first step in monitoring the quality of care and thus take cognizance of those states that have mandatory reporting. The data here are statewide and not specific to services provided under Medicaid.

^{vi} Erdman Karen and Wolfe Sidney M. *Poor Health for Poor Americans: A Ranking of States Medicaid Programs*. Public Citizen Health Research Group, 1988: 30.

Points assigned to this indicator are as follows: **1 Total Possible**

Yes	1
No	0

Source: KFF. State Health Facts. Mandatory Quality Reporting Requirement, 2004.

2. Medicaid Fraud Control Unit in Place

States are required by legislation to take safeguards against waste and illegitimate program expenditures. This means protecting Medicaid funds from unscrupulous and fraudulent providers. While some of these safeguards are preventive in nature (i.e., designed to prevent fraud from occurring), most are aimed at correcting fraud after-the-fact, a method that has been called “pay and chase” because of its reliance on recovering improper payments.

Points assigned to this indicator are as follows: **1 Total Possible**

Yes	1
No	0

Source: Dept. of Health and Human Services, Office of the Inspector General. State Medicaid Fraud Control Units Annual Report, FY 2003: 22-23.

3. Nursing Homes: Nurse Hours per Resident Day

While the data on nursing homes are statewide and not specific to Medicaid, the overwhelming majority (93.9 percent) of nursing homes are certified as Medicaid providers. Moreover, Medicaid accounts for almost half of all nursing home expenditures in the US.^{vii}

Higher staffing levels have been repeatedly found to be associated with higher quality of care in nursing homes. In general, the more nursing hours provided, the better the health status of residents and the fewer the deficiencies found in mandated surveys. An expert panel on nursing care as well as the Institute of Medicine have therefore recommended minimum staffing levels of 4.55 per patient day. The Centers for Medicare and Medicaid Services has reported that staffing levels below 4.1 hours per resident day may provide care that can result in harm and jeopardy to residents.^{viii} Our scores therefore reflect these benchmarks, and we have penalized those states whose nursing home hours are under the acceptable level.

Points assigned to this indicator are as follows: **6 Total Possible**

a. Average total nursing home hours per resident day, 2004

4.1 or more	2
3.8-4.0	0
3.5-3.7	-1
Under 3.5	-2

b. Average total licensed nurse hours per resident day, 2004^{ix}

1.5+	4
1.3-1.4	2
Under 1.3	0

Source: Harrington C, Carrillo H, and Mercado-Scott C. Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004. Department of Social and Behavioral Sciences, University of California, San Francisco. August 2005: 75.

4. Nursing Homes: Average Number of Deficiencies, 2004

This indicator assumes that more deficiencies reflect worse care rather than greater diligence in ferreting out deficient care. This assumption is based on the fact that CMS requires state surveyors of nursing homes to assess whether or not nursing home care meets set standards in 15 major areas covering a number of process and outcome measures.

Points given to this indicator are as follows: **2 Total Possible**

9.0 deficiencies and over	0
6.0-8.9	1
Under 6.0	2

^{vii} Sommers A et al. Medicaid's Long-Term Beneficiaries: An Analysis of Spending Patterns. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Fund. November 2006.

^{viii} Harrington C, Carrillo H, and LaCava C. Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1999 Through 2005. Department of Social and Behavioral Sciences, University of California, San Francisco. September 2006.

^{ix} A 2002 GAO study based on 1999 data found that quality of care in nursing homes is related more to staffing than to spending. GAO -02-431R: Nursing Home Expenditures and Quality. June 13, 2002.

Source: Harrington C, Carrillo H, and Mercado-Scott C. Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004. Department of Social and Behavioral Sciences, University of California, San Francisco. August 2005: 79.

5. Nursing Homes: Percentage of Homes with No Deficiencies, 2004

Points given to this indicator are as follows: **2 Total Possible**

20.0% and over	2
10.0% to 19.9%	1
Under 10%	0

Source: Harrington C, Carrillo H, and Mercado-Scott C. Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004. Department of Social and Behavioral Sciences, University of California, San Francisco. August 2005: 79.

6. Nursing Homes: Percentage of Homes Receiving a Deficiency for Actual Harm or Jeopardy, 2004^x

This indicator reflects the proportion of homes that were found to have the most serious deficiencies in terms of severity and scope of damage.

Points assigned to this indicator are as follows: **1 Total Possible^{xi}**

30.0% and over	-2
20.0% to 29.9%	-1
10.0% to 19.9%	0
Under 10.0%	1

Source: Harrington C, Carrillo H, Mercado-Scott C. Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004. Department of Social and Behavioral Sciences, University of California, San Francisco. August 2005: 81.

7. Nursing Homes: Percentage of Facilities with Deficiencies Related to Quality of Care, 2003

Deficiencies related to quality of care are the second most-often reported deficiency, surpassed only by failures to ensure food sanitation.

Points assigned to this indicator are as follows:^{xii} **0 Total Possible**

45% or more	-2
25%-44.9%	-1
Under 25%	0

Source: Harrington C, Carrillo H, Mercado-Scott C. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1998 Through 2004. Department of Social and Behavioral Sciences, University of California, San Francisco. August 2005: 84.

8. Percent of Children Age 19-35 Months Who Are Immunized

Although data on immunization are statewide and are therefore not specific to Medicaid, they are included here because they are among the few data that reflect health outcomes. Moreover, Medicaid covers half of all low-income children and one-quarter of all children in the US.^{xiii} The program therefore pays for a significant fraction of care provided to children and is likely to cover a commensurate proportion of total immunizations.

For this indicator, we relied on CDC data and used data on estimated coverage levels of children who received the 4:3:1:3:3:1 series, which is the recommended series of vaccines for children 19-35 months.^{xiv}

^{*} Deficiencies are placed in one of 12 categories, labeled "A" through "L" depending on the extent of resident harm (severity) and the number of residents adversely affected (scope). The most dangerous category (L) is for a widespread deficiency that causes actual or potential death or serious injury to residents. The deficiencies included under indicator #6 above are rated as G-level or higher. In 2004, the average percent of facilities that received one or more deficiencies at that level was 15.5%, but there is some evidence that states may be downgrading the severity ratings for deficiencies. See: Harrington C, Carrillo H, and Mercado-Scott C. Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1998-2004. Department of Social and Behavioral Sciences, University of California San Francisco, August 2005.

^{xi} Because this indicator's range of points includes both positive and negative values and those values are asymmetrical on either side of zero, the fraction of the maximum possible points used to convert the raw scores into weighted scores was calculated differently depending on whether a state scored a positive or negative number in this indicator. If positive, the fraction was calculated as outlined in the Scoring Process section of the Methods chapter; if negative, the denominator for the relevant fraction was the absolute value of the minimum possible points. In this case, a state which received a raw score of -1 was assigned a fraction of possible points of -½. This negative fraction was then multiplied by the two relative weights to generate a final score in this indicator.

^{xii} Because the range of points ranged from 0 to -2 and it was not possible to score a positive value for this indicator, the fraction of the maximum possible points used in the formula to convert the raw scores into weighted scores could not be calculated with the same process outlined in the Scoring Process section of the Methods chapter. The denominator of the relevant fraction was the absolute value of the minimum possible points. In this case, a state which received a raw score of -1 was assigned a fraction of possible points of -½.

^{xiii} Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. Health coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy. November 2006: 13.

^{xiv} CDC. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months—United States, 2005. MMWR Weekly, September 15, 2006: 55 (36): 992.

Points assigned to this indicator are as follows: **2 Total Possible**

90%+	2
80-89%	1
Under 80%	0

Source: Centers for Disease Control and Prevention. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months—United States, 2005. MMWR Weekly. September 15, 2006/ 55(36): 988-993.

9. Percent of Children with Emotional, Developmental or Behavioral Problems That Received Mental Health Care, 2003

Like indicator #8 above, these are statewide data and are not specific to Medicaid beneficiaries. Nevertheless, Medicaid covers a significant proportion of this care.

Points assigned to this indicator are as follows: **2 Total Possible**

60% or more	2
50%-59%	1
Under 50%	0

Source: KFF. Statehealthfacts.org. Percent of Children (1-17) with Emotional, Developmental, or Behavioral Problems that Received Mental Health Care, 2003. <http://www.statehealthfacts.kff.org>.

Reimbursement

The financial aspects of Medicaid reflect and refract the complexities of the program's administration and coverage of services. Because states' expenditures qualify for federal matching payments, states have an incentive to increase the share of their budgets devoted to Medicaid. At the same time, any such commitment is at the expense of other pressing areas. States are therefore caught in a bind: on the one hand, they want to take advantage of federal matching dollars; on the other, they want to minimize the share of their funds that they spend on health. Some states have therefore devised creative ways to maximize the amount of federal funds that they draw down, occasionally incurring the wrath of federal authorities and other states as a result.

Any changes in Medicaid financing reverberate throughout a state's economy. Because Medicaid is the second largest line item in state budgets and state dollars are matched by federal funds, even small changes can have a sizeable impact on state jobs and income.^{xv} This has made Medicaid difficult to cut: elected officials, responding to their constituents and to the powerful influence of health professionals, hospitals, and nursing homes that are major employers and purchasers in legislative districts, are reluctant to make spending cuts in balancing their budgets.^{xvi}

Reimbursement is an area that is in flux and that varies greatly from state to state; as a result, there are few indicators that are up-to-date and reliable. We have therefore chosen three that serve as markers of a state's fiscal performance in administering its Medicaid program.

While in health care, as in other aspects of life, more is not necessarily better, there is no doubt that greater per capita Medicaid expenditures allow states to offer a wider range of services and pay their providers better. States that commit greater resources therefore receive higher scores. The first indicator therefore reflects payments per enrollee, while the other indicators focus on reimbursement to providers.

1. Medicaid Payments per Enrollee, by Group, FY 2003^{xvii}

This indicator shows spending per beneficiary, by group. States have discretionary authority to distribute their resources according to their population needs, and may thus be favoring one group vis-à-vis another (e.g., the elderly vs. children) in their allocations. The data are therefore broken down by demographic group, and states that receive a high score for a particular group may receive lower scores for other groups.

Points assigned to this indicator are as follows: **8 Total Possible**

a. Adults	
\$3000 and over	3
\$2500 to \$2999	2

^{xv} Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. The role of Medicaid in State Economies: A Look at the Research. April 2004 3-4.

^{xvi} Fossett JW and Burke CE. Medicaid and State Budgets in FY 2004: Why Medicaid is So Hard to Cut. Rockefeller Institute of Government Federalism Research Group, July 2004: 1-2.

^{xvii} Because these data are broken down by demographic group, they are not skewed by the states' particular population composition.

	\$2000 to \$2499	1
	Under \$2000	0
b. Children		
	\$2500 and over	3
	\$2000 to \$2499	2
	\$1500 to \$1999	1
	Under \$1500	0
c. The elderly		
	\$15,000 and over	2
	\$10,000 to \$14,999	1
	Under \$10,000	0

Source: KFF Database. Statehealthfacts.org. Medicaid Payments per Enrollee, FY 2003.

States pay providers that provide services to Medicaid beneficiaries. As in other aspects of the program, states have broad discretion establishing how much they pay and the modality of payment (fee-for-service, capitation) they adopt. Although Medicaid payment rates have increased, they are still considerably lower than physician payment rates under Medicare or private insurance. For this and other reasons related to administrative hassles, the proportion of U.S. physicians accepting Medicaid patients has decreased slightly over the past decade, and one out of every seven physicians receives no revenue from Medicaid.^{xviii} This trend has led to the care of Medicaid patients becoming increasingly concentrated among physicians who practice in large groups, hospitals, academic medical centers, and community health centers.

2. Physician Fees: Physician Fee Index, by Service^{xix}

The Medicaid fee index^{xx} measures each state's physician fees relative to national average Medicaid fees, and represents only those payments made under fee-for-service under the Medicaid program; these account for 80 percent of acute care Medicaid spending. Because Tennessee does not pay its physicians under fee-for-service, it is omitted from this computation, and receives no score under this category.

Points assigned to this indicator are as follows: **6 Total Possible**

a. Primary Care		
	1.5 and over	2
	1.0 to 1.49	1
	Under 1.0	0
b. Obstetric Care		
	1.5 and over	2
	1.0 to 1.49	1
	Under 1.0	0
c. Other services		
	1.5 and over	2
	1.0 to 1.49	1
	Under 1.0	0

Source: Exhibit 2: Medicaid Fee Indexes and Medicaid-to-Medicare Fee Indexes, 2003, in Zuckerman S et al. Changes In Medicaid Physician Fees, 1998-2003: Implications For Physician Participation. *Health Affairs*, 23 June 2004: W-378.

3. Medicaid-to-Medicare Fee Index, by Service

When Medicaid began, states paid providers under the "usual, customary, and reasonable" (UCR) system that had been adopted by Medicare. These fees attempted to match the private market and sought to lure doctors to accept Medicare assignment. By the mid-1970s, however, states could not keep up with the inflationary trend of the UCR system and adopted fee schedules that were lower than those prevailing in the private sector.^{xxi} Since then, Medicaid physician fees have traditionally lagged behind Medicare fees. Although this gap has narrowed over time, in 2003 Medicaid fees were 69 percent of Medicare fees. Not surprisingly, Medicaid is therefore perceived as a "stepchild" program compared to Medicare, and is somewhat stigmatized as a result. These disparities deter some providers from accepting Medicaid patients, thereby limiting access. Additionally, keeping physician fees low is not a very effective way of holding down costs, because physician fees account for a relatively small proportion of total costs: shaving 20 percent off the cost of physician care results in only two percent overall savings in program costs, and may result in greater use of emergency care, thus more than offsetting any real "savings."^{xxii} Basic equity and practicality therefore favor greater parity in how

^{xviii} Cunningham PJ, May JH. Medicaid Patients Increasingly Concentrated Among Physicians. Tracking Report No. 16, Center for Studying Health System Change. August 2006.

^{xix} Zuckerman S et al. Changes In Medicaid Physician Fees, 1998-2003: Implications for Physician Participation. *Health Affairs*, 23 June 2004: W-374.

^{xx} This index is the weighted sum of the ratios of each state's fees for a given service to the national average, using 2000 expenditure weights. The national average was computed as the weighted average fee, where the weights are equal to Medicaid enrollment in each state. See Zuckerman et al, *op.cit.*: W4-377.

^{xxi} Engel, Jonathan. *Poor People's Medicine: Medicaid and American Charity Care since 1965*. Durham: Duke University Press, 2006:176-177.

^{xxii} Engel, Jonathan. *Poor People's Medicine: Medicaid and American Charity Care since 1965*. Durham: Duke University Press, 2006: 177.

physicians are paid under the two programs. States in which the Medicaid-to-Medicare fee index is closer to 1.0 are therefore scored higher than those where the gap is wider. Because Tennessee does not pay its physicians under fee-for-service, it is omitted from this computation and does not receive a score under this category.

Points assigned to this indicator are as follows: **6 Total Possible**

a. Primary Care		
1.0 and over		2
.50 to .99		1
Under .50		0
b. Obstetric Care		
1.0 and over		2
.50 to .99		1
Under .50		0
c. Other services		
1.0 and over		2
.50 to .99		1
Under .50		0

Source: Zuckerman et al. Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation. *Health Affairs*, 23 June 2004: W4-377.

Ranking Weights

Category weights

Appendix Table 1.
Relative weight by category

Eligibility	.35
Scope of services	.20
Quality of care	.20
Reimbursement	.25
TOTAL	1.00

Category-specific relative weights, by indicator

Appendix Table 2. Eligibility relative weights

Indicator	Weight
1. Children	.1875
2. Pregnant women	.1375
3. Medically needy	.2625
4. Aged, blind, disabled	.2625
5. Breast and cervical cancer	.0300
6. TB patients	.0600
7. SCHIP beneficiaries	.0600
TOTAL	1.0000

Appendix Table 3. Scope of services relative weights, by indicator

Services by type or target group	.4365
1. Targeted case management	.0345
2. Free-standing ambulatory surgery	.0230
3. Diagnostic, screening, preventive services	.0345
4. Home and community-based services	.0345
5. Home health services	.0345
6. Hospice care	.0230
7. In-patient psychiatric services for those under 21	.0345
8. Institutions for mental illness, nursing facilities, and ICF for mental illness, 65+	.0230
9. ICF services for mentally retarded	.0345
10. Nursing facility services other than for mental illness	.0345
11. Program of all-inclusive care for the elderly	.0230
12. Personal care services	.0230
13. Sickle cell services	.0340
14. Private duty nursing services	.0115
15. Rehab services: mental health and substance abuse	.0230
16. Tobacco dependence treatments	.0115
Women's services	.0805
17. Services for pregnant women	.0345
18. Abortions	.0230
19. Contraceptives	.0230
	.1840

Provider-specific services

20. Chiropractor services	.0230
21. Dental services	.0230
22. Nurse anesthetist services	.0230
23. Nurse practitioner services	.0345
24. Optometrist services	.0345
25. Podiatrist services	.0230
26. Psychologist services	.0230

Rehabilitation services

	.0920
27. Occupational therapy	.0230
28. Physical therapy	.0345
29. Speech, hearing, and language services	.0345

Devices and equipment

	.1610
30. Dentures	.0230
31. Eyeglasses	.0345
32. Hearing aids	.0345
33. Medical equipment and supplies	.0345
34. Prosthetic and orthotic devices	.0345

35. Drugs .0345

36. Non-emergency medical transport .0115

TOTAL	1.0000
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Appendix Table 4. Quality of care relative weights

Indicator	Weight
1. Meet mandatory quality reporting requirements	.0830
2. Have Medicaid fraud control unit	.0510
3. Nursing homes: nurse hours per resident day	.1400
4. Nursing homes: average number of deficiencies	.0570
5. Nursing homes: percent with no deficiencies	.0830
6. Nursing homes: percent receiving a deficiency for actual harm or jeopardy	.1400
7. Nursing homes: percent with deficiencies related to quality of care	.0000 (.1400) ^{xxiii}
8. Percent of children 19-35 months old who are immunized	.2100
9. Percent of children with emotional, developmental or behavioral problems that received mental health care	.2360
TOTAL	1.0000

Appendix Table 5. Reimbursement relative weights

Indicator	Weight
1. Payments per enrollee	.1300
2. Physician fee index	.4000
3. Medicaid-to-Medicare fee index	.4700
TOTAL	1.0000

^{xxiii} It was not possible to score a positive value in this indicator, therefore its value relative to the other indicators in this category was zero. However, it was possible to receive a negative raw score in this indicator. In the case of a negative score, the relative weight was .1400.

Glossary

Aid to Families with Dependent Children (AFDC) – Program operating between 1935 and 1996. Enacted in 1935 as part of the original Social Security Act and rescinded as part of welfare reform, the program sought to support needy children deprived of at least one parent’s presence and full support.

Beneficiary – Person eligible for and enrolled in the Medicaid program in the state in which he or she resides. Also referred to as *enrollee*.

Budget neutral – Having no impact on a budget. States may be granted authorization to deviate from certain Medicaid mandates if the proposed changes are *budget neutral* and therefore do not affect the bottom line.

Capitation – Modality of payment whereby a state Medicaid program pays a plan or provider based on the number of Medicaid beneficiaries under its care. Payment is usually a fixed amount per person per month.

Categorically needy – Persons eligible for Medicaid because they fall under specific categories or groups, i.e., children, the aged, individuals with disabilities. These qualify for the basic mandatory package of Medicaid benefits.

Co-pay, co-payment – A fixed dollar amount that a Medicaid beneficiary may have to pay when receiving services. This varies by state, service, and eligibility category.

Cost-sharing – Group of measures requiring Medicaid beneficiaries to bear part of the cost of a service. These can be co-payments (a fixed monetary amount), deductibles (a fixed amount the patient must pay before coverage begins), or co-insurance (a percentage of the total cost of a service). While cost-sharing is often advocated as a way of controlling costs by making beneficiaries “prudent purchasers,” it may also act as a barrier or deterrent to needed care.

Eligibility – Determination of who is covered by Medicaid. Although some populations are covered throughout the nation, others vary from state to state.

Federal Matching Assistance Percentage (FMAP) – Share of the costs of Medicaid borne by the federal government. This varies from one state to another, and currently ranges between 50 percent and 76 percent. States with lower per capita incomes have a higher percentage of their Medicaid costs covered by the federal government. The FMAP may be higher for some services than for others. For example, family planning services are matched at a higher rate than other services as an incentive for states to provide these services.

Federal Poverty Level (FPL) – Income level below which an individual or family is considered poor in the United States. The federal poverty threshold is determined annually by the U.S. Census Bureau and is based on increases in general inflation. The U.S. Department of Health and Human Services has adapted the census poverty thresholds as guidelines for use in Medicaid. At present (2007), these guidelines establish the poverty level for the 48 contiguous states and the District of Columbia at \$10,210 for a single person and \$17,170 for a family of three. The guidelines are somewhat higher for Alaska and Hawaii because of their higher cost-of-living. State Medicaid programs establish their eligibility thresholds as a fraction or multiple of the federal poverty guidelines.

Indicator – Measurement of an aspect of the Medicaid program. These have been grouped by category (eligibility, scope of services, quality of care, and reimbursement). Some indicators are composites of several measures, as described in the Scoring Protocol in the Appendix.

Managed care – Modality of service delivery under which an organization or health plan provides a specific set of services to an enrolled population for a fixed, prepaid annual fee. Currently, most Medicaid beneficiaries are in managed care plans.

Mandated services – Services all states are required to provide to their Medicaid beneficiaries.

Medically needy – Optional Medicaid eligibility group comprising individuals who qualify for coverage because of high medical expenses. These individuals must meet Medicaid's categorical requirements but have incomes that are too high to qualify under "categorically needy" coverage. In some cases, services provided to the medically needy are not as comprehensive as those provided to other Medicaid beneficiaries.

Program of All-Inclusive Care for the Elderly (PACE) – Optional benefit that some states provide to Medicaid beneficiaries 55 years or older who require the level of care usually provided by a skilled nursing facility. This program, originally begun in California, allows beneficiaries to live at home, attend a day treatment center, and get other supplementary services.

Quality of Care – Degree to which Medicaid programs are performing in accordance with accepted standards of care. This category has a limited number of indicators, and includes markers that suggest better monitoring of services or better health outcomes.

Reimbursement – For purposes of this report, this category includes per capita spending by state Medicaid programs for specific groups, and physician payments.

State Children's Health Insurance Program (SCHIP) – Federal-state matching program which provides health coverage for uninsured low-income children. In a few cases, the program may also cover their parents. States have the option of administering SCHIP through their Medicaid program or through a separate program. The average federal matching rate for SCHIP is higher than that for Medicaid, but SCHIP allocations to states are in the form of a block grant, capped at a specific amount, rather than open-ended.

Section 1115 waiver – Legislative measure through which states can receive authorization from the Secretary of Health and Human Services to waive compliance with many of the requirements of the Medicaid statute. This waiver, named for the section of the Social Security Act under which it was enacted, allows states to experiment with different approaches to delivering care under the Medicaid program. These waivers have become increasingly popular, and many states have used them to expand or restrict eligibility, coverage of services, and payment. Waivers are granted for a five year period.

Scope of Services – As used in this report, this refers to coverage of care provided by the different state Medicaid programs. Although there are mandated services that all states must provide, the focus in this report is on optional services or those that exceed the required minimum. Because different populations are eligible for different services, both the *what* and the *who* are taken into account in determining the points assigned to most indicators in our Scoring Protocol.

Social Security Act – Legislation enacted in 1934 to provide economic and other support to specific groups. Medicaid was enacted as Title XIX of the Social Security Act in 1965.

Spend Down – The process of using up all income and assets on medical care costs to become eligible for Medicaid.

Supplemental Security Income (SSI) – Federal program for the poor, aged, and disabled that provides its beneficiaries a monthly amount. In most states, those who are eligible for SSI are also deemed eligible for Medicaid.

Waiver – Provision that allows Medicaid programs to depart from eligibility or benefit rules for temporary periods. While Section 1115 waivers are the best-known, other waivers may be approved to address specific events, such as the disruption of services and population displacement that occurred following Hurricane Katrina.

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