

**Playing Catch-Up:
California Can Improve Medi-Cal Access and Coverage
By Obtaining Available and Additional Federal Support**

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Medi-Cal is the foundation of California's health care system.¹ Created under the auspices of the federal Medicaid program, it provides health care coverage and services to more than 6.5 million low-income Californians – more people than any other state Medicaid program. Medi-Cal spending accounted for more than one out of every six health care dollars spent during 2004.²

California's debate over comprehensive healthcare reform has put a spotlight on Medi-Cal through bipartisan calls for expanding eligibility and increasing the program's provider payments.³ For example, under Governor Arnold Schwarzenegger's reform proposal, federal Medi-Cal dollars represent about half of the revenue needed to cover the plan's estimated \$12 billion cost.⁴ This debate raises two important questions: Should the state try to seek additional federal dollars? Are there additional federal dollars available that the state has not made use of?

This report finds that California has the authority to obtain more federal Medicaid dollars and that doing so would likely increase access to medical care and strengthen the state's overall economy. In addition, this report shows that current federal Medicaid payments to California are so low that an increase in federal spending, as called for in various proposed health care reform plans, would simply put California on par with other major states, such as Pennsylvania and Massachusetts. Even if these proposals are enacted, the level of federal Medicaid support for California would be below that of many other states, such as New York.

FINDING: Relative to other states, California receives a lower level of financial support from the federal government for Medicaid on both a per beneficiary basis and on a per resident basis.

- *On a per beneficiary basis, California ranks 49th out of the 50 states and the District of Columbia for federal spending per beneficiary.* At only \$3,419 per beneficiary, California's average federal spending is dramatically lower than New York (\$5,891 per beneficiary). And both states receive significantly fewer federal dollars than the top ranking state, Alaska, which receives \$7,836 per Medicaid beneficiary. (Please see Appendix A for a full listing of 2005 Medicaid spending per beneficiary across all states.)

- ***On a per-resident basis, California only receives a moderate level of federal support. If California received the same level of federal spending as New York, then California would receive more than double its current federal Medicaid payment.*** On a per-resident basis, California ranks 23rd in federal Medicaid spending.⁵ At \$611 per resident, California's federal Medicaid spending is half that of New York's \$1,260 (Please see Appendix B for a full listing of 2005 Medicaid spending per resident across all states).⁶

If California had received the same level of federal support per resident as New York in 2005, then California would have received an additional \$24 billion in federal dollars. Moreover, if California would receive a 20 percent increase in federal spending per resident, then that would put California's spending on a par with 16th ranked Pennsylvania – translating into an additional \$5 billion in federal dollars for California.

- ***Even in the context of overall level of health spending, the federal government is not providing California as much support as other states.*** As the cornerstone of the California healthcare system, Medicaid spending levels are a function of overall system spending. It is also well established that health care spending varies widely across states.⁷ For example, in 2003, total spending per person by state in the U.S. varied from a high of about \$9,900 in the District of Columbia to a low of about \$3,800 in both Idaho and Utah. California ranks 42nd on total health care spending per resident.⁸ Given California's overall level of spending, one would expect Medi-Cal spending to be low as well.

But, in calculating the total federal dollars received through Medicaid as a percentage of total health care spending per person, it is possible to quantify the level of support that the federal government gives each state's health care system. Using 2003 data (the most recent available for this comparison), California received \$508 federal Medicaid dollars per resident, which is about 11.5 percent of the state's total health care spending per resident (\$4,416). In contrast, New York received \$1,146 federal Medicaid dollars per resident, which is about 18.6 percent of that state's total health care spending per resident (\$6,166). Overall, California only ranks in the middle of a comparison of such percentages and therefore can be considered to be lagging behind other states in federal support. (Please See Appendix C for a listing of this calculation for all states.)

FINDING: California's low level of federal support is a function of low provider reimbursement rates.

Federal Medicaid payments to states are tied directly to each state's level of Medicaid spending. The federal government pays a portion of state costs a rate sometimes called a "matching percentage."⁹ While this percentage varies from state-to-state,¹⁰ the result is that a state will receive more federal dollars when more is spent on Medicaid. Under the federal Medicaid entitlement, California has a matching rate of 50 percent, meaning that California receives about \$.50 from the federal government for every \$1 of state spending. California, like most large states, has the lowest matching percentage possible (set at 50 percent); Mississippi has the highest matching percentage at 75.89 percent for 2007.

In exchange for this support, all states are legally required to operate their Medicaid programs in an efficient manner. To this end, Medi-Cal instituted a number of programs to contain costs over its 40-plus year history. In the early 1980s, California undertook aggressive Medi-Cal cost-containment measures that resulted in a profound reduction in Medi-Cal spending – steps more

aggressive than those taken by many other states. While these cost-containment efforts have protected the state’s General Fund dollars, they have significantly reduced the amount of federal dollars coming into California. As a national innovator in containing costs, California has continued to experience decades of low federal reimbursement. A key part of Medi-Cal’s cost-containment effort has been to contain physician payments.

- ***As a percentage of Medicare, Medi-Cal physician payments are lower than all but six other states – well below the national average.*** Since Medicare is generally regarded as a standard benchmark for health care spending, one objective way to compare physician payment rates is to calculate the ratio of Medicaid payments to Medicare payments for the same service. By surveying state Medicaid programs and analyzing Medicare payment data, a 2004 study calculated a ratio for fee-for-service physician spending between Medicaid and Medicare.¹¹ Indexed at 59 percent across all services, Medi-Cal pays \$.59 on average for a physician service where Medicare would pay \$1.¹² Based on this study, California ranks at the bottom nationwide in payment levels for all physician services and for primary care services. This places California well below the national average.¹³ (Please See Appendix D for a full listing of fee ratios across all states.)
- ***Even among large states, California has a low Medicaid payment rate as a percentage of Medicare.*** Since large states leverage their market power with physicians to lower Medicaid payment rates, it is appropriate to compare Medi-Cal’s payment rates to those of other large states. Yet, even among the ten largest states, California ranks 7th in physician payment rates as a percentage of Medicare.¹⁴ As shown in Table 1, the Georgia Medicaid program pays on average \$.81 for a service where Medicare would pay \$1. In contrast, New Jersey is the lowest payer at \$.35 for every \$1 spent by Medicare.

California does rank higher than New York and New Jersey in payment rates to physicians although those two states exceed California in per beneficiary spending. Given the findings here, it is reasonable to assume that those two states must have higher payment rates than California for other provider types, such as hospitals and nursing homes.¹⁵ There are also likely differences in utilization patterns that would cause those states to receive more federal dollars.

Table 1: Medi-Cal Payments as a Percentage of Medicare Payments Among Large States¹⁶

| State | Ratio |
|---------------------|-------|
| Georgia | 81% |
| Texas | 68% |
| Ohio | 66% |
| Florida | 65% |
| Illinois & Michigan | 63% |
| California | 59% |
| Pennsylvania | 52% |
| New York | 45% |

- ***While it is difficult to compare the level of hospital payments across states, it is clear that Medi-Cal is more aggressive in containing hospital payments than other states.*** In 1982, the State of California created the Selective Provider Contracting Program (SPCP). Under this one-of-a-kind program, California hospitals compete for Medi-Cal inpatient business by negotiating prices with the California Medical Assistance Commission. Those hospitals that do not have competitive prices are excluded from the Medi-Cal

program (with exceptions made for emergency care). No other state takes this approach to hospital contracting. Since SPCP began, Medi-Cal has saved almost \$20 billion in combined federal and state funds.¹⁷ As a unique program, it is reasonable to conclude that SPCP has been a major factor in maintaining low reimbursement rates.

- ***Medi-Cal’s payment rates for managed care also put California at the very bottom of state payments.*** While millions of Medi-Cal beneficiaries receive care through fee-for-service arrangements, about half (50.2 percent) receive services through managed care.¹⁸ Like physician payment rates, Medi-Cal payment rates to managed care entities are lower than those of most other states. With the exception of a few health plans that received rate increases when facing bankruptcy, Medi-Cal has not offered an increase in capitation rates to all plans since State Fiscal Year 2000-2001.

In a national survey of payment rates for capitated Medicaid managed care plans, Medi-Cal ranked 29th out of the 36 states that responded (only 39 states had managed care programs in operation at the time of the survey).¹⁹ (Please see Appendix E for a listing of managed care capitation rates.)

FINDING: California’s low Medi-Cal payment rates have a ripple effect on the health system and the state’s economy.

- ***Low Medi-Cal provider reimbursement rates result in low provider participation and reduced access to care for the neediest Californians.***²⁰ Low Medi-Cal reimbursement levels act as a disincentive for providers, resulting in low provider participation rates in California.²¹ For every 100,000 beneficiaries in Medi-Cal, there are only 46 primary care physicians as compared to a ratio of 70 to 100,000 for the general population (Table 2).²² As a result, only about 25 percent of California’s primary care physicians provide about 80 percent of the primary care visits in Medi-Cal.

However, this situation is reversible. By increasing provider rates, it is possible to increase physician participation. For example, Medi-Cal pays higher rates for obstetric services and has been able to achieve a participation rate on par with that of California’s overall population.²³

Table 2: Physician Participation, Medi-Cal vs. California Overall Per 100,000 Population in Urban Areas

| Provider Type | Medi-Cal Participation Rate | California Overall Participation Rate |
|---------------------|-----------------------------|---------------------------------------|
| Primary Care | 46 | 70 |
| Medical Specialist | 4 | 10 |
| Surgical Specialist | 5 | 15 |
| Ob-Gyn | 15 | 12 |

Low provider participation rates have important consequences for Medi-Cal beneficiaries by making it more difficult for them to find providers. In a survey by the California HealthCare Foundation, 56 percent of beneficiaries said that finding a doctor is either “somewhat or very difficult”.²⁴ In this same survey, over 90 percent indicated that Medi-Cal needed more providers.²⁵ This can have profound impact on health care; limited access to care translates to lower health status and higher costs. For example, a lack of

preventive care and disease management can lead to increased use of otherwise unneeded emergency services.²⁶

- ***Due to low provider reimbursement rates, Californians with private health insurance help to cover the costs of those who are covered by public programs.*** Public programs often pay rates significantly lower than private insurers. A 2006 study estimated that private payers in health care spent about 22 percent more than their costs to help cover provider losses from low provider rates offered by the public sector.²⁷

In California, the Office of the Governor estimated that 7 percent of the cost of private health insurance premiums can be attributed to the cost-shift from Medi-Cal.²⁸ This is on top of an estimated 10 percent of the cost-shift from the uninsured.²⁹ All Californians are paying higher health care premiums to cover low Medi-Cal reimbursement rates.

- ***California could strengthen its overall economy by investing more in Medi-Cal.*** Several studies have shown that increased Medicaid spending has a positive impact on state economies. Medicaid is the largest source of federal funds for states; its spending has ripple effects throughout state economies, generating jobs, income and state tax revenues, and supporting thousands of healthcare providers statewide.³⁰

When states reduce Medicaid spending, they decrease the flow of available dollars to providers for services.³¹ The research shows that those cuts have multiplying effects throughout the economy, of which the magnitude varies depending on the state's federal matching rate, size of the health sector and reliance on public health services. These studies clearly show that reducing state and federal Medicaid spending leads to a decline in economic activity at the state level.³² (Please see Appendix F to see a summary of specific studies conducted in other states on Medicaid's economic impact.)

FamiliesUSA, a national health care advocacy organization, has developed a calculator to better quantify the impact of changes in state spending on the economy.³³ If the state were to spend an additional \$5.5 billion annually on Medi-Cal, it is estimated that this spending would generate an additional \$12.5 billion in economic activity and create another 100,000 jobs in California.

While the primary reason for increasing Medicaid spending should be to achieve appropriate levels of access to quality medical care, it is important to understand the important positive impact that Medicaid spending can have on the economy as a whole.

FINDING: Broad legal authority exists to increase Medi-Cal eligibility and provider payment rates, which are unaffected by President Bush's proposed 2008 budget.

Several of California's political leaders have spoken about the goal of obtaining additional federal Medicaid dollars. In fact, the Governor's health care reform plan relies on obtaining more than \$5 billion in additional federal support. A careful review of the legislative authority needed to do this shows that broad authority exists to change eligibility rules and increase provider payment rates. (Appendix G discusses specifics of the existing legal authority for such planned changes.)

More importantly, the President's proposed 2008 budget does not affect rules governing Medi-Cal eligibility and the setting of provider payment rates. Although the President's budget seeks

to transfer costs from the federal government to states on a number of fronts, it is clear that none of the proposed changes would affect Governor Schwarzenegger's proposed Medi-Cal changes.³⁴ (Appendix H discusses the major changes to Medicaid proposed in the President's Budget.)

Policy Implications and Conclusion

The health reform debate provides an opportunity for policymakers and stakeholders to take a fresh look at Medi-Cal. California has a responsibility to the federal government and taxpayers to operate Medi-Cal efficiently. Based on a comparison to other state's spending, California has done so effectively.

At the same time, the state has both the authority and need to increase its amount of federal dollars. By expanding Medi-Cal eligibility and increasing Medi-Cal provider payment rates, California would increase access to care delivered by the program. After decades of protecting the state and federal budget, it is time to consider how California can best earn its fair share of federal dollars.

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About the Author

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Appendix A: 2005 Federal Medicaid Spending Per Medicaid Beneficiary

| Rank | State | Federal Spending ³⁵ | Number of Beneficiaries ³⁶ | Federal Spending Per Beneficiary |
|-----------|----------------------|--------------------------------|---------------------------------------|----------------------------------|
| 1 | Alaska | \$681,336,000 | 86,950 | \$7,836 |
| 2 | North Dakota | \$384,432,000 | 52,394 | \$7,337 |
| 3 | District of Columbia | \$951,829,000 | 137,324 | \$6,931 |
| 4 | Montana | \$562,936,000 | 83,857 | \$6,713 |
| 5 | New Hampshire | \$684,576,000 | 106,173 | \$6,448 |
| 6 | Maine | \$1,540,332,000 | 250,637 | \$6,146 |
| 7 | Rhode Island | \$1,021,498,000 | 168,700 | \$6,055 |
| 8 | Nebraska | \$1,021,497,000 | 172,308 | \$5,928 |
| 9 | Vermont | \$561,348,000 | 94,942 | \$5,913 |
| 10 | New York | \$24,343,119,000 | 4,131,951 | \$5,891 |
| 11 | New Jersey | \$4,517,358,000 | 773,218 | \$5,842 |
| 12 | Iowa | \$1,625,436,000 | 284,795 | \$5,707 |
| 13 | West Virginia | \$1,703,864,000 | 299,709 | \$5,685 |
| 14 | Minnesota | \$3,235,118,000 | 582,993 | \$5,549 |
| 15 | Massachusetts | \$4,919,734,000 | 924,395 | \$5,322 |
| 16 | Arkansas | \$2,436,921,000 | 458,418 | \$5,316 |
| 17 | Oregon | \$1,949,333,000 | 366,983 | \$5,312 |
| 18 | South Dakota | \$461,802,000 | 88,207 | \$5,235 |
| 19 | Connecticut | \$2,127,062,000 | 407,179 | \$5,224 |
| 20 | North Carolina | \$5,892,636,000 | 1,137,506 | \$5,180 |
| 21 | Maryland | \$2,606,399,000 | 506,662 | \$5,144 |
| 22 | Kansas | \$1,334,905,000 | 261,899 | \$5,097 |
| 23 | New Mexico | \$1,862,351,000 | 365,552 | \$5,095 |
| 24 | Pennsylvania | \$8,911,662,000 | 1,786,685 | \$4,988 |
| 25 | Indiana | \$3,771,102,000 | 758,175 | \$4,974 |
| 26 | Utah | \$1,070,165,000 | 215,475 | \$4,967 |
| 27 | Ohio | \$7,788,132,000 | 1,582,336 | \$4,922 |
| 28 | Missouri | \$4,304,509,000 | 877,421 | \$4,906 |
| 29 | Idaho | \$774,672,000 | 160,996 | \$4,812 |
| 30 | Mississippi | \$2,834,870,000 | 593,266 | \$4,778 |
| 31 | Kentucky | \$3,158,289,000 | 671,933 | \$4,700 |
| 32 | Wisconsin | \$3,049,323,000 | 649,955 | \$4,692 |
| 33 | South Carolina | \$3,043,808,000 | 654,100 | \$4,653 |
| 34 | Arizona | \$4,092,137,000 | 927,186 | \$4,414 |
| 35 | Wyoming | \$252,616,000 | 57,658 | \$4,381 |
| 36 | Oklahoma | \$2,100,680,000 | 486,679 | \$4,316 |
| 37 | Nevada | \$727,428,000 | 175,128 | \$4,154 |
| 38 | Alabama | \$2,843,720,000 | 687,324 | \$4,137 |
| 39 | Texas | \$11,226,479,000 | 2,782,940 | \$4,034 |
| 40 | Tennessee | \$5,382,360,000 | 1,350,352 | \$3,986 |
| 41 | Louisiana | \$3,944,520,000 | 990,615 | \$3,982 |
| 42 | Virginia | \$2,469,787,000 | 627,992 | \$3,933 |
| 43 | Florida | \$8,595,175,000 | 2,201,199 | \$3,905 |
| 44 | Illinois | \$6,433,637,000 | 1,652,088 | \$3,894 |
| 45 | Washington | \$3,242,853,000 | 844,789 | \$3,839 |
| 46 | Michigan | \$5,398,062,000 | 1,421,944 | \$3,796 |
| 47 | Colorado | \$1,516,864,000 | 410,769 | \$3,693 |
| 48 | Delaware | \$483,462,000 | 140,452 | \$3,442 |
| 49 | California | \$22,102,201,000 | 6,463,664 | \$3,419 |
| 50 | Hawaii | \$630,044,000 | 186,262 | \$3,383 |
| 51 | Georgia | \$4,450,437,000 | 1,379,837 | \$3,225 |

Appendix B: 2005 Federal Medicaid Spending Per State Resident and California's Shortfall

| Rank | State | Estimated Federal Spending ³⁷ | Number of Residents ³⁸ | Federal Spending per Resident | Additional Funds California Would Have Received |
|-----------|----------------------|--|-----------------------------------|-------------------------------|---|
| 1 | District of Columbia | \$951,829,000 | 582,049 | \$1,635 | \$37,020,940,840 |
| 2 | New York | \$24,343,119,000 | 19,315,721 | \$1,260 | \$23,461,964,208 |
| 3 | Maine | \$1,540,332,000 | 1,318,220 | \$1,168 | \$20,143,698,438 |
| 4 | Alaska | \$681,336,000 | 663,253 | \$1,027 | \$15,037,656,491 |
| 5 | Mississippi | \$2,834,870,000 | 2,908,496 | \$975 | \$13,136,735,793 |
| 6 | New Mexico | \$1,862,351,000 | 1,925,985 | \$967 | \$12,857,423,202 |
| 7 | Rhode Island | \$1,021,498,000 | 1,073,579 | \$951 | \$12,298,051,662 |
| 8 | West Virginia | \$1,703,864,000 | 1,814,083 | \$939 | \$11,855,313,361 |
| 9 | Tennessee | \$5,382,360,000 | 5,955,745 | \$904 | \$10,571,231,903 |
| 10 | Vermont | \$561,348,000 | 622,387 | \$902 | \$10,506,221,268 |
| 11 | Arkansas | \$2,436,921,000 | 2,775,708 | \$878 | \$9,639,178,159 |
| 12 | Louisiana | \$3,944,520,000 | 4,507,331 | \$875 | \$9,537,533,451 |
| 13 | Massachusetts | \$4,919,734,000 | 6,433,367 | \$765 | \$5,545,652,175 |
| 14 | Kentucky | \$3,158,289,000 | 4,172,608 | \$757 | \$5,263,236,821 |
| 15 | Missouri | \$4,304,509,000 | 5,797,703 | \$742 | \$4,740,472,926 |
| 16 | Pennsylvania | \$8,911,662,000 | 12,405,348 | \$718 | \$3,869,947,299 |
| 17 | South Carolina | \$3,043,808,000 | 4,246,933 | \$717 | \$3,809,741,070 |
| 18 | Arizona | \$4,092,137,000 | 5,953,007 | \$687 | \$2,750,402,506 |
| 19 | North Carolina | \$5,892,636,000 | 8,672,459 | \$679 | \$2,463,291,689 |
| 20 | Ohio | \$7,788,132,000 | 11,470,685 | \$679 | \$2,445,005,133 |
| 21 | Minnesota | \$3,235,118,000 | 5,126,739 | \$631 | \$712,093,181 |
| 22 | Alabama | \$2,843,720,000 | 4,548,327 | \$625 | \$502,213,966 |
| 23 | California | \$22,102,201,000 | 36,154,147 | \$611 | \$- |
| 24 | Connecticut | \$2,127,062,000 | 3,500,701 | \$608 | \$- |
| 25 | North Dakota | \$384,432,000 | 634,605 | \$606 | \$- |
| 26 | Montana | \$562,936,000 | 934,737 | \$602 | \$- |
| 27 | Indiana | \$3,771,102,000 | 6,266,019 | \$602 | \$- |
| 28 | South Dakota | \$461,802,000 | 774,883 | \$596 | \$- |
| 29 | Oklahoma | \$2,100,680,000 | 3,543,442 | \$593 | \$- |
| 30 | Nebraska | \$1,021,497,000 | 1,758,163 | \$581 | \$- |
| 31 | Delaware | \$483,462,000 | 841,741 | \$574 | \$- |
| 32 | Wisconsin | \$3,049,323,000 | 5,527,644 | \$552 | \$- |
| 33 | Iowa | \$1,625,436,000 | 2,965,524 | \$548 | \$- |
| 34 | Idaho | \$774,672,000 | 1,429,367 | \$542 | \$- |
| 35 | Oregon | \$1,949,333,000 | 3,638,871 | \$536 | \$- |
| 36 | Michigan | \$5,398,062,000 | 10,100,833 | \$534 | \$- |
| 37 | New Hampshire | \$684,576,000 | 1,306,819 | \$524 | \$- |
| 38 | New Jersey | \$4,517,358,000 | 8,703,150 | \$519 | \$- |
| 39 | Washington | \$3,242,853,000 | 6,291,899 | \$515 | \$- |
| 40 | Illinois | \$6,433,637,000 | 12,765,427 | \$504 | \$- |
| 41 | Wyoming | \$252,616,000 | 508,798 | \$496 | \$- |
| 42 | Hawaii | \$630,044,000 | 1,273,278 | \$495 | \$- |
| 43 | Texas | \$11,226,479,000 | 22,928,508 | \$490 | \$- |
| 44 | Georgia | \$4,450,437,000 | 9,132,553 | \$487 | \$- |
| 45 | Kansas | \$1,334,905,000 | 2,748,172 | \$486 | \$- |
| 46 | Florida | \$8,595,175,000 | 17,768,191 | \$484 | \$- |
| 47 | Maryland | \$2,606,399,000 | 5,589,599 | \$466 | \$- |
| 48 | Utah | \$1,070,165,000 | 2,490,334 | \$430 | \$- |
| 49 | Virginia | \$2,469,787,000 | 7,564,327 | \$327 | \$- |
| 50 | Colorado | \$1,516,864,000 | 4,663,295 | \$325 | \$- |
| 51 | Nevada | \$727,428,000 | 2,412,301 | \$302 | \$- |

**Appendix C: 2003 Federal Medicaid Spending Per State Resident
as a Percentage of Total Health Expenditures Per State Resident**

| Rank | State | Total Health Expenditures Per Resident | Federal Medicaid Expenditures Per Resident 2003 | Federal Medicaid Spending as a Percentage of Total Health Spending |
|-------------|----------------------|---|--|---|
| 1 | New Mexico | \$3,873 | \$854.68 | 22.1% |
| 2 | Mississippi | \$4,461 | \$865.34 | 19.4% |
| 3 | New York | \$6,166 | \$1,146.06 | 18.6% |
| 4 | Maine | \$5,681 | \$943.48 | 16.6% |
| 5 | Louisiana | \$4,931 | \$808.60 | 16.4% |
| 6 | District of Columbia | \$9,914 | \$1,615.39 | 16.3% |
| 7 | Arkansas | \$4,410 | \$712.18 | 16.1% |
| 8 | West Virginia | \$5,261 | \$821.05 | 15.6% |
| 9 | Vermont | \$5,368 | \$801.85 | 14.9% |
| 10 | Tennessee | \$5,288 | \$780.84 | 14.8% |
| 11 | Arizona | \$3,936 | \$568.52 | 14.4% |
| 12 | Alaska | \$5,996 | \$854.02 | 14.2% |
| 13 | South Carolina | \$4,675 | \$658.24 | 14.1% |
| 14 | Rhode Island | \$5,838 | \$793.56 | 13.6% |
| 15 | Kentucky | \$5,111 | \$690.87 | 13.5% |
| 16 | Idaho | \$3,839 | \$471.69 | 12.3% |
| 17 | Oklahoma | \$4,396 | \$539.03 | 12.3% |
| 18 | Missouri | \$5,370 | \$653.14 | 12.2% |
| 19 | North Carolina | \$4,856 | \$575.69 | 11.9% |
| 20 | Montana | \$4,671 | \$550.17 | 11.8% |
| 21 | Alabama | \$4,861 | \$569.10 | 11.7% |
| 22 | Oregon | \$4,578 | \$526.69 | 11.5% |
| 23 | California | \$4,416 | \$508.11 | 11.5% |
| 24 | Georgia | \$4,350 | \$483.90 | 11.1% |
| 25 | Michigan | \$4,569 | \$505.41 | 11.1% |
| 26 | Pennsylvania | \$5,657 | \$621.09 | 11.0% |
| 27 | Ohio | \$5,354 | \$577.70 | 10.8% |
| 28 | Wyoming | \$4,237 | \$456.65 | 10.8% |
| 29 | Massachusetts | \$6,493 | \$692.90 | 10.7% |
| 30 | Iowa | \$4,846 | \$506.54 | 10.5% |
| 31 | Wisconsin | \$5,295 | \$551.73 | 10.4% |
| 32 | Indiana | \$4,960 | \$513.71 | 10.4% |
| 33 | Texas | \$4,455 | \$459.20 | 10.3% |
| 34 | Washington | \$4,857 | \$495.15 | 10.2% |
| 35 | Nebraska | \$5,183 | \$520.01 | 10.0% |
| 36 | New Hampshire | \$4,995 | \$493.40 | 9.9% |
| 37 | Connecticut | \$5,931 | \$570.73 | 9.6% |
| 38 | North Dakota | \$5,828 | \$558.20 | 9.6% |
| 39 | South Dakota | \$5,342 | \$510.47 | 9.6% |
| 40 | Utah | \$3,839 | \$360.02 | 9.4% |
| 41 | Minnesota | \$5,719 | \$530.20 | 9.3% |
| 42 | Illinois | \$4,826 | \$438.56 | 9.1% |
| 43 | New Jersey | \$5,273 | \$478.23 | 9.1% |
| 44 | Kansas | \$4,851 | \$438.80 | 9.0% |
| 45 | Hawaii | \$4,754 | \$412.61 | 8.7% |
| 46 | Delaware | \$5,869 | \$487.72 | 8.3% |
| 47 | Maryland | \$5,136 | \$424.47 | 8.3% |
| 48 | Florida | \$5,114 | \$420.68 | 8.2% |
| 49 | Virginia | \$4,440 | \$317.96 | 7.2% |
| 50 | Colorado | \$4,595 | \$311.57 | 6.8% |
| 51 | Nevada | \$4,320 | \$277.20 | 6.4% |

Appendix D: Medicaid-To-Medicare Provider Fee Index Ratio: State Rankings³⁹

| Rank | State | All Services |
|-----------|----------------------|--------------|
| 1 | Alaska | 1.37 |
| 2 | Arizona | 1.06 |
| 3 | Wyoming | 1.03 |
| 4 | Delaware | 1.01 |
| 5 | Nevada | 0.98 |
| 6 | North Carolina | 0.97 |
| 7 | Iowa | 0.97 |
| 8 | New Mexico | 0.95 |
| 9 | Nebraska | 0.95 |
| 10 | Arkansas | 0.95 |
| 11 | Idaho | 0.92 |
| 12 | North Dakota | 0.91 |
| 13 | Mississippi | 0.91 |
| 14 | Alabama | 0.90 |
| 15 | South Carolina | 0.89 |
| 16 | West Virginia | 0.88 |
| 17 | Wisconsin | 0.87 |
| 18 | Washington | 0.87 |
| 19 | Oregon | 0.86 |
| 20 | Montana | 0.86 |
| 21 | Vermont | 0.83 |
| 22 | South Dakota | 0.83 |
| 23 | Connecticut | 0.83 |
| 24 | Georgia | 0.81 |
| 25 | Massachusetts | 0.80 |
| 26 | Maryland | 0.80 |
| 27 | Minnesota | 0.79 |
| 28 | Virginia | 0.77 |
| 29 | Kentucky | 0.76 |
| 30 | Kansas | 0.75 |
| 31 | Hawaii | 0.74 |
| 32 | Colorado | 0.74 |
| 33 | Utah | 0.73 |
| 34 | Louisiana | 0.73 |
| 35 | Oklahoma | 0.72 |
| 36 | New Hampshire | 0.72 |
| | United States | 0.69 |
| 37 | Texas | 0.69 |
| 38 | Ohio | 0.68 |
| 39 | Indiana | 0.68 |
| 40 | Maine | 0.65 |
| 41 | Florida | 0.65 |
| 42 | Illinois | 0.63 |
| 43 | Michigan | 0.62 |
| 44 | California | 0.59 |
| 45 | Missouri | 0.56 |
| 46 | Pennsylvania | 0.52 |
| 47 | District of Columbia | 0.52 |
| 48 | New York | 0.45 |
| 49 | Rhode Island | 0.42 |
| 50 | New Jersey | 0.35 |

| Rank | State | Primary Care Services |
|-----------|----------------------|-----------------------|
| 1 | Alaska | 1.38 |
| 2 | Arizona | 1.01 |
| 3 | Delaware | 1.00 |
| 4 | Arkansas | 0.96 |
| 5 | North Carolina | 0.96 |
| 6 | Wyoming | 0.96 |
| 7 | Iowa | 0.94 |
| 8 | New Mexico | 0.93 |
| 9 | Mississippi | 0.90 |
| 10 | North Dakota | 0.90 |
| 11 | Idaho | 0.89 |
| 12 | Alabama | 0.82 |
| 13 | West Virginia | 0.82 |
| 14 | Washington | 0.79 |
| 15 | Nebraska | 0.78 |
| 16 | Maryland | 0.76 |
| 17 | Montana | 0.75 |
| 18 | Oregon | 0.75 |
| 19 | South Carolina | 0.75 |
| 20 | Connecticut | 0.74 |
| 21 | Virginia | 0.73 |
| 22 | Wisconsin | 0.73 |
| 23 | Massachusetts | 0.72 |
| 24 | Hawaii | 0.71 |
| 25 | Nevada | 0.71 |
| 26 | Louisiana | 0.70 |
| 27 | Colorado | 0.68 |
| 28 | South Dakota | 0.68 |
| 29 | Georgia | 0.68 |
| 30 | Oklahoma | 0.67 |
| 31 | New Hampshire | 0.67 |
| 32 | Ohio | 0.66 |
| 33 | Utah | 0.66 |
| 34 | Minnesota | 0.64 |
| 35 | Vermont | 0.64 |
| 36 | Michigan | 0.63 |
| 37 | Kansas | 0.63 |
| 38 | Kentucky | 0.63 |
| 39 | Texas | 0.62 |
| | United States | 0.62 |
| 40 | Indiana | 0.60 |
| 41 | Florida | 0.60 |
| 42 | Illinois | 0.54 |
| 43 | Maine | 0.54 |
| 44 | California | 0.51 |
| 45 | Missouri | 0.50 |
| 46 | Pennsylvania | 0.43 |
| 47 | New York | 0.40 |
| 48 | District of Columbia | 0.35 |
| 49 | New Jersey | 0.34 |
| 50 | Rhode Island | 0.34 |

Please Note:

Tennessee is not included as it only operates a managed care program.

Appendix E: Medicaid Managed Care Payment Rates for Selected States⁴⁰

| Rank | State | Statewide Adjusted Medicaid Managed Care Rates, 2001 |
|-----------|--------------------------------|--|
| 1 | New Mexico | \$208 |
| 2 | North Dakota | \$206 |
| 3 | District of Columbia | \$193 |
| 4 | Kentucky | \$193 |
| 5 | Minnesota | \$191 |
| 6 | North Carolina | \$189 |
| 7 | Delaware | \$183 |
| 8 | Virginia | \$181 |
| 9 | Maryland | \$180 |
| 10 | New Hampshire | \$175 |
| 11 | Indiana | \$174 |
| 12 | Massachusetts | \$171 |
| 13 | Iowa | \$168 |
| 14 | Ohio | \$168 |
| 15 | Connecticut | \$165 |
| 16 | Missouri | \$150 |
| 17 | Rhode Island | \$150 |
| 18 | Washington | \$149 |
| 19 | Hawaii | \$148 |
| 20 | Illinois | \$148 |
| 21 | Nevada | \$148 |
| 22 | New York | \$144 |
| 23 | Utah | \$144 |
| 24 | Arizona | \$141 |
| 25 | New Jersey | \$141 |
| 26 | South Carolina | \$136 |
| 27 | Colorado | \$135 |
| 28 | West Virginia | \$135 |
| 29 | California⁴¹ | \$134 |
| 30 | Pennsylvania | \$133 |
| 31 | Wisconsin | \$133 |
| 32 | Texas | \$129 |
| 33 | Florida | \$126 |
| 34 | Kansas | \$120 |
| 35 | Oklahoma | \$118 |
| 36 | Michigan | \$105 |

Please Note:

- States offering capitated managed care programs through Medicaid at the time of the survey that did not responding include: Nebraska, Oregon, and Tennessee.
- States not offering capitated managed care programs through Medicaid include: Alabama, Alaska, Arkansas, Georgia, Idaho, Louisiana, Maine, Mississippi, Montana, South Dakota, Vermont, and Wyoming.

Appendix F: Summary of Studies on Medicaid's Economic Impact on Select States

Florida.⁴² An analysis of the economic impact of cutting the state's Medicaid budget in 2003 found that:

- Federal Medicaid funds supported 120,950 jobs, \$4.3 billion in income and \$8.7 billion in business activity.
- At the state level, every federal Medicaid dollar generated \$2.7 dollars in income and business activity.
- The state saved \$49.5 million when it cut back Medicaid services in 2003 but, in turn, it passed up \$71.85 million federal Medicaid dollars.
- Those legislative cuts in 2003 cost Florida 1,732 jobs, \$155 million in economic activity and \$59 million in lost salaries and wages, a significant amount for Florida's economy.

South Carolina.⁴³ A 2002 study measured the direct and indirect effect Medicaid spending had on the state's economy and found that:

- Medicaid spending has a ripple effect throughout the state's economy due to the linkages between health services and other businesses. For example, hospitals make purchases from local suppliers, spurring additional economic activity, jobs and income. Also, health industry employees earn incomes that are spent and re-spent throughout the community.
- The study found federal Medicaid dollars in South Carolina supported 61,000 jobs and created \$1.5 billion in income.
- Cutting the Medicaid budget by 4 percent would cause the state to give up the corresponding federal match, and in turn lose 2,472 jobs and \$60 million in income.

Mississippi.⁴⁴ This state has the highest Medicaid federal matching rate at 76 percent. A 2003 economic analysis of the \$1.98 billion the state received in federal Medicaid funding in 2002 found it:

- Directly and indirectly increased Mississippi's economic output by \$2.69 billion due to ripple effects.
- Directly and indirectly created 39,059 jobs.
- Increased personal income by \$1.05 billion, which generated an estimated \$60.7 million in tax revenue.

Appendix G: Existing Federal Authority to Expand Medi-Cal Eligibility and Increase Provider Rates

1. *1931b Coverage Expansion.* Under Medicaid law, states have always had the flexibility to cover additional children. However, the rules regarding the coverage of adults were more restrictive until passage of the 1996 welfare reform law. At that time, states were given the option to define what counts as income and resources when determining Medicaid eligibility by Section 1931 of the Social Security Act.⁴⁵

In addition, federal regulations were changed to allow states greater flexibility in covering parents under what is known as the 100-hour rule (45 Code of Federal Regulations (CFR) Part 233, Section 233.101). California has not exercised its broad flexibility under these rules to cover more adults, and doing so is simply a matter of filing a State Plan Amendment with the federal Centers for Medicaid and Medicare Services.

2. *Physician and Hospital Rate Increases.* Under California's Medicaid State Plan, the state has broad authority to increase Medi-Cal payment rates for physician or outpatient services. California can set physician and outpatient payment rates "at the lesser of usual charges or the limits specified in the California Code of Regulations (CCR)..."⁴⁶ The CCR contains no payment cap for these services; therefore, Medi-Cal would not need to submit a change to the State Plan in order to change rates. Two other relevant rules also seem to permit changes:
 - Federal law also requires that payments under Medi-Cal fall under the "Upper Payment Limit (UPL)," as specified under 42 C.F.R. 447.272. Given California's historical spending, the UPL is not a factor that would limit payments.
 - All Medicaid programs are required to "...assure that payments [to providers] are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available," as specified in Section 1396a(a)(30). There is ample justification for California to meet this criteria.
3. *New 1115 Waiver.* Section 1115 of the Social Security Act gives states the option to receive federal matching funds for activities not otherwise reimbursable under Medicaid law. Granted at the discretion of the Secretary of Health and Human Services, the Governor has called for \$250 million in revenue from a new waiver. This negotiation with the federal government will pose challenges to the state. While options exist, it is not obvious as to how this money can be obtained by the state of California.
4. *Disproportionate Share Hospital (DSH) Payments.* The Governor's plan called for the re-direction of \$1 million in DSH dollars. This has been done in several other states, including Tennessee and Massachusetts, and is permissible under federal law.
5. *Existing Safety Net Care Pool Funding.* Under the 2005 hospital waiver, the Safety Net Care Pool (SNCP) was created with \$766 million in budget authority. The SNCP allows the state to receive federal dollars not normally reimbursable under Medi-Cal, such as delivering care to the uninsured. While certain provisions controlling the SNCP would need to be renegotiated with the federal government, the risk seems minimal that these funds would be unavailable as other states have redirected these dollars are part of California's spending baseline.

Appendix H: Summary of Proposed Medicaid Changes in the President's 2008 Budget⁴⁷

More than four-fifths of the federal administration's newly proposed Medicaid budget reductions would achieve federal savings by shifting costs directly from the federal government to states. The President's 2008 proposed budget would shift Medicaid costs to states by:

- Reducing the federal matching rate from 75 to 50 percent for certain *federally mandated* administrative activities, such as inspecting nursing homes for quality and safety, maintaining a Medicaid management information system, and investigating and prosecuting fraud and abuse in Medicaid.
- Reducing the federal matching rate for the cost of targeted case management services to a flat 50 percent for every state. Targeted case management services help certain Medicaid beneficiaries manage their health and access health care and other needed social services.
- Reducing federal matching rates for determining Medicaid eligibility to 46 states that pool the costs of determining eligibility for families and children receiving Medicaid, Temporary Assistance to Needy Families (TANF), and food stamps.
- Limiting Medicaid payments to pharmacists for drugs with three or more manufacturers to 150 percent of the drug's "average manufacturer price." The Deficit Reduction Act previously set the reimbursement limit for such drugs at 250 percent of the average manufacturer price.
- Limiting the amount of home equity to \$500,000 that an individual, who does not have a spouse living in his/her home, may have and still qualify for Medicaid long-term care services.
- Limiting payments to hospitals, nursing homes, and other institutions operated by state or local governments to strictly servicing Medicaid beneficiaries and no longer reimbursing for the costs of serving uninsured low-income patients.
- Phasing out federal reimbursements for some administrative and transportation costs for eligible children with disabilities that are part of a child's special education plan under the Individuals with Disabilities Education Act (IDEA).
- Limiting the types of services that states can cover with federal matching funds for rehabilitation services, such as special instruction and therapy for Medicaid beneficiaries with mental illness or developmental disabilities.
- Eliminating federal Medicaid payments for the costs of Graduate Medical Education (GME).

¹ Medi-Cal is the primary source of coverage for one out of four California children and one in six non-elderly Californians, and pays for about 40 percent of all births in the state and two-thirds of all nursing home days. *Please See:* California HealthCare Foundation, "Medi-Cal Facts and Figures," 2006.

² Based on data from the National Health Expenditure Project in the Office of the Actuary at the Centers for Medicare and Medicaid Services and California HealthCare Foundation, “Health Care Costs 101: California Addendum,” 2006.

³ Major healthcare reform plans in California have called for increased federal support. Of these plans, only Governor Schwarzenegger has specified a plan for an immediate increase in Medi-Cal provider rates. For Speaker Fabian Núñez, Please See: Bill Ainsworth, “Boosting Medi-Cal viewed as first step,” San Diego Union-Tribune, February 19, 2007. For Senate Republican Caucus, Please See: “The Cal-CARE Plan,” January 2007. For Governor Arnold Schwarzenegger, Please See: Office of the Governor, “Governor’s Health Care Reform Plan,” January 2007. For Senate President Pro Tem Don Perata, Please See: “Health Care Q&A,” December 2006. Also See: California Senate, Office of Research, “Comparison of Perata, Núñez, and Schwarzenegger Health Care Reform Proposals,” January 11, 2007.

⁴ State of California, Office of the Governor, “Governor’s Health Care Proposal,” January 2007.

⁵ There are several reasons why the per beneficiary spending rate is lower than per resident spending level. For example, as compared to other states, California has a higher proportion of children and adults (versus elderly and disabled); this fact would contribute toward driving down California’s federal per beneficiary spending level.

⁶ There are several reasons to believe that “per resident” spending presents a more balanced view of California spending than “per beneficiary” spending. For example, California’s mix of Medicaid beneficiaries includes a higher percentage of children than other states, including New York. This would have the affect of driving down “per beneficiary” spending.

⁷ Please see finding of The Dartmouth Atlas of Health Care at <http://www.dartmouthatlas.org/>.

⁸ Author analysis of spending data. Information is available in Appendix C, though not presented to show this.

⁹ The technical term for this percentage is the Federal Medical Assistance Percentage (FMAP).

¹⁰ The federal government will pay a higher share of Medicaid costs for states with low levels of personal income, and it will pay a lower percentage of costs to states with higher levels of personal income.

¹¹ Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, Len Nichols, Exhibit 2, “Medicaid Fee Indexes and Medicaid-To-Medicare Fee Indexes, 2003,” Health Affairs, June 2004; at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.374v1> “target= blank”><http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.374v1>.

¹² Under the study, Medicare fees were calculated by the Urban Institute using the 2003 Clinical Diagnostic Fee Schedule. Medicare payment rates are not flat nationwide and are adjusted by region to account for local differences in costs. Such adjustments were accounted for by the study.

¹³ It is worth noting that there are examples of Medi-Cal provider classes where state payment levels are near to costs, such as Federally Qualified Health Centers and Skilled Nursing Facilities.

¹⁴ California HealthCare Foundation, “Medi-Cal Facts and Figures,” 2006.

¹⁵ In terms of long-term care spending, California spends less than almost every other state. Please See: Kaiser Commission on Medicaid, “The California Medicaid Program at a Glance,” June 2005.

¹⁶ Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, Len Nichols, Exhibit 2, “Medicaid Fee Indexes and Medicaid-To-Medicare Fee Indexes, 2003,” Health Affairs, June 2004; at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.374v1> “target= blank”><http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.374v1>.

¹⁷ Please See: California Medical Assistance Commission, “Annual Report to the Legislature,” 2006. The report states that SPCP had saved the state a total of approximately \$9.1 billion in State General Funds since 1983. For State Fiscal Year 05-06, the estimated savings were \$858.5 million.

¹⁸ Centers for Medicare and Medicaid Services, 2005 Medicaid Managed Care Enrollment Report, Summary Statistics, June 30, 2005.

¹⁹ John Holahan and Shinobu Suzuki, “Medicaid Managed Care Payment Methods and Capitation Rates in 2001,” Health Affairs, January/February 2003; 22(1): 204-218.

²⁰ Medi-Cal Policy Institute, “Why are Medi-Cal Rates Important,” May 1999.

²¹ Bindman A., Physician Participation in Medi-Cal, 2001, California HealthCare Foundation, Oakland, CA: May 2003.

²² *Ibid.*

²³ *Ibid.*

²⁴ California HealthCare Foundation, “Medi-Cal Facts and Figures,” 2006. Survey data is from 1999.

²⁵ California HealthCare Foundation, “Medi-Cal Facts and Figures,” 2004. Survey data is from 1999.

²⁶ Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*, National Academy of Sciences, 2003.

²⁷ Allen Dobson, Joan DaVanzo, and Namrata Sen *The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications*, Health Affairs, January/February 2006; 25(1): 22-33.

²⁸ State of California, Office of the Governor, “Governor’s Health Care Proposal,” January 2007.

²⁹ Peter Harbage and Len M. Nichols, “A Premium Price,” The New America Foundation, December 2006.

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- ³⁰ FamiliesUSA, "Medicaid: Good Medicine for State Economies," Updated 2004.
- ³¹ Kaiser Commission on Medicaid and the Uninsured. *The Role of Medicaid in State Economies: A Look at the Research*. April 2004. <http://www.kff.org/medicaid/upload/The-Role-of-Medicaid-in-State-Economies-A-Look-at-the-Research-Policy-Brief.pdf>
- ³² Kaiser Commission on Medicaid and the Uninsured. *The Role of Medicaid in State Economies: A Look at the Research*. April 2004. <http://www.kff.org/medicaid/upload/The-Role-of-Medicaid-in-State-Economies-A-Look-at-the-Research-Policy-Brief.pdf>
- ³³ The FamiliesUSA Economic Impact Calculator for California is available at: <http://www.familiesusa.org/issues/medicaid/states/medicaid-calculator.html?state=California> . While the calculator is designed to determine impacts due to the reduction of Medi-Cal spending, author conversations with FamiliesUSA indicate that the calculator can be used to discuss the impact of funding increases.
- ³⁴ An analysis of the specific impact of the President's proposed Medicaid budget on California is beyond the scope of this paper. It is worth mentioning that the President's proposed budget could have a negative budget impact on California's Healthy Families Program. The President's proposal would leave California significantly under funded. Please See: Harbage et al, "SCHIP: What will it cost?," California HealthCare Foundation, Forthcoming.
- ³⁵ Table 8-16, Grants to States for Medicaid, Budget of the United States Government, Fiscal Year 2007, Department of Health and Human Services, Centers for Medicare and Medicaid Services; available at: <http://www.whitehouse.gov/omb/budget/fy2007/bis.html>
- ³⁶ Vern Smith, "Medicaid Enrollment in 50 States," Kaiser Family Foundation, December 2006.
- ³⁷ Table 8-16, Grants to States for Medicaid, Budget of the United States Government, Fiscal Year 2007, Department of Health and Human Services, Centers for Medicare and Medicaid Services; available at: <http://www.whitehouse.gov/omb/budget/fy2007/bis.html>
- ³⁸ U.S. Census Bureau, "Table 1: Annual Estimates of the Population for the United States," December 2006.
- ³⁹ Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, Len Nichols, Exhibit 2, "Medicaid Fee Indexes and Medicaid-To-Medicare Fee Indexes, 2003," Health Affairs, June 2004; at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.374v1>"target=" blank"><http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.374v1>. Data downloaded from statehealthfacts.org.
- ⁴⁰ John Holahan and Shinobu Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001," Health Affairs, January/February 2003; 22(1): 204-218.
- ⁴¹ According to the November 2006 Medi-Cal Budget Estimate, the average Family Two Plan rate is \$104.50 per month.
- ⁴² Priya Sampath. "Penny Wise and Pound Foolish." 2003. <http://www.floridachain.org/pubs/MedicaidReport.pdf>.
- ⁴³ Moore School of Business, University of South Carolina. "Economic Impact of Medicaid in South Carolina." January 2002. <http://research.moore.sc.edu/Research/studies/Medicaid/medicaideconimpact.pdf>.
- ⁴⁴ Benjamin Blair and Meghan Millea. "Economic Impacts of Federal Medicaid Expenditures on the State of Mississippi in 2002." August 2003. <http://www.healthpolicy.msstate.edu/publications/economicimpactfull.pdf>.
- ⁴⁵ Liz Schott and Cindy Mann, "Assuring That Eligible Families Receive Medicaid When TANF Assistance Is Denied or Terminated," Center for Budget and Policy Priorities, *November 5, 1998*.
- ⁴⁶ The "State Plan" is the official document for the federal government controlling the operation of state Medicaid programs. The quote here can be found at Attachment 4.19-B, Page 1, of the state plan.
- ⁴⁷ Leighton Ku, Andy Schneider, and Judy Solomon, "The Administration again Proposes to Shift Federal Medicaid Costs to States," Center on Budget and Policy Priorities, January 14, 2007.