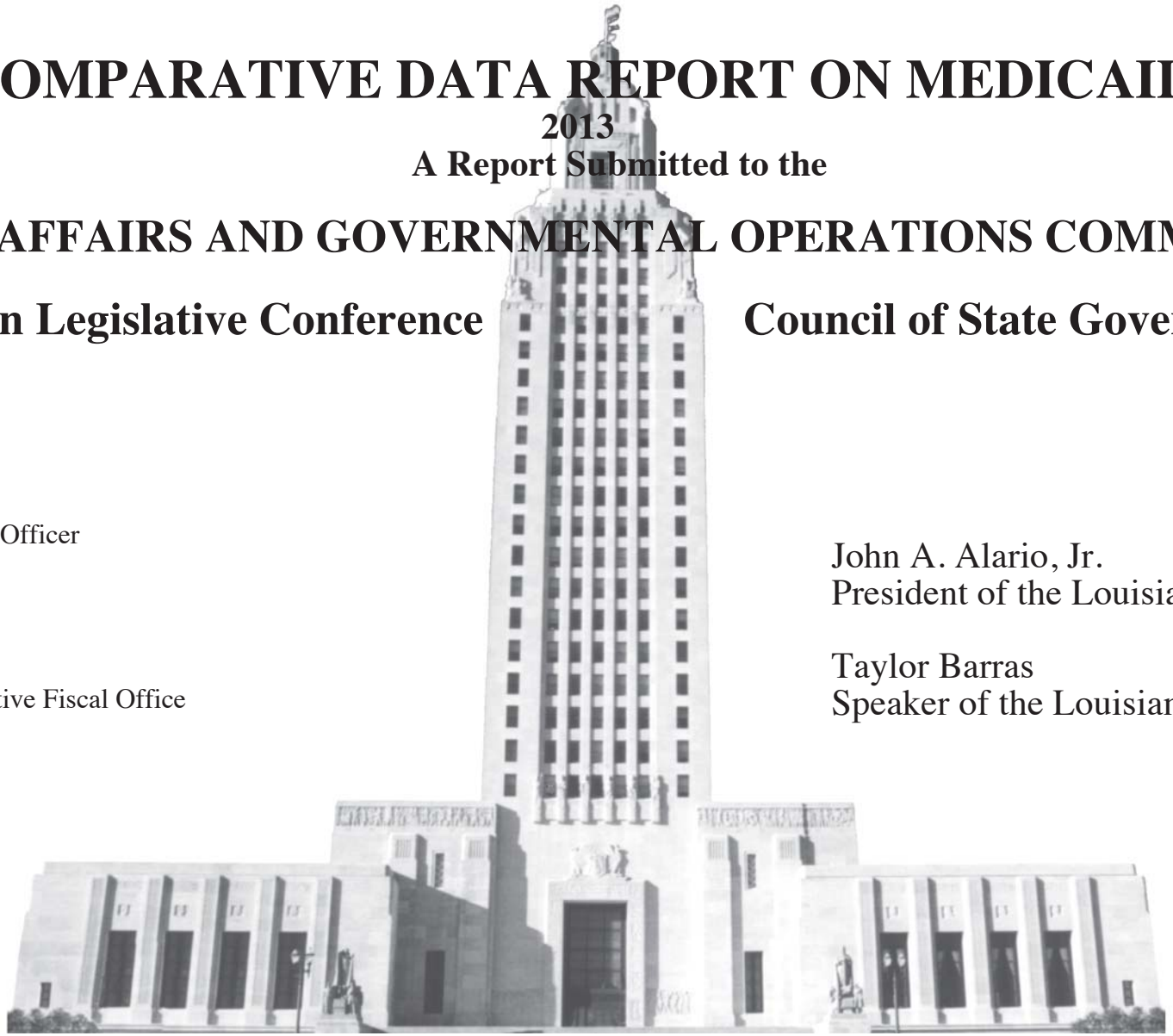
COMPARATIVE DATA REPORT ON MEDICAID

2013

A Report Submitted to the

FISCAL AFFAIRS AND GOVERNMENTAL OPERATIONS COMMITTEE

Southern Legislative Conference **Council of State Governments**



John Carpenter
Legislative Fiscal Officer

Prepared by:
Zach Rau
Shawn Hotstream
Louisiana Legislative Fiscal Office
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John A. Alario, Jr.
President of the Louisiana Senate

Taylor Barras
Speaker of the Louisiana House

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SUMMARY

INTRODUCTION

This report includes statistical tables and a summary of key findings based upon research involving each member state in the Southern Legislative Conference. This survey was initially conducted in 1992 and presented to the Second Congressional Summit on Federal Mandates in Washington, D. C., on April 29, 1992. Subsequent surveys have been presented each year to the Fiscal Affairs and Government Operations Committee of the Southern Legislative Conference.

The format of the survey has been modified in an effort to present a meaningful amount of information without overwhelming the reader with excessive data. Data prior to FFY 06 has been removed from the report, but is still available upon request.

The assistance of legislative staff in each state and Medicaid agency staff that submitted information is greatly appreciated. Staff of the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration) and Medicaid and CHIP Payment Access Commission also provides invaluable assistance each year by locating and forwarding the information needed to complete this report. Thanks as well to several co-workers who assisted with preparation of this report: Evan Brasseaux, Willie Marie Scott, Patrice Thomas, Colleen M. Gil, Grant Krampe, and John D. Carpenter. Comments, questions and suggestions concerning this report are welcomed.

Shawn Hotstream, Section Director
Zach Rau, Fiscal Analyst
Louisiana Legislative Fiscal Office
Post Office Box 44097
Baton Rouge, LA 70804

Phone: (225) 342-7233
FAX: (225) 342-7243
E-Mail: hotstres@legis.la.gov

BACKGROUND

Medicaid (Title XIX of the Social Security Act) is a program of medical assistance for impoverished individuals who are aged, blind, or disabled, or members of families with dependent children. Medical benefits for needy individuals are provided based on a division of state and federal responsibilities. The federal government establishes regulations, guidelines, and policy interpretations describing the framework within which states can administer their programs. The nature and scope of a state's Medicaid Program are specified in a state plan that, after approval by the Department of Health & Human Services, provides the basis for federal funding to the state.

Medicaid is a federal entitlement program established with the 1965 Title XIX amendment to the Social Security Act. This program provides medical assistance to certain individuals having low incomes or resources. Medicaid programs are jointly funded by the federal and state governments and are designed to assist states in providing access to health services to eligible individuals. Within broad guidelines established by the federal government, each state: 1) administers its own program; 2) establishes its own eligibility standards; 3) determines the amount, duration, and scope of services; and 4) sets the reimbursement methodology for these services. As a result, Medicaid programs vary from state to state.

Funding is shared between the federal government and the states, with the federal government matching state contributions at an authorized base rate between 50% and 83%, depending on the state's per capita income (a state's latest 3-year average per capita income in relation to the national average per capita income). The federal participation rate (Federal Medical Assistance Percentage, or FMAP) is adjusted each year to compensate for changes in the per capita income of each state relative to the nation as a whole. In 2015, the FMAP for the SLC states ranged from a rate of 50% (Virginia and Maryland) to 73.43% (Mississippi).

Federal requirements mandate the provision of certain services by any state participating in the Medicaid Program. These services include: inpatient and outpatient hospital services; prenatal care; vaccines for children; rural health services; lab and x-ray services; skilled nursing services; home health care for persons eligible for skilled-nursing services; pediatric and family nurse practitioner services; nurse mid-wife services; physician services; family planning; federally-qualified health center services; and services for the early and periodic screening, diagnosis, and treatment (EPSDT) of those under age 21. States have considerable latitude about the scope of each of these services even though they are mandated. However, states can cover optional services (authorized by the federal government). An example of an optional service is prescription drug coverage. States also can expand Medicaid to cover certain optional eligibility groups. Some examples of these groups may include pregnant women, children, and the medically needy in the case where an individual's income may exceed the federal thresholds.

In addition, states have the authority to waive certain federal provisions that are required to operate Medicaid programs. All waivers require approval by the Centers for Medicare & Medicaid Services (CMS). Medicaid waiver authority is

granted to states under Section 1115 (research and demonstration waiver), 1915(b) and 1915(c). Section 1115 waiver programs provide broad authority in implementing temporary pilot or demonstration projects/studies that may either expand coverage to individuals not typically covered under Medicaid, provide services not typically covered under Medicaid, or alter the service delivery system. Section 1915(c) waivers allow states to provide services that would not otherwise be covered by Medicaid to targeted groups, and services can be capped. An example of a Section 1915(c) waiver is the Home & Community Based Service (HCBS) Waiver Program, which is utilized by all of the SLC states as a means of providing a community service alternative to institutional care for the elderly and disabled.

METHODOLOGY

The purpose of this report is to provide legislators and staff in each state with a reference document that can be used to compare Medicaid spending in a particular state to others throughout the southern region. The first report in this series was published in April 1992 for the Second Congressional Summit on Federal Mandates. That survey utilized data collected from each state on Medicaid Program expenditures for state fiscal years. Since then the surveys have used data reported by each state to the federal government for federal fiscal years (October 1-September 30).

CMS collects voluminous data on state Medicaid programs on CMS Forms 37, 64, and MSIS (formerly 2082). Since each state follows the same report format and utilizes the same definitions and instructions, the information on these forms is the most accurate and consistently available. However, **FFY 13 MSIS data was unavailable for this report as CMS transitions from its current MSIS data reporting system to the Transformed MSIS (T-MSIS) data reporting system. As a result, this report relies on data from the Medicaid and CHIP Payment Access Commission (MACPAC), a federal agency that provides information to Congress, the Department of Health & Human Services, and state agencies. MACPAC issues a report to Congress biannually, and this book relies greatly on data from these reports.**

NOTE ON DATA COLLECTION

The data contained in the MACPAC reports spans from FY 10 to FY 13 and is based on CMS Form 64 Financial Management Report (FMR) and MSIS data. However, MACPAC's datasets are much leaner than those provided by CMS, therefore the state comparison sheets include less information, especially in the areas of recipients by service and recipients and payments by certain demographic data (age, gender, ethnicity, maintenance assistance status). As a result, the FFY 13 report contains three categories related to enrollment and spending by demographics: enrollment by basis of eligibility, average per-enrollee spending by basis of eligibility, and total spending by basis of eligibility.

Futhermore, like MSIS datasets, MACPAC data includes spending by type of service for each state. However, the data definitions for the MACPAC datasets are more consolidated than those of the CMS-provided MSIS datasets, yielding fewer spending categories. Furthermore, reported spending by basis of eligibility and service category will not always match as a result of MACPAC excluding certain costs, such as DSH payments, from spending by basis of eligibility.

Lastly, a new category, "Collections" appears in spending by type of service. This new category is a negative number that includes refunds for erroneous payments and tort collections resulting from third-party claims.

The data collected from the federal reports and from the states have been organized into a "Medicaid State Profile" for each state. These include multi-year histories of total Medicaid spending as well as enrollment and payment data for major eligibility and service categories. To the extent possible, information on provider taxes and eligibility criteria is also included. Each profile contains charts comparing that state to the SLC average in terms of annual payments per enrollee and the number of enrollees per 100,000 population. As a supplement to state data regarding program characteristics and initiatives, information was included from the individual states Medicaid web pages, and Kaiser State Health Facts. Key demographic and poverty indicators were obtained from the U.S. Census Bureau and Bureau of Economic Analysis.

MEDICAID SPENDING IN THE SOUTHERN REGION

The rapid rate of growth in Medicaid spending which occurred during the late 1980's and early 1990's began to decline by FFY 94 in the 16-state southern region. Since that time, the growth rate has been variable. Total actual Medicaid payments (administrative costs excluded) for the 16 SLC states for FFY 15 were $162.2 B, a significant increase of approximately $11.3 B (7.5%) over the FFY 14 level of $151.0 B. The states with the largest dollar increases from FFY 14 to FFY 15 include Texas ($3.3 B, or 10.5%), Kentucky ($1.63 B, or 20.9%), North Carolina ($1.22 B, or 10.2%), and Florida ($1.02 B, or 5%).

The growth in Kentucky is primarily attributable to Medicaid Expansion and is a continuation of a rapid growth trend beginning in FFY 14, when its total payments increased from $5.73 B in FFY 13 to $7.79 B in FFY 14 (36.09%). By contrast, Texas, North Carolina, and Florida have not undertaken Medicaid Expansion, and the growth may be attributable to other factors, such as enrollment growth or altered rate schedules for services that cannot be verified until enrollment data for FFY 14 is released (Note: there is typically a two-year lag between reporting CMS-64 data and population-based data). It is worth noting that enrollment data for the SLC on average declined from FFY 12 to FFY 13 as noted in this report. However, the enrollment decline will likely end in FFY 14 as a result of Medicaid Expansion, with enrollment projected to increase beyond historical levels (Medicaid Expansion coverage began on January 1, 2014).

The increase in total payments for FFY 15 reflects the 9th consecutive year of a single digit percentage increase (from FFY 06) in total Medicaid spending. This single digit annual growth for the last 8 years follows a $3.5 B decrease in expenditures from FFY 05 to FFY 06 (in part due to the way Part D expenditures are reflected), and three consecutive years of single digit percentage increases in total Medicaid spending (FFY 03, FFY 04, and FFY 05). Spending in the years reflected in this report appears to represent a continued effort to control Medicaid growth that had exhibited some years of double digit growth between FFY 99 to FFY 02). See "Southern Region Medicaid Profile".

Total spending for FFY 13 (from CMS 64) is $137.8 B, administrative costs excluded, which is an increase of approximately $2.5 B, or 1.9% from the $135.4 B for FFY 12. Total spending for FFY 14 (from CMS 64) is $151.0 B, or 9.5% over the $137.9 B spent in FFY 13. Total spending for FFY 15 (from CMS 64) is $162.2 B, or 7.5% over the $151.0 B spent in FFY 14. FY 13 exhibited a more controlled growth in Medicaid, but FFY 14 showed a considerable increase that has slowed slightly in FFY 15. The annual rate of change projected over the entire eight-year period from FFY 07 to FFY 15 is 5.8%.

During the early 1990's several factors contributed to the rapid growth in Medicaid spending:

- First, program enrollment increased significantly, mainly due to federal mandates which directed states to expand coverage to pregnant women and children with family incomes at or above the federal poverty level. Such mandates had a major cost impact in southern states, which tend to have large indigent populations and a limited

ability to finance health care programs at the high levels found in other parts of the nation. The number of Medicaid recipients in southern states grew from 11.1 M in FFY 92 to 14.4 M in FFY 98.

- Second, other factors include higher utilization rates (due, in part, to federal mandates such as those calling for more thorough screening of school age children), the targeting of specific populations (AIDS patients, drug-dependent newborns) and higher payments to certain providers.

- Third, states have utilized creative methods to find the revenues needed to pay for Medicaid programs which in many cases have quadrupled in size over the past seven years. These include widespread use of provider taxes, disproportionate share payments and intergovernmental transfers.

As reflected in prior reports, Medicaid spending in the SLC states reflected double digit increases from FFY 99 to FFY 02. The following 3 years (through FFY 05) indicate a more controlled growth. Actual growth figures for FFY 06 (a reduction of 3.6% from prior year) is the result of 10 of the 16 states in the SLC having a reduction in payments. Although FFY 06 spending projects a level of spending below FFY 05, Medicaid spending in FFY 07, FFY 08, and FFY 09 reflect a moderate expenditure increase pattern. FFY 10 spending, although under double digit spending, represents approximately 9% growth over FFY 09.

Total Medicaid expenditure growth in the SLC from FFY 14 to FFY 15 is the result of 15 of the 16 SLC states having an increase in payments (Tennessee reflects a 1.2% decrease in payments from FFY 14). FFY 14 increased 9.5% from FFY 13 while FFY 13 and FFY 12 spending increased only 1.9% and 3.1%, respectively. Total spending in FFY 12 and FFY 13 reflected diminished growth trends, but the significant increase in payments in FFY 14 is partially attributable to Medicaid Expansion taking effect in Arkansas ($687.3 M increase in payments from FFY 13 to 14), Kentucky ($2.07 B increase in payments from FFY 13 to 14), and Maryland ($1.52 B increase in payments from FFY 13 to 14). The enhanced growth trend continued in FFY 15, though not as dramatically as in FFY 14 and may represent a slowing of growth after the initial spike in FFY 14.

Note: In FFY 06, implementation of federal legislation impacted prescription drug coverage for some Medicaid enrollees. The Medicare Modernization Act (MMA) of 2003 was implemented in January 2006. This legislation shifted the costs of prescription drug coverage for certain "dual eligibles" from Medicaid to Medicare Part D plans. States are still required to pay a state share for this coverage (what states would pay under Medicaid, called the 'clawback payment' or 'phase down'). Although the clawback payment is still considered as a Medicaid expenditure, the federal matching funds historically drawn down with this general fund is no longer recorded as a Medicaid payment for FFY 06 and in the future, but is recorded in Medicare. (See "Payments by Type of Service – Prescribed Drugs" expenditures by state.)

Total Medicaid expenditures by eligibility in the 16 SLC states are illustrated in **Chart 1 (page viii)**. This data is only available for FFY 10 – FFY 13. This chart divides Medicaid dollars spent by the following eligibility categories: aged (65

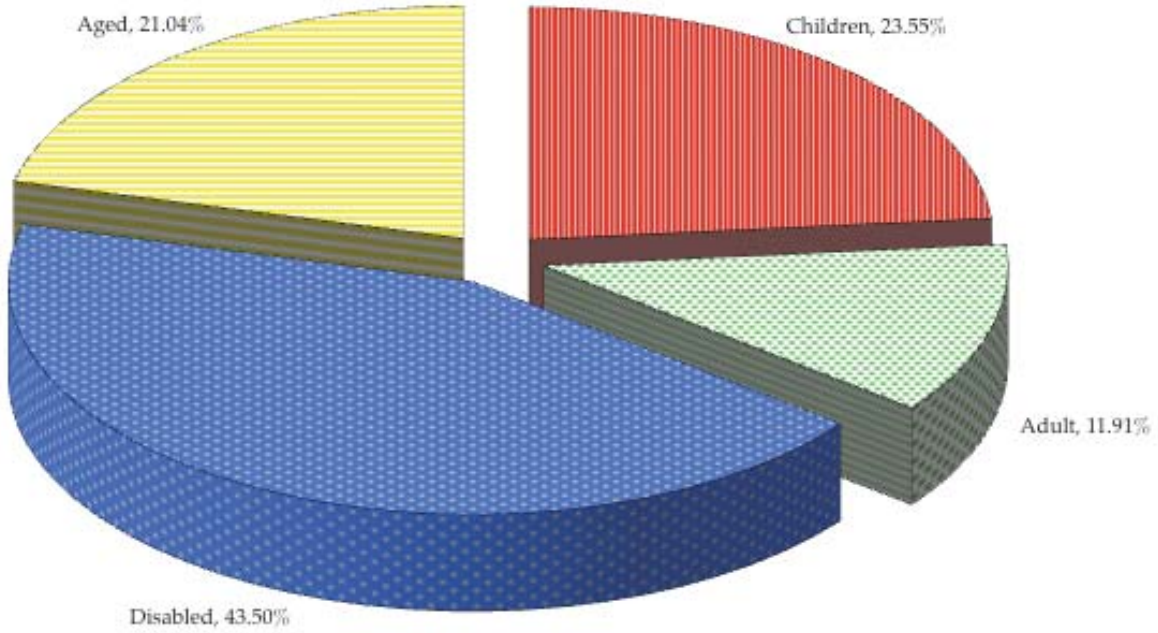
and older), disabled, children, and adults. By far the greatest amount of Medicaid dollars is spent on those who are disabled (43.5%). Expenditures for children were next, accounting for 23.6% of the payments. The remaining classifications of aged (21.04%) and adults (11.6%) make up the balance (32.64%). The total amount of Medicaid payments in the SLC for FFY 13 was approximately $137.8 B (exclusive of DSH payments, pharmacy rebates, and other adjustments), as reflected on the SLC rollup page, 'Spending by Type of Service,' an increase of approximately 1.9% from the FY 12 amount of approximately $135.34 B.

The total number of Medicaid enrollees in the 16 states was approximately 22.9 M during FFY 13 as compared to the FFY 10 number of approximately 21.57 M enrollees, or an average annual decrease of 2.9% per year. The number of enrollees decreased from FFY 12 to FFY 13 by approximately 1.43 M. Note: MACPAC excluded enrollment data from Louisiana due to data reliability concerns, enrollment figures derived from MACPAC total 20.1 M. To account for this, an enrollment figure of approximately 1.4 M derived form Louisiana's 2013 Annual Report on Medicaid is included in all enrollment-based figures.

Chart 2 (page ix) provides a percentage distribution of these enrollees by the same eligibility standards as Chart 1. The greatest number of Medicaid enrollees in the southern region was children (54.2%). Adults followed with approximately 19.6%, while the disabled comprised 18.8% of the total number of enrollees. The balance of 10.9% is attributed to the aged. The average payment per enrollee for all Medicaid services for the SLC states was approximately $6,486. This is a decrease of $111 from FFY 12 to FFY 13 and approximately 2.6% annual decrease from FFY 10. Similar to the enrollment figures, MACPAC did not report per-enrollee expenditure data for Louisiana due to data reliability concerns. To account for this, included is a per-enrollee expenditure derived from Louisiana's total expenditures by service as provided by MACPAC divided by the enrollment figure included in Louisiana's 2013 Annual Report on Medicaid.

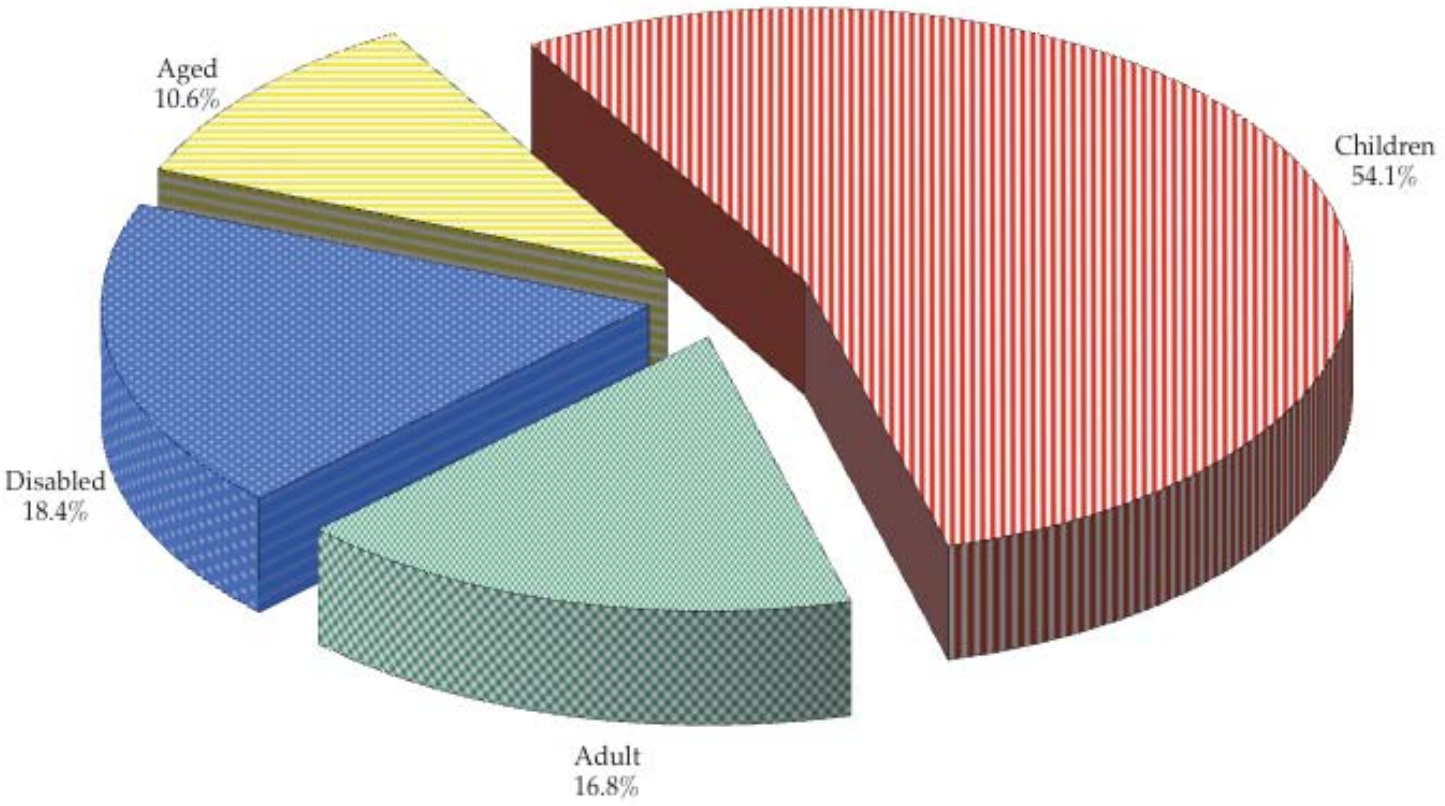
SOUTHERN REGION MEDICAID PROFILE

CHART 1
TOTAL MEDICAID EXPENDITURES IN SLC BY BASIS OF ELIGIBILITY
(FFY 13)



SOUTHERN REGION MEDICAID PROFILE

CHART 2
TOTAL MEDICAID ENROLLEES IN SLC BY ELIGIBILITY BASIS
(FFY 13)



STATE COMPARISONS

The next section contains direct comparisons among the 16 SLC states relative to spending levels and enrollment levels. These comparisons include measures of per capita expenditures, expenditures per enrollee and enrollees per 100,000 population, as well as information on payments for services and on administrative costs. These are included only to indicate broad trends and demonstrate gross levels of spending and eligibility in each state. They should be used with caution when comparing state programs in terms of coverage, cost effectiveness or level of effort. Note: MACPAC excluded payments by enrollee and enrollment data Louisiana from this dataset due to data reliability concerns. To account for this, an enrollment figure from Louisiana's 2013 Annual Report on Medicaid is included rather than one from MACPAC, and a per-enrollee average payment is derived from Louisiana's FFY 2013 payments by type of service.

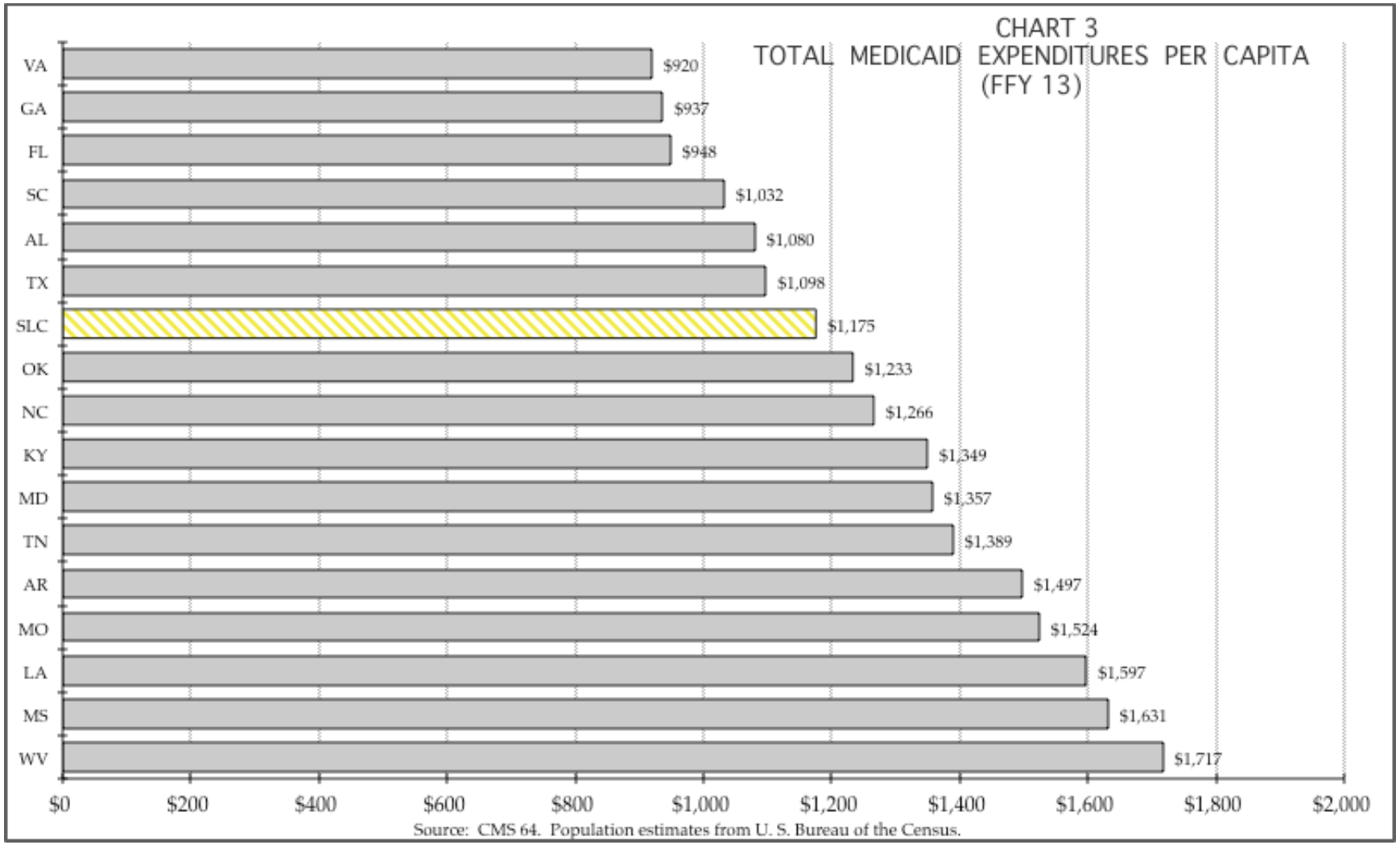
Per Capita Expenditures. Medicaid per capita spending in the 16-state southern region has increased from $1,114 in FFY 10 to $1,175 for FFY 13. States with high numbers of enrollees per unit of population combined with a high level of payments per enrollee rank high in per capita spending. As shown in **Chart 3 (page xi)**, per capita spending for FFY 13 ranges from $920 in Virginia to $1,717 in West Virginia.

Payments per Enrollee. Average annual payments per enrollee for the southern region have decreased from $7,017 in FFY 10 to $6,486 in FFY 13, an average annual decrease of 2.6% over this period. Note**:** expenditure per enrollee comparisons should be viewed with caution unless used in conjunction with a specific well-defined service. The highest payment per enrollee in the SLC region is $9,665 in Missouri, while Alabama posts the lowest payment per enrollee at $4,124 **(See Chart 4, page xii)**

Enrollees per 100,000 Population. The number of enrollees per 100,000 population decreased to 17,500 in FFY 13 from 20,118 in FFY 12. According to this indicator, the highest state was Louisiana with 30,557 per 100,000 population and the lowest was Virginia with 11,309 in FFY 13. A state's rank on this scale is influenced by how liberal its eligibility criteria is for Medicaid and children in low-income families. **(See Chart 5, page xiii)**

SCHIPS Allocation per State. Under the provisions of the legislation that created SCHIPs, states have the option of expanding Medicaid, designing a state plan option, or implementing a combination of both. In the SLC, 2 states have opted to expand Medicaid, 5 states have designed a separate state plan, and 9 states have combined Medicaid expansion with a state-designed plan. Texas, North Carolina, and Florida topped the federal allocation in the SLC with $891.5 M, $304.3 M, and $359 M, respectively. West Virginia was allotted the fewest SCHIP dollars in the SLC, $48.3 M. (**See Table 1, page xiv)**

SOUTHERN REGION MEDICAID PROFILE



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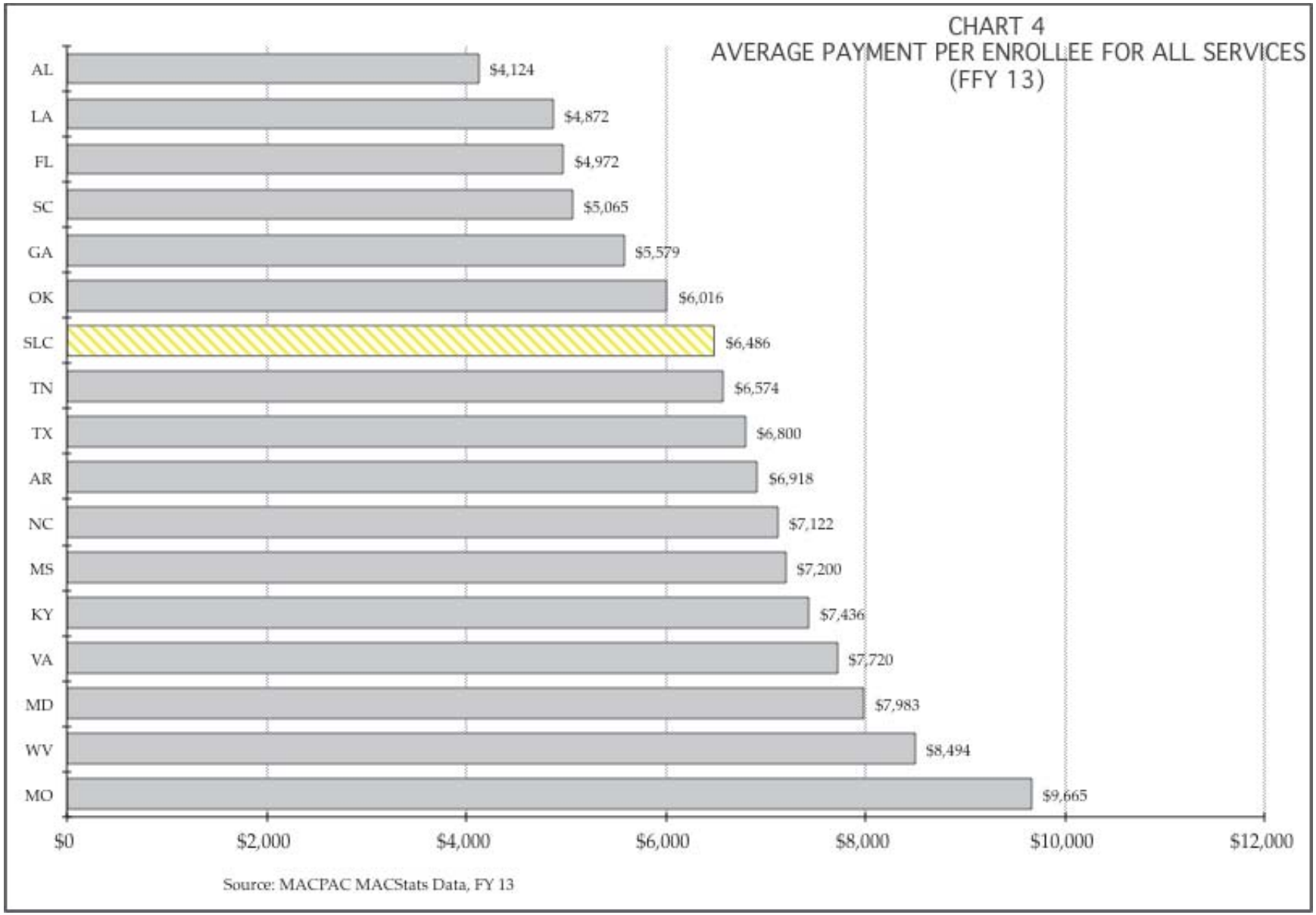

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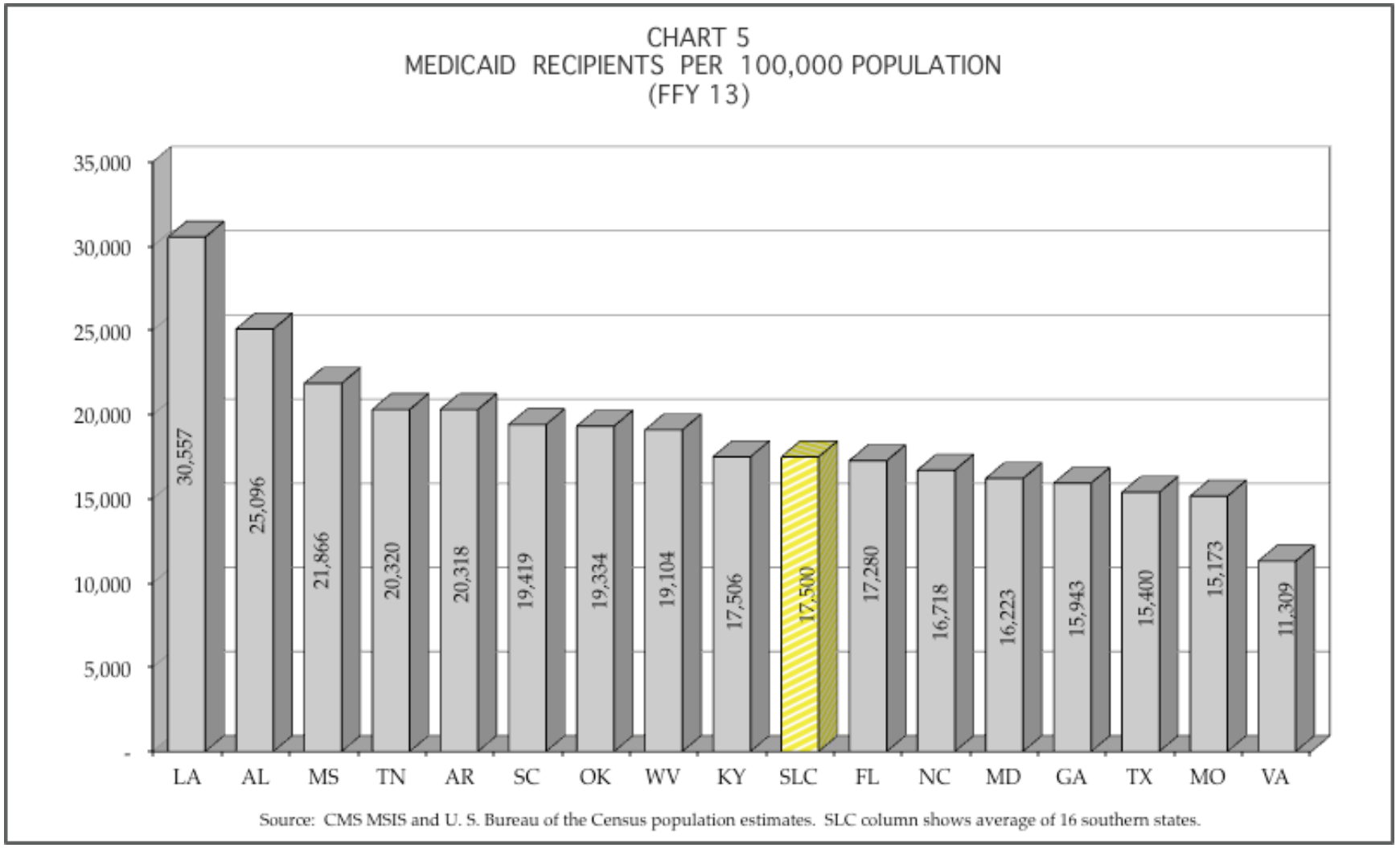

SOUTHERN REGION MEDICAID PROFILE

TABLE 1

SCHIP AND MATCH RATES FOR THE SOUTHERN LEGISLATIVE CONFERENCE STATES

	SCHIP Allotments FFY 13			FFY 13 Federal Match Rates			
	Federal $'s in millions	State $'s in millions	Total Program Allotment in millions	Medicaid	SCHIP	Difference	Type of Plan
* • AL	$162.8	$46.0	$208.80	68.53%	77.97%	9.4%	State Plan Option
* • AR	$103.1	$27.2	$130.3	70.17%	79.12%	9.0%	Combination
* • FL	$359.0	$149.1	$508.1	58.08%	70.66%	12.6%	Combination
* • GA	$282.7	$89.8	$372.5	65.56%	75.89%	10.3%	State Plan Option
* • KY	$147.9	$38.4	$186.3	70.55%	79.39%	8.8%	Combination
* • LA	$171.9	$64.0	$235.9	61.24%	72.87%	11.6%	Combination
* • MD	$160.5	$86.4	$246.9	50.00%	65.00%	15.0%	Medicaid Expansion
* • MS	$176.9	$40.4	$217.3	73.43%	81.40%	8.0%	State Plan Option
* • MO	$122.9	$45.5	$168.4	61.37%	72.96%	11.6%	Combination
* • NC	$304.2	$96.8	$401.0	65.51%	75.86%	10.4%	Combination
* • OK	$114.2	$38.5	$152.7	64.00%	74.80%	10.8%	Combination
* • SC	$98.3	$25.7	$124.0	70.43%	79.30%	8.9%	Medicaid Expansion
* • TN	$200.2	$62.2	$262.4	66.13%	76.29%	10.2%	Combination
* • TX	$891.5	$355.2	$1,246.7	59.30%	71.51%	12.2%	State Plan Option
* • VA	$186.6	$100.5	$287.1	50.00%	65.00%	15.0%	Combination
* • WV	$48.3	$11.8	$60.1	72.04%	80.43%	8.4%	State Plan Option
SLC TOTAL	**$3,531.0**	**$1,277.4**	**$4,808.4**				

Medicaid Disproportionate Share Hospital (DSH) Payment

The Medicaid Disproportionate Share Hospital (DSH) Payment Program was established by the federal government in 1981. The program was designed to enable states to provide financial support to hospitals that incur high levels of unreimbursed costs due to serving a disproportionate share of Medicaid and uninsured patients. The program was not only established to enhance the financial stability of these hospitals, but also to ensure access for the low income and uninsured. Congress authorized DSH payments, or a payment adjustment, to cover these costs.

Individual states make DSH payments to hospitals through their Medicaid programs. States have some flexibility in defining what is considered a low-income provider (which hospitals qualify for reimbursement) within federal guidelines, and states can further decide specific payment methodologies (payment levels based on hospital provider type). However, these state guidelines are restricted through a hospital specific DSH cap (typically can't be greater than costs), and a total DSH cap (total amount that a state can receive). The total state allotments that are currently in place are not necessarily based on state need, but historical DSH funding.

DSH payments are jointly financed by states and the federal government. The required state match to draw down federal financial participation (Federal Medical Assistance Percentage) varies by state, and typically depends on the economy of the state. Furthermore, the "state contribution" required to draw down the federal DSH matching funds or allotment may consist of resources other than state general funds, and may include provider fees, intergovernmental transfer (IGT) funds which are fund transfers from local governments or providers, and/or donations.

Chart 6 represents total DSH payments in the SLC from FY 07 to FY 15. Total DSH funding is separated by general hospital inpatient payments and mental health hospital payments. Total DSH payments in the SLC increased by $1.8 B, or 28% from FFY 14 to FFY 15, and by 36%, or $2.17 B from FY 07 to FY 15. The growth in DSH funding from FFY 14 to 15 is in contrast to the projected trend of decreased use of DSH payments resulting from a reduction of uncompensated care under the auspices of the Affordable Care Act.

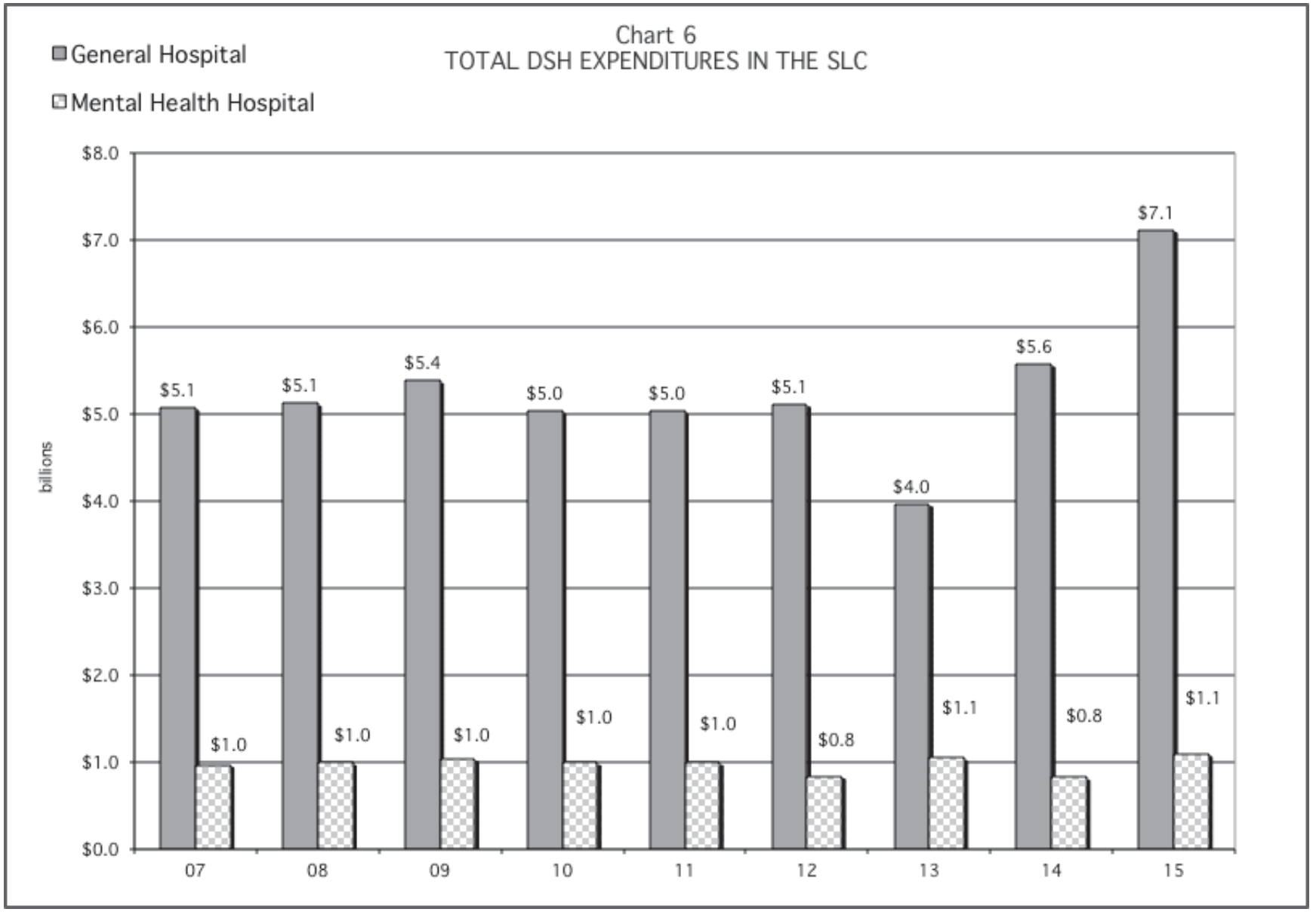
Chart 6
TOTAL DSH EXPENDITURES IN THE SLC
General Hospital
Mental Health Hospital
billions
$8.0
$7.0
$6.0
$5.0
$4.0
$3.0
$2.0
$1.0
$0.0
$5.1
$5.1
$5.4
$5.0
$5.0
$5.1
$4.0
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DEFINITIONS

Capitation: A reimbursement system in which health care providers receive a fixed payment for every patient served, regardless of how many or how few services the patient uses.

Collections: A negative spending number that includes refunds for erroneous payments and tort collections resulting from third-party claims.

Clawback: (or phase down state contribution): Required state payment to Medicare to cover the cost of dual eligiblies for Medicare prescription drug coverage offered under Medicare Part-D.

Diagnostic-Related Group (DRG): This is a system in which the hospital receives a fixed fee for each type of medical procedure regardless of the hospital's cost of providing that service.

DSH Payment: Disproportionate Share Hospital payment: Source of funding/reimbursement from Medicaid to hospitals for uncompensated care costs.

Dual Eligible: Senior or disabled individual enrolled in both Medicaid and Medicare.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT): Medicaid disease prevention program for children.

Federal Medical Assistance Percentage (FMAP): The federal government share of state Medicaid expenditures. Often referred to as financial participation or the federal match rate. The FMAP for each of the 50 states is formula driven and based on per capita incomes. States having low per capita incomes receive a higher federal match.

Federal Poverty Level (FPL): Poverty measure determined by the federal government based on family size.

Fee-for-Service: The traditional way of billing for health care services. There is a separate charge for each patient visit and service provided.

Federal Fiscal Year (FFY): October 1 to September 30.

Home & Community Based Services Waiver: Enable states to disregard certain federal requirements to provide home and community based services to targeted populations who would otherwise require institutionalization (ICF/MR services, and skilled and intermediate care nursing facility services).

Managed Care Organization (MCO): A system of care under which a predetermined number of patients are enrolled, for a pre-determined rate for all or part of their care.

Mandatory Services: Services required to be provided (by CMS) to Medicaid eligibles as a result of operating a Medicaid program.

Medicaid-only Managed Care: Arrangement between a state Medicaid agency and a managed care organization to provide services to Medicaid beneficiaries only (excludes commercial and Medicare enrollees).

Medicaid: A national entitlement health insurance program authorized by Title XIX of the Social Security Act in 1965 that is jointly funded by states and the federal government and operated by the individual states. It is designed to provide medical coverage for the poor and specific groups of uninsured. Eligibility is typically limited to low income children, pregnant women, elderly and individuals with disabilities. States are granted flexibility in designing their Medicaid programs, but must cover certain groups of individuals.

Medicaid and CHIP Payment Access Commission (MACPAC): A federal agency that provides information to Congress, the Dept. of Health and Human Services, and state agencies. MACPAC issues a report to Congress biannually

Medical Saving Accounts: Individual and/or family health funds similar to individual retirement accounts into which employers and employees make tax-deferred contributions.

Medically Needy: A state option that allows Medicaid eligibility to an individual that may qualify under a certain category, but not financially (has too much income or assets to qualify under categorically needy limits). The states allow the individual to reduce their income (by spending down monthly income on medically necessary services to the provider or Medicaid program) to the Medicaid income standard/requirement for the respective category in order to qualify for Medicaid.

Presumptive Eligibility: a state option that allows eligible providers to pre-determine (expedite) eligibility (without verification) under Medicaid before/while Medicaid eligibility is being determined. Services are temporary, or until appropriate Medicaid applications are submitted and eligibility is determined by an individual state.

Primary Care Case Management (PCCM): Programs that use a provider who receives a fee to manage the individual's primary care but reimburses on a fee-for-service basis. The primary care case manager is responsible for health care utilization and access to service.

Prior Authorization: Approval required from state Medicaid programs before physicians can prescribe certain medications. Prior authorization has typically been used by Medicaid programs as a cost saving tool.

Provider Taxes: Broad-based taxes on specific health providers/facilities, such as hospitals or nursing homes; and services such as pharmaceutical services which are used to generate federal Medicaid funds.

Section 1634 State: State option that requires state to provide Medicaid coverage to all aged, blind, and disabled individuals that receive cash assistance through SSI.

Section 1915(b) Waivers: Provision of the Social Security Act that allows states to waive certain programmatic rules governing Medicaid. It is typically used in implementing managed care to implement provider choices. States have generally used one of the following two approaches; capitated or primary care management programs.

Section 1915(c) Home & Community Based Services (HCBS) Waiver: Typically used to allow a state to offer long-term care services in a community based setting as opposed to institutional care.

Section 1115 Waivers (Research and Demonstration projects): Provision of the Social Security Act that allows states, subject to CMS approval, to waive certain requirements of the Medicaid program, such as eligibility rules. These waivers can be used to create small-scale demonstration projects in order to test proposed broad changes in the Medicaid program.

States Health Insurance Program (SCHIP): Federal health insurance program for targeted low-income children under the age of 19 (that do not qualify for Medicaid) authorized by Title XXI of the Social Security Act. The program is jointly funded by states and the federal government, and states receive an enhanced federal match rate. SCHIP is an entitlement program that is capped by the federal government.

T19: All mandatory eligibility groups, as described by Title XIX of the Social Security Act.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000: Federal act that gives states the 'option' to provide breast and cervical cancer treatment services through the Medicaid program (new eligibility category) to certain women.

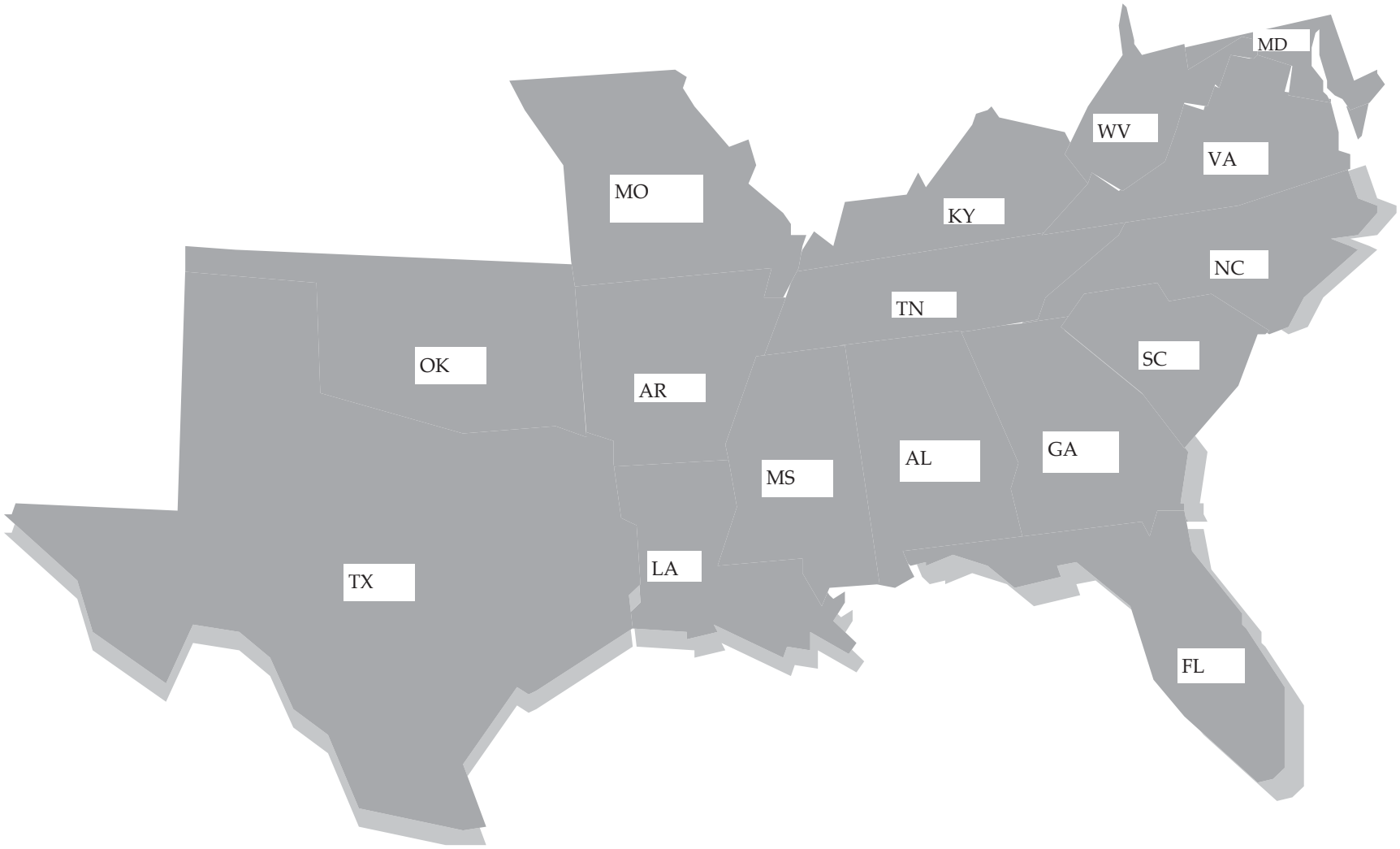
The Centers for Medicare & Medicaid Services (CMS -- formerly HCFA): A federal agency within the Department of Health & Human Services. It was created in 1977 to administer the Medicare and Medicaid programs -- two national health care programs with more that 72 million beneficiaries. While CMS mainly acts as a purchaser of health care services for the Medicare and Medicaid beneficiaries, it also:

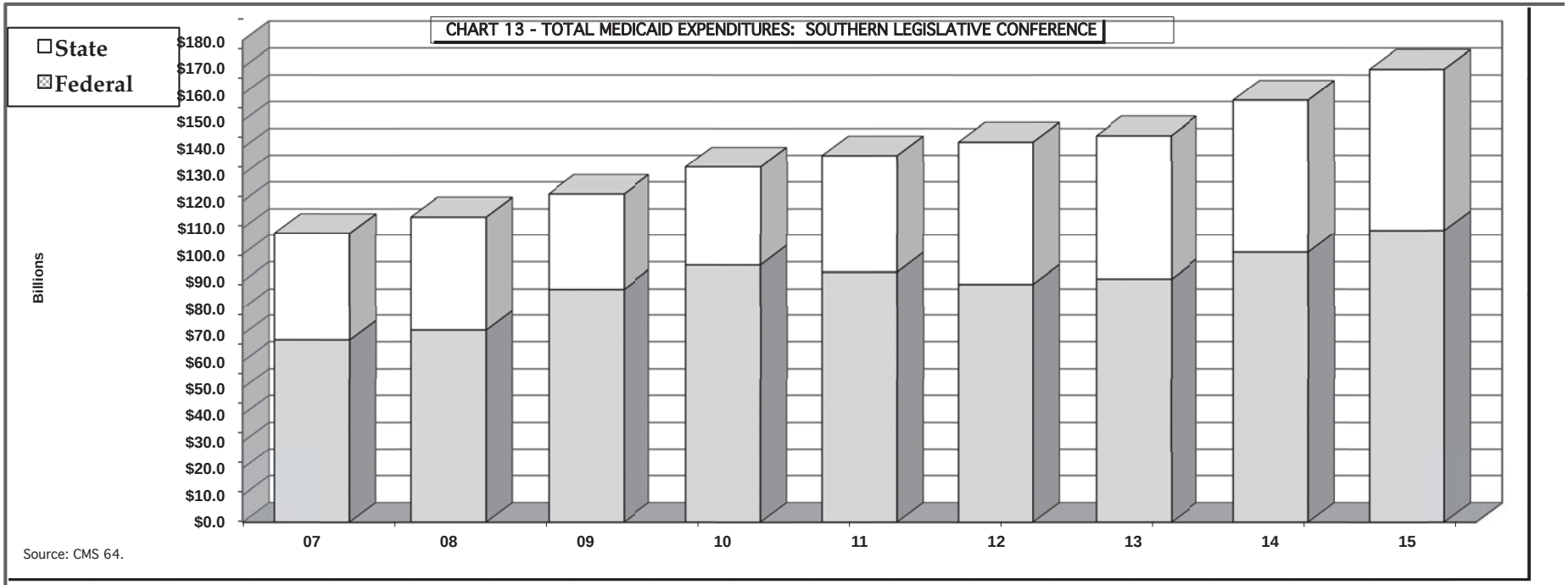
- Assures that Medicare and Medicaid are properly administered by its contractors and state agencies;
- Establishes policies for the reimbursement of health care providers;
- Conducts research on the effectiveness of various methods of health care management, treatment, and financing; and

- Assesses the quality of health care facilities and services.

Waiver: The Secretary of the Department of Health & Human Services can waive certain Medicaid statutory requirements upon request in order to allow states flexibility in operating their Medicaid programs. Waivers are usually implemented to target specific services to specific groups, expand eligibility to new or different groups, implement a new delivery system, or provide a different service.

SOUTHERN REGION MEDICAID PROFILES



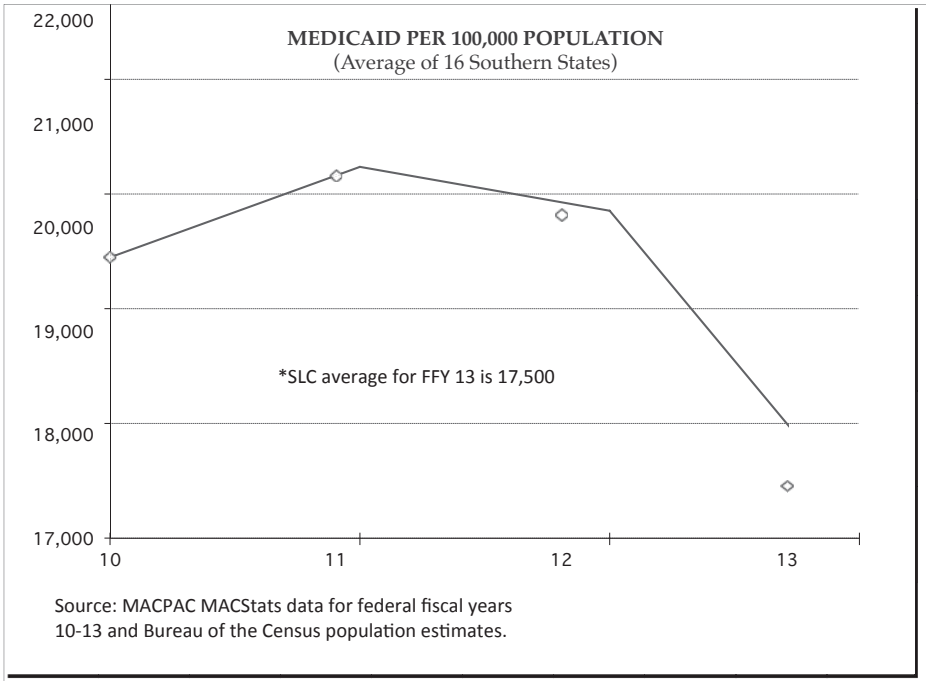


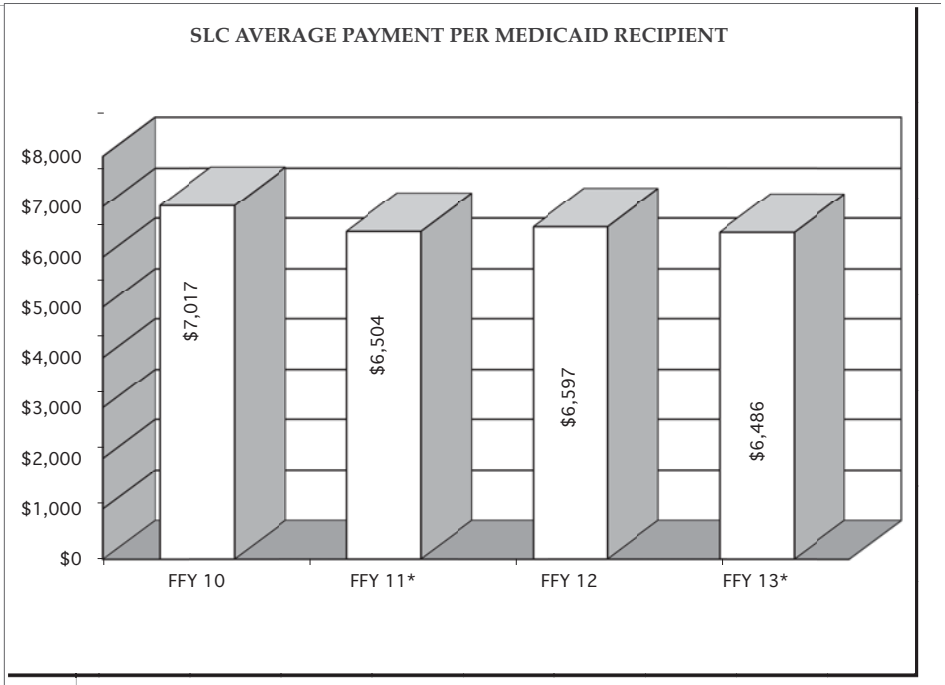
State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14*	FFY 15*	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	103,413,746,498	109,182,631,212	117,379,206,392	127,790,238,147	131,316,434,844	135,353,847,786	137,879,579,180	150,952,861,677	162,219,297,591	*5.8%*	*7.5%*
Federal Share	65,317,890,670	68,862,522,663	84,170,398,316	93,193,623,649	90,050,024,631	84,529,815,993	86,624,002,069	96,345,576,558	104,366,085,555	*6.0%*	*8.3%*
State Share	38,095,855,828	40,320,108,549	33,208,808,076	34,596,614,498	41,266,410,213	50,824,031,793	51,255,577,111	54,607,285,119	57,853,212,036	*5.4%*	*5.9%*
Administrative Costs	4,671,247,861	4,979,773,159	5,278,801,928	5,117,613,727	5,762,082,116	6,831,182,155	6,644,765,947	6,858,159,674	7,135,182,070	*5.4%*	*4.0%*
Federal Share	2,605,957,412	2,745,778,858	2,915,612,685	2,869,926,319	3,401,073,642	4,411,226,637	4,285,800,083	4,450,187,263	4,748,797,444	*7.8%*	*6.7%*
State Share	2,065,290,449	2,233,994,301	2,363,189,243	2,247,687,408	2,361,008,474	2,419,955,518	2,358,965,864	2,407,972,411	2,386,384,626	*1.8%*	*-0.9%*
Admin. Costs as % of Payments	4.52%	4.56%	4.50%	4.00%	4.39%	5.05%	4.82%	4.54%	4.40%		
Growth From Prior Year											
Payments	8.54%	5.58%	13.50%	17.04%	2.76%	3.07%	1.87%	9.48%	7.46%		
Administration	-0.41%	6.60%	13.01%	2.77%	12.59%	18.55%	-2.73%	3.21%	4.04%		

**FFYs 14 & 15 reflect total actual spending reported by each state in region to the Centers for Medicare & Medicaid Services (CMS).*

SOUTHERN LEGISLATIVE CONFERENCE





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$36,008	$36,055	$34,253	$32,326	*-3.5%*	*23.4%*
Physician	$6,530	$6,872	$6,241	$6,048	*-2.5%*	*4.4%*
Dental	$2,814	$3,036	$2,261	$1,685	*-15.7%*	*1.2%*
Other practitioner	$1,206	$1,143	$788	$633	*-19.3%*	*0.5%*
Clinic and health center	$2,685	$2,752	$2,659	$2,238	*-5.9%*	*1.6%*
Other acute	$7,489	$7,423	$11,786	$12,471	*18.5%*	*9.0%*
Drugs	$6,202	$5,918	$4,807	$4,196	*-12.2%*	*3.0%*
Institutional LTSS	$20,322	$20,135	$22,300	$21,965	*2.6%*	*15.9%*
Home and community-based LTSS	$18,220	$18,538	$13,925	$13,921	*-8.6%*	*10.1%*
Managed care and premium assistance	$23,930	$26,084	$33,350	$38,819	*17.5%*	*28.2%*
Medicare Premiums and Coinsurance	$5,428	$6,013	$5,697	$5,887	*2.7%*	*4.3%*
Collections	($2,906)	($2,648)	($2,757)	($2,314)	*-7.3%*	*-1.7%*
Total Spending	**$127,936**	**$131,318**	**$135,340**	**$137,881**	*2.5%*	*100.0%*

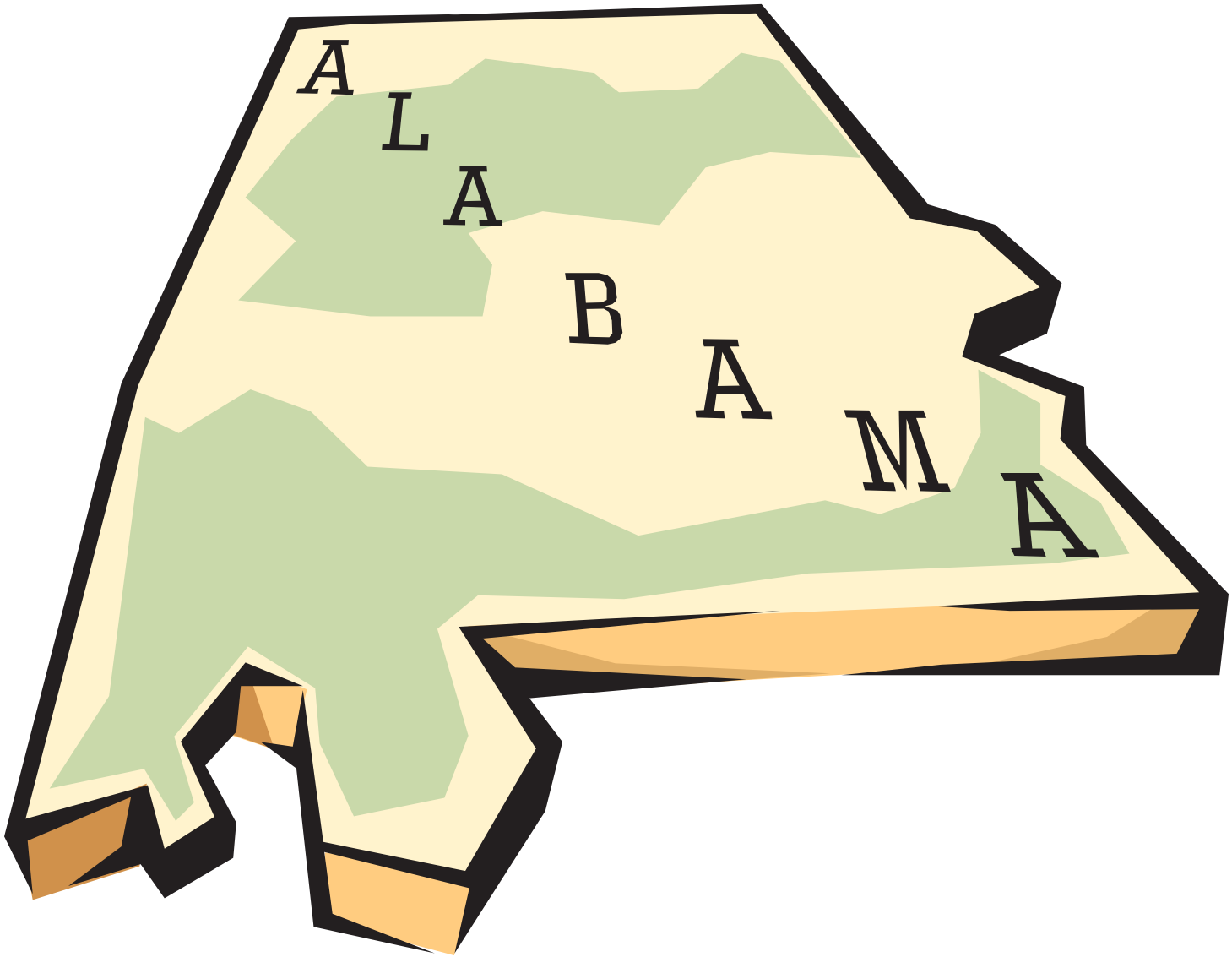
Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11***	**FFY 12**	**FFY 13***	*Annual Change*	*Share of FFY 13*
Children	12,242	13,386	13,129	10,889	*-3.8%*	*50.6%*
Adult	4,652	4,636	4,632	3,240	*-11.4%*	*15.1%*
Disabled	4,146	4,221	4,249	3,781	*-3.0%*	*17.6%*
Aged	2,378	2,472	2,494	2,195	*-2.6%*	*10.2%*
Total*	**23,526**	**24,715**	**24,504**	**21,517**	*-2.9%*	*100.0%*
Total Spending by Basis of Eligibility (millions)						
Children	$31,031	$29,193	$30,386	$29,003	*-2.2%*	*23.6%*
Adult	$15,788	$14,258	$15,219	$14,667	*-2.4%*	*11.9%*
Disabled	$56,584	$51,712	$55,381	$53,584	*-1.8%*	*43.5%*
Aged	$26,981	$24,870	$26,696	$25,917	*-1.3%*	*21.0%*
All Enrollees	**$130,347**	**$120,042**	**$127,638**	**$123,133**	*-1.9%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,020	$2,807	$2,846	$2,876	*-1.6%*	
Adult	$5,442	$5,052	$4,863	$4,724	*-4.6%*	
Disabled	$15,722	$14,557	$14,588	$14,639	*-2.4%*	
Aged	$13,339	$13,403	$13,309	$13,520	*0.5%*	
All Enrollees	**$7,017**	**$6,504**	**$6,597**	**$6,486**	*-2.6%*	
PER CAPITA EXPENDITURES	**$1,113.56**	**$1,136.99**	**$1,167.32**	**$1,175.41**	*1.8%*	

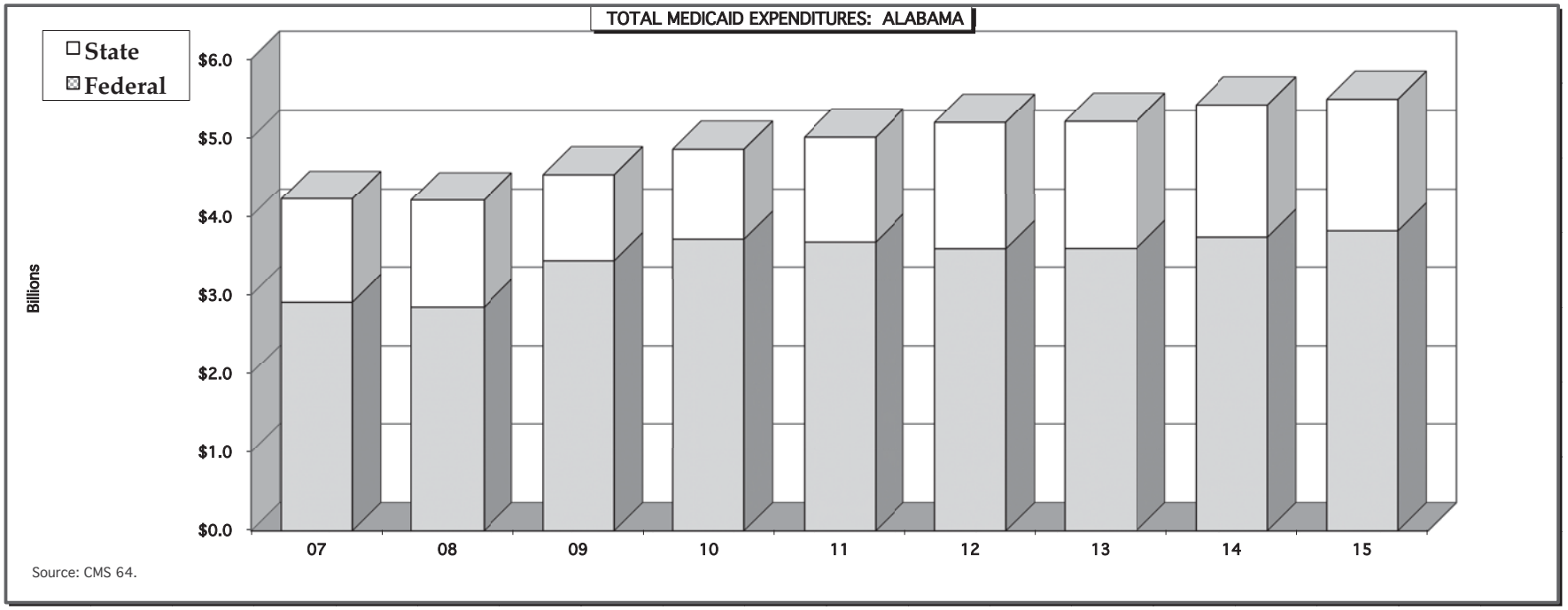
***NOTE:** Due to data reliability concerns, MACPAC excluded payment information in its MSIS-based dataset for TN in FY 11 and LA in FY 13.

STATE MEDICAID PROFILE



Comparative Data Report on Medicaid

Southern Legislative Conference
Louisiana Legislative Fiscal Office



State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$4,092,201,532	$4,062,254,766	$4,389,634,128	$4,708,657,185	$4,793,247,444	$4,980,627,414	$4,999,646,843	$5,211,164,487	$5,264,823,220	*3.2%*	*1.0%*
Federal Share	$2,835,389,645	$2,763,592,925	$3,354,846,699	$3,616,430,349	$3,535,006,318	$3,435,705,246	$3,453,503,232	$3,598,048,101	$3,663,301,858	*3.3%*	*1.8%*
State Share	$1,256,811,887	$1,298,661,841	$1,034,787,429	$1,092,226,836	$1,258,241,126	$1,544,922,168	$1,546,143,611	$1,613,116,386	$1,601,521,362	*3.1%*	*-0.7%*
Administrative Costs	$131,061,780	$143,539,665	$148,158,789	$153,029,106	$221,094,612	$221,622,887	$216,508,665	$212,174,151	$230,848,834	*7.3%*	*8.8%*
Federal Share	$72,345,602	$81,189,243	$80,673,987	$92,306,635	$136,959,218	$153,435,983	$138,657,557	$135,733,327	$151,742,735	*9.7%*	*11.8%*
State Share	$58,716,178	$62,350,422	$67,484,802	$60,722,471	$84,135,394	$68,186,904	$77,851,108	$76,440,824	$79,106,099	*3.8%*	*3.5%*
Admin. Costs as % of Payments	3.20%	3.53%	3.38%	3.25%	4.61%	4.45%	4.33%	4.07%	4.38%		
	69.29%	68.03%	76.43%	76.80%	73.75%	68.98%	69.07%	69.04%	69.58%		
Federal Match Rate*	68.85%	67.62%	77.51%	77.53%	68.54%	68.62%	68.53%	68.12%	68.99%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

ALABAMA

Provider Taxes Currently in Place (FFY 13)

Provider(s)	Tax Rate	Amount
Nursing homes	$1,899.96 per bed/year, privelege tax (plus a supplemental tax of $1,603.08 per bed effective Oct 2011 through Sept 2015)	$103,942,236
Pharmacies	$ .10 per prescription over $3.00	$9,217,778
Private Hospitals	5.14% of net patient revenue for 2012	$241,930,276
Total		$355,090,290

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$417,381,604	$425,584,054	$452,632,758	$463,824,975	$445,819,332	$455,169,284	$470,923,104	$481,227,717	$482,949,270	*2.1%*
Mental Hospitals	$3,301,620	$2,751,350	$3,301,620	$3,301,620	$3,301,620	$3,301,620	$0	$155,073	$0	*-100.0%*
Total	$420,683,224	$428,335,404	$455,934,378	$467,126,595	$449,120,952	$458,470,904	$470,923,104	$481,382,790	$482,949,270	*2.0%*

ACA MEDICAID EXPANSION

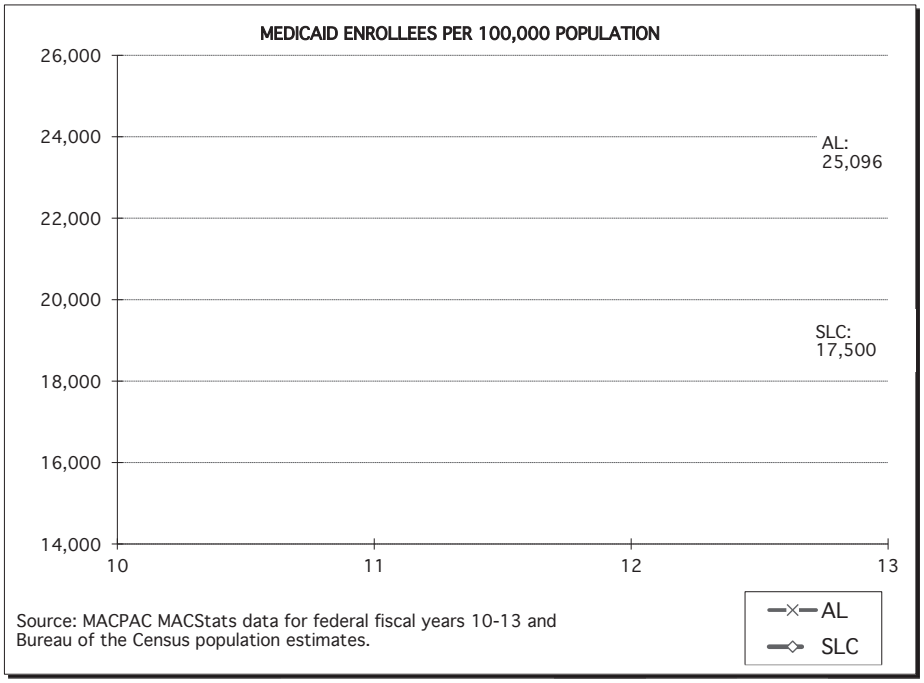
Not expanding Medicaid under ACA as of January 2017.

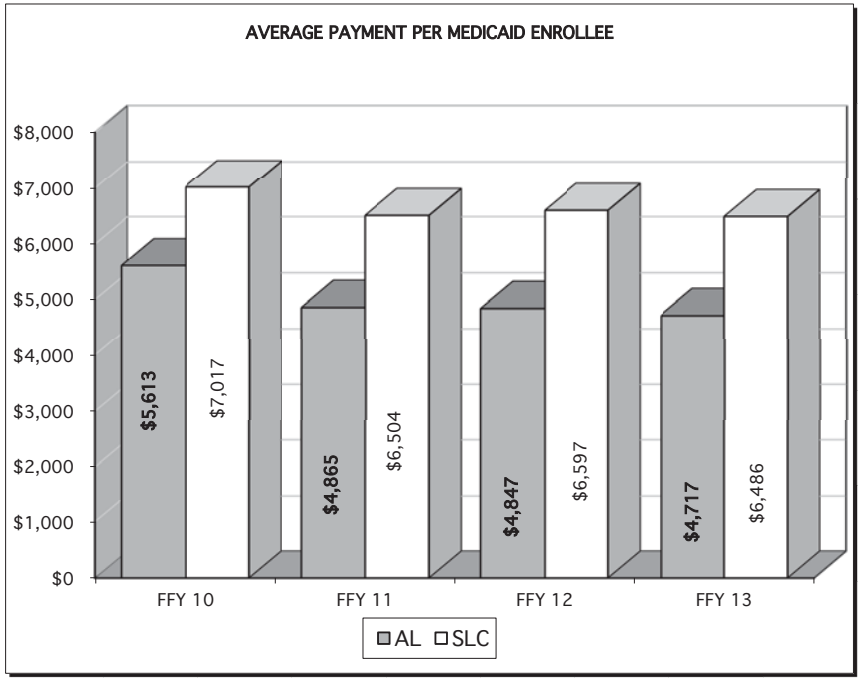
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

		Rank in U.S.
State population—July 1, 2013	4,716,915	*23*
Per capita personal income	$36,501	*42*
Median household income	$42,849	*48*
Population below Federal Poverty Level	883,371	*n/a*
Percent of total state population	18.7%	*9*
Population without health insurance coverage	655,394	*22*
Percent of total state population	13.9%	*25*
Recipients of SNAP benefits	915,322	*18*
Total value of issuance	$1,414,951,864	*19*
Average monthly benefit per recipient	$128.82	*23*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,254	$1,798	$1,896	$1,891	*14.7%*	*37.8%*
Physician	$305	$325	$331	$360	*5.7%*	*7.2%*
Dental	$82	$85	$86	$85	*1.2%*	*1.7%*
Other practitioner	$44	$36	$38	$42	*-1.5%*	*0.8%*
Clinic and health center	$185	$82	$82	$84	*-23.1%*	*1.7%*
Other acute	$213	$200	$492	$481	*31.2%*	*9.6%*
Drugs	$336	$289	$305	$294	*-4.4%*	*5.9%*
Institutional LTSS	$910	$935	$999	$972	*2.2%*	*19.4%*
Home and community-based LTSS	$558	$747	$445	$460	*-6.2%*	*9.2%*
Managed care and premium assistance	$747	$102	$102	$116	*-46.2%*	*2.3%*
Medicare Premiums and Coinsurance	$238	$268	$250	$253	*2.1%*	*5.1%*
Collections	($36)	($72)	($46)	($39)	*2.7%*	*-0.8%*
Total Spending	**$4,836**	**$4,793**	**$4,981**	**$5,000**	*1.1%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	509	538	558	597	*5.4%*	*49.2%*
Adult	176	184	198	244	*11.5%*	*20.1%*
Disabled	212	221	228	242	*4.5%*	*20.0%*
Aged	118	118	119	129	*3.2%*	*10.7%*
Total	**1,016**	**1,061**	**1,104**	**1,212**	*6.1%*	*100.0%*
Total Spending by Basis of Eligibility						
Children	$1,292	$1,064	$1,087	$868	*-12.4%*	*19.0%*
Adult	$432	$442	$475	$708	*17.9%*	*15.5%*
Disabled	$1,833	$1,793	$1,873	$1,937	*1.9%*	*42.4%*
Aged	$1,192	$1,117	$1,133	$1,055	*-4.0%*	*23.1%*
All Enrollees	**$4,749**	**$4,416**	**$4,569**	**$4,568**	*-1.3%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,071	$2,318	$2,297	$2,252	*-9.8%*	
Adult	$3,355	$3,111	$3,113	$2,731	*-6.6%*	
Disabled	$9,637	$9,015	$9,027	$9,001	*-2.3%*	
Aged	$11,216	$10,430	$10,399	$10,173	*-3.2%*	
All Enrollees	**$5,613**	**$4,865**	**$4,847**	**$4,717**	*-5.6%*	
PER CAPITA EXPENDITURES	**$1,015.99**	**$1,044.41**	**$1,080.18**	**$1,079.83**	*2.1%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

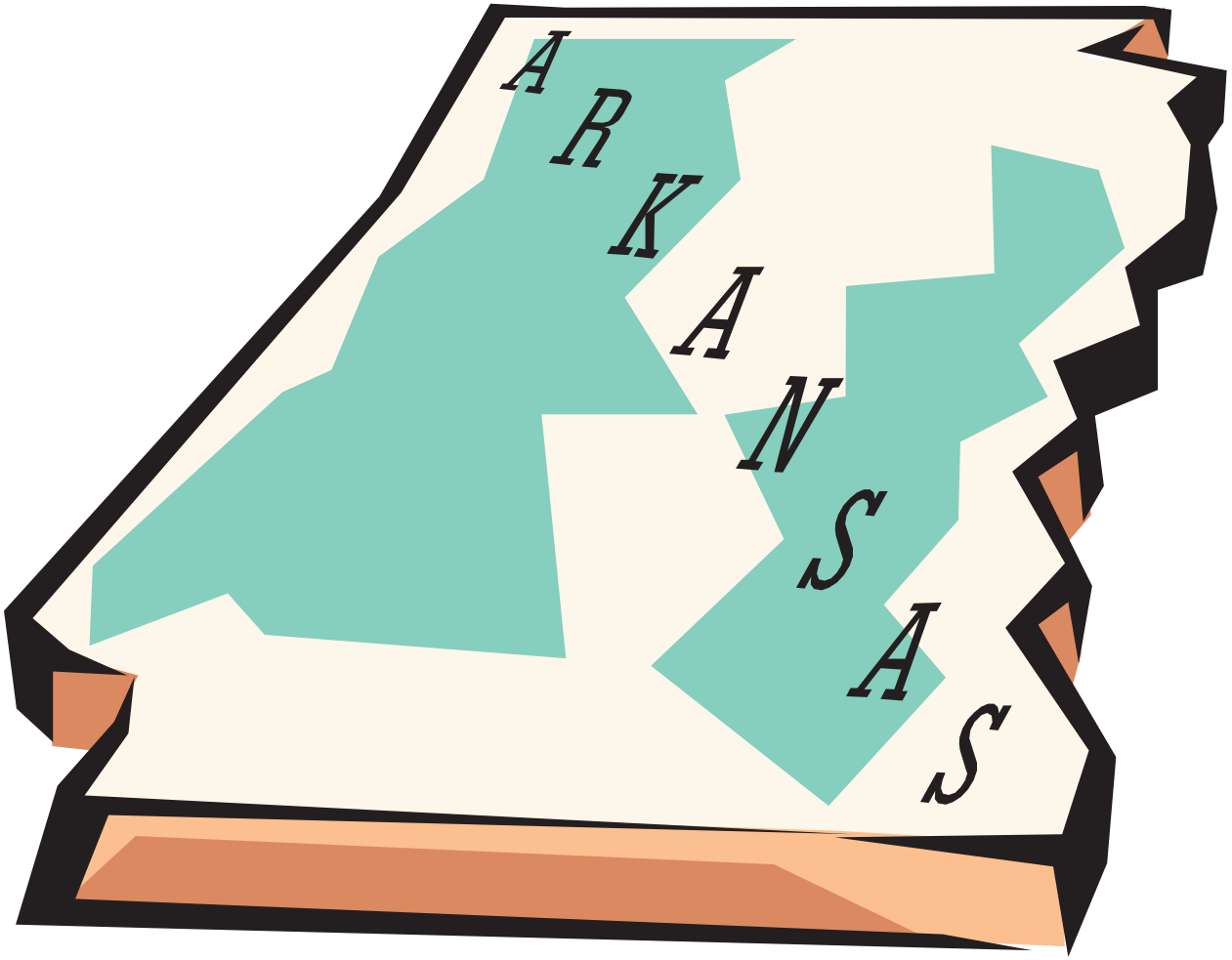
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilites, physical disabilities, and/or mental illnesses.

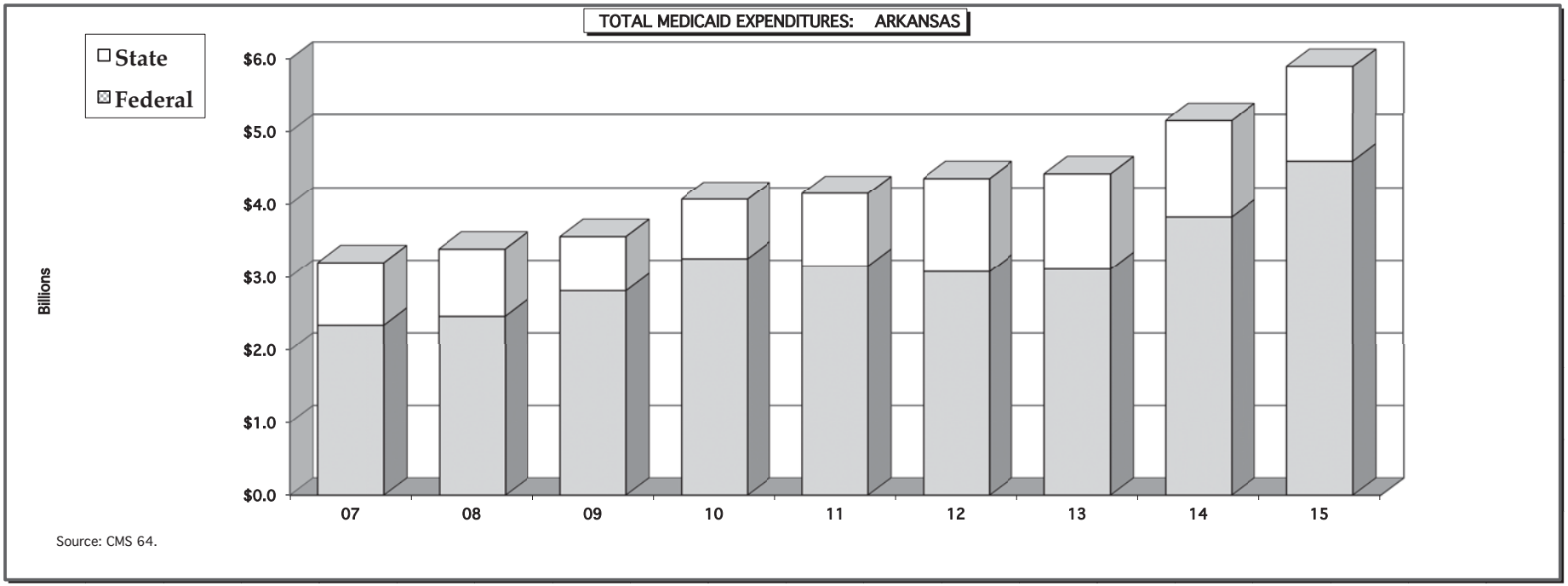
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID): Operating since 1981. Provides services to individuals who are age 3 or older diagnosed with a diagnosis of intellectual disability.
•State of Alabama Independent Living (SAIL): Operating since 1992. Provide services to disabled individuals who are at least 18 years of age, with specific medical diagnoses.
•Living at Home Waiver for Persons w/ID (LAH): Operating since 2002. Provide services to individuals who are age 3 or older diagnosed with an intellectual disability.
•HIV/AIDS Waiver: Provides services to individuals who are at least 21 years of age and who have a diagnosis of HIV/AIDS and/or related illness, operating since 2003.
•Elderly and Disabled Waiver, provides services that would allow elderly and/or disabled individuals to live in the community who otherwise would require nursing home care.
•Alabama Technology Assisted (TA) Waiver is designed for individuals (over 21) who have had a tracheostomy or who are ventilator dependent and require skilled nursing services.
•Alabama Community Transition (ACT) Waiver: Purpose: This waiver will serve individuals with disabilities or a long term illness who currently live in a nursing facility and who desire to transition to the home or community setting.

Managed Care (2013)
•Primary Care Case Management (PCCM)
•Prepaid Ambulatory Health Plan (PAHP): Maternity Care Program
•59.5% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: All Kids
•113,490 enrollees
•Separate Plan (State Designed Plan)
•Enhanced FMAP: 77.97% in 2013
•Federal Allotment: $162.8 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$3,060,407,830	$3,232,563,814	$3,387,530,449	$3,880,864,886	$3,951,827,218	$4,105,082,591	$4,156,350,929	$4,840,075,746	$5,469,511,577	*7.5%*	*13.0%*
Federal Share	$2,251,500,259	$2,364,628,419	$2,706,528,407	$3,143,505,057	$3,036,154,290	$2,908,201,178	$2,936,643,329	$3,615,426,896	$4,301,892,948	*8.4%*	*19.0%*
State Share	$808,907,571	$867,935,395	$681,002,042	$737,359,829	$915,672,928	$1,196,881,413	$1,219,707,600	$1,224,648,850	$1,167,618,629	*4.7%*	*-4.7%*
Administrative Costs	$140,666,972	$155,876,400	$172,088,942	$190,323,829	$201,171,041	$256,832,288	$272,039,980	$314,203,072	$383,183,984	*13.3%*	*22.0%*
Federal Share	$86,725,597	$94,967,171	$104,677,901	$112,150,652	$117,996,555	$165,776,769	$171,311,743	$210,634,544	$264,206,440	*14.9%*	*25.4%*
State Share	$53,941,375	$60,909,229	$67,411,041	$78,173,177	$83,174,486	$91,055,519	$100,728,237	$103,568,528	$118,977,544	*10.4%*	*14.9%*
Admin. Costs as % of Payments	4.60%	4.82%	5.08%	4.90%	5.09%	6.26%	6.55%	6.49%	7.01%		
Federal Match Rate*	73.37%	72.94%	80.46%	81.18%	71.37%	70.71%	70.17%	70.10%	70.88%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

ARKANSAS

Provider Taxes Currently in Place (FFY 13)

	Tax Rate	Amount
Quality Assurance Fee on Nursing Homes		
Nursing Homes	$12.13 per patient day	$72,211,066
Hospital Assessment Fees		
on net patient revenue	1.64%	$64,529,501
ICF/MR	$20.05 per patient day	$11,044,151
Total		$147,784,718

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$45,622,510	$46,145,283	$63,169,873	$60,092,015	$61,223,442	$60,628,045	$61,000,000	$36,760,641	$64,042,846	*5.6%*
Mental Hospitals	$819,350	$0	$0	$819,350	$819,350	$819,350	$0	$819,350	$819,350	*0.0%*
Total	$46,441,860	$46,145,283	$63,169,873	$60,911,365	$62,042,792	$61,447,395	$61,000,000	$37,579,991	$64,862,196	*5.8%*

ACA MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014

-Expansion through 1115 Waiver

-Premium Assistance Model (use Medicaid funds to purchase health insurance coverage for newly eligible individuals under ACA from a Qualified Health Plan in Health Insurance Exchanges (Health Insurance Marketplace)

-Coverage for certain Individuals (mainly adults) to 138% of the Federal Poverty Level

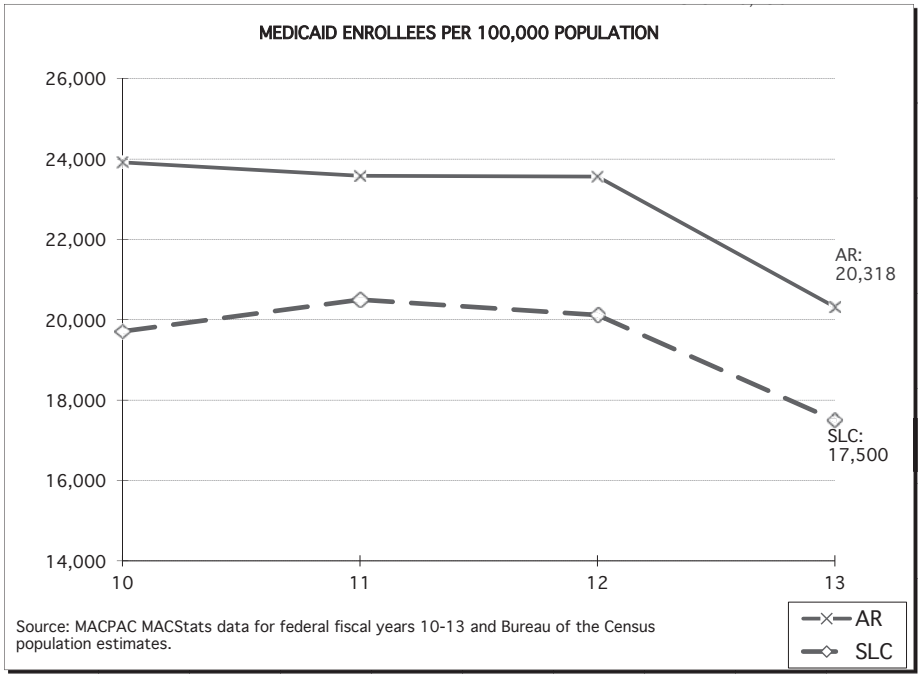
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

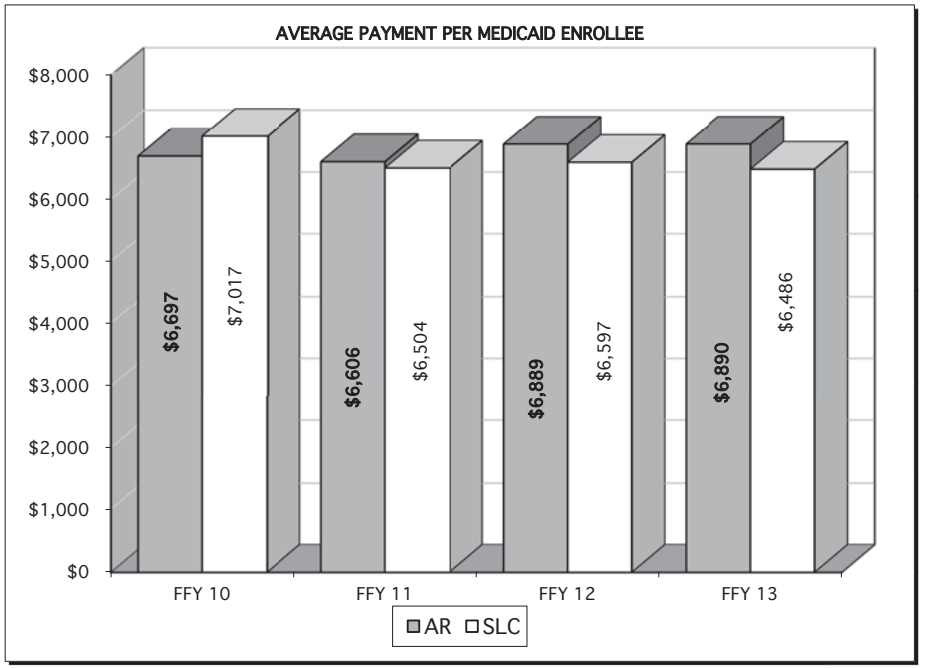
		Rank in U.S.
State population—July 1, 2013	2,879,435	*32*
Per capita personal income	$36,086	*46*
Median household income	$40,511	*50*
Population below Federal Poverty Level	565,469	*n/a*
Percent of total state population	19.7%	*5*
Population without health insurance coverage	481,547	*29*
Percent of total state population	16.7%	*14*
Recipients of SNAP benefits	504,621	*30*
Total value of issuance	$731,845,896	*30*
Average monthly benefit per recipient	$120.86	*48*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

ARKANSAS





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,112	$1,107	$978	$990	*-3.8%*	*23.8%*
Physician	$276	$284	$283	$298	*2.6%*	*7.2%*
Dental	$67	$65	$75	$73	*2.9%*	*1.8%*
Other practitioner	$17	$17	$18	$19	*3.8%*	*0.5%*
Clinic and health center	$237	$177	$186	$113	*-21.9%*	*2.7%*
Other acute	$325	$329	$702	$798	*34.9%*	*19.2%*
Drugs	$182	$159	$153	$159	*-4.4%*	*3.8%*
Institutional LTSS	$774	$784	$989	$965	*7.6%*	*23.2%*
Home and community-based LTSS	$665	$774	$467	$478	*-10.4%*	*11.5%*
Managed care and premium assistance	$16	$15	$17	$19	*5.9%*	*0.5%*
Medicare Premiums and Coinsurance	$269	$296	$291	$296	*3.2%*	*7.1%*
Collections	($59)	($54)	($55)	($50)	*-5.4%*	*-1.2%*
Total Spending	**$3,881**	**$3,952**	**$4,105**	**$4,158**	*2.3%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	364	357	354	310	*-5.2%*	*51.6%*
Adult	119	115	112	82	*-11.7%*	*13.6%*
Disabled	146	151	156	144	*-0.4%*	*24.0%*
Aged	70	71	72	65	*-2.6%*	*10.8%*
Total*	**699**	**693**	**695**	**601**	*-4.9%*	*100.0%*
Total Spending by Basis of Eligibility (millions)						
Children	$835	$872	$1,011	$1,035	*7.4%*	*25.0%*
Adult	$189	$201	$217	$203	*2.4%*	*4.9%*
Disabled	$1,832	$1,842	$1,916	$1,963	*2.3%*	*47.4%*
Aged	$1,084	$1,025	$954	$940	*-4.6%*	*22.7%*
Total	**$3,940**	**$3,944**	**$4,093**	**$4,141**	*1.7%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$2,680	$2,789	$3,288	$3,338	*7.6%*	
Adult	$2,186	$2,346	$2,600	$2,472	*4.2%*	
Disabled	$14,196	$13,590	$13,649	$13,599	*-1.4%*	
Aged	$17,700	$16,464	$15,011	$14,555	*-6.3%*	
All Enrollees	**$6,697**	**$6,606**	**$6,889**	**$6,890**	*1.0%*	
PER CAPITA EXPENDITURES	**$1,393.10**	**$1,413.29**	**$1,478.87**	**$1,497.11**	*2.4%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

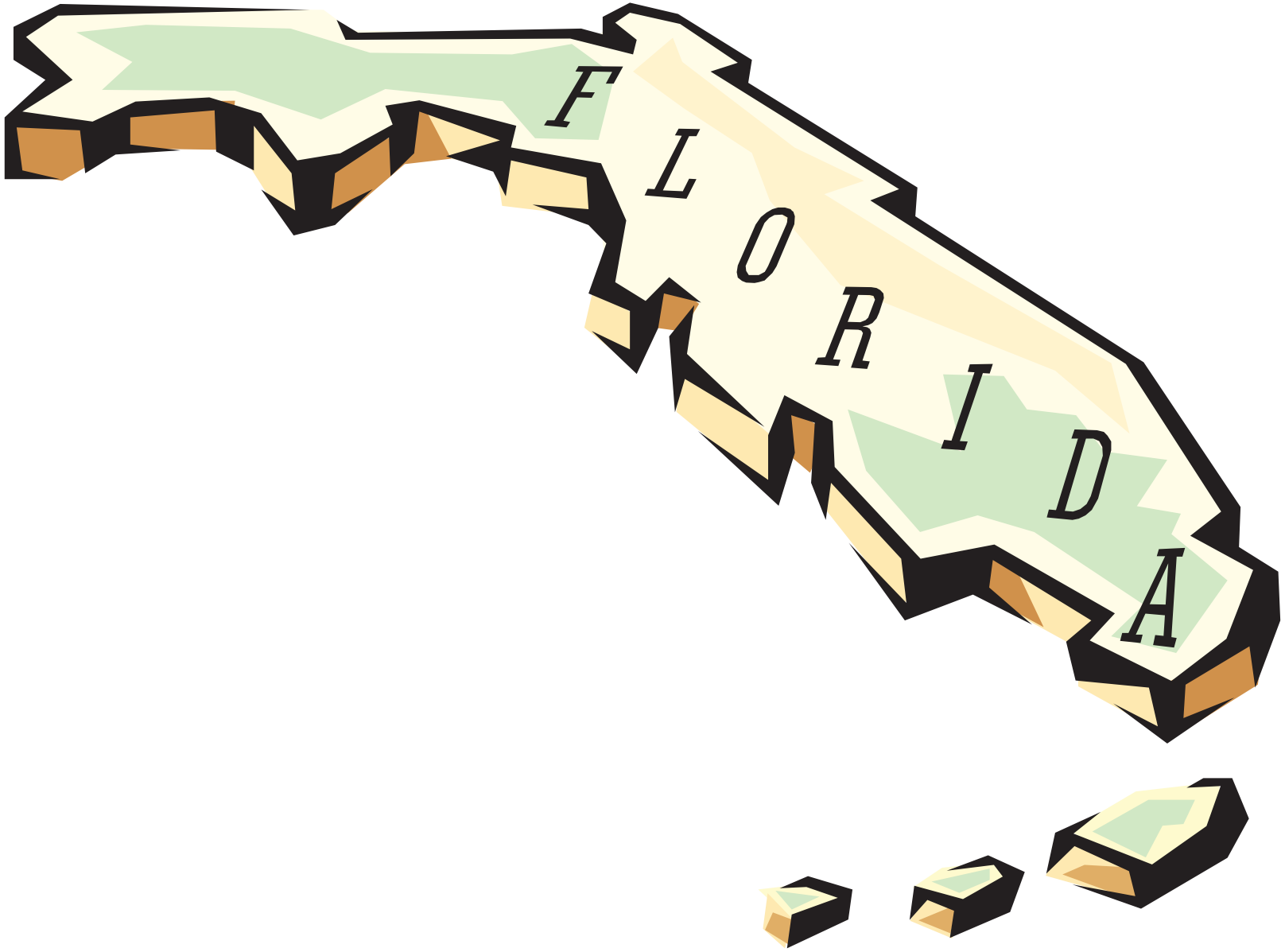
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

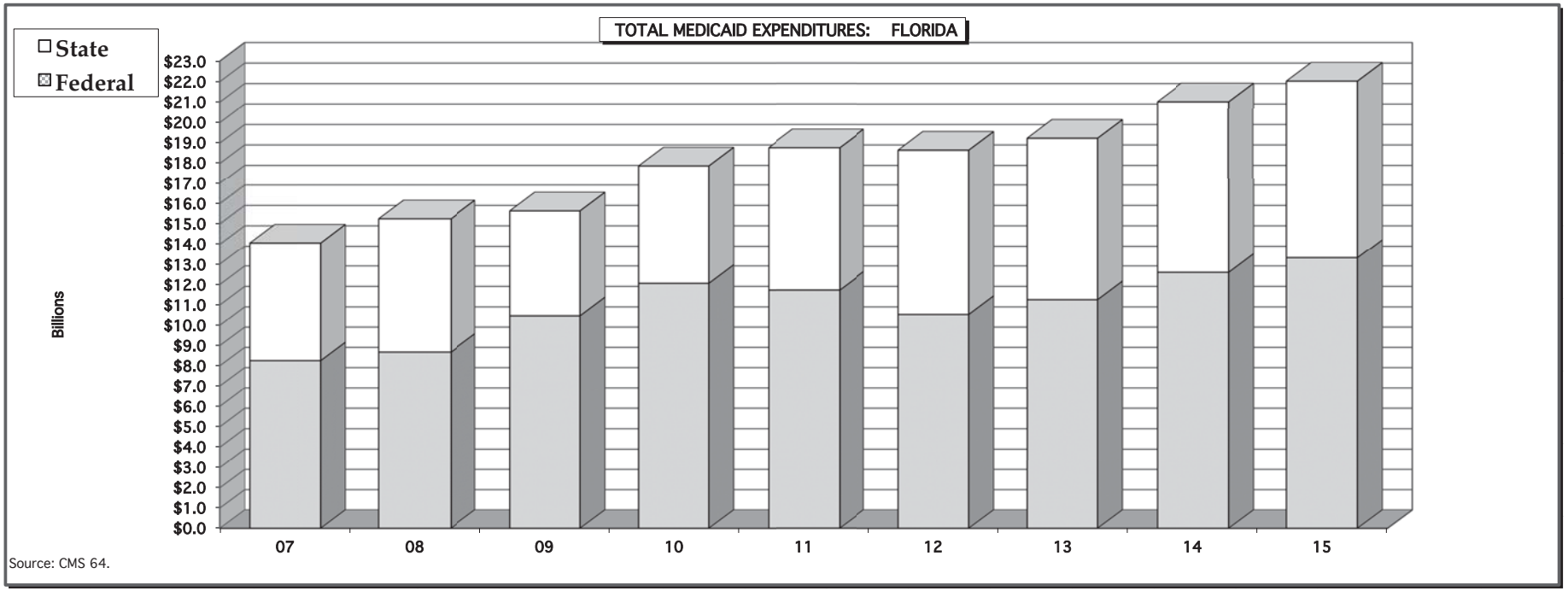
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
These waivers include:
•Alternatives for Adults with Physical Disabilities (AAPD), which provides services to the physically disabled on SSI and other individuals in need of nursing home level of care, ages 21 through 64, implemented 7/1/1997.
•Living Choices/Assisted Living Facility Waiver (LCAL), implemented 1/1/2003, offers an alternative to private dwelling or nursing home care.
•Elder Choices (EC), implementation date 07/01/2009, provides adult day health, homemaker, respite, adult companion services, adult day care, adult family home, chore, home-delivered meals, PERS for aged adults 65 - no max age.
•Alternative Community Services (ACS), implementation date 7/1/2009, provides case management, respite, supported employment, supportive living, specialized medical supplies, adaptive equipment, community transition, consultation, crisis intervention, environmental mods, supplemental support for individuals with autism, MR, DD ages 0 - no max age.

Managed Care (2013)
•Primary Care Case Management Program
•Prepaid Ambulatory Health Plan (PAHP): Non Emergency Transportation
•Program of All Inclusive Care for the Elderly (PACE)
•77.7% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: ARKids First
•109,301 enrollees
•Combination Plan
•Enhanced FMAP: 79.12% in 2013
•Federal Allotment: $103.1 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$13,450,490,934	$14,601,560,259	$14,990,559,595	$17,261,512,630	$18,127,940,651	$17,794,004,730	$18,411,438,180	$20,303,199,078	$21,320,462,370	*5.9%*	*5.0%*
Federal Share	$7,918,951,892	$8,312,917,212	$10,124,194,501	$11,710,947,938	$11,375,206,613	$9,973,557,325	$10,741,660,021	$12,151,293,323	$12,877,061,233	*6.3%*	*6.0%*
State Share	$5,531,539,042	$6,288,643,047	$4,866,365,094	$5,550,564,692	$6,752,734,038	$7,820,447,405	$7,669,778,159	$8,151,905,755	$8,443,401,137	*5.4%*	*3.6%*
Administrative Costs	$608,861,418	$644,573,974	$645,195,361	$615,134,511	$636,992,323	$852,523,485	$819,727,848	$707,017,640	$702,881,953	*1.8%*	*-0.6%*
Federal Share	$331,373,079	$356,796,707	$344,092,834	$343,070,792	$345,625,349	$561,044,464	$513,521,992	$443,733,046	$431,173,089	*3.3%*	*-2.8%*
State Share	$277,488,339	$287,777,267	$301,102,527	$272,063,719	$291,366,974	$291,479,021	$306,205,856	$263,284,594	$271,708,864	*-0.3%*	*3.2%*
Admin. Costs as % of Payments	4.53%	4.41%	4.30%	3.56%	3.51%	4.79%	4.45%	3.48%	3.30%		
Federal Match Rate*	58.76%	56.83%	67.64%	67.64%	55.45%	56.04%	58.08%	58.79%	59.72%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

Provider Taxes Currently in Place (FFY 13)

	Tax Rate	Amount
General Hospitals		
Inpatient Services	1.5% of net operating revenue	$358,034,802
Outpatient Services	1% of net operating revenue	$135,437,334
Nursing home quality assoc. (Began 4/1/2009)	6% of aggregate net patient revenue	$387,829,993
ICF/MR Quality Assessment	6% of aggregate net patient revenue	$13,346,572
Total		$881,302,129

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$216,658,463	$224,136,409	$234,896,769	$253,738,887	$241,187,904	$245,644,494	$241,879,289	$240,214,814	$239,699,117	*1.1%*
Mental Hospitals	$103,809,891	$107,335,371	$112,437,431	$122,087,706	$108,917,486	$119,838,603	$93,130,348	$95,871,943	$119,098,224	*1.7%*
Total	$320,468,354	$331,471,780	$347,334,200	$375,826,593	$350,105,390	$365,483,097	$335,009,637	$336,086,757	$358,797,341	*1.3%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of January 2017.

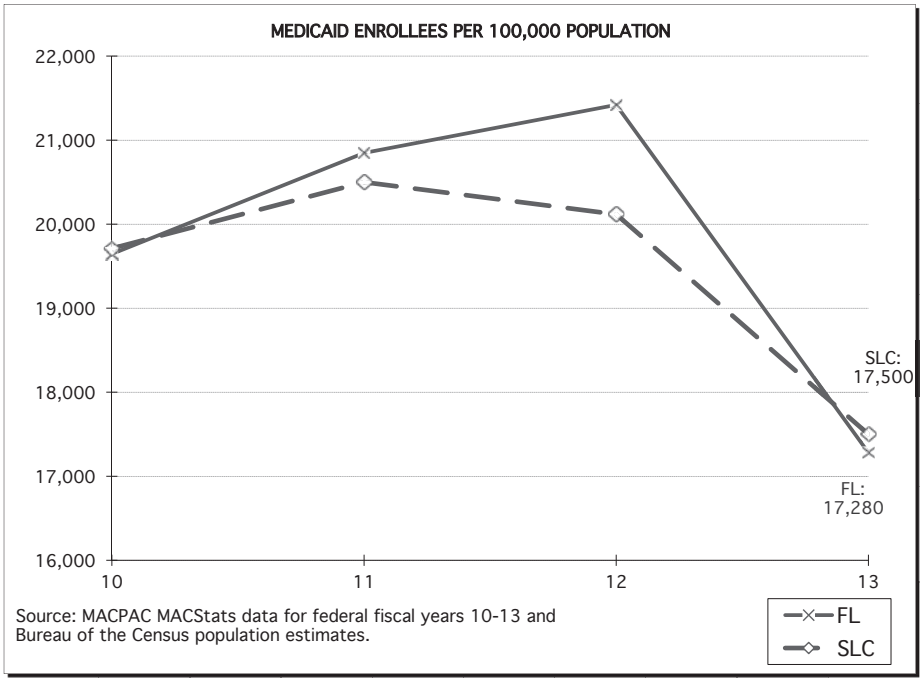
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

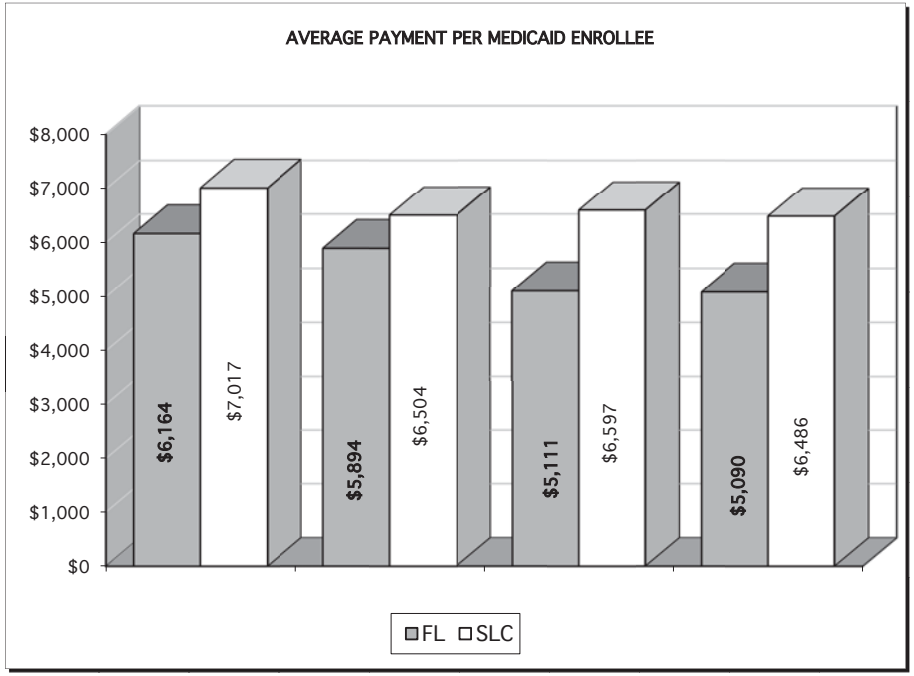
		Rank in U.S.
State population—July 1, 2013	18,778,532	*4*
Per capita personal income	$41,692	*27*
Median household income	$46,036	*40*
Population below Federal Poverty Level	3,253,333	*n/a*
Percent of total state population	17.0%	*16*
Population without health insurance coverage	3,835,202	*3*
Percent of total state population	20.4%	*3*
Recipients of SNAP benefits	3,556,473	*3*
Total value of issuance	$5,906,158,947	*3*
Average monthly benefit per recipient	$138.39	*9*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

FLORIDA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$4,976	$5,149	$4,936	$5,104	*0.9%*	*27.7%*
Physician	$1,089	$1,251	$1,081	$1,231	*4.2%*	*6.7%*
Dental	$114	$139	$189	$257	*31.1%*	*1.4%*
Other practitioner	$42	$43	$45	$40	*-1.6%*	*0.2%*
Clinic and health center	$212	$231	$232	$223	*1.7%*	*1.2%*
Other acute	$913	$879	$1,410	$1,585	*20.2%*	*8.6%*
Drugs	$579	$637	$575	$565	*-0.8%*	*3.1%*
Institutional LTSS	$3,119	$3,200	$3,314	$3,299	*1.9%*	*17.9%*
Home and community-based LTSS	$2,226	$2,208	$1,569	$1,522	*-11.9%*	*8.3%*
Managed care and premium assistance	$2,958	$3,254	$3,312	$3,412	*4.9%*	*18.5%*
Medicare Premiums and Coinsurance	$1,162	$1,289	$1,245	$1,324	*4.4%*	*7.2%*
Collections	($128)	($152)	($113)	($150)	*5.4%*	*-0.8%*
Total Spending	**$17,262**	**$18,128**	**$17,794**	**$18,411**	*2.2%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	1,892	2,011	2,078	1,727	*-3.0%*	*46.6%*
Adult	770	844	896	581	*-9.0%*	*15.7%*
Disabled	570	621	636	586	*0.9%*	*15.8%*
Aged	470	506	536	492	*1.5%*	*13.3%*
Total*	**3,703**	**3,983**	**4,145**	**3,386**	*-2.9%*	*91.4%*
Total Spending by Basis of Eligibility (Millions)						
Children	$3,113	$3,299	$3,038	$3,274	*1.7%*	*18.8%*
Adult	$2,330	$2,456	$2,225	$2,412	*1.2%*	*13.9%*
Disabled	$7,339	$7,513	$6,857	$7,048	*-1.3%*	*40.5%*
Aged	$4,626	$4,662	$4,483	$4,498	*-0.9%*	*25.9%*
Total	**$17,390**	**$17,930**	**$16,602**	**$17,232**	*-0.3%*	*99.1%*
Average Spending by Basis of Eligibility						
Children	$2,079	$2,070	$1,816	$1,899	*-3.0%*	
Adult	$5,543	$5,275	$4,077	$4,155	*-9.2%*	
Disabled	$14,650	$13,882	$12,196	$12,038	*-6.3%*	
Aged	$11,362	$10,597	$9,560	$9,120	*-7.1%*	
All Enrollees	**$6,164**	**$5,894**	**$5,111**	**$5,090**	*-6.2%*	
PER CAPITA EXPENDITURES	**$948.37**	**$982.17**	**$963.54**	**$981.46**	*1.1%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

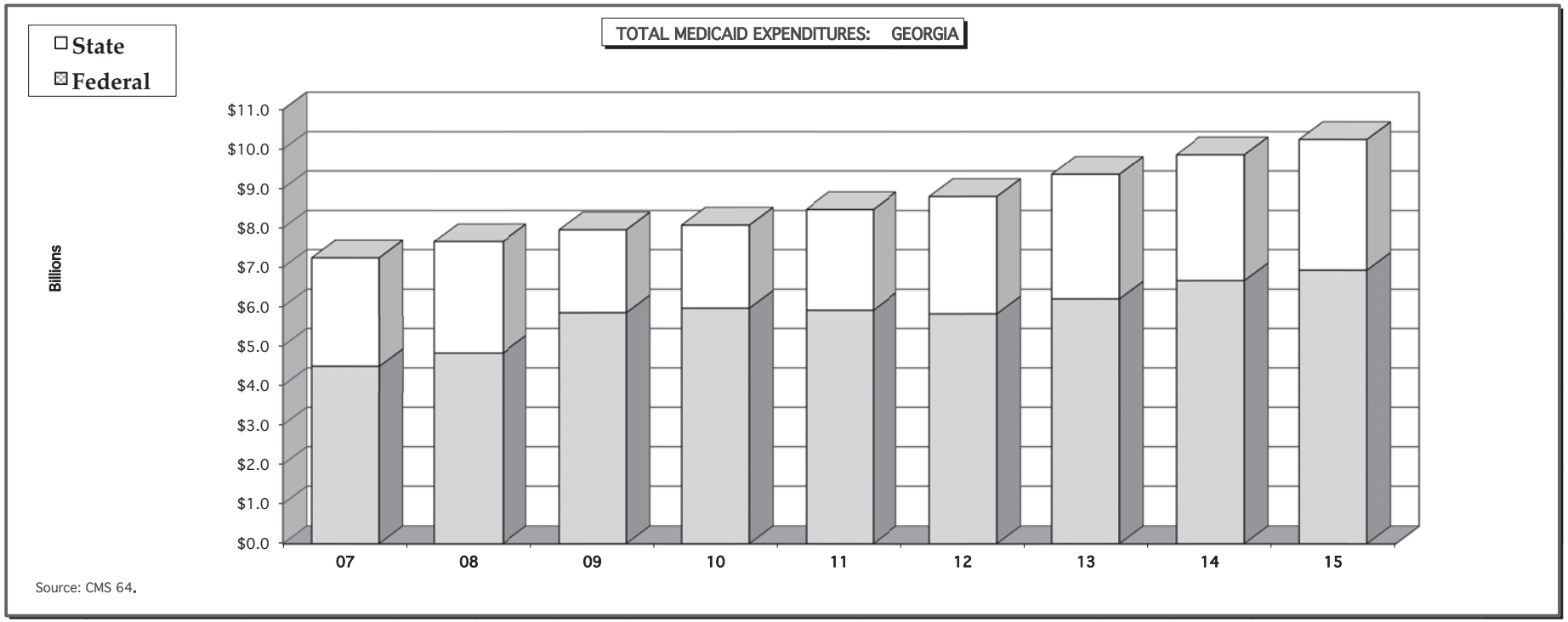
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
- AIDS Project Aids Care (PAC): Operating since 1989.
- Model Waiver: Serves children with Degenerative Spinocerebellar Diseases operating since 1991.
- Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Waiver: Authorized in Regular Session 1998. The state implemented the program in September of 1999.
- Familial Dysautonomia Waiver
- Adult Cystic Fibrosis Waiver: Approved 2002. Provides HCBS to reduce risk of hospitalization.
- iBudget (DD Individual Budgeting) Waiver: Reflects use of an individual budgeting approach and enhanced opportunities for self-determination.
- Long-Term Care Waiver, combination 1915(b) and 1915(c), provides long-term care services and supports to eligible disabled individuals age 18-59 and elderly individuals age 65 or older. Program recipients receive their services through competitively selected managed care organizations.

Managed Care (2013)
- Primary Care Case Management (PCCM)
- Commercial and Medicaid Managed Care Organizations (MCO)
- Prepaid Inpatient Health Plan (PIHP)
- Prepaid Ambulatory Health Plan (PAHP)
- Program of All Inclusive Care for the Elderly (PACE)
- 62.8% of Medicaid enrollment in managed care as of 7/1/2013

Note: As of 7/1/2011 the state of Florida has approximately 67 different managed care plans operating under various plan structures (ie, PCCM, MCO, PIHP, PAHP or PACE).

Children's Health Insurance Program: KidCare
- 473,415 enrollees
- Combination Plan
- Enhanced FMAP: 70.66% in 2013.
- Federal Allotment: $359 M in 2013

STATE MEDICAID PROFILE



State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$6,844,102,301	$7,263,936,317	$7,499,091,546	$7,710,755,659	$8,064,611,365	$8,299,066,366	$8,887,641,041	$9,396,958,654	$9,664,791,833	*4.9%*	*2.9%*
Federal Share	$4,264,991,201	$4,605,975,739	$5,591,727,147	$5,749,597,011	$5,693,531,623	$5,488,136,023	$5,889,062,991	$6,347,390,351	$6,526,112,642	*6.0%*	*2.8%*
State Share	$2,579,111,100	$2,657,960,578	$1,907,364,399	$1,961,158,648	$2,371,079,742	$2,810,930,343	$2,998,578,050	$3,049,568,303	$3,138,679,191	*2.8%*	*2.9%*
Administrative Costs	$392,392,714	$386,160,717	$452,464,090	$361,266,697	$400,415,522	$496,417,326	$471,397,110	$461,176,224	$580,292,608	*7.0%*	*25.8%*
Federal Share	$217,962,939	$211,798,589	$255,140,137	$211,279,804	$215,660,065	$331,362,860	$307,187,850	$311,651,211	$397,640,094	*11.1%*	*27.6%*
State Share	$174,429,775	$174,362,128	$197,323,953	$149,986,893	$184,755,457	$165,054,466	$164,209,260	$149,525,013	$182,652,514	*0.8%*	*22.2%*
Admin. Costs as % of Payments	5.73%	5.32%	6.03%	4.69%	4.97%	5.98%	5.30%	4.91%	6.00%		
Federal Match Rate*	61.97%	63.10%	74.42%	74.96%	65.33%	66.16%	65.56%	65.93%	66.94%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

GEORGIA

Provider Taxes Currently in Place (FFY 13)

	Tax Rate	Amount
Nursing Home	6.00%	$176,864,128
Hospital provider tax	1.45% of net revenue	$234,968,478
Total		$411,832,606

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$408,489,593	$400,877,570	$411,355,202	$434,584,421	$410,126,151	$415,817,421	$429,964,548	$435,057,563	$435,016,070	*1.4%*
Mental Hospitals	$0	$0	$0	$0	$0	$0	$0	$0	$0	*n/a*
Total	$408,489,593	$400,877,570	$411,355,202	$434,584,421	$410,126,151	$415,817,421	$429,964,548	$435,057,563	$435,016,070	*1.4%*

ACA MEDICAID EXPANSION

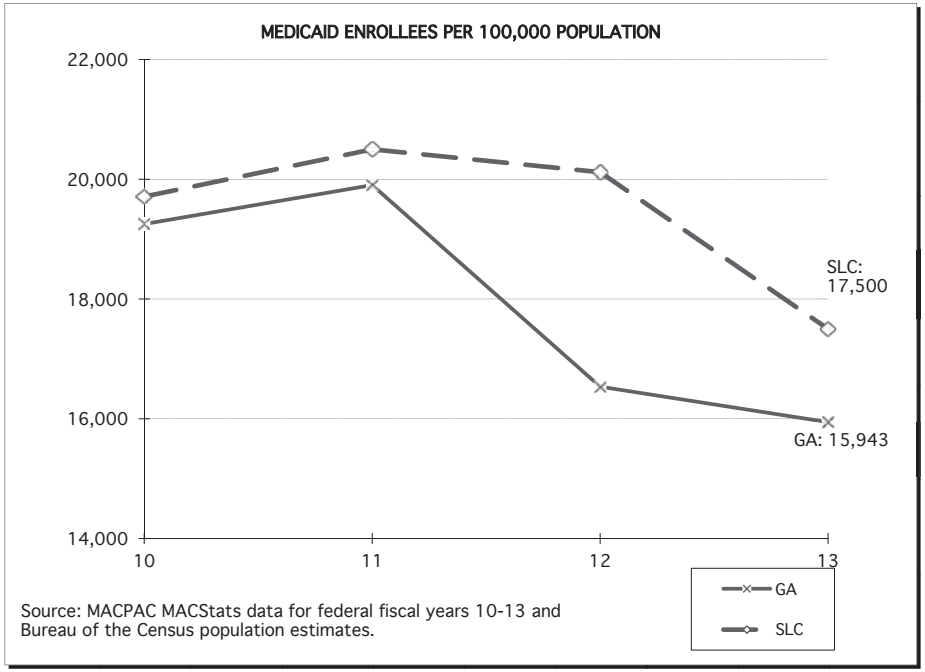
Not expanding Medicaid under ACA as of January 2017.

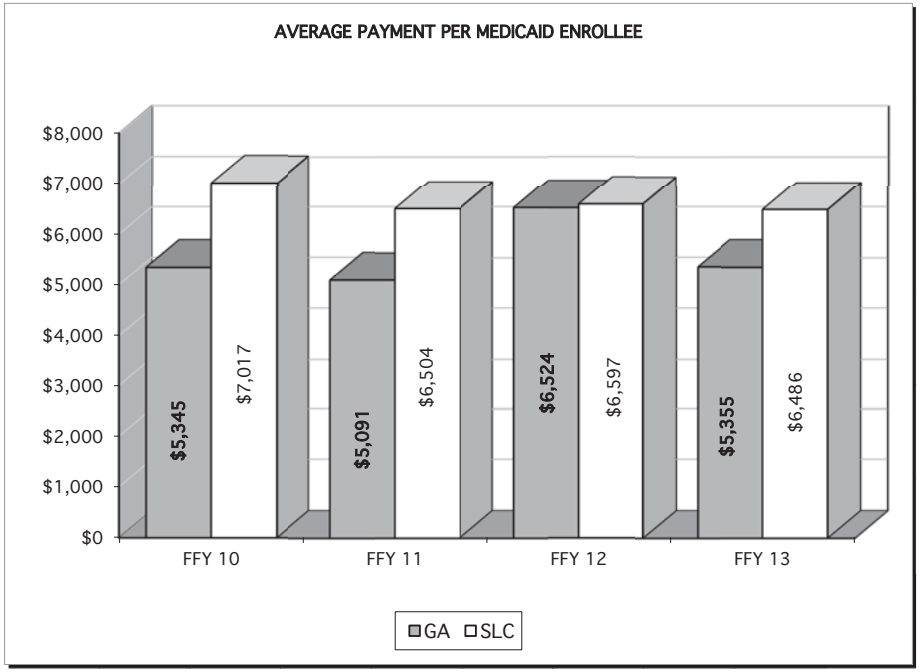
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

		Rank in U.S.
State population—July 1, 2013	9,610,713	*9*
Per capita personal income	$38,179	*40*
Median household income	$47,826	*34*
Population below Federal Poverty Level	1,843,768	*n/a*
Percent of total state population	19.0%	*6*
Population without health insurance coverage	1,822,057	*5*
Percent of total state population	19.0%	*6*
Recipients of SNAP benefits	1,948,189	*6*
Total value of issuance	$3,188,743,586	*6*
Average monthly benefit per recipient	$136.40	*12*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$2,070	$1,787	$2,130	$2,199	*2.04%*	*24.74%*
Physician	$355	$363	$376	$375	*1.84%*	*4.22%*
Dental	$41	$42	$43	$44	*2.38%*	*0.50%*
Other practitioner	$31	$32	$33	$35	*4.13%*	*0.39%*
Clinic and health center	$137	$169	$166	$9	*-59.65%*	*0.10%*
Other acute	$194	$197	$563	$766	*58.06%*	*8.62%*
Drugs	$222	$129	$245	$239	*2.49%*	*2.69%*
Institutional LTSS	$1,226	$1,174	$1,339	$1,420	*5.02%*	*15.98%*
Home and community-based LTSS	$988	$1,027	$895	$907	*-2.81%*	*10.20%*
Medicare Premiums and Coinsurance	$2,235	$2,829	$2,439	$2,642	*5.73%*	*29.73%*
Managed care and premium assistance	$286	$360	$295	$324	*4.25%*	*3.65%*
Collections	($75)	($46)	($227)	($73)	*-0.90%*	*-0.82%*
Total Spending	$7,711	$8,065	$8,299	$8,888	*4.85%*	*100.00%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	1,107	1,139	932	894	*-6.88%*	*56.12%*
Adult	305	309	230	221	*-10.12%*	*13.89%*
Disabled	284	322	309	307	*2.56%*	*19.25%*
Aged	174	184	169	171	*-0.58%*	*10.73%*
Total*	**1,870**	**1,953**	**1,640**	**1,593**	*-5.20%*	*100.00%*
Spending by Basis of Eligibility (millions)						
Children	$1,736	$2,079	$1,914	$2,056	*5.80%*	*24.10%*
Adult	$1,098	$1,132	$949	$1,109	*0.34%*	*13.00%*
Disabled	$3,355	$2,872	$3,528	$3,531	*1.72%*	*41.40%*
Aged	$1,604	$1,610	$1,727	$1,834	*4.57%*	*21.50%*
Total	**$7,785**	**$7,701**	**$8,110**	**$8,530**	*3.09%*	*100.00%*
Average Spending by Basis of Eligibility						
Children	$1,991	$2,345	$2,806	$2,301	*4.95%*	
Adult	$6,191	$6,233	$6,809	$5,000	*-6.87%*	
Disabled	$13,126	$10,133	$12,936	$11,530	*-4.23%*	
Aged	$10,443	$10,103	$11,507	$10,713	*0.85%*	
All Enrollees	**$5,345**	**$5,091**	**$6,524**	**$5,355**	*0.06%*	
PER CAPITA EXPENDITURES	**$831.01**	**$862.70**	**$886.85**	**$936.69**	*4.07%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Comprehensive Supports Waiver Program (COMP) for people with mental retardation or developmental disabilities to help disabled individuals remain in the community.
•New Options Waiver Program (NOW) for people with mental retardation or developmental disabilities to live independently in the community.
•Independent Care Waiver Program (ICWP) assists some adult members with severe physical disabilities to live in their own homes or communities.
•Service Options Using Resources in a Community Environment (SOURCE) links primary care with an array of long-term health services in an individual's home or community to avoid preventable hospital and nursing home care for frail elderly and disabled individuals.
•Community Care Service Programs (CCSP) provides services to people who had functional impairments or disabilities. Helped members remain in their own communities as long as possible.
•Georgia Pediatric Program (GAPP) provides services to medically fragile children with multiple system diagnoses in their homes, communities and in "medical" daycare settings. Implementation Date 04/01/2008.
•Community-Based Alternatives for Youth (CBAY) allows Medicaid-eligible youth – who would otherwise have been placed in Psychiatric Residential Treatment Facilities (PRTF) or were transitioned from PRTFs – to receive community based services designed to prevent reinstitutionalization.

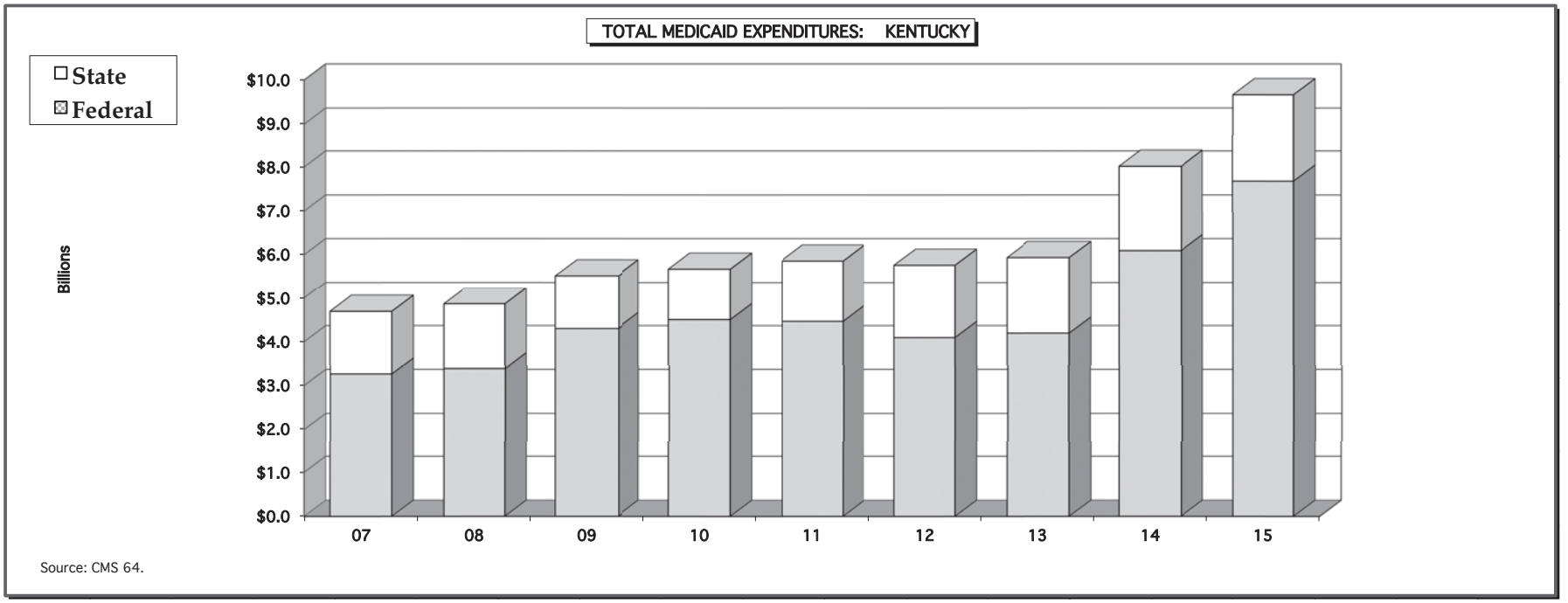
Managed Care (2013)
•Medicaid Managed Care Organization (MCO)
•65.4% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: PeachCare for Kids
•269,906 enrollees
•Separate Plan (State Designed Plan)
•Enhanced FMAP: 75.89% in 2013
•Federal Allotment: $282.7 M in 2013

STATE MEDICAID PROFILE

Comparative Data Report on Medicaid

Southern Legislative Conference
Louisiana Legislative Fiscal Office



State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$4,513,988,817	$4,691,623,964	$5,362,501,971	$5,522,072,289	$5,652,087,484	$5,564,881,723	$5,726,056,802	$7,792,776,771	$9,423,467,372	*12.3%*	*20.9%*
Federal Share	$3,152,412,692	$3,287,407,628	$4,204,693,070	$4,415,426,580	$4,321,833,888	$3,961,974,190	$4,046,516,085	$5,934,824,922	$7,505,717,923	*14.8%*	*26.5%*
State Share	$1,361,576,125	$1,404,216,336	$1,157,808,901	$1,106,645,709	$1,330,253,596	$1,602,907,533	$1,679,540,717	$1,857,951,849	$1,917,749,449	*5.3%*	*3.2%*
Administrative Costs	$176,685,241	$170,959,208	$153,238,352	$147,493,696	$200,943,874	$194,125,683	$208,785,747	$222,880,599	$242,868,698	*6.0%*	*9.0%*
Federal Share	$107,756,708	$96,417,102	$94,852,845	$88,202,643	$142,032,904	$131,802,502	$147,995,921	$157,269,167	$173,167,184	*10.3%*	*10.1%*
State Share	$68,928,533	$74,542,106	$58,385,507	$59,291,053	$58,910,970	$62,323,181	$60,789,826	$65,611,432	$69,701,514	*-1.1%*	*6.2%*
Admin. Costs as % of Payments	3.91%	3.64%	2.86%	2.67%	3.56%	3.49%	3.65%	2.86%	2.58%		
Federal Match Rate*	69.58%	69.78%	79.41%	80.14%	71.49%	71.18%	70.55%	69.83%	69.94%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

KENTUCKY

Provider Taxes Currently in Place (FFY 13)		
	Tax Rate (on gross revenues)	Amount
Hospitals	2.50%	$181,314,307
Home Health	2.00%	$8,070,840
ICF/MR	5.50%	$7,898,940
Nurse Fac (census days)	% based on beds	$65,733,918
Community Living Supports	5.50%	$13,620,413
Other		$313,862
Total		$276,952,280

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$157,367,474	$158,383,443	$170,180,250	$173,659,743	$165,598,513	$171,171,879	$178,925,647	$173,705,954	$188,935,457	*3.0%*
Mental Hospitals	$37,443,072	$37,335,732	$37,443,075	$37,443,072	$37,443,073	$37,298,917	$37,338,019	$37,443,074	$37,692,279	*0.2%*
Total	$194,810,546	$195,719,175	$207,623,325	$211,102,815	$203,041,586	$208,470,796	$216,263,666	$211,149,028	$226,627,736	*2.5%*

MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014.

-Coverage to certain individuals (mainly adults) to 138% of the Federal Poverty Level.

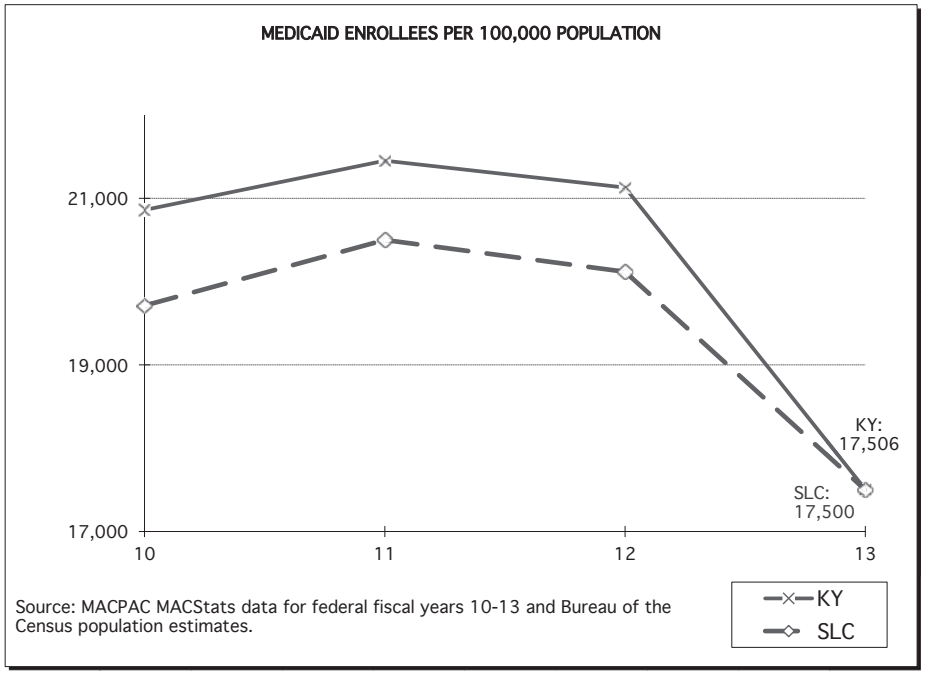
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

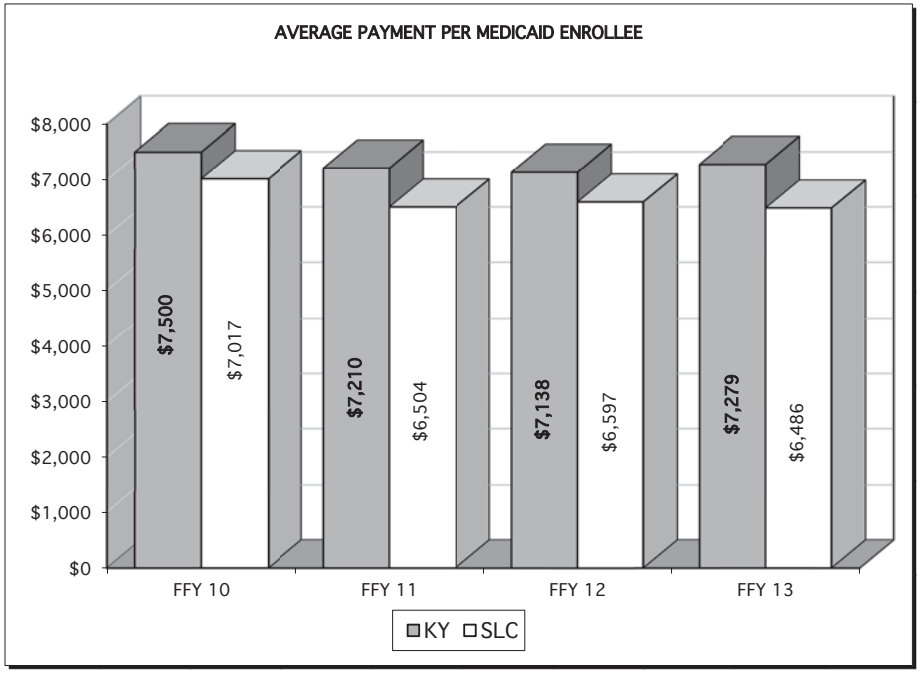
		Rank in U.S.
State population—July 1, 2013	4,273,751	*26*
Per capita personal income	$36,239	*45*
Median household income	$43,399	*47*
Population below Federal Poverty Level	800,635	*n/a*
Percent of total state population	18.8%	*8*
Population without health insurance coverage	614,786	*23*
Percent of total state population	14.4%	*21*
Recipients of SNAP benefits	872,439	*22*
Total value of issuance	$1,332,998,664	*22*
Average monthly benefit per recipient	$127.32	*32*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

KENTUCKY





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,532	$1,576	$616	$457	*-33.18%*	*8.0%*
Physician	$374	$364	$111	$49	*-49.21%*	*0.9%*
Dental	$78	$86	$14	$2	*-70.51%*	*0.0%*
Other practitioner	$42	$1	$9	$3	*-58.51%*	*0.1%*
Clinic and health center	$262	$264	$195	$106	*-26.04%*	*1.9%*
Other acute	$508	$506	$369	$314	*-14.82%*	*5.5%*
Drugs	$299	$253	($39)	$32	*-52.52%*	*0.6%*
Institutional LTSS	$982	$992	$1,071	$1,055	*2.42%*	*18.4%*
Home and community-based LTSS	$572	$663	$581	$618	*2.61%*	*10.8%*
Managed care and premium assistance	$752	$768	$2,563	$2,970	*58.07%*	*51.9%*
Medicare Premiums and Coinsurance	$205	$247	$212	$215	*1.60%*	*3.8%*
Collections	($84)	($68)	($137)	($96)	*4.55%*	*-1.7%*
Total Spending	**$5,522**	**$5,652**	**$5,565**	**$5,726**	*1.22%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	434	449	445	375	*-4.71%*	*48.7%*
Adult	144	147	144	90	*-14.48%*	*11.7%*
Disabled	233	242	238	217	*-2.42%*	*28.1%*
Aged	96	99	99	88	*-2.78%*	*11.5%*
Total	**907**	**937**	**926**	**770**	*-5.31%*	*100.0%*
Spending by Basis of Eligibility (Millions)						
Children	$1,312	$1,236	$1,285	$1,284	*-0.72%*	*22.9%*
Adult	$695	$684	$632	$617	*-3.91%*	*11.0%*
Disabled	$2,562	$2,571	$2,576	$2,652	*1.15%*	*47.3%*
Aged	$1,037	$1,026	$1,000	$1,054	*0.54%*	*18.8%*
Total	**$5,606**	**$5,517**	**$5,493**	**$5,606**	*0.00%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,660	$3,371	$3,455	$3,422	*-2.21%*	
Adult	$7,473	$7,275	$6,812	$6,835	*-2.93%*	
Disabled	$12,146	$11,823	$11,880	$12,236	*0.25%*	
Aged	$12,176	$11,784	$11,289	$11,953	*-0.61%*	
All Enrollees	**$7,500**	**$7,210**	**$7,138**	**$7,279**	*-0.99%*	
PER CAPITA EXPENDITURES	**$1,303.97**	**$1,340.02**	**$1,314.04**	**$1,349.29**	*1.15%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

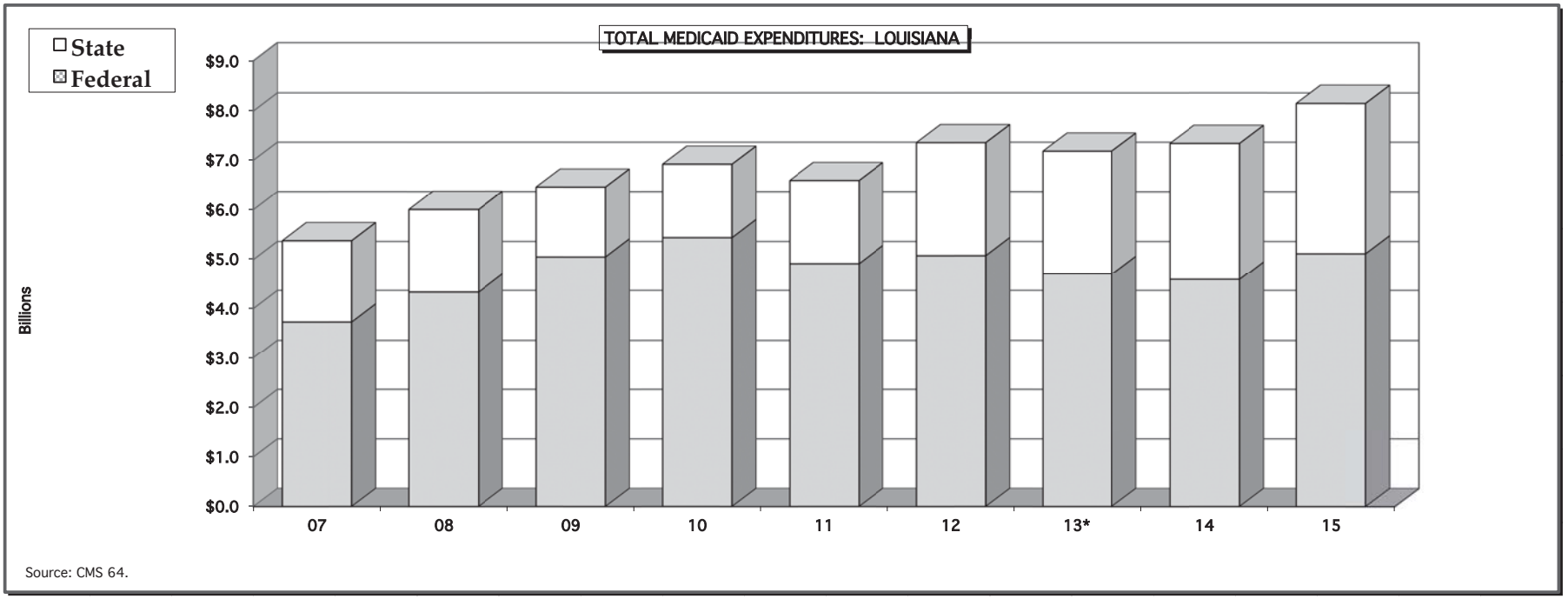
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Acquired Brain Injury (ABI) Waiver: Provides intensive services and supports to adults with acquired brain injuries working to re-enter community life. Operational since April 1999. Residential waiver.
•Acquired Brain Injury Long Term Care (ABI LTC) Waiver: Provides an alternative to institutional care for individuals that have reached a plateau in their rehabilitation level and require maintenance services to avoid institutionalization and to live safely in the community. Residential waiver.
•Home & Community-based Services (HCBs) Waiver: Provides services and support to elderly people or children and adults with disabilities to help them to remain in or return to their homes.
•Michelle P. Waiver (MPW): Developed as an alternative to institutional care for individuals with intellectual or developmental disabilities and allows individuals to remain in their homes with services and supports.
•Model II Waiver (MIIW): Provides services for an individual who is dependent on a ventilator 12 hours or greater per day, meets High Intensity nursing care services 24 hours per day and would otherwise require nursing facility level of care in a hospital
•Supports for Community Living (SCL) Waiver: Developed as an alternative to institutional care for individuals with intellectual and developmental disabilities; and allows individuals to remain in or return to the community in the least restrictive setting. Residential waiver.

Managed Care (2013)
•Medicaid only Managed Care Organization (MCO)
•84.6% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: Kentucky Children's Health Insurance Program (KCHIP)
•84,069 enrollees
•Combination Plan
•Enhanced FMAP: 79.39% in 2013
•Federal Allotment: $147.9 M in 2013

STATE MEDICAID PROFILE



State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments•	$5,207,246,125	$5,831,185,008	$6,271,680,348	$6,720,388,856	$6,297,526,689	$7,056,559,315	$6,888,581,512	$7,055,593,669	$7,863,181,815	*5.1%*	*11.4%*
Federal Share	$3,635,289,649	$4,235,044,685	$4,949,978,444	$5,326,247,967	$4,721,515,304	$4,879,560,881	$4,513,723,837	$4,408,396,823	$4,923,285,050	*2.5%*	*11.7%*
State Share	$1,571,956,476	$1,596,140,323	$1,321,701,904	$1,394,140,889	$1,576,011,385	$2,176,998,434	$2,374,857,675	$2,647,196,846	$2,939,896,765	*10.7%*	*11.1%*
Administrative Costs	$169,051,721	$171,317,338	$183,740,043	$198,102,582	$290,723,004	$297,200,666	$292,825,871	$282,202,964	$289,090,288	*9.1%*	*2.4%*
Federal Share	$93,619,872	$94,608,613	$100,934,536	$111,427,453	$194,433,654	$197,021,293	$187,692,689	$177,438,372	$192,429,518	*12.6%*	*8.4%*
State Share	$75,431,849	$76,708,725	$82,805,507	$86,675,129	$96,289,350	$100,179,373	$105,133,182	$104,764,592	$96,660,770	*3.9%*	*-7.7%*
Admin. Costs as % of Payments	3.25%	2.94%	2.93%	2.95%	4.62%	4.21%	4.25%	4.00%	3.68%		
Federal Match Rate*	69.69%	72.47%	80.75%	81.48%	63.61%	61.09%	61.24%	60.98%	62.05%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

LOUISIANA

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
Nursing Homes	$8.02 per patient day	$72,916,194
ICF/MR Facilities	$14.30 per patient day	$24,298,640
Pharmacy	$.10 per prescription	$8,268,760
Total		$105,483,594

Note: MCO provider tax (2.25% on premiums) assessed in 2012 (collected in 2013)

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$832,906,386	$861,388,614	$837,262,187	$682,129,639	$500,965,884	$657,336,594	$652,022,789	$1,047,714,322	$1,203,528,156	*5.7%*
Mental Hospitals	$100,736,713	$103,860,995	$110,960,284	$108,493,791	$99,185,768	$75,697,359	$114,778,866	$77,954,684	$125,597,759	*3.2%*
Total	$933,643,099	$965,249,609	$948,222,471	$790,623,430	$600,151,652	$733,033,953	$766,801,655	$1,125,669,006	$1,329,125,915	*5.5%*

MEDICAID EXPANSION

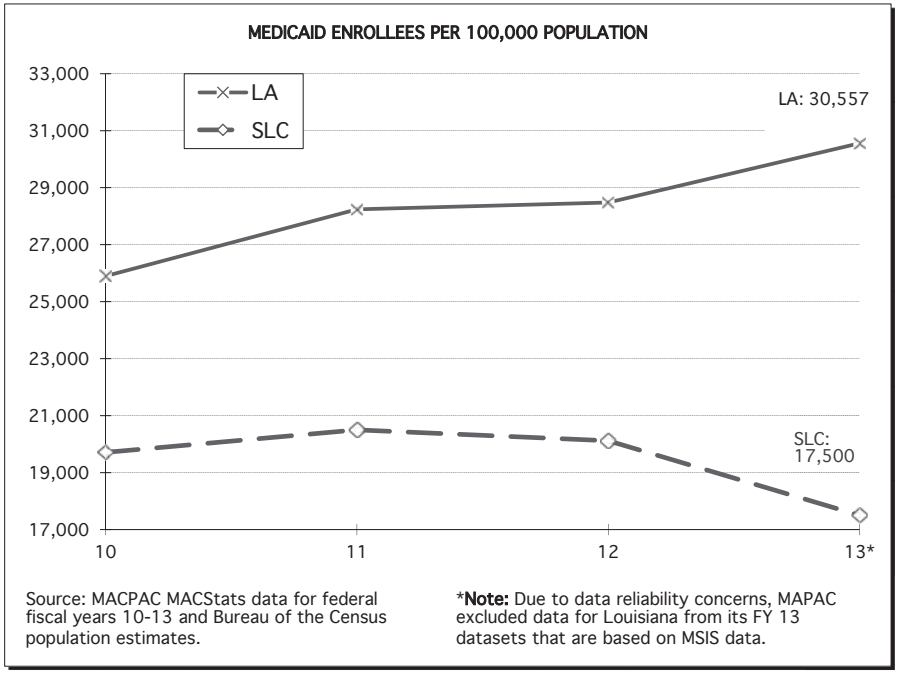
Expanded Medicaid under ACA as of January 2016.

DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

		Rank in U.S.
State population—July 1, 2013	4,463,986	*25*
Per capita personal income	$40,689	*31*
Median household income	$44,164	*44*
Population below Federal Poverty Level	888,019	*n/a*
Percent of total state population	19.8%	*4*
Population without health insurance coverage	763,555	*18*
Percent of total state population	17.1%	*11*
Recipients of SNAP benefits	940,100	*15*
Total value of issuance	$1,479,828,133	*14*
Average monthly benefit per recipient	$131.18	*21*

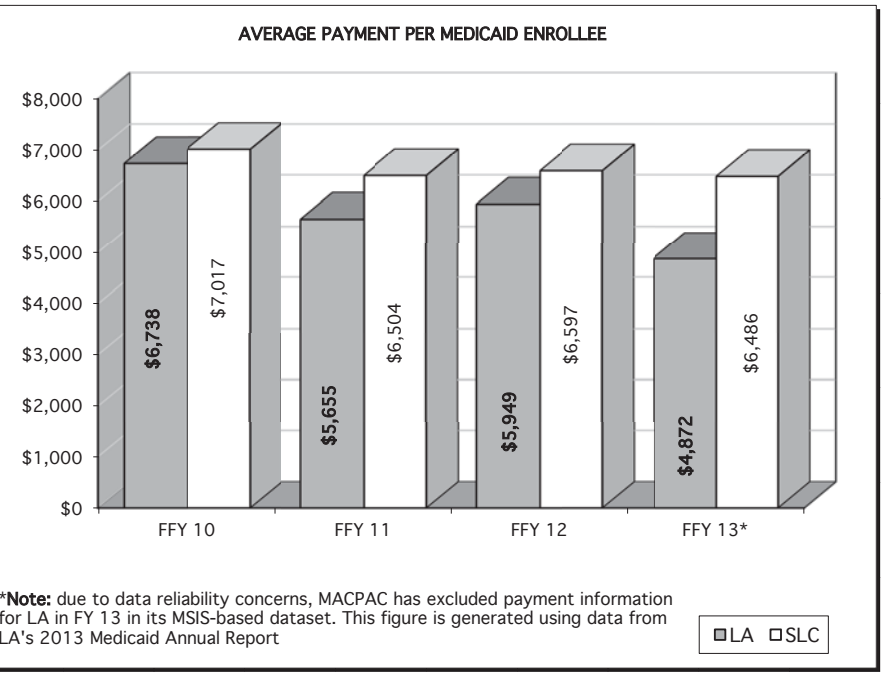
Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.



Source: MACPAC MACStats data for federal fiscal years 10-13 and Bureau of the Census population estimates.

*__Note:__ Due to data reliability concerns, MAPAC excluded data for Louisiana from its FY 13 datasets that are based on MSIS data.



*__Note:__ due to data reliability concerns, MACPAC has excluded payment information for LA in FY 13 in its MSIS-based dataset. This figure is generated using data from LA's 2013 Medicaid Annual Report

DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$2,764	$2,462	$2,115	$2,202	*-7.3%*	*32.0%*
Physician	$516	$523	$411	$317	*-15.0%*	*4.6%*
Dental	$118	$123	$121	$112	*-1.7%*	*1.6%*
Other practitioner	$0	$0	$0	$0	*0.0%*	*0.0%*
Clinic and health center	$183	$199	$146	$106	*-16.6%*	*1.5%*
Other acute	$428	$319	$385	$357	*-5.9%*	*5.2%*
Drugs	$632	$573	$789	$182	*-34.0%*	*2.6%*
Institutional LTSS	$1,248	$1,337	$1,421	$1,453	*5.2%*	*21.1%*
Home and community-based LTSS	$823	$844	$795	$843	*0.8%*	*12.2%*
Managed care and premium assistance	$10	$14	$916	$1,311	*408.0%*	*19.0%*
Medicare Premiums and Coinsurance	$241	$270	$259	$265	*3.2%*	*3.8%*
Collections	($243)	($366)	($302)	($258)	*2.0%*	*-3.7%*
Total Spending	**$6,720**	**$6,298**	**$7,057**	**$6,889**	*0.8%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13***	*Annual Change*	*Share of FFY 13*
Children	612	682	670	n/a	n/a	n/a
Adult	228	255	278	n/a	n/a	n/a
Disabled	222	238	243	n/a	n/a	n/a
Aged	114	119	121	n/a	n/a	n/a
Total	**1,177**	**1,292**	**1,311**	**1,414**	*6.3%*	n/a
Spending by Basis of Eligibility (Millions)						
Children	$1,372	$1,200	$1,305	n/a	n/a	n/a
Adult	$864	$697	$788	n/a	n/a	n/a
Disabled	$3,517	$3,007	$3,326	n/a	n/a	n/a
Aged	$1,219	$1,158	$1,206	n/a	n/a	n/a
Total	**$6,964**	**$6,063**	**$6,625**	n/a	n/a	n/a
Average Spending by Basis of Eligibility						
Children	$3,478	$ 2,141	$ 2,310	n/a	n/a	n/a
Adult	$4,918	$ 3,680	$ 3,628	n/a	n/a	n/a
Disabled	$17,407	$ 14,001	$ 14,978	n/a	n/a	n/a
Aged	$11,805	$ 10,816	$ 11,003	n/a	n/a	n/a
All Enrollees	**$6,738**	**$5,655**	**$5,949**	**$4,872**	*-10.2%*	n/a
PER CAPITA EXPENDITURES	**$1,455.37**	**$1,522.24**	**$1,439.93**	**$1,597.37**	*3.2%*	

***Note:** Due to data reliability concerns, MACPAC has excluded payment and enrollee information for LA in FY 13 in its MSIS-based dataset. Instead, information on enrollment from LA's 2013 Annual Medicaid Report and the total FY 13 Spend is used to generate these figures.

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

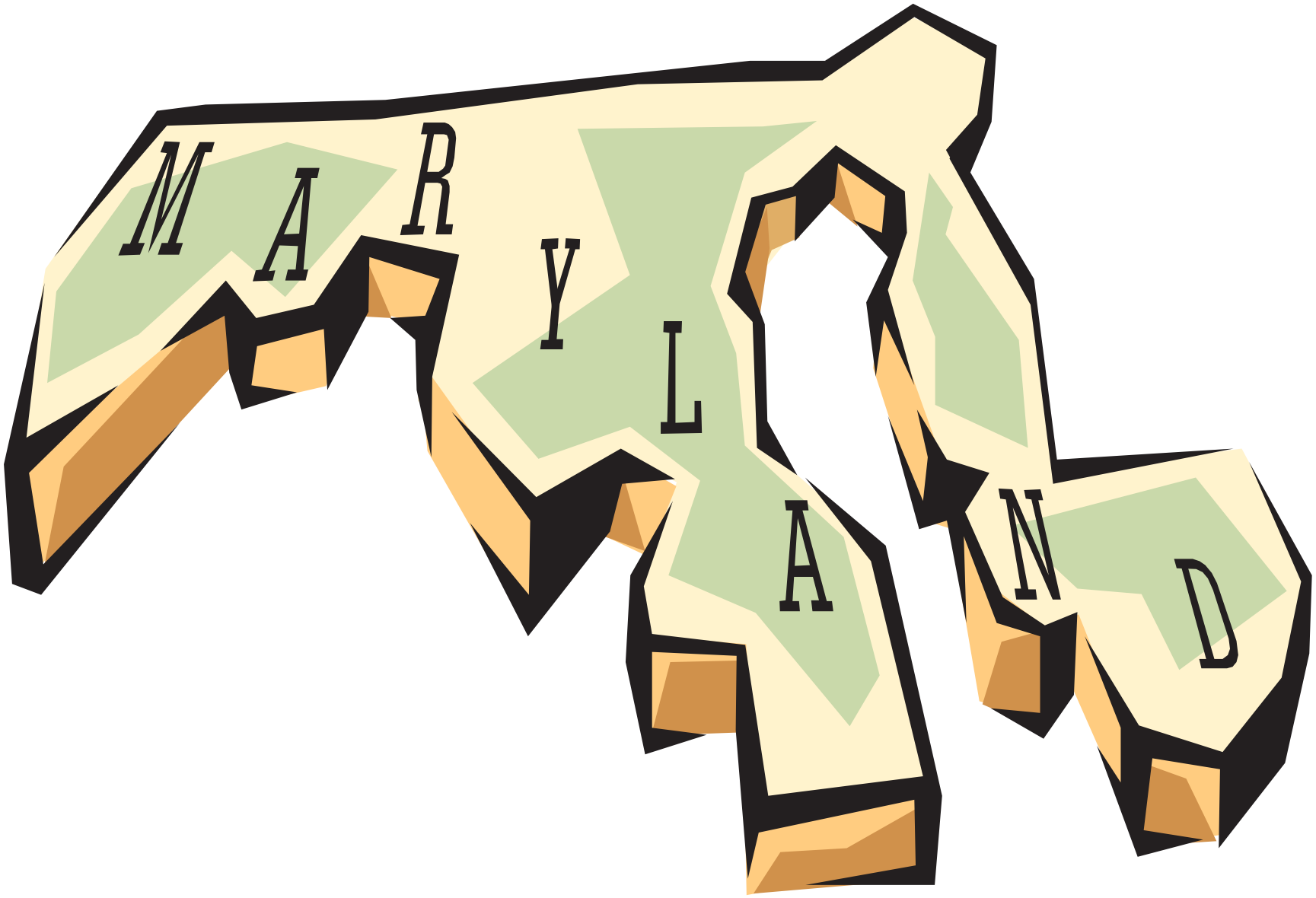
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

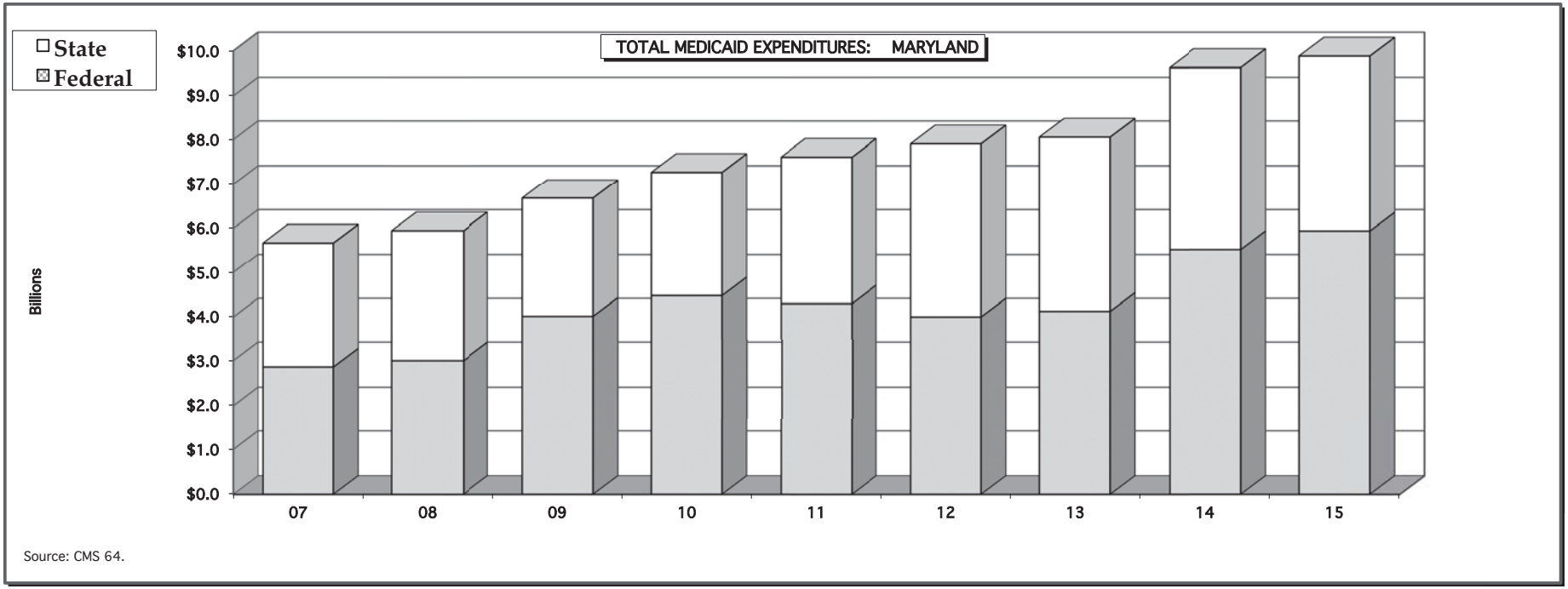
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization.
These waivers include:
•Community Choices Waiver: provides support coordination, transition intensive support coordination, companion service, environmental modifications, personal emergency response system, adult day health care and transitional services in the home or community to elderly or disabled adults who qualify. Replaced the Elderly & Disabled Adult - EDA Waiver in 2011.
•Adult Day Health Care (ADHC) Waiver: Certain services for 5 or more hours a day in an ADHC facility, and includes activities of daily living services, health and nutrition counseling, social services, and exercise programs. Operating since January 1985.
•Supports Waiver (SW): Provides supported employment, day habilitation, prevocational services, respite, habilitation and personal emergency response systems to recipients age 18 and older with a developmental disability which manifested prior to age 22.
•Children's Choice (CC) Waiver: Supplemental support to children with DD that currently live at home with families. Children's Choice is an option offered to children that are requesting services offered under the New Opportunities Waiver. Operating since 2/21/2001.
•New Opportunities Waiver (NOW): Operating since 1/1/1990. Beginning in October 2003, individuals were transitioned out of the MR/DD waiver into the New Opportunity Waiver (NOW) which encompasses additional services and an option for participants to elect consumer direction.
•Residential Options Waiver (ROW), implemented in 2010, provides eligible individuals of all ages services designed to support them to move from Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and nursing facilities to the community
•Coordinated System of Care (CSoC) for Children, created in 2011, provides a single point of entry for families of children who have complex behavioral health needs and are either in or at risk of being in out-of-home placement, such as foster homes, group homes, juvenile detention facilities, and residential treatment centers.

Managed Care (2013)
•Bayou Health Prepaid (Comprehensive MCO and any other type) and Shared Savings (PCCM)
•Program of All Inclusive Care for the Elderly (PACE)
•Greater New Orleans Community Health Connection (PCCM)
•87.6% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: LaChip
•149,968 enrollees
•Combination Plan
•Enhanced FMAP: 72.87% in 2013
•Federal Allotment: $171.9 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$5,383,477,265	$5,637,206,714	$6,340,703,178	$7,011,557,299	$7,319,542,445	$7,564,182,204	$7,688,146,740	$9,210,329,395	$9,410,240,087	*8.9%*	*2.2%*
Federal Share	$2,704,497,496	$2,833,234,329	$3,833,615,861	$4,337,426,768	$4,140,704,095	$3,790,667,523	$3,899,665,853	$5,255,180,379	$5,631,729,430	*12.1%*	*7.2%*
State Share	$2,678,979,769	$2,803,972,385	$2,507,087,317	$2,674,130,531	$3,178,838,350	$3,773,514,681	$3,788,480,887	$3,955,149,016	$3,778,510,657	*5.1%*	*-4.5%*
Administrative Costs	$283,190,977	$306,206,706	$334,146,709	$253,850,805	$286,054,573	$340,237,116	$364,819,468	$415,492,007	$471,463,426	*7.5%*	*13.5%*
Federal Share	$150,101,874	$162,715,379	$179,368,032	$137,121,742	$153,580,393	$207,251,379	$223,887,115	$268,293,049	$305,558,596	*11.1%*	*13.9%*
State Share	$133,089,103	$143,491,327	$154,778,677	$116,729,063	$132,474,180	$132,985,737	$140,932,353	$147,198,958	$165,904,830	*2.4%*	*12.7%*
Admin. Costs as % of Payments	5.26%	5.43%	5.27%	3.62%	3.91%	4.50%	4.75%	4.51%	5.01%		
Federal Match Rate*	50.00%	50.00%	61.59%	61.59%	50.00%	50.00%	50.00%	50.00%	50.00%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
Nursing Home	5.50%	$107,965,980
Managed Care Organization	2% total premiums	$104,000,000
Hospital (began in 2009)	Variable	$508,614,093
*Two separate hospital assessments (one is specific dollar amount per hospital and one is 1.25% of hospital net patient revenue)		$720,580,073
Total		$1,441,160,146

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$72,555,652	$63,435,466	$80,097,795	$60,911,473	$37,973,511	$25,724,403	$41,916,747	$47,227,358	$51,995,264	*-3.3%*
Mental Hospitals	$47,402,136	$47,402,124	$50,411,359	$51,993,138	$50,378,598	$10,600,460	$92,424,069	$53,670,127	$55,969,470	*2.8%*
Total	$119,957,788	$110,837,590	$130,509,154	$112,904,611	$88,352,109	$36,324,863	$134,340,816	$100,897,485	$107,964,734	*-0.4%*

ACA MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014.

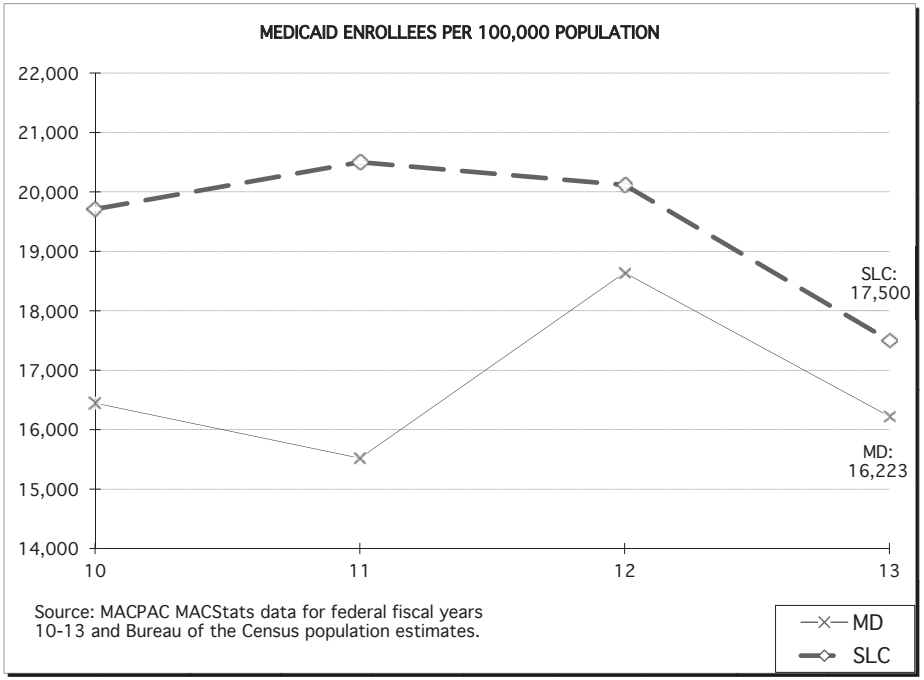
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

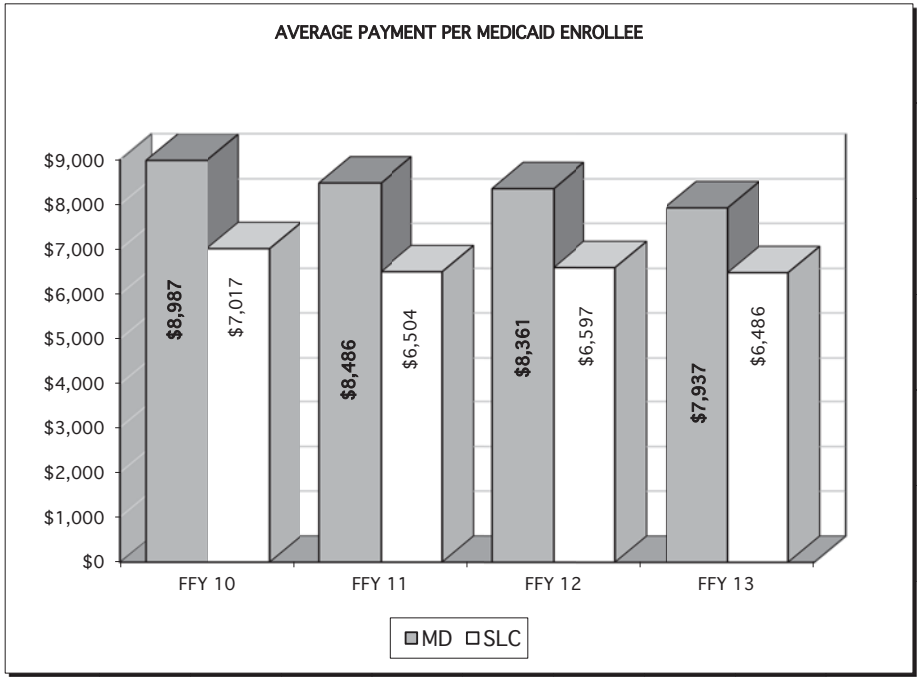
		Rank in U.S.
State population—July 1, 2013	5,737,052	*19*
Per capita personal income	$54,259	*5*
Median household income	$72,483	*1*
Population below Federal Poverty Level	585,571	*n/a*
Percent of total state population	10.1%	*50*
Population without health insurance coverage	602,791	*25*
Percent of total state population	10.5%	*38*
Recipients of SNAP benefits	771,021	*25*
Total value of issuance	$1,178,661,931	*25*
Average monthly benefit per recipient	$127.39	*31*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

MARYLAND





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,168	$1,218	$997	$993	*-5.3%*	*12.9%*
Physician	$101	$85	$79	$93	*-2.7%*	*1.2%*
Dental	$105	$115	$120	$121	*4.8%*	*1.6%*
Other practitioner	$13	$16	$17	$18	*11.5%*	*0.2%*
Clinic and health center	$44	$52	$53	$50	*4.4%*	*0.7%*
Other acute	$339	$335	$867	$793	*32.7%*	*10.3%*
Drugs	$172	$89	$226	$132	*-8.4%*	*1.7%*
Institutional LTSS	$1,060	$1,077	$1,271	$1,322	*7.6%*	*17.2%*
Home and community-based LTSS	$1,334	$1,340	$987	$1,044	*-7.8%*	*13.6%*
Managed care and premium assistance	$2,527	$2,912	$2,843	$2,965	*5.5%*	*38.6%*
Medicare Premiums and Coinsurance	$220	$229	$227	$249	*4.2%*	*3.2%*
Collections	($71)	($148)	($122)	($93)	*9.4%*	*-1.2%*
Total Spending	**$7,012**	**$7,320**	**$7,564**	**$7,688**	*3.1%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	426	426	510	448	*1.7%*	*46.5%*
Adult	277	279	357	305	*3.2%*	*31.7%*
Disabled	145	131	148	137	*-1.9%*	*14.2%*
Aged	76	70	82	74	*-0.9%*	*7.7%*
Total	**952**	**907**	**1,098**	**963**	*0.4%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$1,338	$1,417	$1,461	$1,468	*3.1%*	*19.2%*
Adult	$1,190	$1,387	$1,484	$1,552	*9.3%*	*20.3%*
Disabled	$3,159	$3,173	$3,213	$3,135	*-0.2%*	*41.0%*
Aged	$1,395	$1,410	$1,492	$1,491	*2.2%*	*19.5%*
Total	**$7,082**	**$7,380**	**$7,650**	**$7,647**	*2.6%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,471	$ 3,380	$ 3,399	$ 3,278	*-1.9%*	
Adult	$5,775	$ 5,627	$ 5,352	$ 5,094	*-4.1%*	
Disabled	$24,115	$ 23,416	$ 23,576	$ 22,912	*-1.7%*	
Aged	$21,103	$ 20,332	$ 20,766	$ 20,151	*-1.5%*	
All Enrollees	**$8,987**	**$8,486**	**$8,361**	**$7,937**	*-4.1%*	
PER CAPITA EXPENDITURES	**$1,255.16**	**$1,301.40**	**$1,341.84**	**$1,356.62**	*2.6%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Older Adults Waiver: Senior Assisted Housing Waiver: Operating since 1993. Expanded statewide in 2001. A statewide program for adults 50 and older that meet nursing facility level of care, but wish to receive their long term services and supports in their own home or assisted living, rather than a nursing home.
• Model Waiver For Disabled Children: The Model Waiver began January of 1985. This waiver targets medically fragile individuals including technology dependent individuals who, before the age of 22, would otherwise be hospitalized and are certified as needing hospital or nursing home level of care.
•Living at Home (Home and Community Based Options) Waiver: provides services for older adults and individuals with physical disabilities in order for them to live at home or an assisted living facility instead of a nursing facility.
•Waiver For Children With Autism Spectrum Disorder: Effective 7/1/2001, the Maryland State Department of Education began administering the Autism Waiver, targeted to children ages 1 through the end of the school year that the child turns 21.
•Community Pathways: Implementation Date 07/01/2008. Provides services and supports to individuals, of any age, living in the community through provider agencies that are funded by Developmental Disabilities Administration (DDA).
•New Directions Independence Plus: Implementation Date 07/01/2008. Provides individuals, of any age, the opportunity to self-direct their services and supports in their own home or their family's home.
•Adults with Traumatic Brian Injury Waiver: Maryland's Home and Community-Based Services Waiver for Adults with Traumatic Brain Injury provides services to individuals that must have experienced the (initial) traumatic brain injury after the age of 17.
•Medical Day Care Services is a structured group program that provides health, social, and related support services to functionally disabled adults, age 16 and older.
•Psychiatric Residential Treatment Facilities

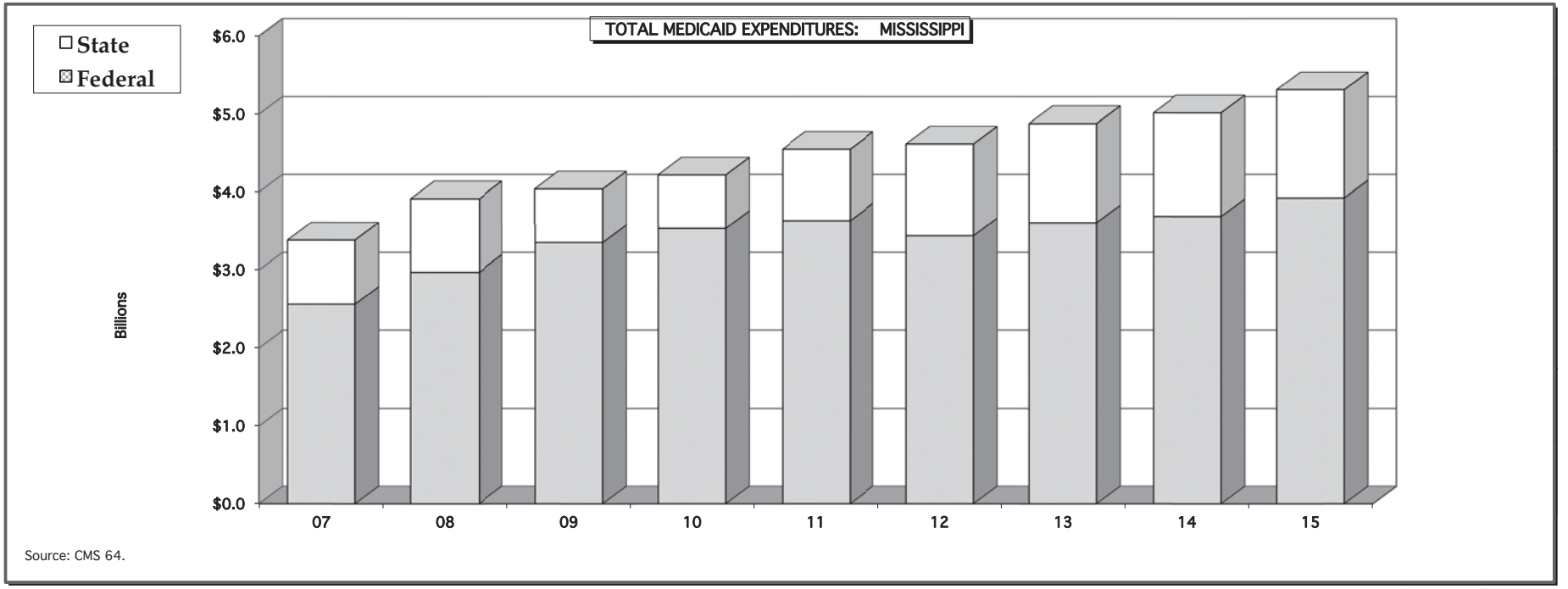
Managed Care (2013)
•Comprehensive Managed Care Organization: (MCO)
•Program of All Inclusive Care for the Elderly (PACE)
•79.4% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: Maryland Children's Health Program (MCHP)
•135,454 enrollees
•Medicaid Expansion
•Enhanced FMAP: 65% in 2013
•Federal Allotment: $160.5 M in 2013

STATE MEDICAID PROFILE

Comparative Data Report on Medicaid

Southern Legislative Conference
Louisiana Legislative Fiscal Office



State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$3,256,111,556	$3,793,448,781	$3,926,907,637	$4,106,064,588	$4,410,842,108	$4,432,068,902	$4,708,563,005	$4,865,309,235	$5,136,317,498	*5.2%*	*5.6%*
Federal Share	$2,486,706,858	$2,902,033,701	$3,277,913,171	$3,469,557,146	$3,547,384,811	$3,299,536,692	$3,484,440,137	$3,584,888,137	$3,806,728,736	*4.6%*	*6.2%*
State Share	$769,404,698	$891,415,080	$648,994,466	$636,507,442	$863,457,297	$1,132,532,210	$1,224,122,868	$1,280,421,098	$1,329,588,762	*6.9%*	*3.8%*
Administrative Costs	$126,624,285	$119,306,225	$110,922,430	$110,491,770	$140,203,278	$186,003,784	$170,612,163	$150,915,134	$177,402,738	*6.8%*	*17.6%*
Federal Share	$71,917,844	$68,548,025	$72,107,000	$63,362,100	$82,607,560	$137,971,291	$120,731,314	$101,688,772	$117,186,584	*9.3%*	*15.2%*
State Share	$54,706,441	$50,758,200	$38,815,430	$47,129,670	$57,595,718	$48,032,493	$49,880,849	$49,226,362	$60,216,154	*2.9%*	*22.3%*
Admin. Costs as % of Payments	3.89%	3.15%	2.82%	2.69%	3.18%	4.20%	3.62%	3.10%	3.45%		
Federal Match Rate*	75.89%	76.29%	84.24%	84.86%	74.73%	74.18%	73.43%	73.05%	73.58%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

MISSISSIPPI

Provider Taxes Currently in Place (FFY 13)

	Tax Rate	Amount
Nursing homes	rate varies by facility category	$83,170,515
ICF/MR-DD	$16.97	$15,838,406
Psychc Residential Treatment fac.	$22.28	$2,338,375
Hospitals		
DSH	Hospital taxes were assessed based on the state share of the federal Disproportionate Share allotment, plus the state share of Upper Payment Limit payments, plus a legislatively mandated amount. The tax base used to assess and collect from hospitals was the non-Medicare days from 2010 Medicare/Medicaid cost reports	$57,922,482
UPL		$129,355,515
Legislative Mandate		$104,000,000
Total		$392,625,293

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$191,203,351	$195,174,691	$211,863,454	$208,213,247	$204,084,644	$210,532,157	$217,999,554	$222,637,569	$224,546,417	*2.4%*
Mental Hospitals	$0	$0	$0	$0	$0	$0	$0	$0	$0	*0.0%*
Total	$191,203,351	$195,174,691	$211,863,454	$208,213,247	$204,084,644	$210,532,157	$217,999,554	$222,637,569	$224,546,417	*2.4%*

ACA MEDICAID EXPANSION

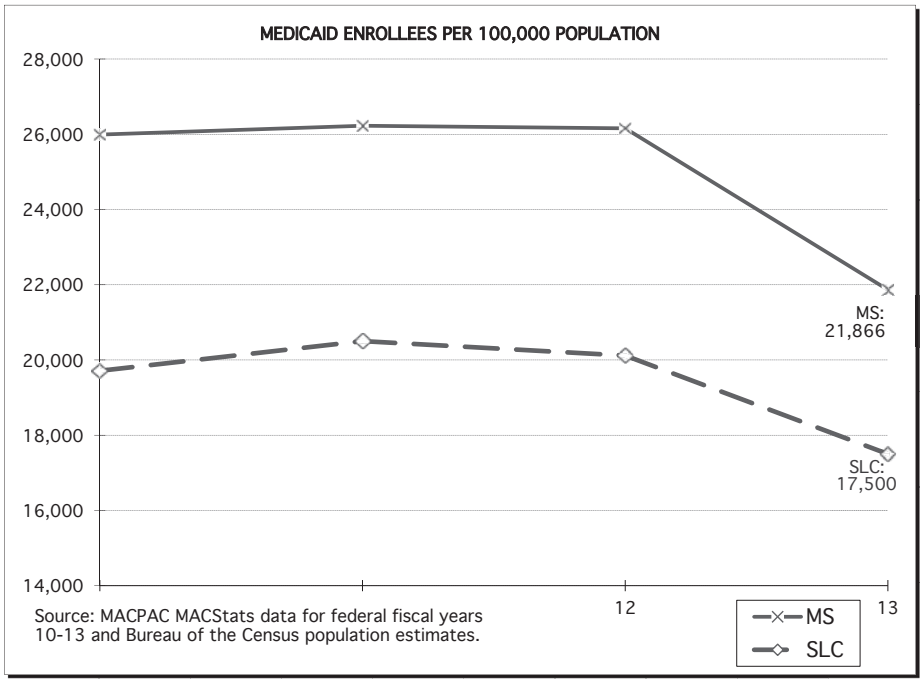
Not expanding Medicaid under ACA as of January 2017.

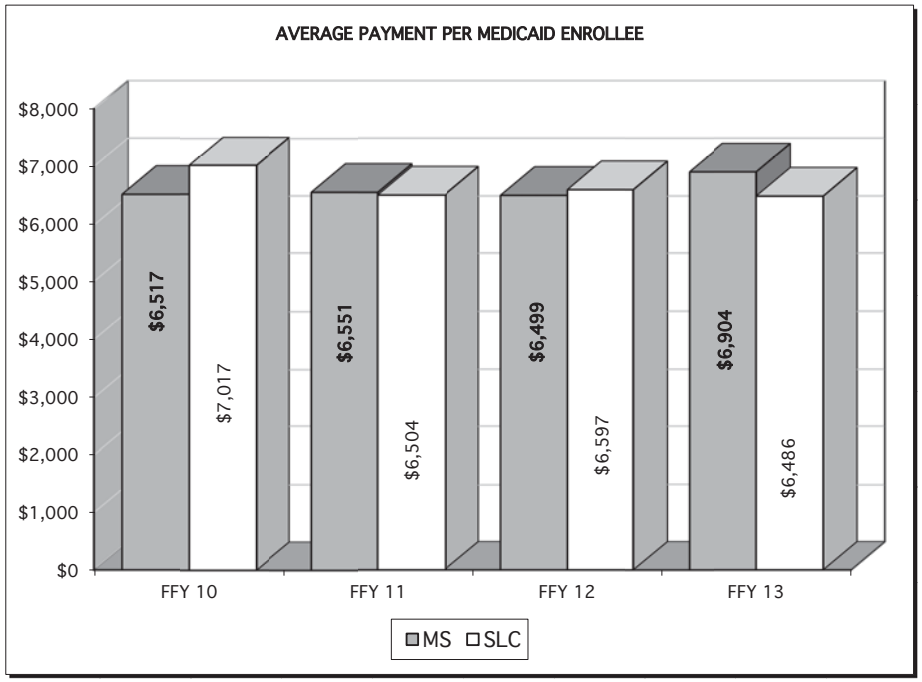
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

		Rank in U.S.
State population—July 1, 2013	2,908,862	*31*
Per capita personal income	$34,478	*50*
Median household income	$37,963	*51*
Population below Federal Poverty Level	695,915	*n/a*
Percent of total state population	24.0%	*2*
Population without health insurance coverage	507,514	*28*
Percent of total state population	17.4%	*9*
Recipients of SNAP benefits	668,624	*26*
Total value of issuance	$993,077,956	*26*
Average monthly benefit per recipient	$123.77	*41*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,642	$1,708	$1,628	$1,660	*0.4%*	*35.3%*
Physician	$298	$311	$290	$216	*-10.2%*	*4.6%*
Dental	$9	$9	$9	$6	*-12.6%*	*0.1%*
Other practitioner	$25	$28	$29	$25	*0.0%*	*0.5%*
Clinic and health center	$77	$75	$80	$88	*4.6%*	*1.9%*
Other acute	$266	$258	$450	$386	*13.2%*	*8.2%*
Drugs	$221	$170	$194	$125	*-17.3%*	*2.7%*
Institutional LTSS	$1,017	$1,018	$1,097	$1,123	*3.4%*	*23.8%*
Home and community-based LTSS	$396	$414	$255	$296	*-9.2%*	*6.3%*
Managed care and premium assistance	$0	$259	$234	$607	*n/a*	*12.9%*
Medicare Premiums and Coinsurance	$194	$208	$201	$204	*1.7%*	*4.3%*
Collections	($40)	($46)	($34)	($28)	*-11.2%*	*-0.6%*
Total Spending	**$4,106**	**$4,411**	**$4,432**	**$4,709**	*4.7%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	400	406	401	328	*-6.4%*	*50.1%*
Adult	116	115	116	84	*-10.2%*	*12.8%*
Disabled	168	170	172	159	*-1.7%*	*24.4%*
Aged	90	90	91	83	*-2.4%*	*12.7%*
Total	**772**	**781**	**781**	**654**	*-5.4%*	*100.0%*
Spending by Basis of Eligibility (Millions)						
Children	$900	$897	$881	$917	*0.6%*	*20.3%*
Adult	$477	$455	$460	$447	*-2.1%*	*9.9%*
Disabled	$1,779	$1,867	$1,859	$2,056	*4.9%*	*45.5%*
Aged	$987	$1,033	$1,055	$1,102	*3.8%*	*24.4%*
Total	**$4,146**	**$4,253**	**$4,255**	**$4,518**	*2.9%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$2,783	$ 2,708	$ 2,652	$ 2,792	*0.1%*	
Adult	$5,771	$ 5,504	$ 5,582	$ 5,305	*-2.8%*	
Disabled	$11,912	$ 12,135	$ 11,784	$ 12,902	*2.7%*	
Aged	$12,295	$ 12,742	$ 12,746	$ 13,238	*2.5%*	
All Enrollees	**$6,517**	**$6,551**	**$6,499**	**$6,904**	*1.9%*	
PER CAPITA EXPENDITURES	**$1,419.56**	**$1,528.22**	**$1,546.75**	**$1,631.30**	*4.7%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

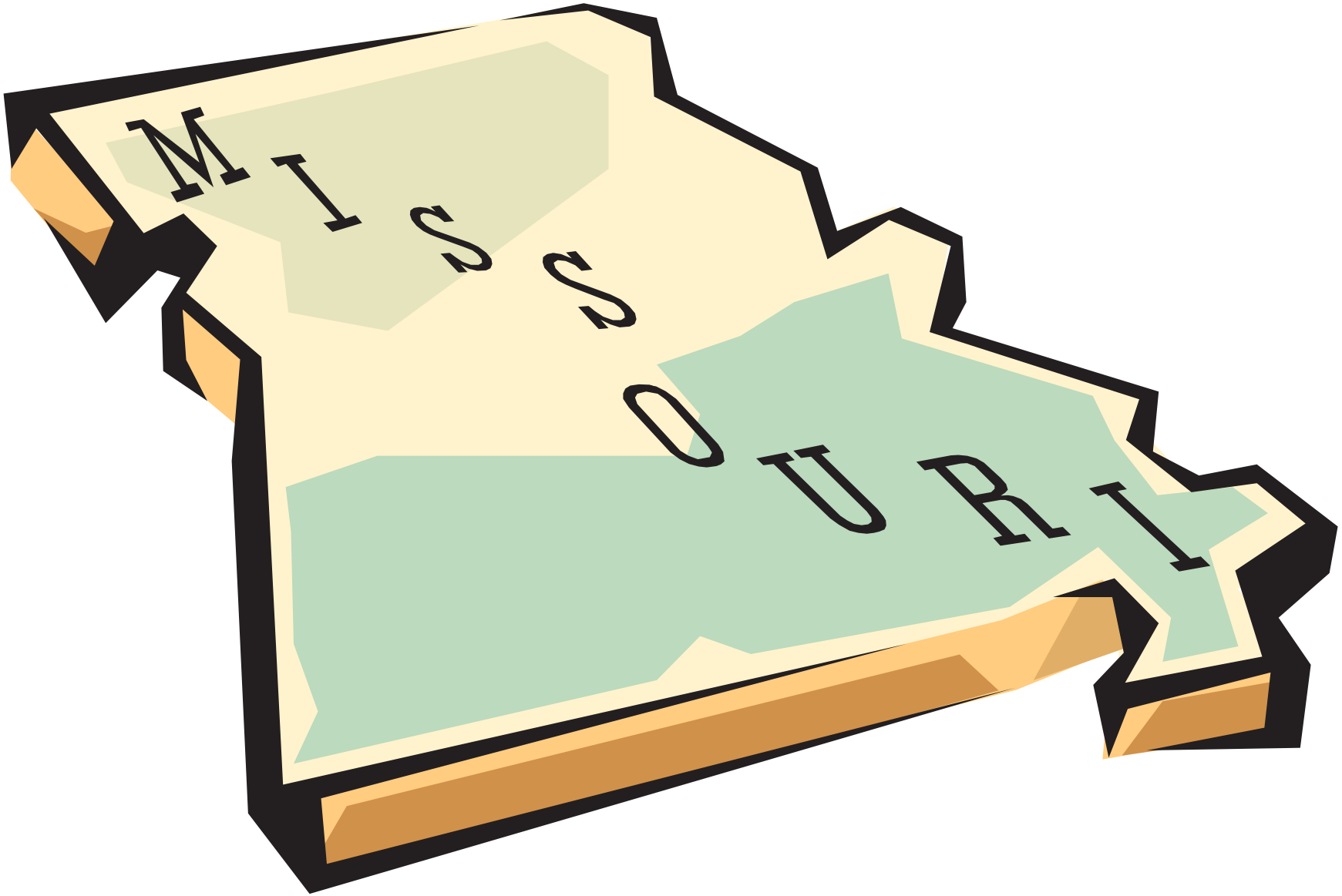
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

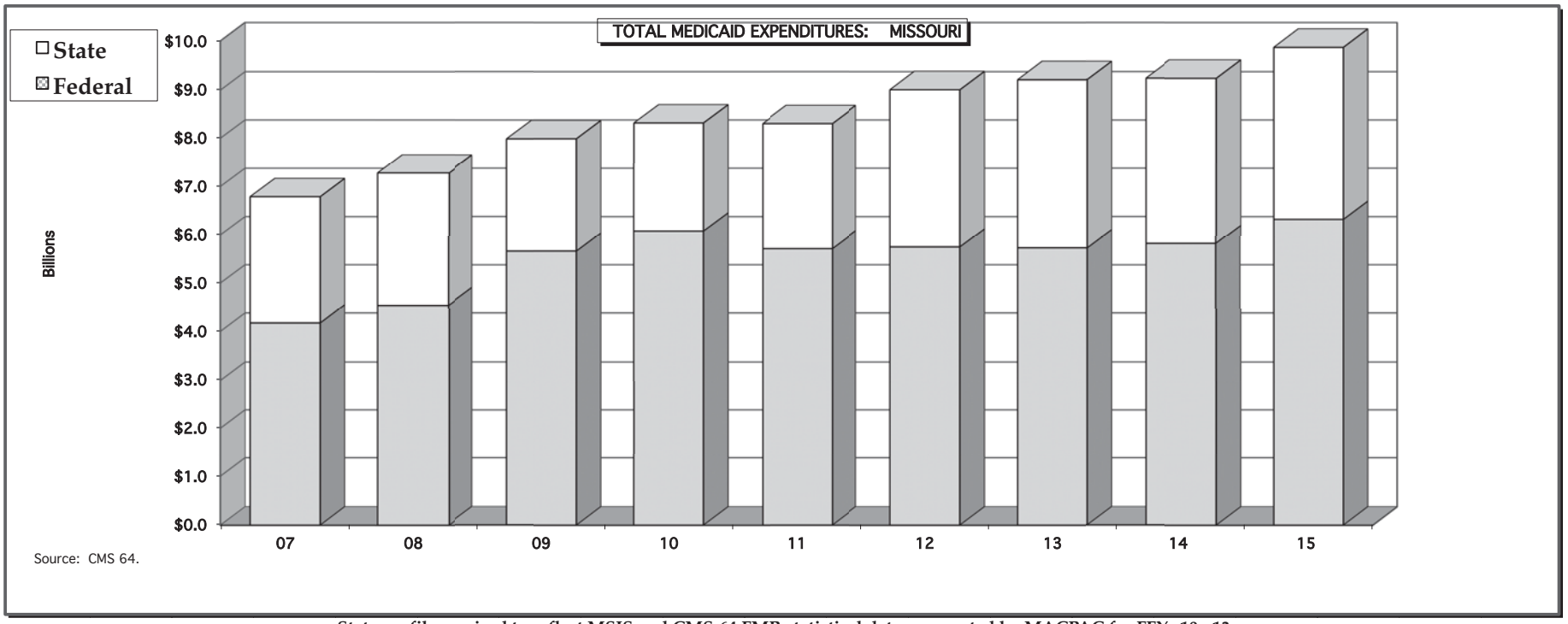
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Elderly and Disabled (E&D) Waiver: Provides home and community-based services to individuals 21 and over who, but for the provision of such services, would require the level of care provided in a nursing facility. Operating since 7/1/1994.
•Independent Living (IL) Waiver: Provides services to beneficiaries who, but for the provision of such services would require the level of care found in a nursing facility. Eligibility for the Independent Living Wavier is limited to individuals age 16 or older who have severe orthopedic and/or neurological impairments.
•Intellectual Disabilities/DD (ID/DD) Waiver: Provides services in non-residential setting such as day services, supervised living services as well as services.

Managed Care (2013)
•Medicaid Managed Care Organization (MCO)
•22.5.% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: CHIP
•93,120 enrollees
•Separate Plan (State Designed Plan)
•Enhanced FMAP: 81.1% in 2013
•Federal Allotment: $176.9 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$6,515,259,281	$6,987,211,010	$7,648,493,348	$7,993,868,056	$8,011,172,790	$8,620,917,909	$8,863,322,084	$8,828,757,766	$9,518,489,904	*5.3%*	*7.8%*
Federal Share	$4,027,108,429	$4,374,382,924	$5,477,126,007	$5,898,733,654	$5,539,526,252	$5,491,425,953	$5,504,048,486	$5,545,242,644	$6,099,250,957	*5.7%*	*10.0%*
State Share	$2,488,150,852	$2,612,828,086	$2,171,367,341	$2,095,134,402	$2,471,646,538	$3,129,491,956	$3,359,273,598	$3,283,515,122	$3,419,238,947	*4.6%*	*4.1%*
Administrative Costs	$270,832,812	$289,950,881	$337,427,940	$318,095,008	$286,268,889	$383,564,996	$346,547,941	$409,922,940	$350,451,191	*3.2%*	*-14.5%*
Federal Share	$143,686,458	$157,795,282	$180,139,779	$177,393,910	$167,571,485	$251,685,974	$219,657,444	$270,839,417	$218,597,478	*5.6%*	*-19.3%*
State Share	$127,146,354	$132,155,599	$157,288,161	$140,701,098	$118,697,404	$131,879,022	$126,890,497	$139,083,523	$131,853,713	*0.0%*	*-5.2%*
Admin. Costs as % of Payments	4.16%	4.15%	4.41%	3.98%	3.57%	4.45%	3.91%	4.64%	3.68%		
Federal Match Rate*	61.60%	62.42%	73.27%	74.43%	63.29%	63.45%	61.37%	62.03%	63.45%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

MISSOURI

Provider Taxes Currently in Place (FFY 13)

	Tax Rate	Amount
General and mental hospitals	5.95% of inpatient/outpatient rev's	$1,060,200
Nursing homes	$12.11 per patient day	$180,300,000
Ambulance (established 9/1/2011)	4.42%	$8,100,000
Pharmacy	1.82% gross retail prescription sales	$95,100,000
ICF/MR DD (began in 2009)	5.95%	$7,300,000
Total		$291,860,200

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Change*
General Hospitals	$512,578,228	$502,063,573	$538,614,537	$546,257,472	$528,236,515	$532,754,243	$496,159,120	$521,723,012	$473,625,424	*-1.0%*
Mental Hospitals	$205,201,602	$167,712,775	$198,763,354	$192,572,458	$171,360,681	$222,834,355	$207,234,539	$207,234,564	$207,234,582	*3.6%*
Total	$717,779,830	$669,776,348	$737,377,891	$738,829,930	$699,597,196	$755,588,598	$703,393,659	$728,957,576	$680,860,006	*0.3%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of January 2017.

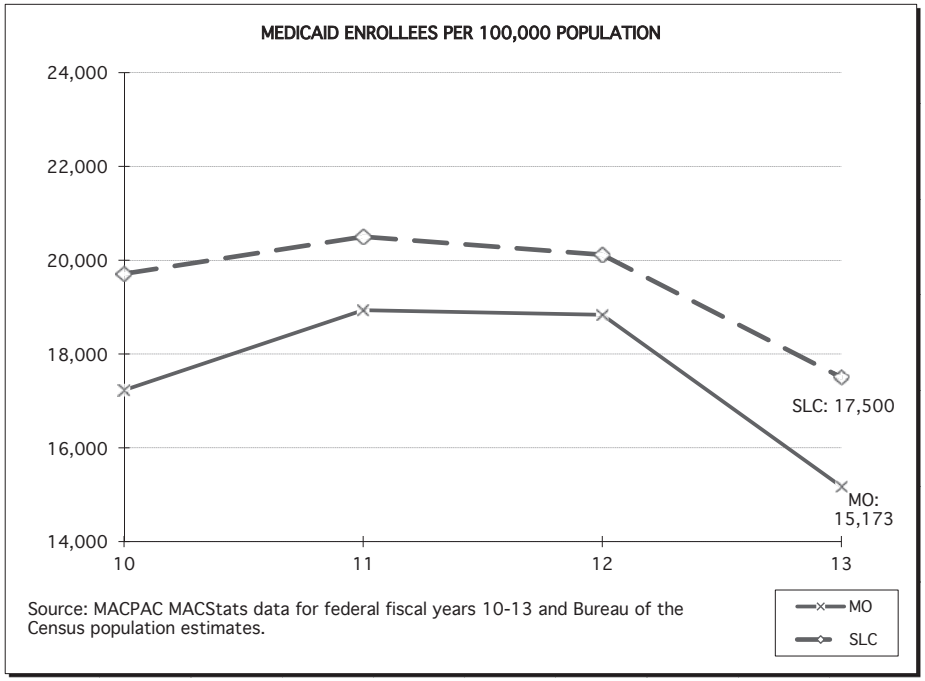
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

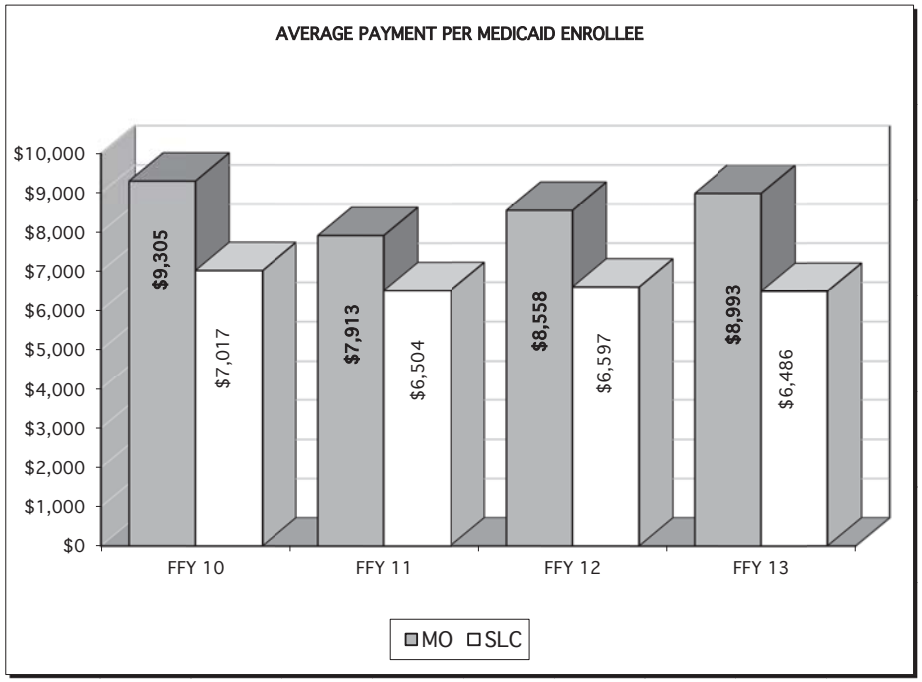
		Rank in U.S.
State population—July 1, 2013	5,892,726	*18*
Per capita personal income	$39,897	*33*
Median household income	$46,931	*38*
Population below Federal Poverty Level	931,066	*n/a*
Percent of total state population	15.9%	*24*
Population without health insurance coverage	776,915	*17*
Percent of total state population	13.2%	*27*
Recipients of SNAP benefits	929,943	*16*
Total value of issuance	$1,428,882,352	*17*
Average monthly benefit per recipient	$128.04	*27*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

MISSOURI





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$3,034	$2,943	$3,017	$2,981	*-0.6%*	*33.6%*
Physician	$30	$27	$21	$38	*8.2%*	*0.4%*
Dental	$15	$15	$15	$15	*0.0%*	*0.2%*
Other practitioner	$13	$11	$14	$11	*-5.4%*	*0.1%*
Clinic and health center	$421	$431	$462	$487	*5.0%*	*5.5%*
Other acute	$354	$272	$552	$837	*33.2%*	*9.4%*
Drugs	$612	$602	$613	$655	*2.3%*	*7.4%*
Institutional LTSS	$1,039	$1,227	$1,556	$1,319	*8.3%*	*14.9%*
Home and community-based LTSS	$1,189	$1,157	$1,062	$1,174	*-0.4%*	*13.2%*
Managed care and premium assistance	$1,093	$1,097	$1,094	$1,116	*0.7%*	*12.6%*
Medicare Premiums and Coinsurance	$319	$310	$307	$318	*-0.1%*	*3.6%*
Collections	($124)	($80)	($106)	($88)	*-10.8%*	*-1.0%*
Total Spending	**$7,994**	**$8,011**	**$8,607**	**$8,863**	*3.5%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	545	577	575	480	*-4.2%*	*52.4%*
Adult	190	239	241	176	*-2.5%*	*19.2%*
Disabled	202	224	222	183	*-3.3%*	*20.0%*
Aged	94	98	97	77	*-6.3%*	*8.4%*
Total	**1,033**	**1,138**	**1,135**	**917**	*-3.9%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$1,813	$1,626	$1,778	$1,947	*2.4%*	*23.6%*
Adult	$728	$680	$717	$759	*1.4%*	*9.2%*
Disabled	$3,727	$3,629	$3,938	$4,066	*2.9%*	*49.3%*
Aged	$1,480	$1,456	$1,538	$1,476	*-0.1%*	*17.9%*
Total	**$7,748**	**$7,392**	**$7,971**	**$8,248**	*2.1%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,991	$3,340	$3,664	$4,056	*0.5%*	
Adult	$5,657	$3,787	$3,977	$4,310	*-8.7%*	
Disabled	$21,770	$19,408	$21,111	$22,183	*0.6%*	
Aged	$18,890	$18,029	$19,297	$19,046	*0.3%*	
All Enrollees	**$9,305**	**$7,913**	**$8,558**	**$8,993**	*-1.1%*	
PER CAPITA EXPENDITURES	**$1,386.24**	**$1,380.47**	**$1,494.40**	**$1,523.88**	*3.2%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

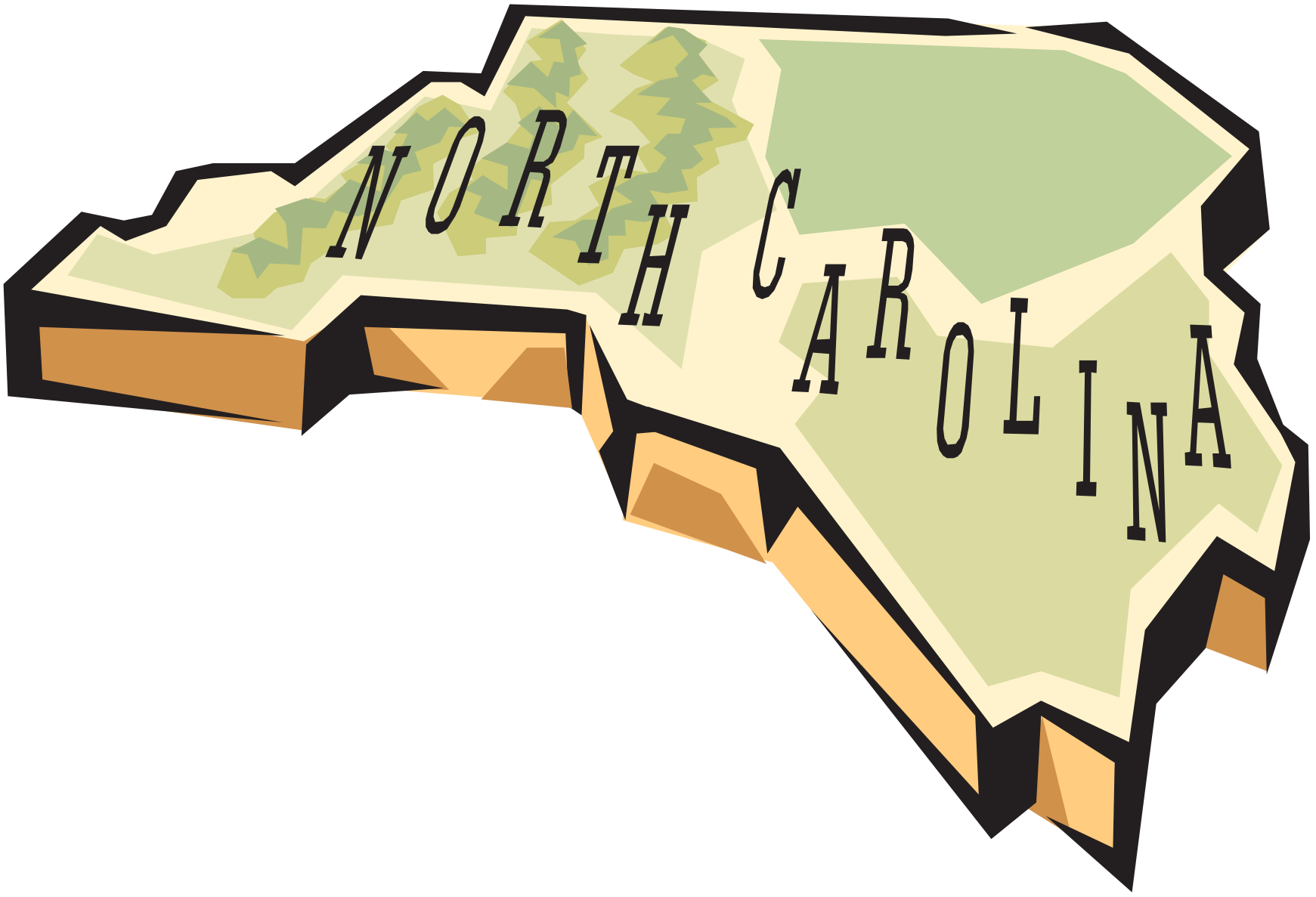
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

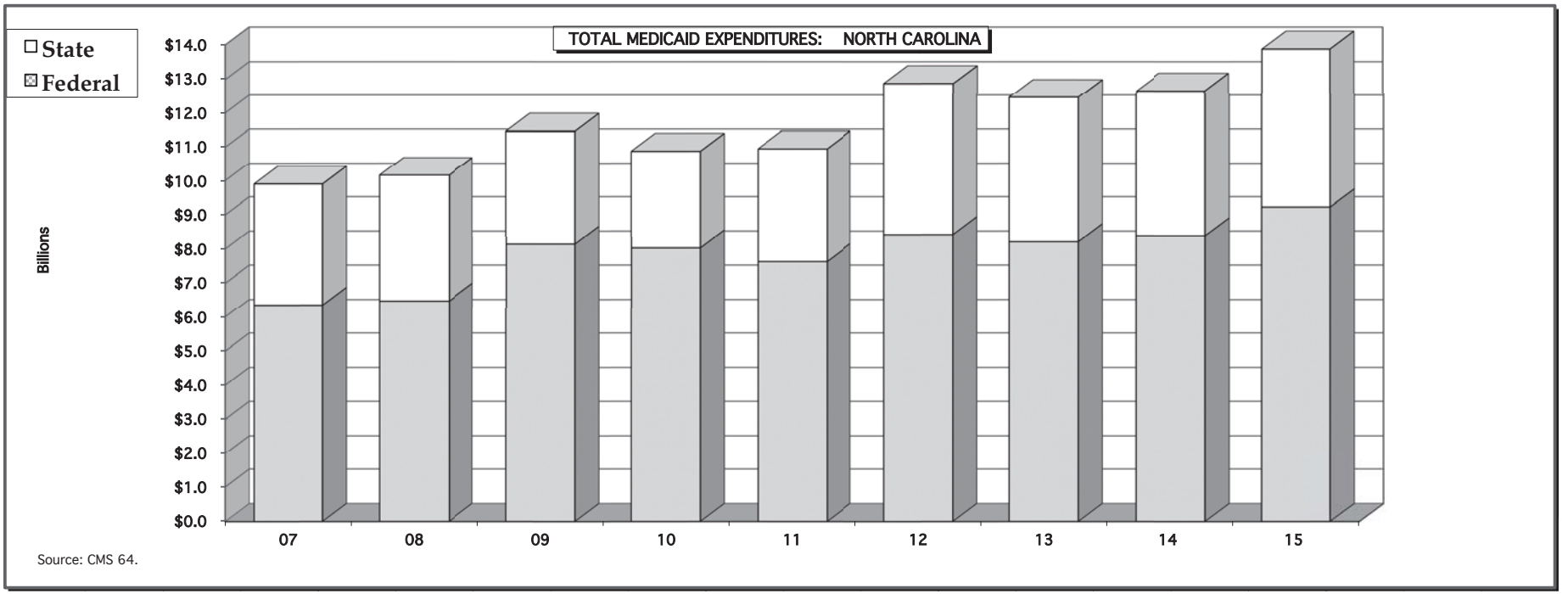
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Aged and Disabled Waiver: Provides in-home services to Missouri residents aged 63 or over who have been assessed to require nursing home care but have chosen to receive the care in their home or community instead. Operating since 4/22/1980.
•Mental Retardation and Developmental Disabilities (MR/DD) Comprehensive Waiver: Operating since 7/1/1988. Provides residential services such as residential habilitation and individualized supported living services.
•AIDS Waiver: operating since 7/1/1998. Provides in home services to participants diagnosed as having AIDS or HIV related illness and meeting nursing home level of care.
•Missouri Children with Developmental Disabilities Waiver: To age 18. Operating since 10/1/1995. This waiver allows the state of Missouri to take into account only the child's income when determining eligibility.
•Medically Fragile Adult Waiver: Provides services to adults with complex medical needs who have reached the age of 21 and are no longer eligible to receive private duty nursing services through the Healthy Children and Youth (HCY) Program. Operating since 7/1/1998.
•Independent Living Waiver: Operating since 1/1/2000. Offers additional personal assistance services beyond the services limited by the state plan for personal care services.
•MR/DD Community Support Waiver: Established 7/1/2003. For persons who have a place to live in the community, usually with family. This waiver has an individual annual cap on the total amount of services a person can receive of $22,000.
•Autism Waiver: Began in July, 2009. A person eligible for the Autism Waiver must be at least three years of age and not more than 18 years of age and be living in the community, with family.
•Partnership for Hope Waiver: Began 10/1/2010. This waiver can serve adults and children and has an annual total waiver service cost limit per participant of $12,000.
•Sarah Jian Lopez Waiver (Missouri Children with Developmental Disabilities - MOCDD Waiver) is a Medicaid model waiver administered by the Division of DD since FY 95.

Managed Care (2013)
•Medicaid Managed Care Organizations (MCO)
•Prepaid Ambulatory Health Plan (PAHP): Transportation
•Program of All Inclusive Care for the Elderly (PACE)
•97.2% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: HealthNet for Kids
•92,918 enrollees
•Combination Plan
•Enhanced FMAP: 72.96% in 2013
•Federal Allotment: $122.9 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$9,397,798,245	$9,613,851,674	$10,888,466,523	$10,302,117,040	$10,297,057,563	$12,074,012,547	$11,721,921,735	$11,992,545,816	$13,212,668,475	*5.4%*	*10.2%*
Federal Share	$6,081,507,375	$6,173,773,062	$7,818,867,023	$7,696,915,390	$7,253,597,380	$7,890,342,312	$7,718,561,097	$7,945,363,734	$8,742,712,115	*6.0%*	*10.0%*
State Share	$3,316,290,870	$3,440,078,612	$3,069,599,500	$2,605,201,650	$3,043,460,183	$4,183,670,235	$4,003,360,638	$4,047,182,082	$4,469,956,360	*4.5%*	*10.4%*
Administrative Costs	$500,405,737	$545,717,546	$572,461,714	$572,598,062	$648,762,805	$801,860,156	$741,262,408	$662,500,412	$665,345,793	*3.4%*	*0.4%*
Federal Share	$272,880,241	$302,115,961	$320,410,516	$332,532,770	$374,060,687	$527,687,143	$493,328,216	$440,421,501	$485,515,429	*8.2%*	*10.2%*
State Share	$227,525,496	$243,601,585	$252,051,198	$240,065,292	$274,702,118	$274,173,013	$247,934,192	$222,078,911	$179,830,364	*-4.9%*	*-19.0%*
Admin. Costs as % of Payments	5.32%	5.68%	5.26%	5.56%	6.30%	6.64%	6.32%	5.52%	5.04%		
	64.52%	64.05%	74.51%	74.98%	64.71%	65.28%	65.51%	65.78%	65.88%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

NORTH CAROLINA

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
ICF/MR-DD	$5.50% for non medicare net patient revenue	$28,096,810
Nursing Home	$6.5%	$116,364,468
Hospitals	n/a	n/a
Total		$144,461,278

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$288,030,609	$273,783,936	$307,159,833	$313,468,558	$258,479,160	$310,124,694	$308,911,922	$249,118,621	$371,017,744	*5.2%*
Mental Hospitals	$142,176,398	$143,163,016	$149,898,377	$154,424,472	$150,452,714	$240,372	$308,464,711	$157,782,898	$160,312,154	*1.9%*
Total	$430,207,007	$416,946,952	$457,058,210	$467,893,030	$408,931,874	$310,365,066	$617,376,633	$406,901,519	$531,329,898	*4.1%*

ACA MEDICAID EXPANSION

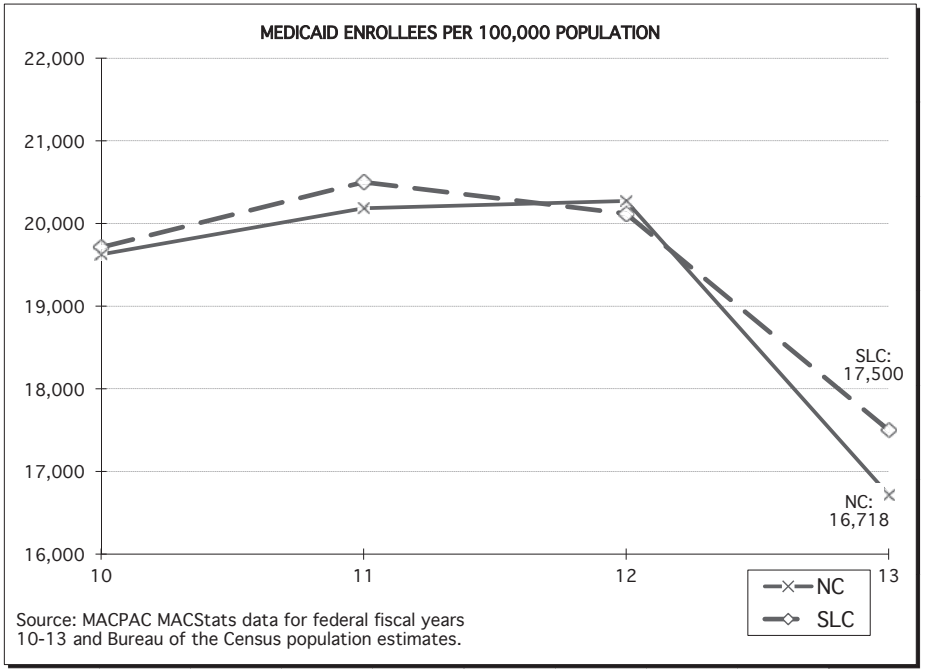
Not expanding Medicaid under ACA as of January 2017.

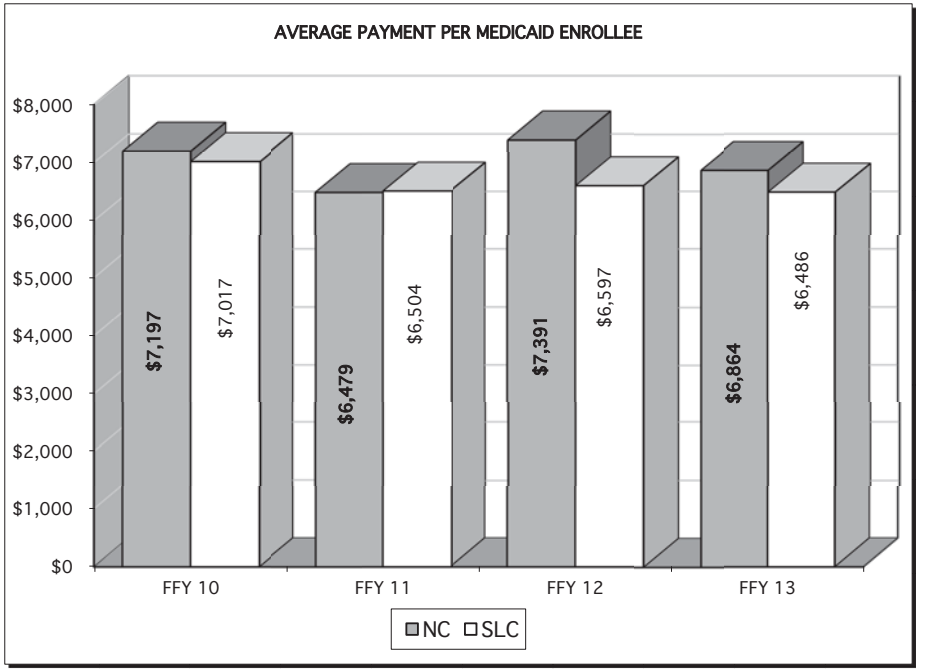
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

		Rank in U.S.
State population—July 1, 2013	9,450,222	*10*
Per capita personal income		
Median household income	$38,457	*39*
	$45,906	*41*
Population below Federal Poverty Level		
Percent of total state population	1,715,397	*n/a*
	17.9%	*13*
Population without health insurance coverage		
Percent of total state population	1,529,230	*7*
	16.2%	*16*
Recipients of SNAP benefits		
	1,703,700	*10*
Total value of issuance		
Average monthly benefit per recipient	$2,491,197,794	*10*
	$121.85	*47*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$3,158	$3,018	$4,413	$3,461	*3.1%*	*29.5%*
Physician	$944	$950	$1,068	$896	*-1.7%*	*7.6%*
Dental	$321	$329	$329	$305	*-1.7%*	*2.6%*
Other practitioner	$33	$34	$28	$86	*37.6%*	*0.7%*
Clinic and health center	$141	$232	$256	$221	*16.2%*	*1.9%*
Other acute	$601	$653	$1,582	$1,227	*26.9%*	*10.5%*
Drugs	$633	$621	$477	$739	*5.3%*	*6.3%*
Institutional LTSS	$1,727	$1,709	$1,769	$1,660	*-1.3%*	*14.2%*
Home and community-based LTSS	$2,669	$2,203	$1,228	$948	*-29.2%*	*8.1%*
Managed care and premium assistance	$270	$356	$687	$1,948	*93.2%*	*16.6%*
Medicare Premiums and Coinsurance	$410	$441	$417	$425	*1.2%*	*3.6%*
Collections	($588)	($250)	($208)	($193)	*-31.0%*	*-1.6%*
Total Spending	**$10,319**	**$10,297**	**$12,074**	**$11,722**	*4.3%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (Thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	981	1,007	1,028	902	*-2.8%*	*54.8%*
Adult	390	411	407	250	*-13.8%*	*15.2%*
Disabled	319	341	351	325	*0.6%*	*19.7%*
Aged	184	189	192	169	*-2.7%*	*10.3%*
Total	**1,876**	**1,948**	**1,976**	**1,646**	*-4.3%*	*100.0%*
Spending by Basis of Eligibility (Millions)						
Children	$2,378	$2,240	$2,825	$2,610	*3.2%*	*23.1%*
Adult	$1,549	$1,409	$1,796	$1,537	*-0.3%*	*13.6%*
Disabled	$4,908	$4,532	$5,340	$5,152	*1.6%*	*45.6%*
Aged	$2,083	$1,957	$2,011	$2,011	*-1.2%*	*17.8%*
Total	**$10,907**	**$10,138**	**$11,972**	**$11,298**	*1.2%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$2,941	$2,720	$3,238	$2,893	*-0.5%*	
Adult	$6,072	$5,247	$6,815	$6,126	*0.3%*	
Disabled	$16,887	$14,844	$16,984	$15,867	*-2.1%*	
Aged	$12,763	$11,768	$11,900	$11,853	*-2.4%*	
All Enrollees	**$7,197**	**$6,479**	**$7,391**	**$6,864**	*-1.6%*	
PER CAPITA EXPENDITURES	**$1,137.64**	**$1,134.16**	**$1,321.01**	**$1,265.88**	*3.6%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

NORTH CAROLINA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

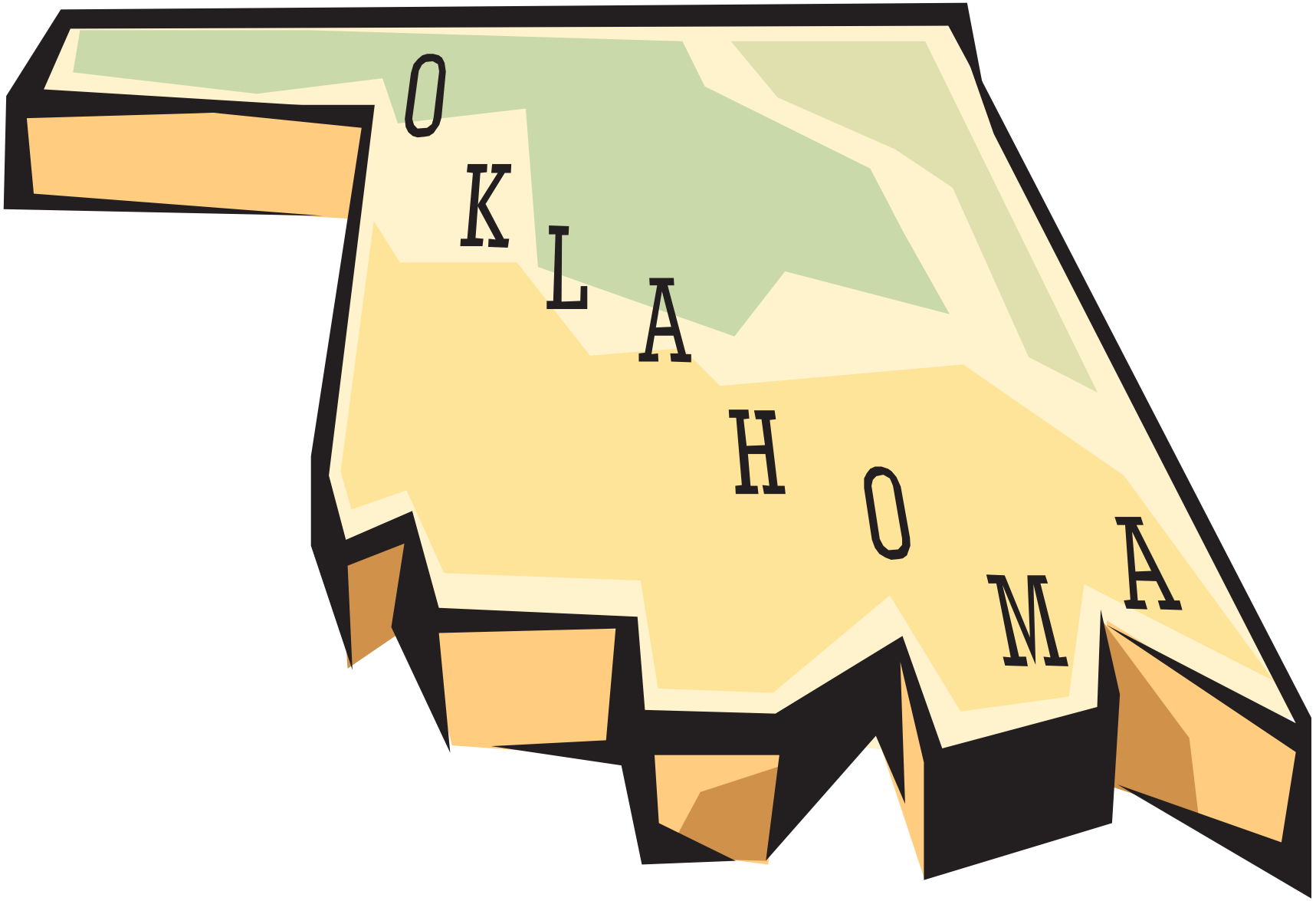
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

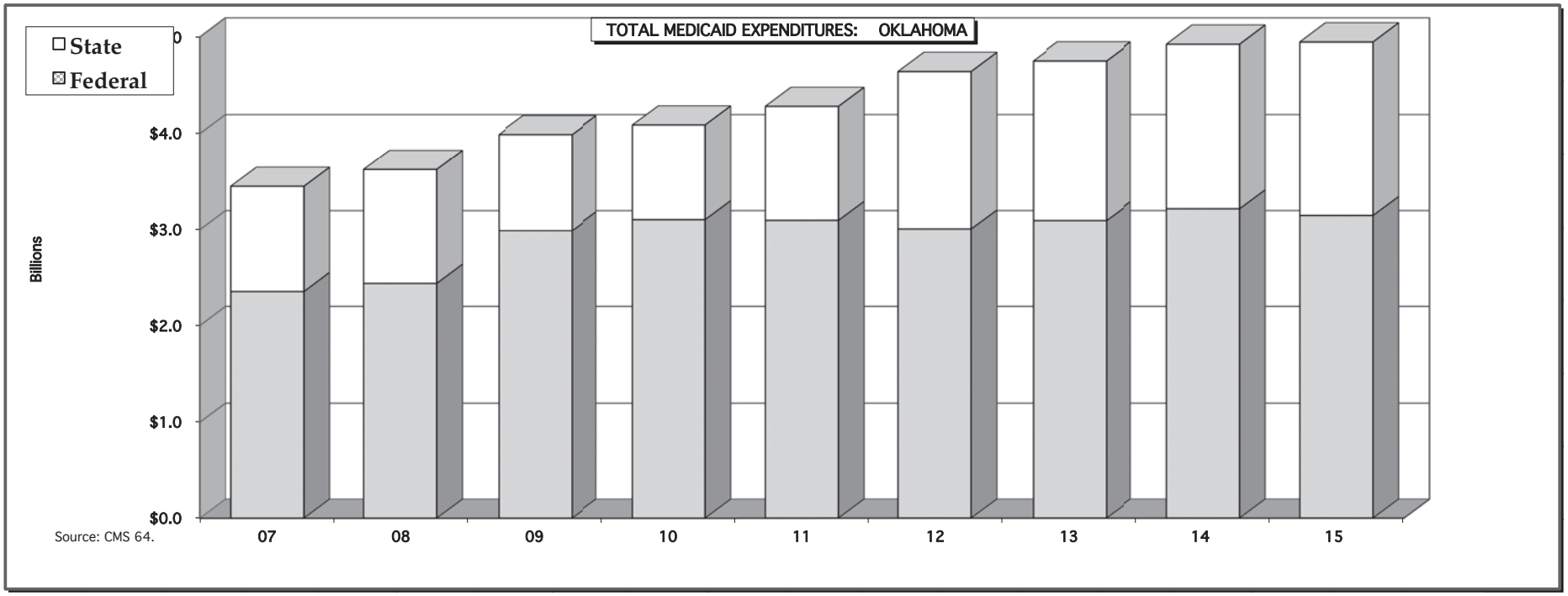
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Elderly and Disabled waiver: This waiver allows older adults and people with disabilities to receive services in their homes or in a community setting.
•Children's waiver: This waiver applies to children who need long-term care due to a condition that makes them 'medically fragile.' Ages 18 and older.
•Comprehensive Waiver: This waiver is designed to support people with developmental disabilities of all ages and diagnoses. It provides a wide array of home and community-based services.
•Supports Waiver: This waiver is designed to complement the Comprehensive waiver by providing many of the same services, but for individuals who need a less intensive level of care (thes ecorrespond roughly to nursing versus intermediate levels of support). It also applies to people with disabilities of all ages. The services provided by the supports waiver are designed to support community living.
•Community Alternatives Program (CAP) for Disabled Adults (DA) Waiver: This waiver allows people with developmental disabilities to receive needed services at home or in the community. Ages 18 and older.

Managed Care (2013)
•Primary Care Case Management (PCCM)
•Prepaid Inpatient Health Plan (PIHP): Mental Health
•Program of All Inclusive Care for the Elderly (PACE)
•76.1% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: NC Health Choice for Children (NCHC)
•260,964 enrollees
•Combination Plan
•Enhanced FMAP: 75.86% in 2013
•Federal Allotment: $304.2 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$3,263,204,924	$3,419,812,221	$3,766,999,610	$3,861,876,770	$4,008,275,083	$4,397,686,300	$4,481,944,280	$4,666,284,967	$4,703,038,531	*5.5%*	*0.8%*
Federal Share	$2,253,292,483	$2,325,404,879	$2,858,649,756	$2,970,982,624	$2,913,588,911	$2,841,979,855	$2,915,783,757	$3,037,693,491	$2,987,216,710	*4.3%*	*-1.7%*
State Share	$1,009,912,441	$1,094,407,342	$908,349,854	$890,894,146	$1,094,686,172	$1,555,706,445	$1,566,160,523	$1,628,591,476	$1,715,821,821	*7.8%*	*5.4%*
Administrative Costs	$187,060,409	$205,811,105	$220,484,128	$227,062,068	$273,465,071	$246,316,769	$270,182,252	$258,905,787	$245,012,336	*2.9%*	*-5.4%*
Federal Share	$107,682,428	$119,083,320	$128,455,053	$132,395,814	$181,397,802	$162,863,415	$176,522,760	$177,512,597	$158,350,018	*4.9%*	*-10.8%*
State Share	$79,377,981	$86,727,785	$92,029,075	$94,666,254	$92,067,269	$83,453,354	$93,659,492	$81,393,190	$86,662,318	*0.0%*	*6.5%*
Admin. Costs as % of Payments	5.73%	6.02%	5.85%	5.88%	6.82%	5.60%	6.03%	5.55%	5.21%		
Federal Match Rate*	68.14%	67.10%	75.83%	76.73%	64.94%	63.88%	64.00%	64.02%	62.30%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
Nursing Home Facility Fee	6% of gross revenues	$64,642,342
Total		$64,642,342

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$37,880,236	$47,302,489	$52,255,880	$37,123,375	$40,706,148	$35,332,877	$41,216,201	$40,250,575	$40,244,528	*-2.7%*
Mental Hospitals	$3,273,247	$3,263,138	$3,283,357	$3,273,248	$3,273,250	$818,306	$543,449	$3,273,248	$3,273,248	*0.1%*
Total	$41,153,483	$50,565,627	$55,539,237	$40,396,623	$43,979,398	$36,151,183	$41,759,650	$43,523,823	$43,517,776	*-2.5%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of January 2017.

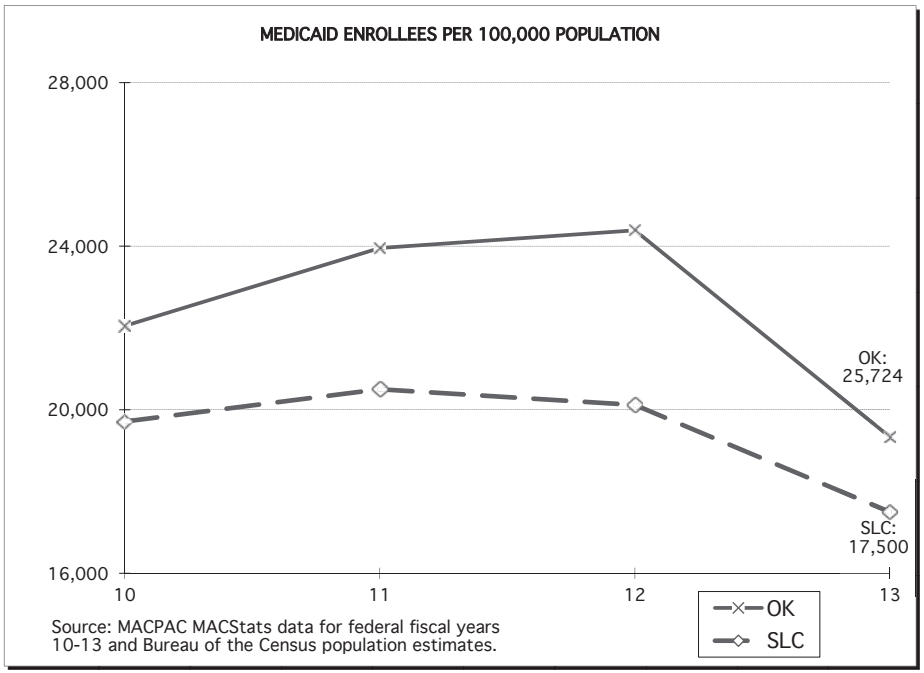
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

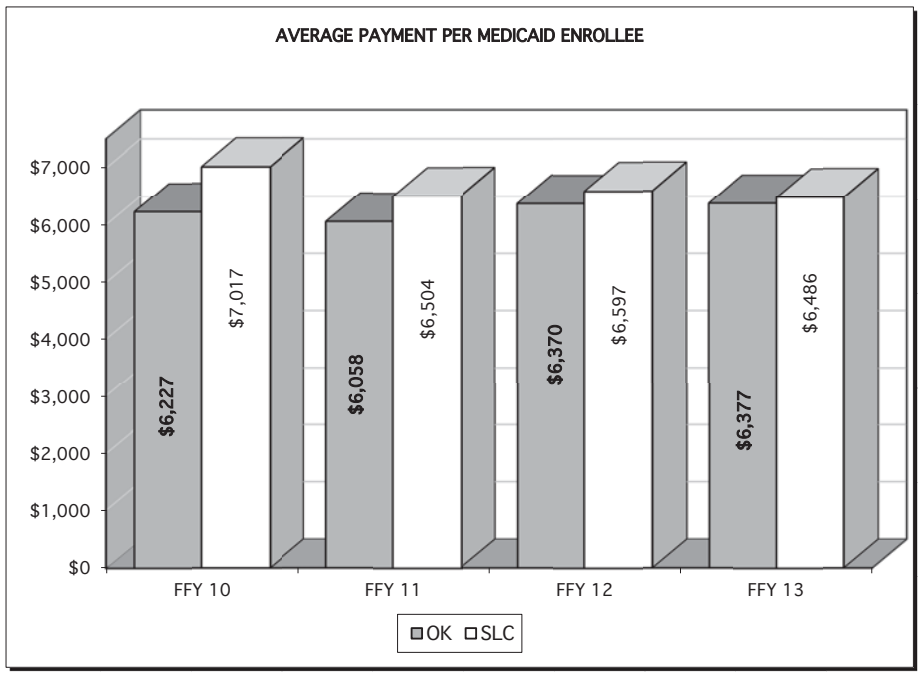
		Rank in U.S.
State population—July 1, 2013	3,702,515	*28*
Per capita personal income	$41,586	*28*
Median household income	$45,690	*42*
Population below Federal Poverty Level	626,906	*n/a*
Percent of total state population	16.8%	*18*
Population without health insurance coverage	679,478	*21*
Percent of total state population	18.4%	*7*
Recipients of SNAP benefits	621,831	*27*
Total value of issuance	$958,684,325	*27*
Average monthly benefit per recipient	$128.48	*25*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

OKLAHOMA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,247	$1,337	$1,581	$1,544	*7.4%*	*34.4%*
Physician	$402	$433	$452	$479	*6.0%*	*10.7%*
Dental	$131	$127	$124	$123	*-2.1%*	*2.7%*
Other practitioner	$29	$31	$32	$38	*9.4%*	*0.8%*
Clinic and health center	$291	$333	$371	$389	*10.2%*	*8.7%*
Other acute	$252	$256	$322	$345	*11.0%*	*7.7%*
Drugs	$244	$260	$294	$297	*6.8%*	*6.6%*
Institutional LTSS	$632	$623	$681	$746	*5.7%*	*16.6%*
Home and community-based LTSS	$588	$556	$499	$511	*-4.6%*	*11.4%*
Managed care and premium assistance	$174	$171	$153	$192	*3.3%*	*4.3%*
Medicare Premiums and Coinsurance	$128	$141	$133	$133	*1.3%*	*3.0%*
Collections	($257)	($261)	($244)	($314)	*6.9%*	*-7.0%*
Total Spending	**$3,862**	**$4,008**	**$4,398**	**$4,482**	*5.1%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	460	493	491	405	*-4.2%*	*54.3%*
Adult	182	221	244	164	*-3.3%*	*22.0%*
Disabled	121	126	128	117	*-1.1%*	*15.7%*
Aged	66	68	68	60	*-3.5%*	*8.0%*
Total	**829**	**907**	**931**	**745**	*-3.5%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$1,108	$1,213	$1,331	$1,369	*7.3%*	*28.8%*
Adult	$507	$570	$714	$742	*13.5%*	*15.6%*
Disabled	$1,730	$1,703	$1,819	$1,849	*2.2%*	*38.9%*
Aged	$774	$739	$742	$794	*0.8%*	*16.7%*
Total	**$4,119**	**$4,225**	**$4,606**	**$4,754**	*4.9%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$2,889	$3,110	$3,389	$3,385	*5.4%*	
Adult	$4,531	$4,226	$4,600	$4,509	*-0.2%*	
Disabled	$16,034	$15,066	$15,765	$15,796	*-0.5%*	
Aged	$1,334	$12,538	$12,481	$13,360	*115.5%*	
All Enrollees	**$6,227**	**$6,058**	**$6,370**	**$6,377**	*0.8%*	
PER CAPITA EXPENDITURES	**$1,087.60**	**$1,130.75**	**$1,216.45**	**$1,233.23**	*4.3%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

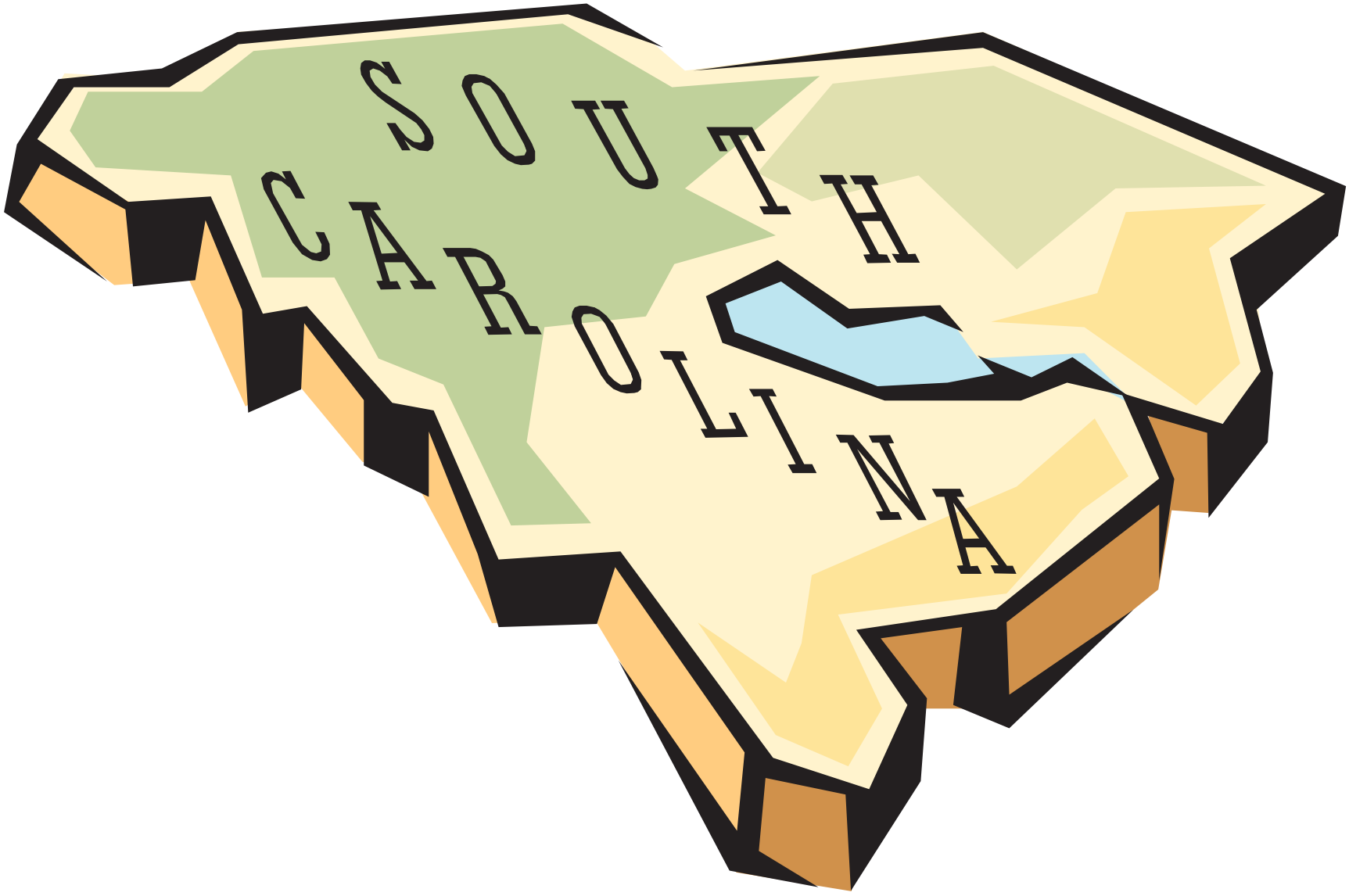
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

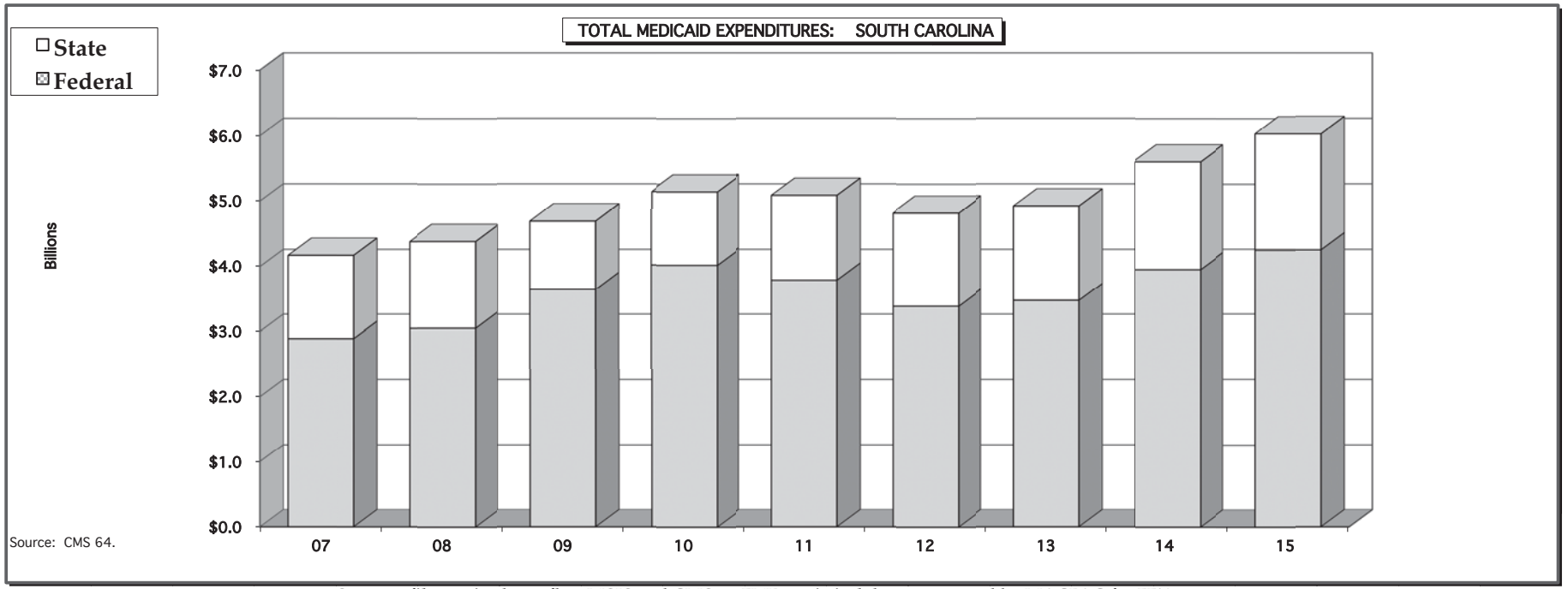
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•ADvantage Waiver: Serves the "frail elderly" (age 65 years and older) and adults with physical disabilities over the age of 21 that qualify for placement in a nursing facility. 23,959 members received services in SFY2012 through this waiver program.
•Community Waiver: Served 2,945 members who are intellectually disabled (ID) and "related conditions" qualified for placement in an intermediate care facility for the intellectually disabled (ICF/ID). This waiver covers children and adults, with the minimum age being 3 years old.
•Homeward Bound Waiver: Designed to serve the needs of individuals who are intellectually disabled or have "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/ID. This waiver covered 729 individuals in SFY 2012.
•In-Home Supports Waiver for Adults: Designed to assist the state in providing adults (ages 18 and older) who are intellectually disabled access to waiver services. This waiver served more than 1,500 adults who would otherwise qualify for placement in an ICF/ID.
•In-Home Supports Waiver for Children: Designed to provide waiver services to children ages 3 through 17 years old with intellectually disabled. During SFY 2012, this waiver served 429 children who qualified for placement in an ICF/ID.
•Medically Fragile: This program offers services to adults age 19 or older who need hospital or skilled nursing facility level of care so they may remain at home or in the residential setting of their choosing. A medically fragile condition is defined as a chronic physical condition which results in prolonged dependency on medical care for which daily skilled nursing intervention is medically necessary. During SFY 2012, 40 members were served.
•My Life; My Choice: Offers adults with physical disabilities ages 19 to 64, who have transitioned from nursing facilities to the residential setting of their choosing through the Living Choice program, an opportunity to enroll in My Life; My Choice following their first year of community living. During SFY 2012, 55 members were served.
•Sooner Seniors: This program offers services to persons 65 and older, with long-term illnesses, who have transitioned from nursing facilities to the residential setting of their choosing through the Living Choice program following their first year of community living.

Managed Care (2013)
•Primary Care Case Management (PCCM): SoonerCare Choice provides a medical home through a primary care physician (PCP)
•Prepaid Ambulatory Health Plan (PAHP): Non-Emergency Transportation (SoonerRide)
•Program of All Inclusive Care for the Elderly (PACE)
•93.7% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: SoonerCare
•147,911 enrollees
•Combination Plan
•Enhanced FMAP: 74.8% in 2013
•Federal Allotment: $114.2 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$4,039,243,153	$4,226,368,216	$4,546,369,802	$4,992,150,984	$4,930,814,886	$4,611,047,760	$4,690,094,944	$5,321,038,897	$5,767,691,574	*5.3%*	*8.4%*
Federal Share	$2,817,242,629	$2,959,803,501	$3,560,256,819	$3,935,513,094	$3,695,163,676	$3,242,314,324	$3,316,650,279	$3,770,711,668	$4,082,623,972	*5.5%*	*8.3%*
State Share	$1,222,000,524	$1,266,564,715	$986,112,983	$1,056,637,890	$1,235,651,210	$1,368,733,436	$1,373,444,665	$1,550,327,229	$1,685,067,602	*4.9%*	*8.7%*
Administrative Costs	$131,781,222	$153,709,511	$147,442,650	$151,178,598	$155,604,433	$204,111,409	$231,544,583	$275,593,704	$260,197,011	*9.2%*	*-5.6%*
Federal Share	$73,501,720	$84,411,389	$83,106,075	$86,752,343	$93,790,010	$138,413,260	$156,682,151	$185,462,837	$172,354,273	*12.6%*	*-7.1%*
State Share	$58,279,502	$69,298,122	$64,336,575	$64,426,255	$61,814,423	$65,698,149	$74,862,432	$90,130,867	$87,842,738	*4.0%*	*-2.5%*
Admin. Costs as % of Payments	3.26%	3.64%	3.24%	3.03%	3.16%	4.43%	4.94%	5.18%	4.51%		
Federal Match Rate*	69.54%	69.79%	79.36%	79.58%	70.04%	70.24%	70.43%	70.57%	70.64%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

SOUTH CAROLINA

Provider Taxes Currently in Place (FFY 12)	Tax Rate	Amount
Hospitals	Hospital tax based on total expenditures of each hospital as a % of total hospital expenditures statewide.	$264,000,000
Total		$264,000,000

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$391,194,227	$388,174,855	$418,343,049	$369,559,336	$474,586,433	$404,834,259	$404,997,905	$446,318,217	$435,532,911	*1.9%*
Mental Hospitals	$52,404,853	$53,835,175	$52,761,795	$48,582,838	$56,065,264	$52,323,602	$52,175,304	$49,069,197	$52,323,601	*-0.5%*
Total	$443,599,080	$442,010,030	$471,104,844	$418,142,174	$530,651,697	$457,157,861	$457,173,209	$495,387,414	$487,856,512	*1.7%*

ACA MEDICAID EXPANSION

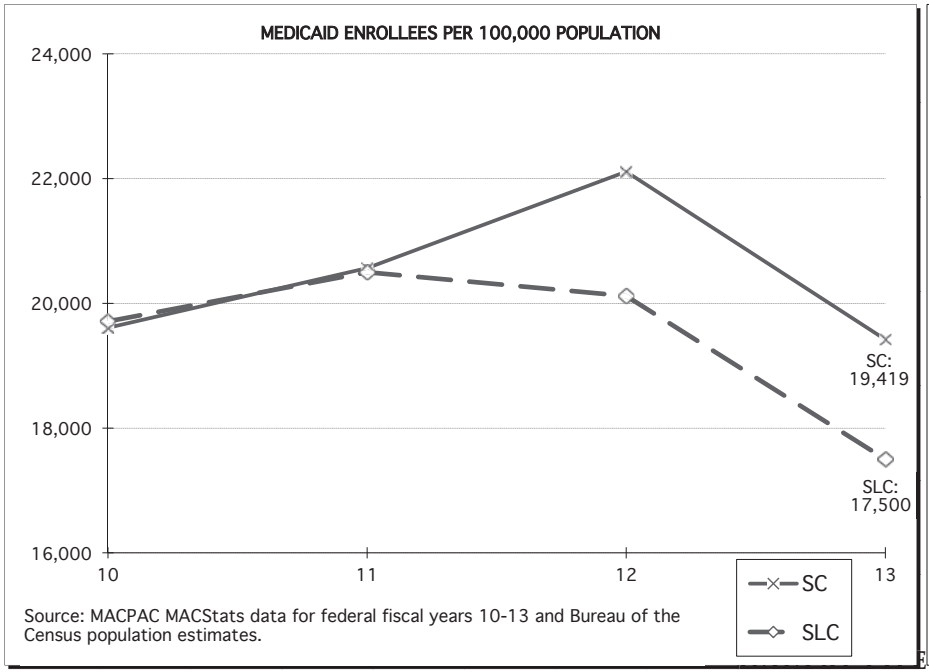
Not expanding Medicaid under ACA as of January 2017.

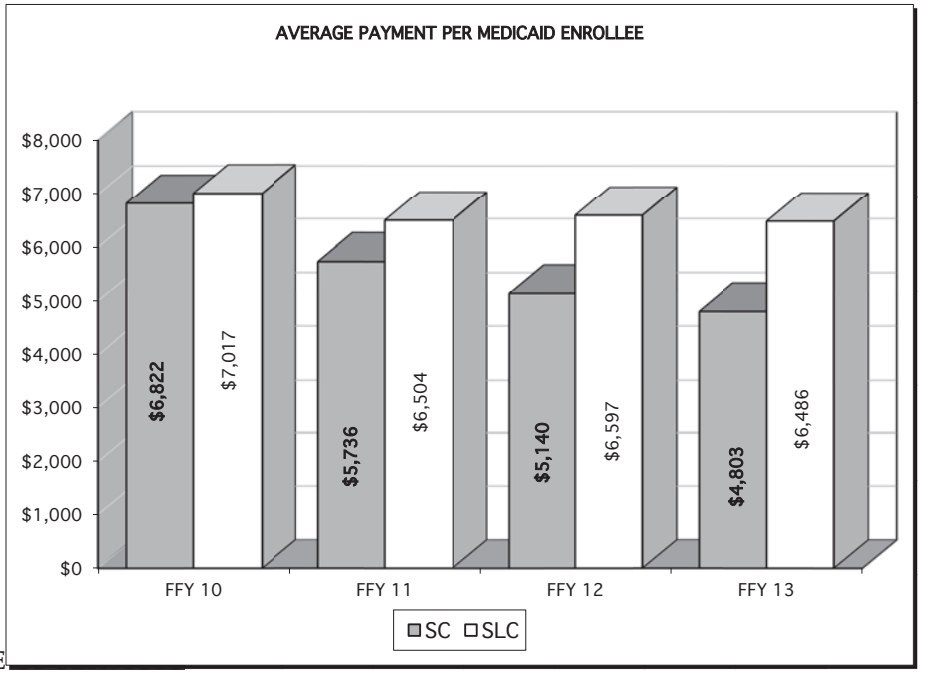
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

		Rank in U.S.
State population—July 1, 2013	4,578,525	*24*
Per capita personal income	$35,453	*48*
Median household income	$44,163	*45*
Population below Federal Poverty Level	860,380	*n/a*
Percent of total state population	18.6%	*10*
Population without health insurance coverage	761,843	*19*
Percent of total state population	16.6%	*15*
Recipients of SNAP benefits	875,866	*21*
Total value of issuance	$1,381,782,118	*21*
Average monthly benefit per recipient	$131.47	*20*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,396	$1,460	$1,121	$1,156	*-6.1%*	*24.6%*
Physician	$276	$244	$191	$214	*-8.1%*	*4.6%*
Dental	$101	$97	$85	$88	*-4.5%*	*1.9%*
Other practitioner	$30	$26	$25	$26	*-4.7%*	*0.6%*
Clinic and health center	$247	$250	$228	$202	*-6.5%*	*4.3%*
Other acute	$229	$223	$318	$288	*7.9%*	*6.1%*
Drugs	$135	$40	$115	$74	*-18.2%*	*1.6%*
Institutional LTSS	$711	$668	$801	$774	*2.9%*	*16.5%*
Home and community-based LTSS	$595	$585	$462	$470	*-7.6%*	*10.0%*
Managed care and premium assistance	$1,290	$1,355	$1,329	$1,441	*3.8%*	*30.7%*
Medicare Premiums and Coinsurance	$161	$181	$172	$173	*2.4%*	*3.7%*
Collections	($181)	($198)	($237)	($216)	*6.1%*	*-4.6%*
Total Spending	**$4,992**	**$4,931**	**$4,611**	**$4,690**	*-2.1%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	464	477	526	489	*1.8%*	*52.8%*
Adult	208	232	257	201	*-1.1%*	*21.7%*
Disabled	154	166	172	157	*0.7%*	*17.0%*
Aged	84	86	88	79	*-1.9%*	*8.5%*
Total	**909**	**961**	**1,044**	**926**	*0.6%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$1,060	$901	$905	$1,023	*-1.2%*	*23.0%*
Adult	$812	$800	$725	$703	*-4.7%*	*15.8%*
Disabled	$2,271	$1,963	$1,844	$1,842	*-6.7%*	*41.4%*
Aged	$1,035	$929	$918	$876	*-5.4%*	*19.7%*
Total	**$5,173**	**$4,598**	**$4,391**	**$4,449**	*-4.9%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$2,705	$2,234	$2,131	$2,094	*-8.2%*	
Adult	$5,334	$4,673	$3,706	$3,499	*-13.1%*	
Disabled	$16,169	$13,145	$11,908	$11,740	*-10.1%*	
Aged	$13,856	$12,177	$11,747	$11,127	*-7.1%*	
All Enrollees	**$6,822**	**$5,736**	**$5,140**	**$4,803**	*-11.0%*	
PER CAPITA EXPENDITURES	**$1,109.46**	**$1,088.53**	**$1,019.87**	**$1,032.12**	*-2.4%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

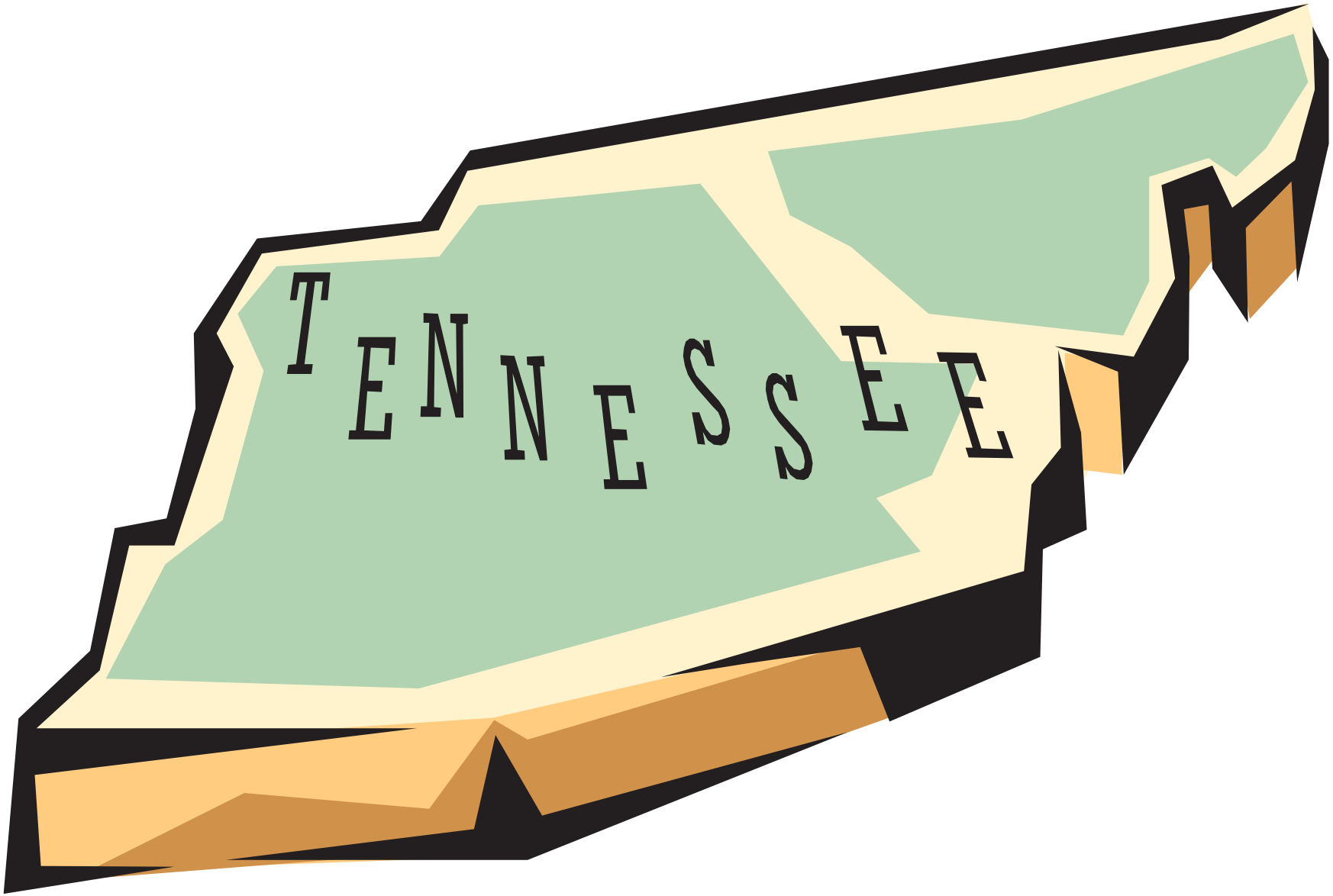
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

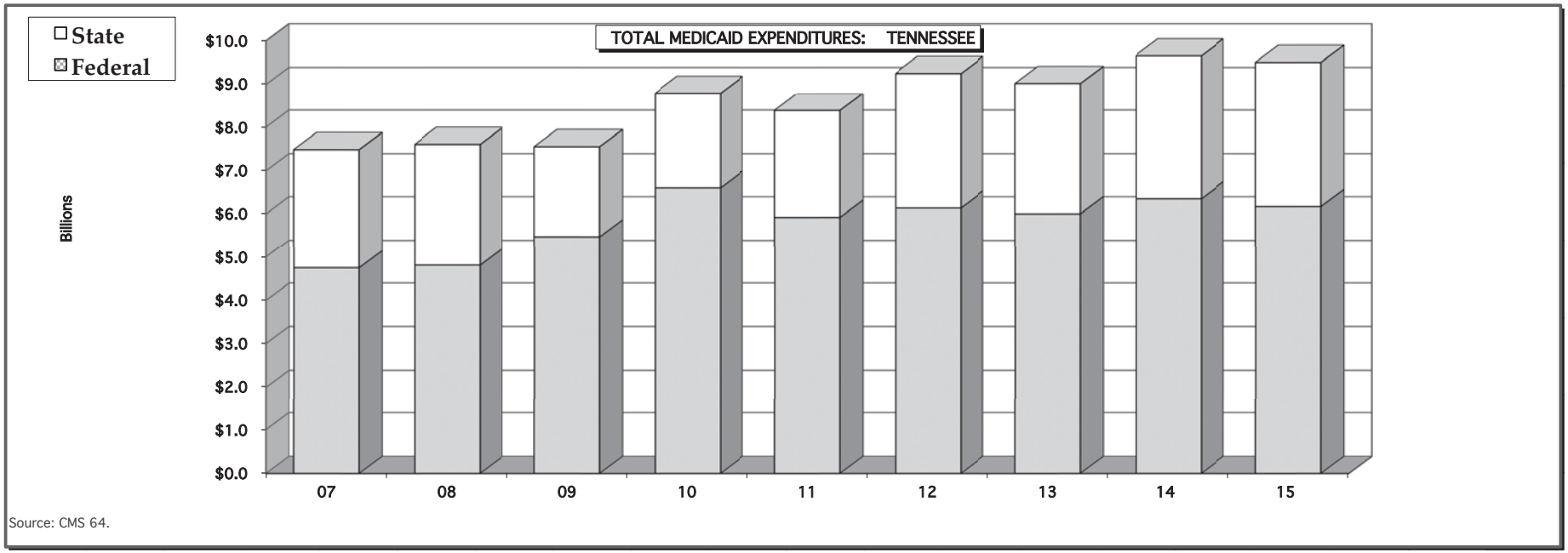
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Intellectual Disability or Related Disabilities (ID/RD) Waiver: The MR/RD Waiver is for persons who (1) have an intellectual disability (mental retardation) or a related disability, (2) are eligible for Medicaid, and (3) who need home and community based services in order to live in the community. Operating since 10/1/1991.
•Head and Spinal Cord Injuries (HASCI) Waiver: Persons up to 65 years of age who have a head or spinal cord injury or both or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to aging. Operating since 7/1/1995.
•Mechanical Ventilator Waiver: Persons age 21 years or older who are dependent upon a mechanical ventilator for breathing and need Nursing Facility level of care. Operating since 12/1/1994.
•Medically Complex Children's Waiver: Persons under the age of 18 who have a chronic medical condition that is expected to last longer than 12 months and is dependent upon comprehensive medical, nursing, and health supervision. Implementation Date 01/01/2009.
•Community Supports Waiver: The eligibility requirements for the Community Supports Waiver are the same as the MR/RD Waiver. Implementation Date 07/01/2009.
•Pervasive Developmental Disorder (PDD) Waiver: Parents or guardians of children ages 3-10 who have been diagnosed with a Pervasive Developmental Disorder by age 8, such as Autism or Asperger's Syndrome, and who require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
•Community Choices Waiver: Persons 18 years of age or older who are unable to perform their own activities of daily living due to illness or disability and who need a Nursing Facility level of care.

Managed Care (2013)
•Medicaid Managed Care Organizations (MCO)
•Primary Care Case Management (PCCM)
•Prepaid Ambulatory Health Plan (PAHP): Transportation
•Program of All Inclusive Care for the Elderly (PACE)
•63.8% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: Healthy Connections Kids
•76,191 enrollees
•Medicaid Expansion
•Enhanced FMAP: 79.3% in 2013
•Federal Allotment: $98.3 M in 2013

STATE MEDICAID PROFILE





Source: CMS 64.

State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$7,070,169,782	$7,133,101,137	$7,246,891,973	$8,441,008,115	$7,969,998,389	$8,751,202,481	$8,677,949,728	$9,205,069,609	$9,094,051,961	*4.1%*	*-1.2%*
Federal Share	$4,508,587,929	$4,557,820,076	$5,307,309,143	$6,407,211,298	$5,692,788,590	$5,826,890,440	$5,784,422,347	$6,063,976,892	$5,916,694,116	*4.4%*	*-2.4%*
State Share	$2,561,581,853	$2,575,281,061	$1,939,582,830	$2,033,796,817	$2,277,209,799	$2,924,312,041	$2,893,527,381	$3,141,092,717	$3,177,357,845	*3.6%*	*1.2%*
Administrative Costs	$413,288,555	$470,990,947	$303,372,656	$353,816,337	$413,622,139	$499,012,090	$344,193,418	$449,172,536	$412,498,278	*-2.2%*	*-8.2%*
Federal Share	$236,708,855	$248,597,132	$166,639,258	$190,120,480	$230,848,573	$308,569,596	$220,129,611	$281,867,286	$250,934,584	*0.2%*	*-11.0%*
State Share	$176,579,700	$222,393,815	$136,733,398	$163,695,857	$182,773,566	$190,442,494	$124,063,807	$167,305,250	$161,563,694	*-5.2%*	*-3.4%*
Admin. Costs as % of Payments	5.85%	6.60%	4.19%	4.19%	5.19%	5.70%	3.97%	4.88%	4.54%		
Federal Match Rate*	63.65%	63.71%	74.23%	75.37%	65.85%	66.36%	66.13%	65.29%	64.99%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
Nursing homes	$2,225 per licensed bed per year	$83,244,800
ICF/MR facilities	5.50%	$13,728,600
Managed Care Org's	5.50%	$309,525,800
Hospital Assessment Fee (implemented in 2011, expires annually)	4.52%	$449,499,800
Total		$855,999,000

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$85,378,380	$165,425,671	$140,721,854	$139,750,254	$139,157,103	$102,252,438	$80,296,386	$0	$817,048,000	*30.5%*
Mental Hospitals	$0	$0	$0	$0	$0	$0	$0	$0	$0	*n/a*
Total	$0	$165,425,671	$140,721,854	$139,750,254	$139,157,103	$102,252,438	$80,296,386	$0	$817,048,000	*30.5%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of January 2017.

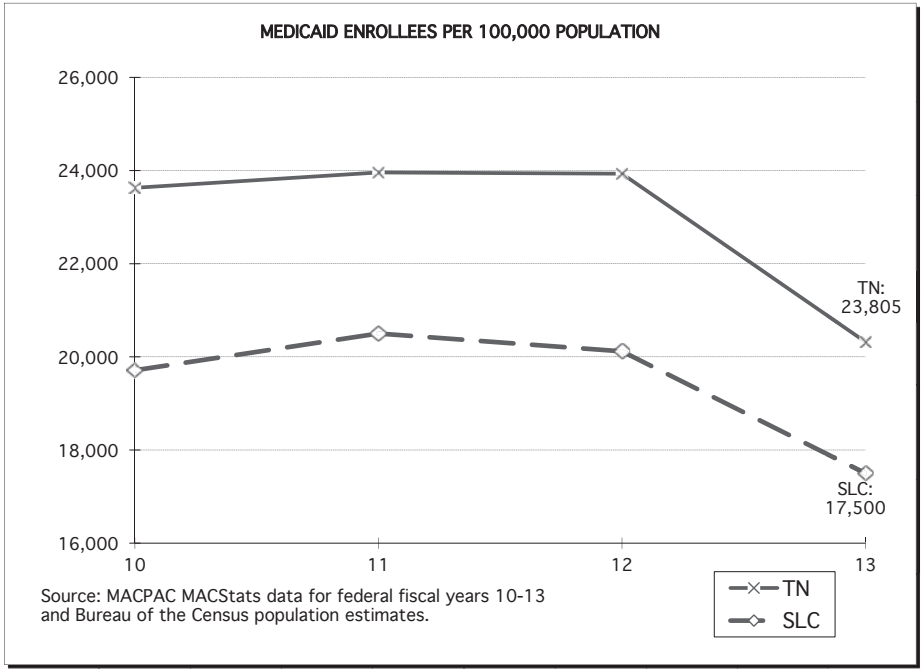
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

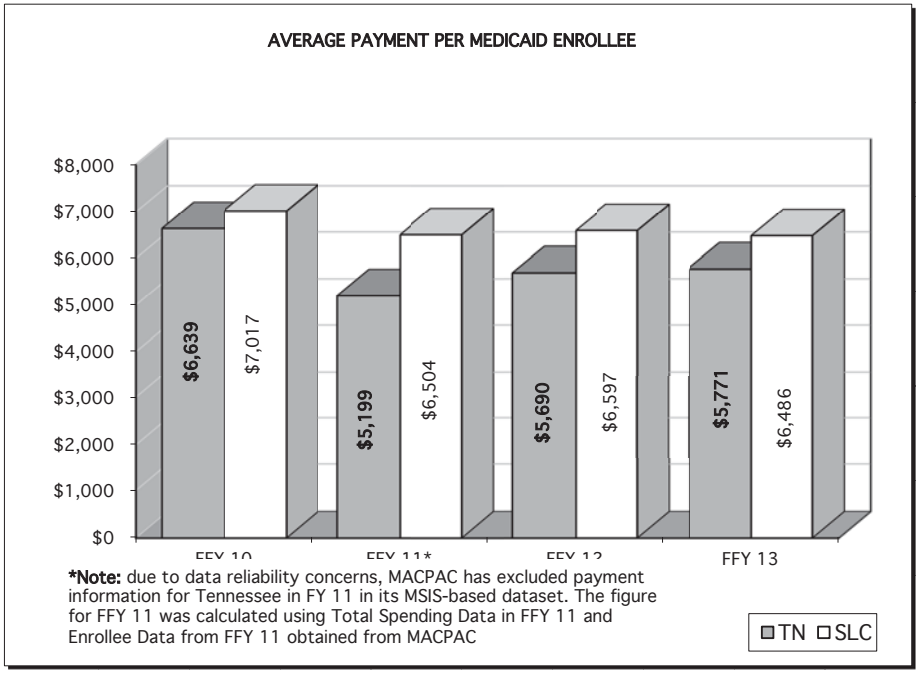
		Rank in U.S.
State population—July 1, 2013	6,300,636	*17*
Per capita personal income	$39,324	*34*
Median household income	$44,297	*43*
Population below Federal Poverty Level		
Percent of total state population	1,126,772	*n/a*
	17.8%	*14*
Population without health insurance coverage		
Percent of total state population	887,807	*16*
	14.1%	*24*
Recipients of SNAP benefits	1,342,089	*11*
Total value of issuance	$2,127,681,953	*11*
Average monthly benefit per recipient	$132.11	*18*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

TENNESSEE





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$962	$974	$1,351	$1,171	*6.8%*	*13.5%*
Physician	$28	$26	$26	$27	*-1.2%*	*0.3%*
Dental	$170	$183	$172	$166	*-0.8%*	*1.9%*
Other practitioner	$0	$1	$1	$1	*n/a*	*0.0%*
Clinic and health center	$30	$39	$37	$42	*11.9%*	*0.5%*
Other acute	$203	$81	$200	$217	*2.2%*	*2.5%*
Drugs	$371	$352	$386	$290	*-7.9%*	*3.3%*
Institutional LTSS	$849	$355	$245	$284	*-30.6%*	*3.3%*
Home and community-based LTSS	$646	$708	$512	$700	*2.7%*	*8.1%*
Managed care and premium assistance	$4,933	$4,959	$5,533	$5,478	*3.6%*	*63.1%*
Medicare Premiums and Coinsurance	$326	$349	$335	$340	*1.4%*	*3.9%*
Collections	($77)	($56)	($47)	($39)	*-20.3%*	*-0.4%*
Total Spending	**$8,441**	**$7,970**	**$8,751**	**$8,678**	*0.9%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (Thousands)	**FFY 10**	**FFY 11***	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	780	794	794	682	*-4.4%*	*51.7%*
Adult	311	322	323	249	*-7.1%*	*18.9%*
Disabled	269	270	278	255	*-1.7%*	*19.3%*
Aged	143	146	150	133	*-2.3%*	*10.1%*
Total	**1,502**	**1,533**	**1,545**	**1,320**	*-4.2%*	*100.0%*
Spending by Basis of Eligibility (Millions)						
Children	$2,095	**n/a**	$1,760	$1,767	*-5.5%*	*23.2%*
Adult	$1,474	**n/a**	$1,226	$1,097	*-9.4%*	*14.4%*
Disabled	$3,484	**n/a**	$3,008	$3,009	*-4.8%*	*39.5%*
Aged	$1,465	**n/a**	$1,534	$1,744	*6.0%*	*22.9%*
Total	**$8,518**	**n/a**	**$7,520**	**$7,617**	*-3.7%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,099	**n/a**	$2,561	$2,594	*-5.8%*	
Adult	$6,019	**n/a**	$4,863	$4,411	*-9.8%*	
Disabled	$14,711	**n/a**	$11,976	$11,776	*-7.1%*	
Aged	$11,752	**n/a**	$11,601	$13,078	*3.6%*	
All Enrollees	**$6,639**	**$5,199**	**$5,690**	**$5,771**	*-4.6%*	
PER CAPITA EXPENDITURES	**$1,383.58**	**$1,310.27**	**$1,432.93**	**$1,388.85**	*0.1%*	

***NOTE:** Due to data reliability concerns regarding completeness and accuracy of monthly reporting and claims, MACPAC excluded payment information in its MSIS-based dataset for TN in FY 11. To adjust for this, a figure generated using FY 11 payments by services divided by total enrollment is included.

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

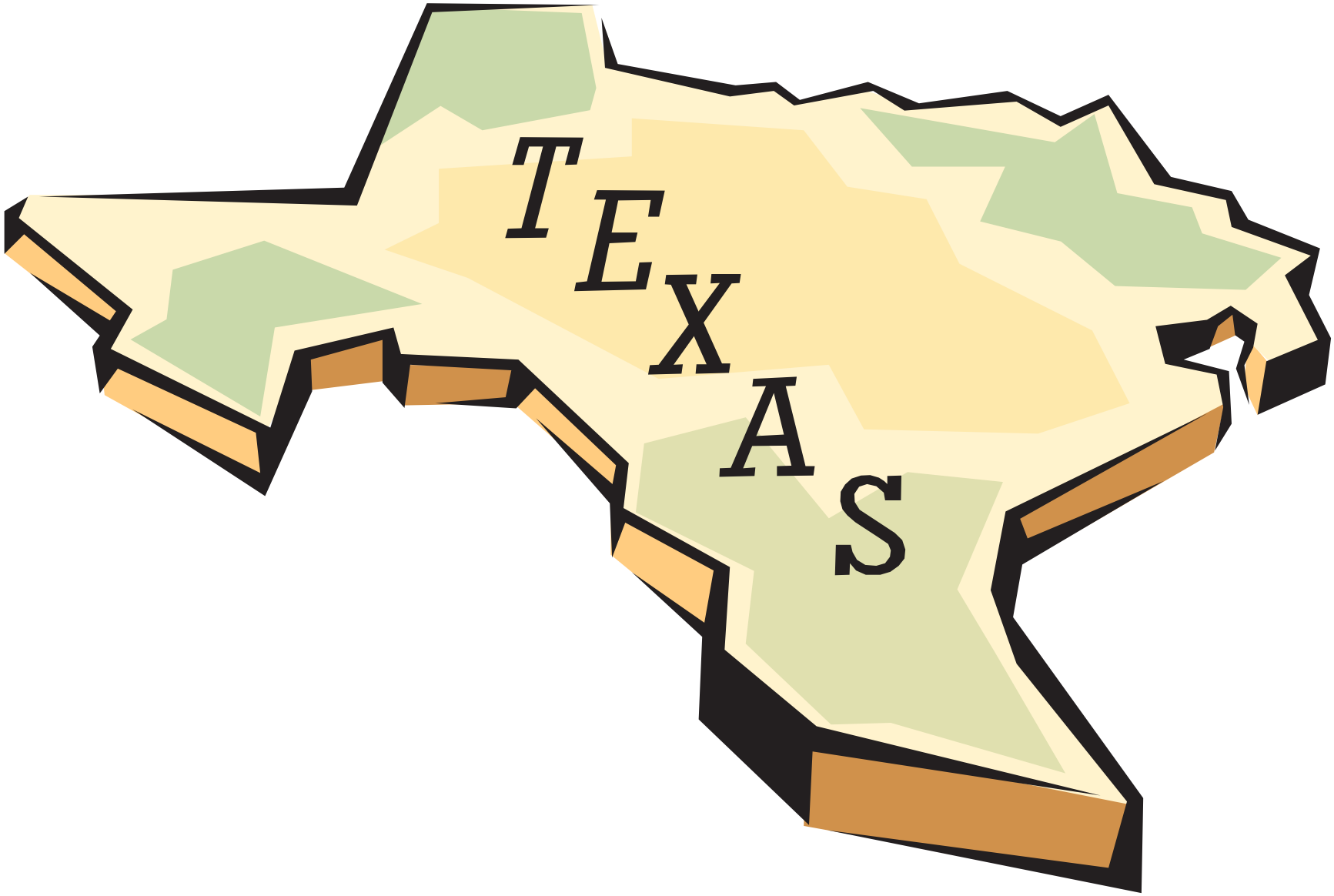
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

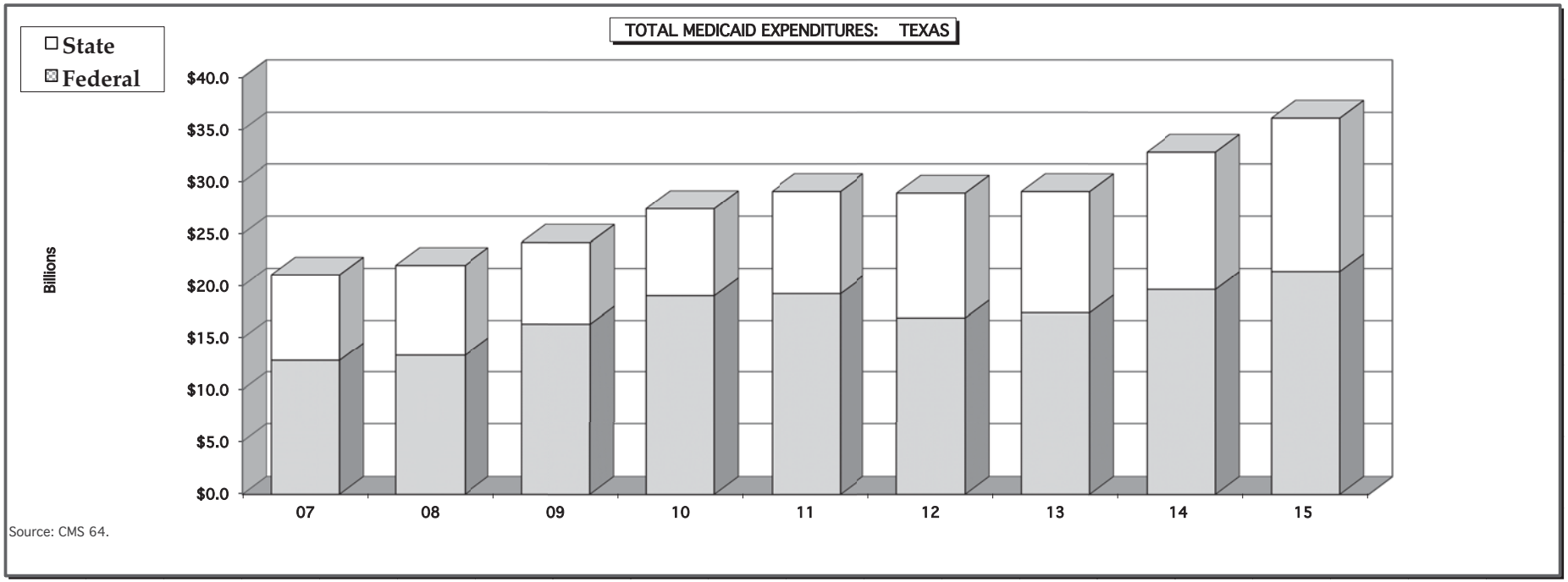
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Statewide Waiver Program: Revised 2007. Serves adults with intellectual disabilities and children under age six with developmental delay who qualify for and, absent the provision of services provided under the Statewide Waiver, would require placement in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
•Comprehensive Aggregate Cap Waiver (formerly Arlington Waiver): Serves individuals with intellectual disabilities who are former members of the certified class in the United States vs. the State of Tennessee, et al. (Arlington Developmental Center), current members of the certified class in the United States vs. the State of Tennessee, et al. (Clover Bottom Developmental Center), and individuals transitioned from the Statewide Waiver (#0128) upon its renewal on 1/1/2015, because they were identified by the state as receiving services in excess of the individual cost neutrality cap established for the Statewide Waiver.
•Self Determination Waiver: Approved 2008. Serves children and adults with intellectual disabilities and children under age 6 with developmental delay who qualify for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private ICF/IID.

Managed Care (2013)
•Medicaid Managed Care Organizations (MCO)
•Program of All Inclusive Care for the Elderly (PACE)
•100% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: CoverKids
•106,473 enrollees
•Combination Plan
•Enhanced FMAP: 76.29% in 2013
•Federal Allotment: $200.2 M in 2013

STATE MEDICAID PROFILE





State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$20,278,820,695	$21,097,176,058	$23,000,014,985	$26,330,687,310	$27,847,444,279	$27,523,481,436	$27,752,018,303	$31,385,332,042	$34,691,253,016	*8.6%*	*10.5%*
Federal Share	$12,352,298,914	$12,805,382,892	$15,710,507,711	$18,476,569,185	$18,506,767,529	$16,075,487,604	$16,596,182,377	$18,790,089,123	$20,430,316,745	*8.1%*	*8.7%*
State Share	$7,926,521,781	$8,291,793,166	$7,289,507,274	$7,854,118,125	$9,340,676,750	$11,447,993,832	$11,155,835,926	$12,595,242,919	$14,260,936,271	*9.5%*	*13.2%*
Administrative Costs	$778,912,684	$880,809,038	$1,198,329,490	$1,100,367,349	$1,247,805,292	$1,410,297,449	$1,334,144,546	$1,445,978,048	$1,456,423,687	*8.7%*	*0.7%*
Federal Share	$440,210,762	$481,722,418	$636,883,348	$586,821,439	$757,489,799	$860,762,277	$831,745,114	$883,762,761	$972,251,209	*12.4%*	*10.0%*
State Share	$338,701,922	$399,086,620	$561,446,142	$513,545,910	$490,315,493	$549,535,172	$502,399,432	$562,215,287	$484,172,478	*3.3%*	*-13.9%*
Admin. Costs as % of Payments	3.84%	4.18%	5.21%	4.18%	4.48%	5.12%	4.81%	4.61%	4.20%		
Federal Match Rate*	60.78%	60.53%	69.85%	70.94%	60.56%	58.22%	59.30%	58.69%	58.05%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
ICF services assessment	5.50%	$60,625,665
Managed Care/Insurance	1.75%	$309,812,324
Total		$1,419,290,449

Note: Includes all collections of insurance premium tax, which is not limited to Medicaid managed care (or health insurance). The rate of 1.75% applies to health insurance, variable rates for other insurance.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13**	FFY 14**	FFY 15	*Annual Change*
General Hospitals	$1,188,607,754	$1,153,726,484	$1,434,371,469	$1,395,676,375	$1,286,627,916	$1,223,452,073	$106,251,351	$1,409,171,616	$2,026,527,612	*9.8%*
Mental Hospitals	$249,637,138	$305,085,587	$311,291,390	$292,569,701	$292,513,583	$292,513,592	$120,496,590	$117,064,477	$303,496,529	*-0.1%*
Total	$1,438,244,892	$1,458,812,071	$1,745,662,859	$1,688,246,076	$1,579,141,499	$1,515,965,665	$226,747,941	$1,526,236,093	$2,330,024,141	*8.1%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of January 2017.

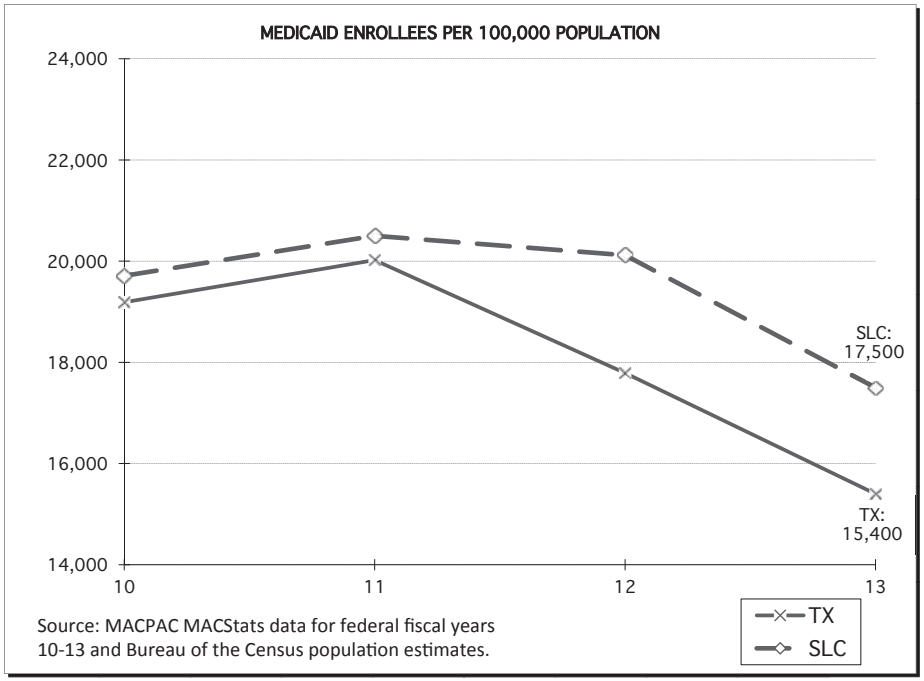
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

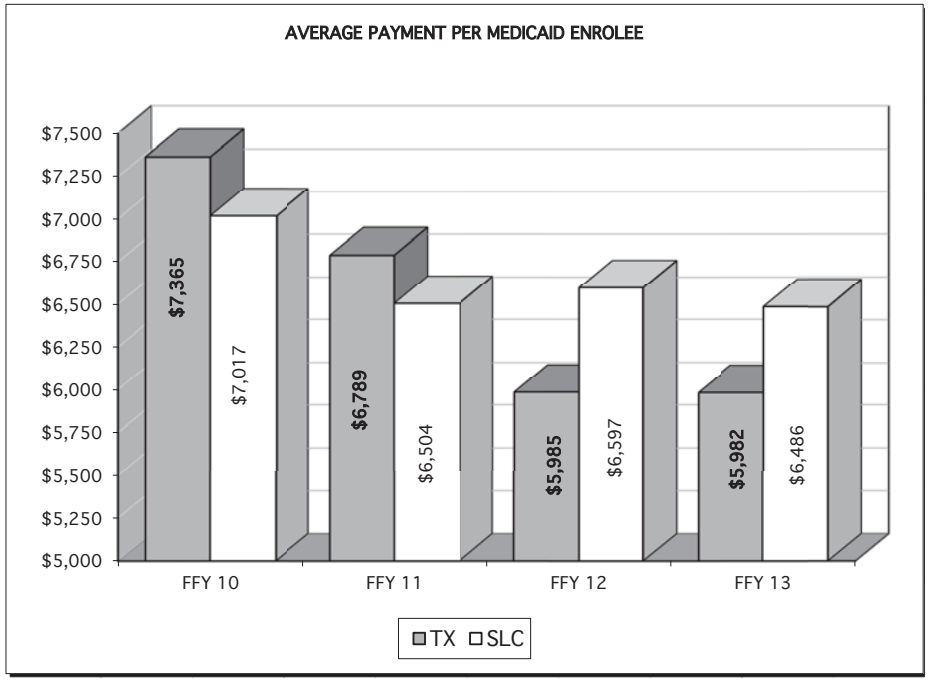
		Rank in U.S.
State population—July 1, 2013	26,060,796	*2*
Per capita personal income	$43,552	*25*
Median household income	$51,704	*24*
Population below Federal Poverty Level		
Percent of total state population	4,530,039	*n/a*
	17.5%	*15*
Population without health insurance coverage		
Percent of total state population	5,746,305	*2*
	22.8%	*1*
Recipients of SNAP benefits	4,041,891	*2*
Total value of issuance	$5,934,441,831	*2*
Average monthly benefit per recipient	$122.35	*46*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

TEXAS





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$8,062	$7,742	$5,939	$4,918	*-15.2%*	*-102.7%*
Physician	$1,156	$1,336	$1,184	$1,130	*-0.8%*	*-101.8%*
Dental	$1,280	$1,428	$688	$93	*-58.3%*	*-107.4%*
Other practitioner	$849	$822	$448	$240	*-34.4%*	*-107.5%*
Clinic and health center	$130	$128	$79	$35	*-35.4%*	*-114.0%*
Other acute	$1,845	$2,033	$2,427	$2,855	*15.7%*	*-95.7%*
Drugs	$1,277	$1,457	$282	$283	*-39.5%*	*-106.5%*
Institutional LTSS	$3,407	$3,348	$3,783	$3,565	*1.5%*	*-98.3%*
Home and community-based LTSS	$3,322	$3,466	$2,456	$2,149	*-13.5%*	*-103.4%*
Managed care and premium assistance	$4,930	$5,760	$9,983	$12,044	*34.7%*	*-96.1%*
Medicare Premiums and Coinsurance	$940	$1,045	$1,016	$1,025	*2.9%*	*-97.0%*
Collections	($869)	($718)	($762)	($587)	*-12.3%*	*-94.5%*
Total Spending	**$26,331**	**$27,847**	**$27,523**	**$27,752**	*1.8%*	*-99.1%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	2,514	3,256	2,979	2,590	*1.0%*	*63.5%*
Adult	1,003	719	557	389	*-27.1%*	*9.5%*
Disabled	867	688	654	669	*-8.3%*	*16.4%*
Aged	460	473	451	433	*-2.0%*	*10.6%*
Total	**4,844**	**5,136**	**4,641**	**4,081**	*-5.6%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$8,758	$9,121	$7,971	$7,390	*-5.5%*	*30.2%*
Adult	$2,584	$2,321	$1,828	$1,688	*-13.2%*	*6.9%*
Disabled	$10,962	$10,875	$9,848	$10,620	*-1.0%*	*43.4%*
Aged	$4,896	$4,669	$4,753	$4,796	*-0.7%*	*19.6%*
Total	**$27,200**	**$26,986**	**$24,375**	**$24,471**	*-3.5%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,698	$3,567	$3,056	$2,846	*-8.4%*	
Adult	$7,524	$6,153	$4,610	$4,306	*-17.0%*	
Disabled	$18,937	$17,409	$15,248	$15,820	*-5.8%*	
Aged	$12,199	$11,183	$11,138	$11,045	*-3.3%*	
All Enrollees	**$7,365**	**$6,789**	**$5,985**	**$5,982**	*-6.7%*	
PER CAPITA EXPENDITURES	**$1,086.62**	**$1,134.12**	**$1,109.01**	**$1,097.56**	*0.3%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

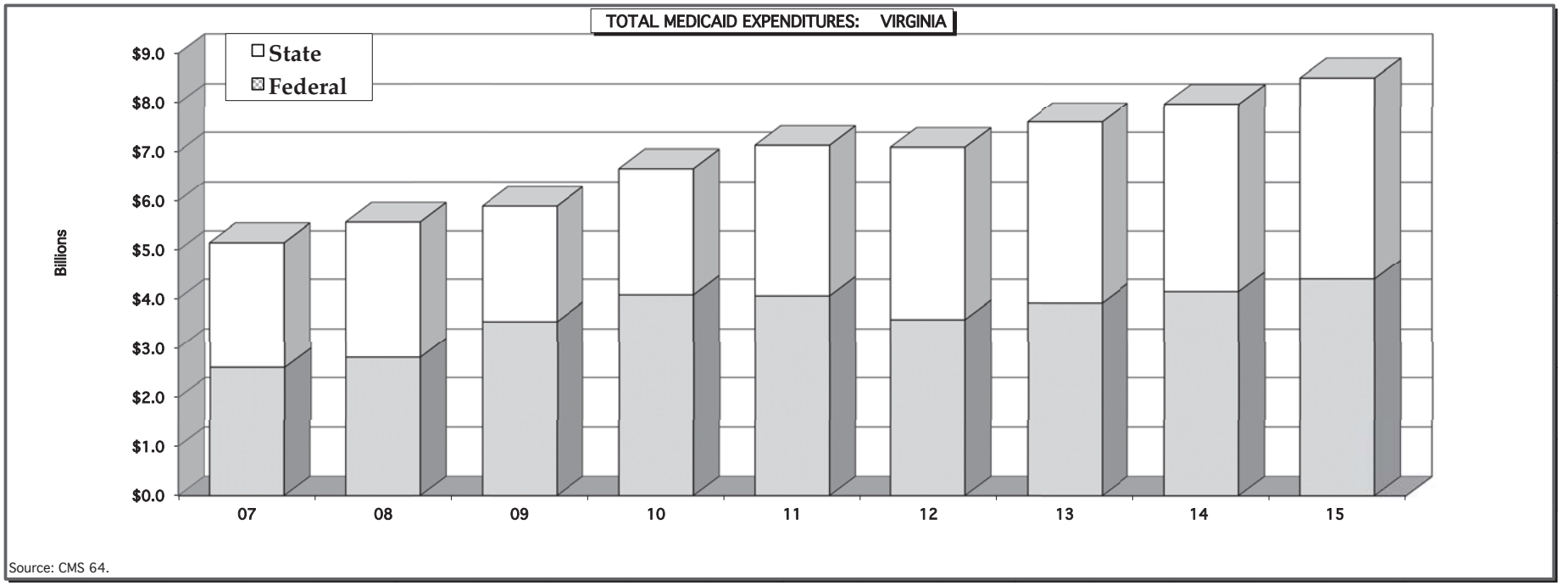
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Community Based Alternatives (CBA): Provides services to aged and disabled adults as a cost-effective alternative to institutionalization.
•Medically Dependent Children's Program (MDCP): Provides home and community-based services to clients under 21 years of age. Service include respite, adjunct supports, adaptive aids, and minor home modification.
•Community Living Assistance and Support Services (CLASS): Provides home and community-based services to persons who have a "related" condition diagnosis qualifying them for placement in an Intermediate Care Facility for persons who have a disability, other than mental retardation originating before age 22.
•Deaf Blind with Multiple Disabilities (DBMD): Provides home and community-based services to adult individuals diagnosed with deaf, blind, and multiple disabilities.
•Home and Community-based Services (HCS): Provides individualized services to consumers living in their family's home, their own homes, or other settings in the community.
•Texas Home Living Waiver (TxHml): Provides individualized services not to exceed $10,000 per year to consumers living in their family's home, their own homes, or other settings in the community.
•Consolidated Waiver: Consolidates CBA, MDCP, CLASS, HCS, and DBMD waivers. Community care case managers develop individualized service plans based on the participant's needs.
•Youth Empowerment Services (YES): Provides comprehensive home and community-based mental health services to youth between the ages of 3 and 18, up to a month before a youth's 19th birthday, who have a serious emotional disturbance.
•STAR+PLUS Waiver: Texas Medicaid managed care program for people who have disabilities or are age 65 or older. People in STAR+PLUS get Medicaid health-care and long-term services and support through a medical plan that they choose.

Managed Care (2013)
•Primary Care Case Management (PCCM)
•Commercial Managed Care Organization (MCO)
•Medicaid Managed Care Organization (MCO)
•Prepaid Inpatient Health Plan (PIHP)
•Prepaid Ambulatory Health Plan (PAHP): Disease Management
•Program of All Inclusive Care for the Elderly (PACE)
•77.3% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: CHIP
•1,034,613 enrollees
•Separate Plan (State Designed Plan)
•Enhanced FMAP: 71.51% in 2013
•Federal Allotment: $891.5 M in 2013

STATE MEDICAID PROFILE



State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$4,882,347,418	$5,327,738,218	$5,692,752,496	$6,407,859,287	$6,893,824,841	$6,806,627,571	$7,218,485,856	$7,547,405,238	$8,032,760,161	*7.1%*	*6.4%*
Federal Share	$2,453,890,344	$2,678,148,723	$3,431,195,336	$3,937,766,039	$3,922,796,258	$3,411,794,033	$3,653,871,309	$3,843,104,790	$4,070,113,405	*7.2%*	*5.9%*
State Share	$2,428,457,074	$2,649,589,495	$2,261,557,160	$2,470,093,248	$2,971,028,583	$3,394,833,538	$3,564,614,547	$3,704,300,448	$3,962,646,756	*6.9%*	*7.0%*
Administrative Costs	$268,985,215	$236,492,480	$193,479,683	$253,485,327	$235,060,591	$282,620,895	$386,507,673	$432,778,067	$478,019,593	*12.4%*	*10.5%*
Federal Share	$147,276,329	$127,519,890	$105,288,044	$137,687,458	$129,748,947	$166,781,392	$257,003,612	$298,749,755	$329,813,829	*17.2%*	*10.4%*
State Share	$121,708,886	$108,972,590	$88,191,639	$115,797,869	$105,311,644	$115,839,503	$129,504,061	$134,028,312	$148,205,764	*5.3%*	*10.6%*
Admin. Costs as % of Payments	5.51%	4.44%	3.40%	3.96%	3.41%	4.15%	5.35%	5.73%	5.95%		
Federal Match Rate*	50.00%	50.00%	61.59%	61.59%	50.00%	50.00%	50.00%	50.00%	50.00%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

VIRGINIA

Provider Taxes Currently in Place (FFY 12)

	Tax Rate	Amount
ICF/DD tax	5.50%	$8,000,000

Note: ICF/MR DD tax added in 2012.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$174,234,203	$166,447,863	$138,141,501	$192,435,368	$189,370,089	$207,850,861	$179,290,338	$169,297,631	$9,125,582	*-38.4%*
Mental Hospitals	$5,235,334	$6,648,533	$7,129,293	$6,284,784	$5,882,489	$6,690,321	$7,178,095	$9,396,945	$11,572,492	*9.7%*
Total	$179,469,537	$173,096,396	$145,270,794	$198,720,152	$195,252,578	$214,541,182	$186,468,433	$178,694,576	$20,698,074	*-29.8%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of January 2017.

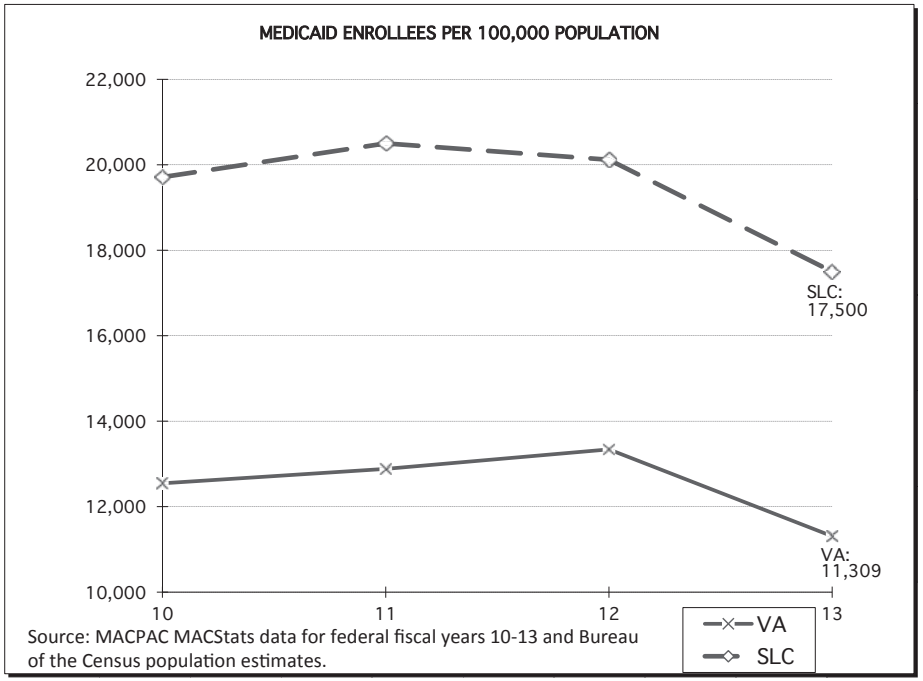
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

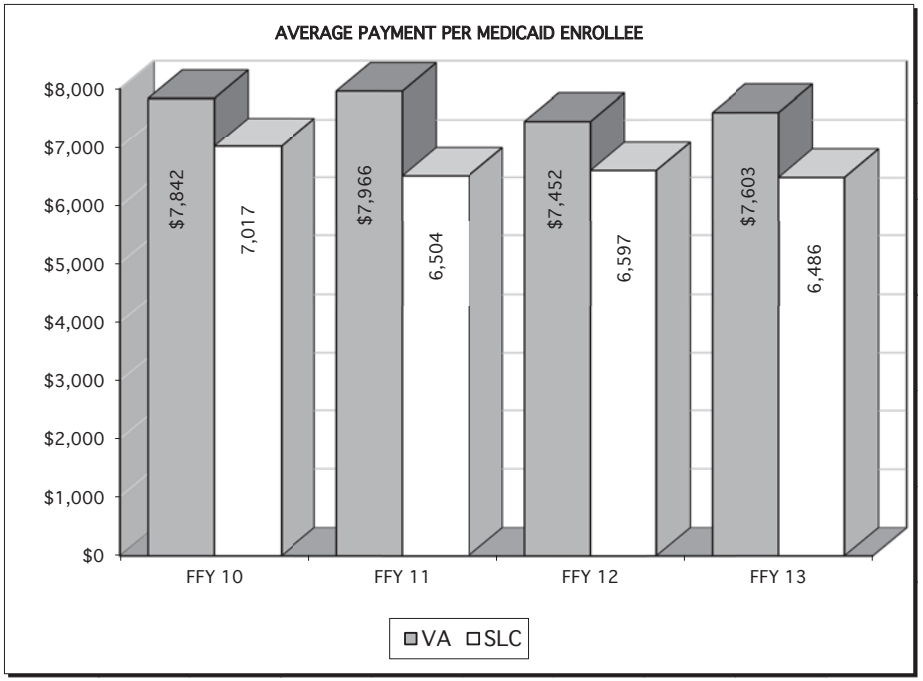
		Rank in U.S.
State population—July 1, 2013	7,881,300	*12*
Per capita personal income		
Median household income	$48,773	*10*
	$62,666	*9*
Population below Federal Poverty Level		
Percent of total state population	938,733	*n/a*
	11.7%	*44*
Population without health insurance coverage		
Percent of total state population	973,047	*13*
	12.3%	*31*
Recipients of SNAP benefits		
	940,932	*14*
Total value of issuance		
Average monthly benefit per recipient	$1,442,442,319	*16*
	$127.75	*29*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

VIRGINIA





DATA BY TYPE OF SERVICE

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$1,120	$1,156	$1,055	$1,011	*-3.4%*	*14.0%*
Physician	$197	$202	$194	$178	*-3.3%*	*2.5%*
Dental	$126	$135	$136	$139	*3.3%*	*1.9%*
Other practitioner	$25	$32	$37	$35	*11.9%*	*0.5%*
Clinic and health center	$58	$59	$56	$52	*-3.6%*	*0.7%*
Other acute	$706	$756	$909	$980	*11.6%*	*13.6%*
Drugs	$132	$125	$72	$27	*-41.1%*	*0.4%*
Institutional LTSS	$1,078	$1,120	$1,263	$1,292	*6.2%*	*17.9%*
Home and community-based LTSS	$1,132	$1,276	$1,159	$1,229	*2.8%*	*17.0%*
Managed care and premium assistance	$1,672	$1,890	$1,804	$2,118	*8.2%*	*29.3%*
Medicare Premiums and Coinsurance	$220	$259	$223	$228	*1.2%*	*3.2%*
Collections	($60)	($115)	($100)	($73)	*6.8%*	*-1.0%*
Total Spending	**$6,408**	**$6,894**	**$6,807**	**$7,218**	*4.0%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	551	566	580	496	*-3.5%*	*53.0%*
Adult	169	180	208	163	*-1.1%*	*17.5%*
Disabled	177	186	190	173	*-0.8%*	*18.5%*
Aged	110	113	115	102	*-2.3%*	*10.9%*
Total	**1,007**	**1,045**	**1,093**	**935**	*-2.4%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$1,507	$1,581	$1,405	$1,499	*-0.2%*	*21.1%*
Adult	$666	$770	$743	$810	*6.7%*	*11.4%*
Disabled	$2,910	$3,039	$3,085	$3,247	*3.7%*	*45.7%*
Aged	$1,377	$1,424	$1,459	$1,549	*4.0%*	*21.8%*
Total	**$6,467**	**$6,814**	**$6,692**	**$7,105**	*3.2%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$3,289	$3,345	$2,889	$3,021	*-2.8%*	
Adult	$5,903	$6,419	$5,255	$4,970	*-5.6%*	
Disabled	$18,421	$18,372	$18,166	$18,762	*0.6%*	
Aged	$14,475	$14,543	$14,464	$15,115	*1.5%*	
All Enrollees	**$7,842**	**$7,966**	**$7,452**	**$7,603**	***-1.0%***	
PER CAPITA EXPENDITURES	**$829.99**	**$878.94**	**$865.24**	**$919.82**	*3.5%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

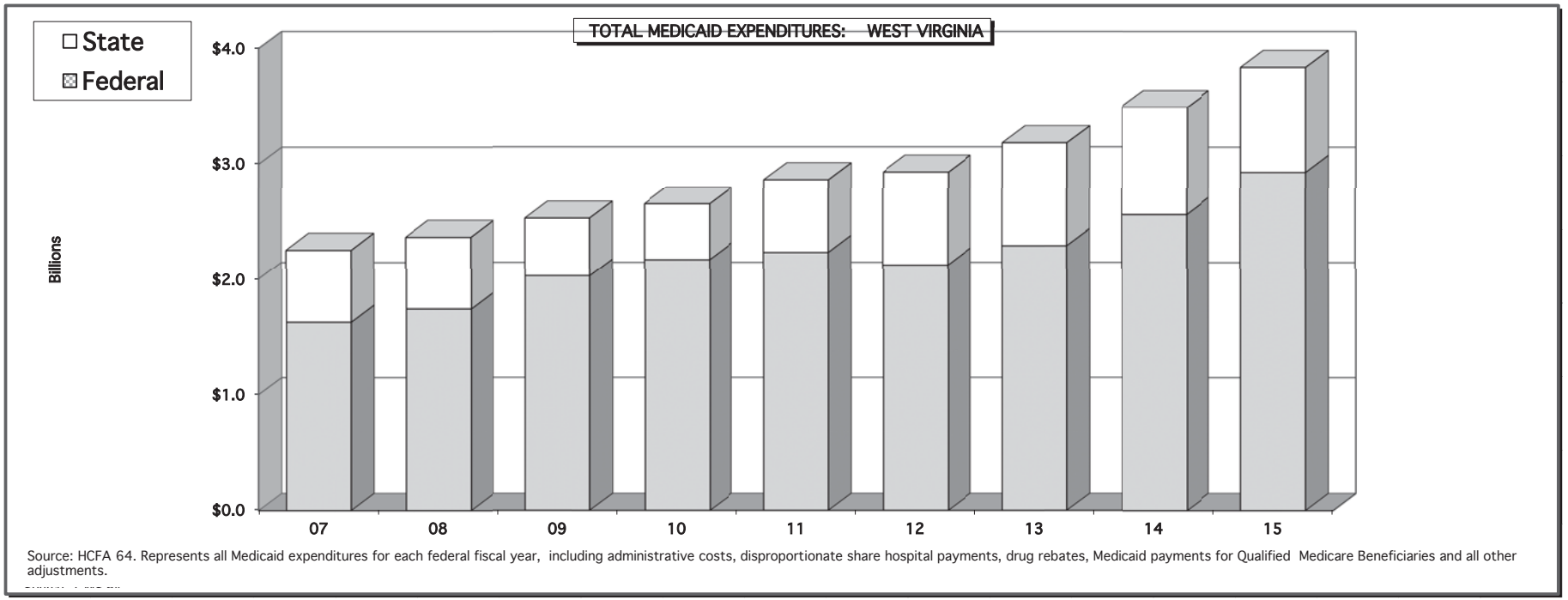
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Elderly or Disabled with Consumer-Direction (EDCD) Waiver: Individuals who: (1) Meet the NF level of care criteria (i.e., they are functionally dependent and have a medical nursing needs); (2) Are determined to be at imminent risk of nursing facility (NF) placement; and (3) Are determined that community- based care services under the waiver are the critical services that enable the individual to remain at home rather than begin placed in a NF.
•Day Supports (DS) Waiver: Individuals on the statewide waiting list for the ID Waiver (Urgent or Non-Urgent List) are eligible. Implemented 7/1/2008.
•Familyand Individual Support Developmental Disabilities Support (DD) Waiver: Individuals who are 6 years of age and older who have a Developmental Disability diagnosis or a related condition and do not have a diagnosis of Intellectual Disability (ID) who: (1) meet the ICF/ID level of care criteria; (2) are determined to be at imminent risk of ICF/ID placement, and (3) are determined that community-based care services under the waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF/ID.
•HIV/AIDS Waiver: Operating since 7/1/1991.
•Technology Assisted Waiver: Individuals who are dependent upon technological support and require substantial, ongoing skilled nursing care.
•Alzheimer's Assisted Living Waiver: Individuals that have Alzheimer's disease, meet the criteria, and reside in an assisted living facility (ALF) special care unit and are receiving an Auxiliary Grant. Implementation date is 8/1/2006.
•Intellectual Disability: Individuals who are up to 6 years of age who are at developmental risk and individuals age 6 and older who have an intellectual disability (ID).
•Children's Mental Health Waiver PRTF: Services children who have serious emotional disturbance or mental illness. This waiver is being phased out. Current participants will be served until services are no longer needed or they are transferred to other programs. No new participants will be accepted.

Managed Care (2013)
•Commercial Managed Care Organization (MCO)
•Medicaid Managed Care Organization (MCO)
•Program of All Inclusive Care for the Elderly (PACE)
•67.8% of Medicaid enrollment in managed care as of 7/11/2013

Children's Health Insurance Program: Family Access to Medical Insurance Security (FAMIS)
•196,911 enrollees
•Combination Plan
•Enhanced FMAP: 65% in 2013
•Federal Allotment: $186.6 M in 2013

STATE MEDICAID PROFILE



Source: HCFA 64. Represents all Medicaid expenditures for each federal fiscal year, including administrative costs, disproportionate share hospital payments, drug rebates, Medicaid payments for Qualified Medicare Beneficiaries and all other adjustments.

State profiles revised to reflect MSIS and CMS-64 FMR statistical data as reported by MACPAC for FFYs 10 - 13.

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Rate of Change*	*Total Change 14-15*
Medicaid Payments	$2,158,876,640	$2,263,593,055	$2,420,608,803	$2,538,797,193	$2,740,221,609	$2,772,398,537	$3,007,417,198	$3,331,020,307	$3,646,548,197	*8.3%*	*9.5%*
Federal Share	$1,574,222,875	$1,682,971,968	$1,962,989,221	$2,100,793,549	$2,154,459,093	$2,012,242,414	$2,169,266,932	$2,453,945,284	$2,801,327,715	*8.9%*	*14.2%*
State Share	$584,653,765	$580,621,087	$457,619,582	$438,003,644	$585,762,516	$760,156,123	$838,150,266	$877,075,023	$845,220,482	*6.5%*	*-3.6%*
Administrative Costs	$91,446,119	$98,351,418	$105,848,951	$111,317,982	$123,894,669	$158,435,156	$173,666,274	$157,246,389	$189,201,652	*11.5%*	*20.3%*
Federal Share	$52,207,104	$57,492,637	$62,843,340	$67,300,284	$77,270,641	$108,797,039	$119,744,994	$105,129,621	$127,876,384	*14.3%*	*21.6%*
State Share	$39,239,015	$40,858,781	$43,005,611	$44,017,698	$46,624,028	$49,638,117	$53,921,280	$52,116,768	$61,325,268	*7.0%*	*17.7%*
Admin. Costs as % of Payments	4.24%	4.34%	4.37%	4.38%	4.52%	5.71%	5.77%	4.72%	5.19%		
Federal Match Rate*	72.82%	74.25%	83.05%	83.05%	73.24%	72.62%	72.04%	71.09%	71.35%		

**Rate shown is for Medicaid payments only. The FMAP (Federal Medical Assistance Percentage) is based on the relationship between each state's per capita personal income and that of the nation as a whole for the 3 most recent years. Federal share of state administrative costs is usually 50% or 75%, depending on function and whether or not medical personnel are used. **FFYs 09, 10, and 11 reflect a blended ARRA adjusted rate per Kaiser State Health Facts.*

WEST VIRGINIA

Provider Taxes Currently in Place (FFY 12)

	Tax Rate *	Amount
•Hospitals (inpatient and outpatient services)	2.50%	$101,300,211
•ICF/MR-DD	5.50%	$4,508,774
•Nursing Facility Services	5.50%	$41,470,907
•Lab and X-Ray services	5.00%	$2,311,488
•Physicians	0.20%	$197,748
•Ambulatory surgical	1.75%	$914,529
•Other (reflected below)	variable	$17,856,690
Total		$168,560,346

Note: Taxes on dental, behavioral health, chiropractic, emergency ambulance, nursing, optician, optometry, podiatry, psychological, and therapist services. Certain provider fees in this category being phased out beginning June 2010.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	*Annual Change*
General Hospitals	$55,900,839	$53,979,213	$54,543,590	$55,087,700	$54,442,288	$56,579,382	$56,546,478	$55,524,660	$53,721,215	*-0.1%*
Mental Hospitals	$18,938,365	$18,684,131	$18,846,282	$18,887,044	$18,870,720	$18,882,149	$18,887,659	$18,887,045	$18,869,278	*0.2%*
Total	$74,839,204	$72,663,344	$73,389,872	$73,974,744	$73,313,008	$75,461,531	$75,434,137	$74,411,705	$72,590,493	*0.0%*

ACA MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014.

*Coverage to certain individuals (mainly adults) to 138% of the Federal Poverty Level.

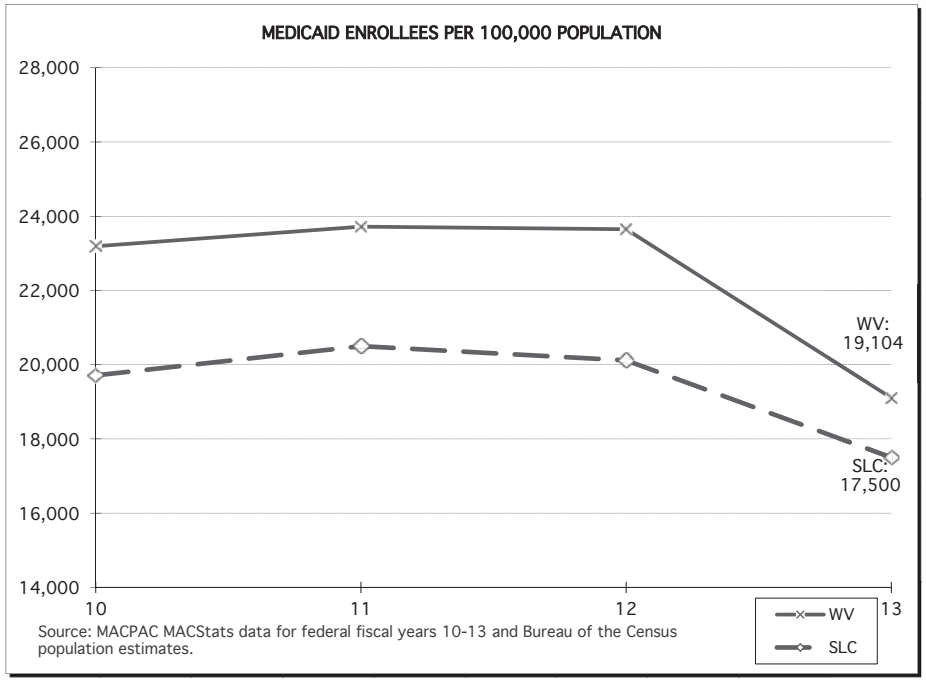
DEMOGRAPHIC DATA & POVERTY INDICATORS (2013)

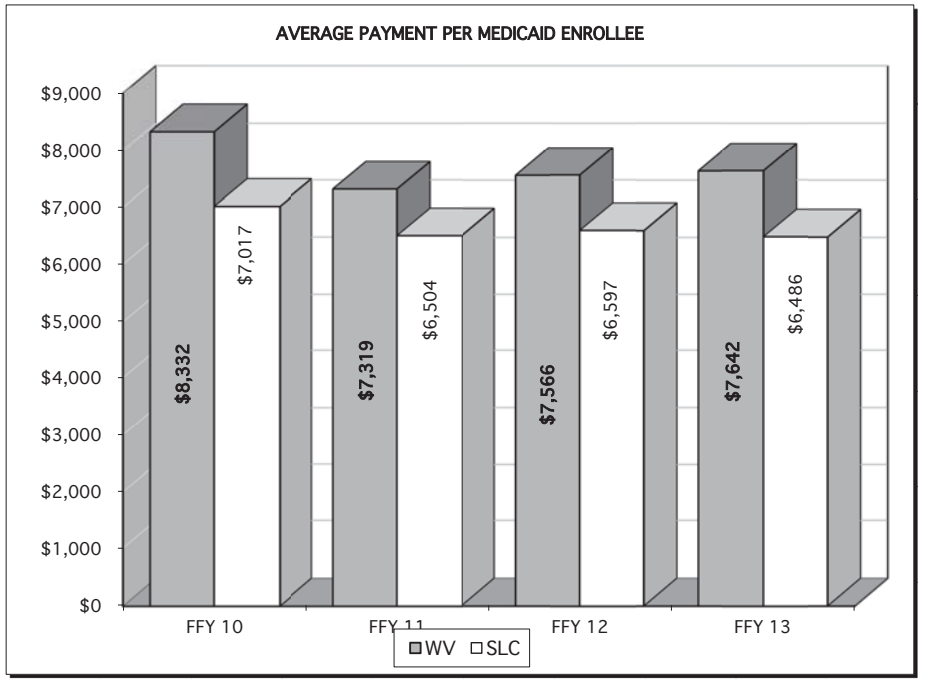
		Rank in U.S.
State population—July 1, 2013	1,824,020	*37*
Per capita personal income	$35,613	*47*
Median household income	$41,253	*49*
Population below Federal Poverty Level	332,347	*n/a*
Percent of total state population	18.5%	*12*
Population without health insurance coverage	261,520	*37*
Percent of total state population	14.3%	*22*
Recipients of SNAP benefits	350,695	*35*
Total value of issuance	$504,485,785	*35*
Average monthly benefit per recipient	$119.88	*49*

Note: 2013 federal poverty level is $11,490 per year for a single person, $15,510 for a family of two and $19,530 for a family of three.

Sources: Bureau of the Census; Bureau of Economic Analysis; and USDA Food & Nutrition Service (FNS) SNAP State Activity Report.

WEST VIRGINIA





DATA BY TYPE OF SERVICE

SPENDING BY TYPE OF SERVICES	FFY 10	FFY 11	FFY 12	FFY 13	*Annual Change*	*Share of FFY 13*
Hospital	$511	$620	$480	$588	*4.8%*	*19.6%*
Physician	$183	$148	$143	$147	*-7.0%*	*4.9%*
Dental	$56	$58	$55	$56	*0.0%*	*1.9%*
Other practitioner	$13	$13	$14	$14	*2.5%*	*0.5%*
Clinic and health center	$30	$31	$30	$31	*1.1%*	*1.0%*
Other acute	$113	$126	$238	$242	*28.9%*	*8.0%*
Drugs	$155	$162	$120	$103	*-12.7%*	*3.4%*
Institutional LTSS	$543	$568	$701	$716	*9.7%*	*23.8%*
Home and community-based LTSS	$517	$570	$553	$572	*3.4%*	*19.0%*
Managed care and premium assistance	$323	$343	$341	$440	*10.9%*	*14.6%*
Medicare Premiums and Coinsurance	$109	$120	$114	$115	*1.8%*	*3.8%*
Collections	($14)	($18)	($17)	($17)	*6.7%*	*-0.6%*
Total Spending	**$2,539**	**$2,741**	**$2,772**	**$3,007**	*5.8%*	*100.0%*

Source: MACPAC datasets based on CMS-64 FMR data for FFY 10-13

DATA BY ENROLLEE CHARACTERISTICS

Enrollees By Basis of Eligibility (thousands)	**FFY 10**	**FFY 11**	**FFY 12**	**FFY 13**	*Annual Change*	*Share of FFY 13*
Children	204	208	208	166	*-6.6%*	*47.0%*
Adult	65	65	64	40	*-15.0%*	*11.2%*
Disabled	56	124	124	110	*25.0%*	*31.1%*
Aged	29	44	44	38	*9.2%*	*10.7%*
Total	**430**	**440**	**439**	**354**	*-6.3%*	*100.0%*
Spending by Basis of Eligibility (millions)						
Children	$414	$446	$429	$495	*6.2%*	*16.8%*
Adult	$194	$252	$242	$283	*13.4%*	*9.6%*
Disabled	$1,218	$1,332	$1,352	$1,477	*6.7%*	*50.1%*
Aged	$728	$655	$692	$696	*-1.5%*	*23.6%*
Total	**$2,553**	**$2,685**	**$2,714**	**$2,949**	*4.9%*	*100.0%*
Average Spending by Basis of Eligibility						
Children	$2,488	$2,662	$2,587	$2,972	*6.1%*	
Adult	$4,824	$6,228	$6,010	$7,143	*14.0%*	
Disabled	$11,432	$12,119	$12,222	$13,423	*5.5%*	
Aged	$20,052	$17,533	$18,041	$18,278	*-3.0%*	
All Enrollees	**$7,319**	**$7,566**	**$7,642**	**$8,332**	*4.4%*	
PER CAPITA EXPENDITURES	**$1,429.23**	**$1,544.04**	**$1,578.87**	**$1,716.73**	*6.3%*	

Source: MACPAC datasets based on MSIS data for FFY 10-13

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: "State Health Facts", The Henry Kaiser Foundation, 2015; state annual report for FY 15 & Medicaid Website; and "Medicaid Managed Care Enrollment Report", CMS 2015.

Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Aged and Disabled Waiver Program (ADW): A long-term care alternative that provides services that enable an individual to remain at or return home rater than receiving nursing home care.
•Intellectual/Developmental Disabilities (I/DD) Waiver (formerly the MR/DD Waiver): Provides services that instruct, train, support, supervise, and assist individuals who have intellectual disabilities and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible in their lives.

•Traumatic Brain Injury (TBI) Waiver: Prevent unnecessary institutionalization by providing services and supports that are person-centered and promotes choice, independence, participant-directed, respect, dignity and community integration.

Managed Care (2013)
•Commercial Managed Care Organization (MCO)
•Primary Care Case Management (PCCM)
•52.8% of Medicaid enrollment in managed care as of 7/1/2013

Children's Health Insurance Program: CHIP
•37,065 enrollees
•Separate Plan (State Designed Plan)
•Enhanced FMAP: 80.43% in 2013
•Federal Allotment: $48.3 M in 2013