Colorado HEALTH Institute

Colorado Medicaid

primer

Colorado Health Institute

Denver, Colorado

Colorado Medicaid

Three things to know . . .

- Medicaid is a publicly financed program that provides health and long-term care coverage to three groups of low-income Coloradans: individuals with disabilities, children and some parents, and elders (65+).

- Medicaid is a state/federal partnership that accounts for one-fifth of Colorado's state budget.

- As the single largest source of federal funding ($1.3 billion) in Colorado's state budget, Medicaid has a substantial impact on the state's economy by generating services and supplies, jobs, income, and state tax revenues.

A NOTE TO THE READER

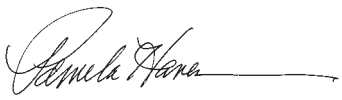
I am pleased to share with you the first in a series of primers about the Medicaid program to be published by the Colorado Health Institute (CHI). Our primers are intended to provide basic facts and objective information about important issues related to health and health care in Colorado.

Although Medicaid was enacted nearly 40 years ago along with Medicare, the program is not well understood. Medicaid plays a substantial role in Colorado's health care system by providing health and long-term care coverage to the state's most vulnerable populations. Although Colorado's Medicaid program is widely regarded as one of the leanest in the nation, it has been a pioneer with regard to home and community-based services for the elderly and disabled populations. These services are both responsive to the needs of the enrollee and cost-effective for the state.

Medicaid is the single largest source of federal matching funds flowing into Colorado. These funds not only make the Colorado health care dollar twice as efficient as if it were spent alone, but they have a significant ripple effect throughout the economy—generating services and supplies, jobs, income, and state tax revenues.

In spite of intense fiscal pressure, the program continues to meet the acute and long-term health care needs of more than 388,000 Coloradans. With the passage of the Amendment 35 tobacco tax initiative, Colorado policymakers will debate how they should appropriate these new health care dollars. These discussions may result in expanded enrollments in Medicaid and the children's health insurance program.

I hope you find this publication informative and that it will contribute to a better understanding of Medicaid by Colorado policymakers, policy analysts, and interested consumers. An introduction to the basic facts of Medicaid can only enhance dialogue and the process of adapting the program to meet future challenges.



Pamela P. Hanes, Ph.D.
President and Chief Executive Officer

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Acknowledgments

The Colorado Health Institute (CHI) wishes to acknowledge staff members Hollis A.Hope and Reid T. Reynolds for research and writing. In addition, CHI thanks the following individuals for their review and insightful feedback on draft versions of this publication: Elisabeth Arenales, Melodie Beck, Michael Boyson, Vivianne Chaumont, Johanna Donlin, Whitney Gustin, Tracy Johnson, Martha King, Lorez Meinhold, Dann Milne, and Barbara Yondorf. And, special thanks to California HealthCare Foundation and Health Policy Institute of Ohio colleagues for providing excellent models.

The Colorado Health Institute (CHI) was established in 2002 as a nonprofit corporation to serve as an independent source of objective, non-partisan health information for Colorado decision-makers in the public and private sectors. CHI was established and funded through a memorandum of understanding between the The Colorado Trust, Caring for Colorado, and Rose Community Foundation.

Table of Contents

Colorado HEALTH Institute

What is Medicaid?

Medicaid is a publicly financed source of health insurance and long-term care coverage for certain eligible population groups. After employer-based coverage, it is the second largest source of health coverage in the nation. Medicaid is anticipated to cover 8.3 percent of Colorado's population in 2005, at a cost of $2.6 billion.

Medicaid is a state/federal partnership that has a significant impact on Colorado's economy—particularly because it draws federal matching funds to the state. Nationally in 2002, the federal government paid for 57 percent of the $250 billion in total Medicaid expenditures. The federal government contributes approximately $1.00 for every dollar of state Medicaid spending in Colorado. The matching rate varies from state to state; ranging in 2005 from $1.00 for every dollar of state Medicaid spending in wealthier states like Colorado, to $3.36 in poorer states. Medicaid accounts for 18.8 percent of the state budget and represents a significant portion of total spending in Colorado on health care services.

How does Medicaid differ from Medicare?

Medicaid ...	Medicare ...
■ is a partnership between the federal government and the states with jointly shared funding and administration. ■ provides health and long-term care coverage to low-income children and their parents, elders, and individuals with disabilities. ■ is a "means-tested" program: individuals must meet certain income criteria and resource (asset) tests in order to qualify.	■ is the federally funded health insurance program for Americans 65 and older, and for many adults with permanent disabilities. ■ provides acute care coverage but very limited long-term care and no prescription drug coverage (to change effective 2006 under the Medicare Modernization Act). ■ requires U.S. citizenship or legal residence for at least five continuous years; an age of 65 or above and eligible for Social Security; or an age below 65 and receiving Social Security due to a permanent disability.

Medicaid was enacted in 1965 at the same time as Medicare with the passage of the Social Security Amendments of 1965 (P.L. 89-97). However, Medicaid and Medicare serve very different purposes. Colorado implemented Medicaid in January 1969. State participation in Medicaid is voluntary and all 50 states choose to participate. Medicaid provides health care coverage to low-income dependent children and their very low-income parents, pregnant women, low-income elders, and individuals with disabilities. It is jointly funded and managed by the federal government and

Colorado HEALTH Institute

the states. Non-disabled, non-elderly single and childless adults, regardless of their income, are ineligible for Medicaid.

In Colorado, Medicaid is administered by the Department of Health Care Policy and Financing (HCPF) within broad federal guidelines and rules that ensure a minimum level of coverage to certain population groups. Colorado has flexibility to cover additional "optional" population groups and services. The state of Colorado is responsible for establishing its own eligibility criteria, benefits package, payment rates, and program administration.

Nationally in 2002, the federal government paid for 57 percent of the $250 billion in total Medicaid expenditures. The federal government contributes approximately $1.00 for every dollar of state Medicaid spending in Colorado.

Who does Medicaid Cover?

As an "entitlement" program, states are required to provide coverage to all individuals in certain population categories. Medicaid eligibility is generally based on an individual's family income and resources and, in some cases, his or her health care needs. Income eligibility criteria are based on federal poverty guidelines for most Medicaid enrollees. Since states have flexibility to expand eligibility ceilings (but may not lower the "floor" or federal minimum to qualify), specific criteria vary greatly among the states.

Medicaid provides three types of health care coverage:
1) health care services for low-income families (mostly women) with children and low-income individuals who are elderly or have disabilities;
2) long-term care for older low-income Americans (65+) and individuals with disabilities; and
3) assistance with co-pays and deductibles for low-income Medicare beneficiaries.

In Colorado, Medicaid covers:

- one in 12 individuals
- one in six children
- 10 percent of all individuals age 65 and above
- six in 10 persons in nursing facilities
- labor and delivery for one in three births

Medicaid Eligibility Groups

Federal statutes define more than 50 groups of individuals that may qualify for Medicaid coverage. Colorado Medicaid covers many distinct groups, each with its own specific eligibility criteria. It may be useful to think in terms of four broad categories of Medicaid eligible groups: elders, individuals with disabilities, pregnant women and parents (mostly women) of low-income children, and low-income children. The major categories within each of these groups are shown in the chart and described briefly below.

Elders

- **SSI** – Individuals age 65 and older who qualify for federal Supplemental Security Income (SSI) payments automatically qualify for Medicaid. For an elderly individuals to qualify for SSI they must have incomes less than 74 percent of FPL and limited resources (less than $2,000 for an individual and $3,000 for a couple). Virtually all SSI recipients age 65 and older also have Medicare coverage.
- **300 Percent eligibles** – Individuals age 65 and older who qualify for nursing facility care because of serious physical or mental impairments, may have incomes up to 300 percent

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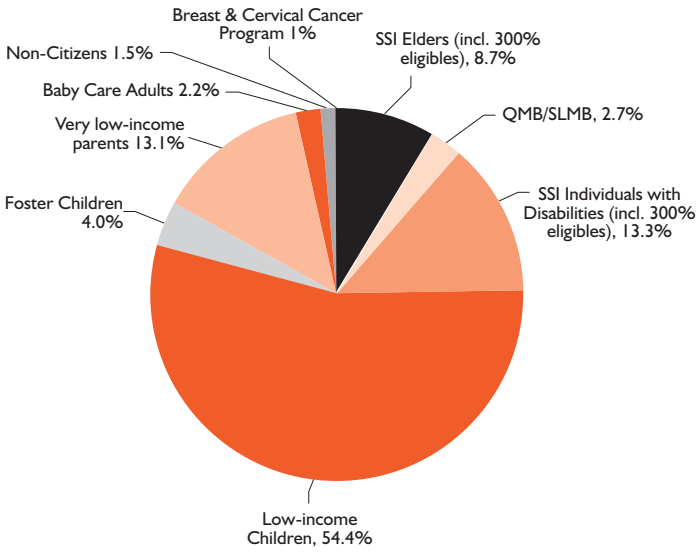
Projected Medicaid Enrollees in Colorado FY 2004-2005



Source: Department of Health Care Policy and Financing, FY 2005-2006 Budget Request, Exhibit O

2004 Federal Poverty Guidelines (FPL) for 48 Contiguous States and Washington, D.C. (in dollars)

Family Size	36% FPL	74% FPL	100% FPL	133% FPL	185% FPL	219% FPL	250% FPL
1	3,352	4,376	9,310	12,382	17,224	20,389	23,275
2	4,496	9,243	12,490	16,612	23,107	27,353	31,225
3	5,641	11,596	15,670	20,841	28,990	34,317	39,175
4	6,786	13,949	18,850	25,071	34,873	41,282	47,125

Source: Federal Register, Vol. 69, No. 30, February 13, 2004

of the SSI standard (219 percent of FPL) and limited resources.

- **Qualified Medicare Beneficiaries (QMB), Specified Low-income Medicare Beneficiaries (SLMB), and Medicare-qualifying Individuals** – Low-income individuals age 65 and older with limited resources who are not eligible for Medicaid benefits, but the state is obligated to pay some or all of their Medicare premiums, out-of-pocket co-insurance payments, and deductibles.

Individuals with Disabilities

- **SSI with disabilities** – Individuals with disabilities of all ages up to 65 who receive SSI cash assistance payments because of a medical condition that prevents them from working (or children who have a severe functional limitation) expected to last at least 12 months or result in death.
- **300 percent eligibles** – Individuals with disabilities under 65 who qualify for nursing facility care because of serious physical or mental impairments may have incomes up to 300 percent of the SSI standard (219 percent of FPL) and limited resources.

Children

- **Low-income children** – Children living in families with low incomes and limited resources are eligible for Medicaid coverage. For children under the age of 6, the income threshold is 133 percent of FPL, for children over 6, the income threshold is 100 percent of FPL.
- **Foster children** – Children who are in state-sponsored adoption assistance programs or foster care are automatically eligible for Medicaid coverage through age 20.

Adults

- **Very low-income parents** – Parents of Medicaid-enrolled children who earn no more than 36 percent of FPL (the Aid to Families with Dependent Children standard as of July 16, 1996) or who are eligible for transitional Medicaid because their incomes have recently increased above the 36 percent threshold.
- **Baby care adults** – Pregnant women and new mothers (60 days post partum) with incomes below 133 percent of FPL.
- **Non-citizens** – Federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for U.S. citizenship.
- **Breast and Cervical Cancer Program** – Uninsured women or those with very limited health care coverage up to 250 percent of FPL, 40-64 years of age with breast or cervical cancer who meet the eligibility criteria.

Dual Eligibility

An important feature of the Medicaid (and Medicare) programs is that there is a sizeable group of people (38 percent in 2002) who are enrolled in both programs. Virtually all elderly Medicaid enrollees are also enrolled in Medicare. Because Medicare does not currently cover prescription drugs or long-term care, Medicaid covers a large portion of the total health care costs for low-income elders. In addition, individuals with disabilities receiving Social Security Disability Income (SSDI) automatically qualify for Medicare as well as Medicaid. The implementation of the Medicare Modernization Act of 2003 will introduce a prescription drug benefit for Medicare beneficiaries.

Mandatory versus Optional Eligibility Categories

Originally intended to assist very low-income populations, states initially had little latitude to cover additional populations. Since the early 1980s, the federal government has given states tools and greater flexibility to expand coverage. In addition to mandatory categorically eligible populations, the federal government has designated certain populations as "optional" for states to include in their Medicaid programs. However, Colorado's Medicaid eligibility requirements cover fewer optional populations than many other states. Populations for whom Medicaid eligibility is optional are more vulnerable and at risk of losing coverage when budget constraints force policymakers to consider cost-cutting measures.

Colorado covers several "optional" categories of individuals, the most significant of which is the 300 percent SSI eligible components of elders and individuals with disabilities. Federally approved optional population groups that Colorado does not serve include women and children with incomes above the federally defined level for mandatory coverage and the "medically needy" (individuals whose out-of-pocket medical expenses lead them to "spend down" to a specified level). Colorado ranks 49th out of 50 states in terms of the percentage of low-income adults who are covered by Medicaid.

Children's Health Insurance Program

In 1997, Congress created a new option for states to cover low-income children not qualifying for Medicaid. The State Children's Health Insurance Program (SCHIP) gives states the option to amend their Medicaid program to include additional children under this initiative or to create a separate program. Colorado developed a separate program known as the Children's Basic Health Plan or Child Health Plan Plus (CHP+) that serves children and pregnant women up to 185 percent of the federal poverty level. In FY 2004-2005 the CHP+ program is expected to enroll 47,600 children and cover prenatal and delivery costs for 874 pregnant women at a cost of $69 million. A detailed discussion of CHP+ is beyond the scope of this primer and CHP+ enrollees and expenditures are not included in the Medicaid figures presented.

For the most part, the Colorado Medicaid program is a "bare bone" program providing mainly the federally required services for federally required populations.

--Joint Budget Committee Staff Briefing Appendix "A Look at the Colorado Medicaid Program," December 8, 2003

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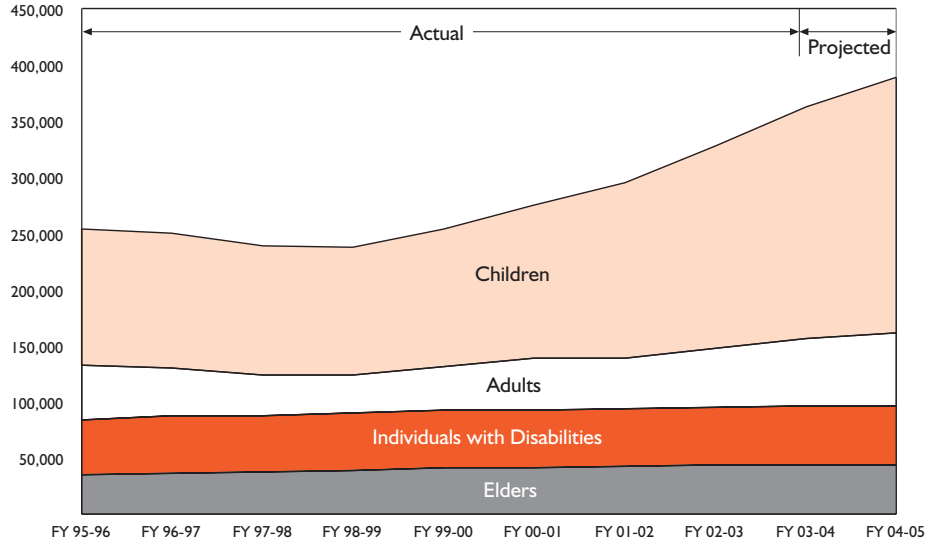
Medicaid Enrollment Growth, FY 1995-1996 to FY 2004-2005



Source: Department of Health Care Policy and Financing, FY 2005-2006 Budget Request, Exhibit A

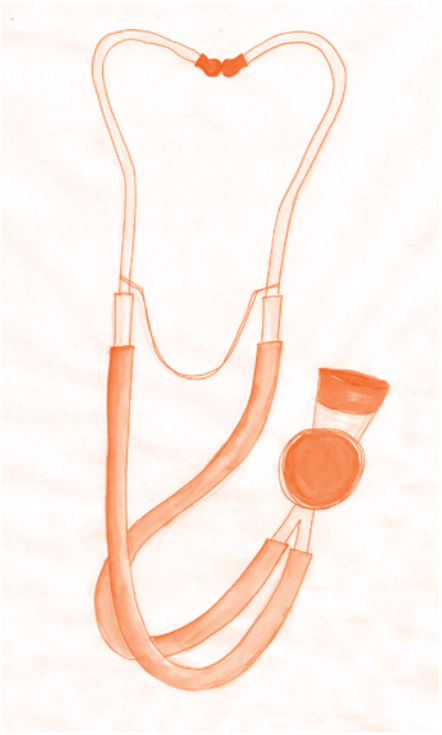
Trends in Colorado Medicaid Caseload and Enrollment

In the late 90s, Colorado's Medicaid caseload was in decline. But, with the downturn in the economy, more low-income children and their parents have qualified for Medicaid coverage. From March 1999 through March 2003, Colorado experienced 49 straight months of above-average caseload growth. Additionally, the implementation in 1998 of the State Children's Health Insurance Plan (SCHIP) in Colorado, known as Child Health Plan Plus (CHP+), extended health care coverage to more children. Aggressive outreach to identify children eligible for CHP+ also boosted Medicaid enrollment, as children found eligible for Medicaid are required to enroll in Medicaid rather than CHP+.

What's a Waiver?

States can apply to the Centers for Medicare and Medicaid Services (CMS) for "waivers" to waive federal rules regarding eligibility (e.g., to allow expansions to additional populations); provider participation (e.g., to allow managed care); and benefits (e.g., to provide enhanced long-term care benefits to a subset of the Medicaid population). Colorado has implemented a series of home and community-based services waivers resulting in considerable cost-savings by virtue of fewer nursing facility admissions and covering some individuals that otherwise might not enroll in Medicaid. These waivers enable income-eligible individuals at risk of institutionalization to receive services in their home or community in addition to the standard Medicaid benefit package. Colorado's waiver programs have enrollment ceilings and some have active waiting lists. The federal Health Insurance Flexibility and Accountability (HIFA) waiver initiative allows states to apply for greater flexibility in how they administer Medicaid and the State Children's Health Insurance Program. States must demonstrate that waiver programs will be "budget neutral," or that the costs associated with the new program will not exceed what would have been spent without the waiver. HIFA waivers are relatively new and their impact on enrollees and providers is still being analyzed in states where they have been implemented.

What Services does Medicaid Pay for?



Medicaid covers a broad and comprehensive range of health, mental health and long-term care services. Those required by federal law include:

- inpatient and outpatient hospital services;
- rural health clinic and federally qualified health center (FQHC) services;
- laboratory and X-ray services;
- physicians' services and pediatric and family nurse practitioners' services;
- nursing home and home health services;
- early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21, including immunizations and well-child care;
- family planning services and supplies; and
- nurse midwife services.

Colorado has the option of choosing among 33 additional services eligible for the federal match and can determine the amount, duration, and scope of services provided. Any "optional" services must be covered for all Medicaid population groups statewide. Colorado covers the following optional services:

- prescription drugs;
- clinic services (including diagnostic, screening, and preventive);
- podiatrists', optometrists', and psychologists' services;
- private duty nursing;
- physical, occupational, and speech therapy;
- prosthetic devices;
- eyeglasses when necessary after surgery;
- rehabilitative services including mental health counseling;
- inpatient psychiatric services for children under age 21 and for those 65 and older;
- intermediate care facilities for the mentally retarded;
- alcohol and drug addiction counseling and treatment for pregnant women;
- case management services;
- program for all-inclusive care for the elderly (PACE);
- hospice care; and
- home and community-based services for qualified populations.

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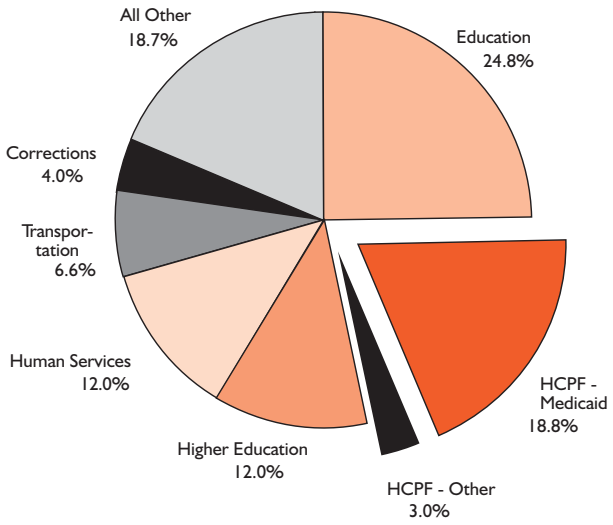
What does Colorado Spend on Medicaid?

Colorado Medicaid is jointly funded through the state General Fund and matching federal funds, with the federal government matching each General Fund dollar with approximately one federal dollar. As shown in the chart below, it is second only to education in terms of state spending.

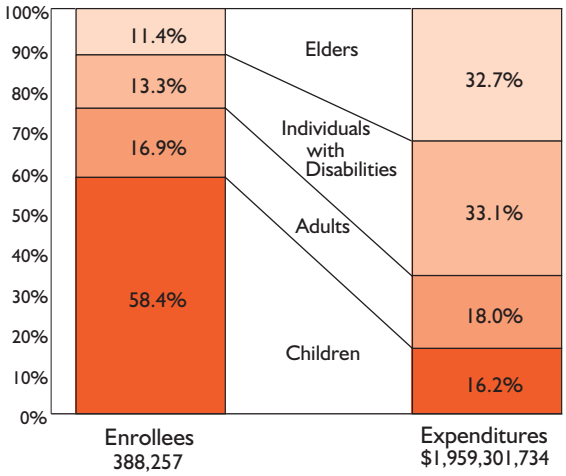
Medicaid as a Portion of all State Spending, FY 2004-2005



Source: Joint Budget Committee, Fiscal Year 2004-2005 Appropriations Report

In Colorado, elders and individuals with disabilities account for one-quarter of Medicaid enrollees, but nearly two-thirds of expenditures. Even though children and their parents combined account for nearly three-quarters of enrollees, less than one-third of Medicaid spending is attributable to these populations. Children account for more than half of all Colorado Medicaid enrollees and only 16 percent of the costs. HCPF estimates that a total of 226,818 low-income children will enroll in Medicaid in FY 2004-05—more than 18 percent of all kids in Colorado. Significantly more Medicaid dollars are used to provide services to elders and individuals with disabilities than adults and children, largely due to the costs of long-term care, prescription drugs, and specialty services. Most elders and some Medicaid enrollees with disabilities are also enrolled in Medicare (commonly known as "dual eligibles"), which pays for most of their doctor visits, hospitalizations, and other Medicare-covered services.

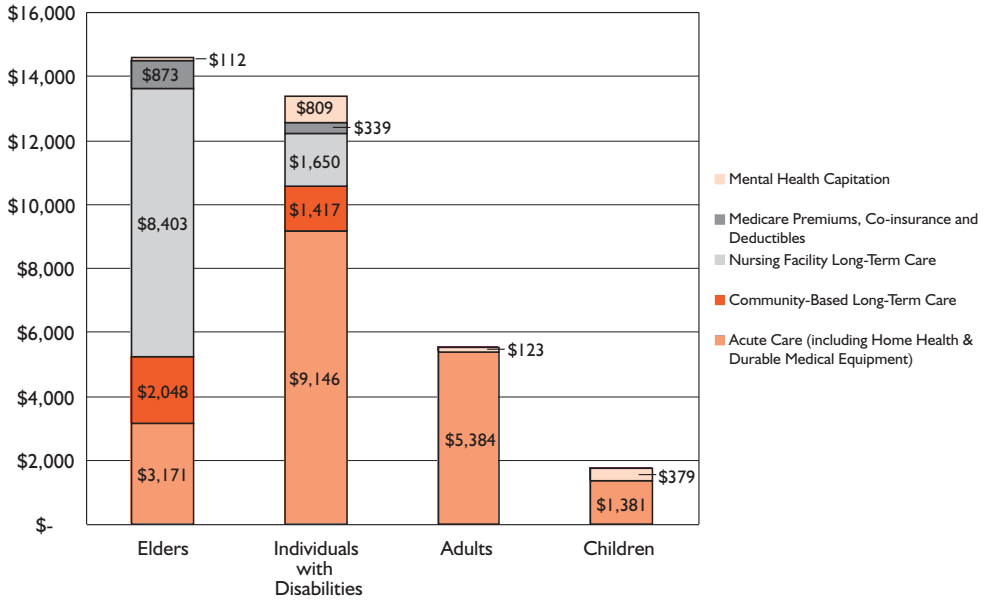
Medicaid Enrollees and Expenditures, FY 2004-2005



Source: Department. of Health Care Policy and Financing, FY 2005-2006 Budget Request, Exhibit O

Based on the appropriated budget for FY 2004-05, Medicaid spending per child is projected to be $1,760, compared to $13,360 per enrollee with disabilities and $14,607 per elderly enrollee. These differences reflect the higher utilization of acute and long-term care services by elderly enrollees and those with disabilities—far more costly than routine health care and preventive services for children and their parents. Acute care includes a range of services from doctor visits, to hospitalizations, durable medical equipment, prescription drugs, and home health services.

Average Annual Expenditure per Enrollee by Population Groups and Type of Coverage, FY 2004-2005

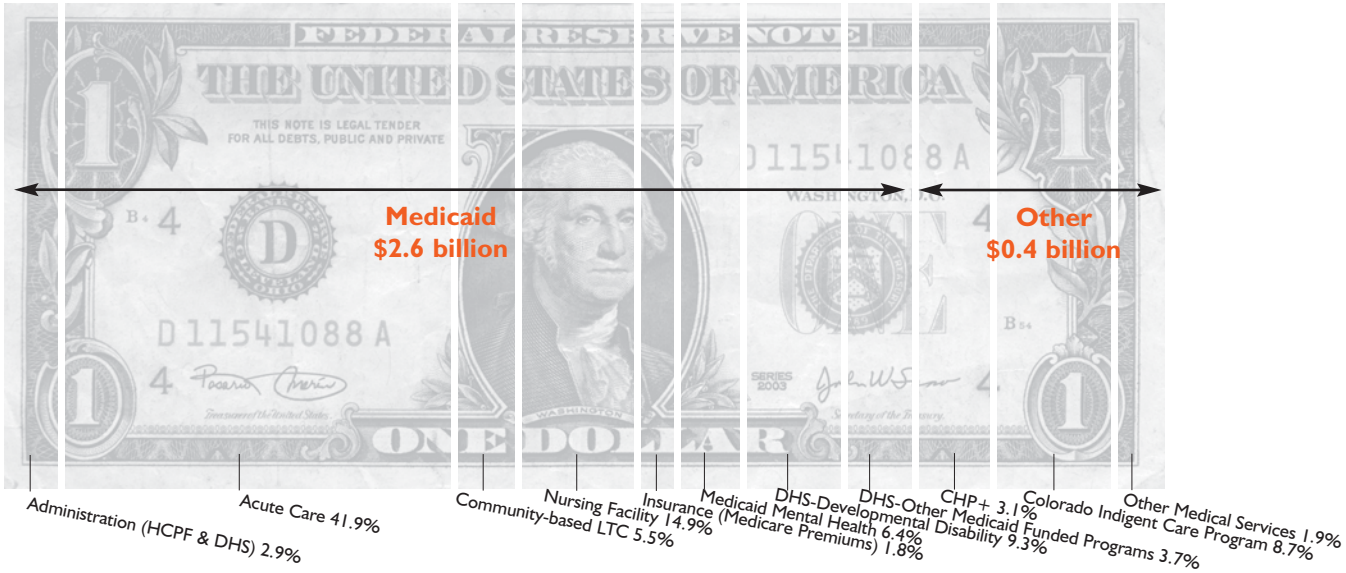


Note: Excludes Department of Human Services and some Medicaid Mental Health Community Services.
Source: Department of Health Care Policy and Financing FY 2005-2006 Budget Request, Exhibit O

Where does the Medicaid Dollar Go?

The bulk of HCPF's $3.0 billion budget is comprised of the Medicaid payments for acute care ($1.3 billion in FY 2004-2005), nursing facilities ($451 million), and services for persons with developmental disabilities ($280 million). Program administration performed by HCPF staff, contractors, and the Department of Human Services (DHS) account for a relatively small portion of the total costs of the Medicaid program.

Department of Health Care Policy and Financing, $3 Billion Appropriation by Major Expenditure Category, FY 2004-2005



Source: Joint Budget Committee Staff Briefing December 8, 2004, pp. 20-35

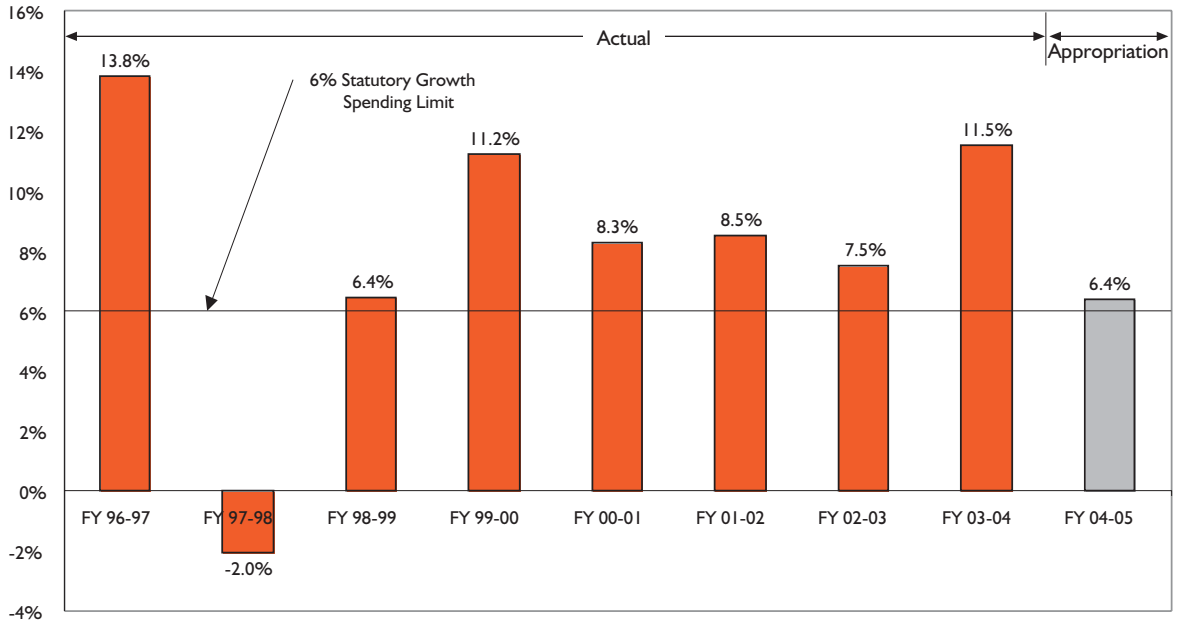
The next largest portion of HCPF's appropriation, $261 million, is for the Colorado Indigent Care Program, which consists of payments to hospitals and clinics that serve a disproportionate share of Medicaid and uninsured Coloradans. In Colorado, these payments represent 8.7 percent of the HCPF budget for FY 2004-2005. More than 160,000 Coloradans received discounted services totaling more than $120 million from 48 hospitals and nearly 100 clinics in 45 counties through this and related programs in FY 2002-2003. CHP+ is appropriated $96 million, mostly from federal and tobacco settlement funds.

In an effort to contain costs, Colorado implemented an aggressive managed care initiative in the mid-1990s for primary and acute care and established home and community-based care waiver programs for long-term care services. The enrollment of Medicaid recipients into managed care organizations has receded significantly since 2002. In spite of these efforts to contain the costs of the program, Medicaid payments to health care providers have nearly doubled in the past 10 years. The primary factor contributing to this growth has been the escalating cost of health care goods and services (the cost of medical services nationally has increased by 42 percent from 1994 to 2003.) In addition, eligibility expansions for children and caseload growth fueled by the downturn in the state's economy have driven costs upward.

Although increases in the cost of Medicaid payments to health care providers have varied from year to year, in recent years increased costs have significantly outpaced the 6 percent statutory limit on General Fund spending. This rapid growth in the second largest component of the General Fund means that there are relatively few new General Fund dollars available for other agencies and programs. Recent cost-containment actions include:

- reductions in provider rates and reimbursements;
- changes to streamline enrollment processes and limit services;
- prescription drug controls; and
- increases in certain co-pays.

Annual Change in Payments for Medical Services, FY 1996-1997 to FY 2004-2005



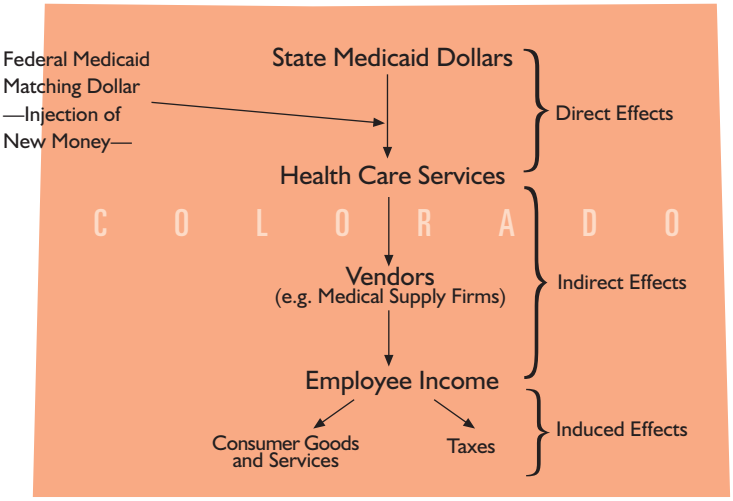
Note: Payments for Medical Services only. Payments for Medicaid Mental Health Community Services and Department of Human Services-administered Medicaid Programs are excluded from this chart. The 6 percent statutory spending growth limit (C.R.S. 24-25-201.1(1)) pertains to total General Fund spending. It is shown here to illustrate that the Medical Services Premium has grown more rapidly than this overall spending limit in eight of the last nine years.
Source: Department of Health Care Policy and Financing, FY 2005-2006 Budget Request, Exhibit S

What is Medicaid's Impact on Colorado's Economy

Every dollar of state spending on Medicaid brings a new federal dollar into Colorado. These dollars have a "multiplier" effect by passing from one person to another in successive rounds of spending. This effect demonstrates that the aggregate impact of Medicaid spending on a state's economy is much greater than the value of services purchased. For example, in fiscal year 2005, the state portion of Medicaid spending in Colorado is projected to be $1.3 billion state dollars, which would generate nearly $3 billion in new business activity, 28,356 new jobs, resulting in approximately $1.1 billion in additional wages. This diagram shows an example of how Medicaid spending flows through an economy.

Conversely, if state Medicaid spending is reduced, the infusion of federal dollars is automatically reduced, which ultimately reduces the amount of dollars circulating through the state's economy.

Flow of Medicaid Dollars Through a State Economy: An Example



Source: "The Role of Medicaid in State Economies: A Look at the Research," Kaiser Commission on Medicaid and the Uninsured, April 2004, p. 3

> The program's financing structure—the federal matching arrangement—and the magnitude of Medicaid spending enable the program to make significant contributions to state economies in terms of jobs, income and overall economic activity.
>
> --Kaiser Commission on Medicaid and the Uninsured, April 2004

Online Resources

Centers for Medicare and Medicaid Services: www.cms.hhs.gov/medicaid

Colorado Department of Health Care Policy and Financing: www.chcpf.state.co.us/

- Who Does What at HCPF: A Staff Resource Directory: www.chcpf.state.co.us/HCPF/refmat/staffdir.asp
- Acronym List: www.chcpf.state.co.us/HCPF/refmat/acronym.asp
- HCPF Budget: www.chcpf.state.co.us/HCPF/Budget/Budgetindex.asp

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