COMPARATIVE DATA REPORT ON MEDICAID

2017

A Report Submitted to the

FISCAL AFFAIRS AND GOVERNMENTAL OPERATIONS COMMITTEE

Southern Legislative Conference **Council of State Governments**

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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 09 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, and John D. Carpenter. Comments, questions and suggestions concerning this report are welcomed.

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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, known as the Federal Medical Assistance Percentage (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 2017, the FMAP for the SLC states ranged from a rate of 50% (Virginia and Maryland) to 74.63% (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, the medically needy, and adults in cases 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 various forms, such as CMS Forms 37, 64, MSIS (formerly 2082), and Transformed MSIS (T-MSIS), intended to replace MSIS. 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, data beyond FFY 14 MSIS data was unavailable for this report as CMS transitions from the MSIS data reporting system to the Transformed MSIS (T-MSIS) data reporting system, as CMS has not released this data. MSIS and T-MSIS data both report demographic information for Medicaid populations, as well as service use and payment information by demography. As a result, the 2017 Comparative Data Report on Medicaid does not include information on demography, unlike prior reports. This report instead compiles information on total payment data and categorical payment data from the Medicaid and CHIP Payment Access Commission (MACPAC), a federal agency that provides information to Congress and the Department of Health & Human Services. Furthermore, this report uses total Medicaid population data from past MACPAC reports for FFYs 11-15 in conjunction with total Medicaid population data as reported by CMS in their Medicaid Managed Care Enrollment reports for FFYs 15-17.

NOTE ON DATA COLLECTION

Like prior MSIS datasets, MACPAC data includes spending by type of service for each state. However, the data definitions for the MACPAC datasets are derived from CMS-64 reports and are more consolidated than those of the CMS-provided MSIS datasets, yielding fewer spending categories, as well as a new category, "Collections." This new category is a negative number that includes refunds for erroneous payments and tort collections resulting from third-party claims. Furthermore, the spending category "Managed Care and Premium Assistance" includes payments for specific services that cannot be delineated, as they are being delivered via the managed care delivery model.

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 from the states' Medicaid waiver information pages on Medicaid.gov is included. Furthermore, key demographic and poverty indicators from the U.S. Census Bureau and Bureau of Economic Analysis are provided, as well information from the Supplemental Nutrition Assistance Program (SNAP) state activity reports.

MEDICAID SPENDING IN THE SOUTHERN REGION

Total actual Medicaid payments (administrative costs excluded) for the 16 SLC states for FFY 17 were $174.0 B, an increase of approximately $3.71 B (2.18%) over the FFY 16 level of $170.3 B. The states with the largest dollar increases from FFY 16 to FFY 17 include Louisiana ($2.38 B, or 27.84%), Florida ($1.48 B, or 6.82%), North Carolina ($1.18 B, or 9.70%), and Arkansas ($783.09 M, or 7.34%).

The growth in Louisiana is likely attributable its opting into Medicaid Expansion, which occurred in FFY 16. Louisiana's increased payments in FFY 17 are partially attributable to capturing the new Medicaid Expansion population as it phases up enrollment. Louisiana's enrollment increased by 121,704 persons, from approximately 1.50 M to 1.62 M. Furthermore, the average per-enrollee payment for Louisiana increased from $5,875 to $6,921, indicating enhanced spending on services in addition to enrollment growth. Maryland, another expansion state, did not have a significant increase in enrollment from FFY 16 to FFY 17 (approximately 1,300 additional enrollees in FFY 17), likely indicating that its enrollment population has stabilized post-Medicaid Expansion. However, Maryland did have an increased average per-enrollee payment that indicates that roughly the same population is utilizing services with increased frequency or at greater reimbursement rates.

By contrast, North Carolina and Florida have not undertaken Medicaid Expansion, although enrollment grew in North Carolina by approximately 82,000 persons (4%) from 2.03 M to 2.11 M from FFY 16 to 17, with average per enrollee payments increasing by $319, from $6,319 to $6,638. Average per enrollee payment growth indicates additional spending on services, which may be attributable to other factors, such as altered rate schedules for services or additional services being offered. Enrollment in Florida remained relatively stable from FFY 16 to 17, and its overall payment growth may similarly be attributable to altered rate schedules for services or additional services being offered.

The increase in total payments for all states in FFY 17 reflects the 10th 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 has been variable, with rapid increases in payments from FFY 14-16, partially attributable to the phase up of Medicaid Expansion. However, FFY 17 shows a slower growth from the previous three years, likely due to a stabilization of the Medicaid Expansion population that began phasing in beginning in FY 14, as 4 of the 6 expansion states expanding Medicaid opted in during FFY 14.

Total Medicaid expenditure growth in the SLC from FFY 16 to FFY 17 is the result of 13 of the 16 SLC states having an increase in payments (Kentucky, Tennessee, and Texas reflect decreases in payments from FFY 16). FFY 16 increased 4.98% from FFY 15 while FFY 14 and FFY 13 spending increased 9.5% and 1.9%, respectively. Total spending in FFY 13 reflected the end of diminished growth trends, and the significant increase in payments in FFY 14 is largely 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), Maryland ($1.52 B increase in payments from FFY 13 to 14), and West Virginia ($323.6 M increase in payments from FFY 13 to 14). The enhanced growth trend continued in FFY 16, though not as dramatically as in FFYs 14-15. FFY 17 continues the trend of slowed growth, even with Louisiana opting into Medicaid Expansion in FFY 16 and receiving a significant increase in payments that year.

Total spending for FFY 15 (from CMS 64) is $162.22 B, administrative costs excluded, which is an increase of approximately $11.27 B, or 7.46% from the $150.95 B for FFY 14. Total spending for FFY 16 (from CMS 64) is $170.30 B, or 4.98% over the $162.22 B spent in FFY 15. Total spending for FFY 17 (from CMS 64) is $174.01 B, or 2.18% over the $170.30 B spent in FFY 16. FY 13 exhibited a more controlled growth in Medicaid, but FFY 14 showed a considerable increase that slowed slightly in FFYs 15-16 and has tapered off considerably in FFY 17.

The rapid growth in payments for FFYs 13-16 is in part attributed to an increased number of enrolled non-disabled adults associated with Medicaid Expansion. All states expanding Medicaid except Louisiana undertook expansion in FFY 14, spiking the number of enrolled adults in the expansion states. Below is a breakdown of each state expanding Medicaid in FFY 14 and their associated enrollment spike of adults derived from MSIS-based enrollment data provided by MACPAC and estimates from the Kaiser Family Foundation. As mentioned previously, each of these states had a significant increase in payments from FFY 13 to 14.

- **Arkansas** – an increase of approximately 148,000 enrolled adults, from 109,000 in FFY 13 to 257,000 in FFY 14
- **Kentucky** – an increase of approximately 310,000 enrolled adults, from 139,000 in FFY 13 to 449,000 in FFY 14
- **Maryland** – an increase of approximately 114,000 enrolled adults, from 389,000 in FFY 13 to 503,000 in FFY 14
- **West Virginia** - an increase of approximately 169,000 enrolled adults, from 62,000 in FFY 13 to 231,000 in FFY 14

Each of these states has exhibited continued growth of payments in FFYs 15-16,. Similarly, all Expansion states except Kentucky had increased payments in FFY 17. When released, data on enrollment and spending by basis of eligibility for FFYs 15-17 in these states will likely help explain payment growth in those years and further indicate if the growth is

attributable to increased enrollment under expansion, or other factors such as increased rates for services throughout Medicaid, or providing additional services to eligibles.

Furthermore, Medicaid enrollment in the southern states overall remained relatively stable from FFY 16 to FFY 17, increasing by approximately 43,000 persons (0.2%), which along with slower payment growth in FFY 17 suggests that enrollment and growth in payments are stabilizing to a degree.

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.

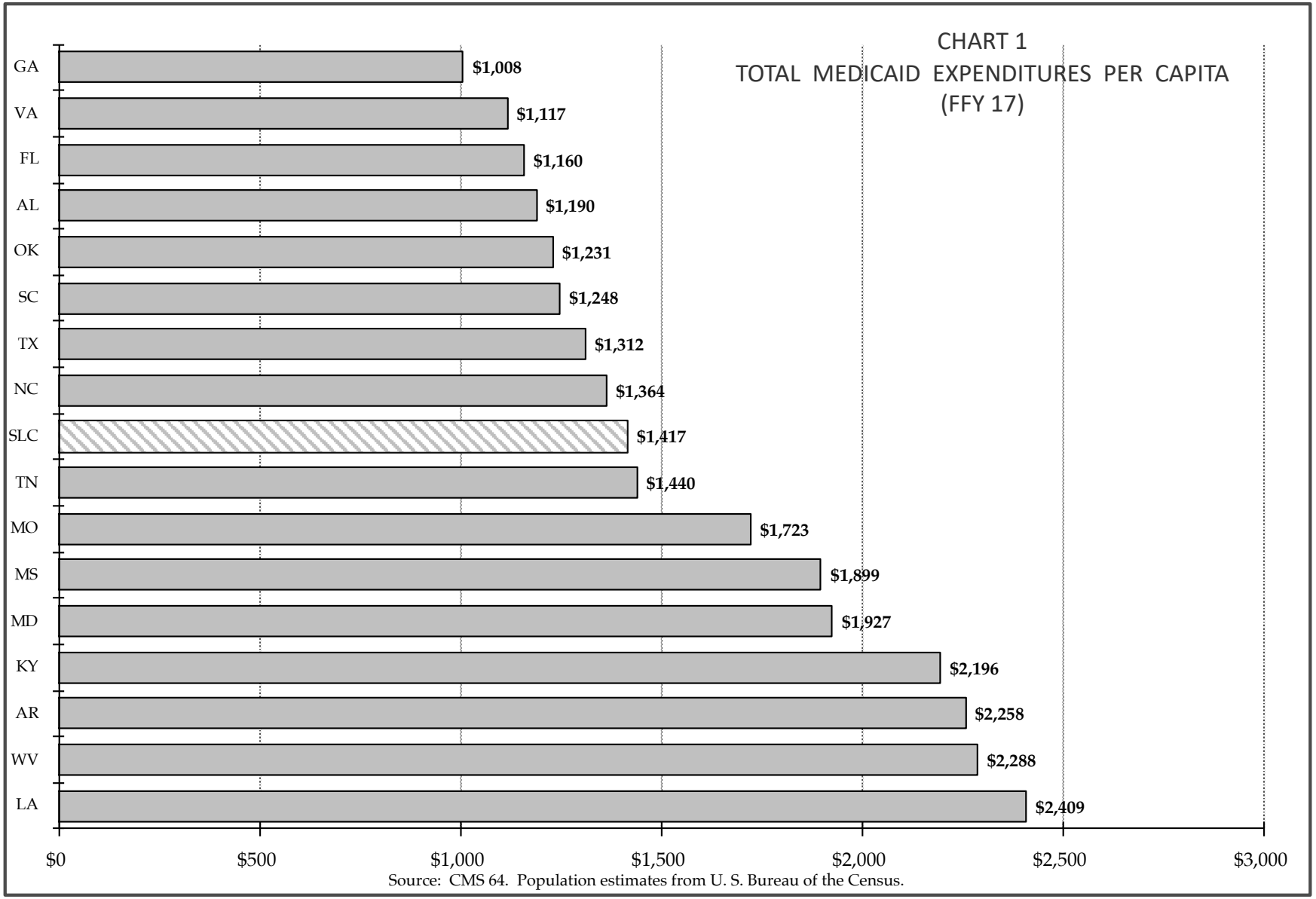
Per Capita Expenditures. Medicaid per capita spending in the 16-state southern region has increased from $1,137 in FFY 11 to $1,417 for FFY 17 (see Page 2), an annual increase of approximately 3.2%. States with high numbers of enrollees per unit of population combined with a high level of payments per enrollee rank high in per capita spending. As shown in **Chart 1 (page vii)**, per capita spending for FFY 17 ranges from $1,008 in Georgia to $2,409 in Louisiana.

Payments per Enrollee. Average annual payments per enrollee for the southern region have increased from $5,556 in FFY 11 to $7,224 in FFY 17 (see Page 2), an average annual increase of 3.8% 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 $10,701 in Missouri, while South Carolina posts the lowest payment per enrollee at $5,149 **(See Chart 2, page viii)**

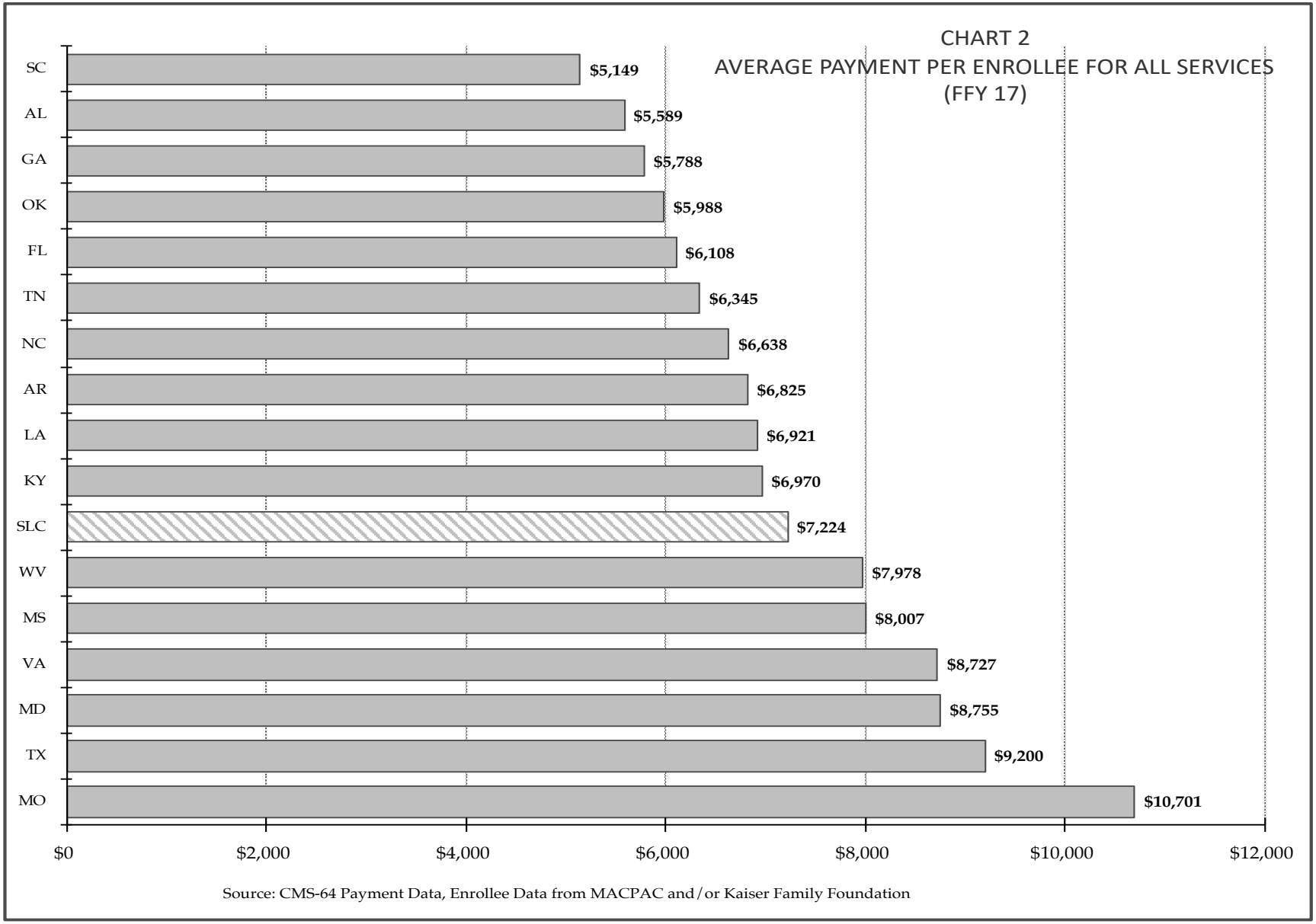
Enrollees per 100,000 Population. The number of enrollees per 100,000 population decreased slightly to 19,610 in FFY 17 from 19,762 in FFY 16. According to this indicator, the highest state was Louisiana with 34,813 per 100,000 population and the lowest was Virginia with 12,802 in FFY 17. Generally, a state's rank on this scale is influenced by a number of demographic factors and their eligibility criteria. **(See Chart 3, page x)**

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 and 14 states have combined Medicaid expansion with a state-designed plan. Texas, Florida, and North Carolina topped the federal allocation in the SLC with $1.04 B, $686.6 M, and $479.5 M, respectively. West Virginia was allotted the fewest SCHIP dollars in the SLC, $61.0 M. (**See Table 1, page ix)**

SOUTHERN REGION MEDICAID PROFILE



SOUTHERN REGION MEDICAID PROFILE

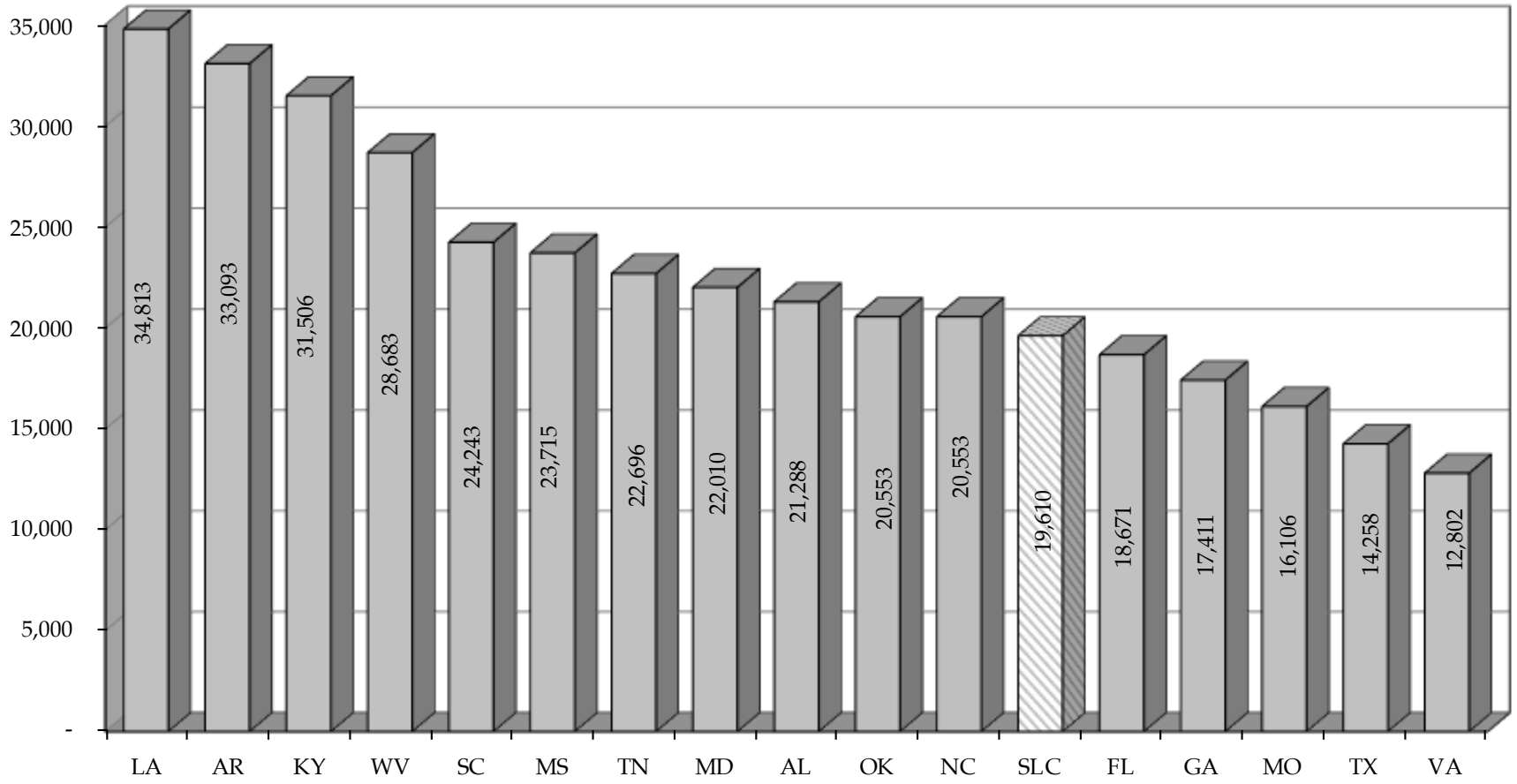


SOUTHERN REGION MEDICAID PROFILE

CHART 3

MEDICAID RECIPIENTS PER 100,000 POPULATION

(FFY 17)



Source: Medicaid Enrollment derived from CMS Managed Care Enrollment Reports and U. S. Bureau of the Census population estimates. SLC column shows average of 16 southern states.

SOUTHERN REGION MEDICAID PROFILE

TABLE 1

SCHIP ALLOTMENTS AND MATCH RATES FOR THE SOUTHERN LEGISLATIVE CONFERENCE STATES

	SCHIP Allotments FFY 17			FFY 17 Federal Match Rates			
	Federal $'s (millions)	State $'s (millions)	Total Program Allotment (millions)	Medicaid	SCHIP	Difference	Type of Plan
Alabama	$319.7	$84.4	$404.12	70.16%	79.11%	9.0%	Combination
Arkansas	$194.4	$52.4	$246.8	69.69%	78.78%	9.1%	Combination
Florida	$686.6	$256.9	$943.5	61.10%	72.77%	11.7%	Combination
Georgia	$404.8	$117.4	$522.2	67.89%	77.52%	9.6%	Combination
Kentucky	$268.2	$69.9	$338.1	70.46%	79.32%	8.9%	Combination
Louisiana	$358.8	$128.7	$487.5	62.28%	73.60%	11.3%	Combination
Maryland	$295.9	$159.3	$455.2	50.00%	65.00%	15.0%	Medicaid Expansion
Mississippi	$316.8	$68.4	$385.2	74.63%	82.24%	7.6%	Combination
Missouri	$175.2	$60.8	$236.0	63.21%	74.25%	11.0%	Combination
North Carolina	$479.5	$144.7	$624.2	66.88%	76.82%	9.9%	Combination
Oklahoma	$249.0	$97.0	$346.0	59.94%	71.96%	12.0%	Combination
South Carolina	$154.2	$38.8	$193.0	71.30%	79.91%	8.6%	Medicaid Expansion
Tennessee	$465.0	$151.1	$616.1	64.96%	75.47%	10.5%	Combination
Texas	$1,038.0	$446.3	$1,484.3	56.18%	69.93%	13.8%	Combination
Virginia	$291.1	$156.7	$447.8	50.00%	65.00%	15.0%	Combination
West Virginia	$61.0	$15.0	$76.0	71.80%	80.26%	8.5%	Combination
SLC TOTAL	$5,758.2	$2,047.9	$7,806.1				

Medicaid Disproportionate Share Hospital (DSH) Payment

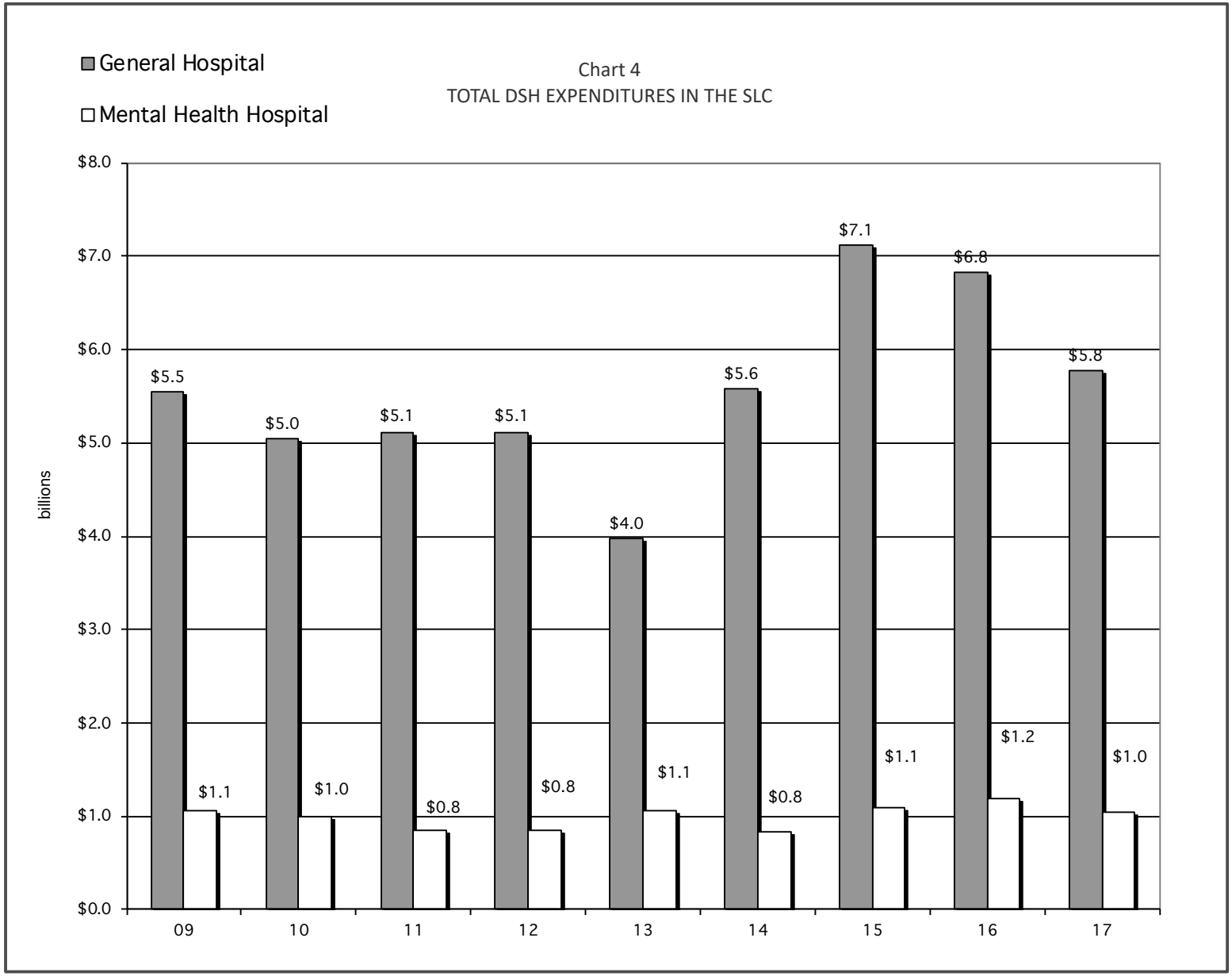
The Medicaid Disproportionate Share Hospital (DSH) Payment Program was established by the federal government in 1981. The program was designed to enable states to provide financial support to hospitals that incur high levels of unreimbursed costs due to serving a disproportionate share of Medicaid and 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 4 (pg. xii) represents total DSH payments in the SLC from FY 09 to FY 17. Total DSH funding is separated by general hospital inpatient payments and mental health hospital payments. Total DSH payments in the SLC decreased by $1.2 M, or 15.03% from FFY 16 to FFY 17.

SOUTHERN REGION MEDICAID PROFILE



DEFINITIONS

Capitation Payment: 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 (category): 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.

Diagnosis-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 state matching funds to draw down 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.

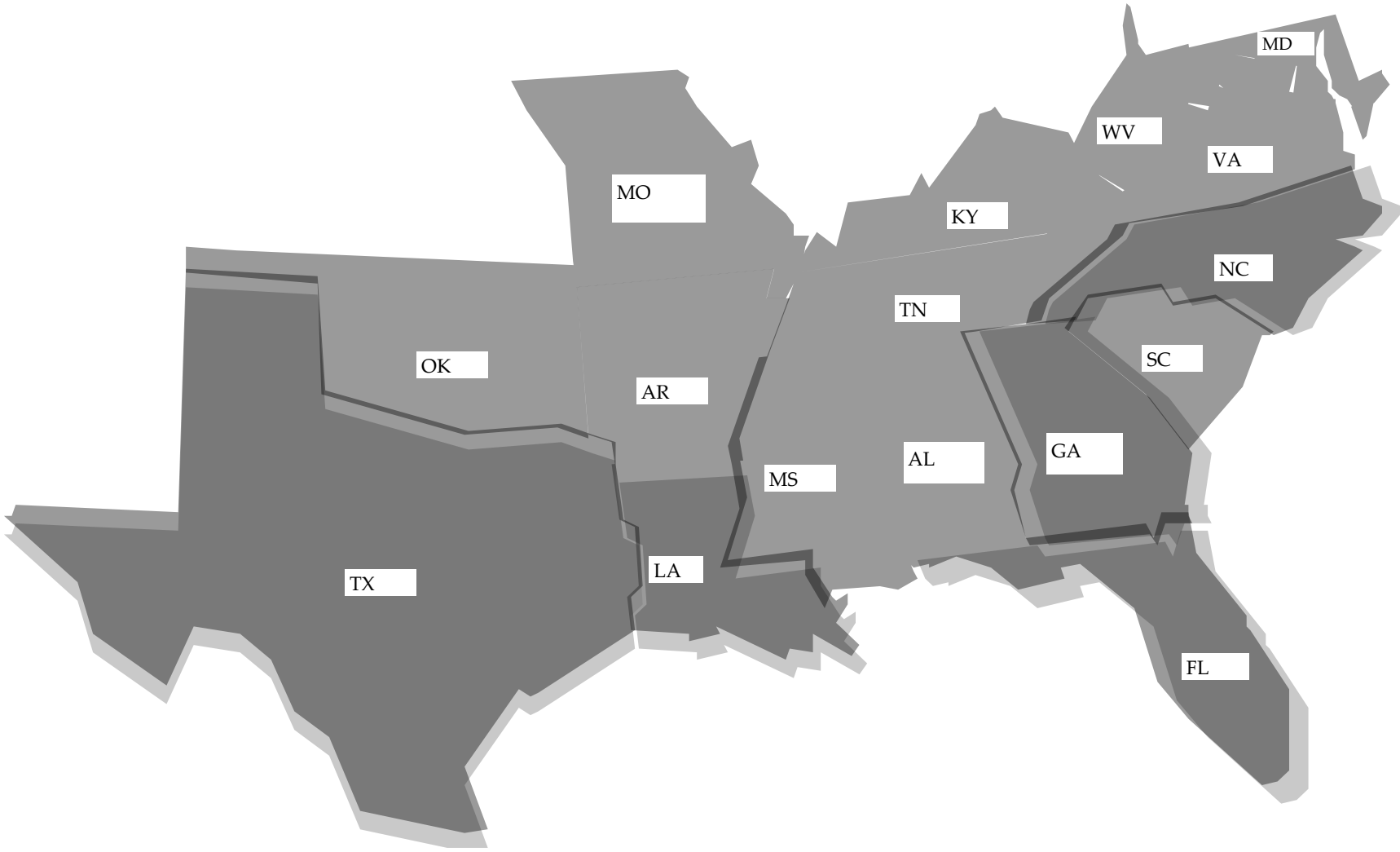
The Breast and Cervical Cancer Prevention and Treatment Act of 2000: Federal act that gives states the 'option' to provide breast and cervical cancer treatment services through the Medicaid program (new eligibility category) to certain women.

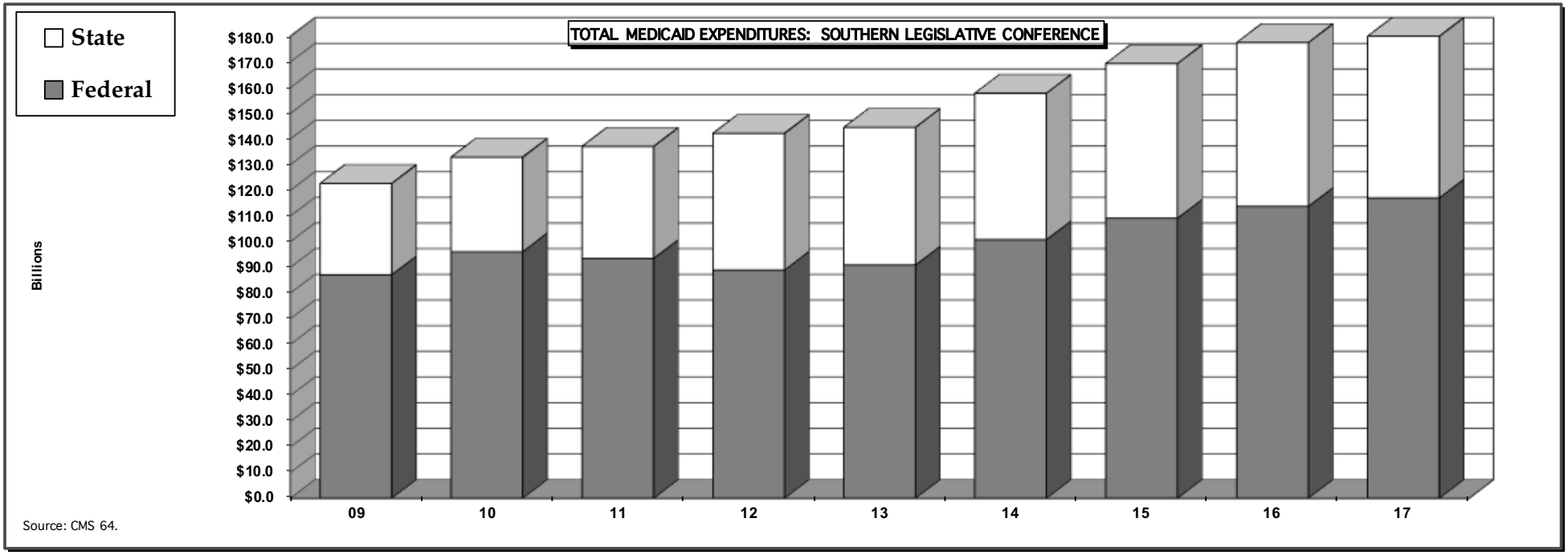
The Centers for Medicare & Medicaid Services (CMS -- formerly HCFA): A federal agency within the Department of Health & Human Services. It was created in 1977 to administer the Medicare and Medicaid programs -- two national health care programs with more that 72 million beneficiaries. While CMS mainly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



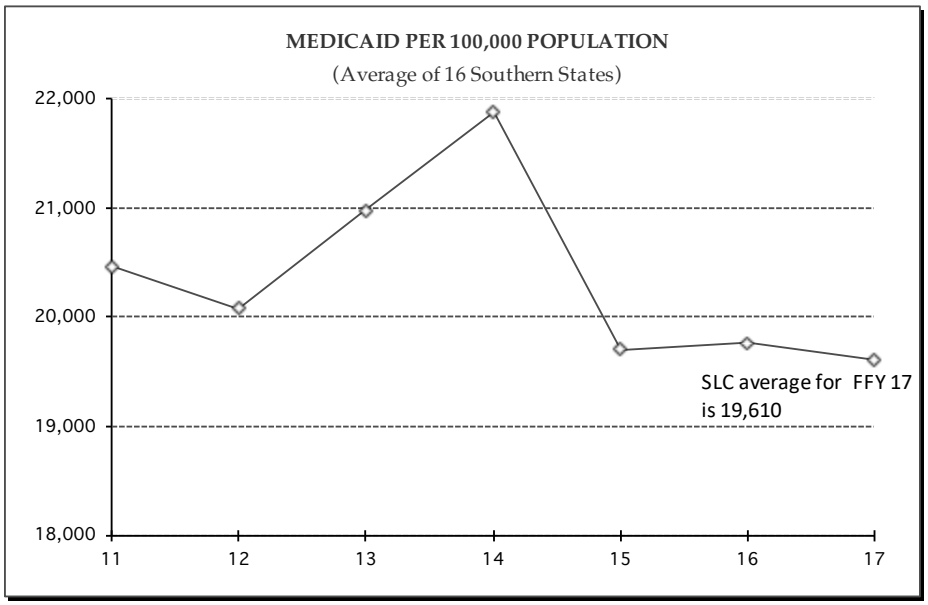


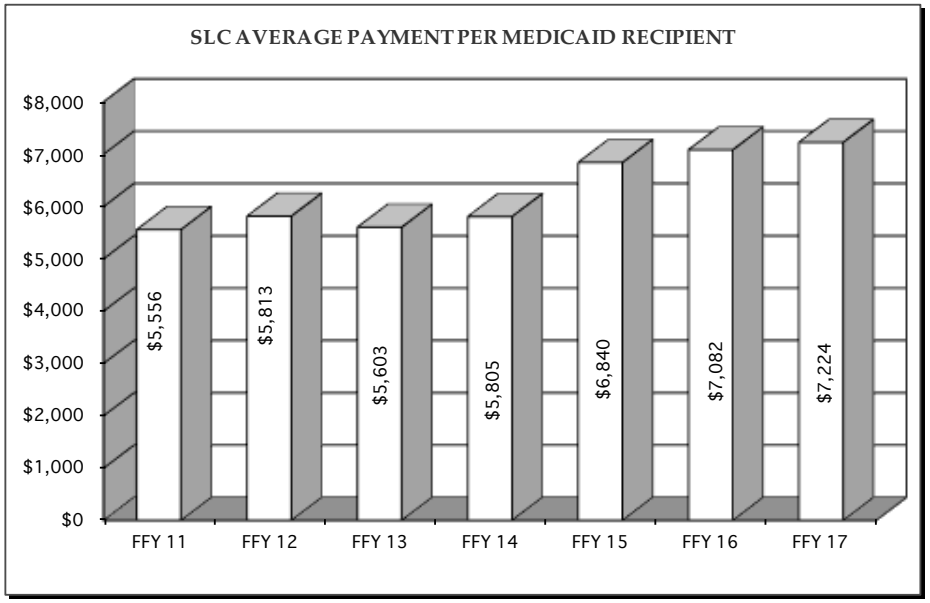
State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$170,299,224,504	$174,014,121,118	*4.47%*	*2.18%*
Federal Share	$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	$109,047,784,167	$112,038,019,806	*3.23%*	*2.74%*
State Share	$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	$61,251,440,337	$61,976,101,312	*7.18%*	*1.18%*
Administrative	$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	$7,241,990,659	$7,381,324,664	*3.80%*	*1.92%*
Federal Share	$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	$4,695,257,458	$4,965,232,028	*6.09%*	*5.75%*
State Share	$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	$2,538,733,201	$2,416,092,636	*0.25%*	*-4.83%*
Admin. Costs as % of Payments	4.50%	4.00%	4.39%	5.05%	4.82%	4.54%	4.40%	4.25%	4.24%		
Growth From Prior Year											
Payments	5.58%	8.87%	2.76%	3.07%	1.87%	9.48%	7.46%	4.98%	2.18%		
Administration	6.60%	-3.05%	12.59%	18.55%	-2.73%	3.21%	4.04%	1.50%	1.92%		

Source: CMS-64 as reported by states to the Centers for Medicare and Medicaid Services (CMS)

SOUTHERN LEGISLATIVE CONFERENCE

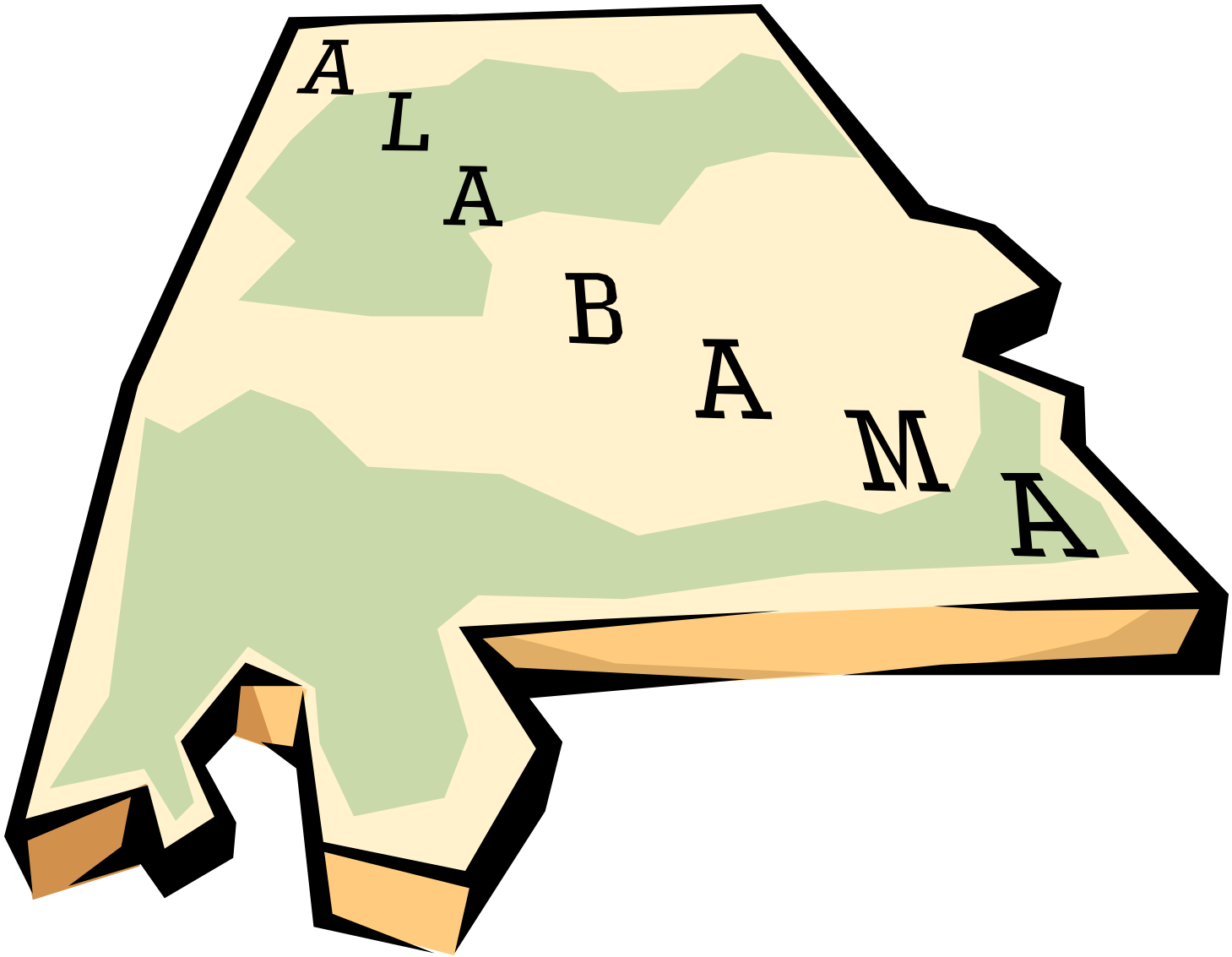


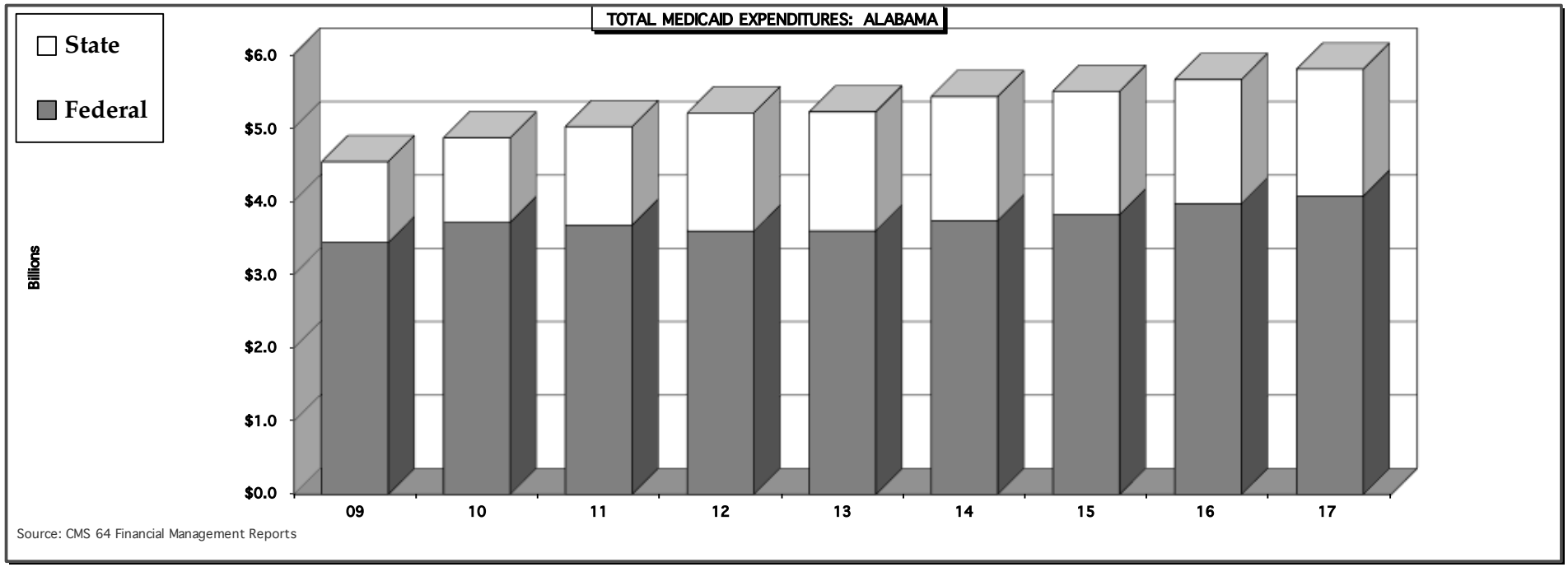


DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (Millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$36,055	$34,253	$32,326	$32,595	$33,861	$33,071	$29,198	*-3.0%*	*16.8%*
Physician	$6,872	$6,241	$6,048	$6,880	$4,756	$4,164	$3,637	*-8.7%*	*2.1%*
Dental	$3,036	$2,261	$1,685	$1,532	$1,285	$1,255	$1,280	*-11.6%*	*0.7%*
Other practitioner	$1,143	$788	$633	$883	$1,015	$1,466	$760	*-5.7%*	*0.4%*
Clinic and health center	$2,752	$2,659	$2,238	$2,188	$2,126	$2,193	$2,078	*-3.9%*	*1.2%*
Other acute	$7,423	$11,786	$12,471	$14,166	$14,029	$14,153	$15,096	*10.7%*	*8.7%*
Drugs	$5,918	$4,807	$4,196	$4,472	$4,274	$3,861	$3,752	*-6.3%*	*2.2%*
Institutional LTSS	$20,135	$22,300	$21,965	$20,425	$18,997	$18,547	$17,336	*-2.1%*	*10.0%*
Home and community-based LTSS	$18,538	$13,925	$13,921	$15,305	$14,403	$15,267	$15,878	*-2.2%*	*9.1%*
Managed care and premium assistance	$26,084	$33,350	$38,819	$50,115	$64,301	$72,085	$79,864	*17.3%*	*45.9%*
Medicare Premiums and Coinsurance	$6,013	$5,697	$5,887	$5,978	$6,057	$6,729	$7,426	*3.1%*	*4.3%*
Collections	($2,648)	($2,757)	($2,314)	($2,586)	($2,888)	($2,489)	($2,291)	*-2.0%*	*-1.3%*
Total Spending	**$131,318**	**$135,340**	**$137,881**	**$151,955**	**$162,219**	**$170,302**	**$174,015**	*4.1%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	24,670,000	24,461,000	25,796,202	27,184,052	24,758,839	25,068,523	25,111,549		
Average Payment Per Enrollee	$5,556	$5,813	$5,603	$5,805	$6,840	$7,082	$7,224		
Average Payment Per Capita	$1,136.99	$1,167.32	$1,175.41	$1,269.98	$1,347.84	$1,399.52	$1,416.55		

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$5,435,036,771	$5,562,217,922	*2.67%*	*2.34%*
Federal Share	$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	$3,824,010,039	$3,919,770,575	*1.74%*	*2.50%*
State Share	$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	$1,611,026,732	$1,642,447,347	*5.27%*	*1.95%*
Administrative	$148,158,789	$153,029,106	$221,094,612	$221,622,887	$216,508,665	$212,174,151	$230,848,834	$222,452,083	$237,612,538	*5.39%*	*6.82%*
Federal Share	$80,673,987	$92,306,635	$136,959,218	$153,435,983	$138,657,557	$135,733,327	$151,742,735	$140,074,782	$148,357,502	*7.00%*	*5.91%*
State Share	$67,484,802	$60,722,471	$84,135,394	$68,186,904	$77,851,108	$76,440,824	$79,106,099	$82,377,301	$89,255,036	*3.16%*	*8.35%*
Admin. Costs as % of Payments	3.38%	3.25%	4.61%	4.45%	4.33%	4.07%	4.38%	4.09%	4.27%		
Federal Match Rate*	77.51%	77.53%	68.54%	68.62%	68.53%	68.12%	68.99%	69.87%	70.16%		

**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 17)

Provider(s)	Tax Rate
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 and a supplemental tax of $525/bed annually, and a secondary supplemental privilege assessment totaling $402/bed annually through August 2019)
Pharmacies	$ .10 per prescription
Private Hospitals	5.50% of net patient revenue

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$452,632,758	$463,824,975	$445,819,332	$455,169,284	$470,923,104	$481,227,717	$482,949,270	$478,160,293	$480,408,569	*0.66%*
Mental Hospitals	$3,301,620	$3,301,620	$3,301,620	$3,301,620	$0	$155,073	$0	$0	$0	*-100%*
Total	**$455,934,378**	**$467,126,595**	**$449,120,952**	**$458,470,904**	**$470,923,104**	**$481,382,790**	**$482,949,270**	**$478,160,293**	**$480,408,569**	*0.58%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

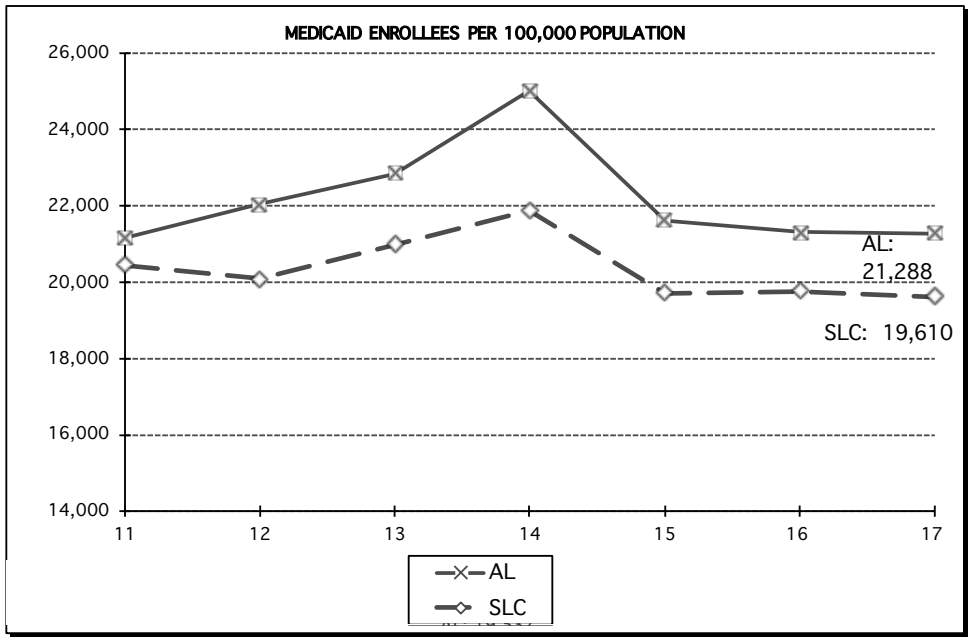
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

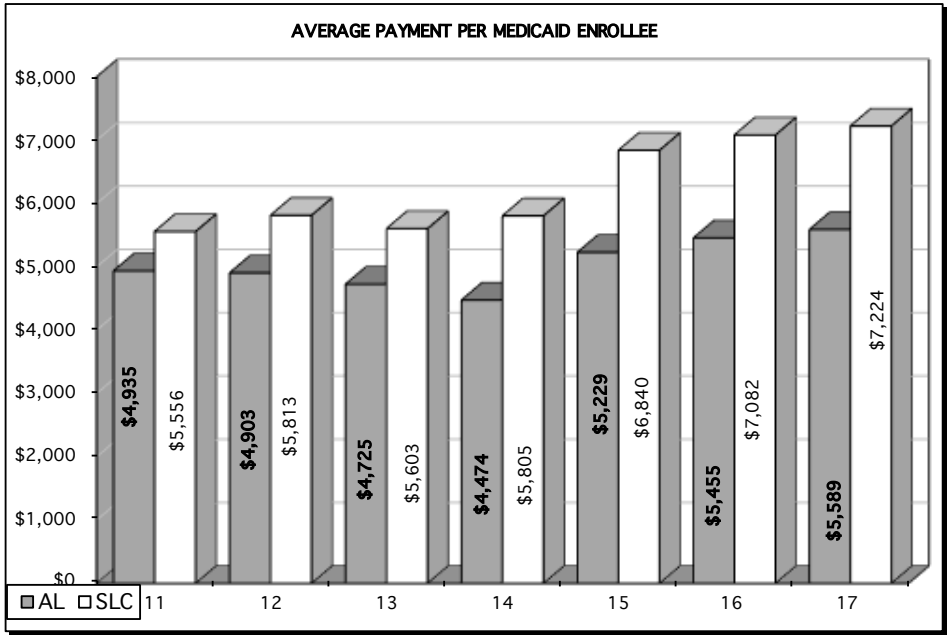
		Rank in U.S.
State population—July 1, 2017	4,752,560	*24*
Per capita personal income	$40,802	*47*
Median household income	$51,113	*45*
Population below Federal Poverty Level	802,656	*17*
Percent of total state population	16.9%	*6*
Population without health insurance coverage	512,029	*21*
Percent of total state population	10.1%	*19*
Recipients of SNAP benefits	804,336	*16*
Total value of issuance	$1,161,155,532	*15*
Average monthly benefit per recipient	$120.30	*18*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

ALABAMA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,798	$1,896	$1,891	$1,909	$1,992	$2,037	$2,096	*2.6%*	*37.7%*
Physician	$325	$331	$360	$503	$427	$393	$460	*6.0%*	*8.3%*
Dental	$85	$86	$85	$84	$80	$83	$74	*-2.4%*	*1.3%*
Other practitioner	$36	$38	$42	$49	$50	$55	$62	*9.4%*	*1.1%*
Clinic and health center	$82	$82	$84	$89	$94	$98	$92	*2.0%*	*1.7%*
Other acute	$200	$492	$481	$499	$621	$424	$535	*17.8%*	*9.6%*
Drugs	$289	$305	$294	$293	$283	$308	$327	*2.1%*	*5.9%*
Institutional LTSS	$935	$999	$972	$1,003	$1,021	$1,033	$1,002	*1.2%*	*18.0%*
Home and community-based LTSS	$747	$445	$460	$459	$467	$499	$500	*-6.5%*	*9.0%*
Managed care and premium assistance	$102	$102	$116	$96	($2)	$236	$117	*2.4%*	*2.1%*
Medicare Premiums and Coinsurance	$268	$250	$253	$258	$261	$296	$330	*3.5%*	*5.9%*
Collections	($72)	($46)	($39)	($30)	($29)	($26)	($31)	*-13.0%*	*-0.6%*
Total Spending	**$4,793**	**$4,981**	**$5,000**	**$5,213**	**$5,265**	**$5,435**	**$5,562**	*2.5%*	*100.0%*

TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA							
Toral Enrollment	1,016,000	1,061,000	1,104,000	1,212,293	1,050,989	1,037,037	1,037,814
Average Payment Per Enrollee	$4,935	$4,903	$4,725	$4,474	$5,229	$5,455	$5,589
Average Payment Per Capita	$1,044.41	$1,080.18	$1,079.83	$1,119.04	$1,131.03	$1,162.96	$1,189.68

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

ALABAMA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

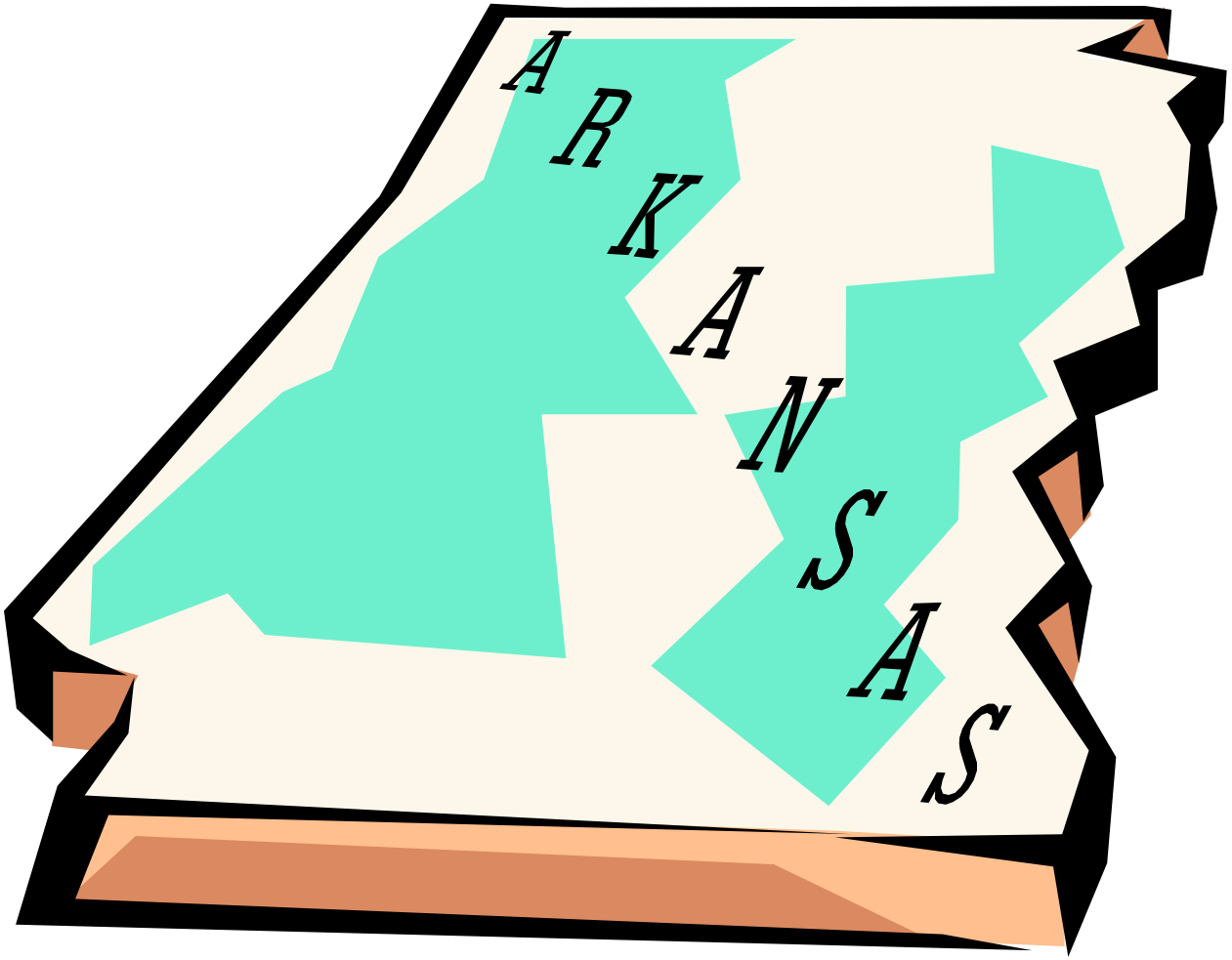
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

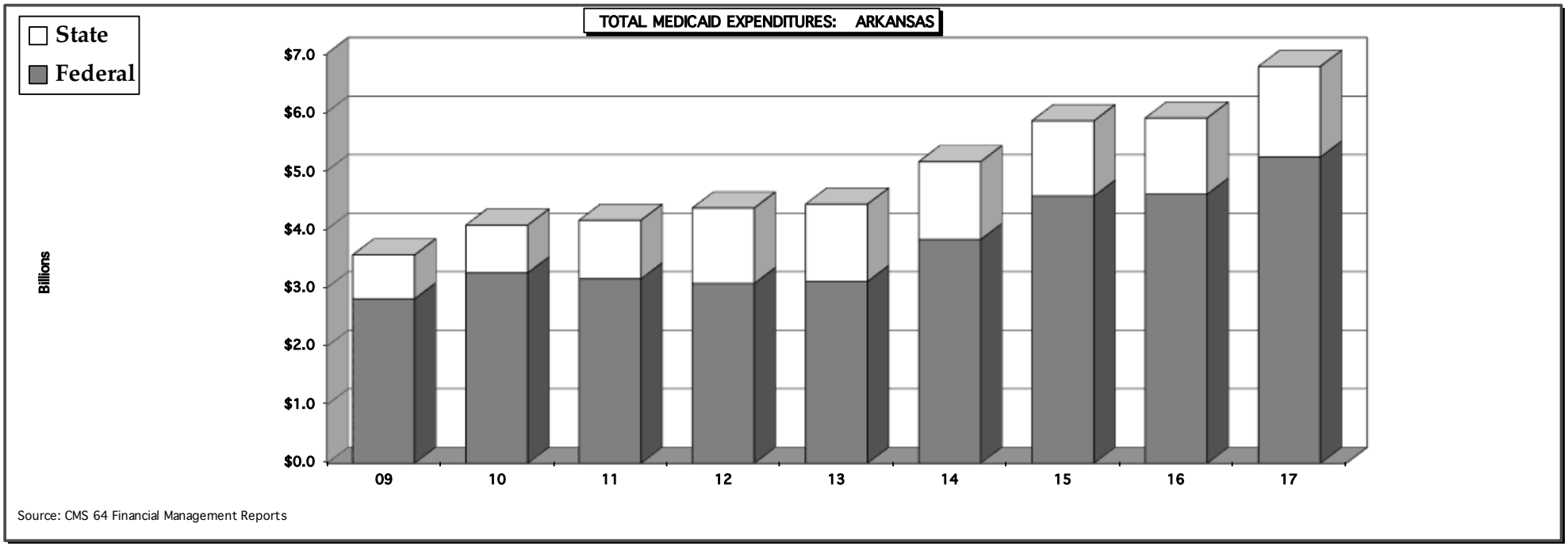
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
- Home & Community-based Waiver for Persons with Intellectual Disabilities (ID): Operating since 1981. Provides services to individuals 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 with 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 (2017)
- Primary Care Case Management (PCCM)
- Program of All-Inclusive Care for the Elderly (PACE)
- 61.37% of Medicaid enrollment (636,919 persons) in managed care in 2017

Children's Health Insurance Program: ALL Kids
- 220,980 enrollees
- Combination Plan
- Enhanced FMAP: 79.11% in 2017
- Federal Allotment: $319.7 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$5,955,864,929	$6,363,923,522	*7.26%*	*6.85%*
Federal Share	$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	$4,668,006,908	$4,942,970,399	*7.82%*	*5.89%*
State Share	$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	$1,287,858,021	$1,420,953,123	*9.63%*	*10.33%*
Administrative Costs	$172,088,942	$190,323,829	$201,171,041	$256,832,288	$272,039,980	$314,203,072	$383,183,984	$381,380,214	$418,288,113	*11.74%*	*9.68%*
Federal Share	$104,677,901	$112,150,652	$117,996,555	$165,776,769	$171,311,743	$210,634,544	$264,206,440	$251,310,756	$290,581,993	*13.61%*	*15.63%*
State Share	$67,411,041	$78,173,177	$83,174,486	$91,055,519	$100,728,237	$103,568,528	$118,977,544	$130,069,458	$127,706,120	*8.31%*	*-1.82%*
Admin. Costs as % of Payments	5.08%	4.90%	5.09%	6.26%	6.55%	6.49%	7.01%	6.40%	6.57%		
Federal Match Rate*	80.46%	81.18%	71.37%	70.71%	70.17%	70.10%	70.88%	70.00%	69.69%		

**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 17)

Provider(s)	Tax Rate
Quality Assurance Fee on Nursing Homes	6% of aggregate annual gross receipts
Hospital Assessment Fees on net patient revenue	Determined annually based upon the percentage needed to generate an amount up the the nonfederal portion of the Upper Payment Limit gap plus the annual fee to be paid to Medicaid
ICF/DD	6% of aggregate annual gross receipts

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$63,169,873	$60,092,015	$61,223,442	$60,628,045	$61,000,000	$36,760,641	$64,042,846	$41,089,308	$66,208,525	*0.52%*
Mental Hospitals	$0	$819,350	$819,350	$819,350	$0	$819,350	$819,350	$819,350	$819,351	*0.00%*
Total	**$63,169,873**	**$60,911,365**	**$62,042,792**	**$61,447,395**	**$61,000,000**	**$37,579,991**	**$64,862,196**	**$41,908,658**	**$67,027,876**	*0.66%*

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 (2017)

		Rank in U.S.
State population—July 1, 2017	2,916,321	*33*
Per capita personal income	$41,063	*46*
Median household income	$48,829	*47*
Population below Federal Poverty Level	478,365	*30*
Percent of total state population	16.4%	*8*
Population without health insurance coverage	311,132	*30*
Percent of total state population	9.5%	*22*
Recipients of SNAP benefits	388,362	*33*
Total value of issuance	$510,832,029	*33*
Average monthly benefit per recipient	$109.61	*48*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

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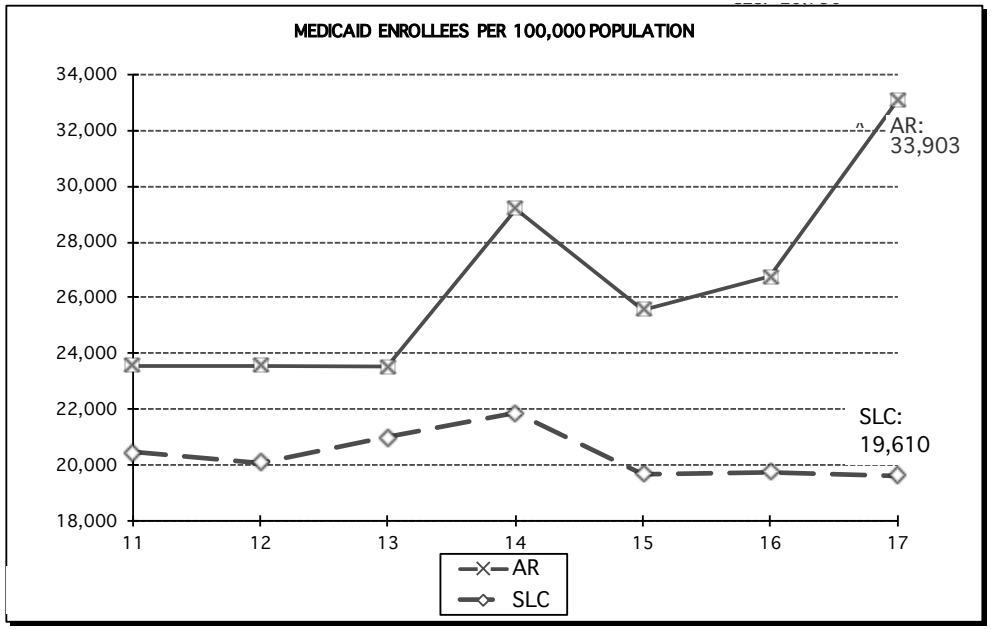
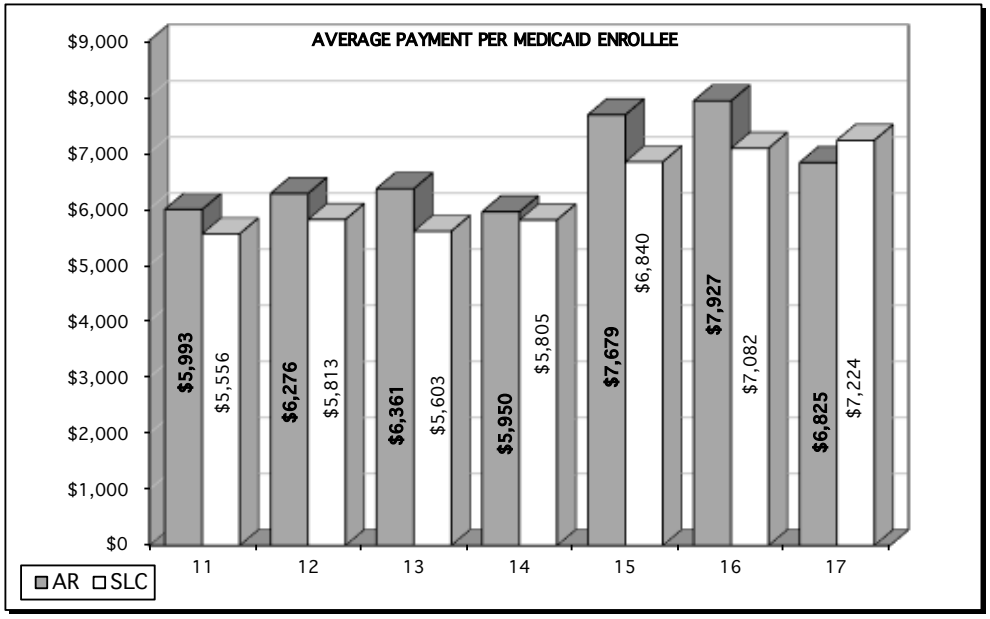




DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,107	$978	$990	$1,009	$1,021	$1,084	$1,141	*0.5%*	*17.9%*
Physician	$284	$283	$298	$339	$334	$336	$354	*3.7%*	*5.6%*
Dental	$65	$75	$73	$74	$79	$78	$81	*3.8%*	*1.3%*
Other practitioner	$17	$18	$19	$22	$23	$25	$26	*7.6%*	*0.4%*
Clinic and health center	$177	$186	$113	$49	$39	$46	$50	*-18.9%*	*0.8%*
Other acute	$329	$702	$798	$903	$927	$970	$986	*20.1%*	*15.5%*
Drugs	$159	$153	$159	$185	$155	$179	$165	*0.6%*	*2.6%*
Institutional LTSS	$784	$989	$965	$998	$957	$1,001	$1,015	*4.4%*	*15.9%*
Home and community-based LTSS	$774	$467	$478	$489	$526	$559	$593	*-4.3%*	*9.3%*
Managed care and premium assistance	$15	$17	$19	$529	$1,170	$1,406	$1,662	*119.1%*	*26.1%*
Medicare Premiums and Coinsurance	$296	$291	$296	$299	$305	$327	$350	*2.8%*	*5.5%*
Collections	($54)	($55)	($50)	($56)	($67)	($54)	($59)	*1.4%*	*-0.9%*
Total Spending	**$3,952**	**$4,105**	**$4,158**	**$4,840**	**$5,470**	**$5,958**	**$6,365**	*8.3%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	693,000	695,000	696,153	866,252	762,166	799,488	993,792		
Average Payment Per Enrollee	$5,993	$6,276	$6,361	$5,950	$7,679	$7,927	$6,825		
Average Payment Per Capita	$1,413.29	$1,478.87	$1,497.11	$1,737.30	$1,965.18	$2,119.19	$2,258.48		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

ARKANSAS

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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 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:

- Living Choices/Assisted Living Facility Waiver (LCAL), implemented 1/1/2003, offers an alternative to private dwelling or nursing home care.
- ARChoices, implementation date 1/1/2016, 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.
- Autism Waiver: Effective 12/7/17, provides consultative clinical and therapeutic services; individual assessment, treatment, and monitoring services; lead therapy intervention, line therapy intervention, therapeutic aides, and behavioral reinforcers for children on the autism spectrum ages 1-7.

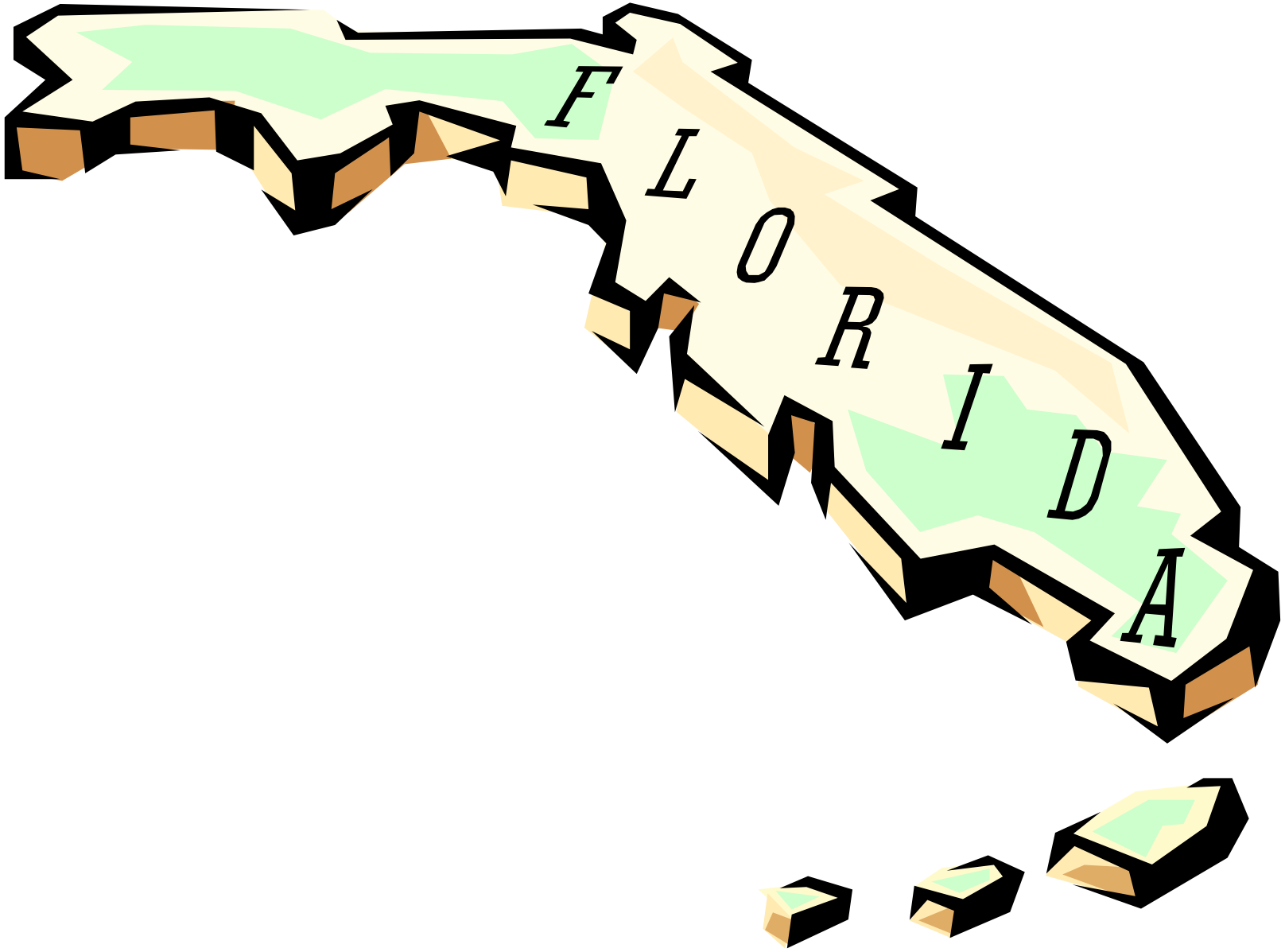
Managed Care (2017)

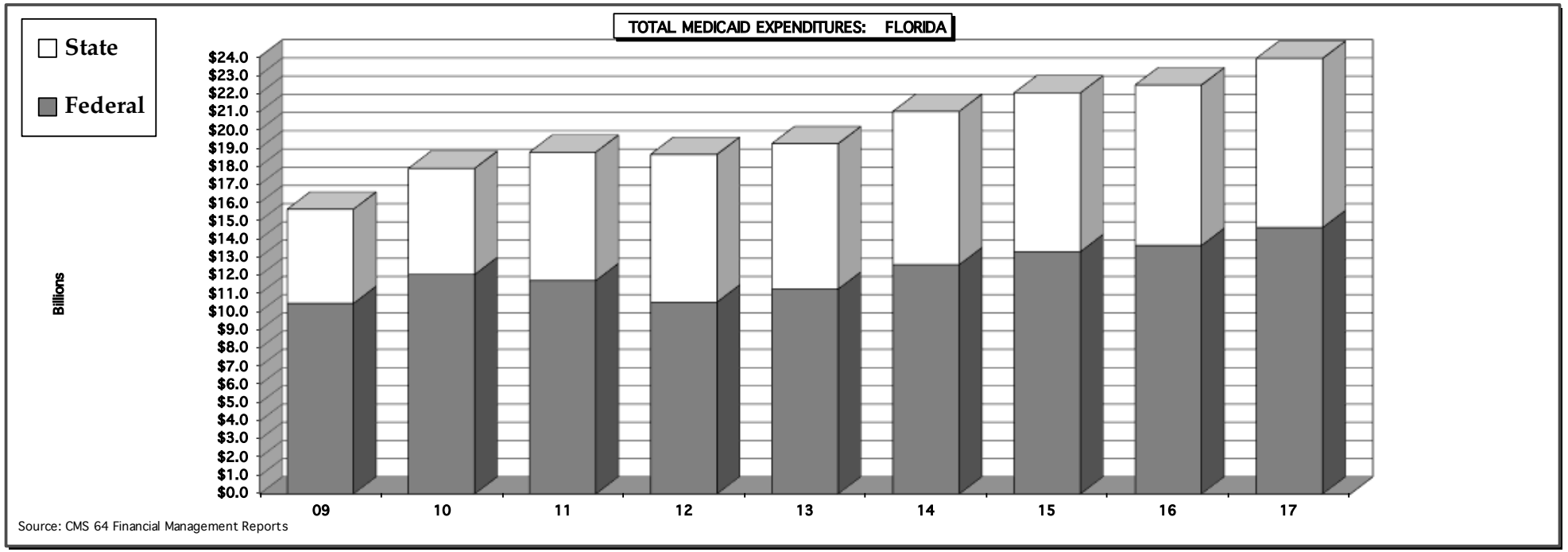
- Primary Care Case Management Program
- Non-Emergency Transportation
- Program of All Inclusive Care for the Elderly (PACE)
- 52.55% of Medicaid enrollment (522,252 persons) in managed care in 2017

Children's Health Insurance Program: ARKids First

- 143,618 enrollees
- Combination Plan
- Enhanced FMAP: 78.78% in 2017
- Federal Allotment: $194.4 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$21,689,957,388	$23,169,178,008	*4.96%*	*6.82%*
Federal Share	$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	$13,202,896,194	$14,186,091,086	*3.82%*	*7.45%*
State Share	$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	$8,487,061,194	$8,983,086,922	*7.05%*	*5.84%*
Administrative Costs	$645,195,361	$615,134,511	$636,992,323	$852,523,485	$819,727,848	$707,017,640	$702,881,953	$769,286,722	$751,775,004	*1.71%*	*-2.28%*
Federal Share	$344,092,834	$343,070,792	$345,625,349	$561,044,464	$513,521,992	$443,733,046	$431,173,089	$446,032,180	$441,562,429	*2.81%*	*-1.00%*
State Share	$301,102,527	$272,063,719	$291,366,974	$291,479,021	$306,205,856	$263,284,594	$271,708,864	$323,254,542	$310,212,575	*0.33%*	*-4.03%*
Admin. Costs as % of Payments	4.30%	3.56%	3.51%	4.79%	4.45%	3.48%	3.30%	3.55%	3.24%		
Federal Match Rate*	67.64%	67.64%	55.45%	56.04%	58.08%	58.79%	59.72%	60.67%	61.10%		

**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 17)

Provider(s)	Tax Rate
General Hospitals	
Inpatient Services	1.5% of net operating revenue
Outpatient Services	1% of net operating revenue
Nursing home quality assoc. (Began 4/1/2009)	6% of aggregate net patient revenue
ICF/DD Quality Assessment	6% of aggregate net patient revenue

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$234,896,769	$253,738,887	$241,187,904	$245,644,494	$241,879,289	$240,214,814	$239,699,117	$239,446,594	$238,034,928	*0.15%*
Mental Hospitals	$112,437,431	$122,087,706	$108,917,486	$119,838,603	$93,130,348	$95,871,943	$119,098,224	$118,226,112	$118,567,327	*0.59%*
Total	**$347,334,200**	**$375,826,593**	**$350,105,390**	**$365,483,097**	**$335,009,637**	**$336,086,757**	**$358,797,341**	**$357,672,706**	**$356,602,255**	*0.29%*

ACA MEDICAID EXPANSION

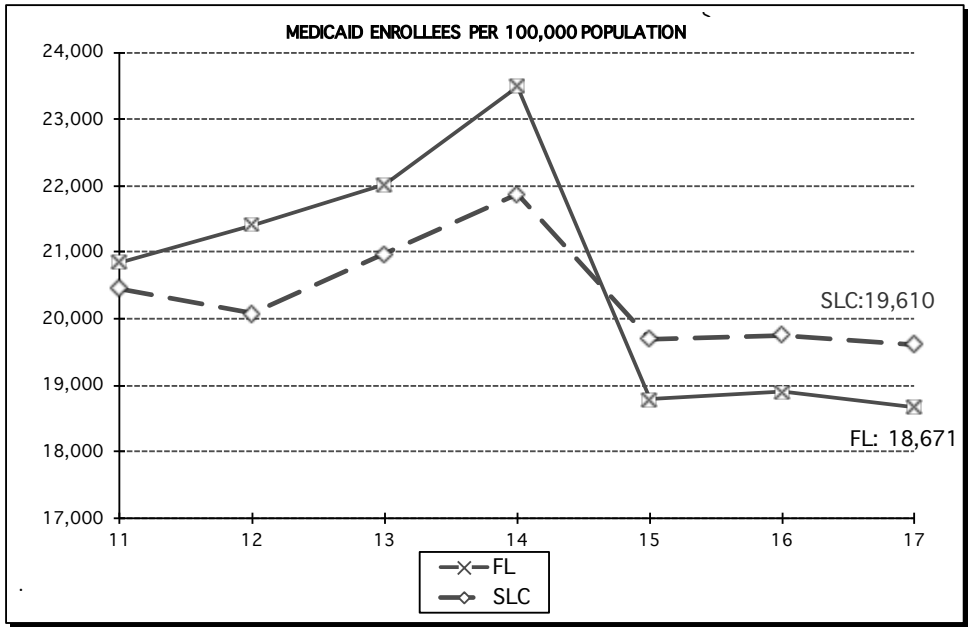
Not expanding Medicaid under ACA as of May 2019

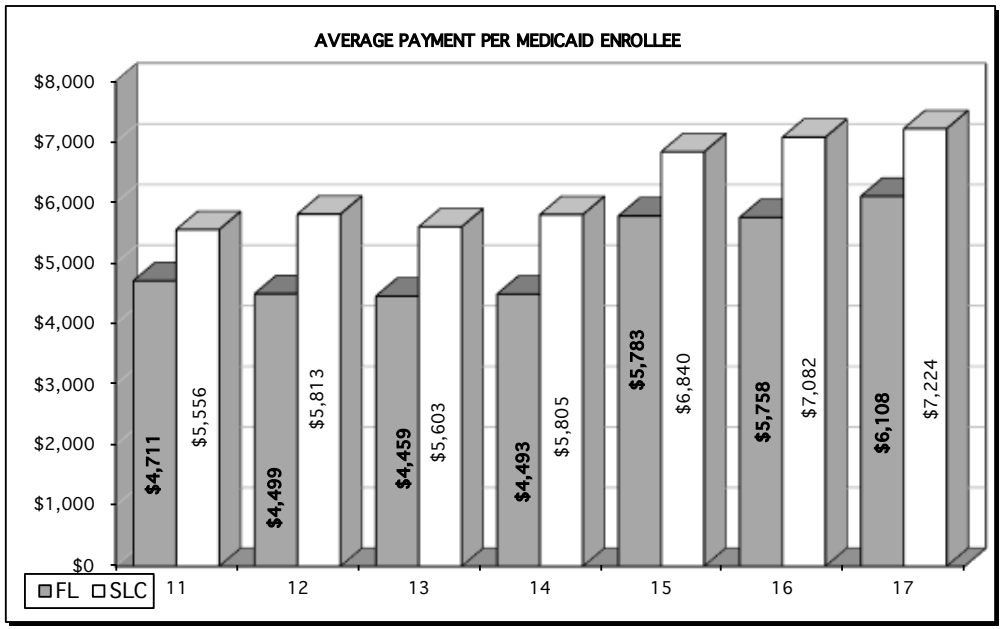
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

		Rank in U.S.
State population—July 1, 2017	20,569,920	*3*
Per capita personal income	$47,701	*27*
Median household income	$53,681	*42*
Population below Federal Poverty Level	2,889,506	*3*
Percent of total state population	14.0%	*18*
Population without health insurance coverage	2,982,945	*3*
Percent of total state population	13.3%	*5*
Recipients of SNAP benefits	3,186,537	*3*
Total value of issuance	$4,783,367,429	*3*
Average monthly benefit per recipient	$125.09	*17*

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 (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	Annual Change	Share of FFY 17
Hospital	$5,149	$4,936	$5,104	$4,942	$3,617	$2,428	$2,290	*-12.6%*	*9.9%*
Physician	$1,251	$1,081	$1,231	$1,330	$545	$439	$239	*-24.1%*	*1.0%*
Dental	$139	$189	$257	$184	$19	$7	$4	*-44.7%*	*0.0%*
Other practitioner	$43	$45	$40	$42	$19	$17	$18	*-13.8%*	*0.1%*
Clinic and health center	$231	$232	$223	$184	$166	$187	$190	*-3.2%*	*0.8%*
Other acute	$879	$1,410	$1,585	$1,446	$556	$545	$541	*-7.8%*	*2.3%*
Drugs	$637	$575	$565	$417	$104	$163	$215	*-16.6%*	*0.9%*
Institutional LTSS	$3,200	$3,314	$3,299	$1,836	$970	$946	$967	*-18.1%*	*4.2%*
Home and community-based LTSS	$2,208	$1,569	$1,522	$1,224	$1,117	$1,149	$1,263	*-8.9%*	*5.5%*
Managed care and premium assistance	$3,254	$3,312	$3,412	$7,459	$13,022	$14,456	$15,898	*30.3%*	*68.6%*
Medicare Premiums and Coinsurance	$1,289	$1,245	$1,324	$1,361	$1,343	$1,504	$1,657	*4.3%*	*7.2%*
Collections	($152)	($113)	($150)	($123)	($156)	($151)	($112)	*-4.9%*	*-0.5%*
Total Spending	**$18,128**	**$17,794**	**$18,411**	**$20,303**	**$21,320**	**$21,690**	**$23,169**	*4.2%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	3,983,000	4,145,000	4,313,012	4,675,800	3,808,334	3,900,380	3,916,490		
Average Payment Per Enrollee	$4,711	$4,499	$4,459	$4,493	$5,783	$5,758	$6,108		
Average Payment Per Capita	$982.17	$963.54	$993.75	$1,072.25	$1,106.39	$1,107.93	$1,159.52		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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.

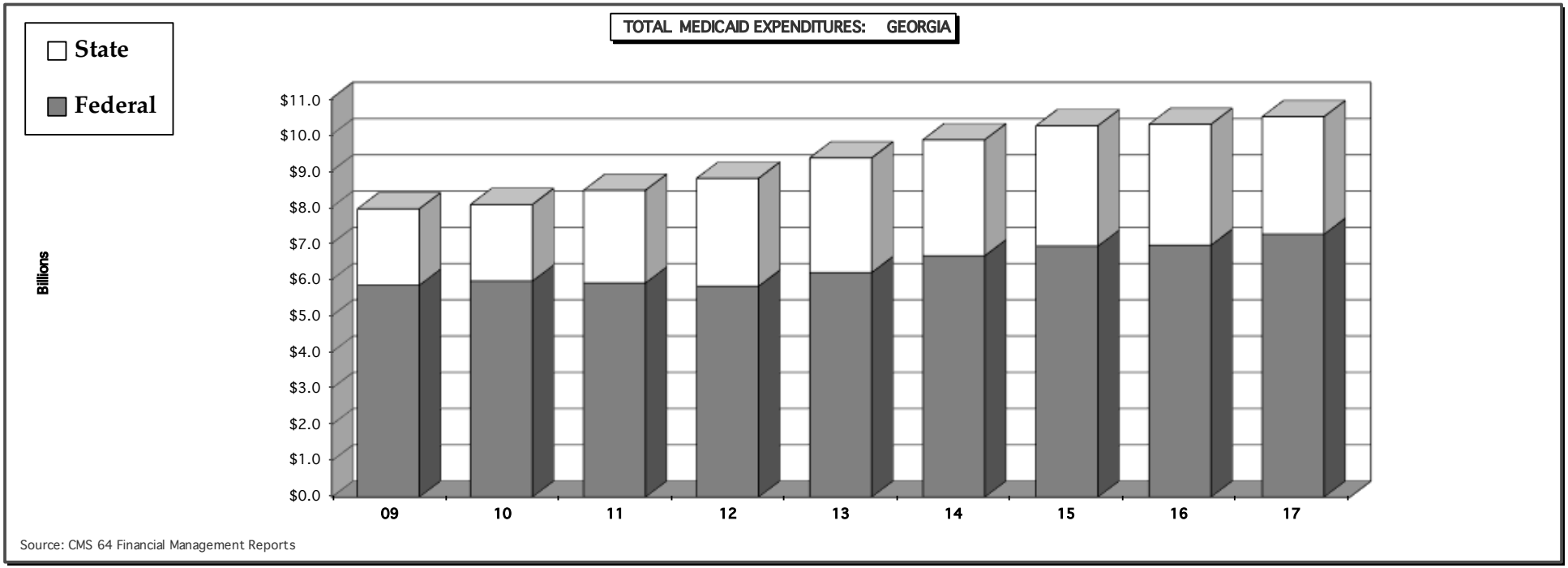
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
- AIDS Project AIDS Care (PAC): Operating since 1989.
- Model Waiver: Serves children with Degenerative Spinocerebellar Diseases operating 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 - Provides respite, assistive technology, adult dental, durable medical equipment, behavioral services, consumable medical supplies, and non-residential support services for medically fragile persons aged 3-64
- 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 (2017)
- Comprehensive Medicaid Managed Care Organizations (MCO)
- Managed Care Long Term Support Services Only
- Program of All Inclusive Care for the Elderly (PACE)
- 83.76% of Medicaid enrollment (3,280,341 persons) in managed care as of 2017

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
- 465,631 enrollees
- Combination Plan
- Enhanced FMAP: 72.77% in 2017
- Federal Allotment: $686.6 M in 2017

STATE MEDICAID PROFILE



State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$9,723,814,007	$10,105,996,059	*3.37%*	*3.93%*
Federal Share	$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	$6,585,684,519	$6,881,663,571	*2.33%*	*4.49%*
State Share	$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	$3,138,129,488	$3,224,332,488	*6.01%*	*2.75%*
Administrative Costs	$452,464,090	$361,266,697	$400,415,522	$496,417,326	$471,397,110	$461,176,224	$580,292,608	$560,090,198	$387,726,419	*-1.70%*	*-30.77%*
Federal Share	$255,140,137	$211,279,804	$215,660,065	$331,362,860	$307,187,850	$311,651,211	$397,640,094	$363,544,828	$370,241,815	*4.22%*	*1.84%*
State Share	$197,323,953	$149,986,893	$184,755,457	$165,054,466	$164,209,260	$149,525,013	$182,652,514	$196,545,370	$17,484,604	*-23.61%*	*-91.10%*
Admin. Costs as % of Payments	6.03%	4.69%	4.97%	5.98%	5.30%	4.91%	6.00%	5.76%	3.84%		
Federal Match Rate*	74.42%	74.96%	65.33%	66.16%	65.56%	65.93%	66.94%	67.55%	67.89%		

**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 17)

Provider(s)	Tax Rate
Nursing Home	6% of net revenue
Hospital provider tax (acute and specialty)	1.45% of net revenue
Trauma Hospital Provider Tax	1.4% of net revenue

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$411,355,202	$434,584,421	$410,126,151	$415,817,421	$429,964,548	$435,057,563	$435,016,070	$432,380,982	$434,087,521	*0.60%*
Mental Hospitals	$0	$0	$0	$0	$0	$0	$0	$0	$0	*0.00%*
Total	**$411,355,202**	**$434,584,421**	**$410,126,151**	**$415,817,421**	**$429,964,548**	**$435,057,563**	**$435,016,070**	**$432,380,982**	**$434,087,521**	*0.60%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

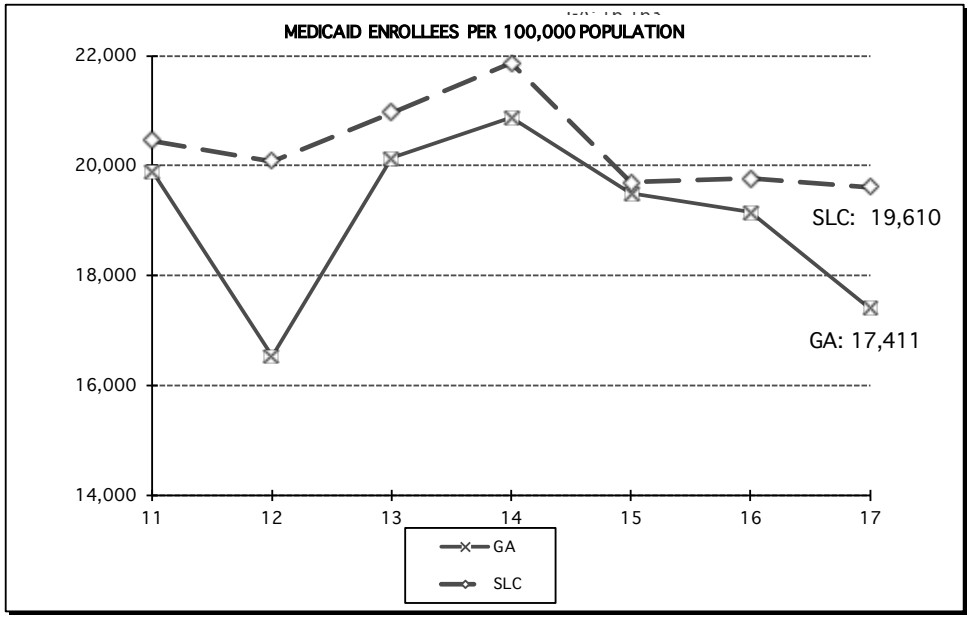
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

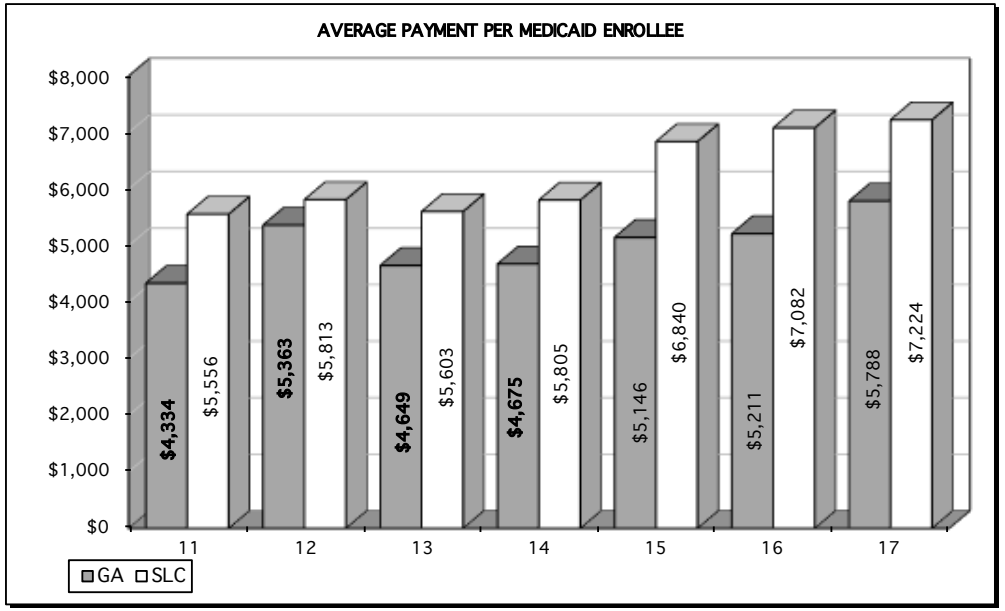
		Rank in U.S.
State population—July 1, 2017	10,154,747	*8*
Per capita personal income	$44,214	*40*
Median household income	$57,016	*35*
Population below Federal Poverty Level	1,517,702	*8*
Percent of total state population	14.9%	*12*
Population without health insurance coverage	1,481,625	*5*
Percent of total state population	15.5%	*4*
Recipients of SNAP benefits	1,625,415	*7*
Total value of issuance	$2,540,245,442	*7*
Average monthly benefit per recipient	$130.24	*9*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

GEORGIA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,787	$2,130	$2,199	$2,139	$2,228	$2,109	$2,091	*2.7%*	*20.7%*
Physician	$363	$376	$375	$431	$373	$349	$335	*-1.3%*	*3.3%*
Dental	$42	$43	$44	$39	$33	$32	$24	*-8.9%*	*0.2%*
Other practitioner	$32	$33	$35	$32	$30	$33	$33	*0.7%*	*0.3%*
Clinic and health center	$169	$166	$9	$15	$19	$19	$19	*-30.4%*	*0.2%*
Other acute	$197	$563	$766	$714	$678	$642	$657	*22.2%*	*6.5%*
Drugs	$129	$245	$239	$277	$369	$227	$250	*11.7%*	*2.5%*
Institutional LTSS	$1,174	$1,339	$1,420	$1,380	$1,371	$1,351	$1,433	*3.4%*	*14.2%*
Home and community-based LTSS	$1,027	$895	$907	$932	$1,036	$1,077	$1,176	*2.3%*	*11.6%*
Medicare Premiums and Coinsurance	$2,829	$2,439	$2,642	$3,194	$3,269	$3,604	$3,738	*4.8%*	*37.0%*
Managed care and premium assistance	$360	$295	$324	$334	$345	$395	$447	*3.7%*	*4.4%*
Collections	($46)	($227)	($73)	($89)	($85)	($113)	($98)	*13.5%*	*-1.0%*
Total Spending	**$8,065**	**$8,299**	**$8,888**	**$9,397**	**$9,665**	**$9,725**	**$10,105**	*3.8%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	1,953,000	1,640,000	2,013,002	2,108,623	1,990,810	1,973,586	1,813,016		
Average Payment Per Enrollee	$4,334	$5,363	$4,649	$4,675	$5,146	$5,211	$5,788		
Average Payment Per Capita	$862.70	$886.85	$936.69	$976.33	$1,002.96	$997.98	$1,007.75		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

GEORGIA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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 population 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.
- Elderly and Disabled Waiver: Effective November 2017, provides aged individuals 65 or older and physically disabled persons aged 0-64 with various services including adult day care personal support services, occupational/physical therapy, alternative living services, emergency response services, skilled nursing, and transition coordination.
- 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 4/01/2008.
- 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.

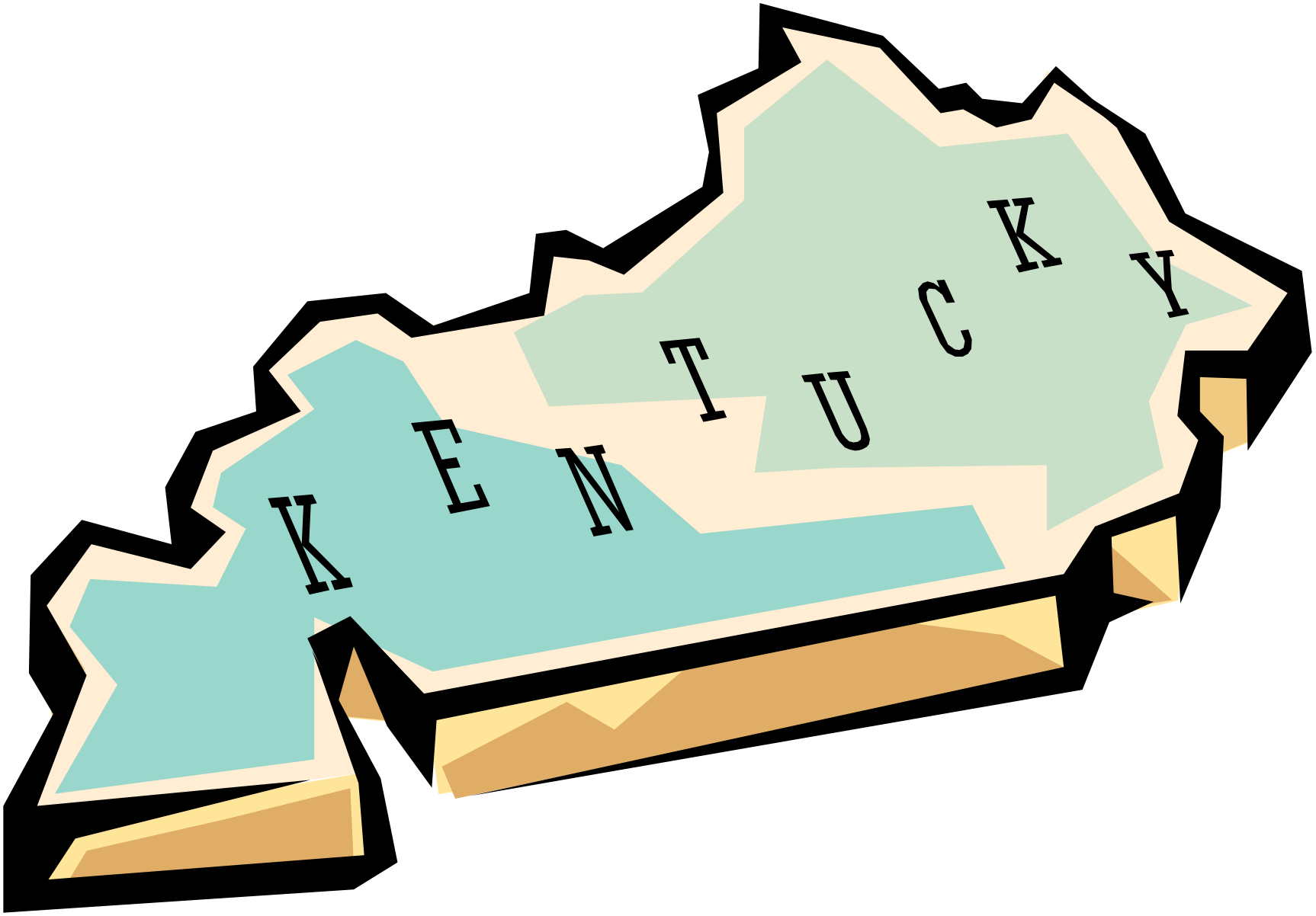
Managed Care (2017)

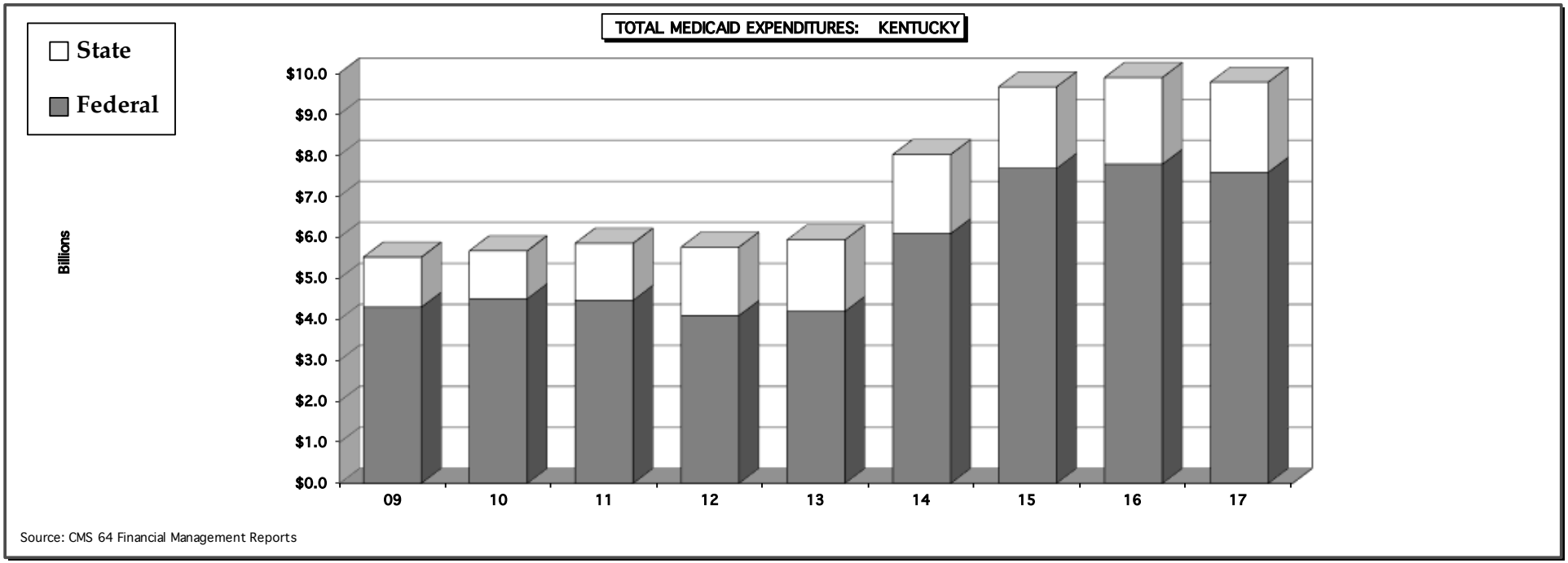
- Comprehensive Medicaid Managed Care Organization (MCO)
- 69.32% of Medicaid enrollment (1,256,809 persons) in managed care in 2017

Children's Health Insurance Program: PeachCare for Kids

- 237,011 enrollees
- Combination Plan
- Enhanced FMAP: 77.52% in 2017
- Federal Allotment: $404.8 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$9,609,364,927	$9,527,255,650	*6.59%*	*1.97%*
Federal Share	$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	$7,575,700,669	$7,400,843,535	*6.48%*	*0.93%*
State Share	$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	$2,033,664,258	$2,126,412,115	*6.99%*	*6.04%*
Administrative Costs	$153,238,352	$147,493,696	$200,943,874	$194,125,683	$208,785,747	$222,880,599	$242,868,698	$284,263,480	$252,992,040	*5.73%*	*17.04%*
Federal Share	$94,852,845	$88,202,643	$142,032,904	$131,802,502	$147,995,921	$157,269,167	$173,167,184	$206,943,923	$182,865,107	*7.57%*	*19.51%*
State Share	$58,385,507	$59,291,053	$58,910,970	$62,323,181	$60,789,826	$65,611,432	$69,701,514	$77,319,557	$70,126,933	*2.06%*	*10.93%*
Admin. Costs as % of Payments	2.86%	2.67%	3.56%	3.49%	3.65%	2.86%	2.58%	2.96%	2.66%		
Federal Match Rate*	79.41%	80.14%	71.49%	71.18%	70.55%	69.83%	69.94%	70.32%	70.46%		

**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 17)	
Provider(s)	Tax Rate (on gross revenues)
Hospitals	2.50%
Home Health	2.00%
ICF/MR	5.50%
Nursing Facility (census days)	% based on beds
Community Living Supports	5.50%

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$170,180,250	$173,659,743	$165,598,513	$171,171,879	$178,925,647	$173,705,954	$188,935,457	$192,300,761	$179,217,953	*0.58%*
Mental Hospitals	$37,443,075	$37,443,072	$37,443,073	$37,298,917	$37,338,019	$37,443,074	$37,692,279	$33,803,747	$38,081,796	*0.19%*
Total	**$207,623,325**	**$211,102,815**	**$203,041,586**	**$208,470,796**	**$216,263,666**	**$211,149,028**	**$226,627,736**	**$226,104,508**	**$217,299,749**	*0.51%*

MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014.

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

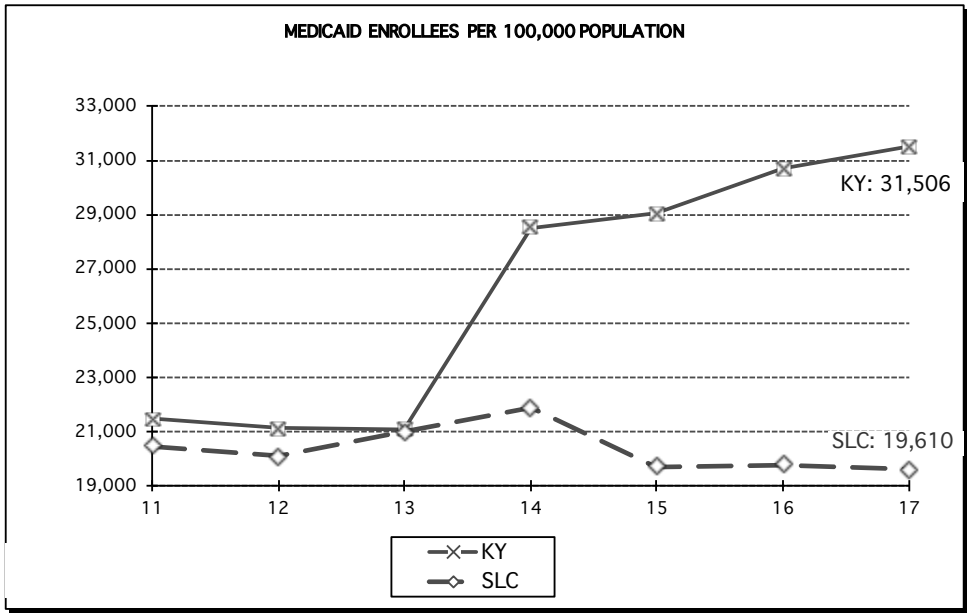
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

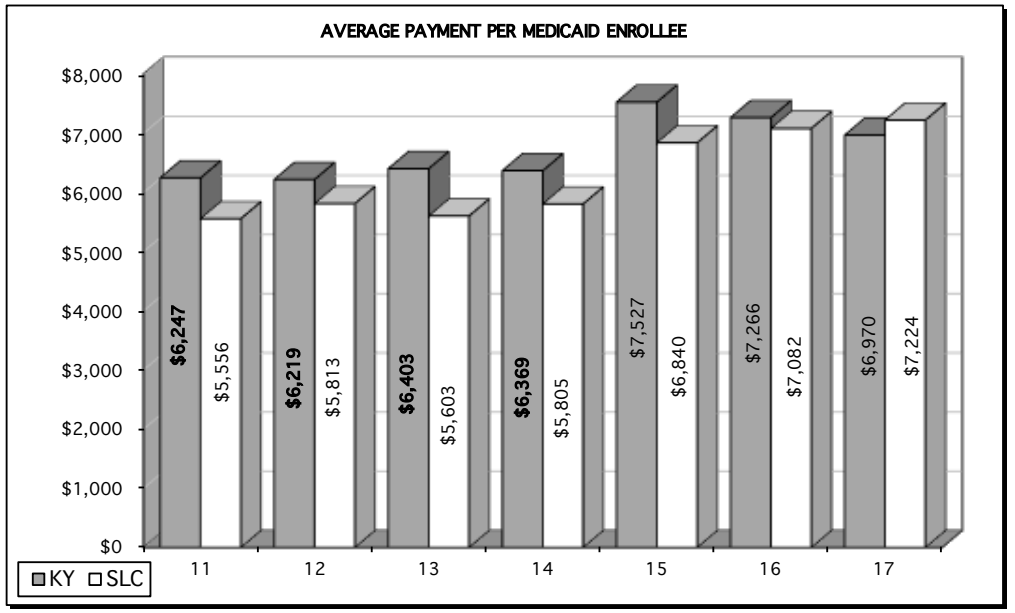
		Rank in U.S.
State population—July 1, 2017	4,316,917	*26*
Per capita personal income	$40,600	*48*
Median household income	$51,348	*44*
Population below Federal Poverty Level	744,239	*21*
Percent of total state population	17.2%	*5*
Population without health insurance coverage	341,351	*28*
Percent of total state population	6.0%	*40*
Recipients of SNAP benefits	654,873	*25*
Total value of issuance	$943,688,786	*24*
Average monthly benefit per recipient	$120.09	*32*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,576	$616	$457	$458	$388	$382	$373	*-21.36%*	*3.9%*
Physician	$364	$111	$49	$57	$33	$47	$35	*-32.36%*	*0.4%*
Dental	$86	$14	$2	$3	$2	$3	$3	*-43.18%*	*0.0%*
Other practitioner	$1	$9	$3	$4	$4	$4	$4	*28.17%*	*0.0%*
Clinic and health center	$264	$195	$106	$113	$119	$202	$191	*-5.27%*	*2.0%*
Other acute	$506	$369	$314	$386	$368	$435	$443	*-2.19%*	*4.7%*
Drugs	$253	($39)	$32	$36	$39	$32	$34	*-28.53%*	*0.4%*
Institutional LTSS	$992	$1,071	$1,055	$1,148	$1,159	$1,144	$1,182	*2.96%*	*12.4%*
Home and community-based LTSS	$663	$581	$618	$735	$785	$848	$835	*3.92%*	*8.8%*
Managed care and premium assistance	$768	$2,563	$2,970	$4,769	$6,392	$6,315	$6,226	*41.74%*	*65.4%*
Medicare Premiums and Coinsurance	$247	$212	$215	$198	$210	$252	$260	*0.89%*	*2.7%*
Collections	($68)	($137)	($96)	($115)	($76)	($55)	($59)	*-2.30%*	*-0.6%*
Total Spending	**$5,652**	**$5,565**	**$5,726**	**$7,793**	**$9,423**	**$9,609**	**$9,527**	*9.09%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	937,000	926,000	926,882	1,258,600	1,284,193	1,361,722	1,403,257		
Average Payment Per Enrollee	$6,247	$6,219	$6,403	$6,369	$7,527	$7,266	$6,970		
Average Payment Per Capita	$1,340.02	$1,314.04	$1,349.29	$1,816.53	$2,184.44	$2,229.18	$2,195.90		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

KENTUCKY

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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.
- Home & Community-based Services (HCBS) Transitions Waiver: Provides various services, including adult day health, case management, personal care, supported employment, specialized medical equipment, occupational/physical therapy, environmental and home adaptations for individuals 65 and older or disabled persons aged 18 to 64. Information on the CMS website indicates this waiver expired in February 2018.

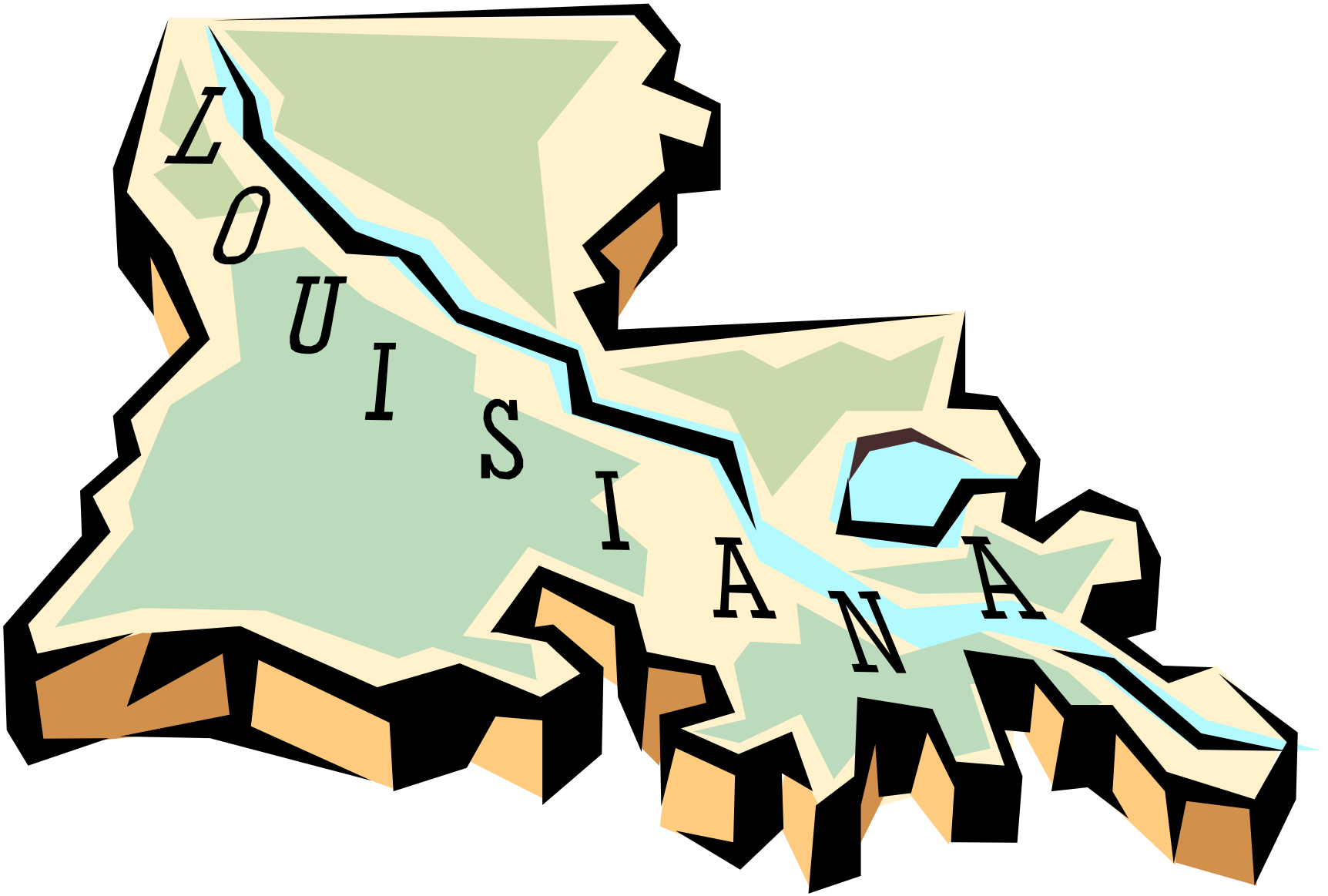
Managed Care (2017)

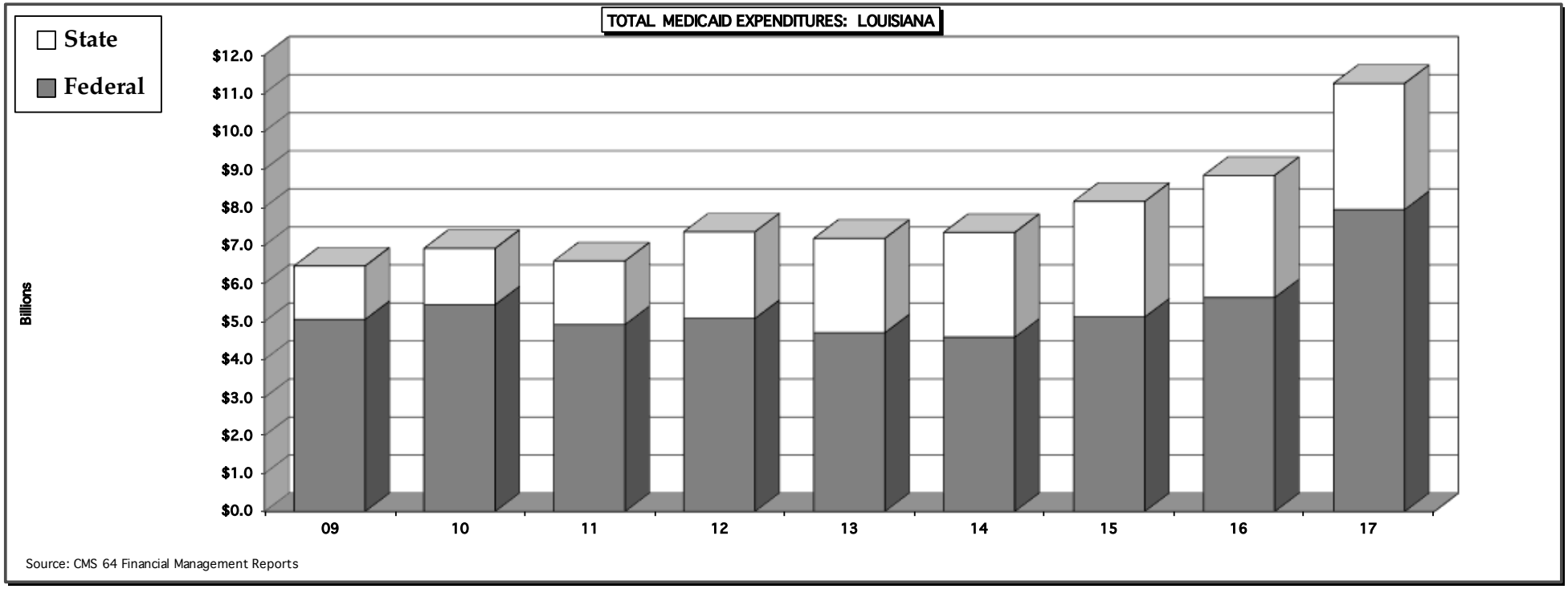
- Medicaid only Managed Care Organization (MCO)
- 93.22% of Medicaid enrollment (1,308,047 persons) in managed care in 2017

Children's Health Insurance Program: Kentucky Children's Health Insurance Program (KCHIP)

- 96,379 enrollees
- Combination Plan
- Enhanced FMAP: 79.32% in 2017
- Federal Allotment: $268.2 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$8,536,666,882	$10,913,541,197	*6.35%*	*27.84%*
Federal Share	$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	$5,430,287,731	$7,711,132,867	*5.05%*	*10.30%*
State Share	$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	$3,106,379,151	$3,202,408,330	*10.33%*	*5.66%*
Administrative Costs	$183,740,043	$198,102,582	$290,723,004	$297,200,666	$292,825,871	$282,202,964	$289,090,288	$300,561,302	$340,586,524	*7.10%*	*3.97%*
Federal Share	$100,934,536	$111,427,453	$194,433,654	$197,021,293	$187,692,689	$177,438,372	$192,429,518	$197,080,857	$228,778,093	*9.52%*	*2.42%*
State Share	$82,805,507	$86,675,129	$96,289,350	$100,179,373	$105,133,182	$104,764,592	$96,660,770	$103,480,445	$111,808,431	*3.39%*	*7.06%*
Admin. Costs as % of Payments	2.93%	2.95%	4.62%	4.21%	4.25%	4.00%	3.68%	3.52%	3.12%		
Federal Match Rate*	80.75%	81.48%	63.61%	61.09%	61.24%	60.98%	62.05%	62.21%	62.28%		

**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 17)

Provider(s)	Tax Rate
Nursing Homes	$11.80 per patient day
ICF/MR Facilities	$14.30 per patient day
Pharmacy	$.10 per prescription
Ground Ambulance Provider Fee	1.5% of net patient revenues
Health Maintenance Organization Premium Tax	5.5% of gross premiums received

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$837,262,187	$682,129,639	$500,965,884	$657,336,594	$652,022,789	$1,047,714,322	$1,203,528,156	$1,193,421,292	$1,091,529,384	*2.99%*
Mental Hospitals	$110,960,284	$108,493,791	$99,185,768	$75,697,359	$114,778,866	$77,954,684	$125,597,759	$90,303,385	$59,629,625	*-6.67%*
Total	**$948,222,471**	**$790,623,430**	**$600,151,652**	**$733,033,953**	**$766,801,655**	**$1,125,669,006**	**$1,329,125,915**	**$1,283,724,677**	**$1,151,159,009**	*2.18%*

MEDICAID EXPANSION

Expanded Medicaid under ACA as of July 2016.

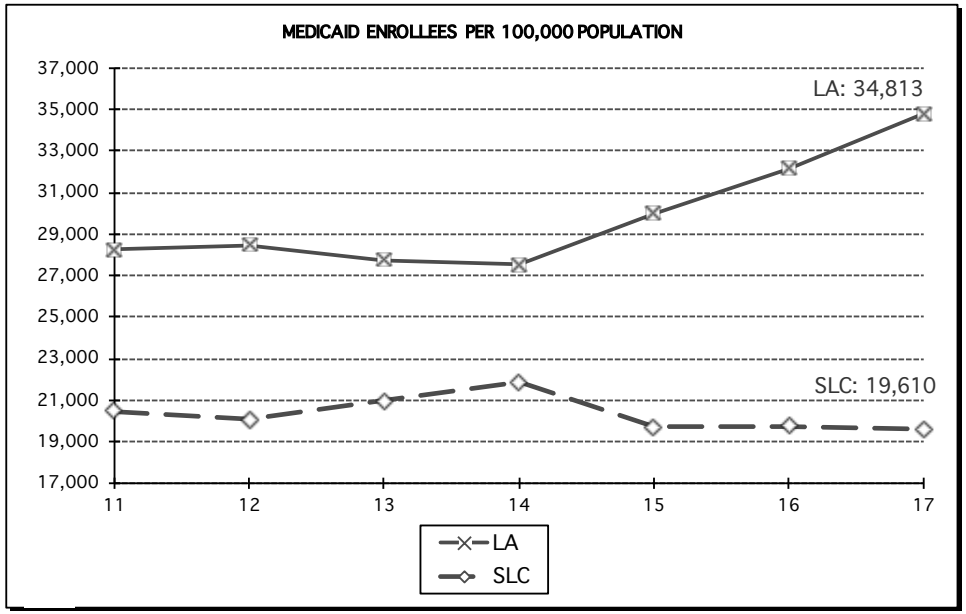
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

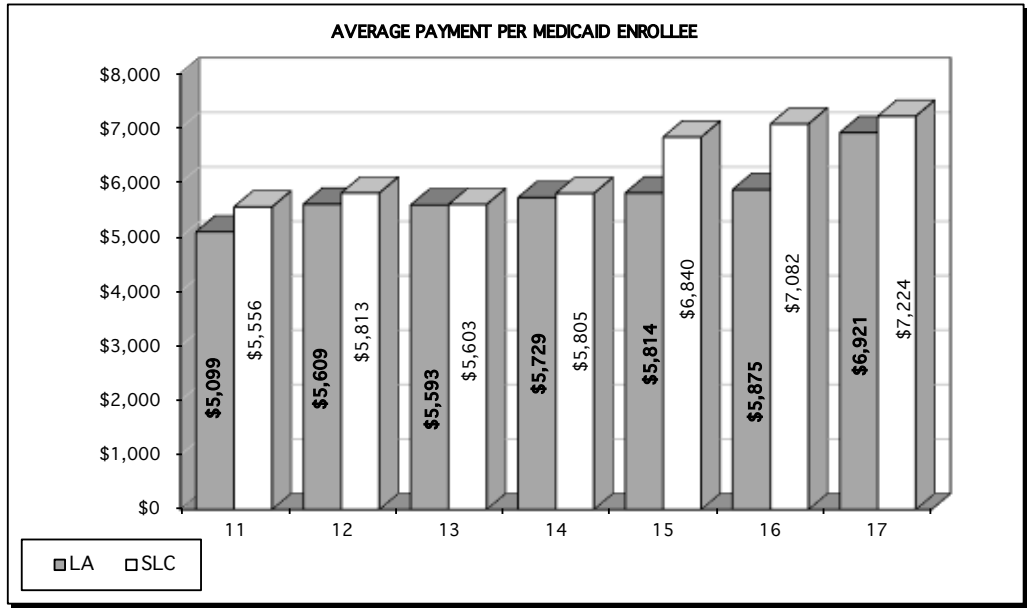
		Rank in U.S.
State population—July 1, 2017	4,553,037	*25*
Per capita personal income	$43,786	*41*
Median household income	$43,903	*50*
Population below Federal Poverty Level	899,039	*13*
Percent of total state population	19.7%	*2*
Population without health insurance coverage	566,927	*19*
Percent of total state population	11.9%	*8*
Recipients of SNAP benefits	928,962	*13*
Total value of issuance	$1,440,110,876	*12*
Average monthly benefit per recipient	$129.19	*11*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

LOUISIANA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$2,462	$2,115	$2,202	$2,212	$1,891	$1,502	$1,402	*-9.0%*	*12.8%*
Physician	$523	$411	$317	$328	$182	$62	$48	*-32.8%*	*0.4%*
Dental	$123	$121	$112	$82	$1	$0	$4	*-42.5%*	*0.0%*
Other practitioner	$0	$0	$0	$0	$0	$0	$0	*n/a*	*0.0%*
Clinic and health center	$199	$146	$106	$89	$63	$40	$29	*-27.5%*	*0.3%*
Other acute	$319	$385	$357	$314	$246	$233	$206	*-7.0%*	*1.9%*
Drugs	$573	$789	$182	$234	$199	$52	$68	*-29.9%*	*0.6%*
Institutional LTSS	$1,337	$1,421	$1,453	$1,334	$1,475	$1,479	$1,488	*1.8%*	*13.6%*
Home and community-based LTSS	$844	$795	$843	$835	$820	$753	$763	*-1.7%*	*7.0%*
Managed care and premium assistance	$14	$916	$1,311	$1,659	$2,904	$4,206	$6,677	*179.5%*	*61.2%*
Medicare Premiums and Coinsurance	$270	$259	$265	$271	$277	$310	$353	*4.6%*	*3.2%*
Collections	($366)	($302)	($258)	($303)	($195)	($101)	($125)	*-16.4%*	*-1.1%*
Total Spending	**$6,298**	**$7,057**	**$6,889**	**$7,056**	**$7,863**	**$8,537**	**$10,914**	*9.6%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	1,292,000	1,311,000	1,284,061	1,280,893	1,402,212	1,504,333	1,626,037		
Average Payment Per Enrollee	$5,099	$5,609	$5,593	$5,729	$5,814	$5,875	$6,921		
Average Payment Per Capita	$1,439.93	$1,597.37	$1,551.90	$1,578.36	$1,745.40	$1,889.02	$2,409.46		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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 6/1/1990. 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.

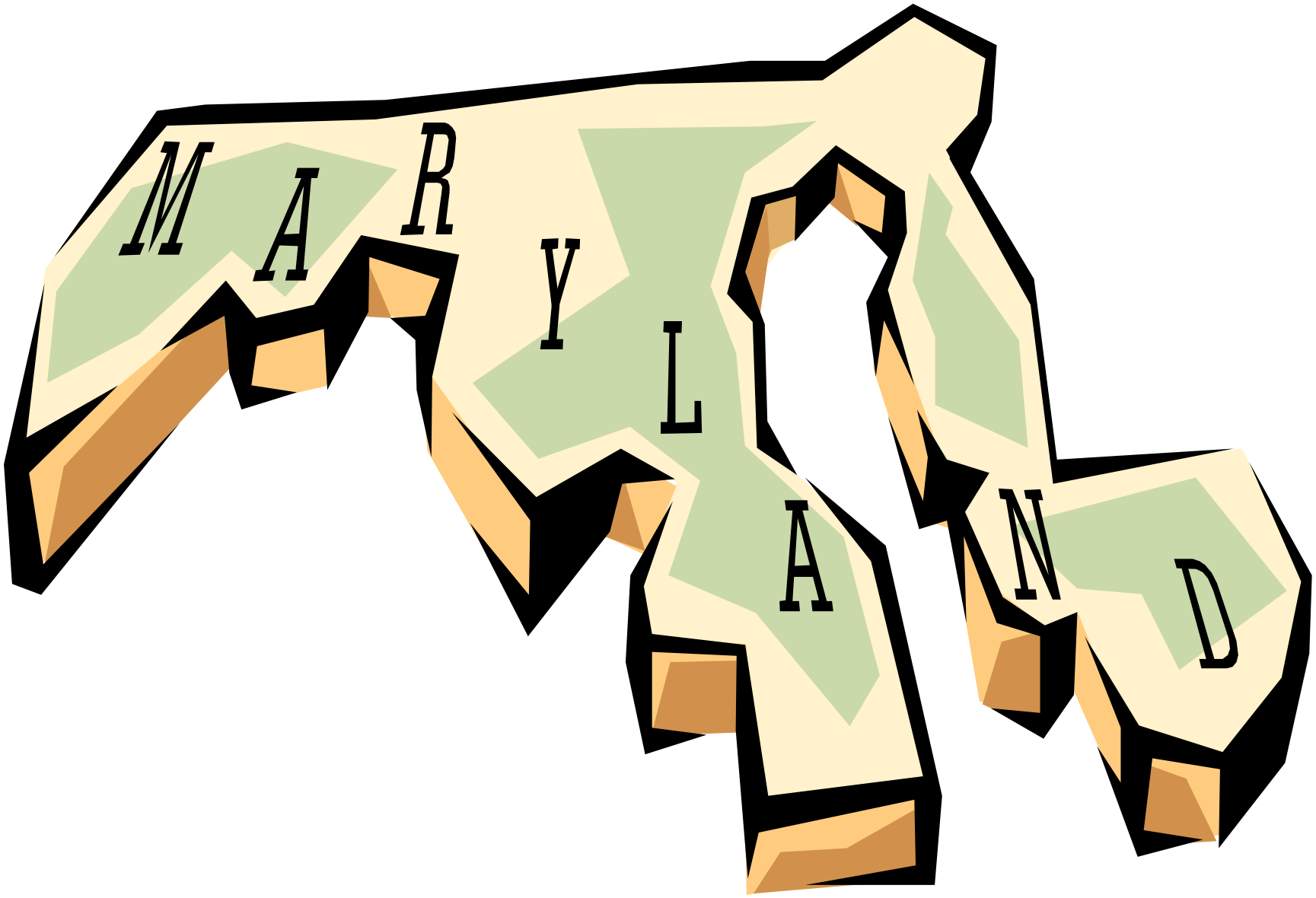
Managed Care (2017)

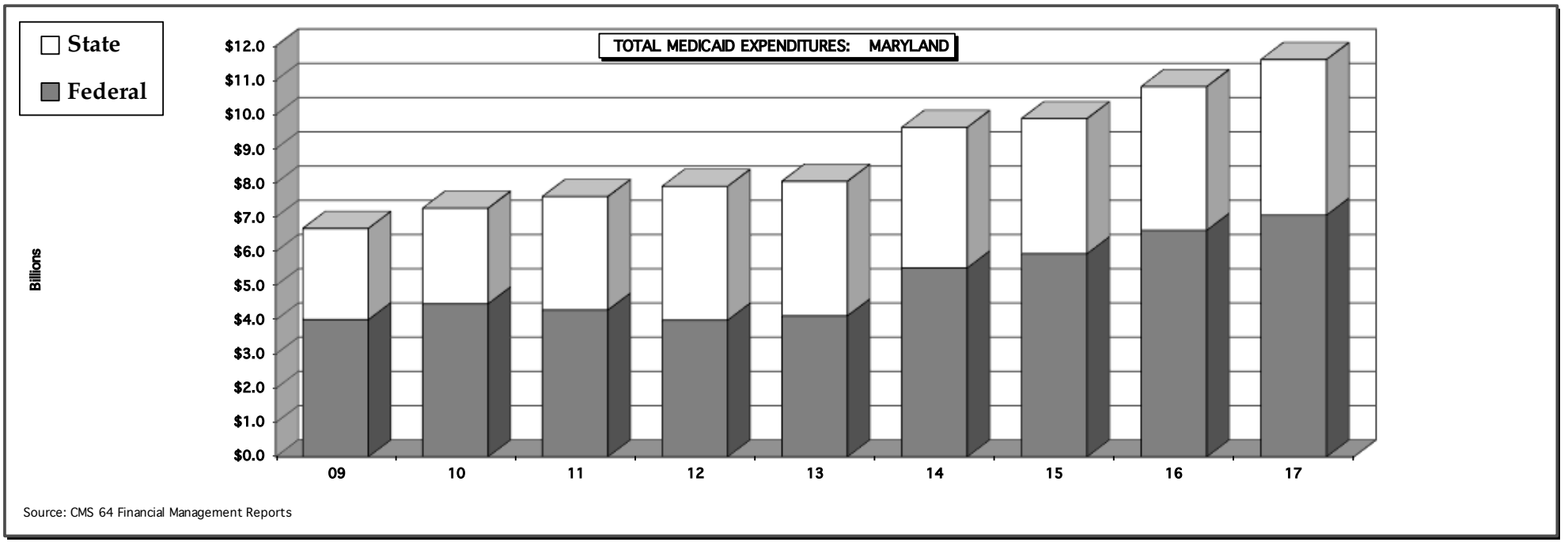
- Comprehensive Managed Care Organizations
- Program of All Inclusive Care for the Elderly (PACE)
- Behavioral Health Organization Services
- Dental Services
- 91.82% of Medicaid enrollment (1,493,106 persons) in managed care in 2017

Children's Health Insurance Program: LaCHIP

- 158,298 enrollees
- Combination Plan
- Enhanced FMAP: 73.60% in 2017
- Federal Allotment: $358.8 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$10,398,319,397	$11,161,406,671	*6.48%*	*7.34%*
Federal Share	$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	$6,361,715,494	$6,775,286,912	*6.53%*	*6.50%*
State Share	$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	$4,036,603,903	$4,386,119,759	*6.41%*	*8.66%*
Administrative Costs	$334,146,709	$253,850,805	$286,054,573	$340,237,116	$364,819,468	$415,492,007	$471,463,426	$420,914,463	$448,717,095	*3.33%*	*6.61%*
Federal Share	$179,368,032	$137,121,742	$153,580,393	$207,251,379	$223,887,115	$268,293,049	$305,558,596	$260,367,749	$289,765,828	*5.47%*	*11.29%*
State Share	$154,778,677	$116,729,063	$132,474,180	$132,985,737	$140,932,353	$147,198,958	$165,904,830	$160,546,714	$158,951,267	*0.30%*	*-0.99%*
Admin. Costs as % of Payments	5.27%	3.62%	3.91%	4.50%	4.75%	4.51%	5.01%	4.05%	4.02%		
Federal Match Rate*	61.59%	61.59%	50.00%	50.00%	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.*

MARYLAND

Provider Taxes Currently in Place (FFY 17)

Provider(s)	Tax Rate
Nursing Home	5.50%
Managed Care Organization	2% total premiums
Hospital (began in 2009)	Variable
*Two separate hospital assessments (one is specific dollar amount per hospital and one is 1.25% of hospital net patient revenue)	

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$80,097,795	$60,911,473	$37,973,511	$25,724,403	$41,916,747	$47,227,358	$51,995,264	$76,759,774	$76,742,478	*-0.47%*
Mental Hospitals	$50,411,359	$51,993,138	$50,378,598	$10,600,460	$92,424,069	$53,670,127	$55,969,470	$42,241,472	$67,639,629	*3.32%*
Total	**$130,509,154**	**$112,904,611**	**$88,352,109**	**$36,324,863**	**$134,340,816**	**$100,897,485**	**$107,964,734**	**$119,001,246**	**$144,382,107**	*1.13%*

ACA MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014.

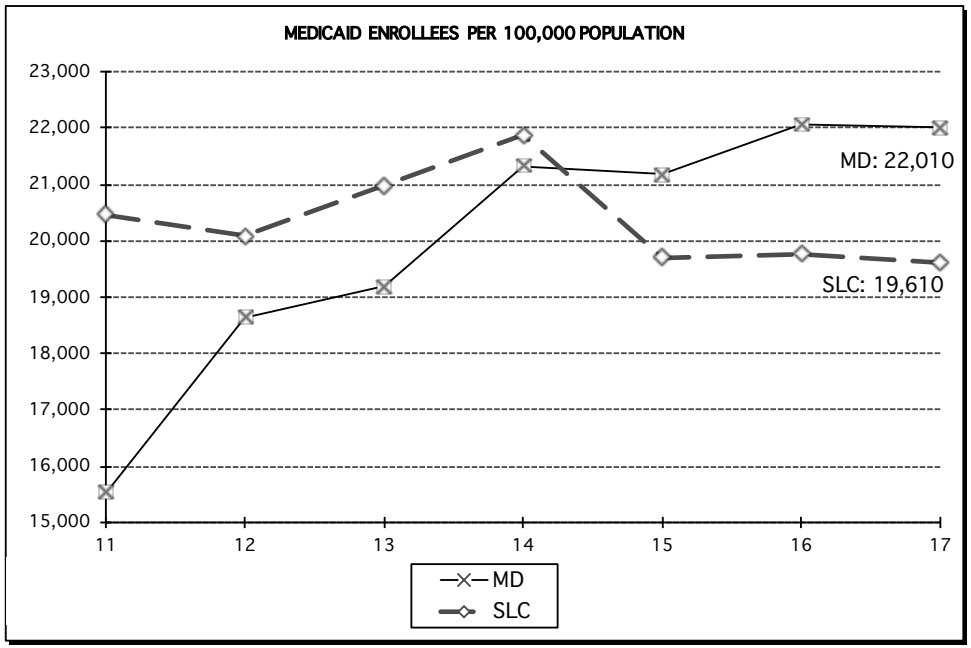
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

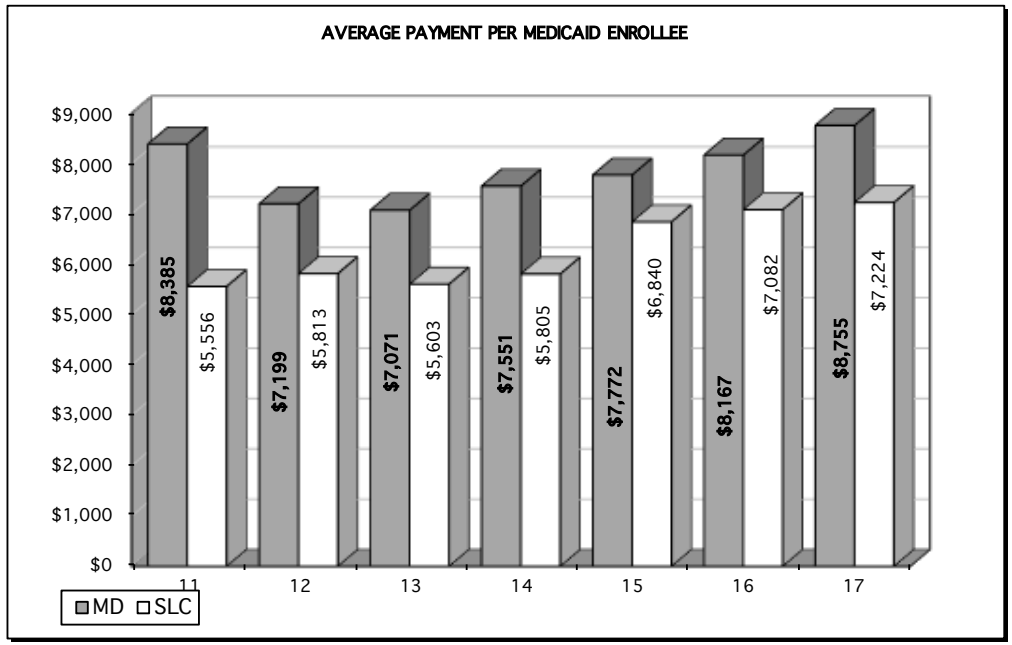
		Rank in U.S.
State population—July 1, 2017	5,915,309	*19*
Per capita personal income	$61,123	*6*
Median household income	$81,084	*2*
Population below Federal Poverty Level	549,171	*27*
Percent of total state population	9.3%	*50*
Population without health insurance coverage	433,369	*23*
Percent of total state population	6.6%	*34*
Recipients of SNAP benefits	684,282	*22*
Total value of issuance	$987,124,236	*22*
Average monthly benefit per recipient	$120.21	*31*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,218	$997	$993	$1,210	$1,107	$1,178	$1,127	*-1.3%*	*10.1%*
Physician	$85	$79	$93	$128	$117	$119	$130	*7.3%*	*1.2%*
Dental	$115	$120	$121	$125	$130	$122	$140	*3.4%*	*1.3%*
Other practitioner	$16	$17	$18	$25	$29	$31	$39	*16.1%*	*0.4%*
Clinic and health center	$52	$53	$50	$57	$100	$142	$156	*20.1%*	*1.4%*
Other acute	$335	$867	$793	$936	$1,014	$1,133	$1,361	*26.3%*	*12.2%*
Drugs	$89	$226	$132	$291	$243	$386	$372	*26.9%*	*3.3%*
Institutional LTSS	$1,077	$1,271	$1,322	$1,338	$1,353	$1,332	$1,389	*4.3%*	*12.4%*
Home and community-based LTSS	$1,340	$987	$1,044	$1,103	$1,183	$1,141	$1,346	*0.1%*	*12.1%*
Managed care and premium assistance	$2,912	$2,843	$2,965	$3,892	$4,005	$4,585	$4,819	*8.8%*	*43.2%*
Medicare Premiums and Coinsurance	$229	$227	$249	$267	$271	$309	$351	*7.4%*	*3.1%*
Collections	($148)	($122)	($93)	($162)	($143)	($81)	($69)	*-11.9%*	*-0.6%*
Total Spending	**$7,320**	**$7,564**	**$7,688**	**$9,210**	**$9,410**	**$10,398**	**$11,162**	*7.3%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	907,000	1,098,000	1,138,829	1,274,700	1,271,445	1,324,796	1,326,080		
Average Payment Per Enrollee	$8,385	$7,199	$7,071	$7,551	$7,772	$8,167	$8,755		
Average Payment Per Capita	$1,301.40	$1,341.84	$1,356.62	$1,610.92	$1,645.20	$1,801.80	$1,927.03		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

MARYLAND

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

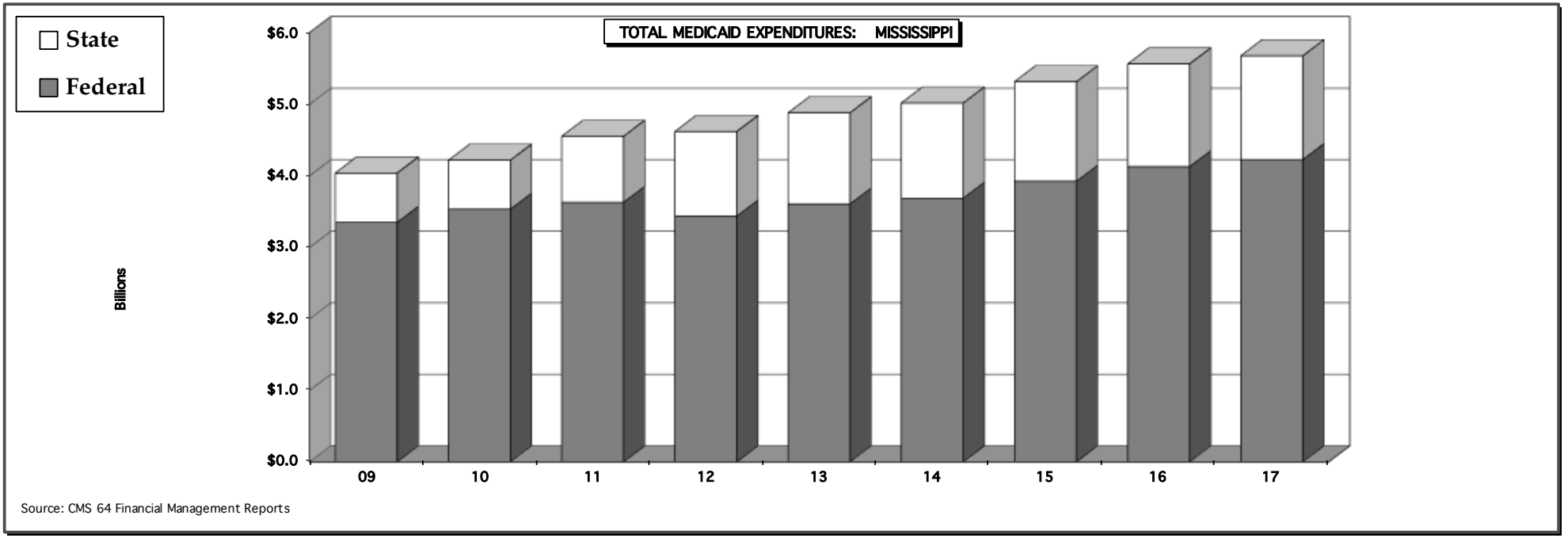
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental 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 Fragile Children: The Model Waiver began January of 1985. This waiver targets medically fragile individuals of all ages and includes case management services, certified nursing assistant services, medical day care, plan of care meetings including physician participation, and private duty nursing.
•Living at Home (Home & 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.
•Waivers 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 7/1/2008. 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 7/1/2008. 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 Brain 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.
•Family Supports Waiver: provides personal supports, respite care services, support broker services, assistive technology and services, behavioral health support services, environmental assessment and modfiication services, and other services for individuals aged 0-21 with developmental disabilities.
•Community Supports Waiver: provides career exploration, day habilitation, medical day care, personal supports, behavioral health support services, assistive technology and services, environmental assessment and modfiication services, and other services for individuals with developmental disabilities (no maximum age).

Managed Care (2017)
•Comprehensive Managed Care Organization: (MCO)
•Program of All Inclusive Care for the Elderly (PACE)
•87.58% of Medicaid enrollment (1,161,315 persons) in managed care in 2017

Children's Health Insurance Program: Maryland Children's Health Program (MCHP)
•141,836 enrollees
•Medicaid Expansion
•Enhanced FMAP: 65.00% in 2017
•Federal Allotment: $295.9 M in 2017

STATE MEDICAID PROFILE



State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$5,397,714,759	$5,462,308,168	*3.73%*	*1.20%*
Federal Share	$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	$4,017,163,865	$4,081,434,505	*2.47%*	*1.60%*
State Share	$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	$1,380,550,894	$1,380,873,663	*8.75%*	*0.02%*
Administrative Costs	$110,922,430	$110,491,770	$140,203,278	$186,003,784	$170,612,163	$150,915,134	$177,402,738	$165,698,679	$214,731,135	*7.62%*	*29.59%*
Federal Share	$72,107,000	$63,362,100	$82,607,560	$137,971,291	$120,731,314	$101,688,772	$117,186,584	$110,563,839	$146,019,670	*8.16%*	*32.07%*
State Share	$38,815,430	$47,129,670	$57,595,718	$48,032,493	$49,880,849	$49,226,362	$60,216,154	$55,134,840	$68,711,465	*6.55%*	*24.62%*
Admin. Costs as % of Payments	2.82%	2.69%	3.18%	4.20%	3.62%	3.10%	3.45%	3.07%	3.93%		
Federal Match Rate*	84.24%	84.86%	74.73%	74.18%	73.43%	73.05%	73.58%	74.17%	74.63%		

**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 17)

Provider(s)	Tax Rate
Nursing homes	rate varies by facility category
ICF/DD	Maximum Allowable by Federal law/regulation
Psychciatric Residential Treatment fac.	Maximum Allowable by Federal law/regulation

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$211,863,454	$208,213,247	$204,084,644	$210,532,157	$217,999,554	$222,637,569	$224,546,417	$223,355,122	$224,073,780	*0.62%*
Mental Hospitals	$0	$0	$0	$0	$0	$0	$0	$0	$0	*n/a*
Total	**$211,863,454**	**$208,213,247**	**$204,084,644**	**$210,532,157**	**$217,999,554**	**$222,637,569**	**$224,546,417**	**$223,355,122**	**$224,073,780**	*0.62%*

ACA MEDICAID EXPANSION

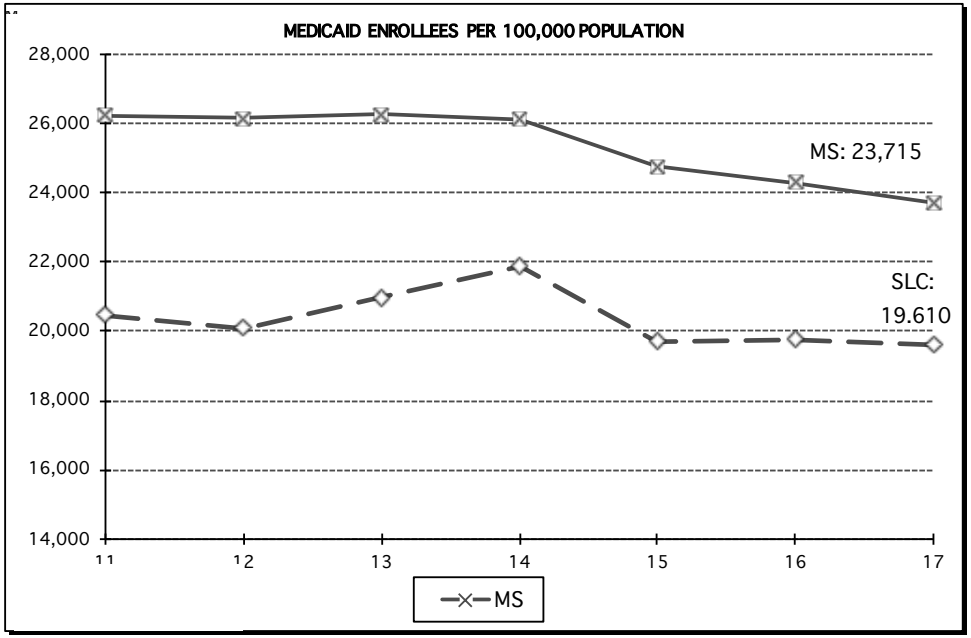
Not expanding Medicaid under ACA as of May 2019

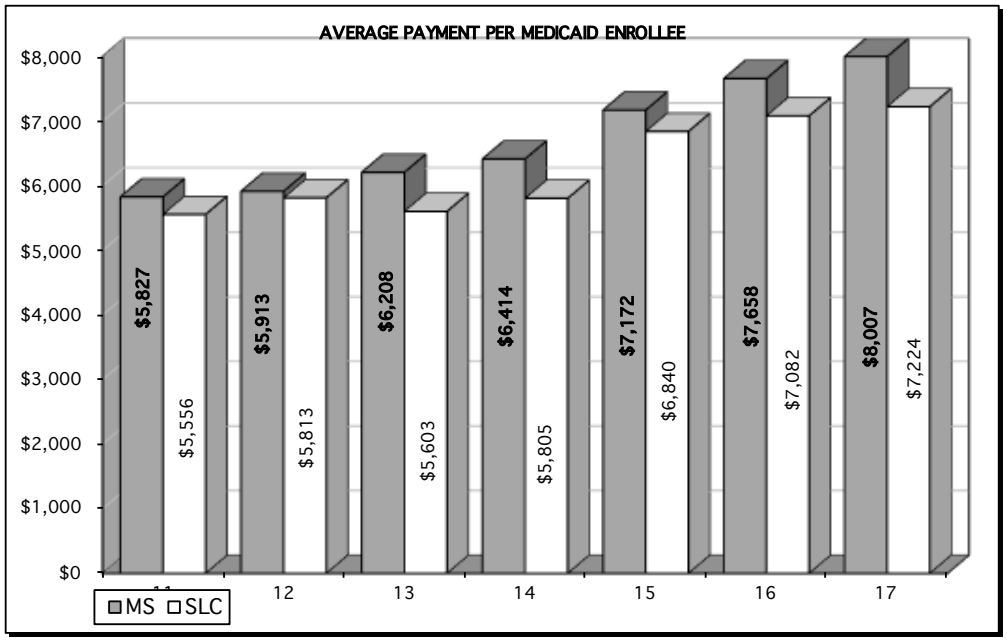
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

		Rank in U.S.
State population—July 1, 2017	2,889,851	*34*
Per capita personal income	$36,567	*51*
Median household income	$43,441	*51*
Population below Federal Poverty Level	571,219	*25*
Percent of total state population	19.8%	*1*
Population without health insurance coverage	398,647	*24*
Percent of total state population	12.7%	*6*
Recipients of SNAP benefits	537,370	*27*
Total value of issuance	$742,934,749	*27*
Average monthly benefit per recipient	$115.21	*41*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,708	$1,628	$1,660	$1,661	$1,684	$751	$633	*-15.2%*	*11.6%*
Physician	$311	$290	$216	$198	$172	$126	$113	*-15.5%*	*2.1%*
Dental	$9	$9	$6	$4	$5	$5	$5	*-9.2%*	*0.1%*
Other practitioner	$28	$29	$25	$23	$21	$7	$9	*-17.7%*	*0.2%*
Clinic and health center	$75	$80	$88	$95	$81	$31	$32	*-13.1%*	*0.6%*
Other acute	$258	$450	$386	$375	$360	$251	$252	*-0.4%*	*4.6%*
Drugs	$170	$194	$125	$147	$104	$46	$55	*-17.1%*	*1.0%*
Institutional LTSS	$1,018	$1,097	$1,123	$1,096	$1,099	$1,074	$1,114	*1.5%*	*20.4%*
Home and community-based LTSS	$414	$255	$296	$315	$345	$366	$434	*0.8%*	*7.9%*
Managed care and premium assistance	$259	$234	$607	$763	$1,074	$2,520	$2,571	*46.6%*	*47.1%*
Medicare Premiums and Coinsurance	$208	$201	$204	$207	$212	$236	$262	*3.9%*	*4.8%*
Collections	($46)	($34)	($28)	($19)	($20)	($15)	($17)	*-15.2%*	*-0.3%*
Total Spending	**$4,411**	**$4,432**	**$4,709**	**$4,865**	**$5,136**	**$5,398**	**$5,462**	*3.6%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	781,000	781,000	785,966	782,053	740,937	726,473	708,992		
Average Payment Per Enrollee	$5,827	$5,913	$6,208	$6,414	$7,172	$7,658	$8,007		
Average Payment Per Capita	$1,528.22	$1,546.75	$1,631.30	$1,675.74	$1,775.78	$1,861.73	$1,898.89		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

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ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

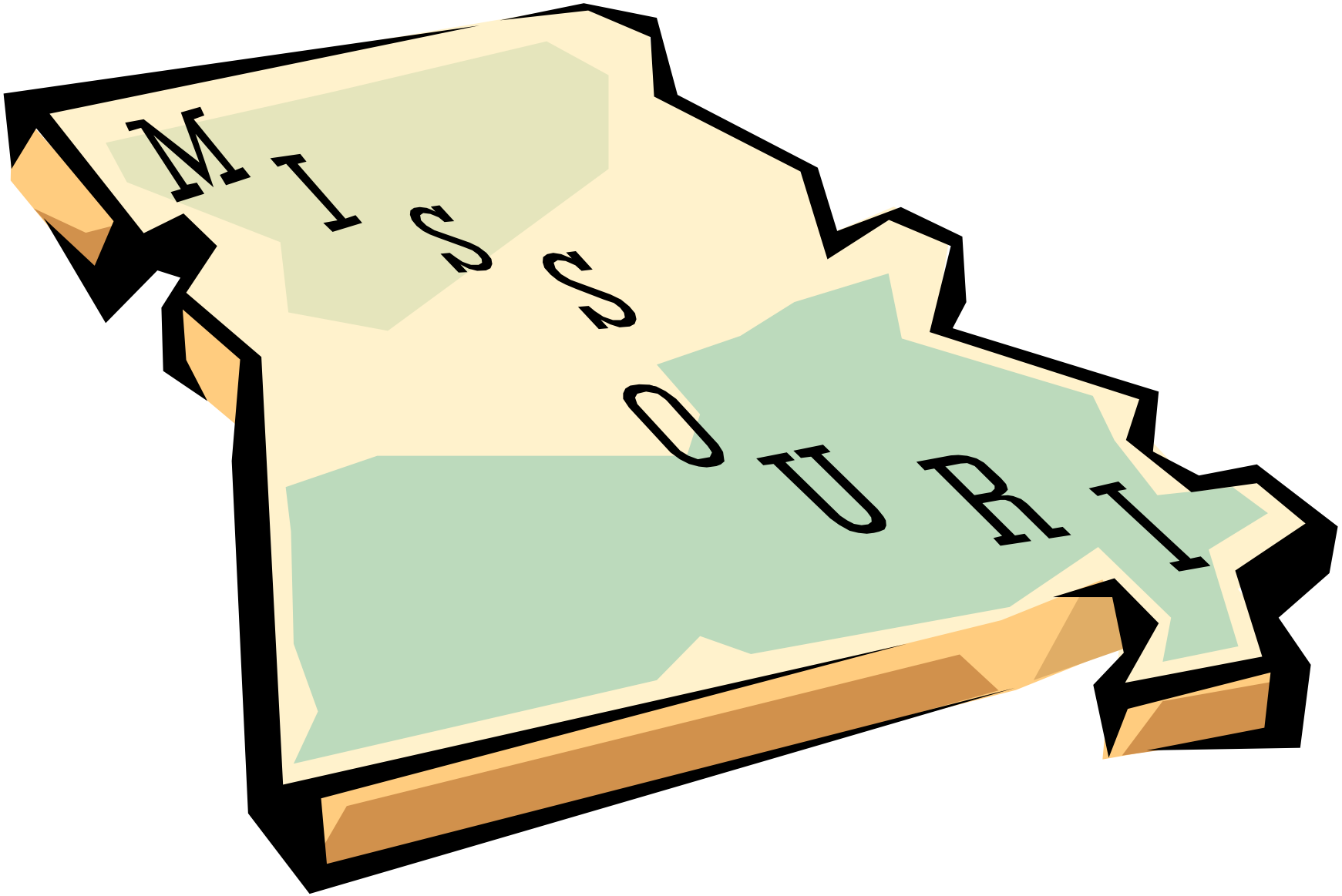
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

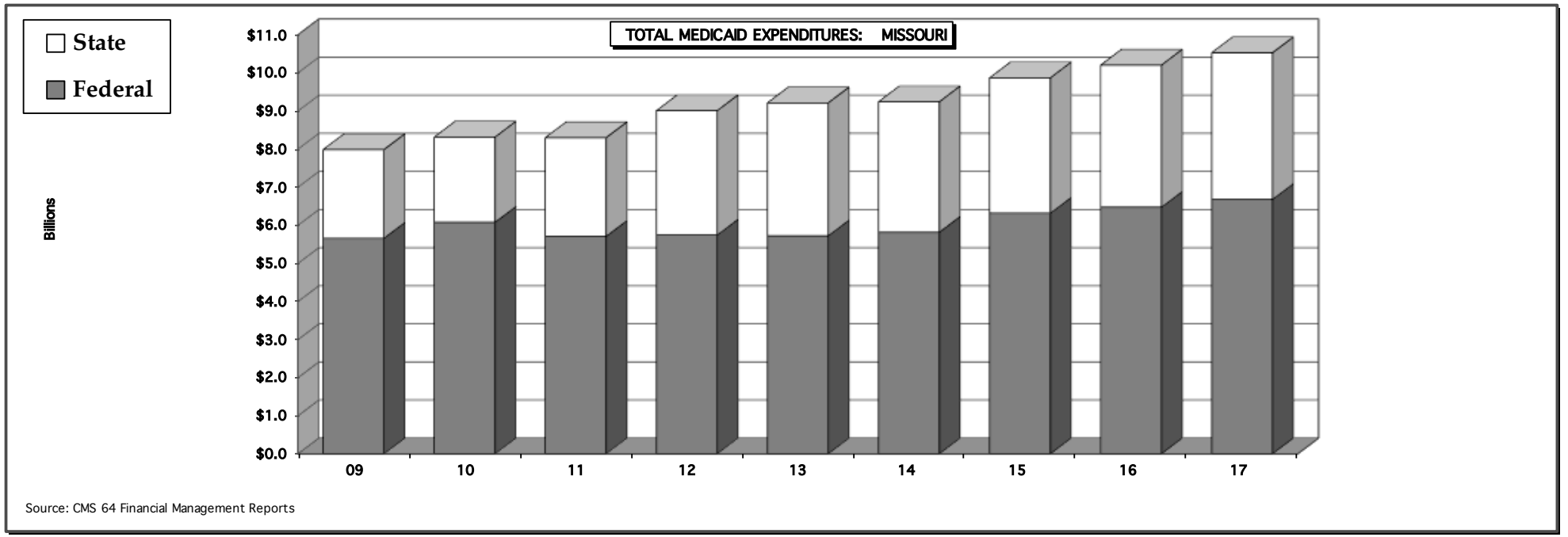
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Elderly and Disabled (E&D) Waiver: Provides home and community-based services to individuals 21 and over who, but for the provision of 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 Waiver is limited to individuals age sixteen (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.
•Assisted Living Waiver: Provides adult residential care for traumatic brain injury participants, assisted living for individuals aged 65 or older and to phyiscally disabled individuals aged 21-64.
•Traumatic Brain Injury (TBI)/Spinal Cord Injury Waiver: Provides case management, personal care attendant, respite, environmental accessibility adaptations, specialized medical equipment and supplies, transition assistance services for individuals with brain injuries and/or physically disabled persons of all ages.

Managed Care (2017)
•Comprehensive Managed Care Organization (MCO)
•68.72% of Medicaid enrollment (487,201 persons) in managed care in 2017

Children's Health Insurance Program: CHIP
•90,904 enrollees
•Combination Plan
•Enhanced FMAP: 82.24% in 2017
•Federal Allotment: $316.8 M in 2017

STATE MEDICAID PROFILE





Source: CMS 64 Financial Management Reports

State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$9,811,515,212	$10,095,843,109	*3.13%*	*2.90%*
Federal Share	$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	$6,224,900,254	$6,397,324,390	*1.74%*	*2.77%*
State Share	$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	$3,586,614,958	$3,698,518,719	*6.10%*	*3.12%*
Administrative Costs	$337,427,940	$318,095,008	$286,268,889	$383,564,996	$346,547,941	$409,922,940	$350,451,191	$390,426,461	$431,896,767	*2.78%*	*10.62%*
Federal Share	$180,139,779	$177,393,910	$167,571,485	$251,685,974	$219,657,444	$270,839,417	$218,597,478	$249,510,171	$280,685,756	*5.05%*	*12.49%*
State Share	$157,288,161	$140,701,098	$118,697,404	$131,879,022	$126,890,497	$139,083,523	$131,853,713	$140,916,290	$151,211,011	*-0.44%*	*7.31%*
Admin. Costs as % of Payments	4.41%	3.98%	3.57%	4.45%	3.91%	4.64%	3.68%	3.98%	4.28%		
Federal Match Rate*	73.27%	74.43%	63.29%	63.45%	61.37%	62.03%	63.45%	63.28%	63.21%		

**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 17)

Provider(s)	Tax Rate
General and mental hospitals	5.95% of inpatient/outpatient revenues
Nursing homes	$12.11 per patient day
Ambulance (established 9/1/2011)	4.42%
Pharmacy	1.82% gross retail prescription sales
ICF/DD (began in 2009)	5.95%

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$538,614,537	$546,257,472	$528,236,515	$532,754,243	$496,159,120	$521,723,012	$473,625,424	$438,033,009	$460,836,846	*-1.72%*
Mental Hospitals	$198,763,354	$192,572,458	$171,360,681	$222,834,355	$207,234,539	$207,234,564	$207,234,582	$223,661,750	$206,871,341	*0.45%*
Total	**$737,377,891**	**$738,829,930**	**$699,597,196**	**$755,588,598**	**$703,393,659**	**$728,957,576**	**$680,860,006**	**$661,694,759**	**$667,708,187**	*-1.10%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

		Rank in U.S.
State population—July 1, 2017	5,928,516	*18*
Per capita personal income	$45,014	*37*
Median household income	$56,885	*37*
Population below Federal Poverty Level	795,732	*19*
Percent of total state population	13.4%	*22*
Population without health insurance coverage	621,543	*16*
Percent of total state population	9.8%	*20*
Recipients of SNAP benefits	758,918	*19*
Total value of issuance	$1,116,216,424	*17*
Average monthly benefit per recipient	$122.57	*23*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

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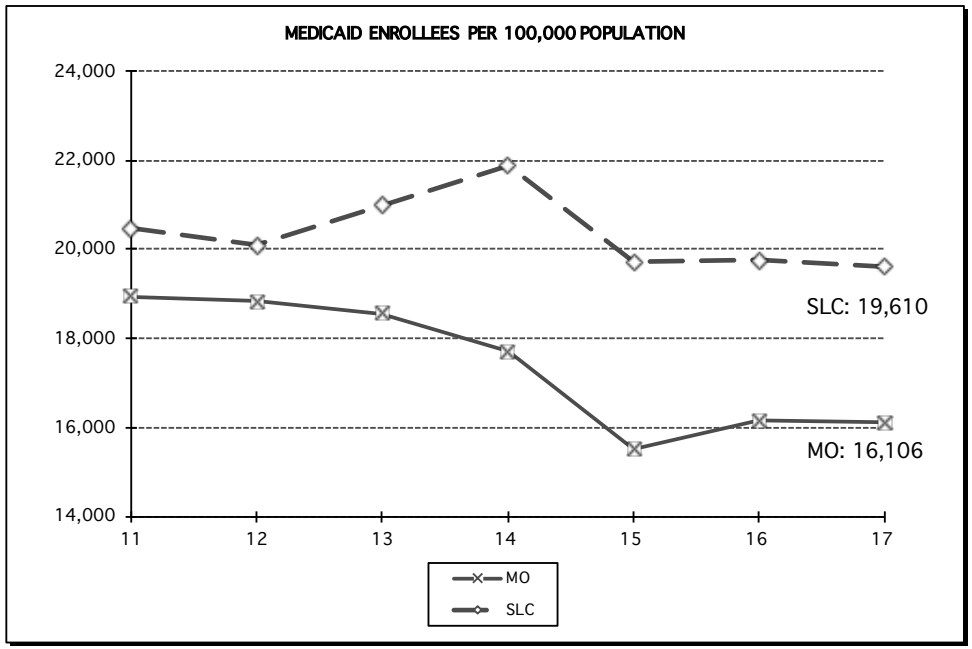
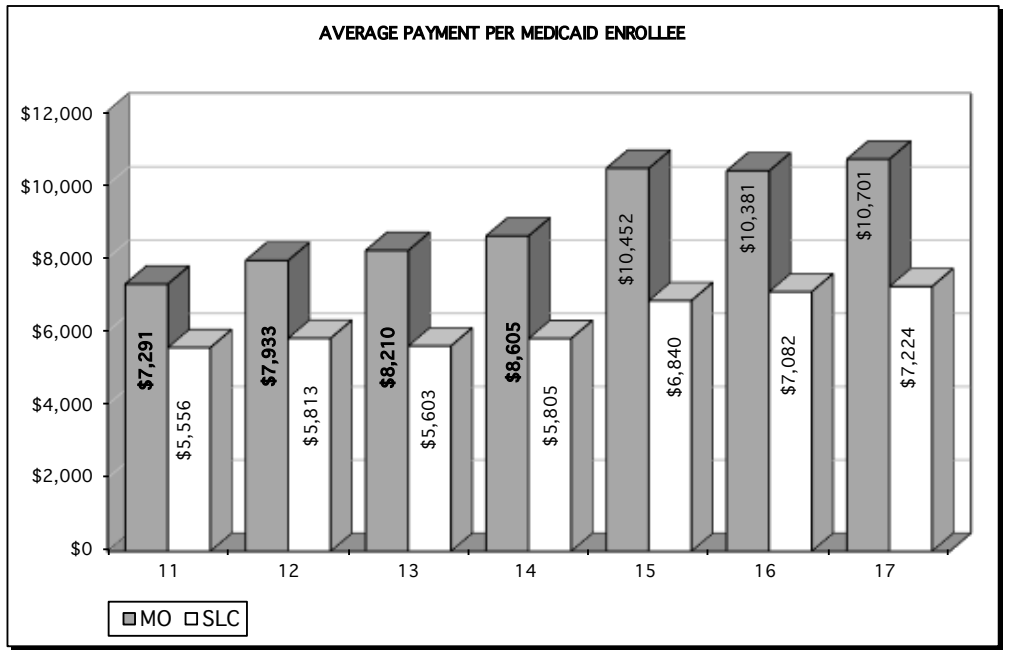




DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$2,943	$3,017	$2,981	$2,881	$3,095	$2,986	$2,833	*-0.6%*	*28.1%*
Physician	$27	$21	$38	$42	$27	$16	$13	*-11.7%*	*0.1%*
Dental	$15	$15	$15	$14	$14	$14	$13	*-2.2%*	*0.1%*
Other practitioner	$11	$14	$11	$12	$12	$13	$13	*2.9%*	*0.1%*
Clinic and health center	$431	$462	$487	$445	$493	$471	$425	*-0.2%*	*4.2%*
Other acute	$272	$552	$837	$819	$922	$1,057	$988	*24.0%*	*9.8%*
Drugs	$602	$613	$655	$648	$705	$663	$618	*0.4%*	*6.1%*
Institutional LTSS	$1,227	$1,556	$1,319	$1,389	$1,395	$1,474	$1,483	*3.2%*	*14.7%*
Home and community-based LTSS	$1,157	$1,062	$1,174	$1,298	$1,433	$1,530	$1,764	*7.3%*	*17.5%*
Managed care and premium assistance	$1,097	$1,094	$1,116	$1,055	$1,171	$1,326	$1,658	*7.1%*	*16.4%*
Medicare Premiums and Coinsurance	$310	$307	$318	$320	$341	$357	$381	*3.5%*	*3.8%*
Collections	($80)	($106)	($88)	($95)	($90)	($93)	($92)	*2.4%*	*-0.9%*
Total Spending	**$8,011**	**$8,607**	**$8,863**	**$8,829**	**$9,518**	**$9,812**	**$10,096**	*3.5%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	1,138,000	1,135,000	1,121,834	1,073,700	944,257	982,776	983,835		
Average Payment Per Enrollee	$7,291	$7,933	$8,210	$8,605	$10,452	$10,381	$10,701		
Average Payment Per Capita	$1,380.47	$1,494.40	$1,523.88	$1,523.57	$1,622.20	$1,675.97	$1,723.43		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

MISSOURI

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

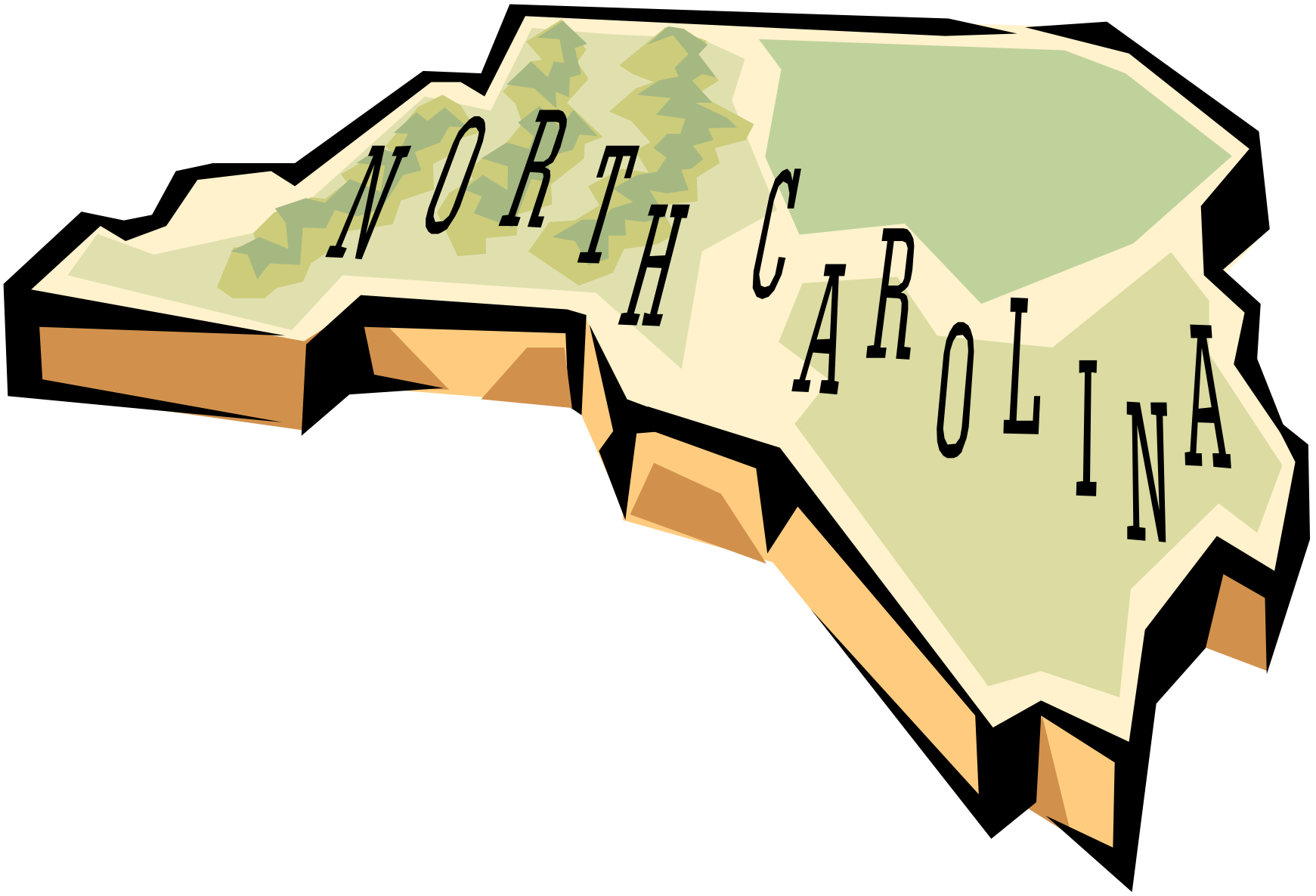
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

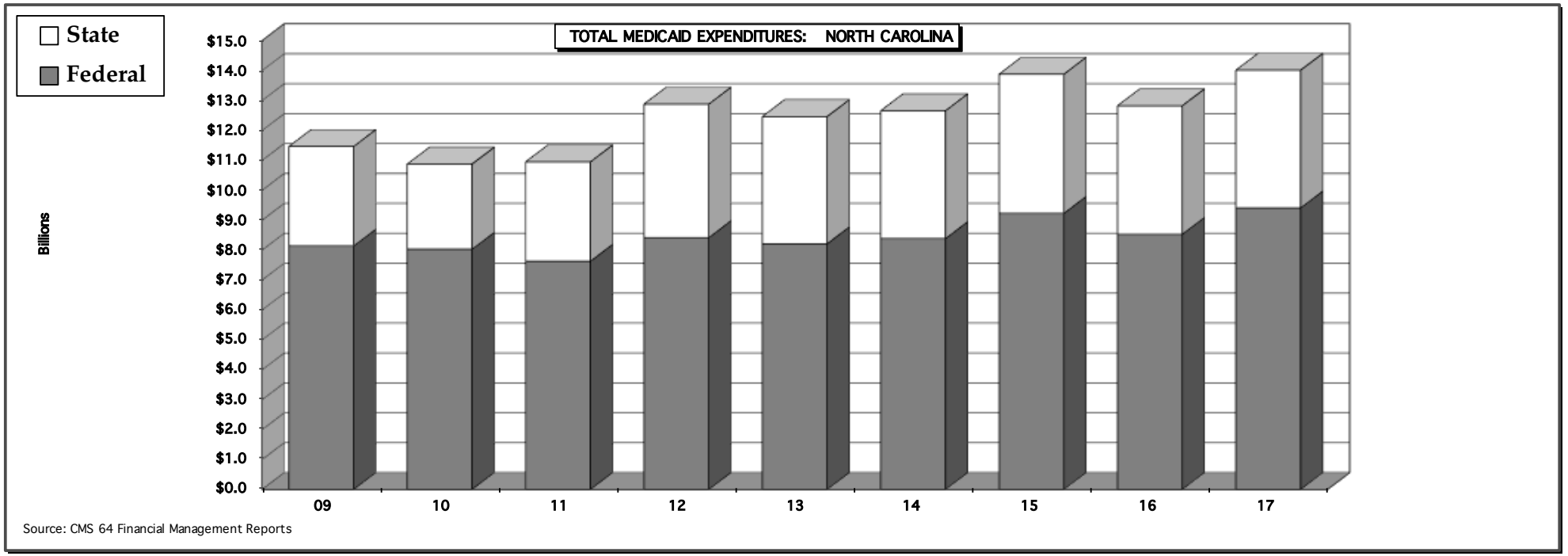
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
- Aged and Disabled Waiver: Provides in-home services to Missouri residents aged 63 or over who have been assessed to require nursing home care but have chosen to receive the care in their home or community instead. Operating since 4/22/1980.
- 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.
- 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 October 1, 2010. This waiver can serve adults and children and has an annual total waiver service cost limit per participant of $1,200.
- Adult Day care: provides services for adults with phyiscal and other disabilities aged 18-63.

Managed Care (2017)
- Comprehensive Managed Care Organizations (MCO)
- Non-Emergency Transportation Services
- Program of All Inclusive Care for the Elderly (PACE)
- 99.13% of Medicaid enrollment (975,297 persons) in managed care in 2017

Children's Health Insurance Program: MO HealthNet for Kids
- 93,800 enrollees
- Combination Plan
- Enhanced FMAP: 74.25% in 2017
- Federal Allotment: $175.2 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$12,157,764,904	$13,336,810,348	*2.28%*	*9.70%*
Federal Share	$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	$8,064,505,659	$8,937,175,483	*1.50%*	*10.82%*
State Share	$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	$4,093,259,245	$4,399,634,865	*4.08%*	*7.48%*
Administrative Costs	$572,461,714	$572,598,062	$648,762,805	$801,860,156	$741,262,408	$662,500,412	$665,345,793	$663,400,490	$674,789,829	*1.84%*	*1.72%*
Federal Share	$320,410,516	$332,532,770	$374,060,687	$527,687,143	$493,328,216	$440,421,501	$485,515,429	$464,447,058	$474,282,930	*4.45%*	*2.12%*
State Share	$252,051,198	$240,065,292	$274,702,118	$274,173,013	$247,934,192	$222,078,911	$179,830,364	$198,953,432	$200,506,899	*-2.51%*	*0.78%*
Admin. Costs as % of Payments	5.26%	5.56%	6.30%	6.64%	6.32%	5.52%	5.04%	5.46%	5.06%		
	74.51%	74.98%	64.71%	65.28%	65.51%	65.78%	65.88%	66.24%	66.88%		

**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 17)

Provider(s)	Tax Rate
ICF/DD	$5.50% for non-Medicare net patient revenue
Nursing Home	6.50%

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$307,159,833	$313,468,558	$258,479,160	$310,124,694	$308,911,922	$249,118,621	$371,017,744	$300,202,712	$353,076,498	*1.56%*
Mental Hospitals	$149,898,377	$154,424,472	$150,452,714	$240,372	$308,464,711	$157,782,898	$160,312,154	$159,719,927	$159,770,729	*0.71%*
Total	**$457,058,210**	**$467,893,030**	**$408,931,874**	**$310,365,066**	**$617,376,633**	**$406,901,519**	**$531,329,898**	**$459,922,639**	**$512,847,227**	*1.29%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

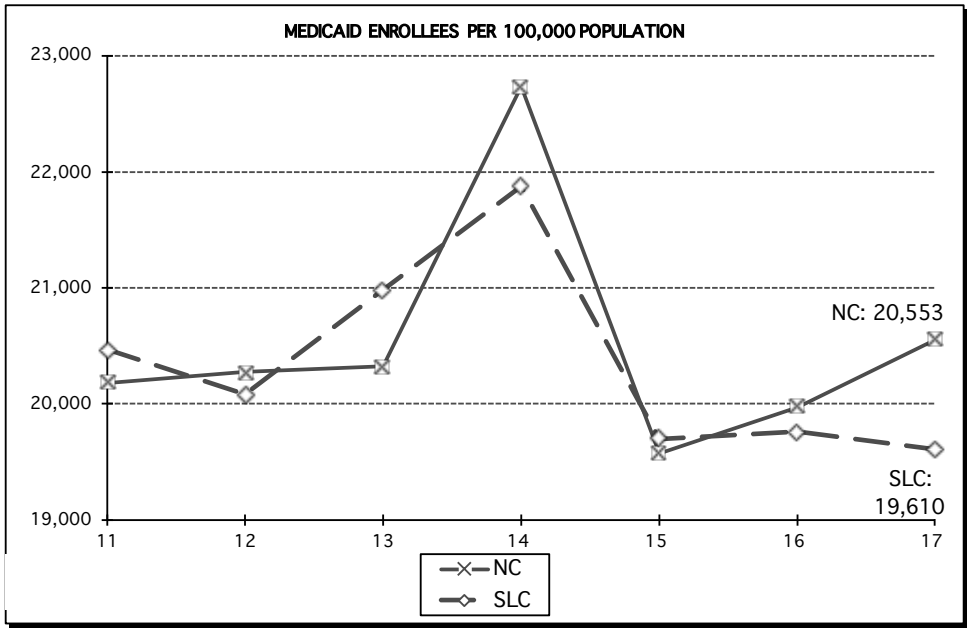
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

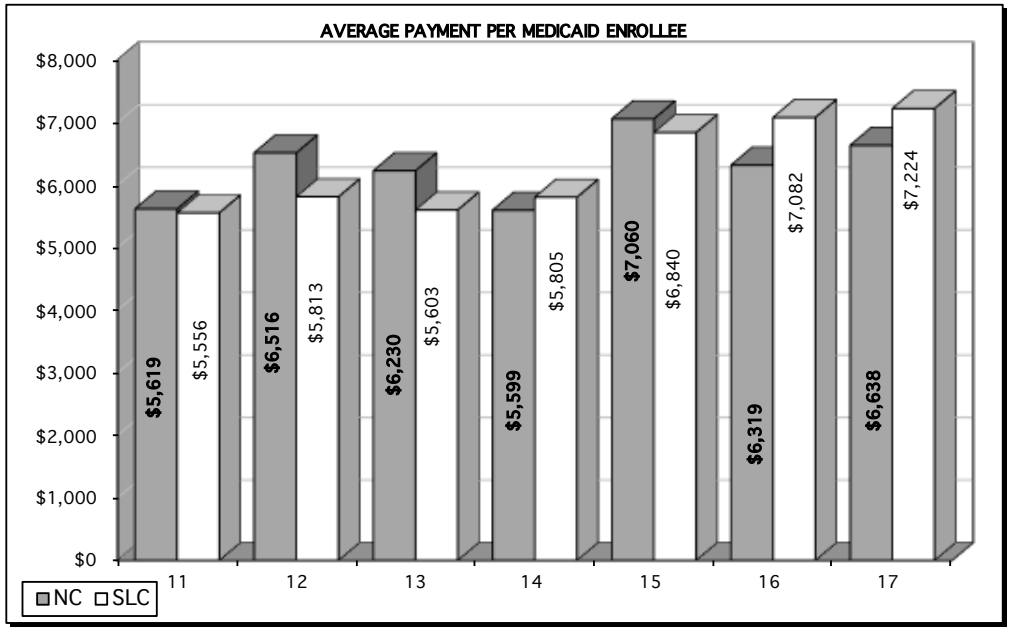
		Rank in U.S.
State population—July 1, 2017	10,009,042	*9*
Per capita personal income	$44,233	*39*
Median household income	$50,343	*46*
Population below Federal Poverty Level	1,471,339	*9*
Percent of total state population	14.7%	*14*
Population without health insurance coverage	1,186,403	*6*
Percent of total state population	11.2%	*11*
Recipients of SNAP benefits	1,365,394	*10*
Total value of issuance	$2,395,550,386	*9*
Average monthly benefit per recipient	$146.21	*30*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

NORTH CAROLINA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual*	*Share of*
Hospital	$3,018	$4,413	$3,461	$3,471	$4,663	$3,561	$4,633	*7.4%*	*34.7%*
Physician	$950	$1,068	$896	$730	$995	$962	$956	*0.1%*	*7.2%*
Dental	$329	$329	$305	$318	$315	$312	$318	*-0.6%*	*2.4%*
Other practitioner	$34	$28	$86	$320	$66	$75	$106	*20.9%*	*0.8%*
Clinic and health center	$232	$256	$221	$247	$180	$241	$267	*2.4%*	*2.0%*
Other acute	$653	$1,582	$1,227	$1,046	$1,095	$1,047	$1,223	*11.0%*	*9.2%*
Drugs	$621	$477	$739	$610	$738	$648	$623	*0.0%*	*4.7%*
Institutional LTSS	$1,709	$1,769	$1,660	$1,377	$1,346	$1,911	$897	*-10.2%*	*6.7%*
Home and community-based LTSS	$2,203	$1,228	$948	$860	$833	$821	$782	*-15.9%*	*5.9%*
Managed care and premium assistance	$356	$687	$1,948	$2,697	$2,843	$2,360	$3,247	*44.5%*	*24.3%*
Medicare Premiums and Coinsurance	$441	$417	$425	$421	$407	$444	$480	*1.4%*	*3.6%*
Collections	($250)	($208)	($193)	($105)	($271)	($224)	($195)	*-4.1%*	*-1.5%*
Total Spending	**$10,297**	**$12,074**	**$11,722**	**$11,993**	**$13,213**	**$12,158**	**$13,337**	*4.4%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	1,948,000	1,976,000	2,000,408	2,260,100	1,965,805	2,028,935	2,110,914		
Average Payment Per Enrollee	$5,619	$6,516	$6,230	$5,599	$7,060	$6,319	$6,638		
Average Payment Per Capita	$1,134.16	$1,321.01	$1,265.88	$1,273.09	$1,381.89	$1,262.34	$1,364.22		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

NORTH CAROLINA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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:

- Innovations Waiver: Provides various services for persons with intellectual and developmental disabilities of all ages, including personal care, residential supports, supported employment, assistive techonology, community living, support, and transition services, crisis services home modifications, and vehicle modifications.
- 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): Provides various services for medically fragile individuals aged 0 -20, including in-home care aide services, assistive technology, case management, community transition, home accesibility and adaptation, education and consultative services, and vehicle modifications.
- 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.
- Traumatic Brain Injury Waiver: Provides various services for persons with brain injury aged 22 and older, including adult day health, day supports, residential supports supported employment, occupational therapy, speech & language therapy, assistive technology, cognitive rehabilitation, community transition, home & vehicle modifications.

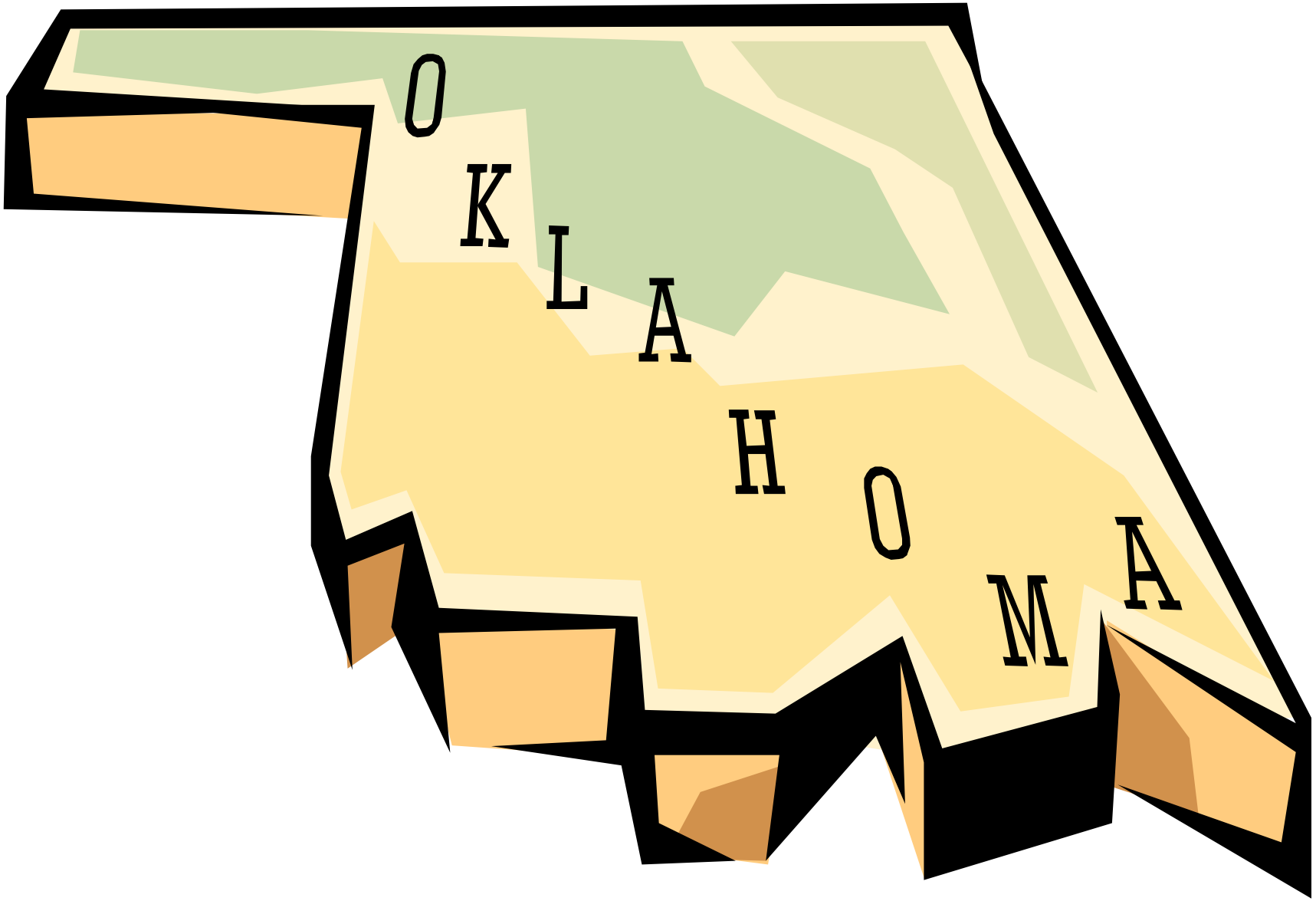
Managed Care (2017)

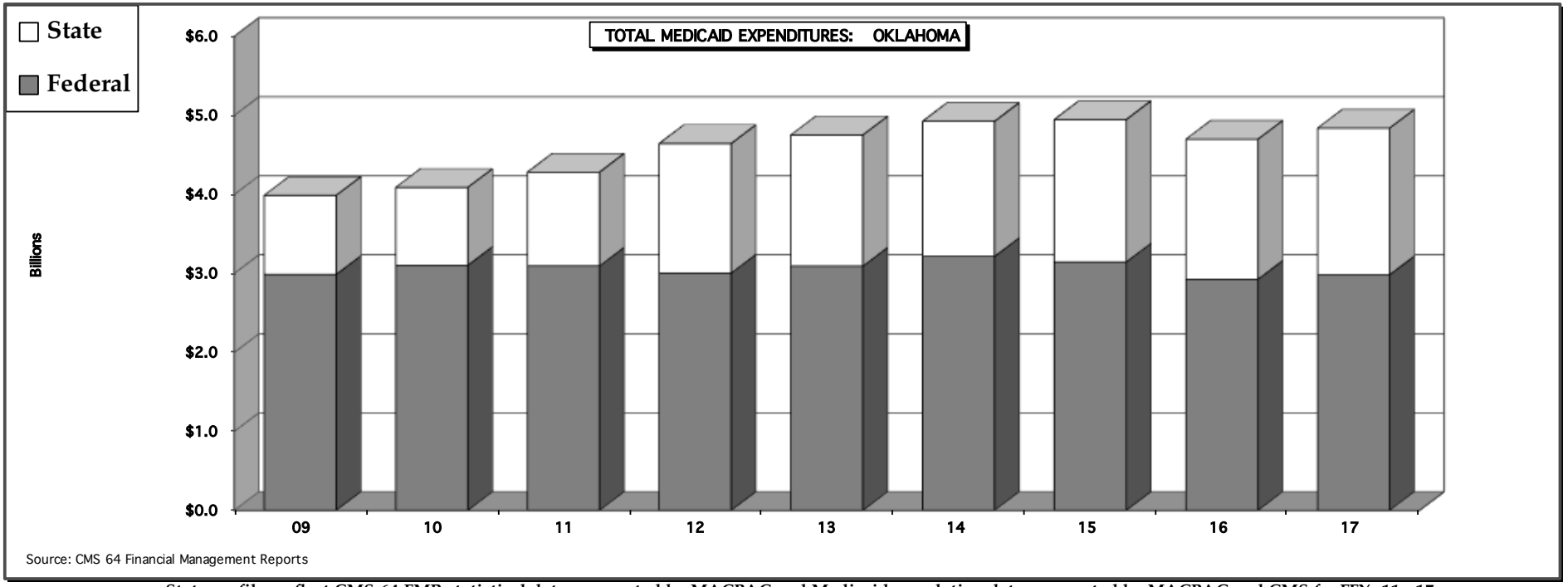
- Primary Care Case Management (PCCM)
- Behavioral Health Organizations
- Program of All Inclusive Care for the Elderly (PACE)
- 76.17% of Medicaid enrollment (1,607,806 persons) in managed care in 2017

Children's Health Insurance Program: NC Health Choice for Children (NCHC)

- 273,850 enrollees
- Combination Plan
- Enhanced FMAP: 76.82% in 2017
- Federal Allotment: $479.5 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$4,460,334,118	$4,630,014,393	*2.32%*	*3.80%*
Federal Share	$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	$2,783,567,716	$2,854,332,222	*-0.02%*	*2.54%*
State Share	$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	$1,676,766,402	$1,775,682,171	*7.73%*	*5.90%*
Administrative Costs	$220,484,128	$227,062,068	$273,465,071	$246,316,769	$270,182,252	$258,905,787	$245,012,336	$238,393,330	$209,539,405	*-0.56%*	*-12.10%*
Federal Share	$128,455,053	$132,395,814	$181,397,802	$162,863,415	$176,522,760	$177,512,597	$158,350,018	$142,313,809	$129,175,133	*0.06%*	*-9.23%*
State Share	$92,029,075	$94,666,254	$92,067,269	$83,453,354	$93,659,492	$81,393,190	$86,662,318	$96,079,521	$80,364,272	*-1.49%*	*-16.36%*
Admin. Costs as % of Payments	5.85%	5.88%	6.82%	5.60%	6.03%	5.55%	5.21%	5.34%	4.53%		
Federal Match Rate*	75.83%	76.73%	64.94%	63.88%	64.00%	64.02%	62.30%	60.99%	59.94%		

**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.*

OKLAHOMA

Provider Taxes Currently in Place (FFY 17)

Providers(s)	Tax Rate
Nursing Home Facility Fee	6% of gross revenues

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$52,255,880	$37,123,375	$40,706,148	$35,332,877	$41,216,201	$40,250,575	$40,244,528	$40,615,232	$40,695,606	*-2.74%*
Mental Hospitals	$3,283,357	$3,273,248	$3,273,250	$818,306	$543,449	$3,273,248	$3,273,248	$3,801,112	$3,273,248	*-0.03%*
Total	**$55,539,237**	**$40,396,623**	**$43,979,398**	**$36,151,183**	**$41,759,650**	**$43,523,823**	**$43,517,776**	**$44,416,344**	**$43,968,854**	*-2.56%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

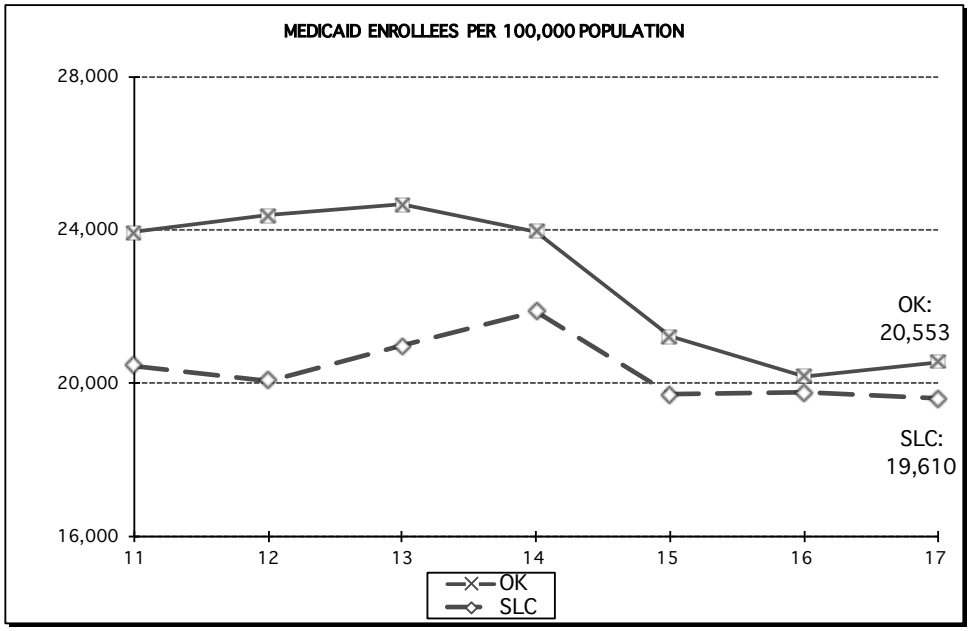
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

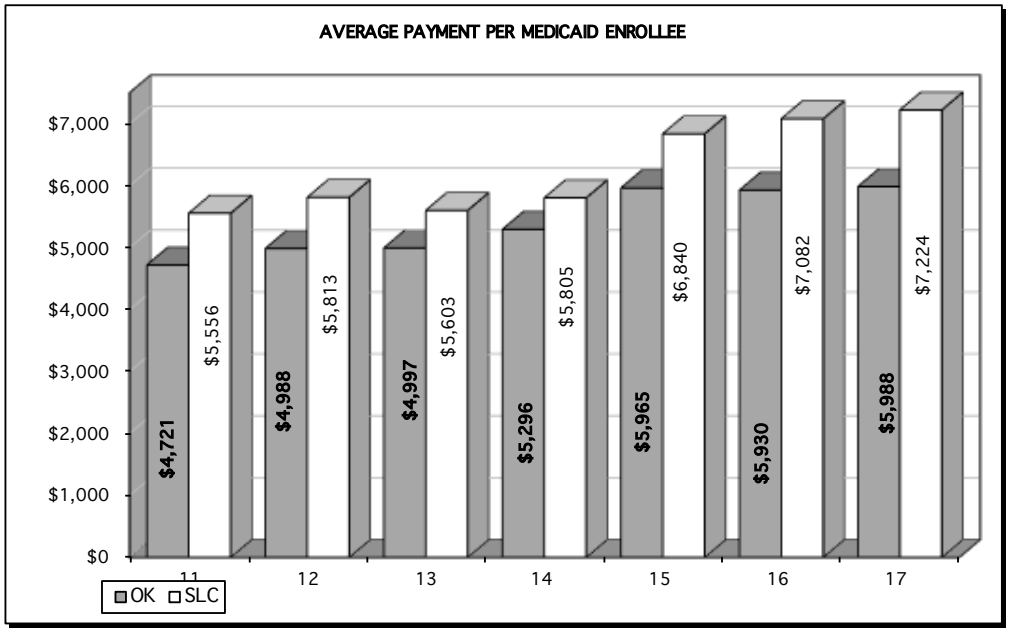
		Rank in U.S.
State population—July 1, 2017	3,814,990	*28*
Per capita personal income	$44,356	*38*
Median household income	$55,006	*40*
Population below Federal Poverty Level	603,864	*24*
Percent of total state population	15.8%	*9*
Population without health insurance coverage	566,777	*20*
Percent of total state population	13.9%	*3*
Recipients of SNAP benefits	603,896	*26*
Total value of issuance	$879,725,084	*25*
Average monthly benefit per recipient	$121.40	*25*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,337	$1,581	$1,544	$1,673	$1,751	$1,688	$1,779	*4.9%*	*38.4%*
Physician	$433	$452	$479	$491	$473	$439	$446	*0.5%*	*10.1%*
Dental	$127	$124	$123	$116	$103	$89	$94	*-4.9%*	*2.2%*
Other practitioner	$31	$32	$38	$43	$41	$34	$32	*0.3%*	*0.9%*
Clinic and health center	$333	$371	$389	$389	$360	$343	$352	*0.9%*	*7.7%*
Other acute	$256	$322	$345	$359	$362	$359	$352	*5.4%*	*7.7%*
Drugs	$260	$294	$297	$297	$367	$341	$393	*7.1%*	*7.8%*
Institutional LTSS	$623	$681	$746	$770	$769	$724	$683	*1.5%*	*16.4%*
Home and community-based LTSS	$556	$499	$511	$526	$546	$528	$552	*-0.1%*	*11.6%*
Managed care and premium assistance	$171	$153	$192	$157	$89	$117	$130	*-4.5%*	*1.9%*
Medicare Premiums and Coinsurance	$141	$133	$133	$146	$136	$151	$169	*3.1%*	*2.9%*
Collections	($261)	($244)	($314)	($300)	($294)	($353)	($350)	*5.0%*	*-6.3%*
Total Spending	**$4,008**	**$4,398**	**$4,482**	**$4,667**	**$4,703**	**$4,460**	**$4,630**	*2.4%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	907,000	931,000	951,000	929,962	829,561	792,387	808,267		
Average Payment Per Enrollee	$4,721	$4,988	$4,997	$5,296	$5,965	$5,930	$5,988		
Average Payment Per Capita	$1,130.75	$1,216.45	$1,233.23	$1,269.51	$1,265.05	$1,196.59	$1,230.61		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

OKLAHOMA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

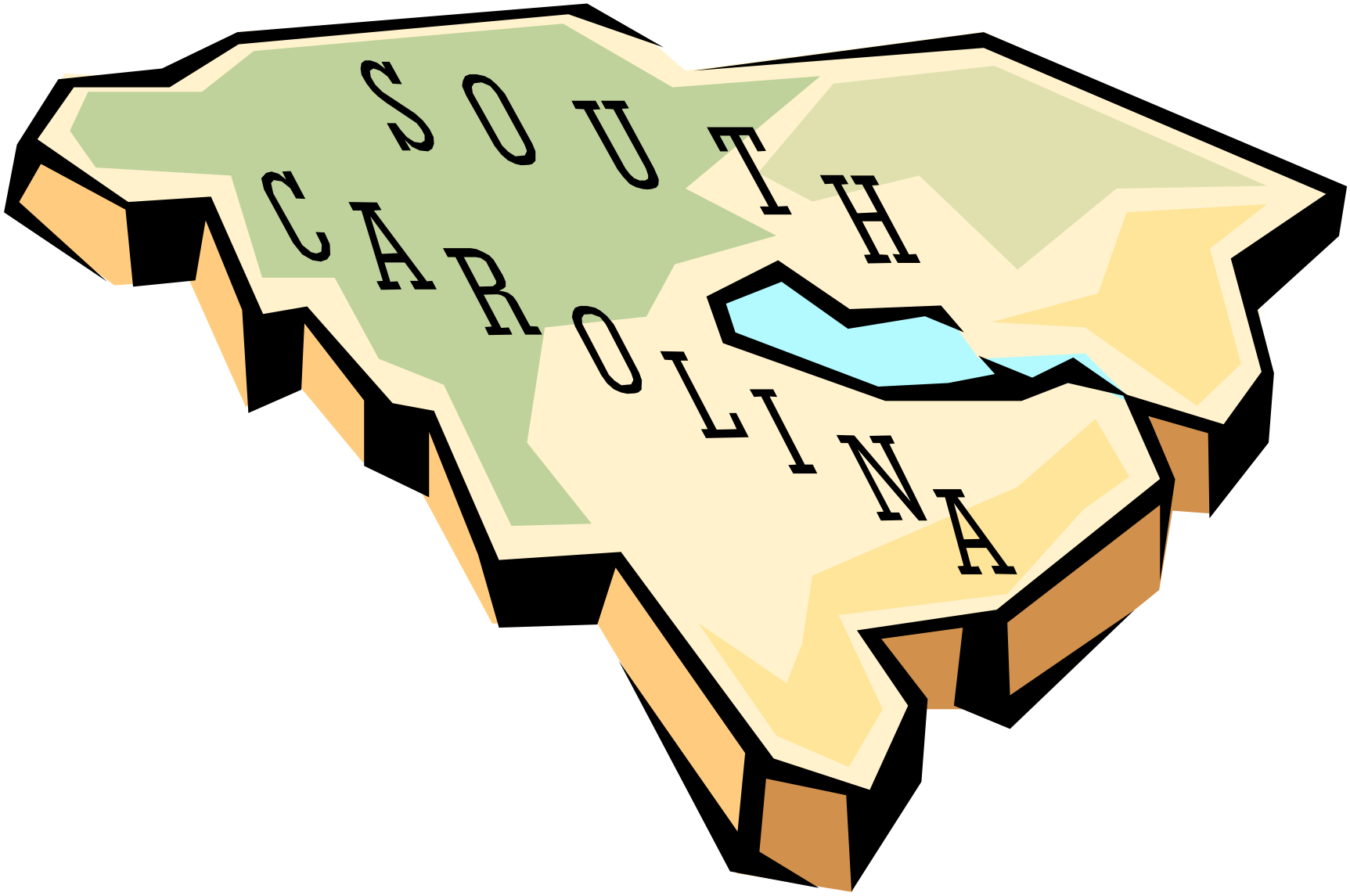
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

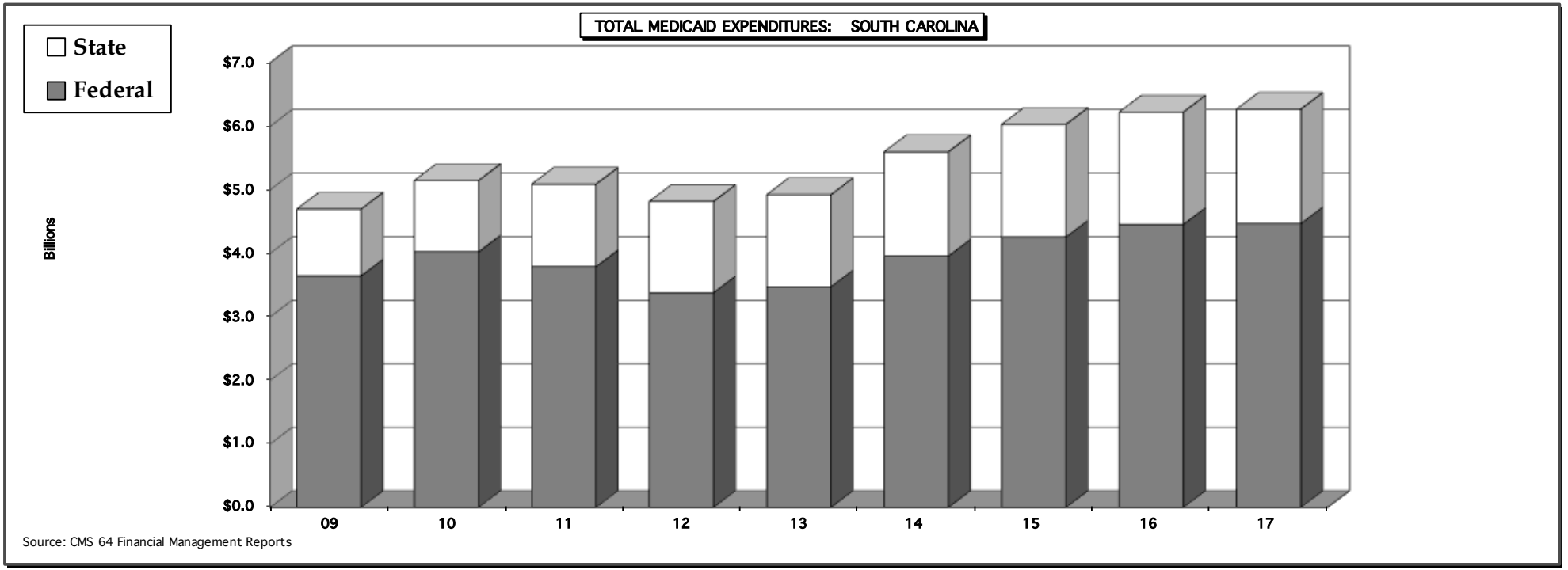
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Advantage Waiver: Serves the "frail elderly" (age 65 years and older) and adults with physical disabilities over the age of 21 that qualify for placement in a nursing facility. 23,959 members received services in SFY 2012 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.

Managed Care (2017)
•Primary Care Case Management (PCCM): SoonerCare Choice provides a medical home through a primary care physician (PCP)
•Non-Emergency Transportation Services (SoonerRide)
•Program of All Inclusive Care for the Elderly (PACE)
•80.83% of Medicaid enrollment (653,362 persons) in managed care in 2017

Children's Health Insurance Program: SoonerCare
•201,006 enrollees
•Combination Plan
•Enhanced FMAP: 71.96% in 2017
•Federal Allotment: $249.0 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$5,941,185,838	$5,963,952,005	*3.06%*	*0.38%*
Federal Share	$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	$4,262,051,425	$4,255,020,889	*2.00%*	*-0.16%*
State Share	$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	$1,679,134,413	$1,708,931,116	*6.30%*	*1.77%*
Administrative Costs	$147,442,650	$151,178,598	$155,604,433	$204,111,409	$231,544,583	$275,593,704	$260,197,011	$289,337,100	$304,469,246	*8.39%*	*5.23%*
Federal Share	$83,106,075	$86,752,343	$93,790,010	$138,413,260	$156,682,151	$185,462,837	$172,354,273	$191,248,079	$211,726,919	*10.95%*	*10.71%*
State Share	$64,336,575	$64,426,255	$61,814,423	$65,698,149	$74,862,432	$90,130,867	$87,842,738	$90,089,021	$92,742,327	*4.15%*	*2.95%*
Admin. Costs as % of Payments	3.24%	3.03%	3.16%	4.43%	4.94%	5.18%	4.51%	4.87%	5.11%		
Federal Match Rate*	79.36%	79.58%	70.04%	70.24%	70.43%	70.57%	70.64%	71.08%	71.30%		

**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.*

SOUTH CAROLINA

Provider Taxes Currently in Place (FFY 17)

Provider(s)	Tax Rate
Hospitals	Hospital tax based on total expenditures of each hospital as a % of total hospital expenditures statewide.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$418,343,049	$369,559,336	$474,586,433	$404,834,259	$404,997,905	$446,318,217	$435,532,911	$471,149,385	$434,872,901	*0.43%*
Mental Hospitals	$52,761,795	$48,582,838	$56,065,264	$52,323,602	$52,175,304	$49,069,197	$52,323,601	$68,885,716	$60,903,051	*1.61%*
Total	**$471,104,844**	**$418,142,174**	**$530,651,697**	**$457,157,861**	**$457,173,209**	**$495,387,414**	**$487,856,512**	**$540,035,101**	**$495,775,952**	*0.57%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

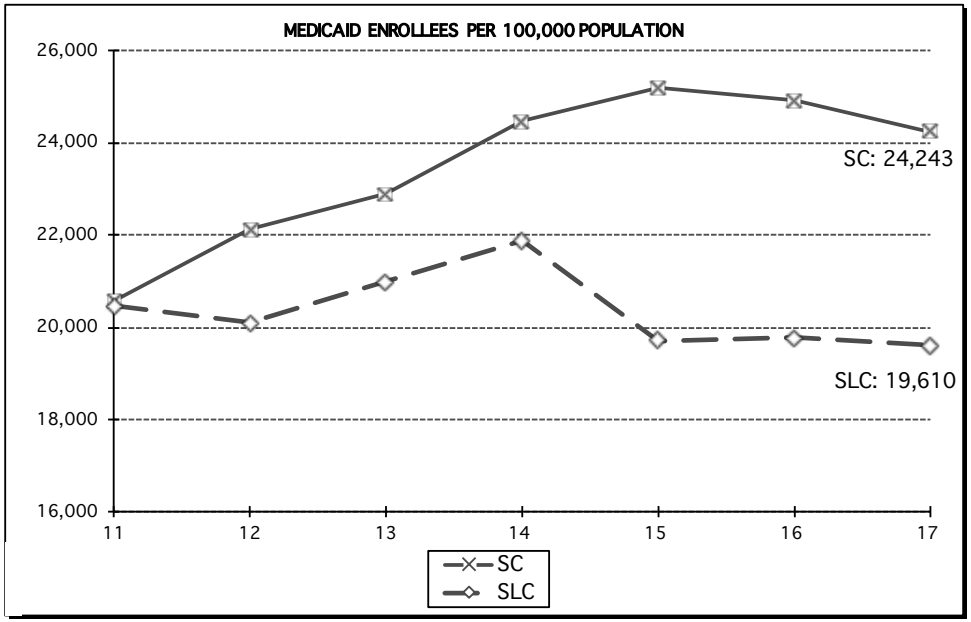
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

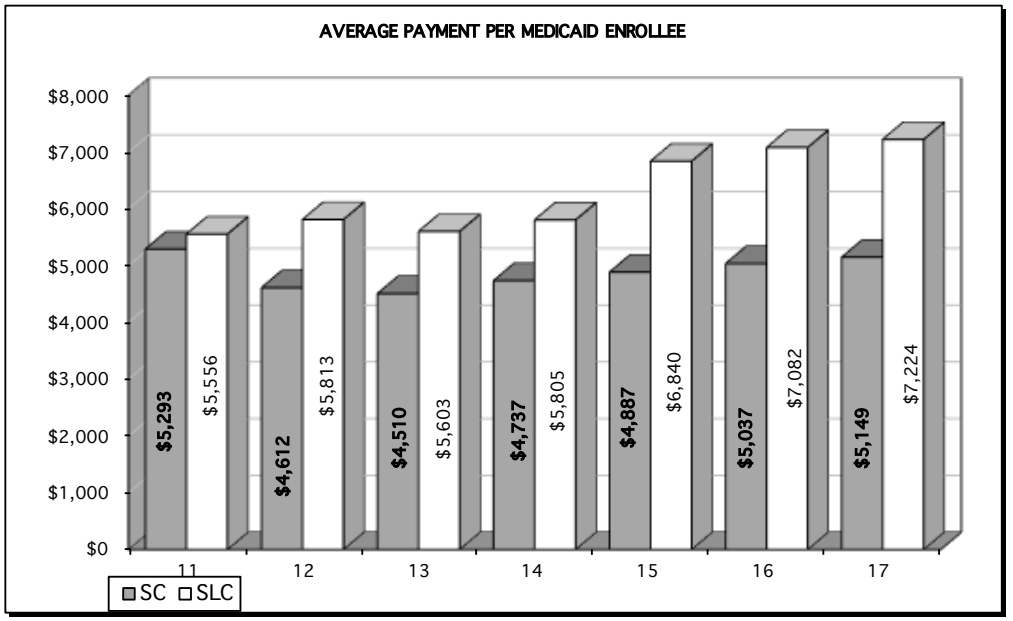
		Rank in U.S.
State population—July 1, 2017	4,882,720	*23*
Per capita personal income	$41,659	*45*
Median household income	$54,971	*41*
Population below Federal Poverty Level	751,907	*20*
Percent of total state population	15.4%	*10*
Population without health insurance coverage	578,318	*18*
Percent of total state population	10.9%	*13*
Recipients of SNAP benefits	719,977	*20*
Total value of issuance	$1,066,150,932	*20*
Average monthly benefit per recipient	$123.40	*20*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 for a family of three.

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

SOUTH CAROLINA





DATA BY TYPE OF SERVICES

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	Annual Change	Share of FFY 17
Hospital	$1,460	$1,121	$1,156	$1,089	$1,079	$1,059	$1,031	*-5.6%*	*17.3%*
Physician	$244	$191	$214	$159	$131	$190	$122	*-10.9%*	*2.0%*
Dental	$97	$85	$88	$94	$114	$126	$127	*4.5%*	*2.1%*
Other practitioner	$26	$25	$26	$22	$19	$17	$19	*-5.3%*	*0.3%*
Clinic and health center	$250	$228	$202	$241	$205	$193	$104	*-13.6%*	*1.7%*
Other acute	$223	$318	$288	$325	$380	$405	$341	*7.3%*	*5.7%*
Drugs	$40	$115	$74	$6	$49	$67	$41	*0.3%*	*0.7%*
Institutional LTSS	$668	$801	$774	$812	$796	$823	$835	*3.8%*	*14.0%*
Home and community-based LTSS	$585	$462	$470	$488	$516	$601	$608	*0.6%*	*10.2%*
Managed care and premium assistance	$1,355	$1,329	$1,441	$2,140	$2,494	$2,555	$2,742	*12.5%*	*46.0%*
Medicare Premiums and Coinsurance	$181	$172	$173	$178	$181	$205	$235	*4.5%*	*3.9%*
Collections	($198)	($237)	($216)	($232)	($196)	($299)	($240)	*3.3%*	*-4.0%*
Total Spending	**$4,931**	**$4,611**	**$4,690**	**$5,321**	**$5,768**	**$5,941**	**$5,964**	*3.2%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	961,000	1,044,000	1,091,299	1,181,368	1,233,430	1,235,361	1,217,302		
Average Payment Per Enrollee	$5,293	$4,612	$4,510	$4,737	$4,887	$5,037	$5,149		
Average Payment Per Capita	$1,088.53	$1,019.87	$1,032.12	$1,158.92	$1,231.15	$1,254.99	$1,248.39		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

SOUTH CAROLINA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

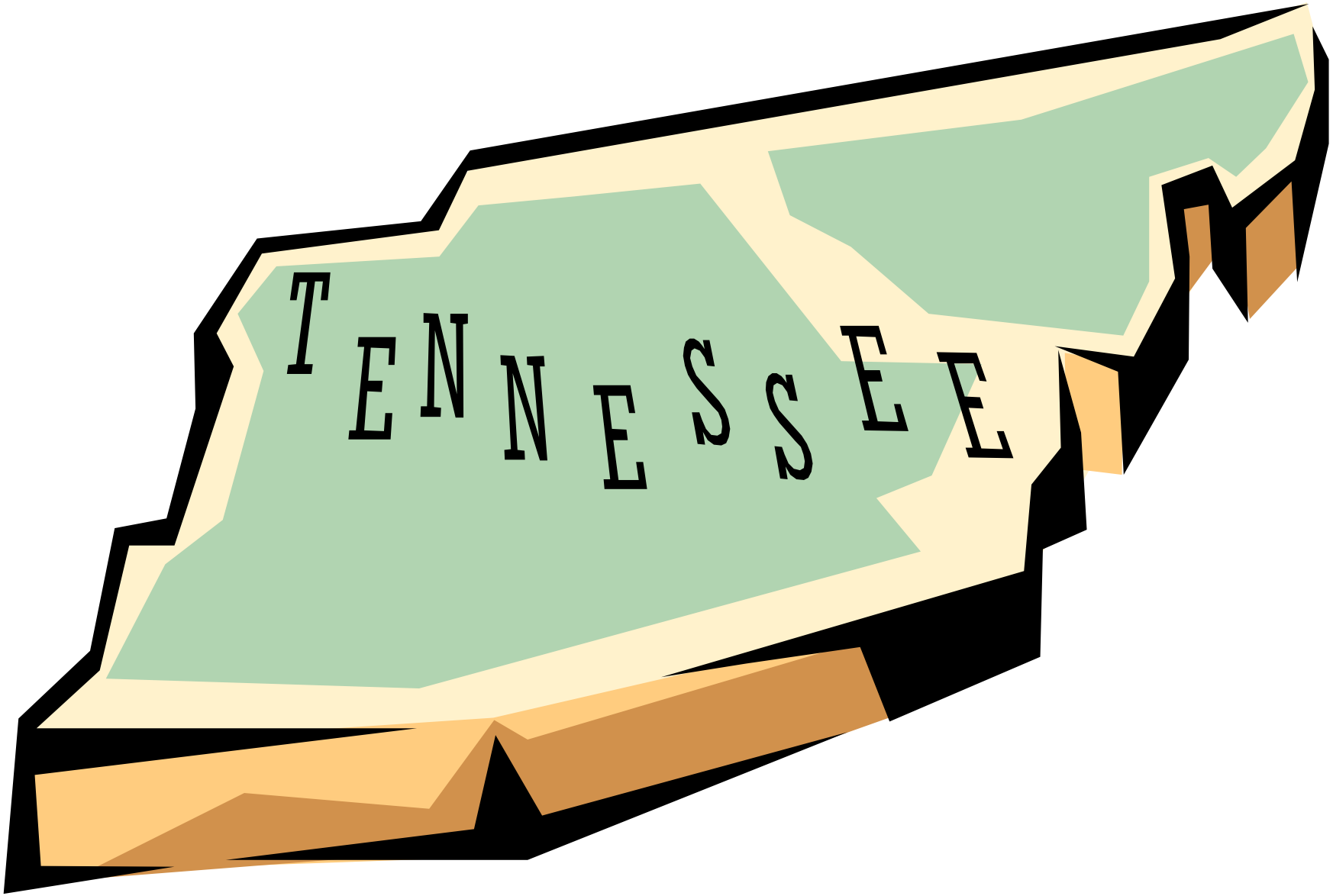
Home & community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

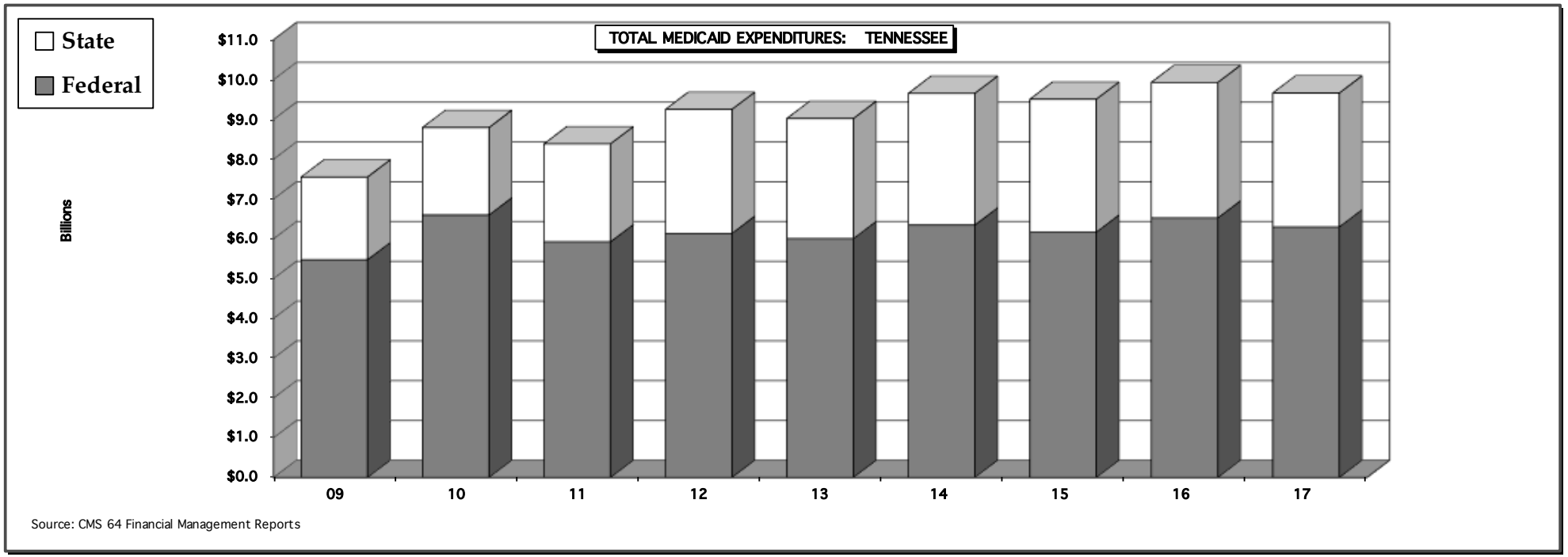
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Intellectual Disability or Related Disabilities (ID/RD) Waiver: The MR/RD Waiver is for persons who (1) have an intellectual disability (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 7/1/2009.
•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.
•HIV/AIDS Waiver: Provides case management, personal care services, prescription drugs, attendant care services, companion care, home accessibility adaptations home delivered meals, personal emergency response systems, residential personal care, specialized medical equipment and supplies for individuals with HIV/AIDS of all ages.
•Psychiatric Residential Treatment Facility (PRTF) Alternative CHANCE Waiver: Provides case management, prevocational services, respite, customized goods and services, intensive family services, medication monitoring and wellness education, peer support, and wraparound para-profoessional services for serious emotional disturbance for individuals aged 4-18.

Managed Care (2017)
•Comprehensive Managed Care Organizations (MCO)
•Primary Care Case Management (PCCM)
•Non-Emergency Transportation Services
•Program of All Inclusive Care for the Elderly (PACE)
•100% of Medicaid enrollment (1,217,302 persons) in managed care in 2017

Children's Health Insurance Program: Healthy Connections Kids
•87,624 enrollees
•Medicaid Expansion
•Enhanced FMAP: 79.91% in 2017
•Federal Allotment: $154.2 M in 2017

STATE MEDICAID PROFILE





State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$9,463,742,287	$9,088,319,089	*2.55%*	*-3.97%*
Federal Share	$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	$6,209,222,133	$5,914,729,016	*1.36%*	*-4.74%*
State Share	$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	$3,254,520,154	$3,173,590,073	*6.35%*	*-2.49%*
Administrative Costs	$303,372,656	$353,816,337	$413,622,139	$499,012,090	$344,193,418	$449,172,536	$412,498,278	$464,727,139	$573,159,583	*8.28%*	*23.33%*
Federal Share	$166,639,258	$190,120,480	$230,848,573	$308,569,596	$220,129,611	$281,867,286	$250,934,584	$314,384,012	$383,621,145	*10.99%*	*22.02%*
State Share	$136,733,398	$163,695,857	$182,773,566	$190,442,494	$124,063,807	$167,305,250	$161,563,694	$150,343,127	$189,538,438	*4.17%*	*26.07%*
Admin. Costs as % of Payments	4.19%	4.19%	5.19%	5.70%	3.97%	4.88%	4.54%	4.91%	6.31%		
Federal Match Rate*	74.23%	75.37%	65.85%	66.36%	66.13%	65.29%	64.99%	65.05%	64.96%		

**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 17)

Provider(s)	Tax Rate
Nursing homes	$2,225 per licensed bed per year
ICF/DD facilities	5.50%
Health Maintenance Organizations	6.00%
Hospital Assessment Fee (implemented in 2011, expires annually)	4.52%

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$140,721,854	$139,750,254	$139,157,103	$102,252,438	$80,296,386	$0	$817,048,000	$73,777,797	$81,742,611	*-5.86%*
Mental Hospitals	$0	$0	$0	$0	$0	$0	$0	$0	$0	*0.00%*
Total	**$140,721,854**	**$139,750,254**	**$139,157,103**	**$102,252,438**	**$80,296,386**	**$0**	**$817,048,000**	**$73,777,797**	**$81,742,611**	*-5.86%*

ACA MEDICAID EXPANSION

Not expanding Medicaid under ACA as of May 2019

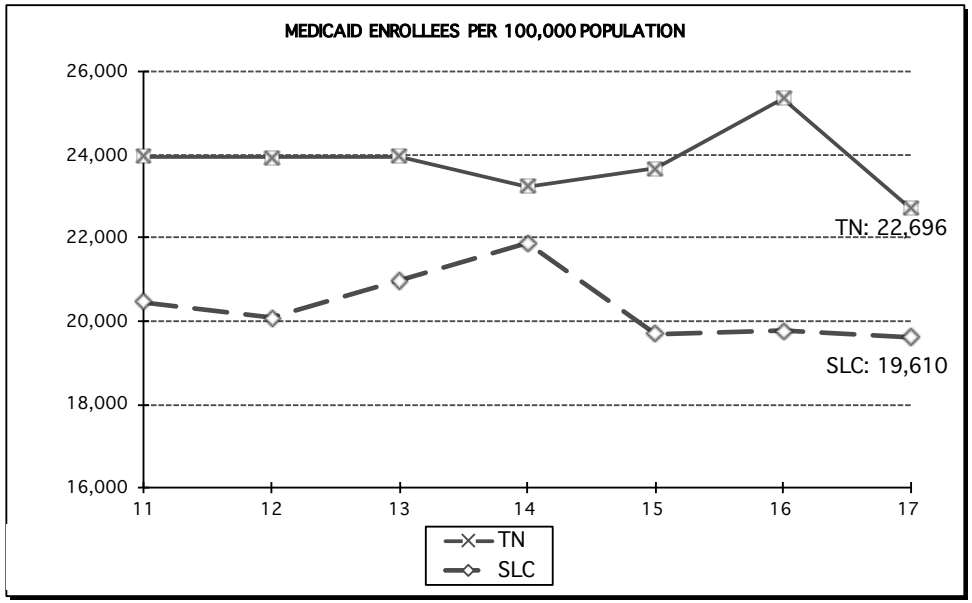
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

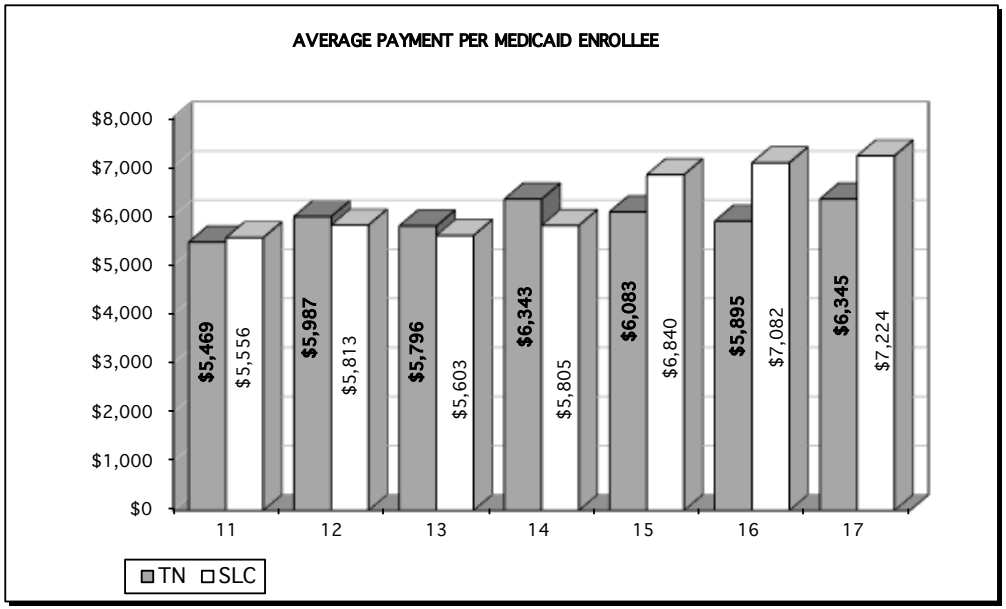
		Rank in U.S.
State population—July 1, 2017	3,555,389	*16*
Per capita personal income	$45,566	*34*
Median household income	$55,240	*39*
Population below Federal Poverty Level	980,284	*12*
Percent of total state population	15.0%	*11*
Population without health insurance coverage	706,290	*13*
Percent of total state population	10.3%	*17*
Recipients of SNAP benefits	1,047,058	*11*
Total value of issuance	$1,586,711,088	*11*
Average monthly benefit per recipient	$126.28	*13*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$974	$1,351	$1,171	$856	$841	$1,111	$909	*-1.1%*	*10.0%*
Physician	$26	$26	$27	$53	$37	$37	$41	*7.8%*	*0.4%*
Dental	$183	$172	$166	$142	$160	$158	$172	*-1.0%*	*1.9%*
Other practitioner	$1	$1	$1	$1	$0	$0	$0	*-23.4%*	*0.0%*
Clinic and health center	$39	$37	$42	$40	$43	$56	$59	*7.3%*	*0.7%*
Other acute	$81	$200	$217	$235	$226	$259	$278	*22.8%*	*3.1%*
Drugs	$352	$386	$290	$485	$424	$433	$506	*6.2%*	*5.6%*
Institutional LTSS	$355	$245	$284	$259	$272	$247	$254	*-5.4%*	*2.8%*
Home and community-based LTSS	$708	$512	$700	$684	$675	$670	$680	*-0.7%*	*7.5%*
Managed care and premium assistance	$4,959	$5,533	$5,478	$6,163	$6,109	$6,137	$5,802	*2.7%*	*63.8%*
Medicare Premiums and Coinsurance	$349	$335	$340	$346	$358	$409	$438	*3.9%*	*4.8%*
Collections	($56)	($47)	($39)	($58)	($50)	($53)	($50)	*-1.8%*	*-0.6%*
Total Spending	**$7,970**	**$8,751**	**$8,678**	**$9,205**	**$9,094**	**$9,464**	**$9,088**	*2.2%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	1,533,000	1,545,000	1,556,721	1,521,990	1,562,745	1,684,268	1,522,658		
Average Payment Per Enrollee	$5,469	$5,987	$5,796	$6,343	$6,083	$5,895	$6,345		
Average Payment Per Capita	$1,310.27	$1,432.93	$1,388.85	$1,474.43	$1,440.32	$1,494.12	$1,440.12		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

TENNESSEE

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

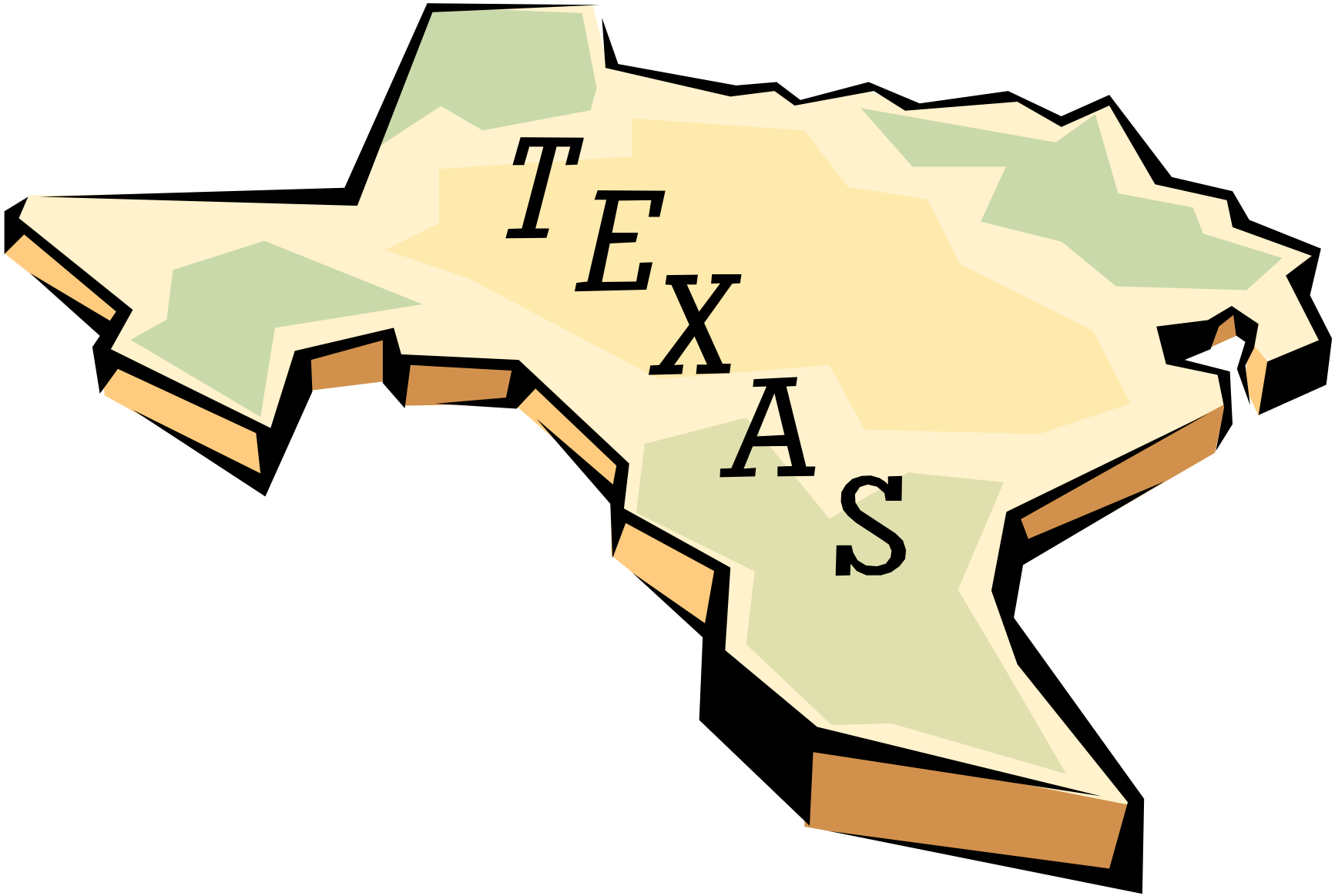
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

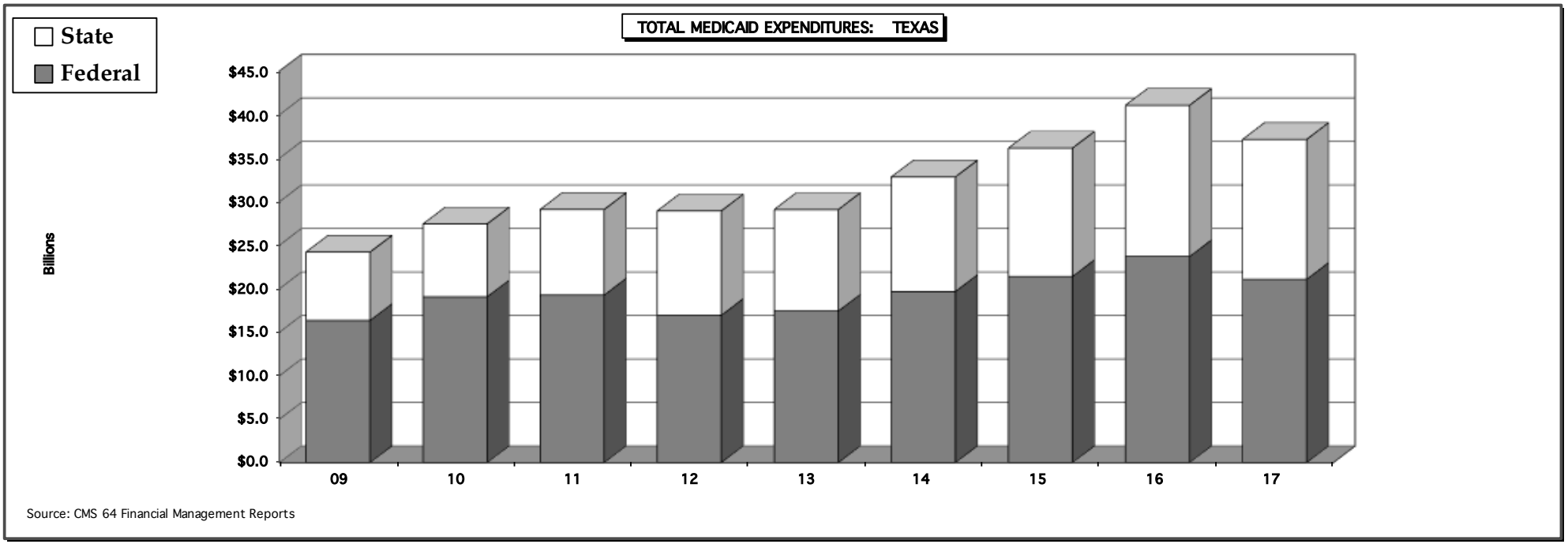
Several HCBS Waivers, under Section 1915 (c), enable the state to provide services to people who otherwise would require institutionalization. These waivers include:
•Statewide HCBS Waiver Program: Revised 2007. Serves adults with intellectual disabilities and children under age 6 with developmental 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 six with developmental delay who qualify for for and, absent the provision of services provided under the Self-Determination waiver, would require placement in a private ICF/IID.

Managed Care (2017)
•Comprehensive Managed Care Organizations (MCO)
•Program of All Inclusive Care for the Elderly (PACE)
•92.57% of Medicaid enrollment (1,409,555 persons) in managed care as of 2017

Children's Health Insurance Program: CoverKids
•103,293 enrollees
•Combination Plan
•Enhanced FMAP: 75.47% in 2017
•Federal Allotment: $465.0 M in 2017

STATE MEDICAID PROFILE





Source: CMS 64 Financial Management Reports

State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$39,563,147,154	$35,644,873,539	*4.99%*	*-9.90%*
Federal Share	$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	$22,728,257,723	$20,111,506,094	*2.78%*	*-11.51%*
State Share	$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	$16,834,889,431	$15,533,367,445	*8.77%*	*-7.73%*
Administrative Costs	$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	$1,505,039,988	$1,507,683,658	*2.58%*	*0.18%*
Federal Share	$636,883,348	$586,821,439	$757,489,799	$860,762,277	$831,745,114	$883,762,761	$972,251,209	$968,195,693	$967,004,223	*4.75%*	*-0.12%*
State Share	$561,446,142	$513,545,910	$490,315,493	$549,535,172	$502,399,432	$562,215,287	$484,172,478	$536,844,295	$540,679,435	*-0.42%*	*0.71%*
Admin. Costs as % of Payments	5.21%	4.18%	4.48%	5.12%	4.81%	4.61%	4.20%	3.80%	4.23%		
Federal Match Rate*	69.85%	70.94%	60.56%	58.22%	59.30%	58.69%	58.05%	57.13%	56.18%		

**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 17)

Provider(s)	Tax Rate
ICF services assessment	5.50%
Managed Care/Insurance	1.75%

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 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$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	$2,402,378,486	$1,510,726,974	*0.58%*
Mental Hospitals	$311,291,390	$292,569,701	$292,513,583	$292,513,592	$120,496,590	$117,064,477	$303,496,529	$418,056,902	$295,868,976	*-0.56%*
Total	**$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**	**$2,820,435,388**	**$1,806,595,950**	*0.38%*

ACA MEDICAID EXPANSION

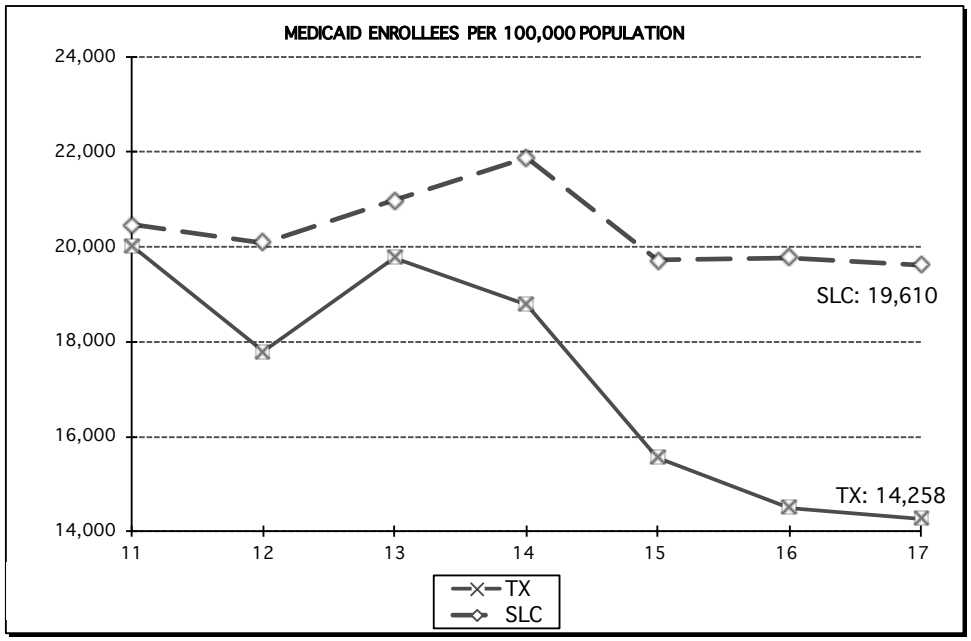
Not expanding Medicaid under ACA as of May 2019

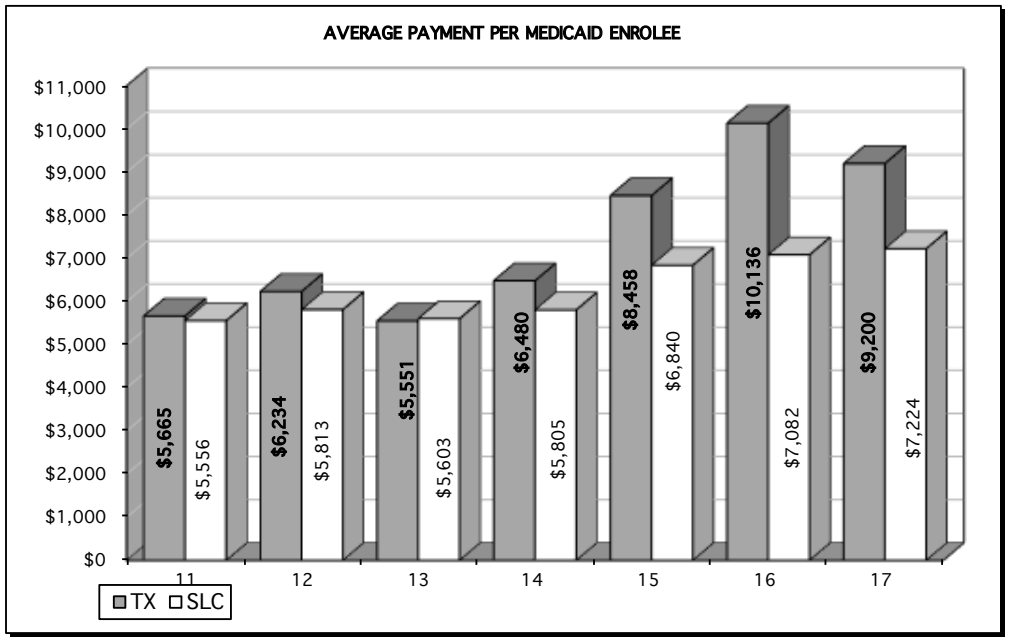
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

		Rank in U.S.
State population—July 1, 2017	27,676,343	*2*
Per capita personal income	$47,332	*28*
Median household income	$59,295	*29*
Population below Federal Poverty Level	4,076,905	*2*
Percent of total state population	14.7%	*14*
Population without health insurance coverage	4,916,911	*1*
Percent of total state population	17.1%	*1*
Recipients of SNAP benefits	3,921,278	*2*
Total value of issuance	$5,805,152,020	*3*
Average monthly benefit per recipient	$123.37	*21*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$7,742	$5,939	$4,918	$5,471	$6,919	$9,705	$5,255	*-6.3%*	*14.7%*
Physician	$1,336	$1,184	$1,130	$1,690	$509	$377	$123	*-32.8%*	*0.3%*
Dental	$1,428	$688	$93	$85	$54	$52	$48	*-43.1%*	*0.1%*
Other practitioner	$822	$448	$240	$237	$645	$1,113	$359	*-12.9%*	*1.0%*
Clinic and health center	$128	$79	$35	$38	$35	$36	$27	*-22.8%*	*0.1%*
Other acute	$2,033	$2,427	$2,855	$4,542	$4,992	$5,075	$5,527	*18.1%*	*15.5%*
Drugs	$1,457	$282	$283	$346	$230	$247	($19)	*n/a*	*-0.1%*
Institutional LTSS	$3,348	$3,783	$3,565	$3,692	$2,993	$2,028	$1,651	*-11.1%*	*4.6%*
Home and community-based LTSS	$3,466	$2,456	$2,149	$3,445	$2,146	$2,653	$2,411	*-5.9%*	*6.8%*
Managed care and premium assistance	$5,760	$9,983	$12,044	$12,634	$16,228	$17,904	$19,694	*22.7%*	*55.2%*
Medicare Premiums and Coinsurance	$1,045	$1,016	$1,025	$1,023	$1,055	$1,139	$1,269	*3.3%*	*3.6%*
Collections	($718)	($762)	($587)	($817)	($1,116)	($767)	($700)	*-0.4%*	*-2.0%*
Total Spending	**$27,847**	**$27,523**	**$27,752**	**$32,385**	**$34,691**	**$39,562**	**$35,645**	*4.2%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	5,136,000	4,641,000	5,240,094	5,066,200	4,273,982	4,051,664	4,038,159		
Average Payment Per Enrollee	$5,665	$6,234	$5,551	$6,480	$8,458	$10,136	$9,200		
Average Payment Per Capita	$1,134.12	$1,109.01	$1,097.56	$1,216.92	$1,315.94	$1,470.00	$1,311.76		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

TEXAS

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

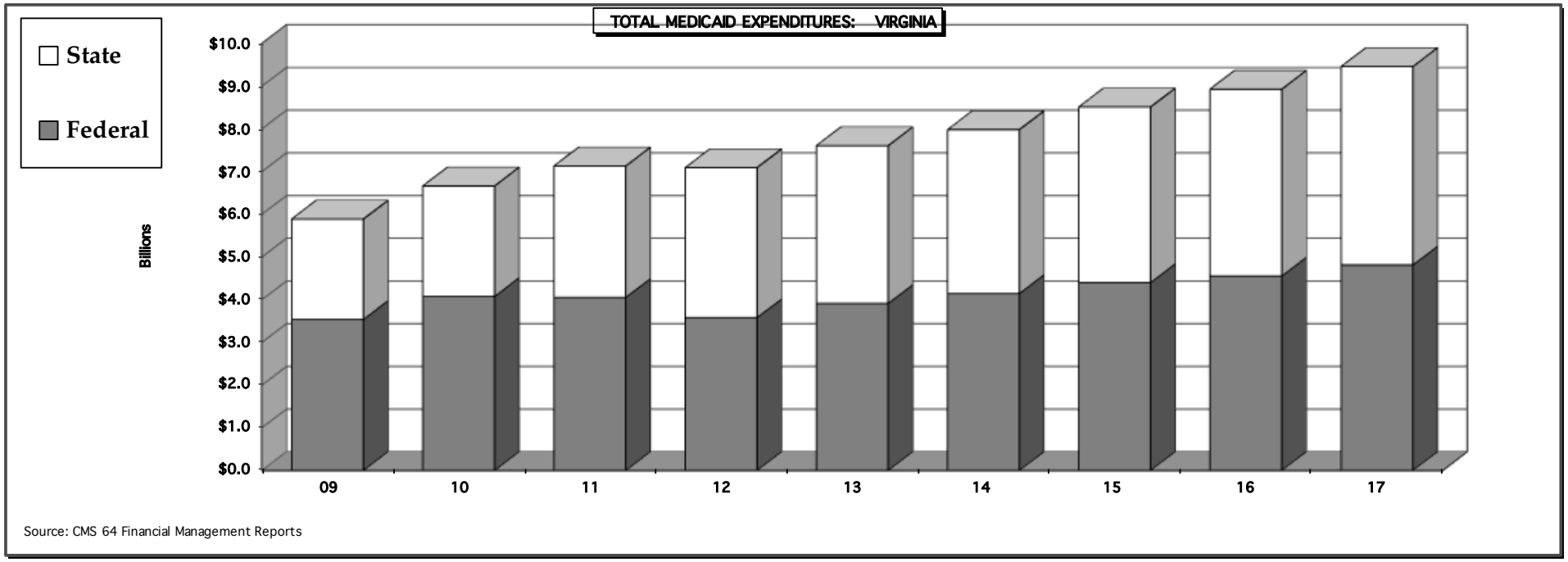
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups , such as people with intellectual or developmental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

Managed Care (2017)
•Primary Care Case Management (PCCM)
•Comprehensive Managed Care Organization (MCO)
•Prepaid Inpatient Health Plan (PIHP)
•Prepaid Ambulatory Health Plan (PAHP): Disease Management
•Non-Emergency Transportation Services
•Program of All Inclusive Care for the Elderly (PACE)
•96.66% of Medicaid enrollment (3,903,380 persons) in managed care in 2017

Children's Health Insurance Program: CHIP
•1,137,899 enrollees
•Combination Plan
•Enhanced FMAP: 69.33% in 2017
•Federal Allotment: $1.38 B in 2017

STATE MEDICAID PROFILE



State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$8,498,905,069	$8,987,642,645	*5.20%*	*5.75%*
Federal Share	$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	$4,268,707,717	$4,503,512,349	*3.07%*	*5.50%*
State Share	$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	$4,230,197,352	$4,484,130,296	*7.90%*	*6.00%*
Administrative Costs	$193,479,683	$253,485,327	$235,060,591	$282,620,895	$386,507,673	$432,778,067	$478,019,593	$428,293,526	$470,388,579	*10.37%*	*9.83%*
Federal Share	$105,288,044	$137,687,458	$129,748,947	$166,781,392	$257,003,612	$298,749,755	$329,813,829	$284,314,490	$308,429,232	*12.68%*	*8.48%*
State Share	$88,191,639	$115,797,869	$105,311,644	$115,839,503	$129,504,061	$134,028,312	$148,205,764	$143,979,036	$161,959,347	*6.99%*	*12.49%*
Admin. Costs as % of Payments	3.40%	3.96%	3.41%	4.15%	5.35%	5.73%	5.95%	5.04%	5.23%		
Federal Match Rate*	61.59%	61.59%	50.00%	50.00%	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 17)

Provider(s)	Tax Rate
ICF/DD tax	5.5% of revenues

Note: ICF/DD tax added in 2012.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$138,141,501	$192,435,368	$189,370,089	$207,850,861	$179,290,338	$169,297,631	$9,125,582	$172,421,124	$43,366,588	*-12.08%*
Mental Hospitals	$7,129,293	$6,284,784	$5,882,489	$6,690,321	$7,178,095	$9,396,945	$11,572,492	$5,001,188	$9,715,497	*3.50%*
Total	**$145,270,794**	**$198,720,152**	**$195,252,578**	**$214,541,182**	**$186,468,433**	**$178,694,576**	**$20,698,074**	**$177,422,312**	**$53,082,085**	*-10.58%*

ACA MEDICAID EXPANSION

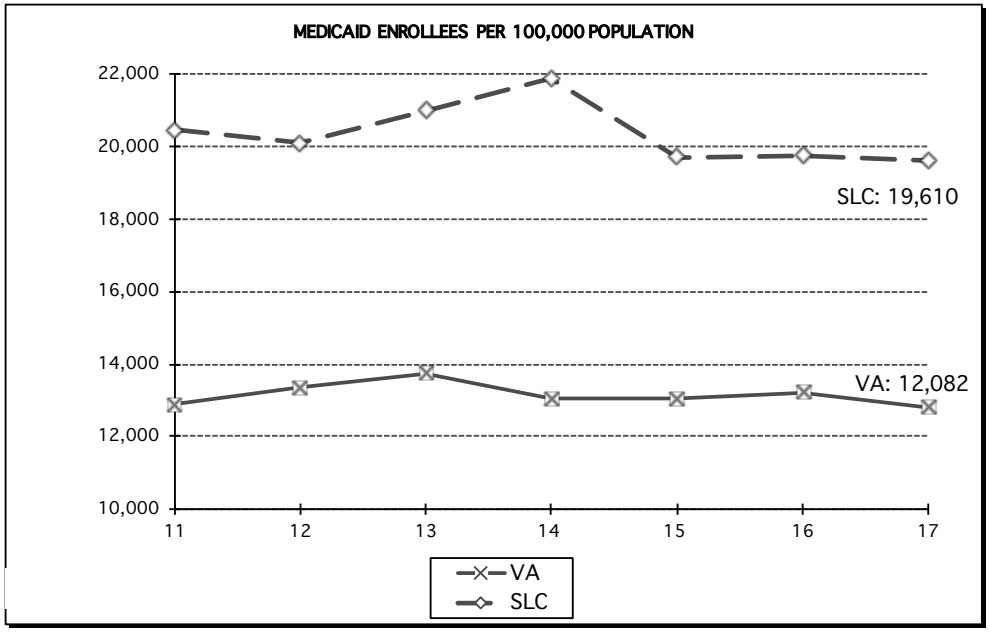
Expanded Medicaid under ACA as of January 2019

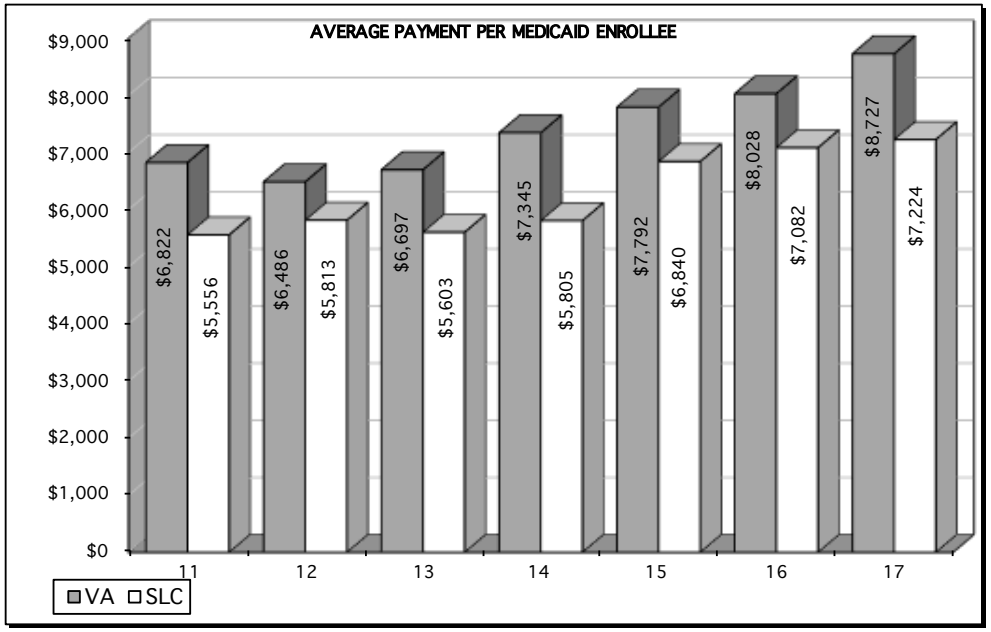
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

		Rank in U.S.
State population—July 1, 2017	8,221,024	*12*
Per capita personal income	$55,137	*12*
Median household income	$71,293	*13*
Population below Federal Poverty Level	874,483	*15*
Percent of total state population	10.6%	*41*
Population without health insurance coverage	810,412	*12*
Percent of total state population	9.1%	*23*
Recipients of SNAP benefits	775,548	*17*
Total value of issuance	$1,115,536,652	*19*
Average monthly benefit per recipient	$119.87	*33*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 SERVICE

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$1,156	$1,055	$1,011	$992	$853	$941	$988	*-2.6%*	*11.0%*
Physician	$202	$194	$178	$202	$162	$147	$139	*-6.0%*	*1.6%*
Dental	$135	$136	$139	$128	$147	$158	$159	*2.8%*	*1.8%*
Other practitioner	$32	$37	$35	$33	$30	$30	$32	*-0.2%*	*0.4%*
Clinic and health center	$59	$56	$52	$50	$46	$54	$64	*1.3%*	*0.7%*
Other acute	$756	$909	$980	$1,006	$1,001	$1,122	$1,197	*8.0%*	*13.3%*
Drugs	$125	$72	$27	$44	$77	$28	$18	*-27.9%*	*0.2%*
Institutional LTSS	$1,120	$1,263	$1,292	$1,246	$1,241	$1,206	$1,161	*0.6%*	*12.9%*
Home and community-based LTSS	$1,276	$1,159	$1,229	$1,326	$1,383	$1,529	$1,656	*4.4%*	*18.4%*
Managed care and premium assistance	$1,890	$1,804	$2,118	$2,356	$2,933	$3,089	$3,340	*10.0%*	*37.2%*
Medicare Premiums and Coinsurance	$259	$223	$228	$228	$231	$259	$292	*2.0%*	*3.2%*
Collections	($115)	($100)	($73)	($64)	($71)	($66)	($57)	*-11.1%*	*-0.6%*
Total Spending	**$6,894**	**$6,807**	**$7,218**	**$7,547**	**$8,033**	**$8,499**	**$8,988**	*4.5%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	1,045,000	1,093,000	1,135,537	1,086,500	1,092,225	1,111,999	1,083,750		
Average Payment Per Enrollee	$6,822	$6,486	$6,697	$7,345	$7,792	$8,028	$8,727		
Average Payment Per Capita	$878.94	$865.24	$919.82	$958.22	$1,015.24	$1,061.38	$1,117.28		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

VIRGINIA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

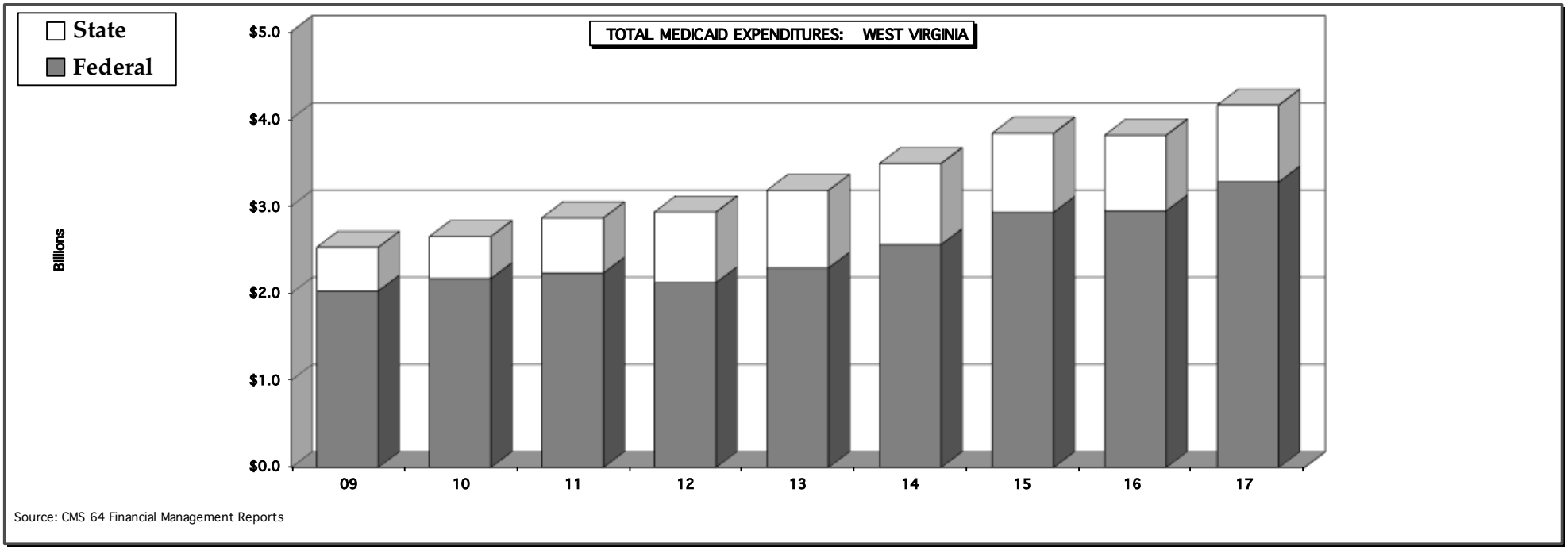
Home & Community-based Services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental 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 Living Waiver: provides a variety of services, including group day services, group home residential, individual supported employment, transportation services, and other services for all individuals with autism and ID/DD regardless of age.
•Commonwealth Coordinated Care Plus: provides adult day health care, personal assistance services, assistive technology, and other services for individuals 65 and older, diasbled persons aged 0 - 64, and technology dependent persons of all ages.
•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.
•Family and 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.
•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. Implemented 8/1/2006.
•Building Independence Waiver: provides several services, including group day services, independent living supports, benefits planning, transportation, environmental modifications, and shared living for individuals with autism and ID/DD aged 18 and older.
•Children's Mental Health PRTF: provides in-home supports, respite, service facilitation, caregiver training, environmental modifications, and other services for persons with serious emotional disturbance aged 0-21.

Managed Care (2017)
•Comprehensive Managed Care Organization (MCO)
•Program of All Inclusive Care for the Elderly (PACE)
•66.80% of Medicaid enrollment (723,896 persons) in managed care in 2017

Children's Health Insurance Program: Family Access to Medical Insurance Security (FAMIS)
•202,974 enrollees
•Combination Plan
•Enhanced FMAP: 65% in 2017
•Federal Allotment: $291.1 M in 2017

STATE MEDICAID PROFILE



State profiles reflect CMS-64 FMR statistical data as reported by MACPAC and Medicaid population data as reported by MACPAC and CMS for FFYs 11 - 17.

	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Rate of Change*	*Total Change 16-17*
Medicaid Payments	$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	$3,655,890,862	$4,000,838,793	*5.74%*	*9.44%*
Federal Share	$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	$2,841,106,121	$3,165,225,913	*5.45%*	*11.41%*
State Share	$457,619,582	$438,003,644	$585,762,516	$760,156,123	$838,150,266	$877,075,023	$845,220,482	$814,784,741	$835,612,880	*6.92%*	*2.56%*
Administrative Costs	$105,848,951	$111,317,982	$123,894,669	$158,435,156	$173,666,274	$157,246,389	$189,201,652	$157,725,484	$156,968,729	*4.48%*	*-0.48%*
Federal Share	$62,843,340	$67,300,284	$77,270,641	$108,797,039	$119,744,994	$105,129,621	$127,876,384	$104,925,232	$112,134,253	*6.65%*	*6.87%*
State Share	$43,005,611	$44,017,698	$46,624,028	$49,638,117	$53,921,280	$52,116,768	$61,325,268	$52,800,252	$44,834,476	*0.46%*	*-15.09%*
Admin. Costs as % of Payments	4.37%	4.38%	4.52%	5.71%	5.77%	4.72%	5.19%	4.31%	3.92%		
Federal Match Rate*	83.05%	83.05%	73.24%	72.62%	72.04%	71.09%	71.35%	71.42%	71.80%		

**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 17)

Provider(s)	Tax Rate
•Hospitals (inpatient and outpatient services)	2.50%
•ICF/MR-DD	5.50%
•Nursing Facility Services	5.50%
•Lab and X-Ray services	5.00%
•Physicians	0.20%
•Ambulatory surgical	1.75%
•Acute Care Hospitals	0.74%
•Other (reflected below)	variable

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 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*
General Hospitals	$54,543,590	$55,087,700	$54,442,288	$56,579,382	$56,546,478	$55,524,660	$53,721,215	$54,615,454	$53,597,134	*-0.19%*
Mental Hospitals	$18,846,282	$18,887,044	$18,870,720	$18,882,149	$18,887,659	$18,887,045	$18,869,278	$18,887,044	$18,885,501	*0.02%*
Total	**$73,389,872**	**$73,974,744**	**$73,313,008**	**$75,461,531**	**$75,434,137**	**$74,411,705**	**$72,590,493**	**$73,502,498**	**$72,482,635**	*-0.14%*

ACA MEDICAID EXPANSION

Expanded Medicaid under ACA as of June 2014.

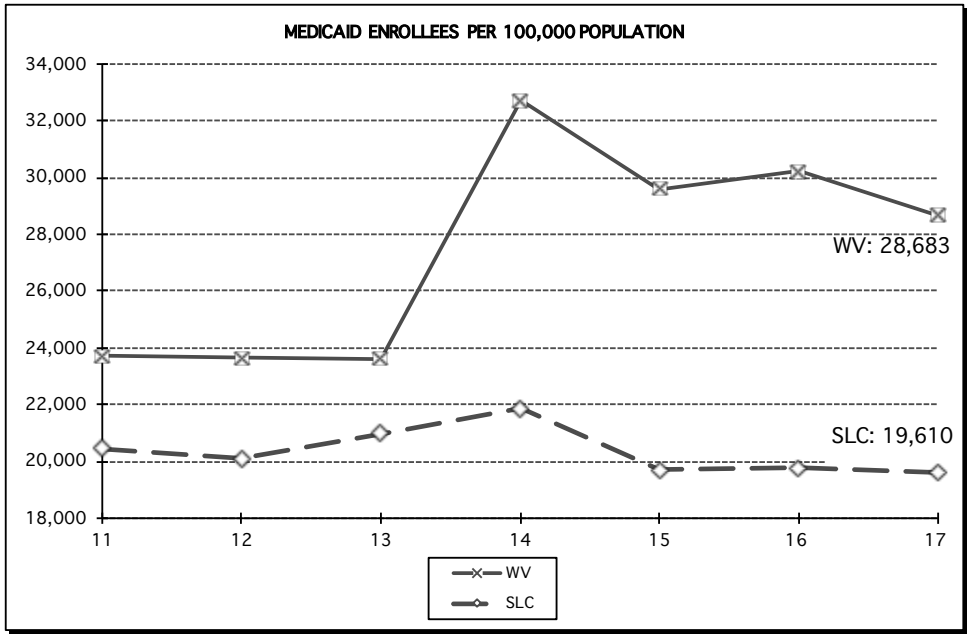
*Coverage to certain individuals (mainly adults) to 138% of the Federal Poverty Level.

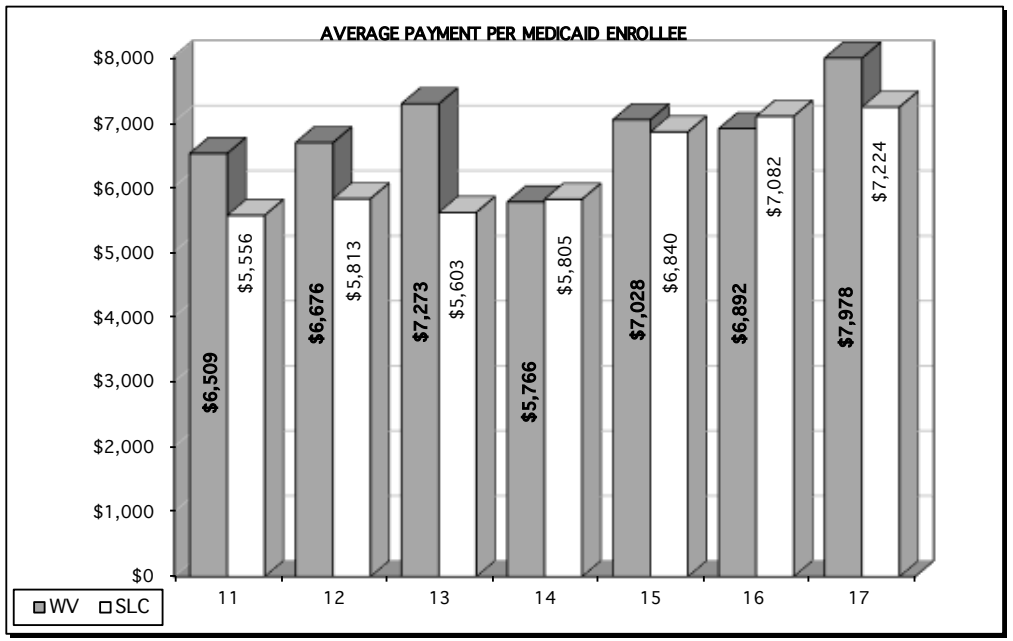
DEMOGRAPHIC DATA & POVERTY INDICATORS (2017)

		Rank in U.S.
State population—July 1, 2017	1,762,467	*38*
Per capita personal income	$38,454	*50*
Median household income	$45,392	*49*
Population below Federal Poverty Level	336,301	*34*
Percent of total state population	19.1%	*4*
Population without health insurance coverage	143,769	*39*
Percent of total state population	6.0%	*40*
Recipients of SNAP benefits	340,308	*35*
Total value of issuance	$481,164,574	*35*
Average monthly benefit per recipient	$117.83	*39*

Note: 2017 federal poverty level is $12,060 per year for a single person, $16,240 for a family of two and $20,420 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 SERVICE

SPENDING BY TYPE OF SERVICES (millions)	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	*Annual Change*	*Share of FFY 17*
Hospital	$620	$480	$588	$622	$732	$549	$619	*0.0%*	*15.5%*
Physician	$148	$143	$147	$199	$239	$125	$83	*-9.1%*	*2.1%*
Dental	$58	$55	$56	$40	$29	$16	$13	*-22.5%*	*0.3%*
Other practitioner	$13	$14	$14	$18	$26	$12	$9	*-6.8%*	*0.2%*
Clinic and health center	$31	$30	$31	$47	$83	$34	$20	*-6.9%*	*0.5%*
Other acute	$126	$238	$242	$261	$281	$196	$210	*8.9%*	*5.3%*
Drugs	$162	$120	$103	$156	$188	$41	$86	*-9.9%*	*2.2%*
Institutional LTSS	$568	$701	$716	$747	$780	$774	$784	*5.5%*	*19.6%*
Home and community-based LTSS	$570	$553	$572	$586	$592	$543	$516	*-1.6%*	*12.9%*
Managed care and premium assistance	$343	$341	$440	$552	$600	$1,269	$1,544	*28.5%*	*38.6%*
Medicare Premiums and Coinsurance	$120	$114	$115	$121	$124	$136	$153	*4.1%*	*3.8%*
Collections	($18)	($17)	($17)	($18)	($29)	($38)	($36)	*12.3%*	*-0.9%*
Total Spending	**$2,741**	**$2,772**	**$3,007**	**$3,331**	**$3,647**	**$3,656**	**$4,001**	*6.5%*	*100.0%*
TOTAL ENROLLMENT AND AVERAGE PAYMENT DATA									
Toral Enrollment	440,000	439,000	437,404	605,018	545,748	553,318	521,186		
Average Payment Per Enrollee	$6,509	$6,676	$7,273	$5,766	$7,028	$6,892	$7,978		
Average Payment Per Capita	$1,544.04	$1,578.87	$1,716.73	$1,886.82	$2,079.98	$2,082.89	$2,288.22		

Source: Payment information derived from MACPAC datasets based on CMS-64 FMR data for FFY 11-17. Recipient data is based upon MACPAC datasets based on MSIS Data for FFY 11-14, CMS Managed Care Enrollment Reports for FFY 15-17, and Census Bureau Population Estimates.

WEST VIRGINIA

ADDITIONAL STATE HEALTH CARE INFORMATION

Sources: MACPAC MACStats, 2018; Centers for Medicare and Medicare Services; and "Medicaid Managed Care Enrollment Report", CMS 2018.

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 rather 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 (2017)
- Comprehensive Managed Care Organization (MCO)
- Primary Care Case Management (PCCM)
- 81.48% of Medicaid enrollment (424,628 persons) in managed care in 2017

Children's Health Insurance Program: CHIP
- 37,464 enrollees
- Combination Plan
- Enhanced FMAP: 80.26% in 2017
- Federal Allotment: $61.0 M in 2017