NGA Center for BEST PRACTICES

Issue Brief

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2010 Maternal and Child Health Update: States Make Progress Towards Improving Systems of Care

Medicaid and the Children's Health Insurance Program (CHIP) provide health insurance coverage to over 60 million low-income children, their parents, and pregnant women. With the passage of recent federal legislation—namely, The Affordable Care Act enacted in March 2010--states now have new program options for enrollees with publicly funded coverage.

The *2010 Maternal and Child Health Update* presents 2010 data gathered from U.S. states and territories in the annual maternal and child health survey conducted by the National Governors Association Center for Best Practices (NGA Center). This year's survey reflects the changing environment resulting from difficult budget situations and health reform, and focuses on initiatives that states have undertaken to improve care management and provide higher quality and more effective care. Key findings among the states and territories include the following:

- **Medical homes programs are increasingly used to coordinate care for children.** Twenty-one of the 41 states that responded to the 2010 survey have established a medical home program that enrolls large segments of the child Medicaid/CHIP population. Various methods are used by states to pay providers in medical home programs: fee-for-service, fee-for-service with a bonus payment, and managed care capitation payment (Table 1).

- **Managed care is the predominant means of delivering Medicaid services to children.** Twenty-seven of the 41 states that responded to the survey are using managed care to deliver Medicaid services to children, with two-thirds or more of children enrolled in many of the states. Seventeen states mandate enrollment of special needs children into their managed care programs (Table 2).

- **Payment reform is becoming a focus for improving care delivery and coordination for children.** States that responded to the survey indicated that they are most interested in payment reforms that include pay-for-performance, accountable care organizations, and emergency room prevention incentives, as ways of improving care delivery (Table 3).

The Affordable Care Act enacted by Congress in March 2010 authorized funding for the expansion of home visitation programs. These programs are a major maternal and child health initiative, giving states grant opportunities to expand evidence-based programs for at-risk children. States responding to the survey reported varying qualifications for home visitation, ranging from age limits for eligibility and enrollment prioritization criteria based on variety of factors including age of mother, marital status, income, and history of abuse (Table 4).

The survey instrument for the 2010 Maternal and Child Health Update was developed by the NGA Center and designed to include data points on emerging issues relevant to maternal and child health populations. The survey was sent individually to all 50 states and the five U.S. territories in August 2010. Responses were received from 41 states and territories in the fall of 2010. The current status of any program may have changed since the collection of data.

Table 1. Medicaid and CHIP Medical Home Programs and Provider Payment Methods, 2010

State	Medical Home Program[1]		Percentage Enrolled		Provider Payment Methods			Adding New Populations
	Medicaid	CHIP	Medicaid	CHIP	Fee-for-Service Payment	Fee-for-Service with Bonus Payment for Case Management	Capitation Payment	
Alaska	No	No						
Arizona[2]	Yes	Yes					✓	Yes
Arkansas[3]	Yes	Yes	100%	100%		✓		Unsure
California[4]	Yes	Yes	100%	100%		✓	✓	Yes
Colorado	Yes	Yes	54%	100%	✓		✓	Yes
Connecticut	Yes	Yes	19%	0.50%	✓			Yes
Delaware[5]	No	No			✓		✓	No
Idaho[6]	Yes	Yes	85%			✓		No
Illinois[7]	Yes	Yes	84%		✓		✓	Yes
Indiana	No	No						Unsure
Iowa	No	No						
Kansas[8]	No	No						Yes
Louisiana[9]	Yes	Yes				✓		Yes
Maine	Yes	Yes						Unsure
Maryland[10]	No	No						Yes
Massachusetts[11]	Yes	Yes					✓	Unsure
Minnesota[12]	Yes	Yes				✓		Unsure
Missouri[13]	No	No			✓			Yes
Montana[14]	Yes	No	92%	73%		✓		Yes
Nebraska[15]								No

[1] For the purpose of this report, the term "medical home" is self-defined by each state.
[2] The Medical homes programs are being developed by MCO's as pilot programs. Enrollment is presently unknown but small.
[3] In Arkansas, ConnectCare is the primary care case management program. All beneficiaries except for Medicare/Medicaid dual-eligibles and pregnant women are required to have a primary care physician.
[4] The Medi-Cal program is pursuing a Section 1115 waiver to mandatorily enroll seniors and persons with disabilities, some of whom are children, into managed care in the year of 2011.
[5] In Delaware, payment is via capitation under managed care and via fee-for-service under state-managed programs.
[6] In Idaho, a disease management pilot provides incentive payments for meeting practice-based standards.
[7] In Illinois, among the 84 percent of individuals enrolled in medical homes, 11 percent are enrolled with a managed care organization (MCO) and 89 percent are enrolled in the state's Primary Care Case Management (PCCM) program, called Illinois Health Connect. The non-dually eligible Aid to the Aged, Blind and Disabled (AABD) population in the state is also enrolled in the PCCM program, but is excluded from the state's voluntary MCO program. Under the new Integrated Care Program, a targeted subset of the non-dually eligible AABD population will be moved into an MCO.
[8] In Kansas, plans are underway to implement a medical home program under Medicaid.
[9] In Louisiana, the "bonus" is a PCCM fee for primary care providers.
[10] Maryland is working with the Maryland Health Care Commission on a statewide Medical Home Program. This multipayer program will include Medicaid enrollees of all ages beginning in July 2011. Approximately 50 practice sites with 200 clinicians and about 30,000 Medicaid patients among 200,000 total patients will participate in the statewide medical home program. Providers will be located in large and small practices, academic programs, and Federally Qualified Health Centers.
[11] Massachusetts will have 46 practices designated as medical homes and currently estimates that they will serve roughly 148,000 Medicaid and CHIP enrollees.
[12] In Minnesota, although health care home care coordination services are available to all Medicaid/CHIP enrollees in the state, payments to providers are restricted to providers serving patients who have one or more complex chronic condition. As the program outcomes are evaluated, payments could be extended to less complex populations served by the health care homes.
[13] The Missouri HealthNet Division is considering applying for funding through federal health care reform law for enrollees with chronic conditions. To date, the division has not defined which new populations would be included.
[14] Montana is planning to implement a medical home program for the Medicaid population only.
[15] Nebraska Medical Home Pilot has been designed and pilot practices selected. Waiting for CMS approval to implement ahead of the January 2012 statutory requirement.

Table 1. Medicaid and CHIP Medical Home Programs and Provider Payment Methods, 2010, continued

State	Medical Home Program[16]		Percentage Enrolled		Provider Payment Method			
	Medicaid	CHIP	Medicaid	CHIP	Fee-for-Service Payments	Fee-for-Service with Bonus Payment for Case Management	Capitation Payments	Adding New Populations
Nevada[17]	No	No						Yes
New Hampshire	No	No						
New Jersey	No	No						
North Carolina	Yes	Yes	91%		✓			Yes
North Dakota	No	No						
Northern Mariana Islands	No	No					✓	Yes
Oklahoma	Yes	Yes	84%			✓		Yes
Oregon	No	No						Yes
Pennsylvania[18]	Yes	No						Unsure
Puerto Rico	No	No						
South Carolina	Yes	Yes						Unsure
South Dakota	No	No						Unsure
Tennessee	Yes	No	100%		✓			No
Utah[19]	Yes	Yes	0.54%				✓	No
Vermont	Yes	Yes			✓			Unsure
Virginia[20]	No	No						Unsure
Virgin Islands	No	No						
Washington[21]	Yes	Yes	80%				✓	Yes
West Virginia	Yes	No	67%		✓		✓	Unsure
Wisconsin	Yes	Yes						Yes
Wyoming	No	No						

[16] For the purposes of this report, "medical home" is self-defined by each state.
[17] Nevada is planning to implement medical homes per the Affordable Care Act.
[18] In Pennsylvania, the medical home model and similar programs are available under Medicaid managed care, either through an automatic linkage to a primary care provider who is responsible for managing individuals'care, or through a specific initiative. Specific initiative include: (a) "Healthy Beginnings Plus," for pregnant woman, which meets traditional/obstetric medical needs and provide care coordination, meets psychosocial and nutritional needs, and promotes health; and (b) "Children and Youth with Special Needs," which has the goal of ensuring that all children receive comprehensive, coordinated care in a medical home. Moreover, Pennsylvania's Chronic Care Commission is using the chronic care model and the medical home concept to improve chronic care for Medicaid and CHIP populations.
[19] Utah's Healthy Outcomes Medical Excellences (HOME) program is a medical home concept program that focuses on Medicaid clients with dual diagnoses, mental health problems, and physical disabilities, and clients who fall under the waiver category. Utah reported that 774 individuals are enrolled in its HOME program.
[20] In Virginia, the Department of Medical Assistance Services is developing a medical home project.
[21] Washington is planning to expand its medical home program to Social Security Income populations in the state in 2012.

Table 2. Managed Care: Data Collection, Special Needs Enrollment, and Plans for Expansion, 2010

State	Percentage of Children Enrolled in Medicaid Managed Care	Types of Data Collected		Special Needs Children Included in Managed Care Plans	Enrollment in Managed Care for Special Needs		Plans for Expansion for Special Needs Population
		Encounter[1]	Quality		Voluntary	Mandatory	
Alaska	0%			NA			
Arizona	95%	✓	✓	Yes		✓	No
Arkansas	0%			NA			
California[2]	55%	✓	✓	Yes		✓	Yes
Colorado[3]	13%	✓	✓	Yes	✓		Yes
Connecticut	32%	✓		Yes		✓	No
Delaware[4]	55%-60%	✓	✓	Yes		✓	No
Idaho	85%			Yes		✓	No
Illinois	84%	✓	✓	NA			No
Indiana[5]	90%	✓	✓	Yes		✓	No
Iowa	NA						NA
Kansas	37%	✓	✓	No			No
Kentucky	20%	✓		Yes		✓	No
Louisiana	NA						
Maine	NA			NA			
Maryland[6]	96%	✓		Yes		✓	No
Massachusetts[7]	55%	✓	✓	Yes		✓	Yes
Minnesota	74%	✓	✓	Yes		✓	Yes
Missouri	47%	✓	✓	Yes		✓	No
Montana	0%			NA			
Nebraska	50%	✓	✓	Yes		✓	
Nevada	68%	✓	✓	Yes	✓		No
New Hampshire	0%			No			

[1] Encounter data capture information about a person's engagement with the health care system, usually in the context of a billable event or health claim. Data elements describe the type of service delivered, the provider that delivered the services, and the plan responsible for payment or managing the benefit.
[2] Medi-Cal collects encounter data, quality-of-care performance measurement scores, member satisfaction survey data, and care utilization data. In addition, California is currently applying for its Medicaid Section 1115 hospital financing waiver, which will include pilot testing four alternative organized health care delivery models for children with special health care needs. The models to be pilot tested will include two full-risk managed care organization (MCO) models—an existing Medicaid MCO and a specialty MCO tailored to the special needs population. The other two alternative delivery models to be pilot tested involve capitation payment but do not put providers fully at risk—an enhanced primary care case management model and an accountable care organization model.
[3] Colorado collects member satisfaction, access, and provider network data.
[4] Delaware collects encounter data, utilization data, provider, and quality-of-care data.
[5] Indiana collects data on financial and operational metrics.
[6] Maryland collects Healthcare Effectiveness Data and Information Set (HEDIS) data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, data on preservice denials, financial monitoring data, pharmacy claims data through coordinated prospective drug utilization review (proDUR), enrollment data, and drug formulary data. For special needs children, Medical Assistance does have a carve-out for children with very expensive medical conditions from mandatory managed care, including technology-dependent children. These children are part of Maryland's Rare and Expensive Case Management program. Medicaid services and case management are provided through the fee-for-service program for individuals in these programs.
[7] Massachusetts collects: Encounter data (claims data); programmatic, financial, and behavioral health reports; HEDIS data; member satisfaction survey data; MassHealth/MCO Quality Improvement Goals. Goal priority areas are: asthma, diabetes, behavioral health, and maternal and child health care management.

Table 2. Managed Care: Data Collection, Special Needs Enrollment, and Plans for Expansion, 2010, continued

State	Percentage of Children Enrolled in Medicaid Managed Care	Types of Data Collected		Special Needs Children Included in Managed Care Plans	Enrollment in Managed Care for Special Needs		Plans for Expansion for Special Needs Population
		Encounter	Quality		Voluntary	Mandatory	
New Jersey	84%	✓	✓	Yes	✓		Yes
North Carolina	91%			Yes	✓		No
North Dakota	0%			NA			
Oklahoma	0%			NA			
Oregon	80%		✓	Yes	✓		No
Pennsylvania[8]	74%	✓	✓	Yes	✓	✓	No
Puerto Rico	7%	✓	✓				
South Carolina				Yes	✓		No
South Dakota	95%	✓		Yes		✓	No
Tennessee	100%	✓	✓	Yes		✓	No
Utah	85%	✓		Yes			No
Vermont	80%	✓	✓	Yes		✓	
Virginia[9]	81%	✓	✓	Yes		✓	No
Washington[10]	80%	✓	✓	Yes	✓		Yes
West Virginia	67%	✓	✓	Yes		✓	No
Wisconsin	78%	✓		Yes	✓		No
Wyoming	0%			NA			

[8] Participation in a medical home is mandatory for children with special needs in 25 Pennsylvania counties; voluntary in a MCO-model or mandatory in an EPCCM model (for recipients who do not enroll in a voluntary MCO) in the remaining 42 counties.
[9] Enrollment in managed care for special needs children is mandatory unless they have Third Party Liability or are enrolled in a Medicaid Section 1915(c) waiver.
[10] Washington will add special needs populations starting in 2012.

Table 3. Options for Improving Delivery of Care: Payment Reforms, 2010

State	Payment Reforms for Children Under Consideration			
	Pay-for-Performance	Bundling	Accountable Care Organizations	Emergency Room Prevention Incentives
Alaska				
Arizona	✓		✓	✓
Arkansas	✓	✓	✓	✓
California	✓	✓	✓	✓
Colorado	✓		✓	✓
Connecticut	✓	✓	✓	✓
Delaware				
Idaho		✓	✓	
Illinois	✓		✓	
Indiana				
Iowa				
Kansas				
Louisiana				
Maine	✓		✓	
Maryland	✓	✓	✓	✓
Massachusetts	✓	✓	✓	
Minnesota	✓	✓		✓
Missouri				
Montana				
Nebraska			✓	
Nevada	✓	✓	✓	✓
New Hampshire				
New Jersey	✓	✓	✓	✓
North Carolina			✓	
North Dakota	✓			✓
Northern Mariana Islands				
Oklahoma				
Oregon			✓	
Pennsylvania	✓	✓	✓	✓
Puerto Rico	✓			✓
South Carolina				
South Dakota	✓			✓
Tennessee	✓	✓	✓	✓
Utah				
Vermont	✓	✓		✓
Virginia				
Virgin Islands				
Washington	✓	✓	✓	✓
West Virginia				
Wisconsin				
Wyoming	✓			

Table 4. Home Visitation Capacity, Eligibility, and Enrollment Criteria, 2010

State	Lead Agency(ies)	Sufficient Provider Capacity	Home Visiting Programs Represented on Early Childhood Advisory Council	Upper Age Limit for Eligibility	Criteria Used to Prioritize Enrollment
Alaska	Title V/Children with Special Health Care Needs section of the Women's, Children's and Family Health in Division of Public Health, Dept. of Health and Social Services	Yes, unsure about rural areas	No	Preschool	Still being defined
Arizona	Dept. of Health Services	Yes	Yes	5	Varies by program
Arkansas	Dept. of Health	Unsure	Yes	1	Teen mothers
California[1]	Dept. of Public Health				
Colorado	Dept. of Public Health and Environment	Unsure	Yes	2	Low-income and first-time mothers
Connecticut	Dept. of Public Health	Yes	No	Varies by program	Varies by program
Delaware	Health and Social Services' Division of Public Health (Title V agency)	Unsure	Yes	Kindergarten	Still being defined
Idaho	Dept. of Health and Welfare	Unsure	Yes	3	Still being defined
Illinois	Dept. of Human Services	Yes	Yes	5	Poor, single-parent, education level, unemployed, large family size
Indiana[2]	Dept. of Health, Division of Maternal and Child Health, Dept. of Child Services	Unsure	No	2	No criteria used
Iowa	Dept. of Public Health	Yes	Yes	2	Varies by program
Kansas	Dept. of Health and Environment	No	Yes	Varies	Varies by program
Kentucky	Dept. for Public Health	Yes	Yes	2	Teen mothers, unsuccessful abortions, poor, unemployed
Louisiana	Dept. of Health and Human Services/Office of Public Health	Yes	Yes	2	Low-income, first-time mothers

[1] California does not currently have a state-level home visitation program but is planning to implement one as part of the Affordable Care Act.
[2] In Indiana, Goodwill Industries provides wraparound service until a child is 5 years old.

Table 4. Home Visitation Capacity, Eligibility, and Enrollment Criteria, 2010, continued

State	Lead Agency(ies)	Sufficient Provider Capacity	Home Visiting Programs Represented on Early Childhood Advisory Council	Upper Age Limit for Eligibility	Criteria Used to Prioritize Enrollment
Maryland[3]	Family Health Administration	Unsure	Yes	5	Currently no prioritization
Massachusetts	Dept. of Public Health	Yes	Yes	Varies by program	Varies; scoring mechanism across 35 indicators
Minnesota	Dept. of Health	Yes	Yes	Varies by program	High-risk populations
Missouri	Dept. of Health and Senior Services	Yes	Yes	2	Low-income, teen mothers, incarcerated parents, history of substance abuse
Montana	Dept. of Public Health and Human Services, Family and Community Health Bureau	Unsure	Yes	1	17 or younger, history of substance abuse, homelessness, special-needs birth
Nebraska	Dept. of Health and Human Services, Public Health Division	Unsure	Yes	Varies by program	Still being defined
Nevada	State Health Division (Title V Maternal and Child Health Program)	Unsure	Yes	Varies by program	Still being defined
New Hampshire	Dept. of Health, Maternal and Child Health Section	Yes	Yes	Varies by program	Low-income, teen mothers, high risk of abuse/neglect
New Jersey	Dept. of Health and Senior Services	Unsure	Yes	2	Varies by program
North Carolina	Division of Public Health	No	Yes	2	Still being defined
Northern Mariana Islands	Division of Public Health	Unsure	No	8	Lack of prenatal care
Oklahoma	Dept. of Health	No	Yes	Varies by program, usually until 5 years	Varies by program
Oregon	Office of Family Health, Public Health Division, Health Authority	Yes	Yes	Until 5 years, up to 21 for special health needs	Varies by program
Pennsylvania[4]	Office of Children Development and Early Learning	Yes	Yes	Until 2 years, for low-income, until 4 years	Annual "Reach and Risk Assessment"

[3] Maryland has 13 indicators to identify communities at risk and added two additional indicators for the recently completed the federally required HIV needs assessment.
[4] Pennsylvania Reach and Risk Assessment measures economic, maternal, and birth outcome risk factors.

Table 4. Home Visitation Capacity, Eligibility, and Enrollment Criteria, 2010, continued

State	Lead Agency(ies)	Sufficient Provider Capacity	Home Visiting Programs Represented on Early Childhood Advisory Council	Upper Age Limit for Eligibility	Criteria Used to Prioritize Enrollment
Puerto Rico	Dept. of Health	No	Yes	2	Low-income
South Carolina	Children's Trust of South Carolina	Unsure	Yes		Still being defined
South Dakota	Dept. of Health	No	No	3	Low-income, first-time mothers, history of abuse
Tennessee	Title V, Maternal and Child Health	No	Yes	6	Risk of maltreatment, teen mothers, first-time mothers
Utah[5]	Dept. of Health	No	Yes	5	Low-income, mothers under 21
Vermont	Dept. for Children and Families	Yes	No	6	Low-income, family history
Virginia	Dept. of Health	Yes	Yes	5	Low-income, teen mothers
Washington	Dept. of Social and Health Services, Dept. of Health, Dept. of Early Learning, Council for Children and Families	No	Yes	6	Varies by program
West Virginia	Office of Maternal, Child and Family Health	Unsure	Yes	5	Communities of need, low-income, teen mothers, history of substance abuse or neglect, serving or formerly served in military
Wisconsin	Dept. of Children and Families	Yes	Yes	2	Low-income, teen mothers, risk of abuse/neglect
Wyoming	Dept. of Health	No	No	2	First-time mothers

[5] Utah's Department of Health contracts with 12 local district health departments, which serve as the lead agencies for the state's home visitation program.

Table 5. State Spending on Prescription Drugs for Children, 2010

State	Percentage of Children's Rx Drug Spending on Behavioral Health Drugs	Cost Containment for Children's Prescription Drugs		
		Prior Authorization	Step Therapy	Quantity Limits
Alaska[1]	11%	✓	✓	
Arizona	not available	✓	✓	
Arkansas	36%			
California[2]	not available			
Colorado	29%	✓	✓	
Connecticut[3]	not available	✓		
Delaware	33%	✓		
Idaho	49%	✓		
Illinois[4]	9%	✓		✓
Indiana	25%	✓	✓	
Iowa	49%			
Kansas	50%	✓		
Kentucky	36%	✓	✓	
Louisiana	6%	✓	✓	
Maine	not available	✓		
Maryland[5]	69 %	✓	✓	✓
Massachusetts[6]	not available			
Minnesota[7]	39%	✓		✓
Missouri	30%			
Montana	44%	✓		✓
Nebraska[8]	40%	✓	✓	✓
Nevada	33%	✓		✓
New Hampshire	19% for 0-12, 17% for 13-18			
New Jersey	not available	✓	✓	
North Carolina	14%	✓		
North Dakota	not available			
Northern Mariana Islands	not available			
Oklahoma	26%	✓	✓	✓
Oregon	not available	✓	✓	
Pennsylvania[9]	45%	✓	✓	

[1] Alaska restricts usage based on therapeutic duplication edits.
[2] California restricts usage based on age for children's drugs.
[3] Connecticut restricts usage for certain diagnoses.
[4] Illinois has age restrictions and duration limits.
[5] For Maryland, age limits are used for some Mental Health drugs and Prospective Drug Utilization Review alerts to pharmacists on high dosages for children.
[6] Massachusetts restricts based on age.
[7] Minnesota does not have a formal step therapy program at this time, but "step through" of a preferred medication is sometimes part of the prior authorization criteria for approval. The state also has age restrictions on some prescription drugs.
[8] Coverage of many drugs in Nebraska is restricted to patients whose ages correspond to ages the Federal Drug Administration has approved for the drug; antipsychotics are covered for young children only upon documentation of medical necessity.
[9] The Pennsylvania Insurance Department, the state agency that administers CHIP, has not set any restrictions; however, the MCOs contracting with CHIP develop their own formularies and apply step therapy and prior authorization.

Table 5. State Spending on Prescription Drugs for Children, 2010, continued

State	Percentage of Children's Rx Drug Spending on Behavioral Health Drugs	Cost Containment for Children's Prescription Drugs		
		Prior Authorization	Step Therapy	Quantity Limits
Puerto Rico	not available	✓	✓	
South Carolina	not available			
South Dakota	39%	✓	✓	
Tennessee	26%		✓	✓
Utah	35%	✓	✓	
Vermont	not available	✓		
Virginia[1]	not available	✓		
Virgin Islands				
Washington	not available	✓	✓	
West Virginia	not available	✓	✓	
Wisconsin		✓	✓	
Wyoming	17%	✓		✓

[1] Virginia has a preferred drug list. If a drug is in a drug class that is on that list and is deemed to be non-preferred by the Pharmacy & Therapeutics Committee, the drug would require prior authorization. The state's preferred drug list applies to children and adults.

Table 6: Medicaid Births as a Percentage of Total Births by State, 2005-2009

State	2005		2006		2007		2008		2009	
	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births
Alabama	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Alaska	5,798	55%	5,921	54%	5,494	50%	5,730	51%	5,891	53%
Arizona	50,407	53%	53,121	52%	53,625	52%	52,081	53%	49,538	54%
Arkansas	2,3407	60%	2,443	62%	2,630	64%	25,928	63%	25,337	64%
California	251,926	46%	NA	NA	NA	NA	NA	NA	NA	NA
Colorado[1]	21,545	31%	23,692	34%	23,531	33%	25,942	37%	26,101	38%
Connecticut[2]	13,423	32%	13,940	33%	14,391	35%	NA	NA	14,500	NA
Delaware	5,213	45%	5,201	44%	NA	NA	6,439	54%	6,202	NA
Florida[3]	99,941	44%	103,323	43%	102,205	42%	NA	NA	NA	NA
Georgia	80,741	57%	84,535	57%	NA	NA	NA	NA	NA	NA
Hawaii	7,220	40%	7,232	38%	7,613	40%	NA	NA	NA	NA
Idaho	9,163	40%	9,341	39%	9,307	37%	9,760	39%	NA	NA
Illinois	73,641	41%	81,453	45%	89,890	50%	83,924	48%	81,104	NA
Indiana	38,408	44%	40,609	45%	40,891	NA	40,642	NA	41,793	NA
Iowa	17,005	43%	17,832	44%	16,708	41%	15,297	38%	15,732	NA
Kansas	17,524	44%	17,514	43%	19,171	46%	17,946	43%	NA	NA
Kentucky	18,432	32%	20,369	34%	18,654	32%	25,775	46%	24,604	44%
Louisiana	NA	NA	43,042	66%	41,178	65%	45,354	70%	NA	NA
Maine	NA	NA	NA	NA	NA	NA	5,400	40%	5,400	40%
Maryland	NA	NA	NA	NA	NA	NA	29,488	39%	30,267	40%
Massachusetts[4]	23,624	35%	28,356	37%	28,941	37%	11,247	15%	12,913	NA
Michigan	51,242	40%	53,198	42%	NA	NA	NA	NA	NA	NA
Minnesota[5]	26,118	37%	28,000	38%	28,198	38%	30,635	42%	31,209	NA
Mississippi	26,065	62%	28,180	61%	28,319	61%	NA	NA	NA	NA
Missouri	36,775	47%	37,965	47%	38,344	47%	33,318	45%	31,326	48%
Montana[6]	4,946	42%	5,076	42%	5,187	41%	4,419	35%	12,076	NA

[1] For Colorado, in 2003 the number of Medicaid births equals the total fee-for-service births in fiscal year (FY) 2003-2004 (23,113) plus the total HMO births reported via HEDIS 2004 for calendar year 2003 (2,475). Beginning FY 2004, only fee-for-service births are counted. Data are from the *Inpatient Utilization Reports* created by the Colorado Foundation of Medical Care. Colorado's total births are from the U.S. Census Bureau, *State Population Estimates by Component of Change*.

[2] Connecticut calendar year matches Department of Social Services claims data with Department of Public Health Vital Records. 2009 data is an estimate.

[3] Florida updated number of Medicaid 2005, 2006, and 2007 births and percentage for total births from the *Florida Birth Query System Report*, Florida Department of Health, Office of Vital Statistics.

[4] Massachusetts' birth data include CHIP births.

[5] Medicaid births for Minnesota include births in Minnesota's 1115 Medicaid expansion program (MinnesotaCare).

[6] Montana's definition of a Medicaid birth is any child that had a paid Medicaid claim indicating delivery or a paid Medicaid claim in the first month of life, or a child that has been matched to a mother eligible for Medicaid and the mother had a paid Medicaid claim indicating a delivery.

Table 6: Medicaid Births as a Percentage of Total Births by State, 2005-2009

State	2005		2006		2007		2008		2009	
	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births	Number of Medicaid Births	Percentage of Total Births
Nebraska	10,889	42%	11,666	44%	11,547	44%	12,667	47%	11,668	43%
Nevada	14,313	NA	15,438	NA	15,678	NA	16,817	44%	17,753	48%
New Hampshire	3,336	27%	3,562	28%	3,737	30%	3,872	31%	3,912	32%
New Jersey	32,995	NA	34,522	NA	35,440	NA	2,890	8%	NA	NA
New Mexico	10,131	56%	15,070	54%	NA	NA	NA	NA	NA	NA
New York	101,091	41%	106,381	43%	106,676	42%	NA	NA	NA	NA
North Carolina	70,877	58%	74,024	59%	NA	NA	64,887	50%	64,439	51%
North Dakota	2,667	32%	2,614	30%	2,864	30%	NA	NA	NA	NA
Ohio	60,249	40%	62,775	41%	61,091	40%	NA	NA	NA	NA
Oklahoma	28,643	56%	30,877	57%	32,888	60%	32,601	61%	33,898	64%
Oregon[7]	20,641	45%	22,064	45%	NA	NA	19,737	41%	19,664	43%
Pennsylvania	NA	NA	NA	NA	NA	NA	57,862	39%	57,371	NA
Puerto Rico	36,314	72%	35,402	73%	33,717	72%	32,765	72%	26,561	60%
Rhode Island	5,798	47%	5,530	46%	5,657	47%	NA	NA	NA	NA
South Carolina	NA	NA	NA	NA	NA	NA	31,485	51%	NA	NA
South Dakota	4,247	37%	4,357	37%	4,671	38%	4,645	39%	4,662	39%
Tennessee	40,785	50%	40,380	57%	NA	NA	43,000	49%	43,000	49%
Texas	213,945	55%	223,128	56%	228,202	56%	NA	NA	NA	NA
Utah	15,464	29%	14,860	27%	15,211	27%	20,173	36%	15,045	34%
Vermont	2,654	41%	2,856	44%	2,827	44%	2,856	44%	2,827	44%
Virginia[8]	24,870	24%	26,989	25%	27,610	25%	28,189	26%	28,047	27%
Washington	39,077	48%	40,317	47%	41,410	47%	43,163	48%	NA	NA
West Virginia	NA	NA	NA	NA	NA	NA	11,921	58%	12,001	NA
Wisconsin	NA	NA	31,442	43%	31,680	44%	32,792	46%	NA	NA
Wyoming	NA	NA	NA	NA	NA	NA	3,353	42%	3,401	43%

[7] Oregon birth counts are different than those reported in prior surveys. Previously, all data came from Vital Statistics; however, not all Oregon Medicaid births were appropriately identified in that data. For that reason, the number and percentage of Oregon Medicaid births comes from Medicaid claims data.
[8] Virginia data is based on the state fiscal year and is derived from the Virginia Department of Health, Office of Vital Statistics.

Table 7. CHIP Coverage and Cost Sharing, 2010

State	CHIP Eligibility or Enrollment Changes	Upper Age Limit for Eligibility for Medicaid Coverage of Foster Children	CHIP Coverage for Children of State Employees	Cost Sharing Levels for CHIP Dental Program, Per Visit
Alaska	No	18, 19-20 yr olds separate program	Yes	$0
Arizona	Enrollment freeze in Jan. 2010	18, 21 in a separate program	No	$0
Arkansas	No	18	Yes	$10
California	No	21	No	$5 below 150% FPL, $10 above that level
Colorado	No	21	No	$0, $5, $10, depending on income
Connecticut	Considering presumptive eligibility	21	No	$0
Delaware	No	21	No	$0
Idaho	No	19	No	$5
Illinois	No	21	No	$2 or $5
Indiana	No	20	No	$0
Iowa	Added dental	18, 19 if in school	No	$0 under 150% FPL
Kansas	No	21	No	$0
Kentucky	Suspended $20/family premium for KCHIP	18	Yes	$0
Louisiana	No	21	No	$0
Maine	No	18	No	$0
Maryland	Pre-populated redetermination form for enrollees	21	Yes	$0
Massachusetts	No	21	Yes	$0
Minnesota[1]	Noncitizen pregnant women and children	21	No	$0
Missouri	No	21	No	$0
Montana	Increased income to 250%	21	No	$0
Nebraska[2]	Increased income to 200%	19	No	$0
Nevada	No	21	No	$0
New Hampshire		19	No	$0

[1] Minnesota adopted Medicaid coverage for lawfully residing, noncitizen pregnant women and children. This slightly reduces enrollment in the separate state CHIP plan for coverage of unborn children.

[2] In 2009, the State of Nebraska increased the income from 185 percent FPL to 200 percent FPL for CHIP-eligible children. Families are now able to apply online; the first Customer Service Center opened in 2010. In addition, there are four planned customer service centers to assist clients.

Table 7. CHIP Coverage and Cost Sharing, 2010, continued

	CHIP Eligibility or Enrollment Changes	Upper Age Limit for Eligibility for Medicaid Coverage of Foster Children	CHIP Coverage for Children of State Employees	Cost Sharing Levels for CHIP Dental Program, Per Visit
New Jersey	No	21	No	$0
North Carolina	No	21	No	$5
North Dakota		No		
Northern Mariana Islands	No	18		$0
Oklahoma	No	26	No	$0
Oregon	Changed FPL rates, enrollment outreach strategies	21	Yes	$0
Pennsylvania	Implemented new income and citizenship verification	18	Yes	$0
Puerto Rico	No	18	No	$0
South Carolina	No	18	No	$0
South Dakota	No	21	No	$0
Tennessee	No	18, 19 if in school	No	$0
Utah	No	No	No	$0
Vermont	No	18	No	$0
Virginia	Citizenship verification implemented; Title IX infants covered without application	18	No	$0
Washington	No	21	No	$0
West Virginia		21		
Wisconsin	Yes	18	No	$.50-$3.00
Wyoming	No	18 or 20, depending on coverage	No	$0-$25 depending on plan

Table 8. Maternal and Child Health Benefit Changes, 2010

State	Benefit Changes	
Alaska	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Arizona	New Benefits	
	Eliminated Benefits	Adults: dental, podiatry, insulin, hearing aids, orthotics, transplants, well-exams, physical therapy, prosthetics, non-emergency transportation
	Altered Benefits	
Arkansas	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Added prior authorization requirements
California	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Optometry exams restored to all beneficiaries
Colorado	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Increased dental screening; new generics; HPV vaccine for boys
Connecticut	New Benefits	Smoking cessation benefits for pregnant mothers
	Eliminated Benefits	
	Altered Benefits	
Delaware	New Benefits	New drug classes added
	Eliminated Benefits	
	Altered Benefits	
Idaho	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Lowered amount reimbursable without PA
Illinois	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Added children's mental health drugs to PA list
Indiana	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Increased behavioral health drugs benefits for CHIP to that of Medicaid
Iowa	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Kansas	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Louisiana	New Benefits	Pediatric Day Health Centers
	Eliminated Benefits	
	Altered Benefits	
Maine	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Maryland	New Benefits	Case management for mentally ill
	Eliminated Benefits	
	Altered Benefits	
Massachusetts	New Benefits	
	Eliminated Benefits	
	Altered Benefits	For adults, no longer cover fillings, root canals, dentures
Minnesota	New Benefits	Coverage for birth centers and midwives
	Eliminated Benefits	Limited dental for nonpregnant adults
	Altered Benefits	See notes[1]

[1] Minnesota modified hospice services for children to allow coverage for treatment of the terminal condition while receiving hospice services. Modified chiropractic services to allow coverage for evaluation and management services and reduce the annual visit limit. Modified rehabilitation (PT, OT, SLP) services to reduce the lifetime service threshold at which authorization is required. Implemented volume purchase contract for eyeglasses.

Table 8. Maternal and Child Health Benefit Changes, 2010, continued

State	Benefit Changes	
Missouri	New Benefits	Added benefits to school-based programs
	Eliminated Benefits	
	Altered Benefits	
Montana	New Benefits	Added benefits for hearing aids, ambulance services
	Eliminated Benefits	
	Altered Benefits	Increased cap on dental benefits; mandated parity for mental health and substance abuse
Nebraska	New Benefits	Residential rehabilitation for adults
	Eliminated Benefits	
	Altered Benefits	Prior authorization for radiology procedures required; preferred drug list modified
New Hampshire	New Benefits	Medicaid hospice added
	Eliminated Benefits	Medicaid chiropractor
	Altered Benefits	Changed cost sharing under CHIP, changed service limit for Medicaid podiatry psychiatry, outpatient hospital and ER
New Jersey	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Mental/behavioral health and dental parity
New Jersey	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Mental/behavioral health and dental parity
North Carolina	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Implemented PA for nonpreferred drugs
North Dakota	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Oklahoma	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Currently updating PA requirements
Oregon	New Benefits	
	Eliminated Benefits	Dental and vision services for non-pregnant adults
	Altered Benefits	Expanded preferred drug list
Pennsylvania	New Benefits	Psychiatric rehab services; orthodontia and dental prosthetics for CHIP
	Eliminated Benefits	
	Altered Benefits	Updated preferred drug list; monetary limits for CHIP
Puerto Rico	New Benefits	Special coverage for autism
	Eliminated Benefits	
	Altered Benefits	
South Carolina	New Benefits	
	Eliminated Benefits	
	Altered Benefits	

Table 8. Benefit Changes, 2010, continued

State	Benefit Changes	
South Dakota	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Added new drugs for PA
Tennessee	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Utah	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Vermont	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Virginia	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Washington	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
West Virginia	New Benefits	
	Eliminated Benefits	
	Altered Benefits	Added more drugs to PA list
Wisconsin	New Benefits	
	Eliminated Benefits	
	Altered Benefits	
Wyoming	New Benefits	For CHIP: medically necessary dental and orthodontia
	Eliminated Benefits	
	Altered Benefits	Mental health parity