

medicaid
and the uninsured

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**Economic Stress and the Safety Net:
A Health Center Update**

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Federally funded health centers provided care to 11.3 million patients in 2002, the vast majority of whom were either uninsured (39%) or covered by Medicaid (34%). This paper provides new information on the demographic profile of health center patients and the revenue sources available for financing their care, including recent increases in federal discretionary funding. It examines the impact of the recent economic downturn on health centers in selected communities, exploring the effect of elevated unemployment levels among lower wage workers, declining private health insurance coverage, and widespread state cutbacks in Medicaid – the single most important source of health center financing.

Part 1 presents an updated profile of health centers, examining their patients and revenues, and documenting the critical role Medicaid plays in financing care for health center patients.¹ Part 2 reports on the challenges health centers around the nation experienced as they attempted to respond in economically stressed urban and rural communities over the past few years. Finally, Part 3 examines how recent increases in federal appropriations relate to growing demand for health center services as the number of low-income, uninsured persons continues to rise. The roughly 7% increase in federal funding between 2002 and 2003 occurred at the same time as the number of uninsured health center patients is estimated to have risen by an even faster rate of 11.4%. From a national perspective, for every one uninsured, low-income patient that a health center is able to treat, there are an average of four additional low-income, uninsured persons. Medicaid coverage remains the largest revenue source for health centers and is the engine that supports health center capacity during an economic downturn, allowing staff to coordinate patient care for those most in need and to secure access to specialty and diagnostic services not offered in a primary care setting.

Part 1. A Profile of Health Centers

Now in their 39th year of existence, health centers have as their mission the provision of affordable and comprehensive primary health care to medically underserved persons. In order to qualify for health center funding, an entity must:

- Be located in or serve a medically underserved urban or rural community, i.e., communities characterized by demonstrably elevated rates of low-income residents and elevated levels of death and disability from preventable causes;
- Offer a comprehensive range of primary health services as well as supportive services such as translation and transportation services that promote access to health care;
- Prospectively adjust the fees charged for services in accordance with patients' ability to pay, using a published sliding fee schedule; and
- Be governed by a community board, a majority of whom use health centers.

Health centers that receive federal grants or that are classified as “look alike” health centers because they meet all federal grant requirements are classified as “federally qualified health centers” for purposes of Medicare and Medicaid payments. This special “FQHC” classification permits cost-related payments in order to ensure that grant funds meant for care of the uninsured are not diverted into offsetting Medicaid payment deficits.

Data on federally funded health centers collected by the federal government through the Uniform Data System (UDS)² indicate that in 2002, 843 health centers, including 71 newly-established health centers, provided primary health care to over 11 million people at more than 4,600 urban and rural sites. Additionally, an estimated 97 “look-alike” FQHCs served approximately 1.2 million patients, bringing the cumulative reach of health centers to 12.5 million persons (Figure 1) and making health centers the single largest primary health care system for medically underserved populations.³

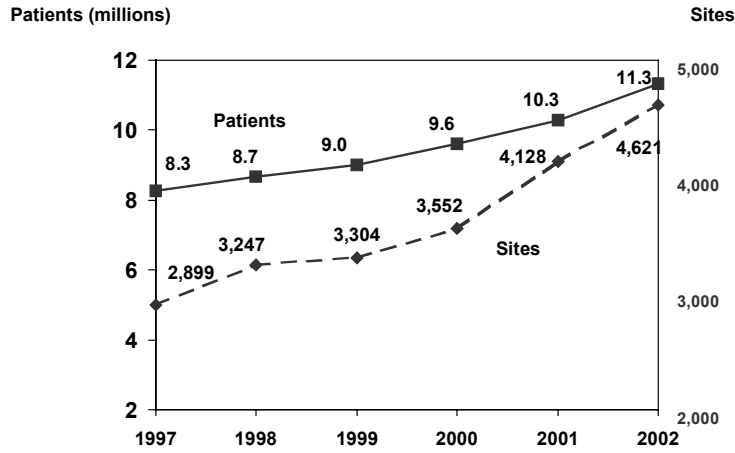
Figure 1. Estimated Number of Patients Served by Federally Funded and “Look-Alike” Health Centers, 2002

<u>Type of Health Center</u>	<u>Number of Centers</u>	<u>Number of Patients Served</u>
Federally-funded Health Centers	843	11.3 million
“Look-alike” Health Centers	97	1.2 million

Source: 2002 UDS data on federally funded health centers, supplemented by data on “look-alike” centers from the National Association of Community Health Centers.

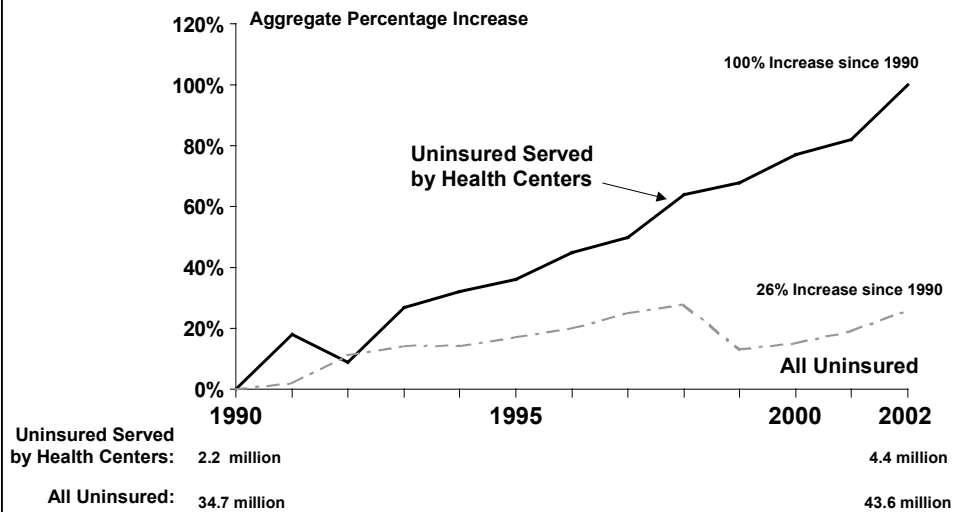
The growth of health centers has been significant. Between 1997 and 2002, the number of federally-funded health center sites grew by 58%, while the number of patients served grew by 36 percent (Figure 2). The number of uninsured health center users virtually doubled over the 1990-2002 time period, far surpassing the national increase in uninsured persons over this time period (Figure 3). Yet even as health centers have expanded to respond to the problem of medical underservice, their penetration remains well below national estimates of need. The 12.5 million persons reached by federally-funded and look-alike health centers in 2002 represented only 25 percent of the estimated 50 million low income persons without a regular source of health care that year.⁴

Figure 2
Growth of Health Center Patients and Sites, 1997-2002



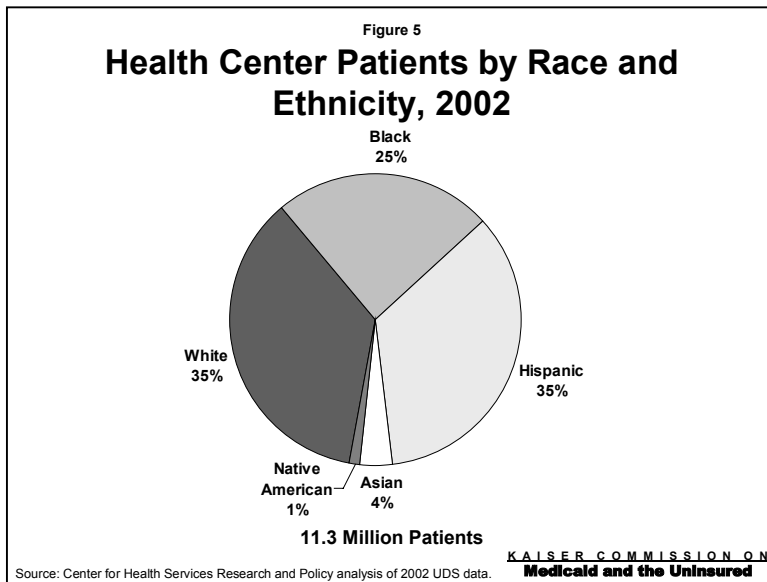
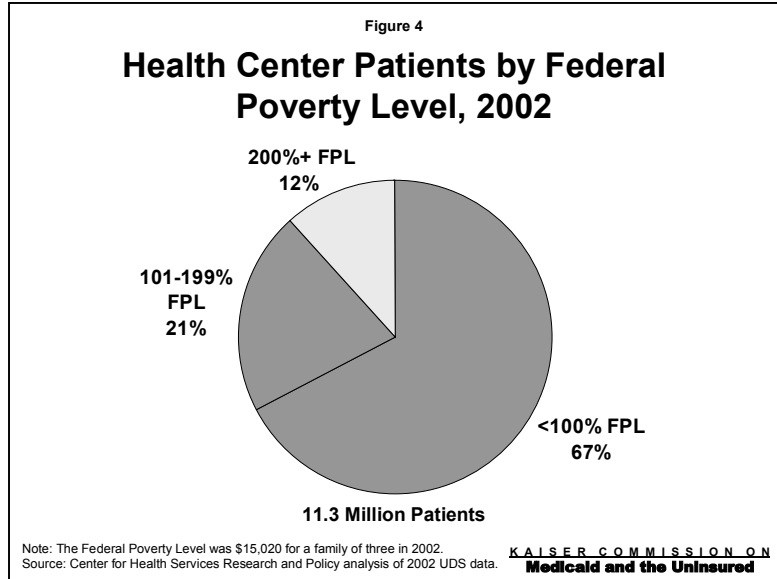
SOURCE: Center for Health Services Research and Policy analysis of 2002 UDS. **KAISER COMMISSION ON Medicaid and the Uninsured**

Figure 3
Aggregate Percentage Growth in Uninsured Population: Total vs. Those Served by Health Centers, 1990-2002

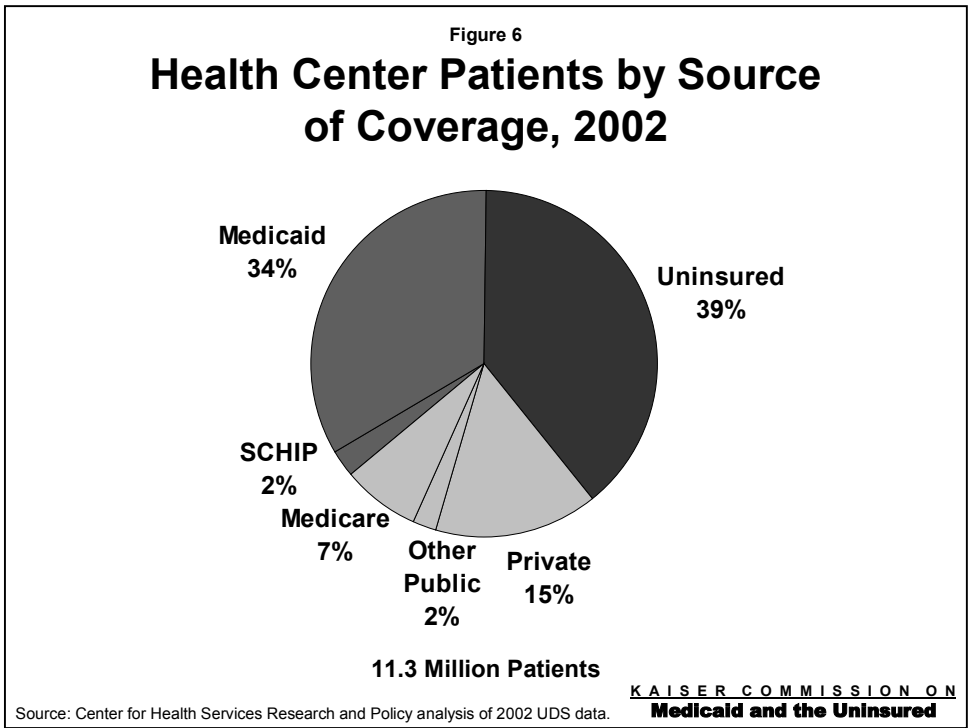


SOURCE: Center for Health Services Research and Policy analysis of 1996-2001 UDS; 1990-1996 figures provided by NACHC; National estimates from Census. **KAISER COMMISSION ON Medicaid and the Uninsured**

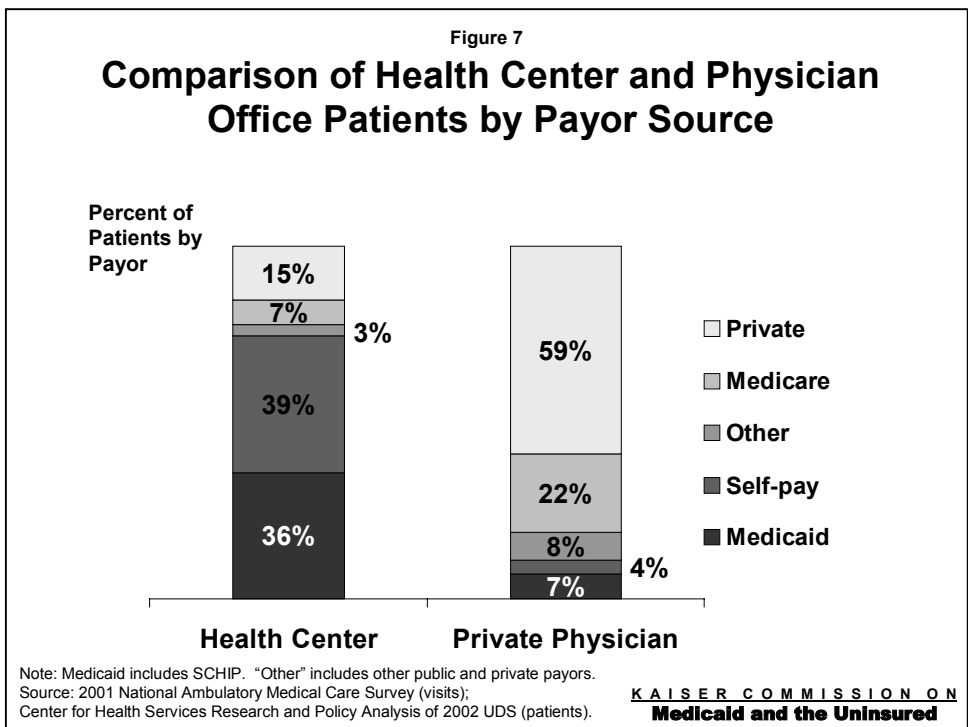
The demographic profile of patients reflect health centers' statutory mission. In 2002, 88 percent of 11.3 million health center patients had family incomes at or below 200 percent of the federal poverty level (Figure 4). Health centers represent an extremely important source of health care for minority populations. In 2002, 65 percent of health center patients were Black, Hispanic, Asian or Native American (Figure 5).



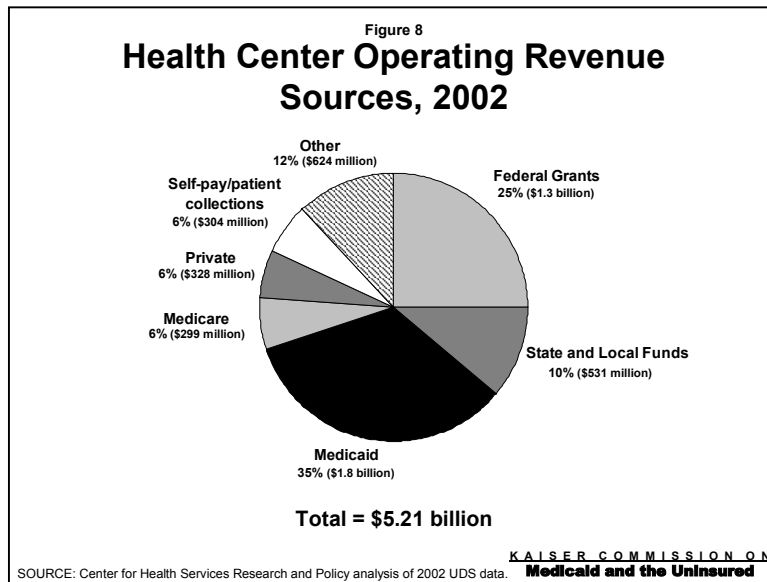
In addition to their service to uninsured patients, health centers represent an extremely important source of health care for Medicaid beneficiaries. In 2002, health centers served over 4 million Medicaid beneficiaries, roughly 10 percent of all persons enrolled in Medicaid that year. Seventy-five percent of all health center patients were either uninsured or enrolled in Medicaid or SCHIP, while only 15 percent had private health insurance (Figure 6).



The patient mix at health centers differs significantly from that found in private primary care practices; whereas Medicaid and “self pay” patients make up three-quarters (75 percent) of the total health center patient population, only one in every ten (11 percent) patients seen in private practices are self-pay or Medicaid (Figure 7).



Health centers depend on two major sources of funding for their operations: Medicaid and government grants. In 2002, federally-funded health centers' total operating revenues stood at \$5.21 billion (Figure 8). When health centers were initially created in 1965, they were virtually wholly supported by federal grants. By 2002, federal grants comprised 25 percent of total operating funds at federally funded health centers; Medicaid accounted for more than one-third (35%) of health centers' total operating revenues.



Although 15 percent of health center patients had private health insurance in 2002, revenues from private health insurance amounted to only 6 percent of operating revenues that year (Figure 9). Thus, while Medicaid supports health centers in proportion to the proportion of health center patients who are Medicaid enrolled, private health insurance revenues are extremely low in relation to the total number of privately insured patients in health center practices.

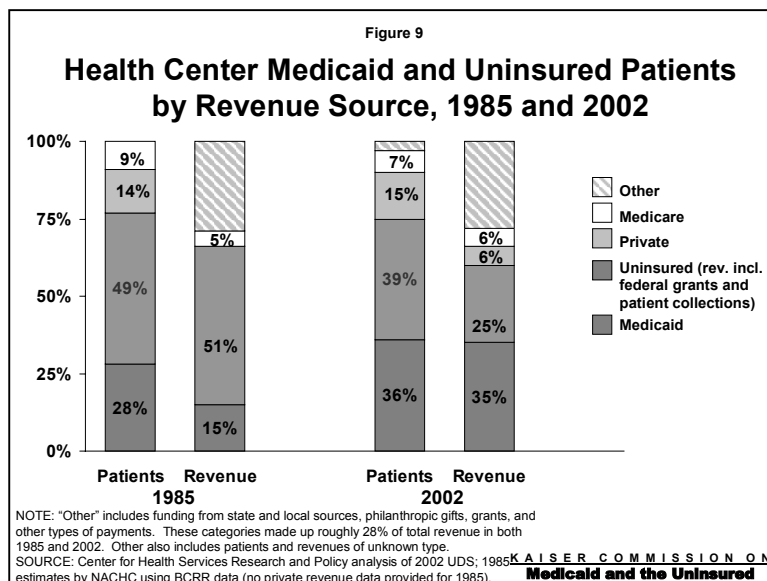


Figure 9 on the previous page, which shows the distribution by payer source of health center patients and revenues in 1985 and 2002, demonstrates the critical role Medicaid has come to play in supporting community health centers. While the share of health center patients who were covered by Medicaid increased by one quarter, reaching 36% in 2002, the proportion of health centers' operating revenues attributable to Medicaid more than doubled during the period, rising from 15% to 35%. At the same time, the share of health center patients who were uninsured dropped by one-fifth (from 49% to 39%), and the portion of health centers' revenues attributable to federal grants – the principal source of payment on behalf of uninsured patients – fell by one-half, from 51% to 25%.

This gap between the proportion of patients who are uninsured and the proportion of revenues that come from grants to support their care underscores the importance of adequate financing through public and private health insurance so as to ensure that grant funds for care of the uninsured are not used instead to defray the cost of serving insured patients. Recent data suggest that Medicaid is paying significantly more per patient than are grant funds. In 2002, Medicaid contributed \$450 per year for each Medicaid patient served. In contrast, grant payments provided only \$299 per year for each uninsured patient served in a health center in 2002.

Health centers have had a considerable impact on the communities they serve as well as on health policy generally. In 2002, federally-funded health centers served an estimated 13 percent of all low-income persons,⁵ 20 percent of poor children with family incomes at or below 100% of federal poverty level,⁶ and managed the health care of 10 percent of all Medicaid beneficiaries.⁷ Health centers have been widely recognized for the quality of their care,⁸ and have had a documented impact on the reduction of racial and ethnic health disparities as measured by infant mortality rates, tuberculosis case rates, death rates, and lack of access to prenatal care.⁹ When combined with the guarantee of adequate financing through Medicaid and other forms of insurance coverage, health centers have had a demonstrated impact on the accessibility and quality of care for low-income populations.¹⁰

Part 2. The Experience of Health Centers During an Economic Downturn

Given their location and their service missions, health centers operate in the communities most likely to bear the worst brunt of an economic downturn such as the one that experts say began in March 2001. The slowdown has been particularly difficult for lower wage workers with limited job skills, and the very low level of job growth in the current economic recovery suggests that employment hardships for these Americans may continue for some time.

In addition to facing a rising number of patients without jobs and who are at increased risk for lack of health insurance, health centers have also had to weather state Medicaid cutbacks and the loss of state and local operating funds, as state budgets have constricted in response to declining revenues. The National Association of Community

Health Centers estimates that during 2003, state grants to health centers decreased overall by \$28 million nationally.¹¹

State Medicaid reductions have been widespread. During 2003, almost every state pursued Medicaid cost containment strategies, including restrictions on eligibility, benefits, provider payments, and increased patient cost sharing.¹² Because health centers serve a substantial proportion of Medicaid enrollees, especially those who are pregnant women, children, and non-disabled members of working families, they can be expected to feel the effects of these reductions. Even where Medicaid-enrolled health center patients do not lose their coverage entirely, coverage for important benefits and services may have been lost. Increased Medicaid patient cost sharing requirements may be absorbed under health centers' grant-supported sliding fee schedules, but this rising need to cross-subsidize Medicaid patients' care places greater pressure on grant funds meant for care of completely uninsured patients. Furthermore, the problems created by tightening public insurance programs are not merely the result of past revenue losses. Structural changes in Medicaid eligibility, as well as state freezes on enrollment in the State Children's Health Insurance Program (SCHIP), mean that as health center patients lose other sources of coverage, they will not be able to qualify for Medicaid.

The decline in grant support has ramifications beyond revenue loss. Health insurance is critical to the proper management of patients with specialized health care needs who require services that cannot be provided in primary care settings. Studies of health centers suggest that clinicians report serious obstacles in securing needed specialty care,¹³ and as the insurance picture erodes further, lack of access to specialty care is expected to grow.

During 2002 and 2003, researchers from the George Washington University Medical Center, School of Public Health and Health Services, interviewed health center staff in 8 urban and rural communities and representatives from state and regional primary care associations regarding the effects of the downturn on health centers and their patients. Researchers selected urban and rural communities located in states with elevated unemployment rates related to the downturn using data from the U.S. Department of Labor. Respondents were asked about the impact of economic conditions on their financial support, patient caseload and health status, and overall operations; whether and how their experiences differed from health centers in less affected communities around the state; and what actions if any their state or local governments had taken to help them. Respondents also provided additional data regarding their patients, revenues, and staffing.

These interviews produced a series of findings that provide some insight into how economic downturns tend to play out in local health care settings:

- Nearly all health centers reported an increase in the number of uninsured patients, even in the years leading up to the onset of the recession in 2001, and all expected to see significant increases over 2002 and 2003;

- All respondents confirmed that their respective communities were experiencing the effects of an economic downturn and reported common measures of economic hardship, set forth in Table 1.

Table 1. The Most Commonly Reported Economic Hardship Measures Across 8 Sites

	Selected communities in							
	FL	LA	MA	NC	OR	SC	TX	WA
Large number of layoffs in hospitality and manufacturing sectors, including primary metals, transportation equipment, food processing, high-tech electronic and computer products, and the wood products industries	✓	✓	✓	✓	✓	✓	✓	✓
A predicted increase in TANF, Medicaid, and/or Food Stamp caseloads ¹⁴	✓	✓	✓	✓	✓	✓	✓	✓
Decline in tourism-related businesses that largely affect low-income wage workers and immigrants	✓	✓		✓		✓	✓	✓
High number of business closures and fewer jobs available	✓		✓	✓				✓
Fewer employers offering health insurance coverage as indicated by growing number of working uninsured patients.				✓	✓		✓	✓
Cessation of health center expansion projects			✓					✓

- Health center respondents reported that their centers felt the impact of the downturn in two ways. First, respondents found that many patients lost coverage, thereby complicating the provision of their health care and driving down revenue expectations for the centers. Second, respondents experienced a surge in new patients who lost coverage as a result of either job cutbacks or unemployment and were left without affordable health care.
- Respondents further noted that their new, or newly uninsured, patients tended to experience serious physical or mental conditions, which they attributed either to the ramifications of job loss or to underlying health problems that might have contributed to job loss as the economy softened.

Nearly all health center respondents indicated that their new uninsured patients had tended to wait to register until health problems became severe. Care delays among new patients were a particularly observed problem across all sites, although respondents reported delays among their newly uninsured patients as well because of fears about inability to make even modest copayments on a

sliding fee scale. Respondents observed that as their patients' incomes fell, they prioritized expenses, placing the payment of household necessities such as food, rent and gas for the car ahead of health care. New patients, who previously had been accustomed to receiving care from the private sector and paying with health insurance, often did not seek out services from the health center until a family member was seriously ill.

Table 2. Trends in Uninsured Patients and Their Health Characteristics

	Study Communities							
	FL	LA	MA	NC	OR	SC	TX	WA
Growing number of established but newly uninsured patients	✓	✓	✓	✓	✓	✓	✓	✓
Growing number of new patients who were previously insured and who lost coverage because of unemployment or other reasons (e.g., reduced work)	✓	✓	✓	✓	✓		✓	✓
Increase in serious mental or physical conditions among new or newly uninsured patients	✓	✓		✓	✓	✓	✓	✓

- Nearly all sites reported significant levels of mental illness and alcohol and addiction disorders among both new uninsured and newly uninsured patients. The increase in patients with mental illness and alcohol and addiction disorders became evident because the cost of their care was much higher and patients frequently needed a level and intensity of intervention beyond the health center's own capabilities. Nearly all respondents believed that despite their best efforts, they were unprepared for the surge in patient volume, particularly in the case of patients with more severe physical and mental health problems. Most reported that waits for appointments became longer because of insufficient financial supports, thereby exacerbating health problems.
- Respondents in states with more generous Medicaid programs consistently reported Medicaid's importance during the downturn, while those with limited programs or serving large immigrant populations saw relatively little help from Medicaid. The information gleaned from these communities tended to show Medicaid's strengths and limitations. In communities located in states with relatively strong programs, Medicaid coverage rose, as would be expected in the case of a means-tested entitlement that is sufficiently elastic to respond to an economic downturn. Respondents reported greater enrollment among established patients, as well as growth in the enrollment of new patients with Medicaid, many of whom reported that their previous health provider would not treat Medicaid patients.

At sites that were either located in states with limited programs or served large immigrant populations, new Medicaid enrollment was more limited. Even here however, respondents consistently noted that outreach and application assistance proved quite useful in securing coverage for a significant proportion of the patients. At the same time, respondents noted, states were eliminating and reducing funds for outreach and application assistance, thereby making enrollment assistance more difficult.

Even where Medicaid programs were generous however, respondents noted that many of the newly unemployed could not qualify. They also noted that the newly eligible tended to be much more costly patients because of the serious health problems they were experiencing by the time they enrolled.

- Respondents noted that while Medicaid payments were more generous than payment levels from private insurers, revenues realized from newly enrolled patients were inadequate to offset the surge in costs that health centers experienced from having to rapidly expand treatment for uninsured patients. Respondents reported that state and local governments typically stepped in with additional help, but all reported that these supports tended to be time limited and all expected to see declines in the assistance they were receiving. Some reported investing additional revenues in Medicaid outreach workers in the hope of boosting Medicaid enrollment to offset the impact of rising levels of uninsured patients.

Part 3. How Adequate is Federal Health Center Funding When Community Need Surges?

Their accessible locations within communities, the affordable services they offer, and the quality of the care they provide all mean that health centers tend to enjoy broad support from federal and state policy makers. Between FY 2001 and FY 2004, total federal discretionary appropriations for health centers grew from \$1.3 billion to \$1.6 billion. This growth in funding represents a 23 percent increase in nominal dollars, and a 15 percent increase when inflation is taken into account.

As appropriations increase, the federal government uses these additional funds in several key ways:

- The government increases “base” funding at existing health centers to respond to growing needs at existing sites;
- The government also provides supplemental funds to existing health centers so that they can add new sites, or to establish new health centers in communities that are not served and are located far enough from an existing health center so that an expansion site is not feasible. In these situations, a portion of the additional spending goes for direct patient care, but a portion is needed to

establish the practice site, hire the personnel, and engage in other activities designed to get a site up and going; and

- Finally, the government undertakes special initiatives to expand certain service capabilities (e.g., dental care expansions) or upgrade clinician skills in addressing critical health problems that are costly, a major source of health disparities, and amenable to appropriate primary care management (e.g., depression, asthma, cardiovascular conditions, and diabetes). These special initiatives, known as “disease collaboratives,” have supported health centers’ ability to respond to community need with high quality care. In 2003, 500 federally-funded health centers have participated in the disease collaboratives.¹⁵

All of these investments are essential to the growth and stability of health centers. They suggest that the program is able to rapidly translate new funding into service and site expansion as well as targeted activities aimed at improving community health.

But despite the relative generosity of these federal funding increases, they have failed to keep pace with expanding need. Figure 10 compares the annual rate of growth of federal appropriations between FY 2002 and 2003 (in real 2003 dollars) against the estimated growth in the number of uninsured health center patients over the same time period. During 2003, the number of uninsured health center patients is estimated to have risen by 11.4% (from 4.4 million to 4.9 million) while inflation-adjusted federal funding increased by only 7.3%, from \$1.403 billion to \$1.505 billion in 2003 dollars. Despite their expanded role, health centers provided services to only one in five (21%) low-income uninsured persons nationally in 2003.¹⁶

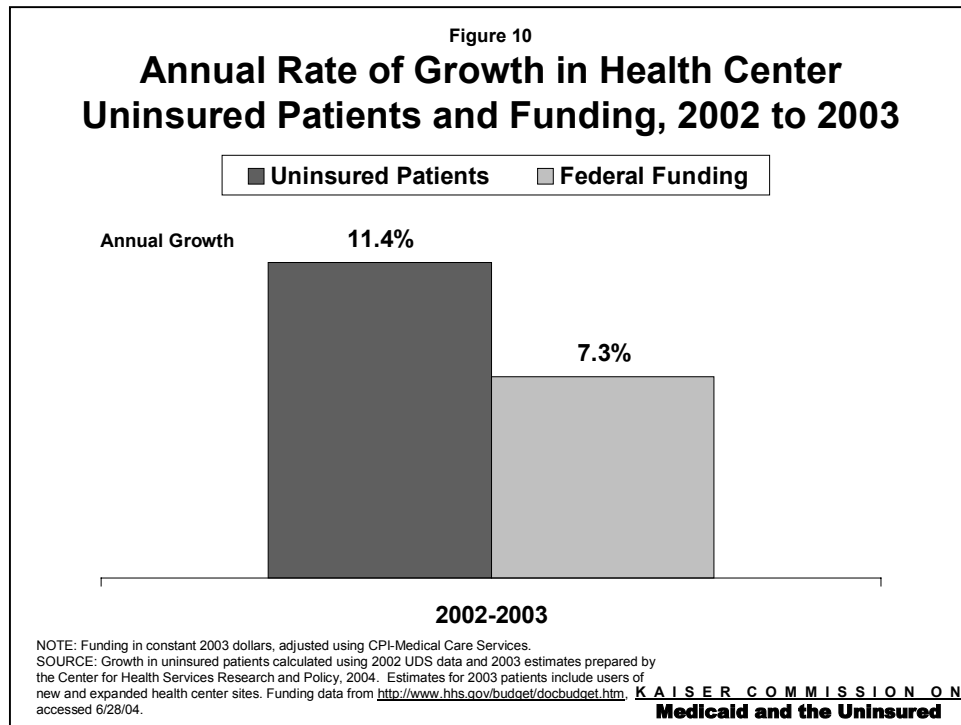


Figure 11 compares low-income health center patients against each state's estimated low-income population over the 2002-2003 time period. Because the low-income are at higher risk of being medically underserved, this estimate compares the uninsured health center population to the group most likely to experience medical underservice. Only in the District of Columbia did the proportion of low-income health center patients exceed 30% of the low-income population. In 20 states, health center penetration into the low-income population was less than 10% of the low-income population.

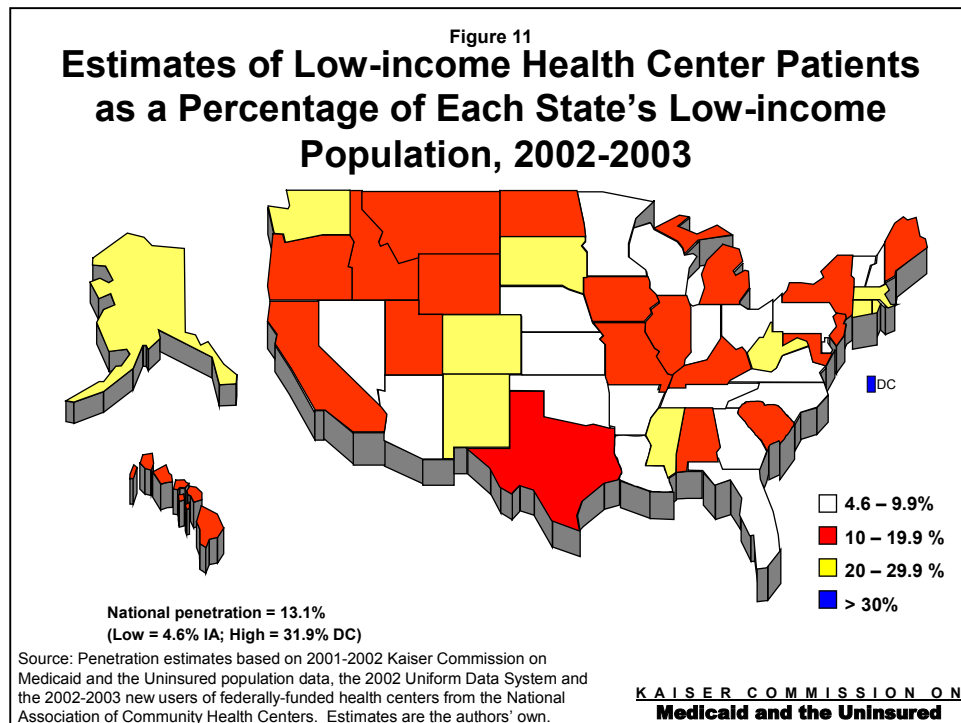
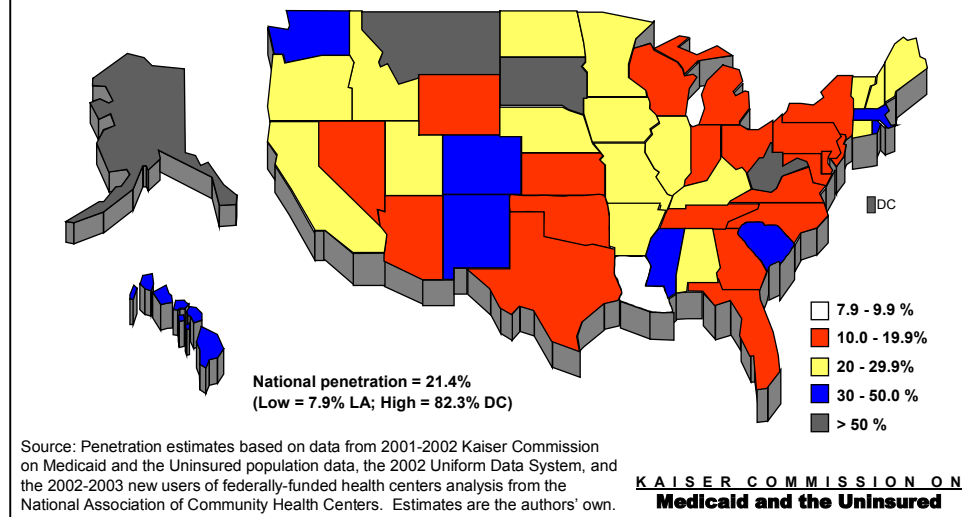


Figure 12 on the next page presents the number of uninsured health center patients, who are predominately low-income, as a percentage of each state's estimated low-income uninsured population over the same 2002-2003 period. Low-income uninsured persons are a group at particularly high risk for medical underservice. In only 8 states did health centers reach at least 30 percent of the low-income uninsured population.

These figures underscore the fact that as essential as health center grants are for supporting care for the uninsured, establishing new health center sites and supporting and improving existing services, the reach of these funds alone is modest in relation to need. Even a program as favorably regarded as the health center program has received federal discretionary appropriations increases that pale in comparison to the level of need, particularly at times when the economy slows, the number of uninsured patients rises, and the severity of problems seen at health centers increases.

Figure 12
**Estimates of Uninsured Health Center Patients
as a Percentage of Each State's Low-income,
Uninsured Population, 2002-2003**



Policy Implications

These findings suggest that for health centers, just as for non-safety net providers, health insurance remains the engine that drives health care capacity and responsiveness. Medicaid – not discretionary appropriations – represents the single largest part of the health center budget. Its impact can be measured both by the comprehensive benefit package it provides health center patients and the cost-based payment rates that it offers specifically to health centers. These rates help ensure that federal discretionary grant funds tied to the uninsured patient population are not spent to offset public program payment shortfalls. Moreover, Medicaid’s uncapped federal-state financing structure ensures that federal funds will be available immediately when Medicaid patient volume increases, unlike discretionary grant funding’s relative unresponsiveness during periods of increasing need.¹⁷ Medicaid’s importance is such that even in states with more limited programs and in communities with high immigrant populations, health centers report investing in Medicaid outreach and enrollment assistance, not only to help patients secure coverage but also because of Medicaid’s impact on the centers’ operating capacity.

Federal discretionary spending increases are, however, a vital means of expanding the health center program. Such increases help stabilize centers and support care for uninsured patients, allow new health centers to be established and expand existing programs, and support highly beneficial quality improvement activities. But even in the case of a program as popular as health centers, these discretionary funding investments are modest in relation to the number of low-income persons without health insurance. From a national standpoint, for every uninsured low-income patient a health

center is able to treat, than are four more low-income, uninsured persons not seen at health centers; in many states, the gap between uninsured low-income patients treated at health centers and the total state uninsured low-income resident population is even greater. Furthermore, health center clinical staff frequently report that in serious cases, patients' needs for specialty care or services exceeds their in-house clinical capabilities and that their ability to manage such patients is seriously compromised when Medicaid or some other form of health insurance is not part of the picture.

This study also suggests that the survival of health centers is especially sensitive to federal and state Medicaid policies in all areas: eligibility, enrollment, benefits and coverage, and provider payment rates. Our discussions with local health centers suggest that when economic hardship hits families, even modest increases in the cost of health care will deter them from seeking care for fear of incurring expenses they absolutely cannot afford. Without question, any coverage is better than none; as a result, reforms aimed at improving Medicaid's reach into the newly unemployed and uninsured lower wage workers are essential to health centers. At the same time, as out-of-pocket health costs rise for low income persons with insurance, even providers such as health centers, which are at least partially equipped to absorb most of these costs for their patients through public subsidies and sliding fee scales, will nonetheless report that patients delay care until the need is urgent. This extreme sensitivity to cost in the health-seeking behavior of the low-income population should be a matter of concern, particularly in the management of ambulatory care-sensitive chronic health conditions that contribute significantly to the pervasive problem of health disparities in the United States.

Endnotes

- ¹ S. Rosenbaum and P. Shin, "Health Centers as Safety Net Providers," *Issue Paper* (Washington D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2003)
- ² Federally-funded health centers are required to submit tabulated financial, utilization, and patient demographic data to the Health Resources and Services Administration.
- ³ Due to lack of reporting requirements, the data on look-alikes are limited to Figure 1.
- ⁴ D. Hawkins and M. Proser, "A Nation's Health at Risk," *Special Topics Issue Brief #4* (Washington, D.C.: National Association of Community Health Centers, March 2004).
- ⁵ Estimates based on 2002 UDS, the 2002 March Current Population Survey, and NACHC data.
- ⁶ Estimates based on 2002 UDS and the 2002 March Current Population Survey.
- ⁷ State low-income estimates based on 2002 Kaiser Commission on Medicaid and the uninsured population data. National 2002 Medicaid data from R.J. Mills and S. Bhandari, "Health Insurance Coverage in the United States:2002," *Current Population Reports* (Washington, D.C.: U.S. Census Bureau, September 2003)
- ⁸ B.E. Baily et al, *Experts with Experience Community & Migrant Health Centers Highlighting a Decade of Service (1990-2000)* (Washington, D.C.:U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, 2002).
- ⁹ P. Shin, K.C. Jones, and S. Rosenbaum, *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of Community Health Centers on Low-income Communities* (Washington, D.C.: National Association of Community Health Centers, 2003).
- ¹⁰ J.E. DeVoe, G.E. Fryer, R. Phillips, and L. Green, "Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care," *American Journal of Public Health*, 93, no. 5 (2003):786-91.
- ¹¹ In a 2003 survey of Primary Care Associations, 18 states reportedly decreased state funding of federally-qualified health centers by \$40.7 million while 4 states increased funding by \$12 million. Nine states remained at level funding and 15 states continue to provide no funding. See R. Schwartz and D. McKinney, "Critical Condition II: Update on the Impact of the State Budget Crisis on Health Centers," *State Policy Report #1* (Washington, D.C.: National Association of Community Health Centers, September 2003).
- ¹² V. Smith, R. Ramesh, K. Gifford, E. Ellis, V. Waichino, and M. O'Malley, *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Growth and Cost Containment Actions* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2004).
- ¹³ M.K. Gusmano, G. Fairbrother, and H. Park, "Exploring the limits of the safety net: community health centers and care for the uninsured," *Health Affairs*, 21, no. 6 (2002):188-194.
- ¹⁴ Although the actual caseloads actually decreased or remained the same in most of the communities during the time period we studied, the interviewees consistently predicted that the economic effects on such services would be impacted as more low-income jobs remained unavailable for a longer period time. In fact, since the time period focused on here, all communities have experienced enrollment increases in at least one of the programs between 1999 and 2002.
- ¹⁵ Number and location of health centers participating in the disease collaboratives available at <<http://www.ncsl.org/programs/health/MPPPT2/sld019.htm>>
- ¹⁶ Estimate based on 2001-2002 data from Kaiser Commission on Medicaid and the Uninsured, the 2002 UDS data, and the 2002-2003 new users of federally-funded health centers from the National Association of Community Health Centers.
- ¹⁷ V. Wachino, A. Schneider, and D. Rousseau, *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2004).

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