



# MACStats: Medicaid and CHIP Program Statistics

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# Overview

MACStats, a standing section in all MACPAC reports to the Congress, presents data and information on Medicaid and the State Children's Health Insurance Program (CHIP) that otherwise can be difficult to find and are spread out across multiple sources. The June 2014 edition of MACStats is divided into five sections.

## Section 1: Trends in Medicaid Enrollment and Spending

- ▶ Growth in Medicaid spending and enrollment has varied over the years, reflecting shifts in federal and state policy along with changing economic conditions (Figures 1 and 2).
- ▶ Enrollment trends vary by eligibility group. Non-disabled children experienced the largest enrollment increase in absolute numbers between fiscal year (FY) 1975 and FY 2011 (Table 1). However, enrollment among the smaller group of individuals qualifying for Medicaid on the basis of a disability showed the largest percentage increase over this time period.

## Section 2: Health and Other Characteristics of Medicaid/CHIP Populations

- ▶ The characteristics of individuals enrolled in Medicaid and CHIP differ from those with other types of coverage, but there is also great diversity within the Medicaid/CHIP population (Tables 2–10).
- ▶ Medicaid/CHIP enrollees generally report being in poorer health and using more services than individuals who have other health insurance or who are uninsured (Tables 3, 6, and 9).

## Section 3: Medicaid Enrollment and Benefit Spending

- ▶ Individuals eligible on the basis of a disability and those age 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Tables 11 and 12).
- ▶ Medicaid spending per enrollee is affected by large numbers of individuals with limited benefits in some states (Table 13).
- ▶ Users of Medicaid long-term services and supports are a small but high-cost population (Figures 5–7).

## Section 4: Medicaid Managed Care

- ▶ About half of Medicaid enrollees are in comprehensive risk-based managed care plans. When limited-benefit plans and primary care case management programs are also included, more than 70 percent of enrollees are in some form of managed care (Table 14).
- ▶ The national percentage of Medicaid benefit spending on any form of managed care ranges from about 10 percent among enrollees age 65 and older to more than 40 percent among non-disabled child and adult enrollees (Table 15).

## Section 5: Technical Guide to the June 2014 MACStats

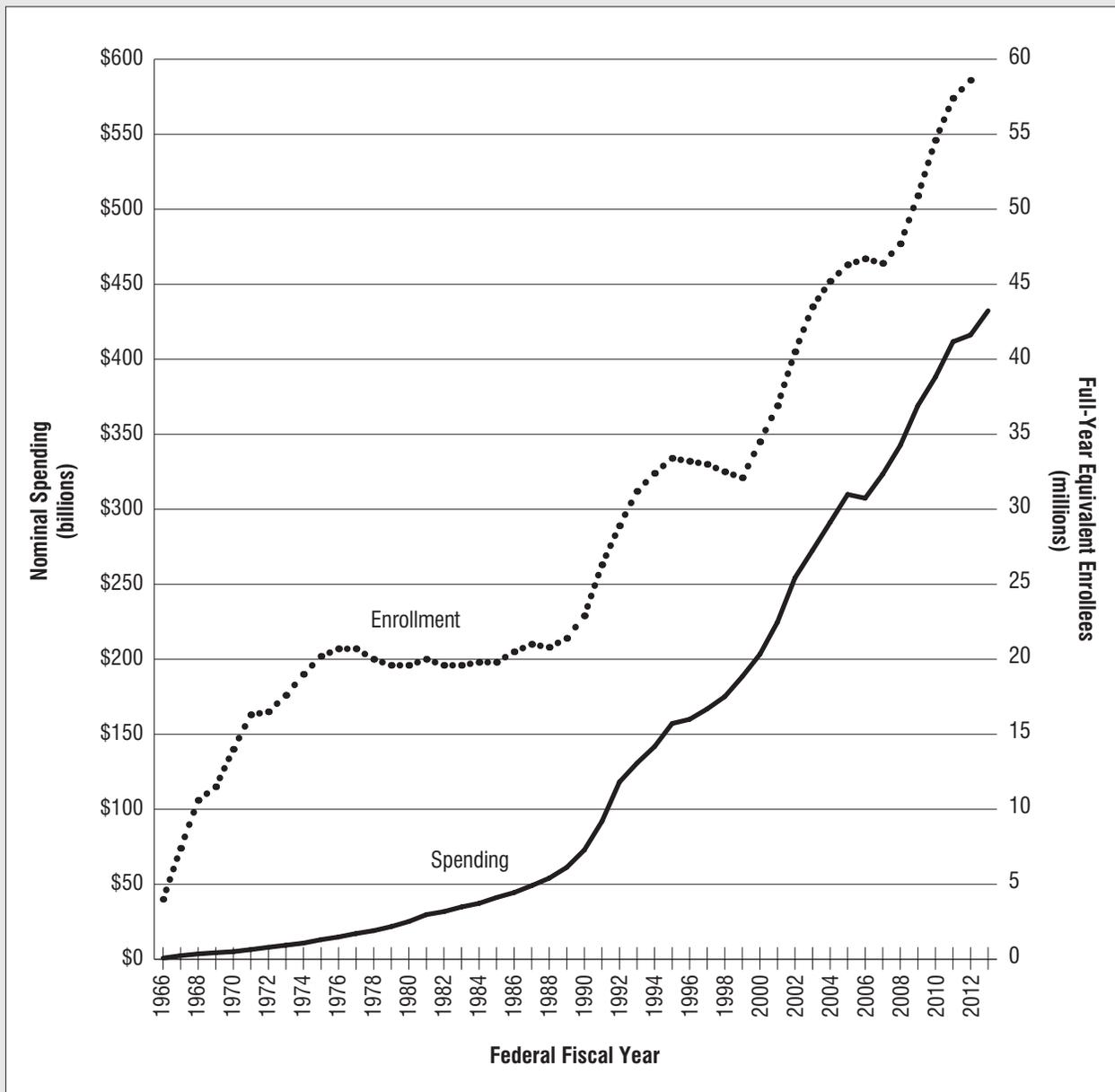
This section provides supplemental information to accompany the tables and figures in Sections 1–4 of MACStats. It describes some of the data sources used in MACStats, the methods that MACPAC uses to analyze these data, and reasons why numbers in MACStats tables and figures—such as those on enrollment and spending—may differ from each other or from those published elsewhere.



## Key Points

### Trends in Medicaid Enrollment and Spending

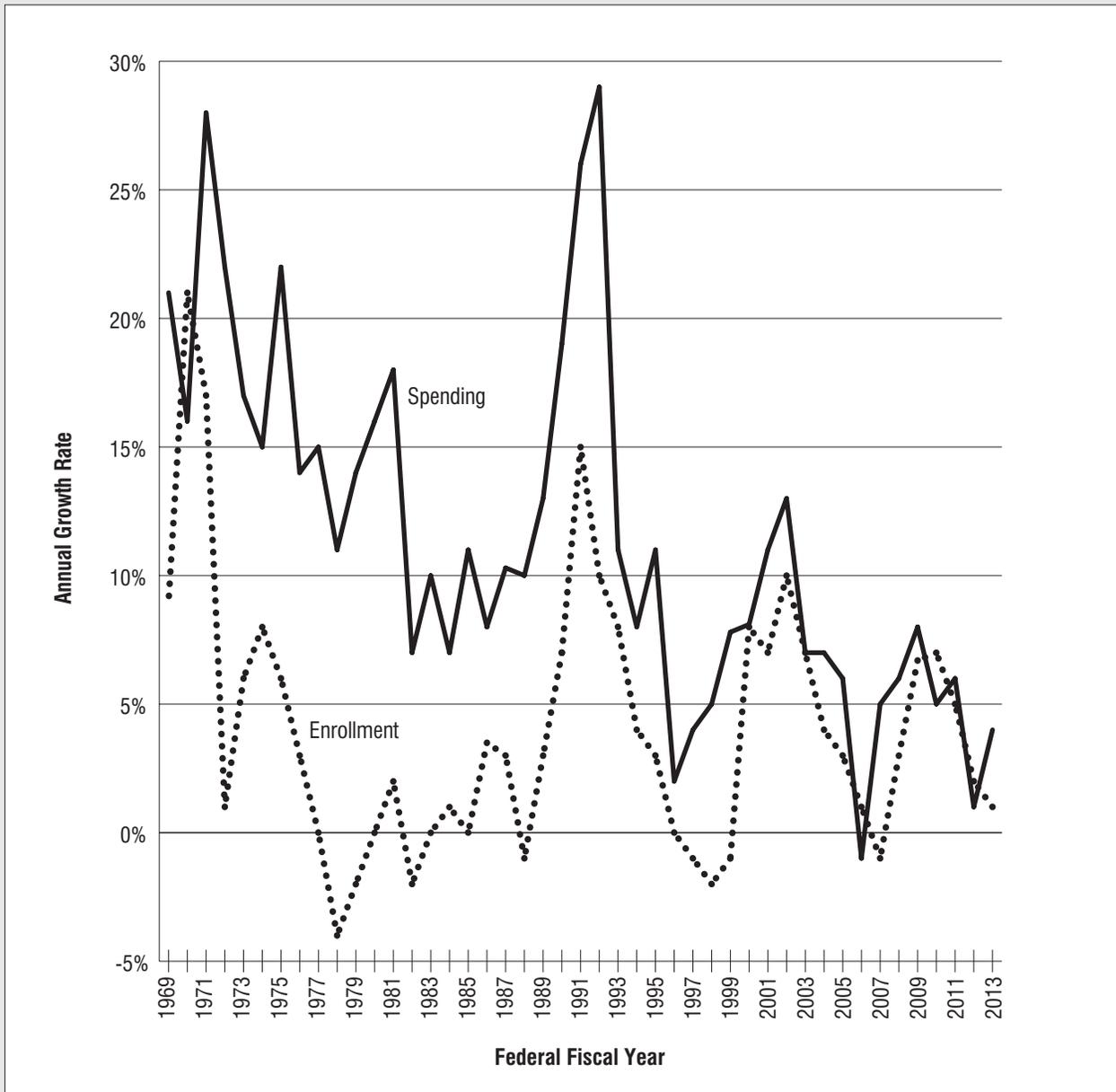
- ▶ Medicaid spending and enrollment are affected by both federal and state policy choices and economic factors. For example, the Congress made a number of changes that expanded eligibility for pregnant women and children between 1984 and 1990, with delayed effective dates or phase-in provisions that resulted in substantial growth in the number of enrollees through the mid-1990s (Figure 1). Economic recessions spurred enrollment growth at the beginning and end of the first decade of the 2000s.
- ▶ Prior to the 1990s, spending tended to grow at a faster annual rate than enrollment (Figure 2). In recent decades, annual growth rates for spending and enrollment have tracked more closely.
- ▶ Enrollment trends vary by eligibility group. Children (excluding those eligible on the basis of a disability) experienced the largest enrollment increase in absolute numbers, from 9.6 million in FY 1975 to 30.2 million in fiscal year (FY) 2011 (Table 1). However, enrollment among the smaller group of individuals qualifying for Medicaid on the basis of a disability showed the largest percentage increase over this time period (3.9 percent).

**FIGURE 1. Medicaid Enrollment and Spending, FY 1966–FY 2013**

**Notes:** Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Numbers exclude coverage financed by CHIP. Enrollment data for fiscal year (FY) 2011–2013 are projected. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). The amounts in this figure may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Enrollment counts are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served. (See Section 5 of MACStats for a discussion of how enrollees are counted.)

**Source:** Data compilation provided to MACPAC by the Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), April 2014.

**FIGURE 2. Annual Growth in Medicaid Enrollment and Spending, FY 1969–FY 2013**



**Notes:** Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Numbers exclude coverage financed by CHIP. Enrollment data for fiscal year (FY) 2011–2013 are projected. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). Annual growth rates prior to FY 1969 (not shown here) exceed 30 percent, reflecting the program’s initial startup period. The amounts in this figure may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Enrollment counts used to calculate growth rates are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served. (See Section 5 of MACStats for a discussion of how enrollees are counted.)

**Source:** Data compilation provided to MACPAC by the Office of the Actuary, Centers for Medicare & Medicaid Services (CMS), April 2014.

**TABLE 1. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FY 1975–FY 2011 (thousands)**

Year	Total	Children	Adults	Disabled	Aged	Unknown
1975	22,007	9,598	4,529	2,464	3,615	1,801
1976	22,815	9,924	4,773	2,669	3,612	1,837
1977	22,832	9,651	4,785	2,802	3,636	1,958
1978	21,965	9,376	4,643	2,718	3,376	1,852
1979	21,520	9,106	4,570	2,753	3,364	1,727
1980	21,605	9,333	4,877	2,911	3,440	1,044
1981	21,980	9,581	5,187	3,079	3,367	766
1982	21,603	9,563	5,356	2,891	3,240	553
1983	21,554	9,535	5,592	2,921	3,372	134
1984	21,607	9,684	5,600	2,913	3,238	172
1985	21,814	9,757	5,518	3,012	3,061	466
1986	22,515	10,029	5,647	3,182	3,140	517
1987	23,109	10,168	5,599	3,381	3,224	737
1988	22,907	10,037	5,503	3,487	3,159	721
1989	23,511	10,318	5,717	3,590	3,132	754
1990	25,255	11,220	6,010	3,718	3,202	1,105
1991	27,967	12,855	6,703	4,033	3,341	1,035
1992	31,150	15,200	7,040	4,487	3,749	674
1993	33,432	16,285	7,505	5,016	3,863	763
1994	35,053	17,194	7,586	5,458	4,035	780
1995	36,282	17,164	7,604	5,858	4,119	1,537
1996	36,118	16,739	7,127	6,221	4,285	1,746
1997	34,872	15,791	6,803	6,129	3,955	2,195
1998	40,096	18,969	7,895	6,637	3,964	2,631
1999	39,748	18,233	7,446	6,690	3,698	3,682
2000	41,212	18,528	8,538	6,688	3,640	3,817
2001	45,164	20,181	9,707	7,114	3,812	4,349
2002	46,839	21,487	10,847	7,182	3,789	3,534
2003	50,716	23,742	11,530	7,664	4,041	3,739
2004	54,250	25,415	12,325	8,123	4,349	4,037
2005	56,276	25,979	12,431	8,205	4,395	5,266
2006	56,264	26,358	12,495	8,334	4,374	4,703
2007	55,210	26,061	12,264	8,423	4,044	4,418
2008	56,962	26,479	12,739	8,685	4,147	4,912
2009	60,880	28,344	14,245	9,031	4,195	5,066
2010	63,730	30,024	15,368	9,341	4,289	4,709
2011 <sup>1</sup>	65,831	30,175	16,069	9,609	4,331	5,646

**Notes:** Beneficiaries (enrollees for whom payments are made) are shown here because they provide the only historical time series data directly available prior to fiscal year (FY) 1990. Most current analyses of individuals in Medicaid reflect enrollees. For additional discussion, see Section 5 of MACStats. The increase in FY 1998 reflects a change in how Medicaid beneficiaries are counted: beginning in FY 1998, a Medicaid-eligible person who received only coverage for managed care benefits was included in this series as a beneficiary. Excludes Medicaid-expansion CHIP and the territories.

Children and adults who qualify for Medicaid on the basis of a disability are included in the disabled category. In addition, although disability is not a basis of eligibility for aged individuals, states may also report some enrollees age 65 and older in the disabled category. Unlike the majority of the June 2014 MACStats, this table does not recode individuals age 65 and older who are reported as disabled, due to a lack of necessary detail in the historical data. Generally, individuals whose eligibility group is unknown are persons who were enrolled in the prior year but had a Medicaid claim paid in the current year.

<sup>1</sup> This table shows the number of beneficiaries. See Table 11 for the number of Medicaid enrollees in FY 2011, which is larger than the number of beneficiaries. Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for FY 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, FY 2011 figures shown here are not directly comparable to earlier years. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The beneficiary counts shown here are unduplicated using this national ID.

**Sources:** For FY 1999 to FY 2011: MACPAC analysis of Medicaid Statistical Information System (MSIS) data. For FY 1975 to FY 1998: Centers for Medicare & Medicaid Services (CMS), *Medicare & Medicaid Statistical Supplement, 2010 edition*, Table 13.4. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2010.html>.







# 2

## Key Points

### Health and Other Characteristics of Medicaid/CHIP Populations

#### Children under age 19, 2010–2012 (Tables 2–4)

- ▶ More than a third (37.4 percent) of children were reported to be Medicaid or CHIP enrollees at the time of the survey, while 53.8 percent of children were in private coverage, and 7.4 percent were uninsured.
- ▶ Children enrolled in Medicaid or CHIP were more likely to be Hispanic (35.2 percent) than are privately insured children (12.7 percent) and less likely to be Hispanic than are uninsured children (39.9 percent); Medicaid/CHIP children were more likely to be non-Hispanic black (23.2 percent) than are privately insured (10 percent) or uninsured children (11.7 percent).
- ▶ Children enrolled in Medicaid or CHIP were more likely than privately insured or uninsured children to be in fair or poor health and to have certain impairments and health conditions (e.g., attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD), asthma, autism).
- ▶ Children enrolled in Medicaid or CHIP were more likely to have had a visit to the emergency department in the past year and to have been regularly taking prescription medications for at least three months.
- ▶ Differences in self-reported health status exist among children enrolled in Medicaid or CHIP. Among these children, 21.6 percent of those receiving Supplemental Security Income (SSI) were reported to be in fair or poor health, compared to 14.6 percent for non-SSI children with special health care needs (SHCN) and 1.1 percent for children who are neither SSI nor SHCN.

- ▶ Prevalence of specific health conditions varies among children enrolled in Medicaid or CHIP. The prevalence of ADHD/ADD among children enrolled in Medicaid or CHIP was 38.5 percent for children receiving SSI, 38.7 percent for non-SSI CSHCN, and 2.1 percent for children who were neither receiving SSI nor CSHCN. The prevalence of asthma for children receiving SSI was 31.9 percent, compared to 39.4 percent for non-SSI CSHCN and 11.7 percent for children who were neither SSI nor CSHCN.
- ▶ SSI children and non-SSI CSHCN were each nearly twice as likely to visit health care providers four or more times within a year as are children with Medicaid or CHIP who are neither SSI nor CSHCN.

### Adults age 19 to 64, 2010–2012 (Tables 5–7)

- ▶ Nearly 1 in 10 (9.7 percent) of non-institutionalized adults age 19 to 64 reported that they were enrolled in Medicaid.
- ▶ Medicaid enrollees in this age group were more likely to be female and to be the parent of a dependent child, compared to those with private insurance, Medicare, or no insurance.
- ▶ Adults younger than 65 enrolled in Medicaid (who are generally eligible on the basis of being the parent of a dependent child, pregnant, or disabled) reported that they were in worse health than were those enrolled in private coverage or the uninsured, but were in better health than those enrolled in Medicare (nearly all of whom are eligible for that program on the basis of a disability).
- ▶ Adults younger than 65 enrolled in Medicaid were more likely than those with private insurance to have had four or more visits to a doctor or other health professional in the past 12 months.
- ▶ Adults with Medicaid were more likely than those with private insurance or no insurance to have visited the emergency department during the past year.
- ▶ Among adults younger than 65 enrolled in Medicaid, 11.4 percent reported they also were enrolled in Medicare. Conversely, of the Medicare enrollees in this age group, 30.9 percent also were enrolled in Medicaid.
- ▶ Differences in self-reported health exist among 19- to 64-year-olds enrolled in Medicaid. Individuals dually enrolled in Medicaid and Medicare, as well as non-dual SSI beneficiaries, report fair or poor health (62.0 and 57.1 percent, respectively) at much higher rates than do non-SSI, non-dual enrollees (20.6 percent).
- ▶ Among 19- to 64-year-olds enrolled in Medicaid, those who were also enrolled in Medicare or SSI were more likely to have limitations in activities of daily living (ADLs)—as well as the presence of chronic conditions such as depression, hypertension, heart disease, diabetes, arthritis, asthma, and chronic bronchitis—than the overall Medicaid population for this age group.

- ▶ Adults younger than 65 who enrolled in Medicaid as well as Medicare or SSI also had higher use of care—in particular, for at-home care and visits to a doctor or other health professional in the past 12 months—than 19- to 64-year-old Medicaid enrollees overall. They were also more likely than 19- to 64-year-old Medicaid enrollees overall to have had an emergency department visit in the past 12 months.

### **Adults age 65 and older, 2010–2012 (Tables 8–10)**

- ▶ Among non-institutionalized adults age 65 and older, 7.6 percent reported being enrolled in Medicaid. Most of these Medicaid enrollees (91.8 percent) reported being dually eligible for Medicare, which covered nearly all individuals age 65 and older.
- ▶ Medicaid enrollees age 65 and older were more likely to be female and less likely to be white (non-Hispanic) than were those with Medicare or private coverage.
- ▶ Compared to those enrolled in private coverage or Medicare, Medicaid enrollees age 65 and older were more likely to report being in fair or poor health, being in worse health compared to 12 months before, and having any of several limitations in their ADLs. Medicaid enrollees age 65 and older were also more likely to have lost all of their natural teeth or have any of a number of specific chronic conditions (such as depression, diabetes, and chronic bronchitis).
- ▶ Medicaid enrollees age 65 and older were also more likely than those with private or Medicare coverage to have received at-home care, to have had multiple visits to a doctor or other health professional, and to have visited an emergency department in the past 12 months.
- ▶ Because more than three-quarters of Medicaid enrollees age 65 and older had functional limitations and therefore drive the overall characteristics of enrollees in this age range, this group of Medicaid enrollees does not show significant differences from the total Medicaid population age 65 and older as often as do those with no functional limitations.
- ▶ Compared to the overall group of Medicaid enrollees age 65 and older, Medicaid enrollees who had no functional limitations were less likely to be 85 years old or older, to report being in fair or poor health, and to have any of several specific chronic health conditions. They were also less likely to have visited a doctor or other health professional or to have visited an ED in the past 12 months.

This section uses data from the federal National Health Interview Survey (NHIS) to describe how Medicaid and State Children’s Health Insurance Program (CHIP) enrollees differ from individuals with other types of coverage in terms of their self-reported demographic, socioeconomic, and health characteristics as well as their use of care. It also explores how subpopulations of individuals enrolled in Medicaid or CHIP can differ markedly from one another, even within the same age group.

Our analysis divides the U.S. population into three age groups corresponding to key eligibility pathways in Medicaid and CHIP: children age 0 to 18, adults age 19 to 64, and adults age 65 and older. Tables for each age group explore the following self-reported characteristics from the survey data: health insurance coverage and demographics, health characteristics, and use of health care. (See Section 5 for a discussion of how estimates of insurance coverage may vary depending on the data source and the time period examined.)

The data are presented in two parts. First, we provide comparisons of Medicaid/CHIP enrollees in that age group to individuals with other sources of health insurance. Second, we show estimates for selected subgroups of Medicaid/CHIP enrollees in that age group. The data presented are for the combined Medicaid/CHIP population because, as described in Section 5, surveys like the NHIS generally do not support valid estimates separately for Medicaid and CHIP enrollees.

Our analyses of subgroups of children are divided into three groups:

- ▶ children who receive Supplemental Security Income (SSI) benefits and are therefore disabled under that program’s definition;
- ▶ children who do not receive SSI, but who are classified as children with special health care needs (CSHCN); and
- ▶ children who neither receive SSI nor are considered CSHCN.

Our analyses of Medicaid enrollees age 19 to 64 years old are divided into three categories, the first two of which are primarily composed of persons with disabilities:

- ▶ individuals also enrolled in Medicare (dually eligible individuals), nearly all of whom have obtained their Medicare coverage after a two-year waiting period following their initial receipt of Social Security Disability Insurance (SSDI) benefits;
- ▶ Medicaid enrollees receiving SSI who are not enrolled in Medicare; and
- ▶ Medicaid enrollees who are neither SSI nor Medicare enrollees.

Our analyses of Medicaid enrollees age 65 and older focus on the differences between those reporting a functional limitation and those not reporting a functional limitation. Individuals with a functional limitation are those who reported any degree of difficulty—ranging from “only a little difficult” to “can’t do at all”—performing any of a dozen activities (such as walking specified distances, moving objects such as a chair, or going out to do things like shopping) by themselves and without special equipment. It should be noted that individuals with functional limitations can vary substantially in their health needs—from being bedridden to being relatively healthy but responding that walking a quarter of a mile is “only a little difficult.” (Individuals in institutions such as nursing homes or assisted living facilities are not interviewed in the NHIS.)



**TABLE 2. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Age 0–18 by Source of Health Insurance, 2010–2012**

	All children	Selected Sources of Insurance <sup>1</sup>			Medicaid/CHIP <sup>2</sup>			
		Medicaid/CHIP <sup>2</sup>	Private <sup>3</sup>	Uninsured <sup>4</sup>	Medicaid/CHIP children	SSI	Non-SSI CSHCN <sup>5</sup>	Neither SSI nor CSHCN
<b>Health Insurance Coverage</b>		<b>37.4%</b>	53.8%	7.4%	<b>100.0%</b>	3.4%	17.6%	79.1%
<b>Age (categories sum to 100%)</b>								
0–5	32.2%*	<b>38.8%</b>	28.9%*	23.0%*	<b>38.8%</b>	19.5%*	26.7%*	42.4%*
6–11	31.3	<b>31.5</b>	31.6	29.3	<b>31.5</b>	38.7*	37.5*	29.8*
12–18	36.5*	<b>29.7</b>	39.5*	47.7*	<b>29.7</b>	41.7*	35.8*	27.8*
<b>Gender (categories sum to 100%)</b>								
Male	51.3%	<b>50.5%</b>	51.8%	51.6%	<b>50.5%</b>	62.5%*	60.6%*	47.8%*
Female	48.7	<b>49.5</b>	48.2	48.4	<b>49.5</b>	37.5*	39.4*	52.2*
<b>Race (categories sum to 100%)</b>								
Hispanic	23.4%*	<b>35.2%</b>	12.7%*	39.9%*	<b>35.2%</b>	20.6%*	24.1%*	38.4%*
White, non-Hispanic	55.5*	<b>37.1</b>	70.7*	40.9*	<b>37.1</b>	41.3	47.6*	34.6*
Black, non-Hispanic	15.2*	<b>23.2</b>	10.0*	11.7*	<b>23.2</b>	35.7*	25.4	22.1
Other and multiple races, non-Hispanic	5.9*	<b>4.5</b>	6.5*	7.5*	<b>4.5</b>	2.3*	2.9*	4.9
<b>Health insurance</b>								
Medicaid/CHIP	37.4%*	<b>100.0%</b>	2.3%*	–	<b>100.0%</b>	100.0%	100.0%	100.0%
Private	53.8*	<b>3.3</b>	100.0*	–	<b>3.3</b>	5.5	5.8*	2.7

See Table 4 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 3. Health Characteristics of Non-Institutionalized Individuals Age 0–18 by Source of Health Insurance, 2010–2012**

	All children	Selected Sources of Insurance <sup>1</sup>			Medicaid/CHIP <sup>2</sup>			
		Medicaid/CHIP <sup>2</sup>	Private <sup>3</sup>	Uninsured <sup>4</sup>	Medicaid/CHIP children	SSI	Non-SSI CSHCN <sup>5</sup>	Neither SSI nor CSHCN
<b>Children with disabilities or with special health care needs</b>								
Receives Supplemental Security Income (SSI)	1.5%*	<b>3.4%</b>	0.4%*	0.7%	<b>3.4%</b>	100.0%*	–	–
Children with special health care needs (CSHCN) <sup>5</sup>	15.4*	<b>20.1</b>	13.3*	10.9	<b>20.1</b>	74.0% <sup>6</sup>	100.0%*	–
<b>Current health status (categories sum to 100%)</b>								
Excellent or very good	82.5%*	<b>73.5%</b>	88.9%*	78.9%	<b>73.5%</b>	44.4%*	54.5%*	79.0%*
Good	15.3*	<b>22.3</b>	10.2*	18.9	<b>22.3</b>	33.9*	30.9*	19.9*
Fair or poor	2.2*	<b>4.2</b>	1.0*	2.2	<b>4.2</b>	21.6*	14.6*	1.1*
<b>Impairments</b>								
Impairment requiring special equipment	1.1%*	<b>1.7%</b>	0.9%*	0.7%	<b>1.7%</b>	12.6%*	5.5%*	0.4%*
Impairment limits ability to crawl, walk, run, play <sup>7</sup>	1.9*	<b>3.0</b>	1.4*	1.1	<b>3.0</b>	20.3*	11.3*	0.4*
Impairment lasted, or expected to last 12+ months <sup>7</sup>	1.7*	<b>2.7</b>	1.2*	0.8	<b>2.7</b>	19.9*	9.8*	0.3*
<b>Specific health conditions</b>								
Ever told child has:								
ADHD/ADD <sup>8</sup>	8.2%*	<b>10.7%</b>	7.1%*	5.7%	<b>10.7%</b>	38.5%*	38.7%*	2.1%*
Asthma	14.0	<b>17.3</b>	12.5*	10.4*	<b>17.3</b>	31.9*	39.4*	11.7*
Autism <sup>7</sup>	1.0	<b>1.3</b>	1.0*	0.7	<b>1.3</b>	12.4*	4.3*	0.0*
Cerebral palsy <sup>7</sup>	0.3*	<b>0.4</b>	0.2*	†	<b>0.4</b>	5.8*	1.2*	0.0*
Congenital heart disease	1.2*	<b>1.6</b>	1.1*	1.0	<b>1.6</b>	8.1*	4.3*	0.7*
Diabetes	0.2	<b>0.2</b>	0.2	†	<b>0.2</b>	†	1.1*	†
Down syndrome <sup>7</sup>	0.1	<b>0.2</b>	0.1	†	<b>0.2</b>	3.0*	0.4	†
Intellectual disability (mental retardation) <sup>7</sup>	0.9*	<b>1.5</b>	0.6*	†	<b>1.5</b>	16.9*	5.1*	0.1*
Other developmental delay <sup>7</sup>	4.5*	<b>5.8</b>	4.0*	3.2	<b>5.8</b>	37.5*	21.3*	0.9*
Sickle cell anemia <sup>7</sup>	0.2*	<b>0.3</b>	0.1*	0.2	<b>0.3</b>	†	0.7*	0.2

See Table 4 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 4. Use of Care by Non-Institutionalized Individuals Age 0–18 by Source of Health Insurance, 2010–2012**

	All children	Selected Sources of Insurance <sup>1</sup>			Medicaid/CHIP <sup>2</sup>			
		Medicaid/CHIP <sup>2</sup>	Private <sup>3</sup>	Uninsured <sup>4</sup>	Medicaid/CHIP children	SSI	Non-SSI CSHCN <sup>5</sup>	Neither SSI nor CSHCN
Received well-child check-up in past 12 months <sup>7</sup>	80.1%*	<b>81.8%</b>	82.5%	53.6%*	<b>81.8%</b>	85.7%	85.9%*	80.7%
Regularly taking prescription drug(s) for 3+ months <sup>7</sup>	13.4*	<b>15.9</b>	12.9*	5.7*	<b>15.9</b>	46.7*	54.6*	5.6*
<b>Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)</b>								
None	9.7%*	<b>8.8%</b>	7.4%*	30.2%*	<b>8.8%</b>	5.3%*	3.1%*	10.2%*
1	21.2*	<b>19.3</b>	21.6*	26.6*	<b>19.3</b>	14.0*	10.7*	21.5*
2–3	36.6	<b>35.5</b>	38.3*	28.0*	<b>35.5</b>	25.2*	26.0*	38.1*
4+	32.5*	<b>36.3</b>	32.7*	15.2*	<b>36.3</b>	55.4*	60.3*	30.2*
<b>Number of emergency room visits in past 12 months (categories sum to 100%)</b>								
None	80.4%*	<b>73.1%</b>	85.0%*	83.8%*	<b>73.1%</b>	64.4%*	58.0%*	76.8%*
1	12.8*	<b>15.8</b>	11.0*	10.4*	<b>15.8</b>	18.4	18.6*	15.0
2–3	5.4*	<b>8.3</b>	3.4*	4.5*	<b>8.3</b>	9.8	15.9*	6.5*
4+	1.5*	<b>2.8</b>	0.6*	1.3*	<b>2.8</b>	7.4*	7.5*	1.6*

**Notes:** CHIP is State Children’s Health Insurance Program. SSI is Supplemental Security Income. CSHCN is children with special health care needs. ADHD is attention deficit hyperactivity disorder. ADD is attention deficit disorder.

\* Difference from Medicaid/CHIP is statistically significant at the 0.05 level.

† Estimate has a relative standard error of greater than 50 percent.

– Quantity zero; amounts shown as 0.0 round to less than 0.1.

1 Health insurance coverage is defined at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of children covered by Medicare (generally children with end-stage renal disease), any type of military health plan (VA, TRICARE, and CHAMP-VA), or other government-sponsored programs.

2 Medicaid/CHIP also includes persons covered by other state-sponsored health plans.

3 Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.

4 Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state-sponsored or other government-sponsored health plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

5 Due in part to changes in the 2011 National Health Interview Survey (NHIS) questionnaire, the CSHCN definition differs slightly from the definition used in MACPAC reports prior to 2013. The CSHCN definition applied here is based on an approach developed by the Child and Adolescent Health Measurement Initiative (CAHMI) to identify “children with chronic conditions and elevated service use or need” in the 2007 NHIS and other prior research. (See CAMHI, Identifying children with chronic conditions and elevated service use or need (CCCESUN) in the National Health Interview Survey (NHIS), Portland, OR: Oregon Health and Science University, 2012; A.J. Davidoff, Identifying children with special health care needs in the National Health Interview Survey: a new resource for policy analysis, Health Services Research 39 (1): 53-71, 2004). CSHCN in this analysis must have at least one diagnosed or parent-reported condition expected to be an ongoing health condition and also meet at least one of five criteria related to elevated service use or elevated need, including reported unmet need for care. For more information on the methods used to identify CSHCN, see text and endnotes in Section 5 of MACStats.

6 For a child to be eligible for SSI, one of the criteria is that the child has a medically determinable physical or mental impairment(s) that results in marked and severe functional limitations and generally is expected to last at least 12 months or result in death. Thus, children who are eligible for SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that these Medicaid/CHIP children who are reported to have SSI did not meet the criteria for CSHCN, it could be because: (1) the parent erroneously reported in the survey that the children received SSI, or (2) the NHIS condition list did not capture, or the parent did not recognize, any of the NHIS conditions as reflecting the child’s circumstances.

7 Question only asked for children age 0 to 17.

8 Question only asked for children age 2 to 17.

**Source:** MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 5. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Age 19–64 by Source of Health Insurance, 2010–2012**

	Adults age 19–64	Selected Sources of Insurance <sup>1</sup>				Medicaid <sup>2</sup>			Neither SSI nor Medicare
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	Uninsured <sup>4</sup>	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	
<b>Health Insurance Coverage</b>		<b>9.7%</b>	65.1%	3.6%	21.0%	<b>100.0%</b>	11.4%	15.1%	73.5%
<b>Age (categories sum to 100%)</b>									
19–24	13.8%*	<b>20.3%</b>	11.6%*	2.4%*	18.6%*	<b>20.3%</b>	3.5%*	13.5%*	24.2%*
25–44	43.1*	<b>45.5</b>	41.8*	19.5*	50.0*	<b>45.5</b>	27.1*	34.5*	50.8*
45–54	23.4*	<b>19.4</b>	25.1*	27.8*	19.6	<b>19.4</b>	33.1*	27.1*	15.8*
55–64	19.7*	<b>14.7</b>	21.6*	50.2*	11.8*	<b>14.7</b>	36.2*	24.9*	9.2*
<b>Gender (categories sum to 100%)</b>									
Male	49.1%*	<b>35.8%</b>	49.0%*	49.3%*	54.2%*	<b>35.8%</b>	41.9%*	45.6%*	32.9%*
Female	50.9*	<b>64.2</b>	51.0*	50.7*	45.8*	<b>64.2</b>	58.1*	54.4*	67.1*
<b>Race (categories sum to 100%)</b>									
Hispanic	15.7%*	<b>21.5%</b>	10.0%*	9.6%*	31.1%*	<b>21.5%</b>	10.1%*	13.6%*	25.0%*
White, non-Hispanic	65.7*	<b>49.4</b>	73.9*	68.6*	48.3	<b>49.4</b>	62.8*	54.9*	46.2*
Black, non-Hispanic	12.5*	<b>23.8</b>	9.6*	19.0*	14.9*	<b>23.8</b>	24.4	27.0	22.9
Other and multiple races, non-Hispanic	6.1*	<b>5.3</b>	6.4*	2.8*	5.7	<b>5.3</b>	2.7*	4.5	5.9
<b>Family characteristics</b>									
Parent of a dependent child <sup>5</sup>	37.3*	<b>47.7</b>	37.4*	12.9*	35.5*	<b>47.7</b>	11.3*	18.5*	59.5*
<b>Health insurance</b>									
Medicaid	9.7%*	<b>100.0%</b>	0.4%*	30.9%*	–	<b>100.0%</b>	100.0%	100.0%	100.0%
Medicare	3.6*	<b>11.4</b>	1.1*	100.0*	–	<b>11.4</b>	100.0*	–	–
Private	65.1*	<b>2.8</b>	100.0*	19.7*	–	<b>2.8</b>	3.3	2.6	2.7

See Table 7 for notes.

Source: MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 6. Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Source of Health Insurance, 2010–2012**

	Adults age 19–64	Selected Sources of Insurance <sup>1</sup>				Medicaid <sup>2</sup>			
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	Uninsured <sup>4</sup>	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
<b>Disability and work status</b>									
Receives Supplemental Security Income (SSI)	2.4%*	<b>19.8%</b>	0.3%*	20.8%	0.5%*	<b>19.8%</b>	41.8%*	100.0%*	–
Receives Social Security Disability Insurance (SSDI)	3.6*	<b>14.7</b>	1.4*	62.2*	0.6*	<b>14.7</b>	65.7*	19.3*	5.9%*
Working	70.4*	<b>34.3</b>	81.3*	10.4*	60.4*	<b>34.3</b>	10.2*	7.8*	43.5*
<b>Current health status (categories sum to 100%)</b>									
Excellent or very good	63.5%*	<b>40.4%</b>	71.2%*	14.3%*	55.4%*	<b>40.4%</b>	12.7%*	15.1%*	49.8%*
Good	25.3*	<b>28.8</b>	22.6*	26.6	31.4*	<b>28.8</b>	25.2	27.8	29.6
Fair or poor	11.2*	<b>30.9</b>	6.2*	59.1*	13.2*	<b>30.9</b>	62.0*	57.1*	20.6*
<b>Health compared to 12 months ago (categories sum to 100%)</b>									
Better	19.4%*	<b>21.4%</b>	19.6%*	17.3%*	17.9%*	<b>21.4%</b>	20.3%	20.9%	21.7%
Worse	7.7*	<b>14.4</b>	5.6*	25.1*	9.5*	<b>14.4</b>	23.2*	21.3*	11.7*
Same	72.9*	<b>64.2</b>	74.8*	57.6*	72.6*	<b>64.2</b>	56.5*	57.9*	66.6*
<b>Activities of daily living (ADLs)</b>									
Help with any personal care needs <sup>6</sup>	1.3%*	<b>6.6%</b>	0.5%*	13.9%*	0.6%*	<b>6.6%</b>	19.8%*	18.4%*	2.1%*
Help with bathing/showering	0.8*	<b>4.4</b>	0.3*	8.5*	0.3*	<b>4.4</b>	12.8*	14.0*	1.1*
Help with dressing	0.7*	<b>3.8</b>	0.3*	7.7*	0.3*	<b>3.8</b>	11.7*	11.1*	1.1*
Help with eating	0.3*	<b>1.9</b>	0.1*	3.7*	0.1*	<b>1.9</b>	6.1*	6.2*	0.4*
Help with transferring (in/out of bed or chairs)	0.6*	<b>3.3</b>	0.2*	6.7*	0.3*	<b>3.3</b>	11.0*	9.2*	0.9*
Help with toileting	0.4*	<b>2.5</b>	0.2*	4.8*	0.1*	<b>2.5</b>	7.7*	7.9*	0.6*
Help getting around in home	0.6*	<b>2.9</b>	0.2*	6.1*	0.2*	<b>2.9</b>	9.6*	8.3*	0.8*
<b>Number of above ADLs reported (categories sum to 100%)</b>									
0	98.7%*	<b>93.5%</b>	99.5%*	86.1%*	99.4%*	<b>93.5%</b>	80.2%*	81.7%*	97.9%*
1	0.2*	<b>0.9</b>	0.1*	2.2*	0.1*	<b>0.9</b>	2.7*	2.1*	0.4*
2	0.3*	<b>1.1</b>	0.1*	2.8*	0.2*	<b>1.1</b>	2.7*	3.2*	0.4*
3	0.2*	<b>1.1</b>	0.1*	2.6*	0.1*	<b>1.1</b>	3.9*	2.6*	0.4*
4+	0.6*	<b>3.4</b>	0.2*	6.4*	0.2*	<b>3.4</b>	10.5*	10.4*	0.9*

**TABLE 6, Continued**

	Adults age 19–64	Selected Sources of Insurance <sup>1</sup>				Medicaid <sup>2</sup>			
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	Uninsured <sup>4</sup>	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
<b>Specific health conditions</b>									
Currently pregnant <sup>7</sup>	3.5%*	<b>9.5%</b>	2.8%*	†	1.6%*	<b>9.5%</b>	†	3.3%*	10.9%
Functional limitation <sup>8</sup>	29.5*	<b>47.1</b>	25.6*	84.3%*	27.8*	<b>47.1</b>	83.0%*	75.9*	35.7*
Difficulty walking without equipment	3.4*	<b>11.8</b>	1.7*	31.7*	2.0*	<b>11.8</b>	32.9*	26.3*	5.7*
Health condition that requires special equipment (e.g., cane, wheelchair)	4.2*	<b>11.9</b>	2.7*	33.2*	2.4*	<b>11.9</b>	33.4*	25.6*	5.8*
Lost all natural teeth	4.6*	<b>8.9</b>	3.4*	18.8*	5.0*	<b>8.9</b>	21.3*	16.1*	5.5*
Depressed/anxious feelings <sup>9</sup>	12.4*	<b>25.9</b>	8.3*	36.2*	16.7*	<b>25.9</b>	39.1*	40.5*	21.0*
Ever told had hypertension	23.7*	<b>30.4</b>	23.0*	56.3*	18.9*	<b>30.4</b>	54.0*	45.2*	23.8*
Ever told had coronary heart disease	2.5*	<b>4.5</b>	2.1*	14.5*	1.5*	<b>4.5</b>	12.7*	7.6*	2.6*
Ever told had heart attack	1.8*	<b>4.0</b>	1.3*	11.6*	1.5*	<b>4.0</b>	10.4*	6.3*	2.5*
Ever told had stroke	1.6*	<b>4.4</b>	1.0*	10.7*	1.2*	<b>4.4</b>	12.2*	9.0*	2.2*
Ever told had cancer	5.2*	<b>5.9</b>	5.7	14.4*	2.8*	<b>5.9</b>	12.9*	9.0*	4.2*
Ever told had diabetes	6.7*	<b>12.3</b>	5.9*	24.8*	5.0*	<b>12.3</b>	26.5*	21.5*	8.3*
Ever told had arthritis	17.3*	<b>23.8</b>	17.0*	55.0*	11.4*	<b>23.8</b>	54.8*	37.0*	16.2*
Ever told had asthma	13.0*	<b>20.0</b>	12.2*	23.4*	11.5*	<b>20.0</b>	30.0*	26.8*	17.0*
Past 12 months, told had chronic bronchitis	3.8*	<b>8.0</b>	2.9*	15.8*	3.3*	<b>8.0</b>	18.8*	13.0*	5.3*
Past 12 months, told had liver condition	1.4*	<b>3.3</b>	1.0*	5.6*	1.1*	<b>3.3</b>	5.6*	7.1*	2.2*
Past 12 months, told had weak/failing kidneys	1.2*	<b>4.0</b>	0.7*	8.8*	1.2*	<b>4.0</b>	12.2*	6.8*	2.2*

See Table 7 for notes.

**Source:** MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 7. Use of Care by Non-Institutionalized Individuals Age 19–64 by Source of Health Insurance, 2010–2012**

	Adults age 19–64	Selected Sources of Insurance <sup>1</sup>				Medicaid <sup>2</sup>			
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	Uninsured <sup>4</sup>	Medicaid adults age 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Had a usual source of care	80.1%*	<b>87.4%</b>	89.6%*	93.9%*	45.4%*	<b>87.4%</b>	95.1%*	92.1%*	85.3%*
Received at-home care in past 12 months	1.2*	<b>4.6</b>	0.8*	9.9*	0.4*	<b>4.6</b>	16.9*	8.3*	2.0*
<b>Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)</b>									
None	22.2%*	<b>14.1%</b>	15.5%*	6.4%*	48.4%*	<b>14.1%</b>	5.5%*	8.7%*	16.4%*
1	18.3*	<b>12.9</b>	19.8*	5.8*	17.4*	<b>12.9</b>	5.0*	9.2*	14.8*
2–3	25.9*	<b>20.8</b>	29.6*	15.7*	17.3*	<b>20.8</b>	14.3*	17.8	22.4
4+	33.6*	<b>52.3</b>	35.0*	72.1*	16.9*	<b>52.3</b>	75.2*	64.3*	46.4*
<b>Number of emergency room visits in past 12 months (categories sum to 100%)</b>									
None	80.3%*	<b>60.9%</b>	84.1%*	60.4%	79.4%*	<b>60.9%</b>	54.4%*	56.4%*	62.7%
1	12.4*	<b>18.0</b>	11.5*	18.6	12.0*	<b>18.0</b>	18.0	17.6	18.2
2–3	5.1*	<b>13.0</b>	3.4*	12.2	5.9*	<b>13.0</b>	16.5*	15.3	12.0
4+	2.2*	<b>8.1</b>	1.0*	8.7	2.6*	<b>8.1</b>	11.1*	10.7*	7.1

**Notes:** SSI is Supplemental Security Income.

\* Difference from Medicaid is statistically significant at the 0.05 level.

† Estimate has a relative standard error of greater than 50 percent.

– Quantity zero; amounts shown as 0.0 round to less than 0.1 in this table.

1 Health insurance coverage is defined as coverage at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of individuals covered by any type of military health plan (VA, TRICARE, and CHAMP-VA) or other government-sponsored programs.

2 Medicaid also includes adults reporting coverage through the CHIP program or other state-sponsored health plans. Medicaid and CHIP cannot be distinguished from each other in the National Health Interview Survey. CHIP enrollment of adults is small, totaling approximately 218,000 ever enrolled during FY 2012. (See March 2014 MACStats Table 3.)

3 Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.

4 Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state-sponsored or other government-sponsored health plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

5 Parent of a dependent child is defined as an adult with at least one dependent child (biological, adopted, step, or foster) in the household; a dependent child is defined as a child age 18 and under or a child age 23 and under who is not working because of going to school.

6 Only adults who report needing assistance with personal care needs are asked about each of the specific personal care needs. Each specific personal care need is reported as the overall population prevalence (rather than the prevalence among those needing help with any personal care needs).

7 Question only asked for females age 18 to 49.

8 Individuals with a functional limitation are those who reported any degree of difficulty—ranging from “only a little difficult” to “can’t do at all”—doing any of a dozen activities (e.g., walking a quarter of a mile, stooping or kneeling) by themselves and without special equipment.

9 Reports feeling sad, hopeless, worthless, nervous, restless, or that everything was an effort all or most of the time.

**Source:** MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 8. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2010–2012**

	Adults age 65+	Selected Sources of Insurance <sup>1</sup>			Medicaid <sup>2</sup>		
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	All Medicaid adults age 65+	Functional limitation <sup>4</sup>	No functional limitation
<b>Health Insurance Coverage</b>		<b>7.6%</b>	52.6%	95.1%	<b>100.0%</b>	79.0%	21.0%
<b>Age (categories sum to 100%)</b>							
65–74	55.7%	<b>55.5%</b>	55.3%	54.6%	<b>55.5%</b>	53.9%	62.1%*
75–84	32.6	<b>32.8</b>	32.9	33.4	<b>32.8</b>	33.1	31.4
85+	11.7	<b>11.7</b>	11.8	12.0	<b>11.7</b>	13.0	6.6*
<b>Gender (categories sum to 100%)</b>							
Male	43.8%*	<b>32.2%</b>	43.7%*	43.3%*	<b>32.2%</b>	29.7%	41.8%*
Female	56.2*	<b>67.8</b>	56.3*	56.7*	<b>67.8</b>	70.3	58.2*
<b>Race (categories sum to 100%)</b>							
Hispanic	7.4%*	<b>23.1%</b>	3.3%*	6.8%*	<b>23.1%</b>	21.9%	28.1%
White, non-Hispanic	79.8*	<b>49.0</b>	87.8*	80.9*	<b>49.0</b>	50.7	42.8
Black, non-Hispanic	8.5*	<b>17.4</b>	6.0*	8.3*	<b>17.4</b>	17.4	17.4
Other and multiple races, non-Hispanic	4.3*	<b>10.5</b>	2.9*	4.0*	<b>10.5</b>	10.0	11.7
<b>Health insurance</b>							
Medicaid	7.6%*	<b>100.0%</b>	0.9%*	7.3%*	<b>100.0%</b>	100.0%	100.0%
Medicare	95.1*	<b>91.8</b>	93.9*	100.0*	<b>91.8</b>	92.6	88.8
Private	52.6*	<b>6.2</b>	100.0*	52.0*	<b>6.2</b>	5.5	8.6

See Table 10 for notes.

**Source:** MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 9. Health Characteristics of Non-Institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2010–2012**

	Adults age 65+	Selected Sources of Insurance <sup>1</sup>			Medicaid <sup>2</sup>		
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	All Medicaid adults age 65+	Functional limitation <sup>4</sup>	No functional limitation
<b>Disability and work status</b>							
Receives Supplemental Security Income (SSI)	3.8%*	29.4%	0.8%*	3.8%*	29.4%	32.6%	17.4%*
Working	15.9*	4.5	19.3*	14.5*	4.5	3.1	9.9*
<b>Current health status (categories sum to 100%)</b>							
Excellent or very good	43.8%*	20.8%	48.4%*	43.6%*	20.8%	13.9%*	47.1%*
Good	33.7*	29.9	34.0*	33.8*	29.9	29.0	33.3
Fair or poor	22.5*	49.3	17.6*	22.6*	49.3	57.1*	19.6*
<b>Health compared to 12 months ago (categories sum to 100%)</b>							
Better	13.7%	14.2%	13.6%	13.7%	14.2%	15.3%	10.3%*
Worse	11.8*	21.0	10.5*	11.8*	21.0	25.0*	5.8*
Same	74.6*	64.8	75.9*	74.5*	64.8	59.7*	83.8*
<b>Activities of daily living (ADLs)</b>							
Help with any personal care needs <sup>5</sup>	6.8%*	20.4%	5.1%*	6.9%*	20.4%	24.7%*	3.1%*
Help with bathing/showering	5.0*	15.5	3.6*	5.1*	15.5	18.8*	2.4*
Help with eating	1.5*	4.8	0.9*	1.5*	4.8	5.8	1.4*
Help with transferring (in/out of bed or chairs)	3.0*	9.6	2.1*	3.0*	9.6	11.4	2.1*
Help with toileting	2.3*	7.1	1.7*	2.3*	7.1	8.3	1.9*
Help getting around in home	2.8*	9.5	1.9*	2.8*	9.5	11.5	1.9*
<b>Number of above ADLs reported (categories sum to 100%)</b>							
0	93.2%*	79.8%	94.9%*	93.1%*	79.8%	75.5%*	96.9%*
1	0.9*	2.6	0.7*	0.9*	2.6	3.1	†
2	1.4*	2.8	1.1*	1.4*	2.8	3.5	†
3	1.4*	4.1	1.2*	1.4*	4.1	5.2	0.0*
4+	3.1*	10.6	2.1*	3.1*	10.6	12.7	2.1*

**TABLE 9, Continued**

	Adults age 65+	Selected Sources of Insurance <sup>1</sup>			Medicaid <sup>2</sup>		
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	All Medicaid adults age 65+	Functional limitation <sup>4</sup>	No functional limitation
<b>Specific health conditions</b>							
Functional limitation <sup>4</sup>	65.1%*	<b>79.0%</b>	63.9%*	65.7%*	<b>79.0%</b>	100.0%*	0.0%*
Difficulty walking without equipment	18.6*	<b>38.8</b>	16.0*	18.9*	<b>38.8</b>	47.2*	6.8*
Health condition that requires special equipment (e.g., cane, wheelchair)	20.7*	<b>38.9</b>	18.5*	21.0*	<b>38.9</b>	47.0*	8.5*
Lost all natural teeth	22.7*	<b>41.2</b>	18.5*	22.9*	<b>41.2</b>	43.7	30.9*
Depressed/anxious feelings <sup>6</sup>	9.3*	<b>20.6</b>	8.0*	9.3*	<b>20.6</b>	25.3*	3.1*
Ever told had hypertension	62.0*	<b>70.5</b>	61.1*	62.3*	<b>70.5</b>	73.9	57.6*
Ever told had coronary heart disease	15.8*	<b>19.6</b>	16.0*	16.1*	<b>19.6</b>	22.4	8.8*
Ever told had heart attack	10.4*	<b>13.6</b>	10.0*	10.6*	<b>13.6</b>	15.3	7.2*
Ever told had stroke	8.2*	<b>15.1</b>	7.1*	8.3*	<b>15.1</b>	17.9	4.5*
Ever told had cancer	24.2*	<b>18.8</b>	26.4*	24.7*	<b>18.8</b>	20.5	12.1*
Ever told had diabetes	20.7*	<b>31.1</b>	19.2*	20.8*	<b>31.1</b>	33.7	20.8*
Ever told had arthritis	49.7*	<b>57.4</b>	51.2*	50.4*	<b>57.4</b>	65.6*	25.9*
Ever told had asthma	10.6*	<b>16.0</b>	10.1*	10.7*	<b>16.0</b>	17.9	8.0*
Past 12 months, told had chronic bronchitis	5.8*	<b>10.3</b>	5.5*	5.9*	<b>10.3</b>	11.7	4.7*
Past 12 months, told had liver condition	1.4*	<b>2.9</b>	1.2*	1.4*	<b>2.9</b>	3.6	†
Past 12 months, told had weak/failing kidneys	4.3*	<b>9.3</b>	3.5*	4.4*	<b>9.3</b>	11.0	2.9*

See Table 10 for notes.

**Source:** MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).

**TABLE 10. Use of Care by Non-Institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2010–2012**

	Adults age 65+	Selected Sources of Insurance <sup>1</sup>			Medicaid <sup>2</sup>		
		Medicaid <sup>2</sup>	Private <sup>3</sup>	Medicare	All Medicaid adults age 65+	Functional limitation <sup>4</sup>	No functional limitation
Received at-home care in past 12 months	8.2%*	<b>19.0%</b>	7.4%*	8.4%*	<b>19.0%</b>	22.9%*	3.9%*
<b>Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)</b>							
None	6.4%*	<b>6.5%</b>	4.8%*	5.9%	<b>6.5%</b>	4.7%	13.0%*
1	10.4*	<b>6.4</b>	10.4*	10.3*	<b>6.4</b>	4.8	12.5*
2–3	25.5*	<b>20.4</b>	26.2*	25.3*	<b>20.4</b>	19.0	25.6
4+	57.7*	<b>66.7</b>	58.6*	58.5*	<b>66.7</b>	71.5*	48.8*
<b>Number of emergency room visits in past 12 months (categories sum to 100%)</b>							
None	76.9%*	<b>66.9%</b>	78.0%*	76.7%*	<b>66.9%</b>	63.2%	80.8%*
1	15.3	<b>17.1</b>	14.9	15.5	<b>17.1</b>	18.8	10.7*
2–3	5.9*	<b>10.7</b>	5.5*	6.0*	<b>10.7</b>	11.6	7.1*
4+	1.9*	<b>5.3</b>	1.6*	1.9*	<b>5.3</b>	6.4	1.3*

**Notes:**

\* Difference from Medicaid is statistically significant at the 0.05 level.

† Estimate has a relative standard error of greater than 50 percent.

– Quantity zero; amounts shown as 0.0 round to less than 0.1 in this table.

- 1 Health insurance coverage is defined as coverage at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of individuals covered by any type of military health plan (VA, TRICARE, and CHAMP-VA) or other government-sponsored programs.
- 2 Medicaid also includes adults reporting coverage through CHIP or other state-sponsored health plans.
- 3 Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care.
- 4 Individuals with a functional limitation are those who reported any degree of difficulty—ranging from “only a little difficult” to “can’t do at all”—doing any of a dozen activities (e.g., walking a quarter of a mile, stooping or kneeling) by themselves and without special equipment.
- 5 Only adults who report needing assistance with personal care needs are asked about each of the following specific personal care needs. Each need is reported as the overall population prevalence (rather than the prevalence among those needing help with any personal care needs).
- 6 Reports feeling sad, hopeless, worthless, nervous, restless, or that everything was an effort all or most of the time.

**Source:** MACPAC analysis of the 2010–2012 National Health Interview Survey (NHIS).







# 3

## Key Points

### Medicaid Enrollment and Benefit Spending

- ▶ Individuals eligible on the basis of a disability and those age 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Tables 11 and 12).
- ▶ Medicaid spending per enrollee is affected by large numbers of individuals with limited benefits in some states (Table 13).
- ▶ Among individuals dually enrolled in Medicaid and Medicare, those age 65 and older account for about 60 percent of enrollment and Medicaid benefit spending (Tables 11 and 12).
- ▶ A large share of Medicaid spending for enrollees eligible on the basis of a disability and enrollees age 65 and older is for long-term services and supports (LTSS), while a substantial portion of spending for non-disabled children and adults is for capitation payments to managed care plans (Figures 3 and 4).
- ▶ LTSS users account for only about 6 percent of Medicaid enrollees, but nearly half of all Medicaid spending (Figure 5). Acute care represents a minority of Medicaid spending for most LTSS users (Figure 6), and average Medicaid benefit spending for these individuals is more than 10 times that of enrollees who are not using LTSS (Figure 7).
- ▶ Medicaid benefit spending per enrollee varies substantially across states (Table 13). Reasons for this variation may include the breadth of benefits that states choose to cover; the proportion of enrollees receiving the full benefit package or a more limited version; enrollee case mix (based on health status and other characteristics); the underlying costs of delivering health care services in specific geographic areas; and state policies regarding provider payments, care management, and other program features.

**TABLE 11. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2011 (thousands)**

State	Total	Percentage of Enrollees in Eligibility Group <sup>1</sup>				Dually eligible Enrollees <sup>2</sup>					
		Children	Adults	Disabled	Aged	All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
						Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
<b>Total</b>	<b>67,605</b>	<b>47.4%</b>	<b>28.3%</b>	<b>14.7%</b>	<b>9.5%</b>	<b>10,179</b>	<b>59.0%</b>	<b>7,552</b>	<b>59.3%</b>	<b>2,627</b>	<b>58.3%</b>
Alabama	1,061	50.7	17.3	20.8	11.1	212	55.1	97	52.4	115	57.4
Alaska	135	54.7	25.0	13.3	7.0	15	53.7	15	53.2	0	68.9
Arizona	1,283	44.5	37.5	10.9	7.1	148	57.9	118	54.5	30	71.1
Arkansas	693	51.5	16.6	21.8	10.2	128	53.2	70	59.3	58	45.8
California	11,690	39.0	43.2	8.9	8.8	1,295	70.2	1,260	70.0	35	75.2
Colorado	762	57.4	21.3	13.5	7.9	94	58.2	69	60.6	25	51.4
Connecticut	785	40.4	36.1	9.8	13.7	155	66.5	83	57.7	72	76.8
Delaware	243	39.9	43.1	10.8	6.2	27	53.1	12	54.0	15	52.3
District of Columbia	232	35.6	40.1	16.2	8.1	23	62.4	16	61.4	7	64.5
Florida	3,983	50.5	21.2	15.6	12.7	739	64.8	387	68.8	352	60.4
Georgia	1,953	58.3	15.8	16.5	9.4	306	58.4	158	58.8	148	58.0
Hawaii	280	41.2	39.5	10.1	9.2	37	67.4	32	67.7	4	65.1
Idaho	267	61.8	14.8	16.2	7.2	40	46.0	27	44.4	13	49.5
Illinois	2,883	52.6	28.3	11.2	7.9	372	56.3	333	55.7	40	61.3
Indiana	1,189	55.2	21.3	15.8	7.8	173	47.8	107	53.2	66	39.0
Iowa	589	46.6	31.6	14.3	7.5	88	49.3	71	46.2	17	62.3
Kansas	416	56.8	14.7	19.2	9.4	72	50.1	49	52.6	23	44.9
Kentucky	937	47.9	15.7	25.8	10.6	195	50.0	113	51.3	82	48.2
Louisiana	1,292	52.8	19.7	18.4	9.2	204	57.1	113	55.4	91	59.3
Maine	435	29.6	26.8	28.3	15.3	104	59.3	59	45.6	45	77.1
Maryland	1,036	47.0	30.8	14.4	7.7	129	55.8	84	55.3	45	56.7
Massachusetts	1,519	25.2	41.7	22.8	10.3	259	51.7	237	47.7	22	95.1
Michigan	2,340	50.5	27.2	16.0	6.3	291	46.3	249	45.4	42	51.4
Minnesota	1,106	41.6	37.0	12.4	9.0	149	53.1	135	52.2	15	60.6
Mississippi	781	52.0	14.7	21.8	11.5	162	55.2	84	57.9	78	52.4
Missouri	1,138	50.7	21.0	19.7	8.6	194	48.0	168	47.4	26	51.8
Montana	135	56.1	16.8	17.4	9.7	25	52.0	17	51.2	8	53.5
Nebraska	254	58.2	19.1	16.0	6.7	37	42.1	37	42.1	0	58.5
Nevada	395	60.4	19.3	12.5	7.8	51	58.9	24	64.4	26	53.7
New Hampshire	171	58.6	13.8	18.0	9.5	35	44.4	23	44.8	12	43.5

**TABLE 11, Continued**

State	Total	Percentage of Enrollees in Eligibility Group <sup>1</sup>				Dually eligible Enrollees <sup>2</sup>					
		Children	Adults	Disabled	Aged	All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
						Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
New Jersey	1,194	52.7%	18.1%	15.9%	13.3%	236	62.6%	206	61.6%	30	69.4%
New Mexico	651	56.3	25.7	11.1	6.9	74	59.4	41	60.3	33	58.2
New York	5,790	36.7	40.1	12.0	11.2	844	67.7	724	66.4	120	75.2
North Carolina	1,948	51.7	21.1	17.5	9.7	340	54.4	263	54.0	77	56.0
North Dakota	85	53.1	21.5	14.2	11.1	16	57.1	13	56.6	3	59.0
Ohio	2,339	47.5	27.1	17.1	8.3	374	48.2	255	49.9	120	44.6
Oklahoma	907	54.3	24.4	13.9	7.5	124	52.5	101	52.3	23	53.4
Oregon	729	48.2	29.1	14.2	8.5	109	55.5	68	57.6	40	52.0
Pennsylvania	2,529	43.8	21.0	25.2	10.0	444	54.1	367	52.7	77	60.7
Rhode Island	199	45.0	21.3	20.5	13.2	41	56.4	35	55.2	6	63.4
South Carolina	961	49.6	24.1	17.3	9.0	163	53.3	140	52.6	23	57.4
South Dakota	132	57.9	17.5	14.9	9.8	22	58.1	14	60.1	8	54.8
Tennessee	1,533	51.8	21.0	17.6	9.5	279	51.7	156	50.7	123	53.0
Texas	5,136	63.4	14.0	13.4	9.2	714	64.5	435	66.4	278	61.5
Utah	372	58.7	24.5	12.2	4.7	36	45.6	31	44.7	5	51.6
Vermont	201	34.1	42.3	12.4	11.2	37	58.8	28	54.7	8	72.6
Virginia	1,045	54.2	17.2	17.8	10.8	192	55.7	127	58.5	65	50.1
Washington	1,397	56.3	21.3	15.2	7.2	181	54.1	132	57.4	48	45.2
West Virginia	440	47.2	14.8	28.1	9.9	87	49.1	51	50.5	36	47.1
Wisconsin	1,274	39.0	36.2	13.2	11.5	227	62.7	206	62.5	21	64.1
Wyoming	89	65.2	14.9	13.1	6.8	12	51.5	7	51.0	4	52.5

**Notes:** Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month; however, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, figures shown here are not directly comparable to earlier years. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. Although state-level information is not yet available, the estimated number of individuals ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 71.2 million for FY 2012 and 71.7 million for FY 2013. These FY 2012–FY 2013 figures exclude about 1 million enrollees in the territories (MACPAC communication with the Office of the Actuary at the Centers for Medicare & Medicaid Services, March 2014).

- 1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.
- 2 Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing. Zeroes indicate enrollment counts less than 500 that round to zero.

**Source:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014.

**TABLE 12. Medicaid Benefit Spending by State, Eligibility Group, and Dually Eligible Status, FY 2011 (millions)**

State	Total	Percentage of Benefit Spending Attributable to Eligibility Group <sup>1</sup>				Dually eligible Enrollees <sup>2</sup>					
		Children	Adults	Disabled	Aged	All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
						Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
<b>Total<sup>3</sup></b>	<b>\$386,354</b>	<b>19.0%</b>	<b>15.3%</b>	<b>42.7%</b>	<b>23.0%</b>	<b>\$140,298</b>	<b>59.7%</b>	<b>\$134,315</b>	<b>60.1%</b>	<b>\$5,983</b>	<b>52.3%</b>
Alabama	4,416	24.1	10.0	40.6	25.3	1,626	67.8	1,424	69.6	203	55.7
Alaska	1,290	27.2	16.5	38.5	17.8	354	54.4	353	54.3	1	71.3
Arizona	8,824	18.8	32.4	34.9	13.9	1,971	56.4	1,907	56.2	64	63.4
Arkansas	3,944	22.1	5.1	46.7	26.0	1,630	60.5	1,432	63.9	198	36.6
California	52,631	17.5	16.3	40.9	25.3	17,805	67.6	17,695	67.6	110	66.2
Colorado	4,196	21.9	14.3	42.0	21.8	1,422	60.5	1,385	60.9	37	45.6
Connecticut	5,844	16.1	20.3	34.3	29.3	2,858	56.9	2,729	56.6	129	64.2
Delaware	1,401	19.6	33.2	31.7	15.5	367	57.1	335	58.1	32	46.5
District of Columbia	2,067	11.3	20.0	48.6	20.1	521	63.1	502	63.4	19	55.0
Florida	17,930	18.4	13.7	41.9	26.0	7,002	63.0	6,186	64.4	816	52.0
Georgia	7,701	27.0	14.7	37.3	20.9	2,383	65.8	2,084	67.8	298	52.0
Hawaii	1,600	14.6	28.2	29.2	28.0	585	73.5	577	73.6	9	68.0
Idaho	1,510	21.8	12.8	49.0	16.3	505	46.3	483	46.5	22	42.3
Illinois	12,587	23.1	16.5	41.1	19.3	3,954	54.5	3,882	54.5	72	51.3
Indiana	6,280	16.6	11.4	48.4	23.7	2,570	55.6	2,403	57.1	168	33.6
Iowa	3,302	17.2	11.3	48.6	22.9	1,498	50.1	1,461	49.9	36	56.7
Kansas	2,623	22.1	8.6	43.0	26.2	1,066	62.3	1,025	63.2	41	40.3
Kentucky	5,517	22.4	12.4	46.6	18.6	1,817	55.6	1,659	56.6	159	45.3
Louisiana	6,063	19.8	11.5	49.6	19.1	1,950	57.7	1,781	58.1	169	53.8
Maine	3	3	3	3	3	3	3	3	3	3	3
Maryland	7,380	19.2	18.8	43.0	19.1	2,158	58.6	2,039	59.1	118	48.8
Massachusetts	13,233	11.8	18.3	45.9	24.1	5,339	55.5	5,297	55.2	42	95.1
Michigan	11,758	18.8	17.1	44.7	19.4	3,639	58.5	3,446	58.0	193	67.2
Minnesota	8,334	18.8	17.4	42.0	21.8	3,401	51.2	3,376	51.2	25	52.9
Mississippi	4,253	21.1	10.7	43.9	24.3	1,587	64.7	1,386	67.3	201	46.2
Missouri	7,392	22.0	9.2	49.1	19.7	2,589	52.0	2,529	52.1	61	48.5
Montana	944	24.1	12.1	37.9	26.0	383	64.5	363	65.4	20	47.7
Nebraska	1,641	20.3	11.8	44.8	23.1	672	51.5	671	51.5	0	58.5
Nevada	1,487	28.1	13.1	41.3	17.6	392	62.7	340	65.0	51	47.5
New Hampshire	1,217	24.1	7.3	39.6	29.0	599	56.1	572	56.5	26	49.2

**TABLE 12, Continued**

State	Total	Percentage of Benefit Spending Attributable to Eligibility Group <sup>1</sup>				Dually eligible Enrollees <sup>2</sup>					
		Children	Adults	Disabled	Aged	All dually eligible enrollees		Dually eligible enrollees with full benefits		Dually eligible enrollees with limited benefits	
						Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
New Jersey	\$9,309	15.8%	7.5%	44.6%	32.0%	\$4,696	60.4%	\$4,650	60.3%	\$45	68.4%
New Mexico	3,366	38.7	28.9	29.3	3.1	349	28.5	294	23.4	55	56.4
New York	50,724	10.4	19.3	41.4	28.8	22,615	61.2	22,336	61.0	279	72.7
North Carolina	10,138	22.1	13.9	44.7	19.3	3,353	57.9	3,223	58.3	130	47.7
North Dakota	707	15.7	8.9	43.4	32.0	398	56.2	393	56.3	5	48.8
Ohio	15,046	14.4	15.7	45.1	24.9	6,257	55.1	5,904	55.9	354	41.9
Oklahoma	4,225	28.7	13.5	40.3	17.5	1,304	53.2	1,272	53.3	32	50.2
Oregon	4,380	16.3	23.3	37.7	22.7	1,523	63.7	1,447	64.8	76	44.2
Pennsylvania	19,663	16.9	9.2	49.6	24.3	7,366	62.5	7,241	62.7	126	56.3
Rhode Island	1,989	22.8	15.5	42.3	19.5	719	52.0	709	52.0	10	50.9
South Carolina	4,598	19.6	17.4	42.7	20.2	1,583	58.6	1,555	58.7	28	54.2
South Dakota	759	25.5	12.4	43.1	19.1	265	54.2	245	54.6	19	49.3
Tennessee	3	3	3	3	3	3	3	3	3	3	3
Texas	26,986	33.8	8.6	40.3	17.3	7,153	63.2	6,408	63.2	745	63.2
Utah	1,742	26.7	15.2	47.7	10.4	464	38.1	458	38.1	7	32.2
Vermont	1,260	4	4	4	4	4	4	4	4	4	4
Virginia	6,814	23.2	11.3	44.6	20.9	2,348	55.3	2,216	56.1	132	42.2
Washington	7,098	23.5	14.7	41.9	20.0	2,259	61.1	2,146	62.2	113	40.5
West Virginia	2,685	16.6	9.4	49.6	24.4	1,023	63.1	956	64.3	67	46.7
Wisconsin	6,966	11.7	17.1	41.5	29.7	3,502	58.1	3,467	58.1	35	54.3
Wyoming	534	20.7	9.5	45.0	24.9	256	51.5	238	52.2	18	41.0

**Notes:** Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information.

- 1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.
- 2 Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing.
- 3 Maine (\$2.3 billion) and Tennessee (\$7.9 billion) were excluded due to MSIS spending data anomalies.
- 4 Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, MACPAC's adjustment methodology is only applied to total Medicaid spending.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

**TABLE 13. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2011**

State	Percentage of FYEs with limited benefits <sup>1</sup>	Total		Percentage of FYEs with limited benefits <sup>1</sup>	Children		Percentage of FYEs with limited benefits <sup>1</sup>	Adults		Percentage of FYEs with limited benefits <sup>1</sup>	Disabled		Percentage of FYEs with limited benefits <sup>1</sup>	Aged	
		Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE	
		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>
<b>Total<sup>3</sup></b>	<b>11.9%</b>	<b>\$7,236</b>	<b>\$7,903</b>	<b>1.3%</b>	<b>\$2,854</b>	<b>\$2,875</b>	<b>28.2%</b>	<b>\$4,368</b>	<b>\$5,380</b>	<b>10.5%</b>	<b>\$19,031</b>	<b>\$20,800</b>	<b>23.5%</b>	<b>\$16,236</b>	<b>\$20,336</b>
Alabama	23.1	4,865	5,671	0.1	2,318	2,316	74.0	3,111	5,294	21.6	9,015	10,911	56.5	10,430	21,546
Alaska	0.4	12,049	12,083	–	5,851	5,851	0.0	9,256	9,254	0.7	31,262	31,479	3.2	27,953	28,790
Arizona	6.0	8,133	8,268	1.6	3,399	3,391	7.5	7,492	7,738	6.2	23,277	23,561	24.5	14,689	18,210
Arkansas	20.4	6,606	7,702	2.3	2,789	2,819	72.9	2,346	5,452	20.7	13,590	15,948	38.3	16,464	24,814
California	28.5	5,857	7,625	6.5	2,621	2,744	63.9	2,397	4,227	0.8	22,411	22,503	4.0	14,235	14,577
Colorado	4.0	7,025	7,114	0.1	2,700	2,677	2.6	5,159	4,836	11.0	19,738	21,755	20.9	17,724	21,845
Connecticut	9.0	8,943	9,604	0.0	3,421	3,421	0.1	5,429	5,410	20.2	28,828	35,300	49.5	18,924	35,679
Delaware	14.1	7,057	7,856	1.3	3,410	3,448	16.4	5,770	6,489	27.0	18,300	24,101	53.3	16,409	32,723
District of Columbia	3.1	10,371	10,533	–	3,210	3,210	0.3	5,501	5,328	5.9	28,690	30,235	24.2	25,271	32,443
Florida	11.2	5,894	6,181	0.2	2,070	2,048	6.5	5,275	4,959	22.5	13,882	16,882	41.9	10,597	16,454
Georgia	8.6	5,091	5,318	0.0	2,345	2,343	0.8	6,233	6,024	19.0	10,133	11,880	47.1	10,103	17,234
Hawaii	1.5	6,725	6,787	0.0	2,284	2,283	0.0	5,168	5,164	4.8	18,010	18,802	10.2	19,816	21,761
Idaho	5.0	7,161	7,400	0.0	2,482	2,479	0.4	8,226	8,045	13.6	19,202	21,854	32.3	15,344	21,767
Illinois	5.0	4,933	5,094	0.1	2,133	2,133	13.2	2,998	3,192	4.8	17,429	18,156	10.8	12,158	13,406
Indiana	6.0	6,494	6,722	–	1,899	1,899	0.0	4,066	4,065	21.2	18,377	22,458	29.2	19,068	25,903
Iowa	10.7	6,975	7,496	1.1	2,530	2,533	25.0	2,803	2,829	7.1	20,673	22,037	25.0	20,223	26,239
Kansas	6.1	7,881	8,233	0.0	3,037	3,036	0.5	5,930	5,723	15.9	15,904	18,494	27.5	21,124	28,411
Kentucky	9.5	7,210	7,716	0.0	3,371	3,368	0.5	7,275	7,199	16.9	11,823	13,745	40.5	11,784	18,402
Louisiana	15.6	5,655	6,353	0.0	2,141	2,139	44.6	3,680	5,299	15.7	14,001	16,149	46.2	10,816	18,502
Maine	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Maryland	7.0	8,486	8,730	0.2	3,380	3,365	8.8	5,627	5,304	12.2	23,416	26,158	32.2	20,332	28,704
Massachusetts	6.7	12,485	13,239	3.8	6,334	6,540	9.6	5,879	6,350	0.5	22,159	22,210	16.5	24,840	29,146
Michigan	6.4	6,054	6,308	0.9	2,200	2,213	16.5	4,260	4,915	5.2	15,508	16,133	15.6	18,190	20,264
Minnesota	4.7	10,161	10,534	0.7	4,212	4,225	8.6	5,734	6,120	4.2	28,168	29,183	12.0	25,470	28,484
Mississippi	15.3	6,551	7,123	0.1	2,708	2,707	34.5	5,504	5,942	22.0	12,135	14,648	45.3	12,742	21,186
Missouri	11.3	7,913	8,654	0.0	3,340	3,340	46.5	3,787	5,491	6.0	19,408	20,398	13.7	18,029	20,469
Montana	6.7	8,836	9,272	–	3,739	3,739	–	7,794	7,794	16.2	17,561	20,345	35.4	22,223	33,053
Nebraska	0.1	8,149	8,134	0.0	2,704	2,701	0.3	6,540	6,436	0.0	20,347	20,348	0.0	30,539	30,551
Nevada	7.7	5,134	5,284	0.1	2,368	2,362	2.1	4,160	3,925	23.9	14,898	18,592	44.4	10,244	16,503
New Hampshire	7.1	8,820	9,291	–	3,545	3,545	–	5,767	5,767	20.8	18,238	22,379	32.1	26,154	37,106

**TABLE 13, Continued**

State	Percentage of FYE with limited benefits <sup>1</sup>	Total		Percentage of FYE with limited benefits <sup>1</sup>	Children		Percentage of FYE with limited benefits <sup>1</sup>	Adults		Percentage of FYE with limited benefits <sup>1</sup>	Disabled		Percentage of FYE with limited benefits <sup>1</sup>	Aged	
		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>		All enrollees	Excluding those with limited benefits <sup>2</sup>
New Jersey	3.0%	\$9,709	\$9,907	0.0%	\$2,835	\$2,835	1.3%	\$5,473	\$5,232	4.9%	\$24,120	\$25,233	13.7%	\$21,390	\$24,468
New Mexico	12.5	6,140	6,601	0.0	4,238	4,233	29.2	7,136	8,621	18.4	15,191	18,141	41.9	2,667	3,248
New York	5.8	10,426	10,813	2.1	2,961	3,008	6.7	5,297	5,321	4.1	31,989	33,164	15.9	25,382	29,403
North Carolina	9.4	6,479	6,940	0.1	2,720	2,718	29.3	5,247	6,611	9.8	14,844	16,183	22.6	11,768	14,711
North Dakota	4.5	10,830	11,269	–	3,139	3,139	0.0	5,574	5,573	11.2	28,914	32,316	22.2	28,468	36,240
Ohio	5.2	7,615	7,839	0.0	2,244	2,244	0.0	4,703	4,702	16.3	19,531	22,632	28.1	23,290	31,104
Oklahoma	9.2	6,058	6,483	0.1	3,110	3,110	32.4	4,226	5,346	8.1	15,066	16,228	18.1	12,538	14,967
Oregon	10.4	7,502	8,131	2.5	2,573	2,629	11.6	6,424	6,928	18.0	17,499	20,795	34.3	18,555	27,255
Pennsylvania	8.6	9,244	9,932	0.2	3,576	3,573	27.9	4,475	5,572	4.9	16,874	17,591	18.6	22,085	26,688
Rhode Island	3.5	11,401	11,668	0.0	5,810	5,802	3.8	8,891	8,900	3.4	22,041	22,688	14.4	16,334	18,727
South Carolina	10.4	5,736	6,099	0.2	2,234	2,233	37.1	4,673	5,756	5.4	13,145	13,771	13.9	12,177	13,895
South Dakota	6.6	7,117	7,421	0.0	3,054	3,053	0.2	6,347	6,333	17.9	18,721	22,101	35.3	13,081	18,880
Tennessee	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>												
Texas	10.1	6,789	7,117	0.0	3,567	3,547	40.1	6,153	7,942	15.1	17,409	19,757	36.6	11,183	15,498
Utah	1.7	6,434	6,436	0.0	2,922	2,914	0.9	4,575	4,286	4.9	21,118	22,060	13.9	12,553	14,345
Vermont	4.5	7,633	<sup>4</sup>	–	<sup>4</sup>	<sup>4</sup>	–	<sup>4</sup>	<sup>4</sup>	8.3	<sup>4</sup>	<sup>4</sup>	27.8	<sup>4</sup>	<sup>4</sup>
Virginia	7.7	7,966	8,389	0.0	3,345	3,344	8.3	6,419	6,625	16.8	18,372	21,451	28.8	14,543	19,506
Washington	11.2	6,206	6,595	0.2	2,489	2,473	42.4	5,155	6,885	12.3	15,954	17,648	21.4	16,362	19,981
West Virginia	8.6	7,566	8,073	–	2,662	2,662	0.0	6,228	6,226	14.6	12,119	13,812	38.8	17,533	27,275
Wisconsin	9.8	6,548	7,079	4.2	1,980	2,023	18.5	3,254	3,616	4.8	18,513	19,253	9.5	16,055	17,570
Wyoming	7.6	7,748	8,004	0.9	2,445	2,462	15.4	5,944	6,195	15.9	23,625	26,850	37.6	26,327	39,833

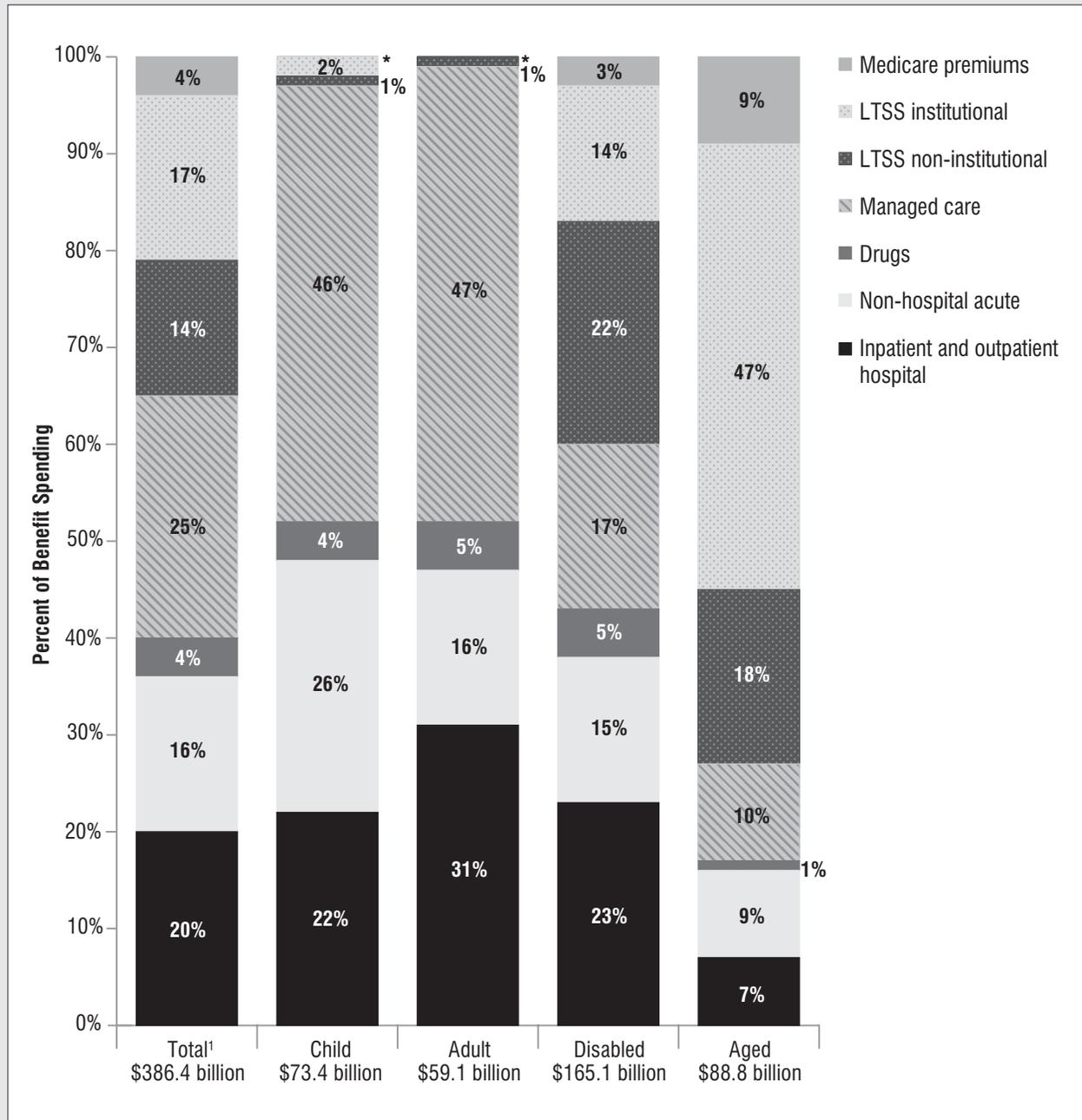
**Notes:** Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information.

Zeros indicate amounts less than 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

- 1 These percentages are likely to be underestimated because comparisons with other data sources indicate that some states do not identify all of their limited-benefit enrollees in MSIS.
- 2 Calculated by removing limited-benefit enrollees and their spending. In this table, enrollees with limited benefits are defined as those reported by states in MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services. Additional individuals may receive limited benefits for other reasons, but are not broken out here.
- 3 Maine (\$2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee (\$7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.
- 4 Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, MACPAC's adjustment methodology is only applied to total Medicaid spending.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

**FIGURE 3. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2011**



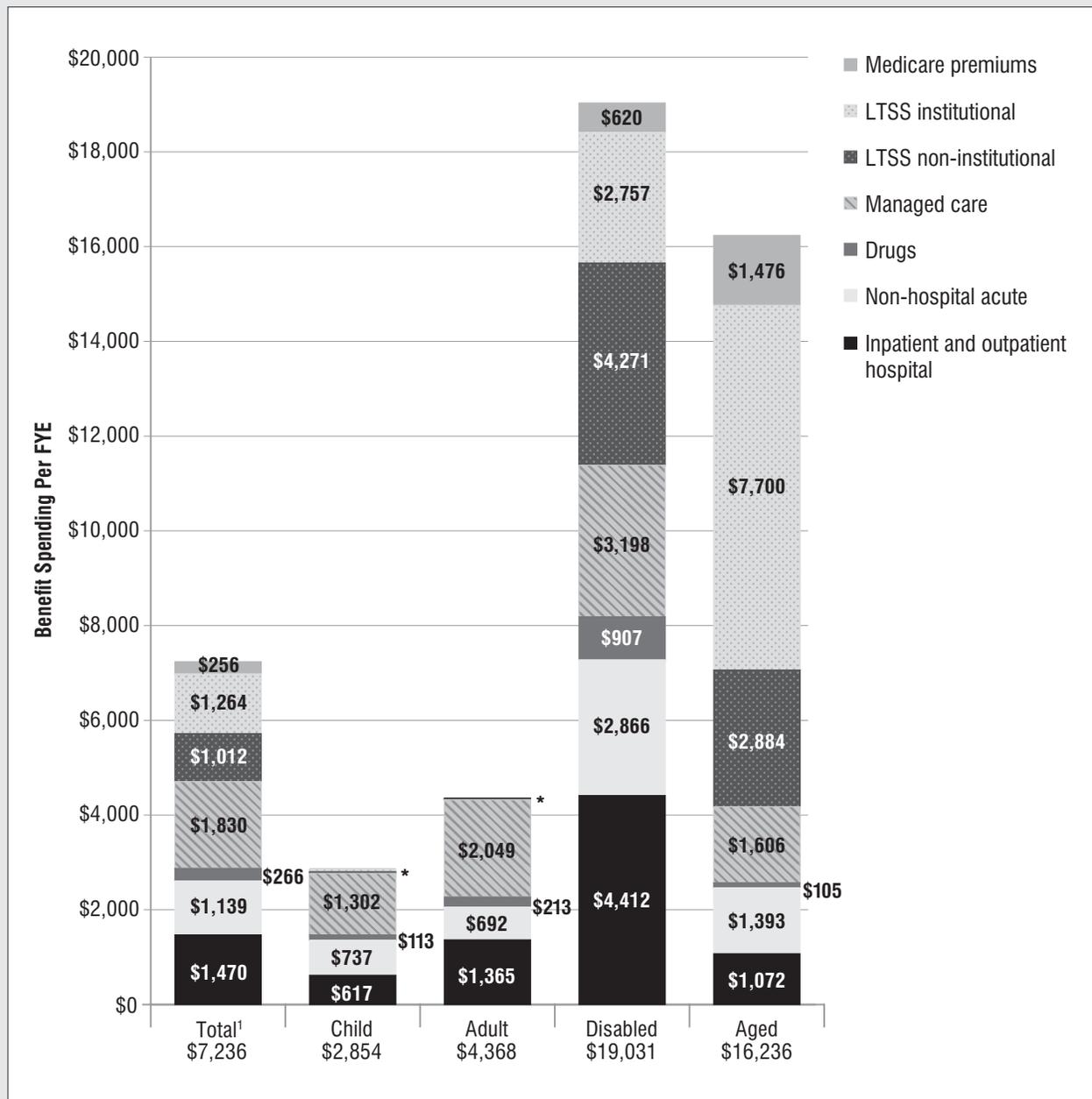
**Notes:** LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information.

\* Values less than 1 percent are not shown.

<sup>1</sup> Maine (\$2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee (\$7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

**FIGURE 4. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2011**



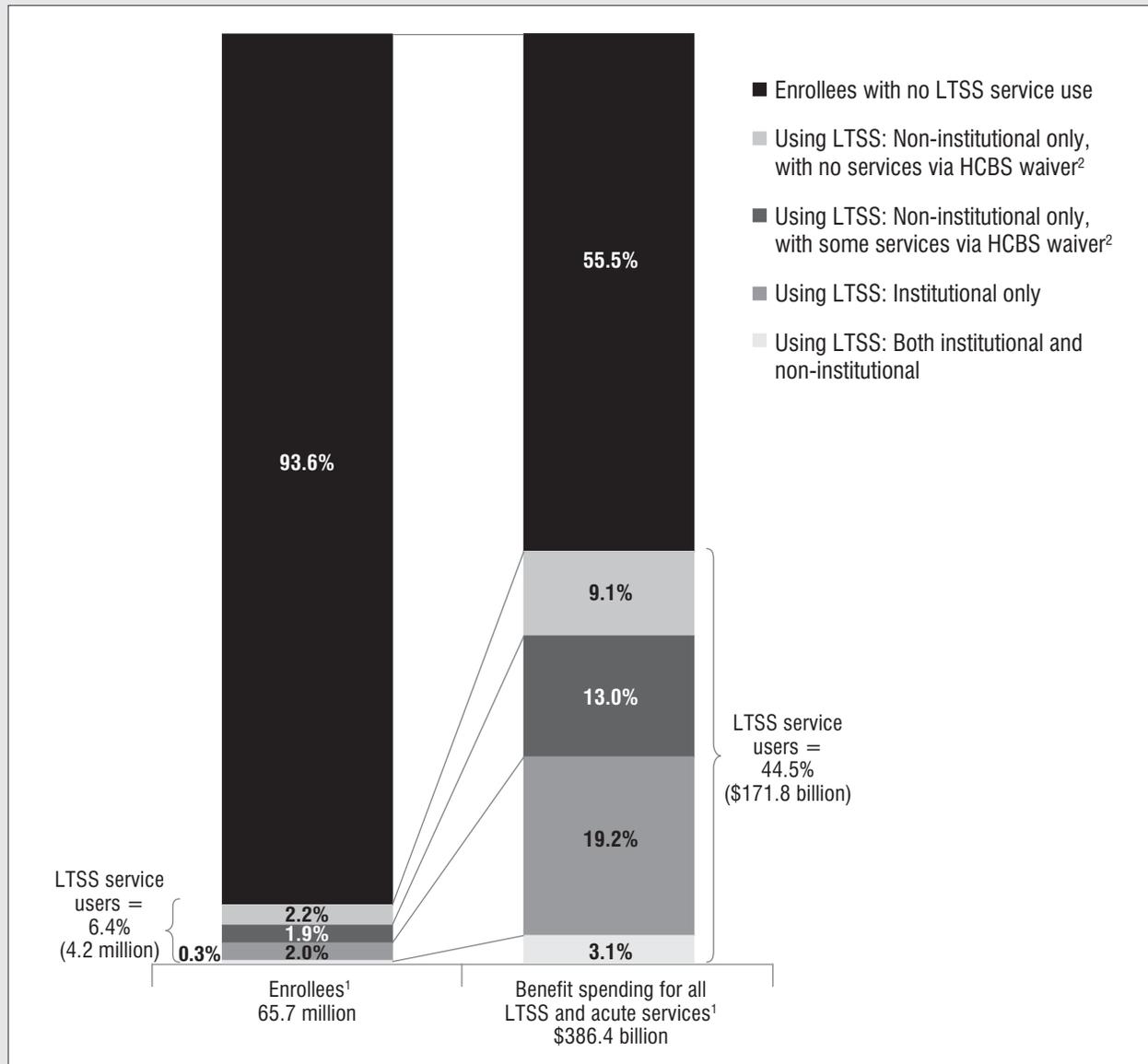
**Notes:** LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits (see Table 13 notes for more information). Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

\* Values less than \$100 not shown.

<sup>1</sup> Maine (\$2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee (\$7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

**FIGURE 5. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2011**



**Notes:** HCBS is home and community-based services. LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals and enrollment counts are unduplicated using unique national identification numbers. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

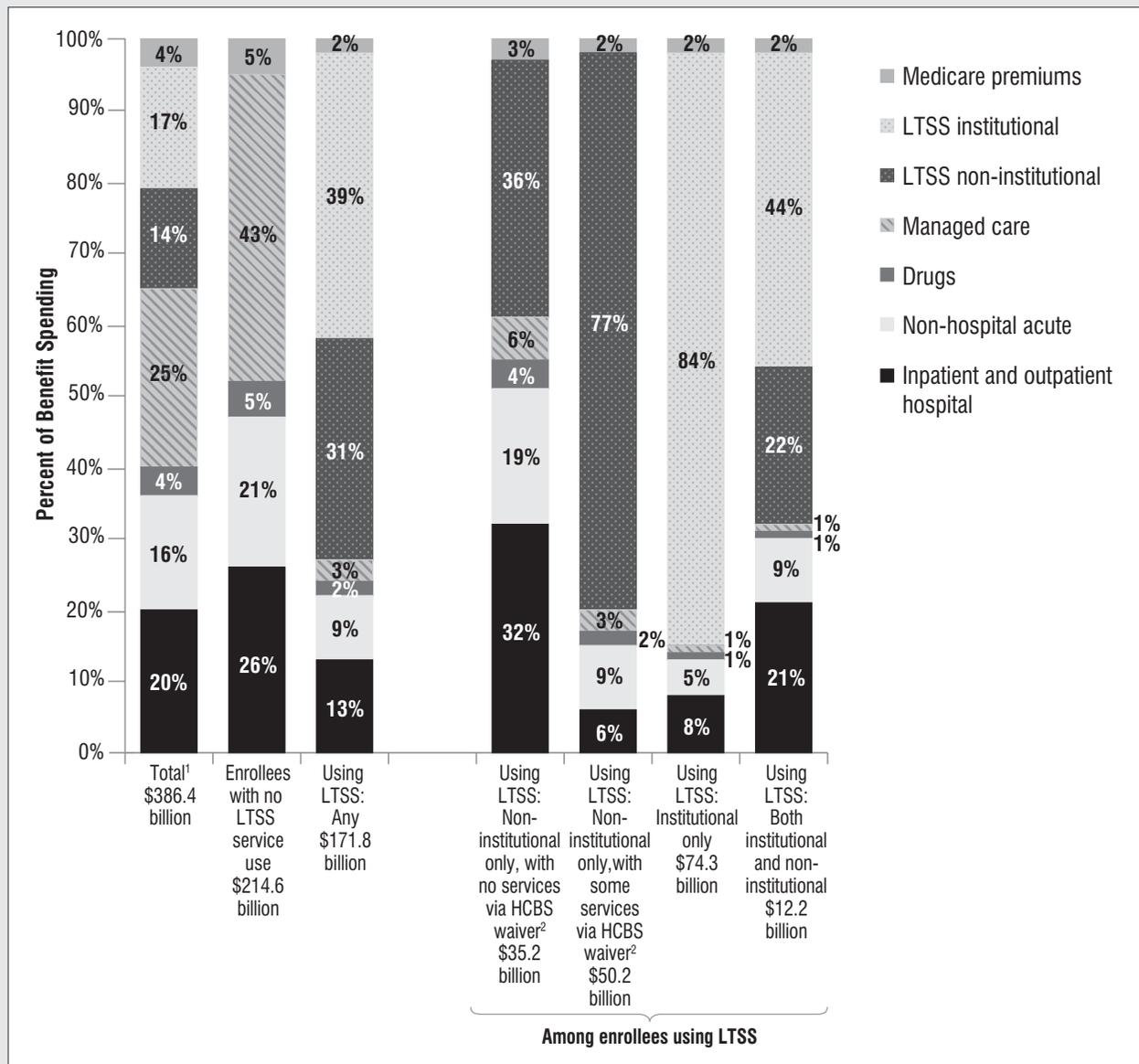
LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement, regardless of the amount. (The data do not allow a breakout of LTSS services delivered through managed care.) For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. More refined definitions that take these and other factors into account would produce different results and will be considered in future Commission work.

1 Maine (\$2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee (\$7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

2 All states have HCBS waivers that provide a range of LTSS for targeted populations of enrollees who require institutional levels of care. Based on a comparison with CMS-372 data (a state-reported source containing aggregate spending and enrollment for HCBS waivers), the number of HCBS waiver enrollees may be underreported in MSIS.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

**FIGURE 6. Distribution of Medicaid Benefit Spending by Long-Term Services and Supports Use and Service Category, FY 2011**



**Notes:** HCBS is home and community-based services. LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Amounts are fee for service unless other use noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

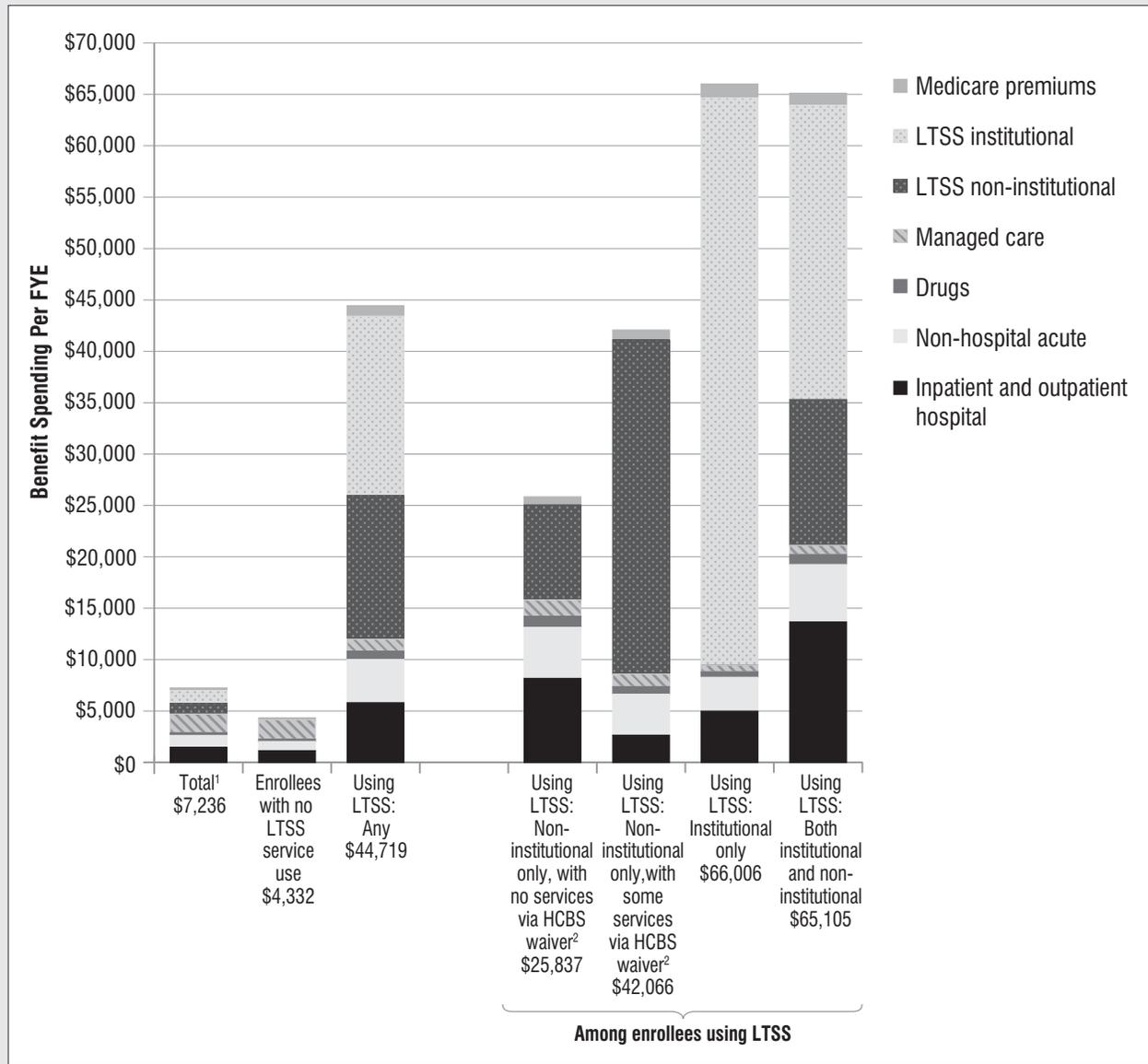
LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement, regardless of the amount. (The data do not allow a breakout of LTSS services delivered through managed care.) For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. More refined definitions that take these and other factors into account would produce different results and will be considered in future Commission work.

1 Maine (\$2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee (\$7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.

2 All states have HCBS waivers that provide a range of LTSS for targeted populations of enrollees who require institutional levels of care. Based on a comparison with CMS-372 data (a state-reported source containing aggregate spending and enrollment for HCBS waivers), the number of HCBS waiver enrollees may be underreported in MSIS.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.

**FIGURE 7. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Long-Term Services and Supports Use and Service Category, FY 2011**



**Notes:** HCBS is home and community-based services. LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and enrollees in the territories and in Medicaid-expansion CHIP. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits (see Table 13 notes for more information). Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files.

LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement, regardless of the amount. The data do not allow a breakout of LTSS services delivered through managed care. For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users. More refined definitions that take these and other factors into account would produce different results and will be considered in future Commission work.

- 1 Maine (\$2.3 billion in benefit spending and 0.4 million enrollees) and Tennessee (\$7.9 billion in benefit spending and 1.5 million enrollees) were excluded due to MSIS spending data anomalies.
- 2 All states have HCBS waivers that provide a range of LTSS for targeted populations of enrollees who require institutional levels of care. Based on a comparison with CMS-372 data (a state-reported source containing aggregate spending and enrollment for HCBS waivers), the number of HCBS waiver enrollees may be underreported in MSIS.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.







## Key Points

### Medicaid Managed Care

- ▶ The term managed care may refer to several different arrangements, including comprehensive risk-based and limited-benefit plans that provide a contracted set of services in exchange for a capitated (per member per month) payment, as well as primary care case management (PCCM) programs that typically pay primary care providers a small monthly fee to coordinate enrollees' care. Depending on the definition that is used, the national percentage of Medicaid enrollees in managed care ranges from about half (reflecting individuals in comprehensive risk-based plans) to more than 70 percent (Table 14).
- ▶ The use of managed care varies widely by state, both in the arrangements used and the populations served. In fiscal year (FY) 2011, nearly all states reported using some form of managed care, including comprehensive risk-based plans, limited-benefit plans, or PCCM programs (Table 14).
- ▶ The national percentage of Medicaid enrollees in any form of managed care ranged from 41 percent among enrollees age 65 and older to 87 percent among non-disabled child enrollees in FY 2011 (Table 14). Participation in comprehensive risk-based managed care plans was lowest among the aged and disabled eligibility groups (14 and 33 percent, respectively) and highest among non-disabled adults and children (48 and 63 percent).
- ▶ For individuals dually enrolled in Medicaid and Medicare, enrollment in Medicaid limited-benefit plans (which typically cover only behavioral health, transportation, or dental services) is more common than enrollment in Medicaid comprehensive risk-based plans or PCCM programs. Forty-one percent of individuals dually enrolled in Medicaid and Medicare were enrolled in some form of Medicaid managed care in FY 2011 (Table 14).
- ▶ The national percentage of Medicaid benefit spending on any form of managed care ranges from about 10 percent among enrollees age 65 and older to more than 40 percent among non-disabled child and adult enrollees (Table 15). In states with comprehensive risk-based managed care, these plans account for the majority of managed care spending.

**TABLE 14. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2011**

State	Any managed care						Comprehensive risk-based managed care					
	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>
<b>Total<sup>2</sup></b>	<b>71.8%</b>	<b>86.5%</b>	<b>61.0%</b>	<b>64.9%</b>	<b>41.0%</b>	<b>41.4%</b>	<b>49.8%</b>	<b>63.3%</b>	<b>48.0%</b>	<b>33.0%</b>	<b>13.9%</b>	<b>13.2%</b>
Alabama	52.2	72.3	25.8	44.5	16.3	17.2	3.1	–	0.0	7.0	14.8	15.6
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	92.9	97.3	90.9	94.0	74.0	79.7	86.3	91.3	83.1	88.6	68.3	74.8
Arkansas	80.6	98.2	49.6	78.1	46.9	47.1	0.0	–	0.0	–	0.1	0.1
California	58.2	76.3	28.8	91.5	88.2	91.0	40.8	64.9	24.6	35.4	18.7	19.1
Colorado	91.1	95.0	89.5	85.6	76.7	72.6	12.7	13.4	11.7	12.9	10.4	8.6
Connecticut	59.2	95.1	57.2	0.9	0.0	0.7	59.2	95.1	57.2	0.9	0.0	0.7
Delaware	87.6	95.9	88.8	74.6	47.9	47.6	78.5	90.8	84.9	49.1	6.6	5.6
District of Columbia	94.7	98.0	96.1	93.8	74.9	71.5	72.4	90.3	91.9	20.5	1.2	2.4
Florida	71.0	90.5	69.8	54.6	15.6	11.7	71.0	90.5	69.8	54.6	15.6	11.7
Georgia	88.1	97.4	90.5	74.0	51.2	50.5	68.8	93.6	85.1	4.6	0.0	0.7
Hawaii	95.3	97.3	95.0	94.3	88.1	88.2	95.3	97.3	95.0	94.3	88.1	88.2
Idaho	–	–	–	–	–	–	–	–	–	–	–	–
Illinois	71.8	85.3	78.1	37.6	8.5	3.9	7.7	9.2	6.7	6.7	3.0	0.4
Indiana	76.9	93.9	89.9	36.2	2.8	3.5	71.2	90.9	89.8	12.1	0.2	1.4
Iowa	79.1	95.9	49.8	91.0	74.7	79.8	0.0	–	–	0.1	0.2	0.1
Kansas	82.2	96.6	79.6	62.8	38.8	42.3	57.0	81.8	67.8	3.2	0.5	0.8
Kentucky	79.8	91.4	90.8	62.0	54.2	50.6	17.7	23.2	19.4	11.4	5.7	6.7
Louisiana	58.9	83.0	38.1	40.1	1.8	3.3	0.0	–	–	0.0	0.2	0.1
Maine	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>
Maryland	73.4	96.0	64.7	57.0	1.3	4.3	73.4	96.0	64.7	57.0	1.3	4.3
Massachusetts	74.0	90.6	82.8	65.3	16.9	14.8	50.2	62.5	61.1	32.0	15.7	12.5
Michigan	89.2	96.3	77.1	90.7	80.7	84.4	71.7	87.1	70.5	52.2	3.4	5.9
Minnesota	68.4	85.3	70.2	13.0	58.7	43.2	68.4	85.3	70.2	13.0	58.7	43.2
Mississippi	9.2	0.5	0.2	40.5	1.0	1.1	9.2	0.5	0.2	40.5	1.0	1.1

**TABLE 14, Continued**

State	Any managed care						Comprehensive risk-based managed care					
	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>
Missouri	<b>69.7%</b>	67.0%	49.4%	91.4%	86.1%	87.5%	<b>44.5%</b>	67.0%	49.0%	1.6%	0.0%	0.3%
Montana	<b>70.3</b>	88.4	75.1	46.2	1.0	2.2	–	–	–	–	–	–
Nebraska	<b>45.0</b>	53.7	49.4	24.7	5.5	2.4	<b>45.0</b>	53.7	49.4	24.7	5.5	2.4
Nevada	<b>82.7</b>	87.6	86.7	71.6	52.0	47.6	<b>57.6</b>	72.1	71.6	2.0	0.0	0.4
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	<b>83.5</b>	89.2	60.9	91.1	83.1	83.8	<b>67.9</b>	87.0	54.9	61.2	18.0	20.5
New Mexico	<b>67.6</b>	79.3	68.6	45.0	3.6	5.0	<b>67.0</b>	79.1	67.1	44.2	3.4	4.6
New York	<b>66.9</b>	80.1	74.0	50.7	15.9	13.3	<b>66.9</b>	80.1	74.0	50.7	15.9	13.3
North Carolina	<b>82.8</b>	96.8	77.6	75.5	33.1	43.2	<b>0.0</b>	–	–	0.0	0.1	0.1
North Dakota	<b>57.8</b>	75.6	74.9	9.1	1.3	1.0	<b>2.3</b>	4.0	0.1	0.2	0.7	0.4
Ohio	<b>76.2</b>	92.8	92.7	38.6	5.1	6.3	<b>76.2</b>	92.8	92.7	38.6	5.1	6.3
Oklahoma	<b>84.0</b>	96.5	57.0	84.8	79.4	77.6	<b>0.0</b>	–	–	0.0	0.1	0.0
Oregon	<b>88.9</b>	96.0	86.7	82.6	66.5	65.3	<b>76.8</b>	86.2	80.2	63.0	35.7	38.0
Pennsylvania	<b>86.5</b>	95.7	78.2	91.9	49.9	64.9	<b>60.0</b>	75.0	60.5	54.0	8.0	8.3
Rhode Island	<b>60.0</b>	88.0	79.1	17.1	0.1	1.0	<b>60.0</b>	88.0	79.1	17.1	0.1	1.0
South Carolina	<b>86.0</b>	94.9	69.7	86.9	79.0	80.6	<b>52.1</b>	68.6	52.7	30.9	0.6	2.6
South Dakota	<b>45.6</b>	58.7	54.9	13.8	0.3	0.8	–	–	–	–	–	–
Tennessee	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>
Texas	<b>75.5</b>	93.3	54.5	49.8	22.1	24.4	<b>52.9</b>	65.6	35.0	32.5	21.7	23.0
Utah	<b>89.0</b>	97.5	68.5	91.7	82.5	87.2	<b>3.4</b>	5.3	0.1	1.9	0.1	0.9
Vermont	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>
Virginia	<b>65.8</b>	83.3	68.7	41.5	13.6	8.3	<b>60.5</b>	78.7	64.6	35.3	4.0	1.8
Washington	<b>84.3</b>	96.4	69.0	73.5	58.2	59.0	<b>84.0</b>	96.3	68.8	71.9	58.1	59.0
West Virginia	<b>55.1</b>	90.2	79.1	2.7	0.0	0.5	<b>52.8</b>	86.5	76.9	2.0	0.0	0.4
Wisconsin	<b>85.1</b>	95.1	89.8	88.7	32.5	52.3	<b>80.4</b>	95.1	89.7	65.2	18.5	35.6
Wyoming	–	–	–	–	–	–	–	–	–	–	–	–

**TABLE 14, Continued. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2011**

State	Percentage of Enrollees											
	Limited-benefit plan						Primary care case management					
	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>
<b>Total<sup>2</sup></b>	<b>35.8%</b>	<b>41.2%</b>	<b>25.4%</b>	<b>41.6%</b>	<b>31.3%</b>	<b>32.0%</b>	<b>13.4%</b>	<b>18.7%</b>	<b>9.0%</b>	<b>12.0%</b>	<b>1.8%</b>	<b>2.4%</b>
Alabama	2.3	0.4	11.8	0.4	—	0.0	47.2	72.2	15.1	37.4	1.5	1.7
Alaska	—	—	—	—	—	—	—	—	—	—	—	—
Arizona	88.3	96.3	89.9	71.7	54.6	60.5	—	—	—	—	—	—
Arkansas	79.4	96.4	48.5	78.0	46.7	46.8	61.8	87.8	25.8	55.0	4.1	5.5
California	54.6	70.1	26.5	90.8	87.0	90.3	—	—	—	—	—	—
Colorado	90.9	95.0	89.5	85.4	74.4	71.1	—	—	—	—	—	—
Connecticut	—	—	—	—	—	—	—	—	—	—	—	—
Delaware	87.5	95.7	88.8	74.5	47.9	47.6	—	—	—	—	—	—
District of Columbia	31.8	15.3	16.9	83.8	74.6	70.3	—	—	—	—	—	—
Florida	—	—	—	—	—	—	—	—	—	—	—	—
Georgia	87.5	96.7	89.4	73.9	51.2	50.5	7.6	0.1	0.0	44.2	2.9	3.2
Hawaii	0.5	1.1	—	0.6	—	—	—	—	—	—	—	—
Idaho <sup>2</sup>	—	—	—	—	—	—	—	—	—	—	—	—
Illinois	3.2	4.4	3.1	0.1	—	0.0	65.5	76.9	72.3	35.9	8.0	3.7
Indiana	—	—	—	—	—	—	9.9	3.5	18.1	24.9	2.7	2.6
Iowa	79.0	95.9	49.8	91.0	74.7	79.8	38.8	62.9	29.1	1.5	0.0	0.2
Kansas	82.1	96.6	79.4	62.6	38.3	42.0	4.5	3.0	1.2	13.3	1.2	0.9
Kentucky	79.6	91.2	90.8	61.8	54.1	50.5	40.4	61.4	58.8	6.6	0.7	0.7
Louisiana	—	—	—	—	—	—	58.8	83.0	38.1	40.1	1.6	3.2
Maine	2	2	2	2	2	2	2	2	2	2	2	2
Maryland	—	—	—	—	—	—	—	—	—	—	—	—
Massachusetts	29.0	35.9	26.6	38.3	1.3	2.7	—	—	—	—	—	—
Michigan	85.3	96.2	63.5	90.1	80.2	84.1	—	—	—	—	—	—
Minnesota	—	—	—	—	—	—	—	—	—	—	—	—
Mississippi	—	—	—	—	—	—	—	—	—	—	—	—
Missouri <sup>2</sup>	25.5	0.1	0.7	91.0	86.1	87.4	—	—	—	—	—	—
Montana	—	—	—	—	—	—	70.3	88.4	75.1	46.2	1.0	2.2
Nebraska	—	—	—	—	—	—	—	—	—	—	—	—
Nevada	82.6	87.5	86.5	71.6	52.0	47.6	—	—	—	—	—	—
New Hampshire	—	—	—	—	—	—	—	—	—	—	—	—
New Jersey	82.5	88.8	56.8	90.9	82.9	83.6	—	—	—	—	—	—

**TABLE 14, Continued**

State	Percentage of Enrollees						Primary care case management					
	Total	Limited-benefit plan			Dual-eligible enrollees <sup>1</sup>	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>	
		Children	Adults	Disabled	Aged							
New Mexico	<b>60.8%</b>	79.3%	43.3%	43.6%	1.9%	3.2%	—	—	—	—	—	
New York	—	—	—	—	—	—	—	—	—	—	—	
North Carolina	<b>75.0</b>	93.9	75.3	56.5	6.4	10.8	<b>78.4%</b>	94.8%	70.2%	66.7%	29.7%	39.4%
North Dakota	<b>5.0</b>	5.0	5.9	7.4	0.5	0.3	<b>55.3</b>	73.7	73.6	1.8	0.0	0.3
Ohio	—	—	—	—	—	—	—	—	—	—	—	—
Oklahoma	<b>81.9</b>	96.4	48.8	84.7	79.3	77.6	<b>57.3</b>	77.3	41.7	36.8	1.2	2.3
Oregon	<b>88.7</b>	95.7	86.7	82.5	66.4	65.2	<b>0.4</b>	0.3	0.1	0.7	0.8	0.7
Pennsylvania	<b>85.9</b>	95.4	76.9	91.6	48.9	64.2	<b>16.8</b>	21.0	16.4	15.9	1.0	1.7
Rhode Island	—	—	—	—	—	—	—	—	—	—	—	—
South Carolina	<b>80.4</b>	88.6	61.5	84.1	78.9	80.1	<b>17.3</b>	21.8	11.6	17.2	7.7	10.8
South Dakota	—	—	—	—	—	—	<b>45.6</b>	58.7	54.9	13.8	0.3	0.8
Tennessee	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>
Texas	<b>10.9</b>	13.3	5.5	9.5	4.2	4.6	<b>25.0</b>	31.3	21.0	15.9	0.3	1.0
Utah	<b>89.0</b>	97.5	68.5	91.7	82.5	87.2	—	—	—	—	—	—
Vermont	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>
Virginia	—	—	—	—	—	—	<b>5.5</b>	4.8	4.2	6.4	9.7	6.5
Washington	—	—	—	—	—	—	<b>1.4</b>	0.9	1.0	3.8	0.4	0.3
West Virginia	—	—	—	—	—	—	<b>2.4</b>	4.0	2.5	0.7	0.0	0.0
Wisconsin	<b>6.3</b>	0.2	0.1	33.3	15.4	19.0	—	—	—	—	—	—
Wyoming	—	—	—	—	—	—	—	—	—	—	—	—

**Notes:** Excludes the territories and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, figures shown here are not directly comparable to earlier years. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs. Enrollees are counted as participating in managed care if they were enrolled during the fiscal year and at least one managed care payment was made on their behalf during the fiscal year; this method underestimates participation somewhat because it does not capture enrollees who entered managed care late in the year but for whom a payment was not made until the following fiscal year. Managed care types do not sum to total because individuals are counted in every category for which a payment was made on their behalf during the year.

Zeros indicate amounts less than 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

- 1 Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; these figures include those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For dually eligible enrollees in a comprehensive Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state.
- 2 Maine (0.4 million enrollees) and Tennessee (1.5 million enrollees) were excluded due to MSIS spending data anomalies.
- 3 Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, managed care enrollment (which, for this table, is based on the presence of managed care spending in MSIS for a given enrollee) is not reported here.

**Source:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data from CMS as of February 2014.

**TABLE 15. Percentage of Medicaid Benefit Spending on Managed Care by State and Eligibility Group, FY 2011**

State	Any managed care						Comprehensive risk-based managed care					
	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>
<b>Total<sup>2</sup></b>	<b>25.3%</b>	<b>45.6%</b>	<b>46.9%</b>	<b>16.8%</b>	<b>9.9%</b>	<b>8.7%</b>	<b>23.9%</b>	<b>44.2%</b>	<b>46.1%</b>	<b>15.1%</b>	<b>8.6%</b>	<b>6.8%</b>
Alabama	2.3	1.6	13.3	0.8	1.0	1.3	0.5	—	0.0	0.5	1.0	1.3
Alaska	—	—	—	—	—	—	—	—	—	—	—	—
Arizona	84.4	85.4	87.0	83.0	80.1	81.1	83.3	84.3	85.2	82.7	79.4	80.5
Arkansas	0.4	1.1	0.5	0.2	0.1	0.1	0.0	—	0.0	—	0.0	0.0
California	20.7	47.9	20.1	12.8	14.9	15.9	19.8	47.4	19.9	12.4	12.7	14.1
Colorado	12.1	17.1	10.4	11.0	10.4	10.2	6.1	5.7	5.5	4.8	9.5	6.9
Connecticut	14.4	48.4	32.5	0.1	0.0	0.1	14.4	48.4	32.5	0.1	0.0	0.1
Delaware	50.6	65.4	83.6	30.4	2.7	2.2	50.5	65.3	83.5	30.3	2.5	2.0
District of Columbia	29.7	67.7	79.2	12.3	1.1	1.8	28.8	67.1	79.1	10.9	0.2	0.4
Florida	18.1	34.5	21.2	15.0	10.0	5.9	18.1	34.5	21.2	15.0	10.0	5.9
Georgia	35.4	84.3	81.8	1.4	0.3	0.7	35.2	84.3	81.8	1.0	0.0	0.4
Hawaii	78.2	76.8	79.5	66.8	89.4	79.2	78.2	76.8	79.5	66.8	89.4	79.2
Idaho	—	—	—	—	—	—	—	—	—	—	—	—
Illinois	2.9	5.3	6.1	1.1	0.9	0.2	2.1	3.4	4.2	1.0	0.9	0.2
Indiana	18.1	54.3	70.0	2.3	0.1	0.2	17.9	54.1	70.0	2.1	0.0	0.2
Iowa	4.8	10.7	6.3	4.1	1.2	2.4	0.1	—	—	0.1	0.2	0.2
Kansas	24.2	59.9	71.2	9.8	2.4	3.4	18.6	53.9	70.4	1.1	0.6	0.5
Kentucky	12.9	24.3	21.6	9.5	1.8	2.1	11.9	21.7	20.4	9.1	1.4	1.8
Louisiana	0.2	0.6	0.1	0.1	0.4	0.2	0.1	—	—	0.0	0.4	0.2
Maine	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>
Maryland	38.3	56.0	79.6	29.0	0.8	1.9	38.3	56.0	79.6	29.0	0.8	1.9
Massachusetts	29.4	49.3	58.6	19.8	15.6	9.6	26.5	44.8	54.4	16.5	15.6	9.5
Michigan	51.2	71.4	71.9	54.0	7.1	20.9	45.0	69.8	70.8	43.2	2.1	3.8
Minnesota	39.0	78.1	78.0	3.9	41.7	22.4	39.0	78.1	78.0	3.9	41.7	22.4
Mississippi	6.1	0.3	0.3	13.5	0.2	0.2	6.1	0.3	0.3	13.5	0.2	0.2
Missouri	14.8	47.0	43.0	0.8	0.9	0.9	14.4	47.0	43.0	0.2	0.0	0.0
Montana	0.8	2.4	0.9	0.3	0.0	0.0	—	—	—	—	—	—
Nebraska	14.8	22.7	40.7	10.9	2.2	0.6	14.8	22.7	40.7	10.9	2.2	0.6
Nevada	22.4	51.5	58.7	0.4	0.3	0.4	22.1	51.2	58.5	0.2	0.0	0.1
New Hampshire	—	—	—	—	—	—	—	—	—	—	—	—
New Jersey	24.4	58.3	71.7	18.4	5.0	4.6	24.0	58.2	71.6	18.1	4.2	3.9

**TABLE 15, Continued**

State	Any managed care						Comprehensive risk-based managed care					
	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>	Total	Children	Adults	Disabled	Aged	Dual-eligible enrollees <sup>1</sup>
New Mexico	68.5%	78.0%	83.3%	47.2%	15.4%	5.9%	68.5%	78.0%	83.3%	47.2%	15.5%	5.9%
New York	22.4	52.5	50.3	10.1	10.6	7.0	22.4	52.5	50.3	10.1	10.6	7.0
North Carolina	3.5	5.3	4.0	3.6	0.9	1.9	0.1	—	—	0.0	0.2	0.2
North Dakota	0.7	2.2	0.4	0.1	0.8	0.5	0.5	1.5	0.0	0.0	0.8	0.5
Ohio	32.8	71.4	80.2	20.7	2.5	2.5	32.8	71.4	80.2	20.7	2.5	2.5
Oklahoma	4.1	5.3	1.9	3.6	4.7	3.9	0.2	—	—	0.0	1.1	0.2
Oregon	47.0	79.8	81.0	36.3	6.6	9.3	45.3	75.8	80.0	34.3	6.0	8.1
Pennsylvania	47.5	84.7	76.4	49.1	7.3	7.3	43.7	79.6	74.4	44.9	4.9	4.0
Rhode Island	35.9	75.3	84.8	13.2	0.0	0.3	35.9	75.3	84.8	13.2	0.0	0.3
South Carolina	28.8	49.5	58.3	20.0	1.8	2.4	28.1	48.2	57.9	19.7	0.3	1.3
South Dakota	0.2	0.7	0.3	0.0	0.0	0.0	—	—	—	—	—	—
Tennessee	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>	<sup>2</sup>
Texas	21.3	38.4	26.3	11.5	8.5	8.9	21.1	37.9	26.1	11.4	8.5	8.9
Utah	21.0	23.0	11.2	25.6	9.4	22.9	1.3	3.0	0.0	1.1	0.1	0.8
Vermont	21.7	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>
Virginia	27.7	43.1	62.8	21.8	4.3	1.0	27.7	43.0	62.8	21.8	4.3	0.9
Washington	26.6	69.8	57.6	3.6	1.6	1.6	26.6	69.8	57.6	3.5	1.6	1.6
West Virginia	12.8	47.2	51.8	0.2	0.0	0.1	12.8	47.1	51.8	0.2	0.0	0.1
Wisconsin	44.3	55.9	58.5	39.2	38.7	40.9	21.8	55.8	58.3	7.3	7.5	7.0
Wyoming	—	—	—	—	—	—	—	—	—	—	—	—

**Notes:** Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See Section 5 of MACStats for additional information. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs.

Zeros indicate amounts less than 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

- Dually eligible enrollees are individuals who are covered by both Medicaid and Medicare; these figures include those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For dually eligible enrollees in a comprehensive Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state.
- Maine (\$2.3 billion in benefit spending) and Tennessee (\$7.9 billion in benefit spending) were excluded due to MSIS spending data anomalies.
- Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, benefit spending based on MACPAC's adjustment methodology is not reported at a level lower than total Medicaid managed care.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of February 2014.





## Technical Guide to the June 2014 MACStats

This section provides supplemental information to accompany the tables and figures in Sections 1–4 of MACStats. It describes some of the data sources used in MACStats, the methods that MACPAC uses to analyze these data, and reasons why numbers in MACStats tables and figures—such as those on enrollment and spending—may differ from each other or from those published elsewhere.

### Interpreting Medicaid and CHIP Enrollment and Spending Numbers

Previous MACPAC reports have discussed reasons why estimates of Medicaid and State Children’s Health Insurance Program (CHIP) enrollment and spending may vary.<sup>1</sup> Here, Tables 16–19 are used to illustrate how various factors can affect enrollment numbers. Table 16 shows enrollment numbers for the entire U.S. population in 2011.<sup>2</sup> Tables 17–19 divide the U.S. population into the three age groups that are commonly used in MACPAC analyses because they correspond to some of the key eligibility pathways in Medicaid and CHIP: children age 0 to 18; adults age 19 to 64; and adults age 65 and older.

#### Data sources

Medicaid and CHIP enrollment and spending numbers are available from administrative data, which states and the federal government compile in the course of administering these programs. The latest year of available data may differ, depending on the source. The administrative data used in this edition of MACStats include the following, which are submitted by the states to the Centers for Medicare & Medicaid Services (CMS):

- ▶ Form CMS-64 data for state-level Medicaid spending, which is used throughout MACStats;

- ▶ Medicaid Statistical Information System (MSIS) data for person-level detail, which is used throughout MACStats;<sup>3</sup>
- ▶ Medicaid managed care enrollment reports, which are used in previous editions of MACStats; and
- ▶ Statistical Enrollment Data System (SEDS) data for CHIP enrollment, used in Tables 16–19.

Additional information is available from nationally representative surveys based on interviews of individuals. The survey data used in Tables 2–10 are from the federal National Health Interview Survey (NHIS), which is described below in more detail.

Tables 16–19 show 2011 survey-based estimates of Medicaid/CHIP enrollment as well as comparable (point-in-time) estimates from the administrative data. Estimates of Medicaid/CHIP enrollment from survey data tend to be lower than numbers from administrative data because survey respondents tend to underreport Medicaid and CHIP, among other reasons described later in this section.

## Enrollment period examined

The number of individuals enrolled at a particular point during the year will be lower than the total number enrolled at any point during an entire year. For example, the administrative data in Table 17 show that 51.3 percent of children (40.3 million) were enrolled in Medicaid or CHIP at some time during fiscal year (FY) 2011. However, numbers from the same data source illustrate that the number of children enrolled at a particular point in time (32.4 million, or approximately 41.3 percent of children) is much smaller than the number ever enrolled during the year.

Point-in-time data may also be referred to as average monthly enrollment or full-year equivalent enrollment.<sup>4</sup> Full-year equivalent enrollment is

often used for budget analyses (such as those by the CMS Office of the Actuary) and when comparing enrollment and expenditure numbers (such as in Figure 1). Per enrollee spending levels based on full-year equivalents (Table 13) ensure that amounts are not biased by individuals' transitions in and out of Medicaid coverage during the year.

## Enrollees versus beneficiaries

Depending on the source and the year in question, data may include slightly different numbers of individuals in Medicaid. Certain terms commonly used to refer to people with Medicaid have very specific definitions in administrative data sources provided by CMS:<sup>5</sup>

- ▶ Enrollees (less commonly referred to as eligibles) are individuals who are eligible for and enrolled in Medicaid or CHIP. Prior to FY 1990, CMS did not track the number of Medicaid enrollees, only beneficiaries. For some historical numbers, CMS has estimated the number of enrollees prior to FY 1990 (Figure 1).
- ▶ Beneficiaries or persons served (less commonly referred to as recipients) are enrollees who receive covered services or for whom Medicaid or CHIP payments are made. Prior to FY 1998, individuals were not counted as beneficiaries if managed care payments were the only Medicaid payments made on their behalf. Beginning in FY 1998, however, Medicaid managed care enrollees with no fee-for-service (FFS) spending were also counted as beneficiaries, which had a large impact on the numbers (Table 1).<sup>6</sup>

The following example illustrates the difference in these terms. In FY 2011, there were 32 million non-disabled child Medicaid enrollees (Table 11). However, there were 30.2 million beneficiaries in this eligibility group—that is, during FY 2011, a Medicaid FFS or managed care capitation payment

was made on their behalf (Table 1).<sup>7</sup> Generally, the number of beneficiaries will approach the number of enrollees as more of these individuals use Medicaid-covered services or are enrolled in managed care.

## Institutionalized and limited-benefit enrollees

Administrative Medicaid data include enrollees who were in institutions such as nursing homes, as well as individuals who received only limited benefits (for example, only coverage for emergency services). Survey data tend to exclude such individuals from counts of coverage; the NHIS estimates in Tables 2–10 do not include the institutionalized.

Table 19 shows point-in-time enrollment among those age 65 and older—5.6 million from the administrative data and 3.1 million from the survey data (NHIS). In percentage terms, the difference between the administrative data and the survey data is largest for this age group. This is primarily because the NHIS excludes the institutionalized and because, when Medicaid pays only for Medicare enrollees' cost sharing, the NHIS generally does not count it as Medicaid coverage. Based on administrative data, 1.6 million Medicaid enrollees age 65 and older received only limited benefits from Medicaid.

## State Children's Health Insurance Program Enrollees

Medicaid-expansion CHIP enrollees are children who are entitled to the covered services of a state's Medicaid program, but whose Medicaid coverage is generally funded with CHIP dollars. Depending on the data source, Medicaid enrollment and spending figures may include both Medicaid enrollees funded with Medicaid dollars and Medicaid-expansion CHIP enrollees funded with CHIP dollars. We

generally exclude Medicaid-expansion CHIP enrollees from Medicaid analyses where possible in MACStats, but in some cases data sources do not allow these children to be broken out separately.

## Methodology for Adjusting Benefit Spending Data

The FY 2011 Medicaid benefit spending amounts shown in the June 2014 MACStats were calculated based on MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.<sup>8</sup> Although the CMS-64 provides a more complete accounting of spending and is preferred when examining state or federal spending totals, MSIS is the only data source that allows for analysis of benefit spending by eligibility group and other enrollee characteristics.<sup>9</sup> We adjust the MSIS amounts for several reasons:

- ▶ CMS-64 data provide an official accounting of state spending on Medicaid for purposes of receiving federal matching dollars; in contrast, MSIS data are used primarily for statistical purposes.
- ▶ MSIS generally understates total Medicaid benefit spending because it excludes disproportionate share hospital payments and additional types of supplemental payments made to hospitals and other providers, Medicare premium payments, and certain other amounts.<sup>10</sup>
- ▶ MSIS generally overstates net spending on prescribed drugs because it excludes rebates from drug manufacturers.
- ▶ Even after accounting for differences in their scope and design, MSIS still tends to produce lower total benefit spending than the CMS-64.<sup>11</sup>
- ▶ The extent to which MSIS differs from the CMS-64 varies by state, meaning that a cross-state comparison of unadjusted MSIS amounts

may not reflect true differences in benefit spending. See Table 20 for unadjusted benefit spending amounts in MSIS as a percentage of benefit spending in the CMS-64.

The methodology MACPAC uses for adjusting the MSIS benefit spending data involves the following steps:

- ▶ MACPAC aggregates the service types into broad categories that are comparable between the two sources. This is necessary because there is not a one-to-one correspondence of service types in the MSIS and CMS-64 data. Even service types that have identical names may still be reported differently in the two sources due to differences in the instructions given to states. Table 21 provides additional detail on the categories used.
- ▶ MACPAC calculates state-specific adjustment factors for each of the service categories by dividing CMS-64 benefit spending by MSIS benefit spending.
- ▶ MACPAC then multiplies MSIS dollar amounts in each service category by the state-specific factors to obtain adjusted MSIS spending. For example, in a state with a FFS hospital factor of 1.2, each Medicaid enrollee with hospital spending in MSIS would have that spending multiplied by 1.2; doing so makes the sum of adjusted hospital spending amounts among individual Medicaid enrollees in MSIS total the aggregate hospital spending reported by states in the CMS-64.<sup>12</sup>

By making these adjustments to the MSIS data, MACPAC attempts to provide more complete estimates of Medicaid benefit spending across states that can be analyzed by eligibility group and other enrollee characteristics. Other organizations, including the Office of the Actuary at CMS, the Kaiser Commission on Medicaid and the Uninsured,

and the Urban Institute use methodologies that are similar to MACPAC's but may differ in various ways—for example, by using different service categories or producing estimates for future years based on actual data for earlier years.

Readers should note that due to changes in both methods and data, the MSIS figures shown in this edition of MACStats are not directly comparable to earlier years. Key differences between the current and previous methodologies include:

- ▶ The exclusion of disproportionate share hospital (DSH) payments from CMS-64 totals used to adjust MSIS spending. In previous editions of MACStats, DSH payments were included in the CMS-64 totals. This was due in part to the fact that DSH payments are used to support hospitals that serve a large number of low-income and Medicaid patients, and could therefore be partially attributed to Medicaid enrollees in MSIS. However, an examination of annual DSH report data submitted by states indicates that for some hospitals, Medicaid DSH payments far exceed their uncompensated care costs for Medicaid patients and may therefore be attributed largely to uninsured patients.<sup>13</sup> As a result, we now exclude DSH payments from CMS-64 totals when we adjust MSIS spending.
- ▶ A more precise separation of home and community-based (HCBS) waiver spending in MSIS. As described later in this section, this edition of MACStats uses more detailed MSIS data files than in previous years.

With regard to changes in data, MSIS Annual Person Summary (APS) files—which are created by CMS and are typically used in MACStats—for FY 2011 were unavailable for many states when MACPAC's 2014 reports to Congress were completed. As a result, MACPAC calculated spending and enrollment from the full MSIS

data files that are used to create the APS files. In general, our calculations closely match those used to create the APS. However, our development of enrollment counts is a notable exception. In MACPAC's analysis of the full MSIS data files, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts were then unduplicated using this national ID, which results in slightly lower enrollment counts as compared to the APS files.

## Understanding Data on Health and Other Characteristics of Medicaid/CHIP Populations

Section 2 of MACStats, which encompasses Tables 2–10, uses data from the federal National Health Interview Survey to describe Medicaid and CHIP enrollees in terms of their self-reported demographic, socioeconomic, and health characteristics as well as their use of care. Background information on the NHIS is provided here, along with information on how children with special health care needs are identified in Tables 2–4 using this data source.

### National Health Interview Survey data

Every year, thousands of non-institutionalized Americans are interviewed about their health insurance and health status for the NHIS.<sup>14</sup> Individuals' responses to the NHIS questions are the basis for the results in Tables 2–10. The NHIS is an annual face-to-face household survey of civilian non-institutionalized persons designed to monitor the health of the U.S. population through the collection of information on a broad range of health topics.<sup>15</sup> Administered by the National

Center for Health Statistics within the Centers for Disease Control and Prevention, the NHIS consists of a nationally representative sample from approximately 35,000 households containing about 87,500 people.<sup>16</sup> Tables 2–10 are based on NHIS data, pooling the years 2010 through 2012.<sup>17</sup> Although there are other federal surveys, the NHIS is used here because it is generally considered to be one of the best surveys for health insurance coverage estimates, and it captures detailed information on individuals' health status.<sup>18</sup>

As with most surveys, information about participation in programs such as Medicaid, CHIP, Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) may not be accurately reported by respondents in the NHIS. As a result, they may not match estimates of program participation computed from the programs' administrative data. In addition, although the NHIS asks separately about participation in Medicaid and CHIP, estimates for the programs are not produced separately from the survey data for several reasons. For example, many states' CHIP and Medicaid programs use the same name, so respondents would not necessarily know whether their children's coverage was funded by Medicaid or CHIP. The separate survey questions are used to reduce surveys' undercount of Medicaid and CHIP enrollees, not to produce valid estimates separately for each program. Thus, survey estimates generally combine Medicaid and CHIP into a single category, as is done in Section 2 of MACStats.

### Children with special health care needs

Tables 2–4 in MACStats present figures for children with special health care needs (CSHCN) who are enrolled in Medicaid or CHIP. As described here, MACPAC uses NHIS data to

construct a CSHCN indicator based on responses to a number of questions contained in the survey.

CSHCN are defined by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration as a group of children who “have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”<sup>19</sup> This definition is used by all states for policy and program planning purposes for CSHCN and encompasses children with disabilities and also children with chronic conditions (e.g., asthma, juvenile diabetes, sickle cell anemia) that range from mild to severe. Children with special health care needs are a broader group than children with conditions severe enough and family incomes so low as to qualify for SSI.<sup>20</sup> Table 2 shows that only 3.3 percent of children with Medicaid or CHIP receive SSI.

To operationalize the MCHB definition of CSHCN, researchers developed a set of survey questions referred to as the CSHCN Screener.<sup>21</sup> The CSHCN Screener is currently used in several national surveys, but not the NHIS. It incorporates four components of the definition of CSHCN considered by researchers as essential: functional limitations, need for health-related services, presence of a health condition, and minimum expected duration of health condition (e.g., 12 months).<sup>22</sup>

It should be noted that CSHCN can vary substantially in their health status and use of health care services. A CSHCN could be a child with intensive health care needs and high health care expenses who has severe functional limitations (e.g., spina bifida, paralysis) and would qualify for SSI if his or her family income were low enough.<sup>23</sup> On the other hand, a CSHCN could also be a child who has asthma, attention deficit disorder, or depression that is well managed through the use of prescription medications. Regardless of whether

functional limitations are mild, moderate, or severe, however, CSHCN share a heightened need for health care services in order to maintain their health and to be able to function appropriately for their age.

Since the NHIS does not include the validated CSHCN Screener, MACPAC’s analysis is based on an alternative approach developed by the Child and Adolescent Health Measurement Initiative (CAHMI 2012), specifically for use in the 2007 NHIS, and on other prior research.<sup>24</sup> The CAHMI definition of CSHCN (CAHMI uses the term “children with chronic conditions and elevated service use or need—CCCESUN”) includes children with at least one diagnosed or parent-reported condition expected to be an ongoing health condition, and who also meet at least one of five criteria related to elevated service use or elevated need:

- ▶ is limited or prevented in his or her ability to do things most children of the same age can do;
- ▶ needs or uses medications prescribed by a doctor (other than vitamins);
- ▶ needs or uses specialized therapies such as physical, occupational, or speech therapy;
- ▶ has above-routine need or use of medical, mental health, home care, or education services; or
- ▶ needs or receives treatment or counseling for an emotional, behavioral, or developmental problem.<sup>25</sup>

The NHIS varies from year to year in the diagnoses and health conditions that parents are asked about, so establishing a consistent definition across the 2010–2012 NHIS data in this analysis required modifying the survey items used in the CAHMI construct of CSHCN. Estimates for CSHCN in this analysis are not directly comparable to those in MACPAC reports prior to 2013 because the

definition of CSHCN used in the 2013 and 2014 reports differs slightly from earlier versions.<sup>26</sup>

## Understanding Managed Care Enrollment and Spending Data

There are four main sources of data on Medicaid managed care available from CMS.

- ▶ **Medicaid Managed Care Data Collection System (MMCDCS).** The MMCDCS provides state-reported aggregate enrollment statistics and other basic information for each managed care plan within a state. CMS uses the MMCDCS to create an annual Medicaid managed care enrollment report, which is the source of information on Medicaid managed care most commonly cited by CMS, as well as by outside analysts and researchers.<sup>27</sup> CMS also uses the MMCDCS to produce an annual summary of state Medicaid managed care programs that describes the managed care programs within a state (generally defined by the statutory authority under which they operate), each of which may include several managed care plans.<sup>28</sup>
- ▶ **Medicaid Statistical Information System (MSIS).** The MSIS provides person-level and claims-level information for all Medicaid enrollees.<sup>29</sup> With regard to managed care, the information collected for each enrollee includes: (1) plan ID numbers and types for up to four managed care plans (including comprehensive risk-based plans, primary care case management programs, and limited-benefit plans) under which the enrollee is covered, (2) the waiver ID number, if enrolled in a 1915(b) or other waiver, (3) claims that provide a record of each capitated payment made on behalf of the enrollee to a managed care plan (generally referred to as capitated claims), and (4) in some states, a record of

each service received by the enrollee from a provider under contract with a managed care plan (which generally do not include a payment amount and are referred to as encounter or “dummy” claims). All states collect encounter data from their Medicaid managed care plans, but some do not report them in MSIS. Managed care enrollees may also have FFS claims in MSIS if they used services that were not included in their managed care plan’s contract with the state.

- ▶ **CMS-64.** The CMS-64 provides aggregate spending information for Medicaid by major benefit categories, including managed care. The spending amounts reported by states on the CMS-64 are used to calculate their federal matching dollars.
- ▶ **Statistical Enrollment Data System (SEDS).** The SEDS provides aggregate statistics on CHIP enrollment and child Medicaid enrollment that include the number covered under FFS and managed care systems. SEDS is the only comprehensive source of information on managed care participation among separate CHIP enrollees across states.

CMS’s FY 2012 Medicaid managed care enrollment report was unavailable when MACPAC’s June 2014 report to the Congress was completed. Although the enrollment report generally contains the most recent information available from CMS on Medicaid managed care for all states, it does not provide information on characteristics of enrollees in managed care aside from dual eligibility for Medicare (e.g., basis of eligibility and demographics such as age, sex, race, and ethnicity). As a result, we supplement statistics from the enrollment report with MSIS and CMS-64 data; for example, Tables 14 and 15 use MSIS data to show the percentage of various populations in managed care and the percentage of their Medicaid benefit spending accounted for by managed care.

When examining managed care statistics from various sources, the following issues should be noted:

- ▶ Figures in the annual Medicaid managed care enrollment report published by CMS include Medicaid-expansion CHIP enrollees. Although we generally exclude these children (about 2 million, depending on the time period) from Medicaid analyses, it is not possible to do so with the CMS’s annual Medicaid managed care enrollment report data. Tables 14 and 15—which show the percentage of child, adult, disabled, aged, and dually eligible enrollees who are enrolled in Medicaid managed care and the percentage of their Medicaid benefit spending that was for managed care—are based on MSIS data and exclude Medicaid-expansion CHIP enrollees.<sup>30</sup>
- ▶ The types of managed care reported by states may differ somewhat between the Medicaid managed care enrollment report and the MSIS. For example, some states report a small number of enrollees in comprehensive risk-based managed care in one data source but not the other. Anomalies in the MSIS data are documented by CMS as it reviews each state’s quarterly submission, but not all issues may be identified in this process.<sup>31</sup>
- ▶ The Medicaid managed care enrollment report provides point-in-time figures (e.g., as of July 1, 2012). In contrast, CMS generally uses MSIS to report on the number of enrollees ever in managed care during a fiscal year (although point-in-time enrollment can also be calculated from MSIS based on the monthly data it contains).

**TABLE 16. Medicaid and CHIP Enrollment by Data Source and Enrollment Period, 2011**

<b>Medicaid and CHIP Enrollment (All Ages)</b>	<b>Administrative Data</b>		<b>Survey Data (NHIS)</b>
	<b>Ever enrolled during the year</b>	<b>Point in time</b>	<b>Point in time</b>
Medicaid	67.6 million	55.0 million	Not available
CHIP	8.2 million	5.5 million	Not available
Totals for Medicaid and CHIP	75.8 million	60.4 million	50.5 million
<b>U.S. Population</b>	<b>Census Bureau</b>		<b>Survey Data (NHIS)</b>
	312.3 million	311.0 million	305.9 million, excluding active-duty military and individuals in institutions
<b>Medicaid and CHIP Enrollment as a Percentage of U.S. Population</b>			
	24.3%	19.4%	16.5%

See Table 19 for notes.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

**TABLE 17. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Children Under Age 19, 2011**

<b>Medicaid and CHIP Enrollment Among Children Under Age 19</b>	<b>Administrative Data</b>		<b>Survey Data (NHIS)</b>
	<b>Ever enrolled during the year</b>	<b>Point in time</b>	<b>Point in time</b>
Medicaid	32.3 million	27.1 million	Not available
CHIP	7.9 million	5.3 million	Not available
Totals for Medicaid and CHIP	40.3 million	32.4 million	29.5 million
<b>Children Under Age 19</b>	<b>Census Bureau</b>		<b>Survey Data (NHIS)</b>
	78.5 million	78.4 million	78.7 million, excluding active-duty military and individuals in institutions
<b>Medicaid and CHIP Enrollment as a Percentage of All Children</b>			
	51.3%	41.3%	37.5%

See Table 19 for notes.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

**TABLE 18. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Adults Age 19–64, 2011**

Medicaid and CHIP Enrollment Among Adults Age 19–64	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	28.8 million	22.2 million	Not available
CHIP	0.2 million	0.2 million	Not available
Totals for Medicaid and CHIP	29.0 million	22.4 million	17.8 million
Adults Age 19–64	Census Bureau		Survey Data (NHIS)
	192.1 million	191.4 million	187.4 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 19–64			
	15.1%	11.7%	9.5%

See Table 19 for notes.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

**TABLE 19. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Adults Age 65 and Older, 2011**

Medicaid and CHIP Enrollment Among Adults Age 65 and Older	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	6.5 million	5.6 million	Not available
CHIP	–	–	Not available
Totals for Medicaid and CHIP	6.5 million	5.6 million	3.1 million
Adults Age 65 and Older	Census Bureau		Survey Data (NHIS)
	41.7 million	41.1 million	39.7 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 65 and Older			
	15.5%	13.7%	7.9%

**Notes:** Excludes U.S. territories. Medicaid enrollment numbers obtained from administrative data include 8.8 million individuals ever enrolled during the year who received limited benefits (e.g., emergency services only, Medicaid payment only for Medicare enrollees’ cost sharing), of whom 0.5 million were under age 19, 6.7 million were age 19 to 64, and 1.6 million were age 65 or older. In the event individuals were reported to be in both Medicaid and CHIP during the year, individuals were counted only once in the administrative data based on their most recent source of coverage. Overcounting of enrollees in the administrative data may occur because individuals may move and be enrolled in two states’ Medicaid or CHIP programs during the year; however, Medicaid enrollment counts shown here are unduplicated using unique national identification (ID) numbers. The National Health Interview Survey (NHIS) excludes individuals in institutions (such as nursing homes) and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage. Administrative data and Census Bureau data are for FY 2011 (October 2010 through September 2011); the NHIS data are for sources of insurance at the time of the survey in calendar year 2011. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population in the month in FY 2011 with the largest count; the number of residents ever living in the United States during the year is not available. The Census Bureau point-in-time number is the average estimated monthly number of U.S. residents for FY 2011.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014, CHIP Statistical Enrollment Data System (SEDS) data as of May 2014, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau vintage 2012 data on the monthly postcensal resident population by single year of age, sex, race, and Hispanic origin.

**TABLE 20. Medicaid Benefit Spending in MSIS and CMS-64 Data by State, FY 2011 (billions)**

State	Excluding DSH from CMS-64 Total			Including DSH in CMS-64 Total		
	MSIS	CMS-64	MSIS as a percentage of CMS-64	MSIS	CMS-64	MSIS as a percentage of CMS-64
<b>Total<sup>1</sup></b>	<b>\$352.5</b>	<b>\$386.4</b>	<b>91.2</b>	<b>\$352.5</b>	<b>\$403.5</b>	<b>87.4</b>
Alabama	4.2	4.4	94.7	4.2	4.9	86.0
Alaska	1.3	1.3	98.4	1.3	1.3	97.3
Arizona	9.4	8.8	107.0	9.4	9.0	105.0
Arkansas	3.5	3.9	89.8	3.5	4.0	88.4
California	37.2	52.6	70.8	37.2	54.9	67.8
Colorado	3.5	4.2	82.9	3.5	4.4	79.4
Connecticut	5.8	5.8	99.9	5.8	6.0	96.6
Delaware	1.5	1.4	105.2	1.5	1.4	104.8
District of Columbia	2.1	2.1	102.2	2.1	2.1	98.7
Florida	19.3	17.9	107.7	19.3	18.3	105.7
Georgia	8.4	7.7	108.8	8.4	8.1	103.3
Hawaii	1.4	1.6	89.0	1.4	1.6	87.9
Idaho	1.4	1.5	94.1	1.4	1.5	92.6
Illinois	11.7	12.6	93.3	11.7	13.0	90.3
Indiana	5.7	6.3	90.2	5.7	6.6	85.8
Iowa	3.2	3.3	98.2	3.2	3.4	95.8
Kansas	2.7	2.6	102.3	2.7	2.7	99.6
Kentucky	5.5	5.5	99.8	5.5	5.7	96.2
Louisiana	5.3	6.1	87.4	5.3	6.7	79.5
Maine	1	1	1	1	1	1
Maryland	7.0	7.4	94.6	7.0	7.5	93.5
Massachusetts	11.1	13.2	84.0	11.1	13.2	84.0
Michigan	11.6	11.8	98.8	11.6	12.1	95.7
Minnesota	7.9	8.3	95.3	7.9	8.4	94.3
Mississippi	3.7	4.3	86.3	3.7	4.5	82.3
Missouri	6.2	7.4	83.5	6.2	8.1	76.3
Montana	0.8	0.9	82.9	0.8	1.0	81.4
Nebraska	1.5	1.6	94.3	1.5	1.7	92.2
Nevada	1.4	1.5	93.9	1.4	1.6	88.7
New Hampshire	1.0	1.2	84.8	1.0	1.4	75.6
New Jersey	8.3	9.3	89.1	8.3	10.6	78.4
New Mexico	2.6	3.4	75.9	2.6	3.4	75.2
New York	51.2	50.7	100.9	51.2	53.9	95.0
North Carolina	9.5	10.1	94.1	9.5	10.5	90.4
North Dakota	0.7	0.7	102.7	0.7	0.7	102.4
Ohio	15.4	15.0	102.3	15.4	15.7	98.0
Oklahoma	3.6	4.2	86.3	3.6	4.3	85.4
Oregon	3.6	4.4	81.8	3.6	4.4	80.8
Pennsylvania	17.7	19.7	90.0	17.7	20.5	86.2
Rhode Island	1.5	2.0	76.0	1.5	2.1	71.5
South Carolina	5.0	4.6	109.4	5.0	5.1	98.1
South Dakota	0.7	0.8	98.3	0.7	0.8	98.2
Tennessee	1	1	1	1	1	1
Texas	22.4	27.0	83.1	22.4	28.6	78.5
Utah	2.1	1.7	120.0	2.1	1.8	118.4
Vermont	1.1	1.3	83.3	1.1	1.3	80.9
Virginia	6.1	6.8	89.0	6.1	7.0	86.5
Washington	6.3	7.1	88.3	6.3	7.4	84.2
West Virginia	2.9	2.7	109.0	2.9	2.8	106.1
Wisconsin	5.6	7.0	80.8	5.6	7.0	80.8
Wyoming	0.6	0.5	108.1	0.6	0.5	107.9

**Notes:** See text for a discussion of differences between Medicaid Statistical Information System (MSIS) and CMS-64 data. Both sources reflect unadjusted amounts as reported by states. Includes federal and state funds. Both sources exclude spending on administration, the territories, and Medicaid-expansion CHIP enrollees; in addition, the CMS-64 amounts exclude \$7.4 billion (excluding Maine and Tennessee) in offsetting collections from third-party liability, estate, and other recoveries. In previous editions of MACStats, disproportionate share hospital (DSH) payments were included in the CMS-64 totals used to adjust MSIS spending. However, as described in the text of this section, we now exclude DSH payments from the CMS-64 totals when we adjust MSIS spending. For comparison purposes, MSIS spending as a percentage of the CMS-64 is shown here including and excluding DSH payments.

<sup>1</sup> Maine (\$2.4 billion in CMS-64 spending with DSH, \$2.3 billion without) and Tennessee (\$8.0 billion in CMS-64 spending with DSH, \$7.9 billion without) were excluded due to MSIS spending data anomalies.

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) spending data and CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

**TABLE 21. Service Categories Used to Adjust FY 2011 Medicaid Benefit Spending in MSIS to Match CMS-64 Totals**

Service Category	MSIS Service Types <sup>1</sup>	CMS-64 Service Types
<b>Hospital</b>	<ul style="list-style-type: none"> <li>▶ Inpatient hospital</li> <li>▶ Outpatient hospital</li> </ul>	<ul style="list-style-type: none"> <li>▶ Inpatient hospital non-DSH</li> <li>▶ Inpatient hospital non-DSH supplemental payments</li> <li>▶ Inpatient hospital GME payments</li> <li>▶ Outpatient hospital non-DSH</li> <li>▶ Outpatient hospital non-DSH supplemental payments</li> <li>▶ Emergency services for aliens<sup>2</sup></li> <li>▶ Emergency hospital services</li> <li>▶ Critical access hospitals</li> </ul>
<b>Non-hospital acute care</b>	<ul style="list-style-type: none"> <li>▶ Physician</li> <li>▶ Dental</li> <li>▶ Nurse midwife</li> <li>▶ Nurse practitioner</li> <li>▶ Other practitioner</li> <li>▶ Non-hospital outpatient clinic</li> <li>▶ Lab and X-ray</li> <li>▶ Sterilizations</li> <li>▶ Abortions</li> <li>▶ Hospice</li> <li>▶ Targeted case management</li> <li>▶ Physical, occupational, speech, and hearing therapy</li> <li>▶ Non-emergency transportation</li> <li>▶ Private duty nursing</li> <li>▶ Rehabilitative services</li> <li>▶ Other care, excluding HCBS waiver</li> </ul>	<ul style="list-style-type: none"> <li>▶ Physician</li> <li>▶ Physician services supplemental payments</li> <li>▶ Dental</li> <li>▶ Nurse midwife</li> <li>▶ Nurse practitioner</li> <li>▶ Other practitioner</li> <li>▶ Other practitioner supplemental payments</li> <li>▶ Non-hospital clinic</li> <li>▶ Rural health clinic</li> <li>▶ Federally qualified health center</li> <li>▶ Lab and X-ray</li> <li>▶ Sterilizations</li> <li>▶ Abortions</li> <li>▶ Hospice</li> <li>▶ Targeted case management</li> <li>▶ Statewide case management</li> <li>▶ Physical therapy</li> <li>▶ Occupational therapy</li> <li>▶ Services for speech, hearing, and language</li> <li>▶ Non-emergency transportation</li> <li>▶ Private duty nursing</li> <li>▶ Rehabilitative services (non-school-based)</li> <li>▶ School-based services</li> <li>▶ EPSDT screenings</li> <li>▶ Diagnostic screening and preventive services</li> <li>▶ Prosthetic devices, dentures, eyeglasses</li> <li>▶ Freestanding birth center</li> <li>▶ Health home with chronic conditions</li> <li>▶ Tobacco cessation for pregnant women</li> <li>▶ Care not otherwise categorized</li> </ul>
<b>Drugs</b>	<ul style="list-style-type: none"> <li>▶ Drugs (gross spending)</li> </ul>	<ul style="list-style-type: none"> <li>▶ Drugs (gross spending)</li> <li>▶ Drug rebates</li> </ul>

**TABLE 21, Continued**

Service Category	MSIS Service Types <sup>1</sup>	CMS-64 Service Types
<b>Managed care and premium assistance</b>	<ul style="list-style-type: none"> <li>▶ HMO (i.e., comprehensive risk-based managed care; includes PACE)</li> <li>▶ PHP</li> <li>▶ PCCM</li> </ul>	<ul style="list-style-type: none"> <li>▶ MCO (i.e., comprehensive risk-based managed care)</li> <li>▶ MCO drug rebates</li> <li>▶ PACE</li> <li>▶ PAHP</li> <li>▶ PIHP</li> <li>▶ PCCM</li> <li>▶ Premium assistance for private coverage</li> </ul>
<b>LTSS non-institutional</b>	<ul style="list-style-type: none"> <li>▶ Home health</li> <li>▶ Personal care</li> <li>▶ HCBS waiver</li> </ul>	<ul style="list-style-type: none"> <li>▶ Home health</li> <li>▶ Personal care</li> <li>▶ Personal care – 1915(j)</li> <li>▶ HCBS waiver</li> <li>▶ HCBS – 1915(i)</li> <li>▶ HCBS – 1915(j)</li> </ul>
<b>LTSS institutional</b>	<ul style="list-style-type: none"> <li>▶ Nursing facility</li> <li>▶ ICF/ID</li> <li>▶ Inpatient psychiatric for individuals under age 21</li> <li>▶ Mental health facility for individuals age 65 and older</li> </ul>	<ul style="list-style-type: none"> <li>▶ Nursing facility</li> <li>▶ Nursing facility supplemental payments</li> <li>▶ ICF/ID</li> <li>▶ ICF/ID supplemental payments</li> <li>▶ Mental health facility for under age 21 or age 65+ non-DSH</li> </ul>
<b>Medicare<sup>3, 4</sup></b>		<ul style="list-style-type: none"> <li>▶ Medicare Part A and Part B premiums</li> <li>▶ Medicare coinsurance and deductibles for QMBs</li> </ul>

**Notes:** DSH is disproportionate share hospital; EPSDT is Early and Periodic Screening, Diagnostic, and Treatment; GME is graduate medical education; HCBS is home and community-based services; HMO is health maintenance organization; ICF/ID is intermediate care facility for persons with intellectual disabilities; LTSS is long-term services and supports; MCO is managed care organization; MSIS is Medicaid Statistical Information System; PACE is Program of All-inclusive Care for the Elderly; PAHP is prepaid ambulatory health plan; PIHP is prepaid inpatient health plan; PHP is prepaid health plan, either a PAHP or a PIHP; PCCM is primary care case management; QMB is qualified Medicare beneficiary.

Service categories and types reflect fee-for-service spending unless noted otherwise. Service types with identical names in MSIS and CMS-64 data may still be reported differently in the two sources due to differences in the instructions given to states; amounts for those that appear only in the CMS-64 (e.g., drug rebates) are distributed across Medicaid enrollees with MSIS spending in the relevant service categories (e.g., drugs).

- 1 Claims in MSIS include both a service type (such as inpatient hospital, physician, personal care, etc.) and a program type (including HCBS waiver). When adjusting MSIS data to match CMS-64 totals, we count all claims with an HCBS waiver program type as HCBS waiver, regardless of their specific service type. Among claims with an HCBS waiver program type, the most common service types are other, home health, rehabilitation, and personal care.
- 2 Emergency services for aliens are reported under individual service types throughout MSIS, but primarily inpatient and outpatient hospital. As a result, we include this CMS-64 amount in the hospital category.
- 3 Medicare premiums are not reported in MSIS. We distribute CMS-64 amounts proportionately across dually eligible enrollees in MSIS for each state.
- 4 Medicare coinsurance and deductibles are reported under individual service types throughout MSIS. We distribute the CMS-64 amount for QMBs across CMS-64 spending in the hospital, non-hospital acute, and institutional LTSS categories prior to calculating state-level adjustment factors, based on the distribution of Medicare cost sharing for hospital, Part B, and skilled nursing facility services among QMBs in 2009 Medicare data. See MedPAC and MACPAC, *Data book: Beneficiaries dually eligible for Medicare and Medicaid*, Table 4 (2013). [http://www.macpac.gov/publications/Duals\\_DataBook\\_2013-12.pdf](http://www.macpac.gov/publications/Duals_DataBook_2013-12.pdf).

**Sources:** MACPAC analysis of Medicaid Statistical Information System (MSIS) data and CMS-64 Financial Management Report (FMR) net expenditure data.

## Endnotes

<sup>1</sup> Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2012 (Washington, DC: MACPAC, 2012): 87–89. <http://www.macpac.gov/reports/>.

<sup>2</sup> Table 16 is modeled after Table 1 in the March 2014 edition of MACStats (Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2014 (Washington, DC: MACPAC, 2014): 75. <http://www.macpac.gov/reports/>). Table 1 of the March 2014 MACStats shows estimates for 2013 and is partly based on projections by the Office of the Actuary at the Centers for Medicare & Medicaid Services. To produce the age breaks used in Tables 16–19, however, numbers were calculated by MACPAC directly from the MSIS. FY 2011 is the latest year for which enrollment data are available in MSIS for all states.

<sup>3</sup> MACPAC has adjusted benefit spending from MSIS to match CMS-64 totals; see the discussion later in Section 5 for details.

<sup>4</sup> Because administrative data are grouped by month, the point-in-time number from administrative data generally appears under a few different titles—average monthly enrollment, full-year equivalent enrollment, or person-years. Average monthly enrollment takes the state-submitted monthly enrollment numbers and averages them over the 12-month period. It produces the same result as full-year equivalent enrollment or person-years, which is the sum of the monthly enrollment totals divided by 12.

<sup>5</sup> See, for example, Centers for Medicare & Medicaid Services (CMS), *Medicare & Medicaid statistical supplement, 2010 edition*, Brief summaries and glossary (Baltimore, MD: CMS, 2010). <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2010.html>.

<sup>6</sup> States make capitated payments for all individuals enrolled in managed care plans, even if no health care services are used. Therefore, all managed care enrollees are currently counted as beneficiaries, regardless of whether or not they have any health service use.

<sup>7</sup> Some individuals who are counted as beneficiaries in CMS data for a particular fiscal year were not enrolled in Medicaid during that year; they are individuals who were enrolled and received services in a prior year, but for whom a lagged payment was made in the following year. These individuals are often reported as having an unknown basis of eligibility in CMS data.

<sup>8</sup> Medicaid benefit spending reported here excludes amounts for Medicaid-expansion CHIP enrollees, the territories, administrative activities, the Vaccines for Children program (which is authorized by the Medicaid statute but operates as a separate program), and offsetting collections from third-party liability, estate, and other recoveries.

<sup>9</sup> For a discussion of these data sources, see Medicaid and CHIP Payment and Access Commission (MACPAC), Improving Medicaid and CHIP data for policy analysis and program accountability, in *Report to the Congress on Medicaid and CHIP*, March 2011 (Washington, DC: MACPAC, 2011). [http://www.macpac.gov/reports/MACPAC\\_March2011\\_web.pdf](http://www.macpac.gov/reports/MACPAC_March2011_web.pdf).

<sup>10</sup> Some of these amounts, including certain supplemental payments to hospitals and drug rebates, are lump sums that are not paid on a claim-by-claim basis for individual Medicaid enrollees. Nonetheless, we refer to these CMS-64 amounts as benefit spending, and the adjustment methodology described here distributes them across Medicaid enrollees with MSIS spending in the relevant service categories.

<sup>11</sup> Government Accountability Office (GAO), *Medicaid: Data sets provide inconsistent picture of expenditures* (Washington, DC: 2012). <http://www.gao.gov/assets/650/649733.pdf>; Administrative databases, in *Databases for estimating health insurance coverage for children: A workshop summary*, edited by T. Plewes (Washington, DC: The National Academies Press, 2010): 72. <http://www.nap.edu/catalog/13024.html>.

<sup>12</sup> The sum of adjusted MSIS benefit spending amounts for all service categories totals CMS-64 benefit spending, exclusive of offsetting collections from third-party liability, estate, and other recoveries. These collections, \$7.4 billion in FY 2011 (excluding Maine and Tennessee), are not reported by type of service in the CMS-64 and are not reported at all in MSIS.

<sup>13</sup> See Centers for Medicare & Medicaid Services (CMS), *Medicaid disproportionate share hospital (DSH) payments*. <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html>.

<sup>14</sup> Although the discussion in this section generally omits the term non-institutionalized for brevity, all estimates exclude individuals living in nursing homes and other institutional settings.

<sup>15</sup> Centers for Disease Control and Prevention (CDC), *About the National Health Interview Survey* (Atlanta, GA: CDC, 2012). [http://www.cdc.gov/nchs/nhis/about\\_nhis.htm](http://www.cdc.gov/nchs/nhis/about_nhis.htm).

<sup>16</sup> The annual NHIS questionnaire consists of three major components—the Family Core, the Sample Adult Core, and the Sample Child Core. The Family Core collects information for all family members regarding household composition and socioeconomic and demographic characteristics, along with basic indicators of health status, activity limitation, and health insurance. The Sample Adult and Sample Child Cores obtain additional information on the health of one randomly selected adult and child in the family.

<sup>17</sup> Data were pooled to yield sufficiently large samples to produce reliable subgroup estimates and to increase the capacity to detect meaningful differences between subgroups and insurance categories.

<sup>18</sup> G. Kenney and V. Lynch, Monitoring children’s health insurance coverage under CHIPRA using federal surveys, in *Databases for estimating health insurance coverage for children: A workshop summary*, edited by T. Plewes (Washington, DC: National Academies Press, 2010): 72. <http://www.nap.edu/catalog/13024.html>.

<sup>19</sup> M. McPherson, et al., A new definition of children with special health care needs, *Pediatrics* 102 (1998): 137–140.

<sup>20</sup> For children under age 18 to be determined disabled under SSI rules, the child must have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to cause death or last at least 12 months (§1614(a)(3)(C)(i) of the Social Security Act). For additional discussion of disability as determined under the SSI program and its interaction with Medicaid eligibility, see Chapter 1 in MACPAC’s March 2012 report to the Congress.

<sup>21</sup> The CSHCN Screener was developed by CAHMI and is currently used in the National Survey of Children with Special Health Care Needs, the Medical Expenditure Panel Survey, and other federal surveys. For more information on the CSHCN Screener, see C.D. Bethell, D. Read, R.E. Stein, et al., Identifying children with special health care needs: Development and evaluation of a short screening instrument, *Ambulatory Pediatrics* 2 (2002): 38–48.

<sup>22</sup> Child and Adolescent Health Measurement Initiative (CAHMI), *Approaches to identifying children and adults with special health care needs: A resource manual for state Medicaid agencies and managed care organizations* (Baltimore, MD: Centers for Medicare and Medicaid Services, 2002).

<sup>23</sup> Children who are receiving SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that children who are reported to have SSI did not meet the criteria for CSHCN, it could be because: (1) the parent erroneously reported in the survey that the child received SSI, or (2) the NHIS condition list did not capture, or the parent did not recognize, any of the NHIS conditions as reflecting the child’s health circumstances.

<sup>24</sup> Child and Adolescent Health Measurement Initiative (CAHMI), *Identifying children with chronic conditions and elevated service use or need (CCCESUN) in the National Health Interview Survey (NHIS)* (Portland, OR: Oregon Health and Science University, 2012); Davidoff, A.J., Identifying children with special health care needs in the National Health Interview Survey: A new resource for policy analysis, *Health Services Research* 39 (2004): 53–71.

<sup>25</sup> The CAHMI algorithm differs from the CSHCN Screener in three main respects (CAHMI 2012—see endnote 24 for source). First, the CSHCN Screener uses a non-condition specific approach, which identifies a broader range of children with chronic childhood conditions who have special needs. The CAHMI algorithm limits CSHCN to children identified by parents as having a specific diagnosis in a condition set collected in the NHIS. Second, the CSHCN Screener captures children with above routine use of medical and health services that is the result of an ongoing condition, based on brief follow-up questions. The NHIS does not include the duration of conditions or identify elevated service use or need directly related to each condition. Thus, the CAHMI algorithm collects data on elevated service use and need independent from the condition set. Third, the CAHMI algorithm identifies a small number of additional children as having elevated need when parents report an unmet need due to cost through one of three survey items. As a result of these differences, the children identified from the CAHMI algorithm in the NHIS are not equivalent in health and function characteristics to children identified by the CSHCN Screener in other surveys. The CAHMI criteria differ from criteria developed by Davidoff (2004—see endnote 24 for source) in that Davidoff does not recognize unmet need due to cost as part of the definition of elevated need.

<sup>26</sup> The algorithm in this analysis begins with the NHIS conditions referred to as the limited condition set by CAHMI (2012—see endnote 24 for source), then excludes seven conditions that were dropped in the 2011 NHIS (depression, learning disability, cancer, neurological problem, phobia or fears, gum disease, lung or breathing problem). To capture CSHCN potentially lost from this change and other children with a broader range of chronic conditions, affirmative responses to three other survey items were treated as qualifying conditions (has difficulties with emotions/concentration/behavior or getting along in last four weeks, has chronic condition that limits activity, and fair or poor health). These items were also added to better align the CSHCN definition with the 18-year-olds, whom the NHIS treats as adults. The NHIS Sample Adult Core contains slightly different condition items. In order to align the CSHCN definitions more closely, the condition set for 18-year-olds was expanded to add mental retardation or developmental problems that cause difficulty with activity, cancer, symptoms of depression in the past 30 days, fair or poor health, and any unspecified condition that causes functional limitation and is chronic. In the MACPAC analysis, two or more emergency department visits reported in the last 12 months was added as another measure of elevated service use.

<sup>27</sup> Centers for Medicare & Medicaid Services (CMS), *Medicaid managed care enrollment report* (Baltimore, MD: CMS). <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicare-Managed-Care/Medicare-Managed-Care-Enrollment-Report.html>.

<sup>28</sup> Centers for Medicare & Medicaid Services (CMS), *National summary of state Medicaid managed care programs as of July 1, 2011* (Baltimore, MD: CMS). <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicare-Managed-Care/State-Program-Descriptions.html>.

<sup>29</sup> For enrollees with no paid claims during a given period (e.g., fiscal year), their MSIS data are limited to person-level information (e.g., basis of eligibility, age, sex, etc.).

<sup>30</sup> We generally exclude Medicaid-expansion CHIP children from Medicaid analyses because their funding stream (CHIP, under Title XXI of the Social Security Act) differs from that of other Medicaid enrollees (Medicaid, under Title XIX). In addition, spending (and often enrollment) for the Medicaid-expansion CHIP population is reported by CMS in CHIP statistics, along with information on separate CHIP enrollees.

<sup>31</sup> See Centers for Medicare & Medicaid Services (CMS), *MSIS state data characteristics/anomalies report*, January 7, 2013 (Baltimore, MD: CMS, 2013). <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicareDataSourcesGenInfo/downloads/anomalies1.pdf>.

