Medicaid and CHIP Program Statistics: June 2011 MACStats

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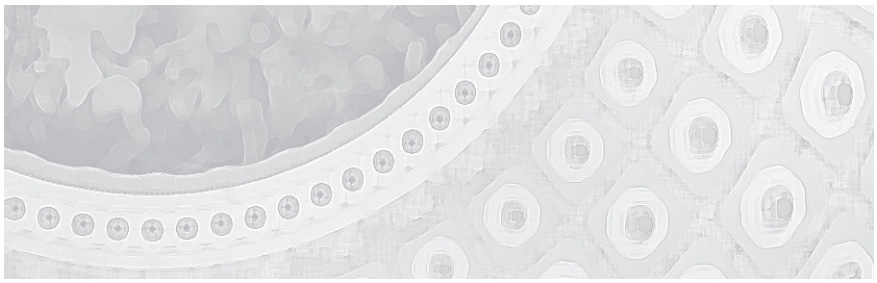


Overview of MACStats

MACStats is a standing section in all MACPAC reports to the Congress. It was created because data and information on the Medicaid and CHIP programs can often be difficult to find and are spread out across a variety of sources. The June 2011 edition of MACStats illustrates trends in Medicaid enrollment and spending, as well as health and other characteristics, service use, and spending among Medicaid and CHIP populations. It also supplements the Report's Medicaid managed care sections with state-level data on Medicaid managed care plans, enrollment, and spending.

In addition to state-level data by eligibility group, data highlighting users of long-term services and supports (LTSS) and other enrollee subgroups such as children with special health care needs are presented. These data illustrate how specific Medicaid populations differ in terms of their characteristics, service use, and spending.

Medicaid and CHIP serve a variety of low-income populations (Tables 9, 10, and 11 in the March 2011 MACStats), including non-disabled children and adults who account for a large share of program enrollment—nearly 75 percent of all Medicaid enrollees in FY 2008. Many of the June 2011 MACStats tables and figures include data and information for all Medicaid eligibility groups. However, the discussion at the front of each section has a particular focus on persons with disabilities—in part because these individuals account for a small portion of Medicaid enrollees but a substantial portion of the program's spending growth, a key issue for states and the federal government as they consider options for slowing that growth. The Commission will examine this population and others, including those dually eligible for Medicaid and Medicare, in greater depth in future reports to the Congress. In addition, future Commission work will examine CHIP enrollment and spending in greater depth.

In this June 2011 *Report to the Congress: The Evolution of Managed Care in Medicaid,* MACStats is divided into four sections:

- Section 1: Trends in Medicaid Enrollment and Spending
- Section 2: Medicaid and CHIP Populations
- Section 3: Medicaid Managed Care
- Section 4: Technical Guide to the June 2011 MACStats

Following are some key points in the June 2011 MACStats, which include the fact that in many Medicaid program statistics, persons with disabling conditions may not be easy to identify. Although many individuals have complex health care needs or conditions that might be considered disabling (Tables 3A-5C), the term "disabled" in the Medicaid program generally refers to individuals under age 65 who qualify for federal Supplemental Security Income (SSI) benefits or meet similar criteria (Section 4 of MACStats).

Section 1: Trends in Medicaid Enrollment and Spending

- Individuals with disabilities account for a disproportionate share of Medicaid benefit spending growth (Table 2).
- Individuals age 65 and older account for about 60 percent of dual eligible enrollees (i.e., those enrolled in both Medicaid and Medicare) and dual eligible Medicaid benefit spending; younger dual eligibles account for the remaining 40 percent (Tables 6 and 7).

Section 2: Medicaid and CHIP Populations

- Medicaid/CHIP enrollees differ from individuals with other types of coverage, as well as from each other when subgroups of enrollees are examined, in terms of health status and the presence of certain health conditions (Tables 3A-5C).[1]
- Disabled and aged enrollees have per enrollee Medicaid benefit spending that is three to five times larger than that of other children and adults (Figure 4), with wide variation by state (Table 8).
- LTSS users account for a small share of Medicaid enrollees but a large share of Medicaid spending that includes both LTSS and acute care (Figures 5-7).

Section 3: Medicaid Managed Care

- Depending on the definition used, the percentage of Medicaid enrollees in managed care ranges from less than half to more than 70 percent (Table 9).
- Non-disabled children and adults under age 65 are more likely to be enrolled in managed care than persons with disabilities and individuals age 65 and older (Table 11).

[1] Health and other characteristics presented in Tables 3A-5C are for the Medicaid/CHIP population as a whole because the data source (the National Health Interview Survey) does not publish separate results for Medicaid and CHIP enrollees. The other tables and figures in Section 2 are specific to Medicaid.

Section 4: Technical Guide to the June 2011 MACStats

There are several key issues to be aware of when interpreting the June 2011 MACStats. Section 4 provides a guide to these issues, which are briefly summarized here.

- **Sources of Variation in Medicaid and CHIP Numbers.** Data on Medicaid and CHIP enrollees and spending are available from a variety of sources. Each may produce unique insights into the programs and their enrollees' characteristics; however, the number of enrollees and program spending can vary across the different sources. Much of this is attributable to differences that are described in greater detail in Section 4, including the sources of data, the enrollment period examined, and the individuals included in the analyses.
- **Medicaid Statistics on Persons with Disabilities.** Individuals under age 65 who qualify for Medicaid on the basis of a disability are categorized in most Medicaid program statistics as disabled, rather than as children or adults. Conversely, there may be some individuals with disabilities—broadly defined—who are counted in the child and adult categories, if those individuals do not receive SSI benefits or meet similar criteria. Adults age 65 and older are included in the aged category regardless of disability status. As a result, there are many Medicaid enrollees who have physical or mental impairments that might be considered disabling but who are not counted as disabled in various program statistics.
- **MACPAC Adjustments to Spending Data.** The FY 2008 Medicaid benefit spending amounts reported in the June 2011 MACStats were calculated based on Medicaid Statistical Information System (MSIS) data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[2] Although the CMS-64 provides a more complete accounting of spending and is preferred when examining state or federal totals, MSIS is the only data source that allows for analysis of benefit spending by eligibility group and other enrollee characteristics. 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. By adjusting the MSIS data, we are attempting to provide comparable 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. More on MACPAC's methodology is included in Section 4.
- **Sources of Variation in Medicaid Managed Care Numbers.** In MACStats and the managed care discussion in this Report, many of the statistics cited on managed care are from the *2009 Medicaid Managed Care Enrollment Report* published by CMS. However, the enrollment report does not provide information on characteristics of enrollees in managed care (e.g., basis of eligibility and demographics such as age, sex, and race/ethnicity) aside from dual eligibility status, nor their spending and non-managed care service use. As a result, we supplement statistics from the enrollment report with MSIS and CMS-64 data, which differ from each other in a variety of ways that are noted in Section 4.

[2] For a discussion of these data sources, see MACPAC, Improving Medicaid and CHIP Data for Policy Analysis and Program Accountability, in *Report to the Congress on Medicaid and CHIP: March 2011*. http://www.macpac.gov/reports/MACPAC_March2011_web.pdf.

SECTION 1

Trends in Medicaid Enrollment and Spending

Overall Medicaid spending growth is driven by growth in the number of people covered by Medicaid and in program spending per person. Both have grown at different rates over time, as illustrated in Figure 1. Sometimes this growth (or lack thereof) was driven by broad economic changes; at other times, trends in Medicaid enrollment and spending reflected changes in federal and state Medicaid policies.

For example, in the late 1970s and early 1980s, inflation levels were high economy-wide, causing rapid Medicaid spending growth while enrollment was flat. From the mid-1980s to the mid-1990s, numerous Medicaid-specific changes occurred, such as eligibility expansions and states' use of supplemental payments and alternative financing mechanisms. In the mid- to late 1990s, program growth was affected by federal Medicaid changes—primarily welfare reform, which delinked Medicaid eligibility for low-income families from the receipt of cash welfare assistance.[3] In the mid-2000s, enrollment growth slowed. Spending actually declined from FY 2005 to FY 2006, primarily because of the shift of dual eligibles' outpatient prescription drug spending from Medicaid to Medicare Part D.[4] In the early and late 2000s, the economic recessions spurred increased program enrollment and, thus, program spending.[5]

Total Medicaid spending can be measured in different ways, as can the number of program participants. In turn, these measurement differences can affect how much spending growth is attributed to the number of people covered versus program spending per person.

[3] For a discussion of growth from the program's beginnings through the late 1990s, see J. Klemm, Medicaid spending: A brief history, *Health Care Financing Review* 22 (Fall 2000): 105-112. https://www.cms.gov/HealthCareFinancingReview/Downloads/00fallpg105.pdf.

[4] J. Holahan et al., *Why did Medicaid spending decline in 2006?* A detailed look at program spending and enrollment, 2000-2006 (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Issue Paper #7697, October 2007). http://www.kff.org/medicaid/upload/7697.pdf. .

[5] Holahan and A. Yemane, Enrollment is driving Medicaid costs—But two targets can yield savings, *Health Affairs* 28 (2009): 1453-1465.

For example, Figure 2 shows three different ways to express Medicaid spending. First, Medicaid spending is shown in nominal, or current, dollars—that is, in the dollar amounts for each respective year. However, more items and services could be purchased for a dollar in 1975 than in 2008. There are two ways to adjust for this effect. One is to convert nominal historical spending to real, inflation-adjusted amounts based on *economy-wide* inflation. This is the approach commonly taken among organizations and researchers whose scope is not limited to health care, such as the Congressional Budget Office (CBO).[6] A second alternative, used by CMS, is to convert nominal historical Medicaid spending to real dollars using *health care* inflation,[7] which has generally exceeded economy-wide inflation. Using real dollars adjusted for health care inflation places Medicaid spending in the context of the overall U.S. health care system—recognizing that Medicaid faces the same cost pressures as other health care payers.

As shown in Figure 2, real historical Medicaid spending adjusted for health care inflation is higher than when adjusted for economy-wide inflation. This is because health care inflation has exceeded economy-wide inflation in most years.

To understand why the real historical Medicaid spending amounts shown in Figure 2 are higher when adjusted for health care inflation—and lower when adjusted for economy-wide inflation—it is helpful to consider the fact that inflation increases the dollar amount required to purchase the same amount of goods and services over time. As a result, to reproduce a purchase of goods and services in the health care sector in FY 1975 (or any year between FY 1975 and FY 2008) using FY 2008 dollars, the FY 2008 dollar amount must be larger than the original dollar amount to account for health care inflation. Since health care inflation generally exceeded economy-wide inflation over the period FY 1975 to FY 2008, an FY 2008 dollar amount that accounts only for economy-wide inflation—of which health care is just one component—would not be sufficient to reproduce that same health sector purchase.

Table 2 decomposes growth in Medicaid benefit spending[8] from FY 1975 to FY 2008 into two factors: the number of people served by Medicaid ("beneficiaries" or "recipients" as described in Section 4), and per beneficiary spending. According to this MACPAC analysis, growth in the number of beneficiaries is responsible for 68 percent of real (i.e., health care inflation-adjusted) Medicaid benefit spending growth from FY 1975 to FY 2008.[9] The remaining 32 percent is attributable to per beneficiary spending, which can reflect a number of factors, such as the changing breadth of Medicaid benefit packages, increased health care utilization or treatment intensity specific to

[6] For example, see: Congressional Budget Office (CBO), *The Long-Term Budget Outlook, June 2010 (revised August 2010)* (Washington, DC: CBO, 2010), http://www.cbo.gov/ftpdocs/115xx/ doc11579/06-30-LTBO.pdf; CBO, Appendix B in *The Long-Term Outlook for Health Care Spending* (Washington, DC: CBO, 2007), http://www.cbo.gov/ ftpdocs/87xx/doc8758/11-13-LT-Health.pdf; and CBO, Table 2 in *Medicaid Spending Growth and Options for Controlling Costs* (Washington, DC: CBO, 2006), http://www.cbo.gov/ftpdocs/73xx/doc7387/07-13-Medicaid.pdf..

[7] See, for example, Table 13.10 in CMS, *Health Care Financing Review 2010 Statistical Supplement,* 2010. https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp

[8] Benefit spending excludes administration and the Vaccines for Children program. As described in Section 4, FY 2008 benefit spending amounts are from MSIS and have been adjusted to match totals reported by states in CMS-64 data. FY 1975 spending amounts do not need a similar adjustment because the data on which benefit spending were based in that year closely matched the CMS-64.

[9] Results can differ if using different years or eras. The period FY 1975 to FY 2008 is used here to examine factors driving growth over the Medicaid program's long history, rather than a particular time period (e.g., recent growth fueled by recessions in the early and late 2000s). Historical analyses of Medicaid spending often begin with FY 1975, after the program had stabilized following its initial startup growth.

Medicaid, and state and federal policies regarding provider payments, care management and other issues.[10]

The FY 1975–FY 2008 decomposition of growth by eligibility groups—aged, disabled, children, and adults—reveals that half of overall Medicaid benefit spending growth was attributable to enrollees with disabilities. This is driven mostly by enrollment growth for this population, which has outpaced all other groups (Table 2). Children accounted for approximately 21 percent of Medicaid spending growth between FY 1975 and FY 2008. Over that period, the aged and other adults each accounted for approximately 15 percent and 14 percent, respectively, of Medicaid benefit spending growth.

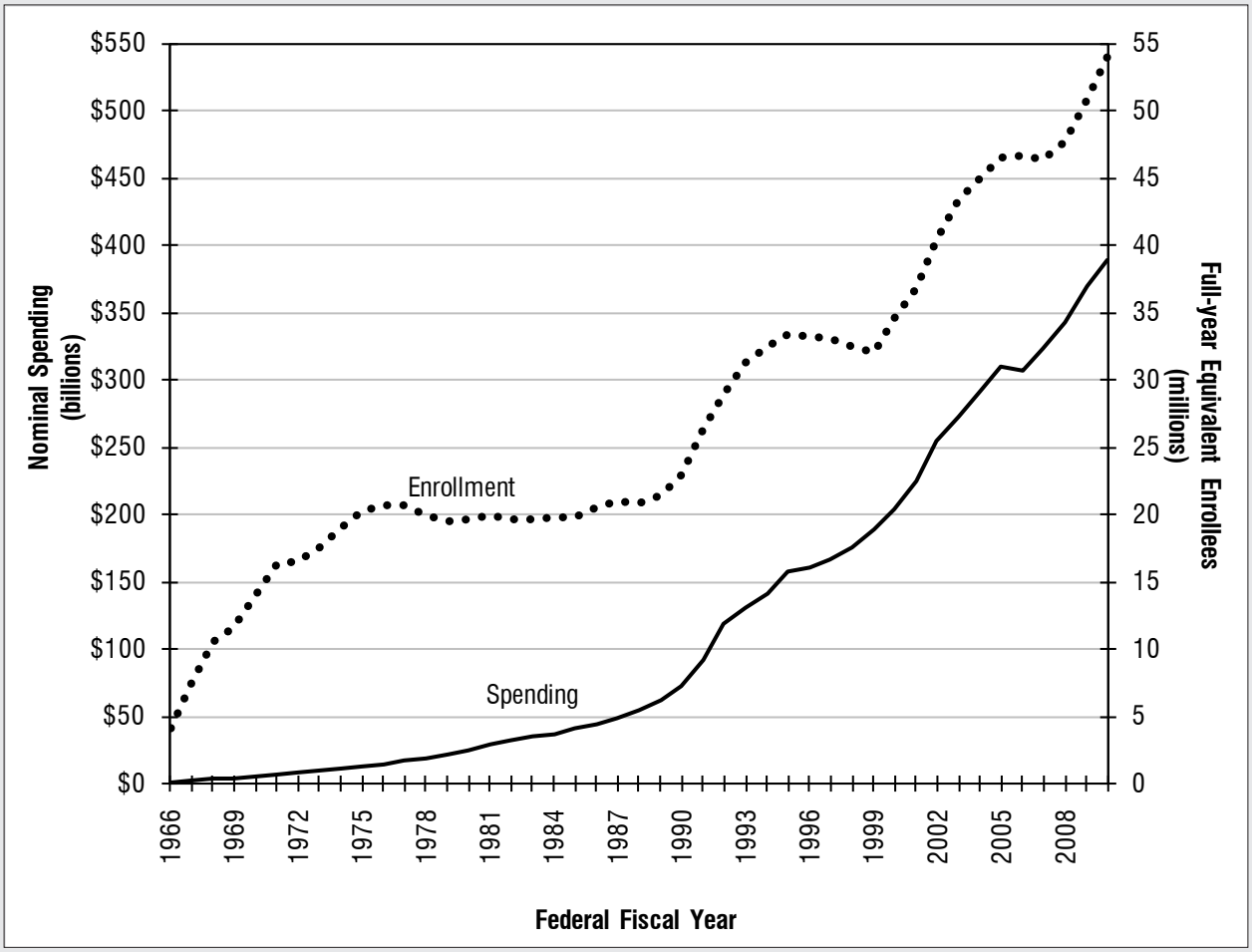
By FY 2008, the number of disabled beneficiaries had risen to 8.7 million, from 2.5 million in FY 1975. Although some of this increase is due to growth in the number of disabled individuals in the general population and the number of individuals receiving SSI benefits, some is due to federal Medicaid expansions since the 1980s that increased the number of persons with disabilities enrolled in the program, including home and community-based waivers and the Medicare Savings Programs (MSPs) under which state Medicaid programs pay all or some of low-income Medicare beneficiaries' Medicare premiums and cost sharing.[11]

Although children experienced the largest enrollment increase in absolute numbers, their annual growth rates were lower than those for the disabled. In addition, because the per recipient spending for children is low, it has a smaller impact on overall growth in Medicaid benefit spending.

[10] As noted in the text, the real Medicaid spending figures used in this calculation are adjusted for health care inflation. If the real Medicaid spending figures were instead adjusted for economy-wide inflation, the portion of growth attributable to per beneficiary spending would be higher— because health care inflation in excess of economy-wide inflation would be added to the list of explanatory factors such as the changing breadth of Medicaid benefit packages. For example, if the FY 1975 spending amounts were converted to real dollars using economy-wide inflation rather than health care inflation, only 40 percent of real Medicaid benefit spending growth would be attributable to growth in the number of beneficiaries, and per beneficiary spending would account for 60 percent of the growth.

[11] MSPs—the Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary (SLMB) Program, and Qualifying Individual (QI) Program—are administered by state Medicaid programs; the amount of Medicare premiums and cost sharing (i.e., deductibles and coinsurance) paid varies by the type of MSP. See Social Security Administration, *Trends in the Social Security and Supplemental Security Income Disability Programs* (Baltimore, MD: SSA Publication No. 13-1183, August 2006): 29. http://www.socialsecurity.gov/policy/docs/chartbooks/disability_trends/trends.pdf.

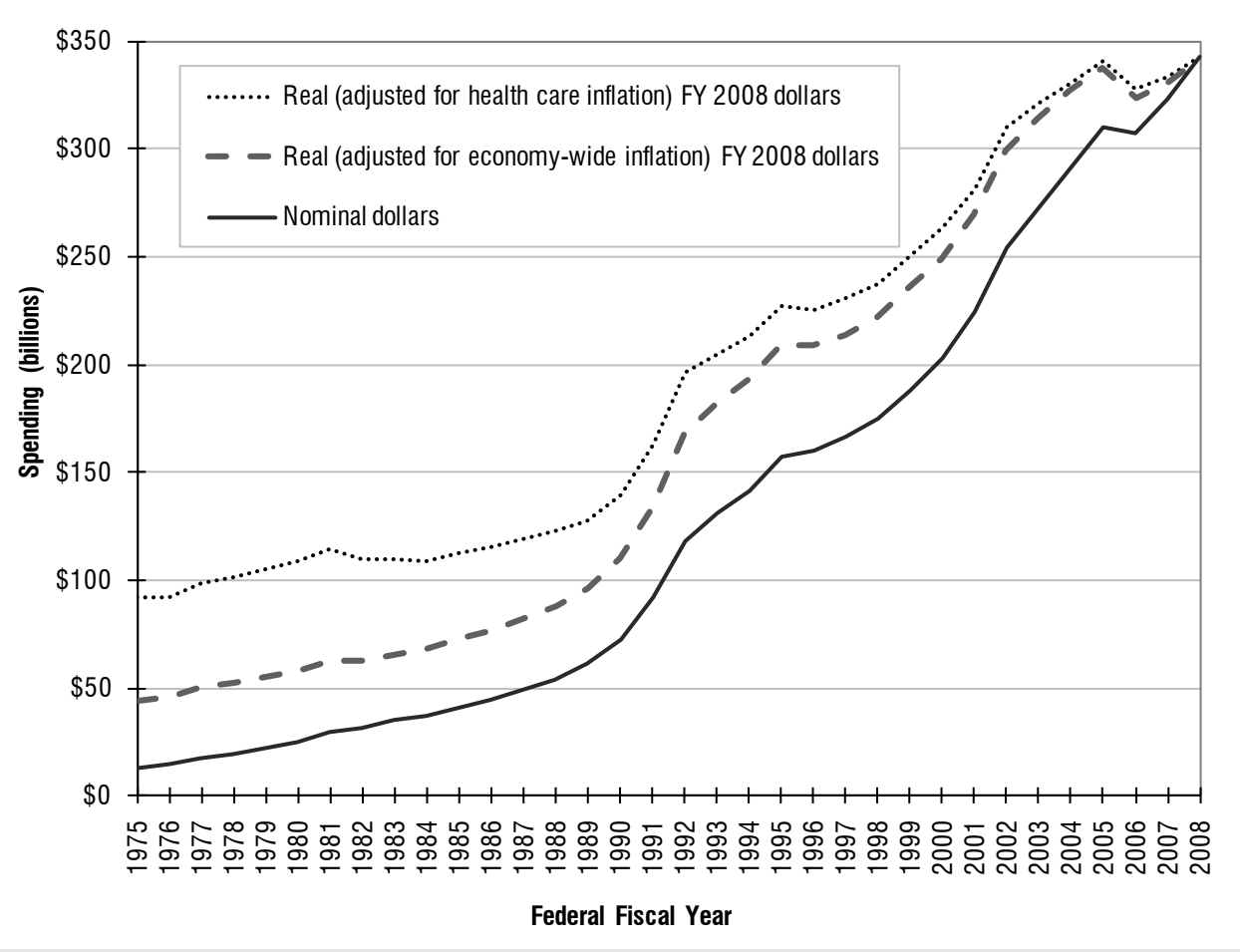
FIGURE 1. Medicaid Enrollment and Spending, FY 1966–FY 2010



Notes: Data prior to FY 1977 have been adjusted to new fiscal year basis (Oct. 1 - Sep. 30); data for FY 2009 and FY 2010 are projected. Spending includes federal and state funds for benefits and administration; excludes the Vaccines for Children program; may differ from amounts published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Enrollment counts are full-year equivalents and have been estimated from counts of persons served for fiscal years prior to FY 1990 (see Section 4 of MACStats for a discussion of how enrollees are counted). Excludes Medicaid-expansion CHIP.

Source: Data compilation provided to MACPAC by Centers for Medicare & Medicaid Services, Office of the Actuary, May 2011

FIGURE 2. Medicaid Spending in Nominal and Real Dollars, FY 1975–FY 2008



Notes: Includes benefits and administrative spending. The bottom line in the figure shows actual (nominal) spending. The middle line transforms nominal Medicaid spending to real FY 2008 dollars by adjusting for economy-wide inflation, using the Gross Domestic Product (GDP) price deflator. The top line also shows real FY 2008 dollars, but based on inflation for health care in particular. Real historical Medicaid spending adjusted for health care inflation is higher than when adjusted for economy-wide inflation, which reflects the long history of health care inflation in excess of economy-wide inflation. The drop in spending for FY 2006, compared to FY 2005, is partly the result of the implementation of Medicare Part D.

Sources: Nominal Medicaid spending from Figure 1; real spending based on MACPAC analysis of nominal spending and quarterly National Income and Product Account (NIPA) historical tables, Quarter 1 of 2011

TABLE 1. Number of Medicaid Persons Served (Beneficiaries or Recipients), by Eligibility Group, FY 1975–FY 2008 (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[1]	56,962	26,479	12,739	8,685	4,147	4,912

Notes: Beneficiaries are shown here because they provide the only historical time series data directly available prior to FY 1990. Most current analyses of individuals in Medicaid reflect enrollees. For additional discussion, see Section 4 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, during the year, received only coverage for managed care benefits was included in this series as a beneficiary. Excludes Medicaid-expansion CHIP children. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. 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.

1 This table shows the number of beneficiaries. See Table 6 for the number of Medicaid enrollees in FY 2008 data from CMS.

Sources: For FY 1999 to FY 2008: MACPAC analysis of Medicaid Statistical Information System (MSIS) as of May 2011. For FY 1975 to FY 1998: Centers for Medicare & Medicaid Services (CMS) *Medicare & Medicaid Statistical Supplement, 2010 edition,* Table 13.4

TABLE 2. Components of Growth in Real Medicaid Benefit Spending, FY 1975–FY 2008

		FY 1975 (in FY 2008 dollars)	FY 2008	Annual Growth Rate	Relative Contribution to Real Spending Growth, FY 1975 to FY 2008
All Eligibility Groups					
	Spending per beneficiary	$4,234	$6,504[1]	1.3%	32.2%
	Number of beneficiaries (millions)	20.2	52.1	2.9%	67.8%
	Total benefit spending (millions)	**$85,549**	**$338,552**	**4.3%**	**100.0%**
Children					
	Spending per beneficiary	$1,658	$2,571[1]	1.3%	4.9%
	Number of beneficiaries (millions)	9.6	26.5	3.1%	15.7%
	Total benefit spending (millions)	**$15,914**	**$68,080**	**4.5%**	**20.6%**
Adults					
	Spending per beneficiary	$3,315	$3,887[1]	0.5%	1.2%
	Number of beneficiaries (millions)	4.5	12.7	3.2%	12.5%
	Total benefit spending (millions)	**$15,012**	**$49,512**	**3.7%**	**13.6%**
Disabled					
	Spending per beneficiary	$9,292	$17,332[1]	1.9%	12.9%
	Number of beneficiaries (millions)	2.5	8.7	3.9%	37.6%
	Total benefit spending (millions)	**$22,896**	**$150,531**	**5.9%**	**50.4%**
Aged					
	Spending per beneficiary	$8,776	$16,984[1]	2.0%	13.2%
	Number of beneficiaries (millions)	3.6	4.1	0.4%	2.1%
	Total benefit spending (millions)	**$31,727**	**$70,429**	**2.4%**	**15.3%**

Notes: Beneficiaries are shown here because they provide the only historical time series data available prior to FY 1990. Most current analyses of individuals in Medicaid reflect enrollees, as shown in Table 6. For additional discussion of the definitions of enrollees and beneficiaries, see Section 4 of MACStats.

Dollar amounts were adjusted for inflation using the Gross Domestic Product (GDP) price deflator for health care (see text for additional discussion). In this table, real Medicaid spending growth is attributed to either spending per beneficiary and number of beneficiaries, where the interaction of the two factors is allocated according to the shares separately attributable to spending per beneficiary and the number of beneficiaries.

Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category.

The number of beneficiaries excludes individuals whose basis of Medicaid eligibility is unknown. In this analysis, FY 1975 benefit spending for these individuals was allocated proportionally to the four eligibility groups in the table. FY 2008 benefit spending reflects MSIS data that have been adjusted to match CMS-64 totals; see Section 4 of MACStats for a discussion of the methodology used.

Results can differ if using different years or eras. The period FY 1975 to FY 2008 is used here to examine factors driving growth over the Medicaid program's long history, rather than a particular time period (e.g., recent growth fueled by recessions in the early and late 2000s).

1 Benefit spending per beneficiary shown here differs from the FY 2008 benefit spending per full-year equivalent enrollee shown in Table 8.

Sources: MACPAC analysis using data from CMS, 2010 Medicare and Medicaid Statistical Supplement (FY 1975), and from Medicaid Statistical Information System (MSIS) and CMS-64 net financial management report data (FY 2008)

Medicaid and CHIP Populations

This section of MACStats shows how Medicaid and CHIP enrollees differ from individuals with other types of coverage in terms of their general health, disability and work status, their need for assistance with activities of daily living (ADLs), and other characteristics (Tables 3A-5C). It also indicates that Medicaid populations—for example, low-income non-disabled children and adults, persons with disabilities, and individuals age 65 and older—differ markedly from each other in their characteristics, service use, and spending (shown throughout Section 2).

Health and Other Characteristics of Medicaid/CHIP Populations (Tables 3A-5C)

Every year, thousands of non-institutionalized[12] Americans are interviewed about their health insurance and health status for the National Health Interview Survey (NHIS), which is the source of data for Tables 3A through 5C. 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.[13] Administered by the National Center for Health Statistics (NCHS) within the Centers for Disease Control and Prevention (CDC), the NHIS consists of a nationally representative sample from approximately 35,000 households containing about 87,500 people.[14] Tables 3A through 5C are based on NHIS data, pooling the years 2007 through 2009.[15] Although there are other federal surveys, NHIS is used here because it is

[12] Although the discussion below generally omits the term "non-institutionalized" for brevity, all estimates exclude individuals living in nursing homes and other institutional settings.

[13] Centers for Disease Control and Prevention (CDC), About the National Health Interview Survey, last modified April 18, 2011. http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[14] 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, socio-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.

[15] 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.

generally considered to be one of the best surveys for health insurance coverage estimates, and it captures detailed information on individuals' health status.[16]

Tables 3A-C provide estimates of children age 0-18, Tables 4A-C of adults age 19-64, and Tables 5A-C of adults age 65 and older. Each age group's tables display the following:

- Health insurance coverage and demographics: Tables 3A, 4A, and 5A;
- Health: Tables 3B, 4B, and 5B; and
- Use of health care: Tables 3C, 4C, and 5C.

All of these tables are broken into two parts—first comparing Medicaid/CHIP enrollees in that age group to individuals with other sources of health insurance, then comparing subgroups of Medicaid/CHIP enrollees with each other.[17]

Children Under Age 19

Table 3A, which focuses on children's health insurance status and demographics, shows that 32.1 percent of children were Medicaid/CHIP enrollees, while 57.6 percent of children were in private coverage and 9.1 percent were uninsured. The table then provides estimates of how those children's characteristics differ, depending on their source of health insurance, with an asterisk noting where those differences from Medicaid/CHIP children are statistically significant. For example, Medicaid/CHIP children are more likely to be Hispanic (32.9 percent) than privately insured children (12.2 percent) and less likely to be Hispanic than uninsured children (38.6 percent); Medicaid/CHIP children are more likely to be non-Hispanic black (24.6 percent) than privately insured (9.5 percent) or uninsured children (10.6 percent).

Table 3B, which focuses on children's health, shows that Medicaid/CHIP children are 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., ADHD/ADD, asthma). Table 3C, which focuses on children's health care use, shows that Medicaid/CHIP children were more likely to have had a visit to the emergency room in the past year, and to have been regularly taking prescription medications for at least three months.

The right-hand portion of Tables 3A-C groups the Medicaid/CHIP enrollees under age 19 into mutually exclusive categories:

- Children who receive Supplemental Security Income (SSI) benefits and are therefore disabled under that program's definition;[18]
- 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.

CSHCN are defined by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration (HRSA) 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

[16] 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: The National Academies Press, 2010): 72. http://www.nap.edu/catalog/13024.html.

[17] Health and other characteristics presented in Tables 3A-5C are for the Medicaid/CHIP population as a whole because the data source (the National Health Interview Survey) does not publish separate results for Medicaid and CHIP enrollees.

[18] For a discussion of disability as determined under the SSI program, see the discussion of Medicaid eligibility for persons with disabilities in MACStats Section 4.

generally."[19] This definition, which is used by all states for policy and program planning purposes for CSHCN, is a broad classification that encompasses children with disabilities and also children with chronic conditions (e.g., asthma, juvenile diabetes, sickle cell anemia) that range from mild to severe. It includes children who are "at risk" of these conditions and those who have been diagnosed, as well as children who require "related services" not traditionally considered health services (for example, social and home care services, school and developmental programs).

Very few children have conditions severe enough and family incomes so low as to qualify for SSI (see Section 4). Therefore, CSHCN designation is intended to capture a broader group of children with chronic health conditions. Many researchers use the MCHB definition for CSHCN, although they may not include the at-risk population in their analyses. MACPAC analyses of CSHCN in this Report may not fully include the at-risk population. Based on an approach developed by researchers,[20] children with special health care needs are identified in MACStats as those who have at least one of five broad symptoms of a chronic health problem as a result of a health condition lasting at least 12 months. By this definition, a CSHCN:

- 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, or education services; or
- needs or receives treatment or counseling for an emotional, behavioral, or developmental problem.[21]

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, cerebral palsy, paralysis) and would qualify for SSI if his or her family income were low enough.[22] 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.

As described earlier, many health and demographic characteristics of children enrolled in Medicaid/CHIP differ significantly from children with other coverage. In addition, among the children enrolled

[19] M. McPherson et al., A new definition of children with special health care needs, *Pediatrics* 102 (1998): 137-140.

[20] C. Bethell et al., Identifying children with special health needs: Development and evaluation of a short screening instrument, *Ambulatory Pediatrics* 2 (2002): 38-48.

[21] Since the NHIS does not explicitly include the standard CSHCN screening questions, this analysis uses an adaptation developed by Christine Coyer of the Urban Institute for the 2007-2009 NHIS based on an operationalization of the CSHCN screener for the 1999-2000 NHIS (Davidoff, A. Identifying children with special health care needs in the National Health Interview Survey: A new resource for policy analysis, *Health Services Research*, 39 (2004): 53-72). While the method used in this edition of MACStats attempts to replicate the standard CSHCN screener as much as possible, there are other ways to operationalize the CSHCN definition using the NHIS.

[22] 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 12 months or result in death. Thus, children who are receiving SSI should meet the criteria for being a child with special health care needs (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 the child's receipt of SSI in the survey, or (2) the parent correctly reported SSI but neglected to report the child's health information related to his/her eligibility for SSI and thus classification as a CSHCN.

in Medicaid/CHIP, the three subgroups identified often vary significantly from Medicaid/CHIP children overall:

- **Significant differences in general health exist among children enrolled in Medicaid/CHIP.** As shown in the right-hand portion of Table 3B, among children enrolled in Medicaid/CHIP, 18.5 percent of those receiving SSI are in fair or poor health, compared to 11.4 percent for non-SSI CSHCN and 1.0 percent for children who are neither SSI nor CSHCN.[23]
- **Incidence of specific health conditions varies among children enrolled in Medicaid/CHIP.** As shown in the right-hand portion of Table 3B, the incidence of ADHD/ADD among Medicaid-CHIP enrolled children is 39.0 percent for SSI children, 39.4 percent for non-SSI CSHCN, and 1.9 percent for children who are neither SSI nor CSHCN. The incidence of asthma reported by SSI children was 30.1 percent, compared to 40.8 percent for non-SSI CSHCN and 10.7 percent for children who are neither SSI nor CSHCN.
- **Significant differences in use of recent care exist among children enrolled in Medicaid/CHIP.** As shown in the right-hand portion of Table 3C, SSI children and non-SSI CSHCN are each nearly twice as likely to visit health care providers four or more times within a year than Medicaid/CHIP children who are neither SSI nor CSHCN.

Adults Age 19-64

According to the NHIS estimates shown in Table 4A, 8.4 percent of non-institutionalized adults age 19-64 were enrolled in Medicaid or CHIP.[24] The Medicaid/CHIP enrollees in this age group tend to be in much worse health than those enrolled in private coverage or the uninsured, but in better health than those enrolled in Medicare.

Dual eligibles are individuals who are enrolled in both Medicaid and Medicare.[25] For 19-64-year-olds, dual eligibles are low-income individuals who are eligible for Medicare on the basis of a disability and for Medicaid on a basis that may or may not include disability.[26] Table 4A shows that Medicaid/CHIP enrollees in this age group, 12.4 percent also were enrolled in Medicare; conversely, of the Medicare enrollees in this age group, 31.0 percent also were enrolled in Medicaid.

The right-hand portion of Tables 4A-C groups the 19-64-year-old Medicaid/CHIP enrollees into three mutually exclusive categories:

- Dual eligibles;
- Medicaid enrollees receiving SSI who are not dual eligibles; and
- Medicaid/CHIP enrollees who are neither SSI nor Medicare enrollees.

The right-hand portions of Tables 4A-C illustrate how these groups of individuals vary significantly from 19-64-year-old Medicaid/CHIP enrollees overall:

[23] Although this particular statistical significance testing is not displayed in Table 3B, all of these estimates are significantly different from one another.

[24] Federal surveys such as NHIS do not publish separate results for Medicaid and CHIP enrollment. CHIP enrollment of adults is small, totaling less than 350,000 ever enrolled during FY 2010 (Table 3, March 2011 MACStats).

[25] Enrollment in CHIP-financed coverage is prohibited for those with other coverage, such as Medicare.

[26] Most dual eligibles under age 65 have obtained their Medicare coverage after a two-year waiting period following their initial receipt of Social Security Disability Insurance (SSDI) benefits. During the two-year waiting period and beyond, SSDI beneficiaries may have incomes low enough to qualify for SSI benefits and therefore Medicaid; they may also qualify for Medicaid via other pathways (e.g., as a low-income parent or an individual with high medical expenses who "spends down" to a Medicaid income eligibility level). For information on SSI and SSDI, see the discussion of Medicaid eligibility for persons with disabilities in Section 4.

Significant differences in general health exist among 19-64-year-olds enrolled in Medicaid/CHIP. Table 4B shows that dual eligibles and the non-dual SSI beneficiaries report fair or poor health (62.9 percent and 57.9 percent, respectively)[27] at much higher rates than non-SSI, non-dual enrollees (21.3 percent).

Among 19-64-year-olds enrolled in Medicaid/CHIP, incidence of specific health conditions is highest for persons with disabilities. Table 4B also shows that dual eligibles and non-dual SSI beneficiaries were more likely to report the presence of chronic conditions such as heart disease, diabetes, depression, chronic bronchitis and arthritis than the overall Medicaid/CHIP enrollees in this age group.

Table 4C shows that among 19-64-year-olds enrolled in Medicaid/CHIP, persons with disabilities have higher use of recent care. Dual eligibles and non-dual SSI beneficiaries also made more visits to health care providers within a year and were more likely to receive home care within the past year than 19-64-year-old Medicaid/CHIP enrollees overall, as shown in Table 4C.

Adults Age 65 and Older

According to the NHIS estimates shown in Table 5A, 7.3 percent of non-institutionalized adults age 65 and older were enrolled in Medicaid.[28] Medicare covered 95.2 percent of those aged 65 and older. Table 5A also shows that of Medicaid enrollees age 65 and older, 91.0 percent were dual eligibles.[29] Conversely, of the Medicare enrollees in this age group, 7.0 percent also were enrolled in Medicaid.

The right-hand portion of Tables 5A-C groups the Medicaid enrollees age 65 and older into two mutually exclusive categories:

- Those with a functional limitation; and
- Those without 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"—doing any of a dozen activities[30] 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 in one's home[31] to being relatively healthy but responding that walking a quarter of a mile is "only a little difficult." The right-hand portion of Tables 5A-C illustrates how these two groups of individuals vary significantly from aged Medicaid/CHIP enrollees overall. However, because more than three-quarters of aged Medicaid enrollees have functional limitations, those with functional limitations drive the overall characteristics of aged enrollees, and thus do not show significant differences from the total as often as those with no functional limitations.

[27] Although this particular statistical significance testing is not displayed in Table 4B, these two estimates are significantly different from the estimate for non-dual SSI beneficiaries (21.3 percent).

[28] Even though survey estimates are generally not published separately for Medicaid and CHIP, CHIP is not included in this portion of the NHIS estimates because its occurrence among those aged 65 and older would be rare. Enrollment in CHIP-financed coverage is prohibited for those with other coverage, such as Medicare, and 95 percent of those 65 and older have Medicare.

[29] Nearly all individuals are entitled to Medicare coverage upon turning 65; as with Medicare enrollees under age 65, they may have incomes low enough or medical expenses high enough to also qualify for Medicaid.

[30] The activities asked about in the survey are the following: walk a quarter of a mile, walk up 10 steps without resting, stand or be on your feet for about two hours, sit for about two hours, stoop or kneel, reach up over your head, use your fingers to grasp or handle small objects, lift or carry something as heavy as 10 pounds, push or pull large objects like a living room chair, go out to do things like shopping, participate in social activities such as visiting friends, or do things to relax at home such as reading or watching TV.

[31] Individuals in institutions such as nursing homes are not interviewed in the NHIS.

TABLE 3A. Health Insurance and Demographic Characteristics of Non-institutionalized Individuals Age 0-18 by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]			Medicaid/CHIP[2]			
	All Children	Medicaid/ CHIP[2]	Private[3]	Uninsured[4]	Medicaid/ CHIP children	SSI	Non-SSI CSHCN[5]	Neither SSI nor CSHCN
Health Insurance Coverage		**32.1%**	57.6%	9.1%	**100.0%**	3.0%	17.9%	79.1%
Age (categories sum to 100%)								
0-5	32.2%*	**39.0%**	29.5%*	24.8%*	**39.0%**	16.7%*	24.5%*	43.2%*
6-11	30.6	**30.9**	30.7	29.2	**30.9**	34.6	38.1*	29.2
12-18	37.2*	**30.0**	39.8*	46.1*	**30.0**	48.7*	37.4*	27.6*
Gender (categories sum to 100%)								
Male	51.2%	**51.4%**	50.9%	50.9%	**51.4%**	62.9%*	60.0%*	49.0%*
Female	48.8	**48.6**	49.1	49.1	**48.6**	37.1*	40.0*	51.0*
Race (categories sum to 100%)								
Hispanic	21.4%*	**32.9%**	12.2%*	38.6%*	**32.9%**	23.8%*	21.5%*	35.8%*
White, non-Hispanic	56.2*	**35.0**	70.4*	42.9*	**35.0**	34.3	44.8*	32.9
Black, non-Hispanic	14.6*	**24.6**	9.5*	10.6*	**24.6**	36.5*	25.2	24.0
Other and multiple races, non-Hispanic	7.8	**7.5**	7.9	7.9	**7.5**	5.4	8.5	7.3
Health insurance								
Medicaid/CHIP	32.1%*	**100.0%**	2.4%*	–	**100.0%**	100.0%	100.0%	100.0%
Private	57.6*	**4.3**	100.0*	–	**4.3**	11.5*	6.3*	3.6

See Table 3C for sources and notes.

TABLE 3B. Health Characteristics of Non-institutionalized Individuals Age 0-18 by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]			Medicaid/CHIP[2]			
	All Children	Medicaid/ CHIP[2]	Private[3]	Uninsured[4]	Medicaid/ CHIP children	SSI	Non-SSI CSHCN[5]	Neither SSI nor CSHCN
Children with disabilities or with special health care needs								
Receives supplemental security income (SSI)	1.2%*	**3.0%**	0.4%*	0.3%	**3.0%**	100.0%*	–	–
Children with special health care needs (CSHCN)[5]	14.8*	**20.3**	12.7*	11.3	**20.3**	79.7*[6]	100.0*	–
Current health status (categories sum to 100%)								
Excellent or very good	82.8%*	**72.7%**	89.2%*	76.9%*	**72.7%**	42.3%*	53.9%*	78.1%*
Good	15.4*	**23.9**	10.0*	20.9*	**23.9**	39.3*	34.7*	20.9*
Fair or poor	1.8*	**3.4**	0.8*	2.2*	**3.4**	18.5*	11.4*	1.0*
Impairments								
Impairment requiring special equipment	1.0%*	**1.5%**	1.0%*	0.3%*	**1.5%**	11.7%*	4.9%*	0.3%*
Impairment limits ability to crawl, walk, run, play[7]	1.8*	**2.5**	1.5*	1.4*	**2.5**	19.7*	8.2*	0.6*
Impairment lasted, or expected to last 12+ months[8]	1.6*	**2.3**	1.3*	1.3*	**2.3**	19.6*	7.7*	0.4*
Specific health conditions								
Ever told child has:								
ADHD/ADD[8]	7.5%*	**10.7%**	6.3%*	5.2%*	**10.7%**	39.0%*	39.4%*	1.9%*
Asthma	13.6*	**16.6**	12.7*	9.9*	**16.6**	30.1*	40.8*	10.7*
Autism[7]	0.8*	**1.1**	0.7*	†	**1.1**	10.2*	4.2*	†
Cerebral palsy[7]	0.7	**0.8**	0.8	0.6	**0.8**	6.8*	1.7*	0.3
Congenital heart disease	1.3	**1.5**	1.2	0.9*	**1.5**	5.1*	5.1*	0.6
Diabetes	0.2	**0.3**	0.2	†	**0.3**	†	1.1*	0.1
Down syndrome[7]	0.1	**0.2**	0.1	†	**0.2**	2.2*	0.8*	†
Mental retardation[7]	0.6*	**1.2**	0.3*	†	**1.2**	13.6*	4.4*	0.0
Other developmental delay[7]	4.0*	**5.8**	3.4*	2.7*	**5.8**	43.9*	21.8*	0.8
Sickle cell anemia[7]	0.2	**0.3**	0.1*	†	**0.3**	1.6	0.8*	0.1

See Table 3C for sources and notes.

TABLE 3C. Use of Care by Non-institutionalized Individuals Age 0-18 by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]			Medicaid/CHIP[2]			
	All Children	Medicaid/ CHIP[2]	Private[3]	Uninsured[4]	Medicaid/ CHIP children	SSI	Non-SSI CSHCN[5]	Neither SSI nor CSHCN
Received well-child check-up in past 12 months[7]	75.8%*	**78.9%**	78.5%	46.1%*	**78.9%**	83.0%	83.3%*	77.7%
Regularly taking prescription drug(s) for 3+ months[8]	12.8*	**15.1**	12.9*	5.8*	**15.1**	51.3*	52.9*	5.0*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)								
None	11.3%*	**9.3%**	8.6%	35.2%*	**9.3%**	6.1%	4.4%*	10.5%
1	21.4*	**19.6**	21.9*	23.6*	**19.6**	17.8	8.5*	22.1*
2-3	35.9	**35.2**	37.8*	26.3*	**35.2**	21.9*	27.3*	37.4*
4+	31.3*	**36.0**	31.7*	14.8*	**36.0**	54.2*	59.8*	30.0*
Number of emergency room visits in past 12 months (categories sum to 100%)								
None	79.3%*	**71.6%**	83.0%*	82.2%*	**71.6%**	61.1%*	59.9%	74.7%*
1	13.7*	**17.0**	12.1*	11.5*	**17.0**	23.1	20.8*	15.9
2-3	5.7*	**8.7**	4.3*	5.1*	**8.7**	7.7	13.3*	7.7
4+	1.3*	**2.7**	0.6*	1.2*	**2.7**	8.0*	5.9*	1.7*

Notes: Health insurance coverage is defined at the time of the survey. Totals of health insurance coverage may sum to more than 100% 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. In order to focus on a consistent sample across the measures included in this table, the tabulations reported here are based on the NHIS sample child/adult weights. Somewhat different estimates might be obtained using the broader person file weights for the subset of variables that are available for all persons in the household. This analysis provides conservative estimates of statistical significance; it does not take into account subgroups' non-independence by incorporating the covariance.

† Estimates with a relative standard error of greater than 50% are indicated with a dagger and are not shown.

* Difference from Medicaid/CHIP is statistically significant at the 95 percent confidence level.

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

1 Not separately shown are the estimates of children covered by Medicare (0.3%, generally children with end-stage renal disease, ESRD), any type of military health plan (VA, TRICARE, and CHAMP-VA), or other government programs.

2 Medicaid/CHIP health insurance coverage 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 A person was defined as uninsured if he/she did not have any private health insurance, Medicaid, CHIP, Medicare, state-sponsored or other government-sponsored health plans, or military plan. A person was also defined as uninsured if he/she had only Indian Health Service (IHS) coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

5 A standard screener has been developed by researchers (Bethell et al., 2002) to identify children with special health care needs (CSHCN) as those who have at least one of five broad symptoms of a chronic health problem (e.g., needs or uses prescription medications) as a result of a health condition(s) lasting at least 12 months. Since the NHIS does not explicitly include the standard CSHCN screener, this analysis adapted Davidoff's (2004) methodology for identifying CSHCN which was developed for the 1999-2000 NHIS, to the 2007-2009 NHIS. While this method attempts to replicate the standard CSHCN screener as much as possible on the NHIS, there are other ways of operationalizing the CSHCN definition on the NHIS.

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 result 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 child with special health care needs (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 parents erroneously reported the child's receipt of SSI in the survey, or (2) the parents neglected to report in the survey the child's health information related to his/her eligibility for SSI and thus as a CSHCN.

7 Question only asked for children age 0 to 17.

8 Question only asked for children age 2 to 17.

Source: Urban Institute analysis of the National Health Interview Survey (NHIS) for MACPAC; the estimates for 2007-2009 are based on household interviews of a sample of the civilian non-institutionalized population

TABLE 4A. Health Insurance and Demographic Characteristics of Non-institutionalized Individuals Age 19-64 by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]				Medicaid/CHIP[2]			
	All Non-aged Adults	Medicaid/ CHIP[2]	Private[3]	Medicare	Uninsured[4]	Medicaid/ CHIP non-aged adults	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Health Insurance Coverage		**8.4%**	67.5%	3.4%	20.4%	**100.0%**	12.4%	16.0%	71.6%
Age (categories sum to 100%)									
19-24	13.5%*	**17.8%**	11.0%*	1.7%*	20.5%*	**17.8%**	1.4%*	9.8%*	22.6%*
25-44	44.4*	**47.4**	43.3*	23.3*	50.4*	**47.4**	34.4*	38.7*	51.7*
45-54	23.8*	**19.4**	25.9*	28.0*	18.3	**19.4**	30.4*	26.3*	15.8*
55-64	18.3*	**15.4**	19.7*	47.0*	10.8*	**15.4**	33.8*	25.2*	9.9*
Gender (categories sum to 100%)									
Male	49.3%*	**33.7%**	49.1%*	50.2%*	55.1%*	**33.7%**	44.0%*	38.6%*	30.7%*
Female	50.7*	**66.3**	50.9*	49.8*	44.9*	**66.3**	56.0*	61.4*	69.3*
Race (categories sum to 100%)									
Hispanic	14.8%*	**22.0%**	9.6%*	8.4%*	30.2%*	**22.0%**	9.0%*	15.0%*	25.9%*
White, non-Hispanic	66.4*	**48.0**	73.9*	67.9*	49.5	**48.0**	64.2*	52.1	44.3*
Black, non-Hispanic	12.1*	**23.4**	9.9*	18.4*	13.7*	**23.4**	20.6	27.6	22.8
Other and multiple races, non-Hispanic	6.7	**6.6**	6.7	5.3*	6.6	**6.6**	6.2	5.4	7.0
Health Insurance									
Medicaid/CHIP	8.4%*	**100.0%**	0.4%*	31.0%*	–	**100.0%**	100.0%	100.0%	100.0%
Medicare	3.4*	**12.4**	1.0*	100.0*	–	**12.4**	100.0*	–	–
Private	67.5*	**3.1**	100.0*	20.9*	–	**3.1**	1.8	3.8	3.2

See Table 4C for sources and notes.

TABLE 4B. Health Characteristics of Non-institutionalized Individuals Age 19-64 by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]				Medicaid/CHIP[2]			
	All Non-aged Adults	Medicaid/ CHIP[2]	Private[3]	Medicare	Uninsured[4]	Medicaid/ CHIP non-aged adults	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Disability and work status									
Receives SSI	2.3%*	**21.0%**	0.3%*	21.4%	0.4%*	**21.0%**	40.8%*	100.0%*	0.0
Receives SSDI	3.0*	**13.9**	1.2*	60.3*	5.0*	**13.9**	62.1*	14.5	5.5*
Working	7.4*	**3.6**	82.8*	12.1*	66.2*	**36.0**	9.5*	9.7*	46.6*
Current health status (categories sum to 100%)									
Excellent or very good	64.3%*	**37.7%**	71.2%*	11.8%*	57.4%*	**37.7%**	9.0%*	17.3%*	47.2%*
Good	24.7*	**30.0**	22.3*	26.9*	30.1	**30.0**	28.2	24.8*	31.6
Fair or poor	11.0*	**32.2**	6.4*	61.3*	0.1*	**32.2**	62.9*	57.9*	21.3*
Health compared to 12 months ago (categories sum to 100%)									
Better	19.3%	**20.1%**	19.6%	16.7%*	18.2%*	**20.1%**	17.9%	20.3%	20.4%
Worse	8.0*	**17.2**	5.9*	25.4*	9.2*	**17.2**	29.8*	21.8*	14.0*
Same	72.8*	**62.8**	74.4*	57.9*	72.6*	**62.8**	52.3*	57.9*	65.6
Activities of daily living (ADLs)									
Help with any personal care needs[5]	1.2%*	**6.7%**	0.5%*	13.3%*	0.5%*	**6.7%**	19.0%*	13.7%*	2.9%*
Help with bathing/showering	0.7*	**4.5**	0.3*	8.3*	0.2*	**4.5**	12.7*	9.7*	1.9*
Help with dressing	0.7*	**3.9**	0.3*	7.9*	0.2*	**3.9**	12.0*	8.0*	1.6*
Help with eating	0.2*	**1.5**	0.1*	2.3	0.1*	**1.5**	3.9*	3.8*	0.6*
Help with transferring (in/out of bed or chairs)	0.6*	**3.5**	0.3*	7.3*	0.2*	**3.5**	9.5*	6.7*	1.7*
Help with toileting	0.4*	**2.6**	0.1*	5.2*	0.1*	**2.6**	8.2*	5.2*	1.0*
Help getting around in home	0.5*	**2.7**	0.2*	5.3*	0.1*	**2.7**	7.1*	4.1	1.6*
Number of above ADLs reported (categories sum to 100%)									
0	99.0%*	**94.3%**	99.6%*	88.6%*	99.7%*	**94.3%**	83.6%*	88.1%*	97.5%*
1	0.2*	**0.8**	0.1*	1.9*	0.1*	**0.8**	2.2*	2.4*	0.3*
2	0.2*	**1.5**	0.1*	2.7*	0.1*	**1.5**	3.9*	3.0	0.7*
3	0.2*	**0.9**	0.1*	2.2*	0.0*	**0.9**	3.1*	1.5	0.4*
4+	0.4*	**2.4**	0.2*	4.6*	0.1*	**2.4**	7.1*	4.9*	1.1*

TABLE 4B, Continued

	All Non-aged Adults	Selected Sources of Insurance[1]				Medicaid/CHIP[2]			
		Medicaid/ CHIP[2]	Private[3]	Medicare	Uninsured[4]	Medicaid/ CHIP non-aged adults	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Specific health conditions									
Currently pregnant	1.3%*	**4.8%**	1.1%*	†	0.7%*	**4.8%**	†	0.9%*	6.5%*
Functional limitation[6]	27.2*	**48.5**	23.7*	82.8%*	24.5*	**48.5**	83.2%*	75.2*	36.7*
Difficulty walking without equipment	3.2*	**12.6**	1.7*	33.5*	1.8*	**12.6**	36.0*	23.9*	6.1*
Health condition that requires special equipment (e.g., cane, wheelchair)	3.9*	**13.3**	2.5*	33.0*	2.0*	**13.3**	36.1*	25.2*	6.7*
Lost all natural teeth	4.6*	**9.6**	3.4*	18.4*	4.9*	**9.6**	20.3*	16.8*	6.1*
Depressed/anxious feelings[7]	11.6*	**28.0**	7.7*	34.8*	15.7*	**28.0**	43.3*	39.1*	23.1*
Ever told had hypertension	22.4*	**32.2**	21.8*	55.0*	17.1*	**32.2**	55.8*	46.7*	24.8*
Ever told had coronary heart disease	2.3*	**4.2**	2.0*	13.4*	1.3*	**4.2**	10.2*	7.6*	2.5*
Ever told had heart attack	1.8*	**3.9**	1.4*	10.5*	1.2*	**3.9**	8.9*	7.6*	2.2*
Ever told had stroke	1.4*	**4.4**	0.9*	11.5*	1.0*	**4.4**	10.7*	8.1*	2.4*
Ever told had cancer	4.9*	**6.1**	5.1*	11.5*	2.9*	**6.1**	11.4*	9.6*	4.5*
Ever told had diabetes	6.4*	**12.7**	5.7*	25.9*	4.8*	**12.7**	30.2*	19.4*	8.1*
Ever told had arthritis	17.0*	**24.8**	17.0*	51.2*	10.8*	**24.8**	50.1*	38.9*	17.3*
Ever told had asthma	12.4*	**19.7**	11.8*	21.0*	11.2*	**19.7**	26.4*	27.0*	16.9*
Past 12 months, told had chronic bronchitis	3.7*	**8.1**	3.0*	12.5*	3.7*	**8.1**	13.6*	13.9*	5.9*
Past 12 months, told had liver condition	1.4*	**3.5**	1.0*	6.0*	1.3*	**3.5**	7.8*	6.1*	2.1*
Past 12 months, told had weak/failing kidneys	1.2*	**4.2**	0.7*	8.1*	1.2*	**4.2**	9.8*	6.8*	2.7*

See Table 4C for sources and notes.

TABLE 4C. Use of Care by Non-institutionalized Individuals Age 19-64 by Source of Health Insurance, 2007–2009

	All Non-aged Adults	Selected Sources of Insurance[1]				Medicaid/CHIP[2]			
		Medicaid/ CHIP[2]	Private[3]	Medicare	Uninsured[4]	Medicaid/ CHIP non-aged adults	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Received at-home care in past 12 months	1.2%*	**5.2%**	0.9%*	9.1%*	0.4%*	**5.2%**	14.6%*	9.3%*	2.5%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)									
None	21.6%*	**13.9%**	15.5%*	6.2%*	46.9%*	**13.9%**	3.2%*	8.9%*	16.9%*
1	18.2*	**11.4**	19.2*	6.6*	18.7*	**11.4**	3.4*	8.3*	13.5*
2-3	26.6*	**20.7**	30.3*	15.6*	17.3*	**20.7**	15.1*	16.0*	22.6
4+	33.7*	**54.0**	35.1*	71.5*	17.1*	**54.0**	78.3*	66.8*	47.0*
Number of emergency room visits in past 12 months (categories sum to 100%)									
None	80.1%*	**59.8%**	83.4%*	59.0%	79.4%*	**59.8%**	54.0%	53.1%*	62.3%
1	12.6*	**18.5**	11.7*	19.3	12.5*	**18.5**	18.8	20.0	18.1
2-3	5.3*	**13.0**	3.9*	13.2	6.0*	**13.0**	15.6	15.2	12.1
4+	2.0*	**8.7**	1.0*	8.4	2.1*	**8.7**	11.5	11.7*	7.5

Notes: Health insurance coverage is defined at the time of the survey. Totals of health insurance coverage may sum to more than 100% 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 programs. In order to focus on a consistent sample across the measures included in this table, the tabulations reported here are based on the NHIS sample adult weights. Somewhat different estimates might be obtained using the broader person file weights for the subset of variables that are available for all persons in the household. This analysis provides conservative estimates of statistical significance; it does not take into account subgroups' non-independence by incorporating the covariance.

† Estimates with a relative standard error of greater than 50% are indicated with a dagger and are not shown.

* Difference from Medicaid/CHIP is statistically significant at the 95 percent confidence level.

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

1 Not separately shown are the estimates of individuals covered by any type of military health plan (VA, TRICARE, and CHAMP-VA) or other government programs.

2 Medicaid/CHIP health insurance coverage also includes persons covered by other state-sponsored health plans. Federal surveys such as NHIS do not publish separate results for Medicaid and CHIP enrollment. CHIP enrollment of adults is small, totaling less than 350,000 ever enrolled during FY 2010 (March 2011 MACStats).

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

4 A person was defined as uninsured if he/she did not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plans, or military plan. A person was also defined as uninsured if he/she had only Indian Health Service (IHS) coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

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

6 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.

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

Source: Urban Institute analysis of the National Health Interview Survey (NHIS) for MACPAC; the estimates for 2007-2009 are based on household interviews of a sample of the civilian non-institutionalized population

The NHIS analysis file for sample adults had been previously constructed with funding under the Robert Wood Johnson Foundation's State Health Access Reform Evaluation (SHARE) initiative as part of another project. We appreciate Sharon Long's willingness to share that file with MACPAC.

TABLE 5A. Health Insurance and Demographic Characteristics of Non-institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]			Medicaid[2]		
	All Aged Adults	Medicaid[2]	Private[3]	Medicare	All Medicaid aged adults	Functional limitation[4]	No functional limitation
Health Insurance Coverage		**7.3%**	57.4%	95.2%	**100.0%**	76.8%	23.2%
Age (categories sum to 100%)							
65-74	53.7%	**53.4%**	53.5%	52.5%	**53.4%**	51.2%	61.0%
75-84	34.7	**36.0**	34.7	35.6	**36.0**	36.3	0.4
85+	11.6	**10.6**	11.8	11.9	**10.6**	12.6	3.7*
Gender (categories sum to 100%)							
Male	43.1%*	**33.7%**	43.4%*	42.6%*	**33.7%**	29.7%	47.3%*
Female	56.9*	**66.3**	56.6*	57.4*	**66.3**	70.3	52.7*
Race (categories sum to 100%)							
Hispanic	6.9%*	**23.1%**	3.0%*	6.5%*	**23.1%**	22.3%	25.7%
White, non-Hispanic	80.0*	**47.2**	87.8*	80.9*	**47.2**	49.3	40.5
Black, non-Hispanic	8.4*	**18.3**	5.5*	8.2*	**18.3**	19.6	13.4*
Other and multiple races, non-Hispanic	4.7*	**11.4**	3.6*	4.4*	**11.4**	8.7	20.4*
Health insurance							
Medicaid/CHIP	7.3%*	**100.0%**	0.7%*	7.0%*	**100.0%**	100.0%	100.0%
Medicare	95.2*	**91.0**	94.6*	100.0*	**91.0**	91.7	89.2
Private	57.4*	**5.3**	100.0*	57.0*	**5.3**	4.7	6.8

See Table 5C for sources and notes.

TABLE 5B. Health Characteristics of Non-institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]			Medicaid[2]		
	All Aged Adults	Medicaid[2]	Private[3]	Medicare	All Medicaid aged adults	Functional limitation[4]	No functional limitation
Disability and work status							
Receives SSI	3.8%*	**37.4%**	0.5%*	3.8%*	**37.4%**	37.8%	34.8%
Working	15.0*	**4.2**	17.8*	13.7*	**4.2**	2.5	9.5*
Current health status (categories sum to 100%)							
Excellent or very good	40.7%*	**16.1%**	44.8%*	40.4%*	**16.1%**	10.8%*	33.8%*
Good	34.3	**32.4**	35.3	34.4	**32.4**	29.5	42.4*
Fair or poor	25.1*	**51.5**	19.9*	25.2*	**51.5**	59.7*	23.7*
Health compared to 12 months ago (categories sum to 100%)							
Better	13.4%	**13.4%**	13.3%	13.3%	**13.4%**	13.2%	13.9%
Worse	12.7*	**22.1**	11.4*	12.8*	**22.1**	26.3*	7.9*
Same	73.8*	**64.6**	75.3*	73.9*	**64.6**	60.4	78.2*
Activities of daily living (ADLs)							
Help with any personal care needs[5]	6.4%*	**18.7%**	4.6%*	6.6%*	**18.7%**	23.0%	4.3%*
Help with bathing/showering	4.7*	**15.3**	3.3*	4.8*	**15.3**	18.9	3.0*
Help with dressing	3.8*	**11.5**	2.7*	3.9*	**11.5**	14.3	2.3*
Help with eating	1.5*	**5.0**	1.0*	1.5*	**5.0**	6.1	1.4*
Help with transferring (in/out of bed or chairs)	2.9*	**9.3**	1.9*	3.0*	**9.3**	11.3	2.1*
Help with toileting	2.2*	**7.2**	1.5*	2.3*	**7.2**	8.8	1.4*
Help getting around in home	2.6*	**8.2**	1.8*	2.7*	**8.2**	10.1	1.4*
Number of above ADLs reported (categories sum to 100%)							
0	94.1%*	**82.5%**	95.9%*	94.0%*	**82.5%**	78.2%	97.0%
1	1.6*	**3.5**	1.4*	1.7*	**3.5**	4.4	†
2	1.3*	**4.6**	0.8*	1.3*	**4.6**	6.0	†
3	0.7*	**2.3**	0.5*	0.8*	**2.3**	2.8	† *
4+	2.2	**7.0**	1.5	2.2	**7.0**	8.6	1.4

TABLE 5B, Continued

	All Aged Adults	Selected Sources of Insurance[1]			Medicaid[2]		
		Medicaid[2]	Private[3]	Medicare	All Medicaid aged adults	Functional limitation[4]	No functional limitation
Specific health conditions							
Functional limitation[4]	62.9%*	**76.8%**	61.9%*	63.5%*	**76.8%**	100.0%*	0.0%*
Difficulty walking without equipment	18.6*	**35.2**	16.3*	18.9*	**35.2**	43.3*	6.6*
Health condition that requires special equipment (e.g., cane, wheelchair)	19.8*	**34.8**	17.5*	20.2*	**34.8**	43.3	7.0*
Lost all natural teeth	25.2*	**42.9**	21.5*	25.3*	**42.9**	45.5	34.5*
Depressed/anxious feelings[6]	9.3*	**22.3**	7.3*	9.4*	**22.3**	26.0	10.5*
Ever told had hypertension	61.4*	**70.9**	60.9*	62.0*	**70.9**	74.9	57.0*
Ever told had coronary heart disease	15.0*	**19.1**	15.2*	15.2*	**19.1**	21.3	12.1
Ever told had heart attack	11.8*	**16.1**	11.2*	11.9*	**16.1**	17.5*	11.8*
Ever told had stroke	8.9*	**13.1**	8.4*	9.1*	**13.1**	16.2	3.0*
Ever told had cancer	23.2*	**18.2**	26.1*	23.5*	**18.2**	20.4	10.0*
Ever told had diabetes	18.9*	**29.2**	16.9*	19.1*	**29.2**	33.2*	16.0*
Ever told had arthritis	50.0*	**57.5**	50.3*	50.6*	**57.5**	66.4	27.8
Ever told had asthma	10.7*	**14.3**	10.5*	10.7*	**14.3**	15.7	9.7*
Past 12 months, told had chronic bronchitis	5.7*	**9.6**	5.1*	5.8*	**9.6**	11.1	4.7
Past 12 months, told had liver condition	1.4*	**3.1**	1.3*	1.5*	**3.1**	3.3	†*
Past 12 months, told had weak/failing kidneys	4.3	**8.2**	3.8	4.4	**8.2**	9.2	4.3

See Table 5C for sources and notes.

TABLE 5C. Use of Care by Non-institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2007–2009

		Selected Sources of Insurance[1]			Medicaid[2]		
	All Aged Adults	Medicaid[2]	Private[3]	Medicare	All Medicaid aged adults	Functional limitation[4]	No functional limitation
Received at-home care in past 12 months	7.3%*	**19.0%**	6.4%*	7.5%*	**19.0%**	23.0%	6.0%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)							
None	6.4%	**6.2%**	5.0%	6.0%	**6.2%**	3.8%*	14.1%*
1	9.8	**8.0**	9.9	9.4	**8.0**	6.4	13.3*
2-3	24.7*	**16.5**	26.0*	24.8*	**16.5**	14.1	24.5*
4+	59.1*	**69.2**	59.0*	59.7*	**69.2**	75.6*	48.1*
Number of emergency room visits in past 12 months (categories sum to 100%)							
None	76.2%*	**66.3%**	77.8%*	75.9%*	**66.3%**	62.6%	78.5%*
1	15.0	**16.4**	14.9	15.1	**16.4**	17.0	14.5
2-3	6.6*	**12.2**	5.5*	6.8*	**12.2**	14.4	5.1*
4+	2.2*	**5.1**	1.9*	2.3*	**5.1**	6.0	2.0*

Notes: Health insurance coverage is defined at the time of the survey. Totals of health insurance coverage may sum to more than 100% 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 programs. In order to focus on a consistent sample across the measures included in this table, the tabulations reported here are based on the NHIS sample adult weights. Somewhat different estimates might be obtained using the broader person file weights for the subset of variables that are available for all persons in the household. This analysis provides conservative estimates of statistical significance; it does not take into account subgroups' non-independence by incorporating the covariance.

† Estimates with a relative standard error of greater than 50% are indicated with a dagger and are not shown.

* Difference from Medicaid/CHIP is statistically significant at the 95 percent confidence level.

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

1 Not separately shown are the estimates of individuals covered by any type of military health plan (VA, TRICARE, and CHAMP-VA) or other government programs. Also not shown are estimates of the aged uninsured (0.6%). The sample size is not sufficient to support published estimates of their characteristics. A person was defined as uninsured if he/she did not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plans, or military plan. A person was also defined as uninsured if he/she had only Indian Health Service (IHS) coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

2 Medicaid health insurance coverage also includes persons covered by other public programs, excluding Medicare (e.g., other state-sponsored health plans). Even though survey estimates are generally not published separately for Medicaid and CHIP, CHIP is not shown in the labels of this portion of the NHIS estimates because its occurrence among those aged 65 and older would be rare. Enrollment in CHIP-financed coverage is prohibited for those with other coverage, such as Medicare, and 95% of those 65 and older have Medicare.

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 specific personal care need is reported as the overall population incidence (rather than the incidence 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: Urban Institute analysis of the National Health Interview Survey (NHIS); the estimates for 2007-2009 are based on household interviews of a sample of the civilian non-institutionalized population

Medicaid Enrollment and Spending (Tables 6–8 and Figures 3–7)

Tables 6 to 8 and Figures 3 to 7 show Medicaid enrollment and spending, with various breakouts by state, eligibility group, dual eligible status, and type of service. They are based on Medicaid Statistical Information System (MSIS) data for FY 2008 (the most recent available for all states) that have been adjusted to match benefit spending totals reported by states in CMS-64, as discussed in Section 4 of MACStats.

Medicaid benefit spending varies widely across populations:

- Non-disabled adults and children represent the majority of Medicaid enrollees nationally and within each state (Table 6), but disabled and aged enrollees account for the largest share of the program's spending on benefits (Table 7).
- Disabled and aged enrollees have per person Medicaid benefit spending that is 3 to 5 times larger than that of other enrollees (Figure 4 and Table 8).
- Individuals age 65 and older account for about 60 percent of dual eligible enrollment and dual eligible Medicaid benefit spending; younger dual eligibles account for the remaining 40 percent (Tables 6 and 7).
- Spending by type of service also varies among populations: a higher share of spending for disabled and aged enrollees goes to cover long-term services and supports, while a substantial portion of spending for non-disabled children and adults goes to managed care payments (Figures 3 and 4).
- The users of long-term services and supports (LTSS)—primarily disabled and aged enrollees—account for a small share of Medicaid enrollees, but a large share of Medicaid spending on both LTSS and acute care (Figures 4 through 7).

Medicaid benefit spending per enrollee also varies substantially across states (Table 8). Reasons for this variation may include the breadth of benefits that states choose to cover; the portion of enrollees receiving a full benefit package or a more limited version; enrollee case mix (based on health status and other characteristics); the underlying cost of delivering health care services in a geographic area; and state policies regarding provider payments, care management, and other issues.

Information reported by states in MSIS indicates that the portion of enrollees receiving limited benefits ranged from less than 2 percent in five states to more than 20 percent in another three in FY 2008 (Table 8). These percentages vary by enrollee population; for example, in many states with family planning waivers, a substantial portion of non-disabled adult enrollees received limited benefits.[32]

Even when comparisons are limited to similar populations, Medicaid spending per enrollee still varies substantially across states. For example, one analysis of disabled enrollees with similar income levels (i.e., low enough to qualify for cash assistance under the SSI program) receiving full Medicaid-only fee-for-service benefits (i.e., excluding enrollees with limited benefits, those with Medicare coverage, and those in managed care) found that Medicaid spending per enrollee on acute care in the highest spending state was more than double the

[32] In FY 2008, the following states had implemented waivers providing Medicaid coverage limited to family planning: AL, AZ, AR, CA, DE, FL, IA, IL, LA, MD, MI, MN, MO, MS, NY, NC, NM, OK, OR, PA, RI, SC, TX, VA, WA, and WI. See CMS, *Section 1115 Demonstrations, State Profiles: Approvals Through January 31, 2009* (Baltimore, MD: CMS).

amount in the lowest spending state.[33] It also found that most of the cross-state variation in Medicaid spending per enrollee was a result of differences in the quantity of services provided rather than the unit price of services, that LTSS Medicaid spending per enrollee varied more than acute care, and that variation in Medicaid spending per enrollee exceeded that of Medicare.

[33] See Robert Wood Johnson Foundation, *Geographic variation and health care cost growth: Research to inform a complex diagnosis* (Washington, DC: AcademyHealth, October 2009). http://www.academyhealth.org/files/HCFO/HCFOPolicyBriefOCT09.pdf; and R. Kronick and T. Gilmer, Inter- and intrastate variation in Medicaid expenditures, presentation at the AcademyHealth Annual Research Meeting, June 28, 2009, http://www.academyhealth. org/files/2009/sunday/KronickR.pdf.

TABLE 6. Medicaid Enrollment by State, Eligibility Group, and Dual Eligible Status, FY 2008 (thousands)

State	Total	Percentage of Enrollees in Eligibility Group[1]				Dual Eligible Status[2]					
						All duals		Duals with full benefits		Duals with limited benefits	
		Children	Adults	Disabled	Aged	Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
Total	**58,800**	**48.2%**	**26.1%**	**16.5%**	**9.1%**	**9,155**	**60.9%**	**7,134**	**60.9%**	**2,021**	**61.0%**
Alabama	909	48.2	16.2	24.3	11.3	208	58.9	100	54.2	108	63.3
Alaska	113	56.5	23.0	14.0	6.4	13	54.7	13	54.2	0	73.3
Arizona	1,539	45.7	39.6	9.2	5.4	148	58.8	115	55.1	33	71.6
Arkansas	685	52.4	18.2	19.2	10.2	118	56.1	69	61.2	50	49.1
California	10,590	39.0	42.6	10.9	7.5	1,201	70.8	1,175	70.6	27	77.6
Colorado	572	58.3	17.4	14.8	9.5	83	60.3	68	60.0	15	61.7
Connecticut	553	52.1	23.7	12.2	12.0	103	61.4	78	59.5	25	67.4
Delaware	192	42.5	38.6	12.0	6.9	24	55.5	11	54.4	13	56.5
District of Columbia	163	45.2	25.5	23.4	6.0	22	60.6	19	60.5	3	61.5
Florida	3,021	50.5	18.8	18.5	12.2	601	66.0	349	69.0	253	61.8
Georgia	1,683	57.6	17.3	17.0	8.2	264	60.5	146	61.0	118	59.9
Hawaii	219	41.9	35.9	11.8	10.4	33	69.3	30	70.0	3	62.4
Idaho	205	60.8	13.1	18.2	8.0	31	50.4	22	50.2	9	51.0
Illinois	2,390	56.2	22.3	14.5	7.1	313	58.0	275	57.1	39	64.1
Indiana	1,049	55.8	21.1	15.0	8.1	156	50.9	101	54.9	55	43.8
Iowa	475	46.5	29.0	15.5	8.9	81	52.3	68	49.9	13	65.1
Kansas	355	56.0	14.8	19.1	10.1	63	52.9	47	54.4	16	48.7
Kentucky	841	46.0	16.3	29.1	8.6	178	53.0	110	53.9	68	51.6
Louisiana	1,055	52.7	17.6	19.3	10.4	180	60.1	107	58.0	73	63.1
Maine	344	34.9	31.3	17.3	16.5	92	61.3	53	48.2	39	79.3
Maryland	753	49.0	24.2	18.9	7.9	110	59.2	74	60.0	35	57.4
Massachusetts	1,489	29.0	26.5	33.7	10.8	255	53.9	248	52.7	7	95.6
Michigan	1,919	55.4	21.2	16.3	7.1	264	50.5	234	50.1	30	54.0
Minnesota	808	48.4	25.5	14.5	11.6	132	56.0	120	54.8	12	67.4
Mississippi	737	49.4	16.9	23.3	10.4	151	58.5	81	60.9	69	55.8
Missouri	988	53.1	18.8	18.7	9.3	172	51.3	156	51.1	16	54.0
Montana	110	54.5	18.8	18.1	8.7	18	56.7	16	54.4	3	71.0
Nebraska	227	54.7	19.2	15.6	10.4	42	54.3	38	53.5	4	61.4

TABLE 6, Continued

State	Total	Percentage of Enrollees in Eligibility Group[1]				Dual Eligible Status[2]					
						All duals		Duals with full benefits		Duals with limited benefits	
		Children	Adults	Disabled	Aged	Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
Nevada	260	55.6%	19.8%	15.4%	9.2%	40	60.6%	22	65.6%	18	54.6%
New Hampshire	148	60.0	13.8	16.1	10.1	29	49.1	21	49.5	8	47.9
New Jersey	953	53.4	13.9	20.8	11.9	204	66.8	175	66.2	28	70.4
New Mexico	506	61.0	20.2	13.6	5.3	56	61.5	40	61.4	16	61.7
New York	4,937	39.3	36.4	15.1	9.2	737	68.9	659	67.7	79	78.8
North Carolina	1,684	51.8	19.8	17.5	10.8	310	57.6	250	57.2	60	59.5
North Dakota	71	50.3	21.4	15.4	12.9	15	59.4	11	59.3	4	59.7
Ohio	1,947	46.5	25.2	18.6	9.6	304	52.1	205	54.3	98	47.4
Oklahoma	723	56.5	19.4	15.1	9.0	114	56.9	95	56.8	19	57.7
Oregon	520	50.7	23.0	16.5	9.8	90	56.6	62	58.1	28	53.1
Pennsylvania	2,199	45.3	19.6	24.4	10.7	392	56.5	333	55.3	59	62.9
Rhode Island	186	46.0	18.9	23.7	11.4	39	59.2	34	57.3	6	70.5
South Carolina	840	49.3	23.6	17.9	9.1	151	55.7	132	55.2	19	59.1
South Dakota	120	58.4	17.0	16.1	8.5	21	60.5	14	61.7	7	58.0
Tennessee	1,479	48.7	20.5	24.1	6.6	285	51.4	216	44.6	68	73.0
Texas	4,278	62.7	14.0	13.3	10.1	626	67.6	408	68.6	219	65.7
Utah	295	54.5	27.7	13.0	4.8	31	47.3	28	46.5	3	55.3
Vermont	168	38.8	36.2	14.1	10.9	32	60.7	25	55.1	7	79.7
Virginia	866	53.3	16.2	19.1	11.4	171	58.0	119	60.2	52	52.8
Washington	1,180	54.7	22.2	15.6	7.6	150	54.2	114	56.5	36	47.0
West Virginia	402	47.5	14.7	28.5	9.4	80	51.2	50	51.6	30	50.5
Wisconsin	974	40.9	29.4	15.6	14.0	210	68.4	194	68.5	16	67.6
Wyoming	78	65.1	14.7	13.1	7.1	10	53.9	7	52.5	3	56.7

Notes: Numbers reflect individuals ever enrolled during the year, even if for a single month. Excludes Medicaid-expansion CHIP enrollees and the territories. Estimates based on MSIS APS data may differ slightly from those derived from MSIS state summary data used in MACPAC, *Report to the Congress: March 2011*.

Although more recent state-level information is not available, the estimated number ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) nationally is 62.9 million for FY 2009; 67.7 million for FY 2010; 70.4 million for FY 2011; and 71.7 million for FY 2012. These FY 2009–FY 2012 figures include about one million enrollees in the territories. (Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, *2010 Actuarial Report on the Financial Outlook for Medicaid,* 2010; MACPAC communication with OACT, February 2011.)

1 Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category.

2 Dual eligibles with limited benefits receive Medicaid assistance with Medicare premiums and cost sharing only.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2011

TABLE 7. Medicaid Benefit Spending by State, Eligibility Group, and Dual Eligible Status, FY 2008 (millions)

State	Total	Percentage of Benefit Spending Attributable to Eligibility Group[1]				Dual Eligible Status[2]					
						All duals		Duals with full benefits		Duals with limited benefits	
		Children	Adults	Disabled	Aged	Total	Percentage attributable to age 65+	Total	Percentage attributable to age 65+	Total	Percentage attributable to age 65+
Total	**$338,552**	**20.1%**	**14.6%**	**44.5%**	**20.8%**	**$117,796**	**62.1%**	**$113,725**	**62.4%**	**$4,071**	**54.4%**
Alabama	4,078	27.2	9.9	41.2	21.6	1,586	70.1	1,387	71.4	199	60.9
Alaska	890	26.9	14.2	39.3	19.6	275	60.0	275	60.0	1	55.8
Arizona	7,506	25.7	33.2	30.8	10.2	1,333	56.7	1,286	56.3	48	65.6
Arkansas	3,287	24.4	5.5	44.1	26.0	1,363	59.6	1,183	62.9	180	38.0
California	39,042	16.9	17.6	45.1	20.4	13,196	67.6	13,129	67.6	67	71.5
Colorado	3,169	22.9	11.9	41.4	23.8	1,122	62.8	1,102	62.9	19	57.2
Connecticut	4,544	18.8	9.6	38.8	32.9	2,283	62.3	2,235	62.6	48	51.5
Delaware	1,102	20.0	29.4	33.2	17.3	307	62.1	280	63.3	27	49.4
District of Columbia	1,446	17.7	15.2	53.9	13.2	364	61.6	350	62.5	14	39.8
Florida	14,691	19.5	12.8	45.1	22.7	5,655	63.5	5,104	64.6	552	53.4
Georgia	7,338	26.2	18.3	38.9	16.6	2,016	68.0	1,833	69.4	183	54.4
Hawaii	1,207	15.5	23.2	38.2	23.1	401	69.3	396	69.4	5	58.5
Idaho	1,207	24.7	12.2	46.3	16.9	354	54.3	337	54.7	16	45.6
Illinois	11,602	26.7	13.7	47.7	11.9	3,052	57.3	2,984	57.4	68	52.8
Indiana	6,151	19.7	11.3	48.9	20.0	2,144	55.1	2,033	56.1	111	37.5
Iowa	2,844	18.0	13.5	46.1	22.4	1,220	52.2	1,195	52.2	25	56.2
Kansas	2,274	19.9	8.8	44.2	27.1	883	55.4	857	55.9	27	41.1
Kentucky	4,809	21.1	13.7	48.5	16.8	1,518	64.3	1,398	65.7	121	48.1
Louisiana	6,068	18.8	13.3	50.5	17.4	1,790	57.2	1,646	57.3	143	56.3
Maine	2,253	22.4	14.3	43.7	19.6	794	54.3	735	53.0	58	69.5
Maryland	5,701	19.8	12.2	48.9	19.0	1,800	63.9	1,692	64.7	107	50.9
Massachusetts	10,822	18.2	15.8	42.6	23.4	4,008	59.1	3,997	59.0	11	93.6
Michigan	9,847	21.8	17.1	41.3	19.9	2,996	65.6	2,939	65.9	57	46.1
Minnesota	6,978	19.0	11.2	47.3	22.4	3,004	50.5	2,984	50.5	20	52.7
Mississippi	3,812	20.4	11.2	45.0	23.4	1,448	65.9	1,258	68.2	190	50.9
Missouri	7,090	25.3	11.2	46.4	17.1	2,045	55.7	2,013	55.9	32	42.4
Montana	776	23.8	13.1	39.4	23.7	284	67.8	277	68.1	7	55.0

TABLE 7, Continued

State	Total	Percentage of Benefit Spending Attributable to Eligibility Group[1]				Dual Eligible Status[2]					
						All duals		Duals with full benefits		Duals with limited benefits	
		Children	Adults	Disabled	Aged	Total	Percentage attributable to age 65+	Total	Percentage attributable to age 65+	Total	Percentage attributable to age 65+
Nebraska	1,588	24.2%	9.6%	41.4%	24.8%	665	55.9%	660	56.0%	5	47.7%
Nevada	1,317	28.0	11.2	43.8	17.0	335	64.2	298	66.4	37	46.4
New Hampshire	1,257	27.5	9.6	36.2	26.7	525	60.7	504	61.0	21	52.2
New Jersey	9,425	16.3	8.3	53.2	22.1	4,103	63.2	4,064	63.2	39	68.7
New Mexico	3,045	32.9	14.8	42.5	9.8	712	59.2	683	59.2	30	57.4
New York	47,618	11.3	17.8	47.9	23.0	19,792	61.9	19,611	61.8	181	76.5
North Carolina	10,162	24.3	16.3	42.0	17.5	2,951	59.5	2,858	59.8	93	48.7
North Dakota	534	14.1	10.2	42.2	33.5	299	59.9	293	60.1	6	45.6
Ohio	12,414	13.4	13.5	46.5	26.7	4,573	58.4	4,264	59.5	308	42.7
Oklahoma	3,539	27.3	11.1	41.5	20.1	1,240	56.5	1,217	56.6	22	51.5
Oregon	3,220	20.6	16.3	40.5	22.7	1,148	63.5	1,103	64.2	45	45.5
Pennsylvania	16,300	16.7	10.1	44.1	29.1	6,342	71.6	6,260	71.7	82	58.4
Rhode Island	1,834	19.2	9.6	55.7	15.5	599	53.7	591	53.7	8	54.4
South Carolina	4,437	22.9	15.9	42.8	18.4	1,477	59.3	1,455	59.4	21	54.0
South Dakota	656	24.9	12.5	40.8	21.9	256	64.1	242	64.8	14	51.9
Tennessee	7,176	21.4	16.9	46.9	14.9	2,506	53.6	2,427	53.1	79	70.6
Texas	21,461	34.9	10.3	37.7	17.1	5,385	65.3	4,923	65.2	462	66.5
Utah	1,517	29.4	16.3	43.3	11.0	390	43.9	386	43.9	4	44.3
Vermont	1,080	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	5,384	22.5	11.0	45.9	20.6	1,841	58.4	1,735	59.3	106	44.5
Washington	6,293	22.3	14.4	42.1	21.1	1,888	62.8	1,809	63.8	79	41.7
West Virginia	2,278	19.1	9.7	50.1	21.1	792	64.9	741	66.1	51	47.6
Wisconsin	4,989	12.3	14.9	43.5	29.4	2,371	64.5	2,346	64.6	25	55.2
Wyoming	493	25.7	10.4	41.9	22.1	203	52.7	193	52.9	10	49.8

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 4 of MACStats for methodology.

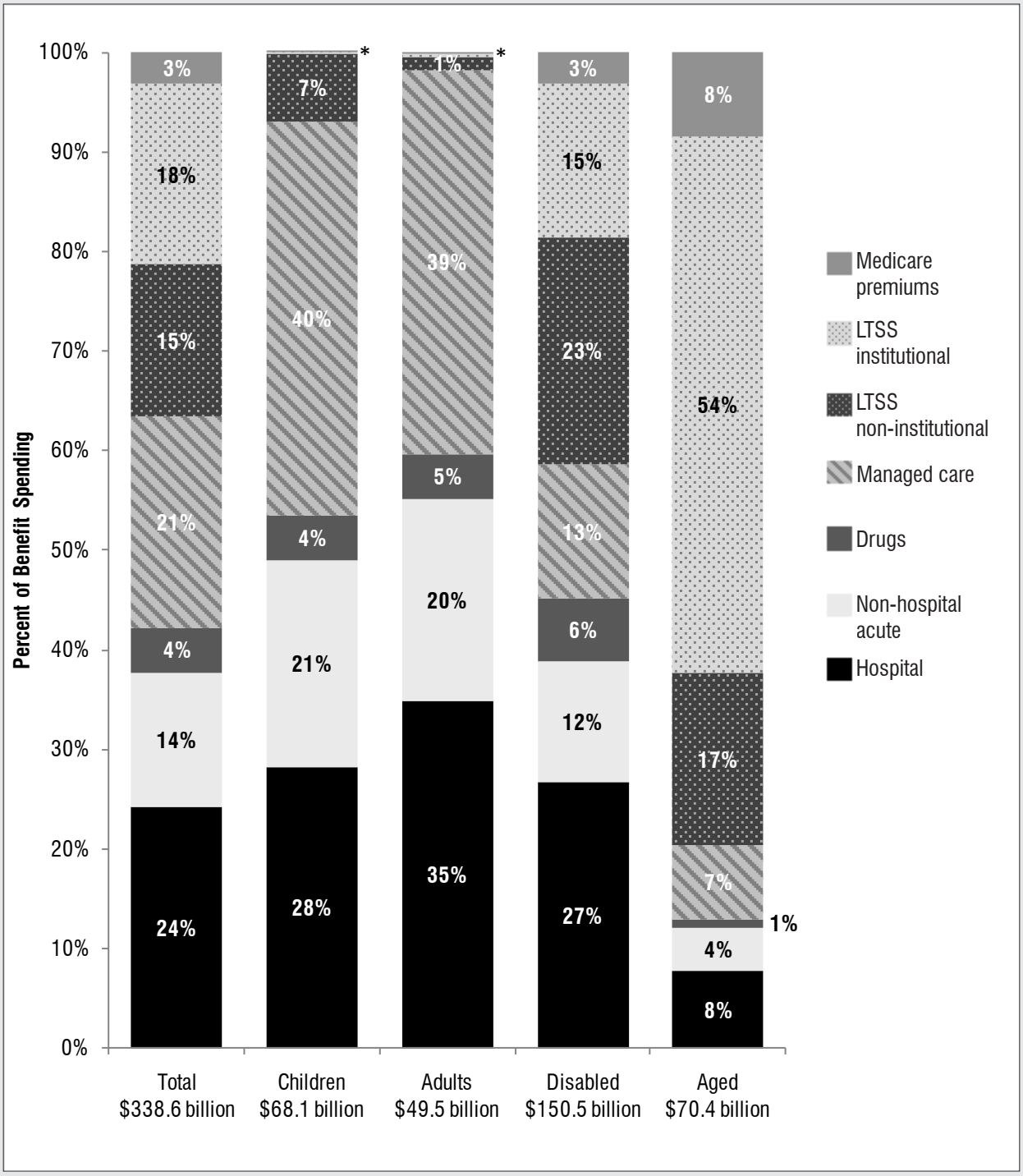
1 Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category.

2 Dual eligibles with limited benefits receive Medicaid assistance with Medicare premiums and cost-sharing only.

3 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.

Source: 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 May 2011

FIGURE 3. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2008



Notes: LTSS = long-term services and supports. Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. Amounts are fee for service unless otherwise noted. Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 4 of MACStats for methodology including a list of services in each category.

*Medicare premiums and LTSS institutional total less than 1%.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2011

TABLE 8. Medicaid Benefit Spending per Full-year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2008

State	Total			Children			Adults			Disabled			Aged		
	Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE	
		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]
Total	**11.4%**	**$7,267**	**$7,893**	**1.6%**	**$3,025**	**$3,051**	**29.5%**	**$4,651**	**$5,656**	**8.0%**	**$17,128**	**$18,316**	**23.7%**	**$15,146**	**$19,081**
Alabama	23.4	5,427	6,315	0.1	3,144	3,143	74.6	3,765	5,901	17.2	8,416	9,688	67.2	9,679	25,500
Alaska	0.3	10,291	10,314	–	4,871	4,871	0.0	7,670	7,666	0.7	24,279	24,421	2.4	26,891	27,511
Arizona	11.0	6,511	6,864	4.4	3,639	3,693	17.9	5,935	6,464	4.4	17,817	17,934	31.7	10,653	14,421
Arkansas	20.2	5,855	6,796	2.1	2,703	2,728	72.1	2,011	5,099	19.0	12,617	14,360	34.8	14,060	19,843
California	29.6	4,829	6,227	8.5	2,076	2,184	66.4	2,193	3,612	0.5	16,384	16,407	5.0	11,328	11,621
Colorado	4.1	7,563	7,650	0.3	3,051	3,012	6.2	6,122	5,592	6.6	18,011	19,056	16.5	16,127	18,971
Connecticut	4.6	9,718	10,081	–	3,497	3,497	0.0	4,129	4,129	11.7	29,197	32,613	25.3	25,909	34,098
Delaware	15.9	7,324	8,248	2.5	3,460	3,518	19.8	6,042	6,850	24.0	17,336	21,954	55.8	16,099	33,881
District of Columbia	2.2	10,439	10,392	0.0	4,072	4,072	0.7	6,514	5,863	3.6	23,332	23,922	18.7	22,720	27,190
Florida	13.7	6,584	7,006	0.2	2,563	2,544	27.9	5,651	5,361	17.3	14,033	16,252	41.3	10,736	16,677
Georgia	8.3	5,811	6,137	0.0	2,662	2,661	0.8	8,101	7,889	16.1	11,203	12,959	51.9	10,147	19,379
Hawaii	1.3	6,685	6,742	0.0	2,356	2,355	0.0	4,827	4,824	3.8	19,623	20,303	7.4	14,102	15,060
Idaho	5.1	7,518	7,813	–	3,058	3,058	0.0	9,663	9,663	11.7	16,508	18,402	29.6	14,421	19,747
Illinois	5.4	5,739	5,938	0.1	2,621	2,620	19.6	4,191	4,646	5.2	17,270	18,069	13.0	9,905	11,156
Indiana	7.5	7,440	7,820	1.2	2,547	2,569	5.6	5,021	4,971	19.2	21,375	25,795	30.2	17,413	23,999
Iowa	10.5	7,640	8,261	1.6	2,969	2,996	26.2	4,032	4,576	5.7	19,174	20,166	20.7	17,659	21,770
Kansas	5.3	8,463	8,803	0.0	3,044	3,041	0.7	6,610	6,409	12.1	16,776	18,793	22.8	20,602	26,209
Kentucky	8.8	7,050	7,525	0.0	3,263	3,259	0.2	7,594	7,555	12.8	10,451	11,663	50.2	13,000	24,238
Louisiana	13.5	6,659	7,305	0.0	2,343	2,342	39.9	5,763	7,674	13.4	16,569	18,718	42.7	10,656	17,183
Maine	11.7	7,682	8,472	0.1	4,993	4,996	0.2	3,716	3,714	12.9	17,876	20,137	53.4	8,733	17,017
Maryland	13.3	9,433	10,102	1.2	3,760	3,744	37.3	5,608	5,325	11.0	21,686	23,853	32.5	21,422	30,216
Massachusetts	1.5	8,665	8,739	0.0	5,434	5,434	0.0	5,372	5,371	0.1	10,774	10,777	12.7	18,041	20,145
Michigan	5.2	6,291	6,550	1.2	2,424	2,447	15.1	5,991	6,871	4.3	14,324	14,823	13.3	16,800	19,026
Minnesota	4.8	11,329	11,826	0.9	4,347	4,373	11.9	5,733	6,333	3.3	31,008	31,967	10.9	23,221	25,896
Mississippi	18.9	6,284	7,062	0.1	2,723	2,722	53.4	4,469	6,353	18.6	11,029	12,767	49.6	12,846	22,822
Missouri	5.8	8,799	9,084	0.1	4,101	4,100	25.8	6,140	6,584	3.8	20,424	21,108	9.3	15,594	16,993
Montana	2.3	9,542	9,679	–	4,161	4,161	0.0	7,940	7,939	3.0	18,317	18,685	17.8	24,465	29,210
Nebraska	1.9	8,878	9,020	–	3,755	3,755	0.0	6,221	6,221	4.1	20,608	21,398	10.2	19,642	21,747
Nevada	8.7	7,071	$7,357	0.3	3,585	3,579	3.0	4,958	4,449	21.2	17,326	20,978	39.0	11,004	16,512

TABLE 8, Continued

State	Total			Children			Adults			Disabled			Aged		
	Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit Spending per FYE	
		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]
New Hampshire	5.7%	$10,851	$11,315	–	$4,927	$4,927	0.0	$9,382	$9,383	16.5%	$22,174	$25,969	26.3%	$27,333	$35,862
New Jersey	3.6	11,719	11,947	0.0%	3,577	3,574	1.9%	8,643	7,616	4.4	27,203	28,350	19.2	21,121	25,674
New Mexico	11.1	7,132	7,651	0.0	3,844	3,836	41.3	5,580	7,207	8.8	20,678	22,430	37.8	13,056	19,792
New York	2.9	11,706	11,909	0.8	3,381	3,392	2.7	6,099	6,191	2.0	32,727	33,157	13.4	28,085	31,641
North Carolina	7.5	7,614	7,993	0.1	3,542	3,538	21.7	7,937	9,026	8.2	15,884	17,065	19.7	10,973	13,303
North Dakota	6.6	10,137	10,729	–	2,922	2,922	0.0	5,650	5,649	14.4	23,430	26,970	27.4	23,513	31,879
Ohio	5.4	7,787	8,025	–	2,180	2,180	0.0	4,672	4,672	14.1	18,127	20,454	26.1	21,122	27,435
Oklahoma	7.1	6,412	6,761	0.0	2,985	2,985	30.4	5,164	6,535	6.8	15,199	16,172	16.4	12,701	14,941
Oregon	11.0	8,272	9,017	3.9	3,494	3,592	13.6	6,664	7,104	15.2	16,986	19,652	29.2	16,511	22,671
Pennsylvania	4.2	9,120	9,424	0.2	3,404	3,401	7.1	5,478	5,725	4.0	14,782	15,290	16.3	23,592	27,830
Rhode Island	4.0	11,626	11,952	0.0	4,937	4,932	5.2	6,275	6,262	2.6	25,205	25,715	21.2	15,864	19,578
South Carolina	11.9	6,422	6,913	0.3	3,005	3,006	44.5	4,840	6,230	4.7	13,704	14,289	14.2	11,968	13,744
South Dakota	6.2	6,933	7,230	0.0	2,941	2,941	0.1	6,267	6,254	17.3	15,332	17,962	33.3	16,557	23,764
Tennessee	4.8	5,735	5,950	0.0	2,545	2,543	0.2	5,302	5,284	6.0	10,014	10,562	46.0	12,646	22,345
Texas	6.5	6,702	6,815	0.0	3,768	3,742	2.2	7,232	6,063	13.5	15,656	17,571	33.6	9,393	12,718
Utah	1.5	7,612	7,540	0.1	4,145	4,135	1.4	5,249	4,751	3.7	20,014	20,621	9.2	14,250	15,324
Vermont	4.9	8,051	[3]	–	[3]	[3]	–	[3]	[3]	5.9	[3]	[3]	32.9	[3]	[3]
Virginia	8.0	7,609	7,968	0.0	3,224	3,220	11.4	6,193	6,243	14.6	16,459	18,692	27.3	12,813	16,704
Washington	9.6	6,691	7,130	0.2	2,654	2,651	34.2	5,192	6,880	10.1	16,586	17,961	18.3	17,361	20,562
West Virginia	8.0	7,031	7,467	0.0	2,838	2,838	0.0	6,197	6,192	12.4	11,138	12,415	40.1	14,717	23,335
Wisconsin	9.3	6,346	6,834	1.2	1,960	1,967	25.7	3,473	4,156	3.0	15,431	15,806	8.5	12,290	13,301
Wyoming	5.5	8,478	8,756	0.7	3,341	3,355	3.8	7,535	7,590	13.1	23,267	26,110	33.4	23,583	33,793

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 4 of MACStats for methodology.

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.

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

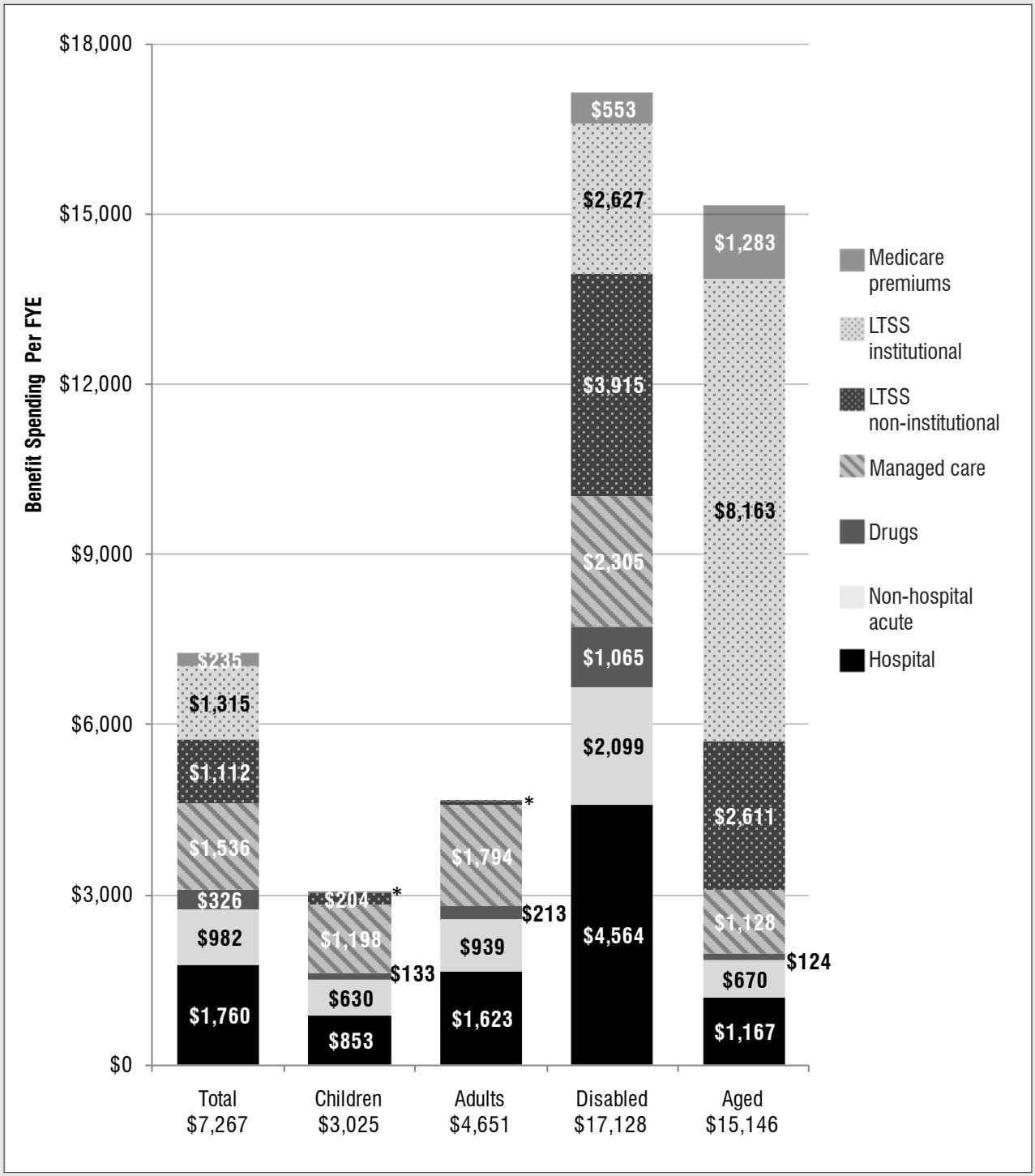
1 These percentages are likely to be underestimated because comparisons with other data sources indicate that some states do not identify all of their limited benefit enrollees in MSIS.

2 Calculated by removing limited benefit enrollees and their spending.

3 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.

Source: 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 May 2011

FIGURE 4. Medicaid Benefit Spending Per Full-year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2008

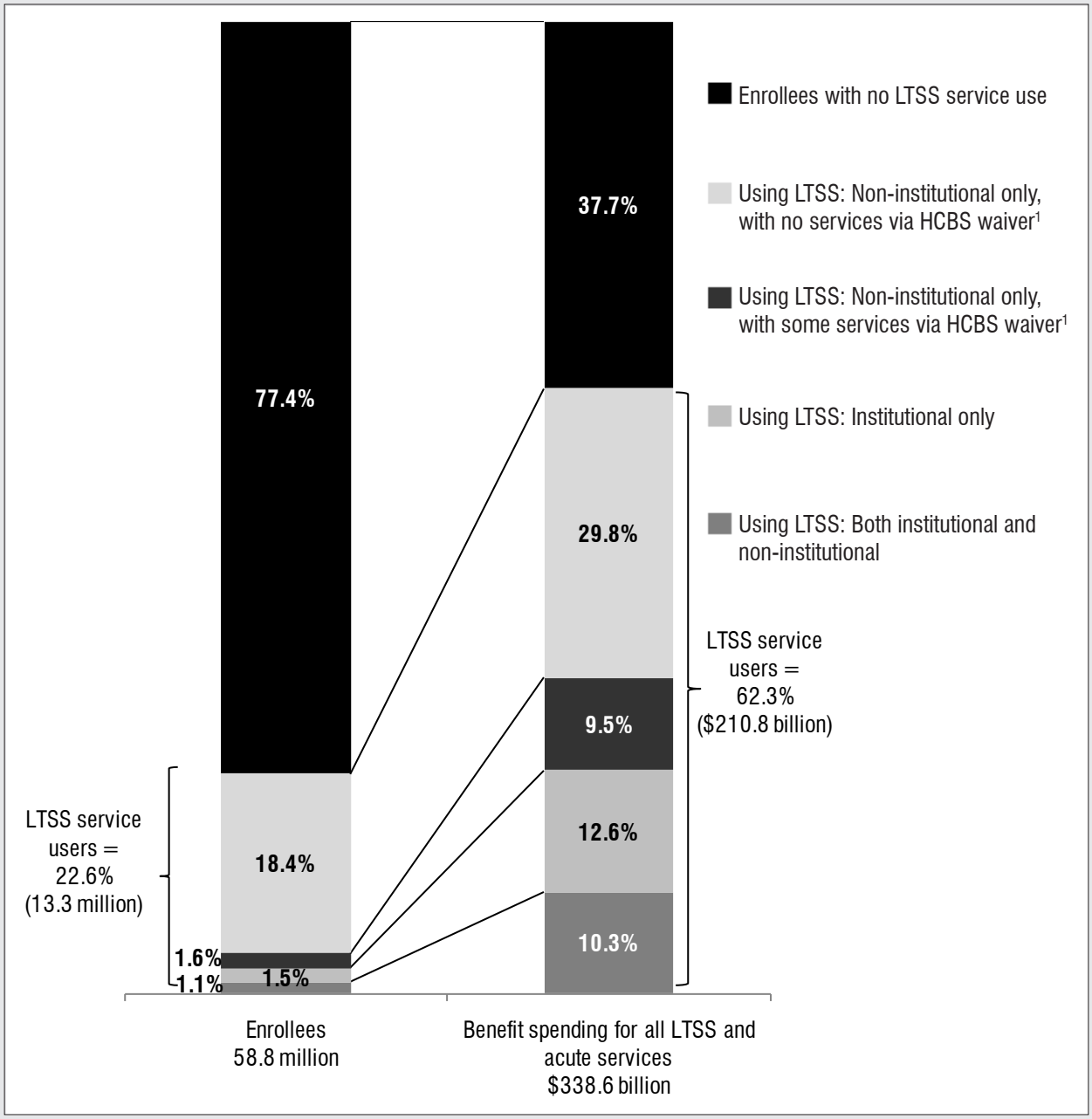


Notes: LTSS = long-term services and supports. Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. Amounts are fee for service unless otherwise noted. Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 4 of MACStats for methodology, including a list of services in each category. Amounts reflect all enrollees, including those with limited benefits; see Table 8 notes for more information.

* Values less than $100 not shown.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data as of May 2011

FIGURE 5. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-users of Long-term Services and Supports, FY 2008



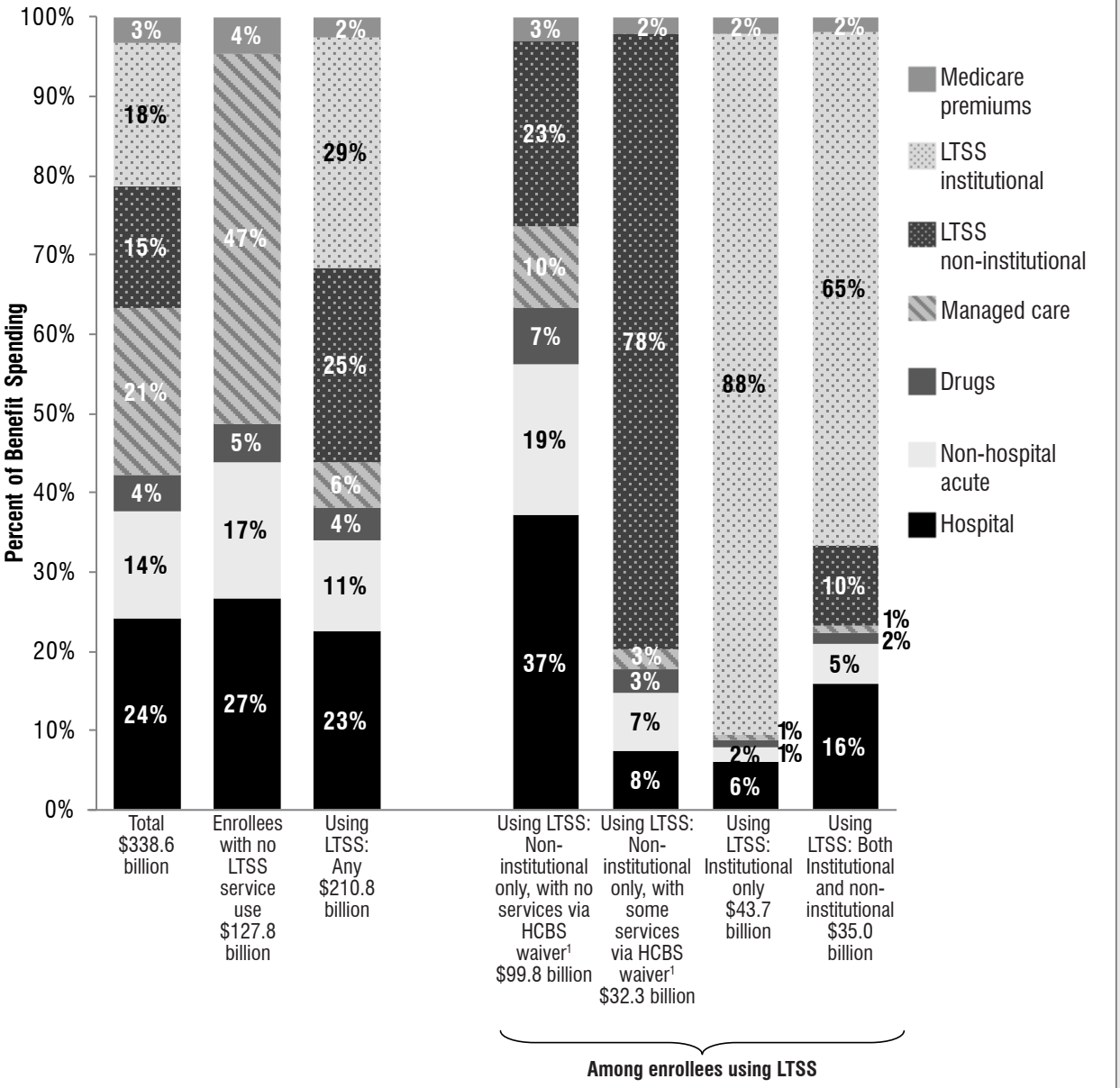
Notes: HCBS = home and community-based services, LTSS = long-term services and supports.

Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 4 of MACStats for methodology, including a list of services in each category. 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 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.

Source: 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 May 2011

FIGURE 6. Distribution of Medicaid Benefit Spending by Long-term Services and Supports Use and Service Category, FY 2008



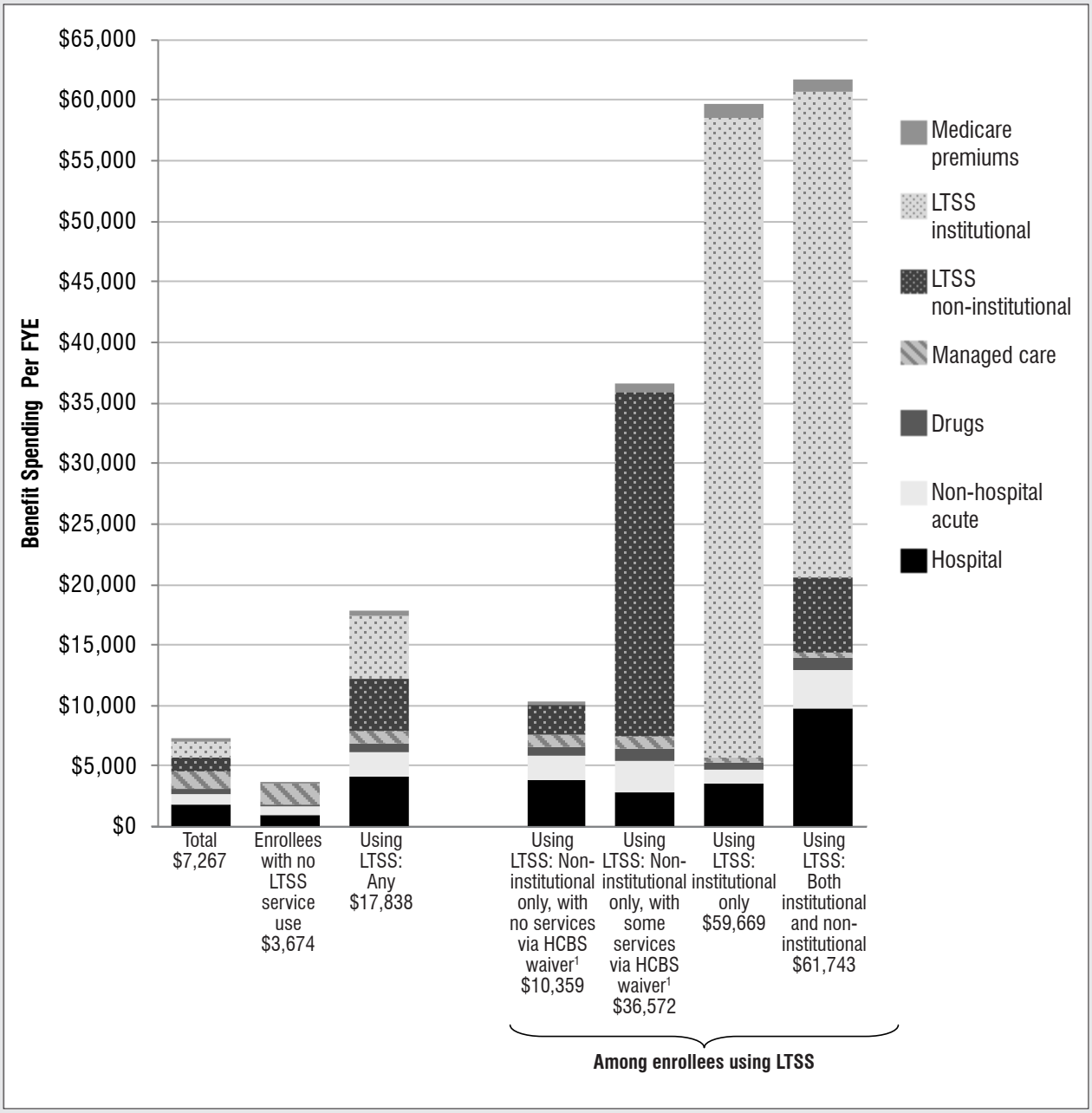
Notes: HCBS = home and community-based services, LTSS = long-term services and supports.

Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 4 of MACStats for methodology, including a list of services in each category. 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 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.

Source: 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 May 2011

FIGURE 7. Medicaid Benefit Spending per Full-year Equivalent (FYE) Enrollee by Long-term Services and Support Use and Service Category, FY 2008



Notes: HCBS = home and community-based services, LTSS = long-term services and supports.

Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 4 of MACStats for methodology, including a list of services in each category. 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. Amounts reflect all enrollees, including those with limited benefits; see Table 8 notes for more information.

1 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.

Source: 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 May 2011

Medicaid Managed Care

The tables in this section provide a state-level supplement to the review of Medicaid managed care in this Report. The national percentage of Medicaid enrollees in managed care (including Medicaid-expansion CHIP) ranges from less than half to 71 percent, depending on the definition of managed care that is used (Table 9). As noted throughout this Report, however, the use of managed care varies widely by state, both in the arrangements used and the populations served. All but two states report using some combination of managed care that involves comprehensive risk-based plans, limited-benefit plans, and primary care case management (PCCM) programs (Tables 9 and 10).

Table 11 shows the share of each of the major Medicaid eligibility groups that is enrolled in managed care, by state. The national percentage of Medicaid enrollees (excluding Medicaid-expansion CHIP) in any form of managed care ranges from 33 percent among aged enrollees to 85 percent among child enrollees. Participation in comprehensive risk-based managed care plans was lowest among the aged and disabled (11 percent and 28 percent, respectively) and highest among adults and children (44 percent and 60 percent). For the total enrollees category, the percentages in any form of managed care and in comprehensive risk-based managed care differ somewhat between Tables 9 and 11; as noted in Section 4, this is due to a variety of differences between MSIS and Medicaid Managed Care Enrollment Report data.

Table 12 shows the share of Medicaid benefit spending for each of the major Medicaid eligibility groups that goes toward payments for managed care. The national percentage of Medicaid benefit spending on any form of managed care ranges from about 7 percent among aged enrollees to nearly 40 percent among non-disabled child and adult enrollees. In states with comprehensive risk-based managed care, these plans make up the majority of managed care spending.

TABLE 9. Percentage of Medicaid Enrollees in Managed Care by State, June 30, 2009

State	Total Medicaid Enrollees	Percentage of Enrollees			
		Any managed care[1]	Comprehensive risk-based or PCCM[2,3]	Comprehensive risk-based[2]	PCCM
Total	**49,450,645**	**71.2%**	**61.5%[4]**	**46.8%**	**14.7%**
Alabama	812,220	66.5	54.6	–	54.6
Alaska	101,702	–	–	–	–
Arizona	1,223,271	89.6	89.6	89.6	–
Arkansas	645,389	79.2	63.7	0.0	63.7
California	6,955,761	52.2	51.9	51.9	–
Colorado	467,556	95.1	14.6	9.8	4.8
Connecticut	455,878	75.2	75.2	75.2	0.0
Delaware	170,562	73.9	68.9	68.9	–
District of Columbia	153,779	97.8	62.8	62.8	–
Florida	2,426,010	66.0	57.3	38.5	18.8
Georgia	1,385,721	92.0	68.3	60.5	7.8
Hawaii	235,203	97.0	97.0	97.0	–
Idaho	198,000	84.1	84.1	–	84.1
Illinois	2,320,700	55.1	55.1	7.7	47.4
Indiana	961,986	74.0	73.9	67.3	6.7
Iowa	397,823	82.9	42.9	0.0	42.9
Kansas	297,290	86.6	55.6	47.5	8.1
Kentucky	768,777	83.0	60.4	20.7	39.7
Louisiana	1,006,842	68.7	72.4	0.0	72.4
Maine	280,148	63.7	63.7	–	63.7
Maryland	787,366	78.7	74.9	74.9	–
Massachusetts	1,227,109	59.6	58.9	35.7	23.2
Michigan	1,629,959	88.8	66.8	66.8	–
Minnesota	675,149	63.1	63.1	63.1	–
Mississippi	673,630	76.1	–	–	–
Missouri	895,077	98.7	44.9	44.9	–
Montana	84,785	66.6	0.5	0.0	0.4
Nebraska	214,699	83.6	34.8	16.8	18.0
Nevada	213,440	83.7	49.8	49.8	–

TABLE 9, Continued

State	Total Medicaid Enrollees	Percentage of Enrollees			
		Any managed care[1]	Comprehensive risk-based or PCCM[2,3]	Comprehensive risk-based[2]	PCCM
New Hampshire	124,498	77.6%	–	–	–
New Jersey	968,598	74.9	74.9%	74.9%	–
New Mexico	464,852	74.2	74.3	74.3	–
New York	4,422,121	66.2	65.5	65.1	0.4%
North Carolina	1,442,396	70.2	69.3	0.0	69.3
North Dakota	60,111	67.6	48.8	0.0	48.8
Ohio	1,951,511	70.4	70.4	70.4	–
Oklahoma	625,546	88.5	65.9	0.0	65.9
Oregon	474,835	88.1	74.0	71.4	2.6
Pennsylvania	1,920,134	82.1	64.0	50.4	13.7
Rhode Island	177,981	62.1	67.7	67.7	–
South Carolina	763,225	100.0	56.6	44.8	11.8
South Dakota	107,196	79.7	79.7	–	79.7
Tennessee	1,230,750	100.0	94.2	94.2	–
Texas	3,343,241	64.6	64.6	42.7	21.9
Utah	238,358	85.9	24.5	–	24.5
Vermont	156,503	87.8	87.8	87.8	–
Virginia	814,820	63.9	64.0	57.3	6.6
Washington	1,103,291	86.0	53.2	52.7	0.4
West Virginia	325,653	46.0	50.5	46.0	4.5
Wisconsin	1,004,704	60.4	57.8	57.8	–
Wyoming	64,489	–	–	–	–

Notes: PCCM = primary care case management. Excludes the territories; unlike other tables and figures in the June 2011 MACStats, includes Medicaid-expansion CHIP enrollees.

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

1 Any managed care includes comprehensive risk-based plans, limited-benefit plans, and PCCM programs.

2 Comprehensive risk-based managed care includes plans categorized by CMS and states as commercial, Medicaid-only, Health Insuring Organizations (HIOs), and Programs of All-Inclusive Care for the Elderly (PACE). HIOs exist only in California where selected county-authorized health systems serve Medicaid enrollees. PACE combines Medicare and Medicaid financing for qualifying frail elderly dual eligibles. Some states report a larger number of enrollees in these comprehensive risk-based plans than they do for their unduplicated number of enrollees in any form of managed care; it is unclear whether this is a reporting error or whether there were some enrollees participating in more than one comprehensive risk-based plan as of the reporting date (June 30, 2009).

3 Figure is based on the sum of enrollees reported in comprehensive risk-based plans and PCCM programs; it is assumed that individuals are not enrolled in both types of managed care as of the reporting date, but this cannot be verified based on enrollment report data.

4 Unrounded figure is 61.47% and is reported as 61% throughout the text of this Report.

Source: MACPAC analysis of 2009 Medicaid Managed Care Enrollment Report data from CMS, as reported by states

TABLE 10. Number of Managed Care Entities by State and Type, June 30, 2009

State	Comprehensive Risk-based Plans[1]				Limited-benefit Plans[1]			
	Commercial MCO	Medicaid-only MCO	HIO	PACE	PIHP	PAHP	PCCM	Other
Total	**149**	**159**	**4**	**67**	**150**	**60**	**36**	**9**
Alabama	0	0	0	0	2	0	1	0
Alaska	0	0	0	0	0	0	0	0
Arizona	0	29	0	0	1	0	0	0
Arkansas	0	0	0	1	0	1	1	0
California	23	2	4	5	1	13	0	0
Colorado	0	2	0	3	6	0	1	0
Connecticut	1	2	0	0	0	0	1	0
Delaware	0	2	0	0	0	0	0	1
District of Columbia	0	3	0	0	1	1	0	0
Florida	22	5	0	2	26	10	1	3
Georgia	0	3	0	0	0	1	1	0
Hawaii	4	1	0	1	0	0	0	0
Idaho	0	0	0	0	0	2	1	0
Illinois	1	2	0	0	0	0	1	0
Indiana	4	1	0	0	0	0	2	1
Iowa	0	0	0	1	1	0	1	0
Kansas	0	2	0	2	1	1	1	0
Kentucky	0	1	0	0	0	1	1	0
Louisiana	0	0	0	1	0	0	1	0
Maine	0	0	0	0	0	0	1	0
Maryland	0	7	0	1	0	5	0	0
Massachusetts	2	2	0	6	1	0	1	0
Michigan	0	14	0	4	18	0	0	0
Minnesota	6	3	0	0	0	0	0	0
Mississippi	0	0	0	0	0	1	0	0
Missouri	0	6	0	1	0	1	0	0
Montana	0	0	0	1	0	1	1	0
Nebraska	1	0	0	0	0	0	1	1

TABLE 10, Continued

State	Comprehensive Risk-based Plans[1]				Limited-benefit Plans[1]			
	Commercial MCO	Medicaid-only MCO	HIO	PACE	PIHP	PAHP	PCCM	Other
Nevada	1	1	0	0	0	1	0	0
New Hampshire	0	0	0	0	0	1	0	0
New Jersey	2	3	0	2	0	0	0	0
New Mexico	5	1	0	1	1	0	0	0
New York	21	13	0	5	17	0	4	1
North Carolina	0	0	0	2	1	0	2	0
North Dakota	0	0	0	1	0	1	1	0
Ohio	0	7	0	2	0	0	0	0
Oklahoma	0	0	0	1	0	1	2	0
Oregon	2	13	0	1	9	8	1	0
Pennsylvania	11	0	0	10	38	2	1	0
Rhode Island	2	1	0	1	0	1	0	0
South Carolina	0	6	0	2	0	3	1	0
South Dakota	0	0	0	0	0	0	1	0
Tennessee	0	6	0	1	2	0	0	2
Texas	6	13	0	2	1	1	1	0
Utah	0	0	0	0	11	1	1	0
Vermont	0	1	0	1	0	0	0	0
Virginia	3	2	0	4	0	1	1	0
Washington	8	0	0	1	1	1	1	0
West Virginia	3	0	0	0	0	0	1	0
Wisconsin	21	5	0	1	11	0	0	0
Wyoming	0	0	0	0	0	0	0	0

Notes: HIO = Health Insuring Organization; MCO = managed care organization; PACE = Program of All-Inclusive Care for the Elderly; PAHP = prepaid ambulatory health plan; PIHP = prepaid inpatient health plan; PCCM = primary care case management. Excludes the territories.

Comprehensive risk-based managed care includes plans categorized by CMS and states as commercial, Medicaid-only, Health Insuring Organizations (HIOs), and Programs of All-Inclusive Care for the Elderly (PACE). HIOs exist only in California where selected county-authorized health systems serve Medicaid enrollees. PACE combines Medicare and Medicaid financing for qualifying frail elderly dual eligibles. In the data reporting instructions provided by CMS to states, commercial plans are those that provide comprehensive services to both Medicaid and commercial and/or Medicare enrollees; Medicaid-only plans are those that provide comprehensive services to only Medicaid enrollees, not to commercial or Medicare enrollees. Based on an examination of plan names, it appears that states differ in their categorizations; for example, plans that operate in different states but are affiliated with the same parent company may be reported as commercial in one state and Medicaid-only in another.

1 These terms are used throughout the Report to categorize the various plan types shown; see Annex C for additional plan definitions.

Source: *2009 Medicaid Managed Care Enrollment Report* data from CMS, as reported by states

TABLE 11. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2008

State	Percentage of Enrollees									
	Any managed care					Comprehensive risk-based managed care				
	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Total	**68.3%**	**84.6%**	**57.1%**	**58.4%**	**32.9%**	**46.0%**	**60.0%**	**43.8%**	**27.9%**	**10.9%**
Alabama	67.2	97.2	21.0	62.0	17.2	2.8	0.0	0.0	5.8	12.6
Alaska	–	–	–	–	–	–	–	–	–	–
Arizona	87.3	94.6	79.2	95.6	70.8	80.8	88.3	72.0	88.7	67.4
Arkansas	59.9	85.1	24.2	54.5	4.4	–	–	–	–	–
California	58.1	77.1	26.7	93.8	85.9	37.3	62.0	22.0	23.9	15.0
Colorado	90.4	95.2	84.3	85.7	79.6	19.9	24.6	12.3	16.1	11.1
Connecticut	59.7	81.4	72.4	0.9	0.0	59.7	81.4	72.4	0.9	0.0
Delaware	87.5	97.0	87.3	78.1	46.4	73.0	85.9	78.8	48.6	2.6
District of Columbia	64.8	89.9	84.6	11.6	0.2	64.8	89.9	84.6	11.6	0.2
Florida	70.3	88.9	75.5	52.7	12.4	63.1	82.6	57.0	49.8	11.8
Georgia	88.4	95.8	89.3	81.5	48.0	67.2	90.8	83.9	2.8	0.0
Hawaii	75.9	97.1	93.4	12.8	1.3	75.9	97.1	93.4	12.7	1.3
Idaho	89.8	97.5	92.5	79.9	49.6	0.2	0.0	0.1	0.6	0.5
Illinois	67.5	83.3	71.4	30.3	5.9	7.4	10.1	7.7	0.1	0.1
Indiana	77.1	90.7	85.0	48.8	14.5	69.8	89.2	85.0	14.0	0.1
Iowa	75.5	94.6	57.7	92.4	4.5	1.5	2.3	1.5	0.1	0.0
Kansas	85.4	94.6	89.2	79.2	40.7	85.4	94.6	89.2	79.2	40.7
Kentucky	88.6	95.0	96.9	84.7	51.3	19.0	23.6	20.3	15.2	4.6
Louisiana	62.6	88.7	44.1	41.4	1.4	0.0	–	–	0.0	0.1
Maine	–	–	–	–	–	–	–	–	–	–
Maryland	67.0	93.2	46.2	53.2	0.8	67.0	93.2	46.2	53.2	0.8
Massachusetts	54.6	82.8	73.7	29.6	10.1	31.2	58.6	37.1	10.1	8.8
Michigan	70.4	86.5	63.9	53.4	3.0	66.7	81.2	62.7	50.6	2.5
Minnesota	69.2	87.1	71.4	12.2	61.0	69.2	87.1	71.4	12.2	61.0
Mississippi	–	–	–	–	–	–	–	–	–	–
Missouri	73.1	66.7	59.5	96.2	91.3	46.9	66.6	59.2	1.8	0.0
Montana	48.7	62.7	36.9	42.1	0.6	–	–	–	–	–
Nebraska	36.9	46.5	42.0	19.9	2.9	17.5	21.9	20.3	9.7	1.3

TABLE 11, Continued

State	Percentage of Enrollees									
	Any managed care					Comprehensive risk-based managed care				
	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Nevada	87.9%	95.9%	87.6%	76.2%	59.9%	54.9%	73.9%	68.4%	1.7%	0.0%
New Hampshire	–	–	–	–	–	–	–	–	–	–
New Jersey	70.6	92.7	80.9	42.6	8.2	70.6	92.7	80.9	42.6	8.2
New Mexico	66.8	79.3	56.6	50.4	3.4	66.7	79.2	56.5	50.0	3.4
New York	66.1	79.6	75.9	39.8	12.8	66.1	79.6	75.9	39.8	12.8
North Carolina	71.0	91.5	62.2	54.2	16.2	0.0	–	–	0.0	0.0
North Dakota	52.8	72.4	74.8	1.6	0.0	–	–	–	–	–
Ohio	71.3	87.7	88.5	40.3	6.8	71.3	87.7	88.5	40.3	6.8
Oklahoma	86.1	96.1	58.7	86.4	82.1	–	–	–	–	–
Oregon	86.6	92.8	83.1	82.4	70.7	70.6	80.1	72.5	58.1	37.4
Pennsylvania	87.8	95.1	86.1	92.1	49.7	59.6	73.0	65.1	53.1	7.1
Rhode Island	61.0	89.6	90.4	11.4	0.2	61.0	89.6	90.4	11.4	0.2
South Carolina	89.8	98.6	69.8	94.2	85.3	30.6	43.5	26.0	16.6	0.0
South Dakota	100.0	100.0	100.0	100.0	100.0	–	–	–	–	–
Tennessee	93.0	97.0	97.4	92.0	53.9	92.9	96.9	97.4	91.7	53.9
Texas	71.7	90.3	51.5	45.4	19.4	46.8	59.8	34.8	22.4	14.9
Utah	73.1	87.6	44.1	74.0	73.3	0.3	0.1	–	1.6	0.2
Vermont	67.8	82.4	83.3	39.0	1.8	–	–	–	–	–
Virginia	66.6	83.9	72.4	43.8	16.3	59.6	78.1	67.2	35.9	2.8
Washington	67.0	84.7	55.8	47.3	12.8	65.8	84.1	55.3	42.6	12.1
West Virginia	55.3	90.1	78.9	3.1	0.0	48.9	79.9	70.9	1.7	0.0
Wisconsin	54.1	76.3	58.3	27.0	10.4	51.5	75.0	57.4	22.3	2.9
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. 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.
Figures shown here may differ from Table 9, which uses Medicaid Managed Care Enrollment Report data. Reasons for differences include differing time periods (ever in FY 2008 for MSIS), state reporting anomalies (e.g., some states report a very small number of comprehensive risk-based enrollees in MSIS who may be miscategorized), and Medicaid-expansion CHIP enrollees (excluded here but included in Table 9). Although the enrollment report used for Table 9 is a commonly cited source, it does not provide information on the characteristics of enrollees in managed care (e.g., eligibility group) or their spending and non-managed care service use. MSIS data are used here to provide this additional level of detail.

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

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2011

TABLE 12. Percentage of Medicaid Benefit Spending on Managed Care by State and Eligibility Group, FY 2008

State	Percentage of Benefit Spending									
	Any managed care					Comprehensive risk-based managed care				
	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Total	**21.1%**	**39.6%**	**38.6%**	**13.5%**	**7.4%**	**18.2%**	**34.5%**	**34.8%**	**10.9%**	**6.4%**
Alabama	15.3	40.3	6.5	8.7	0.5	0.1	0.0	0.0	0.1	0.2
Alaska	–	–	–	–	–	–	–	–	–	–
Arizona	84.0	86.0	83.0	84.2	81.5	70.0	64.6	65.4	78.1	74.7
Arkansas	0.4	1.3	0.4	0.2	0.0	–	–	–	–	–
California	15.5	39.1	13.7	8.9	12.0	13.9	35.5	12.5	8.1	10.0
Colorado	12.5	21.3	7.7	11.3	8.6	5.9	7.8	4.1	4.4	7.7
Connecticut	13.5	45.8	51.3	0.1	0.0	13.5	45.8	51.3	0.1	0.0
Delaware	39.0	47.0	70.3	26.3	1.0	38.2	45.1	69.3	26.0	0.8
District of Columbia	19.6	40.7	51.7	8.5	0.0	19.6	40.7	51.7	8.5	0.0
Florida	16.8	31.0	16.6	14.2	9.7	15.3	28.2	16.2	12.4	9.6
Georgia	30.4	67.4	65.6	1.6	0.7	29.1	65.1	64.8	0.3	0.0
Hawaii	29.2	72.7	74.5	1.5	0.2	28.4	68.0	74.4	1.5	0.2
Idaho	3.0	9.0	2.8	0.6	0.9	0.0	0.0	0.0	0.0	0.0
Illinois	2.0	4.7	4.8	0.1	0.3	1.3	3.1	3.4	0.0	0.2
Indiana	18.4	50.4	62.7	2.8	0.0	18.4	50.3	62.7	2.7	0.0
Iowa	4.5	8.5	6.4	4.5	0.1	0.3	0.9	0.9	0.0	0.0
Kansas	23.0	59.0	72.5	9.6	2.1	22.9	58.9	72.5	9.6	2.1
Kentucky	16.6	27.8	21.2	15.6	1.5	15.1	24.0	19.5	14.8	1.2
Louisiana	0.1	0.2	0.0	0.0	0.0	0.0	–	–	0.0	0.0
Maine	–	–	–	–	–	–	–	–	–	–
Maryland	32.1	52.6	66.9	27.4	0.5	32.1	52.6	66.8	27.4	0.5
Massachusetts	26.0	49.4	39.7	17.3	14.4	22.1	45.4	30.7	13.2	14.3
Michigan	43.0	54.9	62.9	47.2	3.9	37.3	52.5	54.7	39.4	1.3
Minnesota	30.4	67.7	67.9	3.8	36.1	30.4	67.7	67.9	3.9	36.1
Mississippi	–	–	–	–	–	–	–	–	–	–
Missouri	14.8	39.8	37.4	0.7	1.1	14.3	39.8	37.4	0.1	0.0
Montana	0.4	1.2	0.3	0.2	0.0	–	–	–	–	–

TABLE 12, Continued

State	Percentage of Benefit Spending									
	Any managed care					Comprehensive risk-based managed care				
	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Nebraska	5.7%	10.8%	14.4%	3.6%	0.7%	5.6%	10.6%	14.3%	3.6%	0.7%
Nevada	13.9	33.6	38.2	0.4	0.3	13.2	32.0	37.2	0.1	0.0
New Hampshire	–	–	–	–	–	–	–	–	–	–
New Jersey	16.2	43.5	54.9	8.0	1.4	16.2	43.5	54.9	8.0	1.4
New Mexico	47.2	69.2	58.7	36.3	3.6	39.4	55.4	54.7	29.9	3.5
New York	16.5	37.9	40.1	6.8	8.1	16.5	37.8	40.1	6.8	8.1
North Carolina	1.2	1.9	0.5	1.5	0.2	0.0	–	–	0.0	0.0
North Dakota	0.3	1.5	0.9	0.0	0.0	–	–	–	–	–
Ohio	32.9	75.3	80.5	23.6	3.6	32.9	75.3	80.5	23.6	3.6
Oklahoma	4.6	10.2	3.9	2.7	1.6	–	–	–	–	–
Oregon	36.7	53.5	63.1	32.6	9.7	28.5	37.3	56.1	24.3	8.1
Pennsylvania	41.4	73.5	66.8	47.0	5.6	27.0	50.6	48.4	29.1	2.8
Rhode Island	19.3	49.9	73.0	4.9	0.0	19.3	49.8	73.0	4.9	0.0
South Carolina	8.0	15.2	11.3	5.7	1.6	6.7	12.6	10.4	5.1	0.0
South Dakota	0.2	0.6	0.2	0.1	0.1	–	–	–	–	–
Tennessee	48.4	72.1	73.1	41.0	9.7	35.3	55.7	59.5	25.7	8.8
Texas	18.3	32.2	21.5	8.9	8.9	18.0	31.8	21.4	8.5	8.9
Utah	11.1	7.5	4.3	17.8	4.9	0.7	0.3	–	1.4	0.1
Vermont	78.2	1	1	1	1	1	1	1	1	1
Virginia	23.5	38.3	50.1	19.3	2.4	23.4	38.3	50.1	19.3	2.4
Washington	24.1	65.6	58.7	1.7	1.5	24.1	65.6	58.7	1.7	1.5
West Virginia	11.7	37.8	44.8	0.2	0.0	11.7	37.7	44.8	0.2	0.0
Wisconsin	26.2	44.7	51.0	16.5	20.2	17.1	41.6	49.0	8.7	3.0
Wyoming	–	–	–	–	–	–	–	–	–	–

Note: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 4 of MACStats for methodology. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs.

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

1 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.

Source: 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 May 2011

Technical Guide to the June 2011 MACStats

This section provides supplemental information to accompany the tables and figures in Sections 1, 2, and 3 of MACStats. It describes key issues to be aware of when interpreting the data, compare numbers across tables and figures, or reconcile findings with data from other sources.

Guide to Interpreting Medicaid and CHIP Numbers

As described in MACPAC's March 2011 Report, there are several reasons why estimates of Medicaid and CHIP enrollment and spending may vary.[34] These issues are noted here in relation to the tables and figures in the June 2011 of MACStats. In addition, MACPAC has made certain adjustments to spending data in MACStats that are described in detail later in this section.

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 the programs. The latest year of available data differs, depending on the source. The administrative data used in this edition of MACStats include the following, which are submitted to CMS by states:

- Form CMS-64 for state-level Medicaid spending, as used throughout MACStats;
- The Medicaid Statistical Information System (MSIS) for person-level detail, as used throughout MACStats[35]; and

[34] See MACPAC, *Report to the Congress on Medicaid and CHIP: March 2011* (Washington, DC: MACPAC, 2001): 75-77. http://www.macpac.gov/reports/ MACPAC_March2011_web.pdf.

[35] MACPAC has adjusted benefit spending from MSIS to match CMS-64 totals; see discussion later in Section 4 for details.

- Medicaid managed care enrollment reports, as used in Tables 9 and 10.

Additional information is available from some nationally representative surveys based on interviews of individuals. The survey data used in Tables 3A-5C are from HHS's National Health Interview Survey (NHIS).

Enrollment Period Examined

The number of individuals enrolled at a particular point during the year will be 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.[36] Full-year equivalent enrollment is often used for budget analyses, such as those by CMS's Office of the Actuary, and when comparing enrollment and expenditure numbers, as in Figure 1. Per enrollee spending levels based on full-year equivalents (Table 8) ensure that amounts are not biased by individuals' transitions in and out of Medicaid coverage during the year.

Enrollees versus Beneficiaries

Depending on the data source and the year in question, CMS may refer to individuals in Medicaid as enrollees or eligibles—or as beneficiaries, recipients, or persons served. For this version of MACStats and the topics examined in this report, it is important to recognize how individuals and spending are counted and described in administrative data sources provided by CMS:

- **Enrollees or eligibles**—CMS refers to individuals who are eligible for and enrolled in Medicaid or CHIP as either enrollees or eligibles.
- **Beneficiaries, recipients, or persons served**—Enrollees who receive covered services or for whom Medicaid or CHIP payments are made (including managed care payments) are generally referred to as beneficiaries, recipients, or persons served.[37]
- **Medicaid-expansion CHIP**—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.

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 1990 (Figure 1).

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).[38]

The following example illustrates the difference in these terms. In FY 2008, there were 9.7 million disabled Medicaid *enrollees* (Table 6). However, there were 8.7 million disabled *beneficiaries*—that is, during FY 2008, a Medicaid fee for service or

[36] Average monthly enrollment takes the state-submitted monthly enrollment numbers (i.e., 12 separate point-in-time 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 total person-months for the year divided by 12.

[37] See, for example, CMS, Brief Summaries and Glossary in *Health Care Financing Review 2010 Statistical Supplement,* https://www.cms.gov/MedicareMedicaidStatSupp/LT/list.asp.

[38] In a given year, it is possible that no payments were made for an enrollee who used no Medicaid services and was not enrolled in managed care. However, if the individual were enrolled in managed care, the state would make capitated Medicaid payments to the plan on behalf of the individual, even if no health care services were used. Therefore, all managed care enrollees are now counted as beneficiaries, whether or not they use any health services.

managed care capitation payment was made on their behalf (Table 1).[39] 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.[40]

Institutionalized and Limited-benefit Enrollees

Administrative Medicaid data include those 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 3A-5C do not include the institutionalized.

CHIP Enrollees

Medicaid-expansion CHIP enrollees are children who are entitled to the covered services of the state Medicaid program but are generally funded with CHIP dollars. We exclude these children from Medicaid analyses where possible, but in some cases data sources do not allow Medicaid-expansion CHIP enrollees to be broken out separately (e.g., Table 9 includes these enrollees, while nearly all other tables and figures in MACStats exclude them).

Medicaid Eligibility for Persons with Disabilities

The following briefly describes Medicaid eligibility for persons with disabilities. The purpose of this section is to provide context for interpreting the health characteristics and Medicaid enrollment, service use and expenditures of the disabled populations in the tables and figures in MACStats and the managed care sections of this Report.

For purposes of program enrollment and spending data, the Medicaid program's classification of "disabled" generally refers to Medicaid enrollees under age 65 who qualify for Medicaid on the basis of a disability. Medicaid enrollees who qualify for coverage due to a disability have conditions that include physical impairments and limitations (e.g., quadriplegia), intellectual or developmental impairments (e.g., mental retardation, cerebral palsy), and severe mental and emotional conditions, including mental illness (e.g., schizophrenia).

- For most enrollees with disabilities, qualifying on the basis of a disability means qualifying for benefits under the federal Supplemental Security Income (SSI) program.[41]
- Working individuals with disabilities with incomes too high to qualify for SSI may qualify for Medicaid through other disability-related provisions that would lead them to be classified as disabled in most Medicaid program statistics, including Medicaid buy-in programs, described later in this section; many of these individuals receive Social Security Disability Insurance (SSDI) benefits.

[39] 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 usually have an "unknown" basis of eligibility in CMS data.

[40] Analyses of growth in the number of Medicaid beneficiaries will sometimes refer to "enrollment growth" in a generic sense.

[41] Eleven states use different Medicaid eligibility rules from the federal SSI program. Known as "209(b) states," these states can use more restrictive eligibility criteria (financial and non-financial) for Medicaid eligibility than the federal SSI program, as long as the Medicaid rules are no more restrictive than the rules the state had in place in 1972 when SSI was enacted.

- Individuals with disabilities—or conditions that might be considered disabling—who have incomes too high to qualify for SSI but still have low incomes or high medical expenses may also be covered at state option through poverty level, medically needy, special income level, and other eligibility pathways (March 2011 MACStats Table 11). Some of these pathways are specific to people who require an institutional level of care, but services may be provided in the community (e.g., under a 1915(c) home and community-based services (HCBS) waiver) or in a nursing or other facility depending on the state and the individual's circumstances.[42] The extent to which individuals under age 65 who qualify for Medicaid through one of these pathways are classified as disabled in program statistics may vary based on state practices.
- Individuals with disabilities may also qualify for Medicaid under provisions that are unrelated to disability status—for example, as a child in foster care or as the low-income parent of a dependent child.

Of the 58.8 million people enrolled in Medicaid in FY 2008, 9.7 million (16.5 percent) were nonelderly individuals who qualified for Medicaid benefits on the basis of a disability (Table 6), including approximately 1.4 million individuals under age 19. Approximately 4 million of these individuals are also eligible for Medicare, and are known as dual eligibles.[43]

Qualifying for SSI and Medicaid

SSI provides cash assistance to low-income people who are aged, blind, or disabled and meet certain income and resource requirements. The SSI monthly income standard for 2011 is $674 (75 percent of the federal poverty limit, or FPL) for an individual and $1,011 (83 percent FPL) for a couple. The asset standard is $2,000 and $3,000 for individuals and couples, respectively.

To meet the definition of disability for SSI, an adult must have a medically determinable physical or mental impairment (or multiple impairments) that prevents the individual from being engaged in substantial gainful activity (SGA) (§1614(a)(3)(A) of the Social Security Act). The impairment must be expected to last at least 12 months. A person who is earning more than a certain monthly amount (net of impairment-related work expenses) is considered to be engaging in substantial gainful activity. The monthly SGA amount for 2011 is $1,640 for blind individuals and $1,000 for non-blind individuals.

Children under age 18 meet SSI's disability definition if they have a medically determinable physical or mental impairment that results in "marked and severe functional limitations" (§1614(a)(3)(C)(i) of the Social Security Act). Again, the impairment must be expected to last for at least 12 months. A child may be eligible for SSI as early as the date of birth. At age 18 the Social Security Administration (SSA) will reevaluate the individual's impairments based on the definition of disability for adults.

[42] HCBS waivers target populations that are "at risk of institutional care," including the frail elderly, individuals with physical disabilities, individuals with mental retardation and developmental disabilities, medically fragile or technology-dependent children, individuals with HIV/ AIDS, and individuals with traumatic brain and spinal cord injury.

[43] This includes "partial" dual eligible enrollees who receive only limited Medicaid benefits (i.e., financial assistance for Medicare premiums, deductibles and cost sharing) known as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs).

In 39 states and the District of Columbia, individuals who receive cash assistance under SSI on the basis of a disability are automatically eligible for Medicaid. In 32 of these states the SSI application is also the Medicaid application, and Medicaid eligibility starts the same month as SSI eligibility, based on SSA's determination of disability. Seven states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah) use the same rules to decide eligibility for Medicaid that SSA uses for SSI, but require the filing of a separate application. The state makes the final eligibility determination.

Eleven states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia) may use Medicaid eligibility rules that are more restrictive than the federal SSI program. These states are known as 209(b) states. In 209(b) states, both the financial and non-financial eligibility criteria for Medicaid eligibility determination can be more restrictive than the federal SSI program as long as the Medicaid rules are no more restrictive than the rules the state had in place in 1972 when the SSI program was enacted.

Medicaid and the Working Disabled

Basing the definition of disability on an individual's work status has the potential to create a disincentive for individuals to return to work. To address this issue, Medicaid includes mandatory (e.g., for Qualified Severely Impaired Individuals) and optional (e.g., Medicaid buy-in programs) provisions that allow certain individuals with disabilities to work and retain Medicaid eligibility. As of 2009, over 150,000 individuals were enrolled in Medicaid coverage under Medicaid optional buy-in programs for the working disabled.[44]

Qualified Severely Impaired Individuals

Some individuals with disabilities are able to work, but only when they have medical coverage for their condition. Under Section 1905(q) of the Social Security Act, states must continue Medicaid eligibility for individuals under age 65 who (1) continue to have a disabling physical or mental impairment on the basis of which they were found to be disabled, (2) need Medicaid coverage in order to continue working, (3) would lose SSI and Medicaid because their earnings exceed the substantial gainful activity monthly standard, and (4) continue to meet other requirements for Medicaid and SSI. These individuals are entitled to receive Medicaid after the loss of SSI due to earnings until they reach an income level considered sufficient by SSA for them to purchase a "reasonable equivalent" of SSI benefits, Medicaid benefits, and publicly funded attendant care services.

Medicaid Buy-In Programs

There are several other options for individuals who want to return to work without losing their Medicaid benefits. The Balanced Budget Act of 1997 (BBA, P.L. 105-33) created a state option to permit workers with disabilities to buy into Medicaid; states may charge these individuals a monthly premium or other cost sharing based on income. To qualify, individuals must:

- meet the definition of disabled under the Social Security Act and be eligible for SSI payments if not for earnings;
- have earnings that exceed the maximum amount permitted for the maintenance of Medicaid benefits as a qualified severely impaired individual; and

[44] M. Kehn et al., Appendix B-14 in A *Government Performance and Results (GPRA) report: The status of the Medicaid Infrastructure Grants Program as of 12/31/09* (Washington, DC: Mathematica Policy Research Inc., 2010).

- be in a family whose net income is less than 250 percent of the FPL for its size. For a family of three in 2011 this would be $3,860 a month. States may use less restrictive methodologies to increase the income and resource thresholds.

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA, P.L.106-170) created two additional Medicaid buy-in options for the working disabled.

- Section 1902(a)(10)(A)(ii)(XV) of the Social Security Act allows states to offer a buy-in to working age individuals (age 18-64) who would be eligible, except for earnings, for SSI. States can set eligibility limits on assets and earned and unearned income and set the methodologies for determining income and resources. States can impose premiums or other cost sharing based on income.
- Section 1902(a)(10)(A)(ii)(XVI) allows states to continue coverage for working individuals with disabilities whose medical conditions remain severe but who would otherwise lose SSI eligibility due to medical improvement as determined at a regularly scheduled continuing disability review. Eligibility is limited to individuals who cease to be eligible for the first TWWIIA buy-in due to medical improvement. States can impose premiums or other cost sharing based on income.

For both TWWIIA buy-ins, states may require premiums or cost sharing set on a sliding scale based on income. They may charge 100 percent of the premium to individuals whose income exceeds 250 percent FPL but is below 450 percent FPL, provided that these premiums do not exceed 7.5 percent of income. States must require payment of 100 percent of the premium for individuals whose adjusted gross income, as defined by the Internal Revenue Service, exceeds $75,000, except that a state may subsidize the premiums with unmatched state funds. In order to receive federal matching funds for these buy-ins, states must meet a maintenance of effort requirement for funds that had previously been spent on state programs to enable people with disabilities to work, but this maintenance of effort requirement specifically excludes money spent for Medicaid.

Social Security Disability Insurance

The federal Social Security Disability Insurance (SSDI) program provides cash benefits to some individuals with a physical or mental impairment or blindness regardless of income level. In certain cases the disabled person's spouse or children can receive benefits as well. SSDI beneficiaries are generally eligible for Medicare two years after the onset of disability. Some individuals in this 24-month waiting period—and beyond, after they obtain Medicare coverage—have high medical expenses that lead them to "spend down" onto Medicaid, or low incomes that qualify them for Medicaid under another eligibility pathway. Individuals who are enrolled in both programs are referred to as dual eligibles.

Individuals qualify for SSDI based on their contributions to the Social Security Trust Fund through the Federal Insurance Contributions Act (FICA) Social Security tax paid on their earnings. In order to be eligible for SSDI an individual generally must have paid Social Security taxes for enough years to be covered under Social Security insurance; the number of years varies by the individual's age. The amount of monthly disability benefits is based on an individual's lifetime average earnings covered by Social Security.

The medical requirements for disability payments are the same under both SSDI and SSI, and the same process is used for both programs to determine disability. This includes not being able to work, or working but earning less than the SGA level.

The SSDI program also pays benefits to certain adults who have not worked enough to qualify for Social Security insurance (including some who have never worked). Their eligibility can be based on a parent's Social Security earnings record if they are currently or formerly dependent on that parent. These adults must be unmarried, and their disability must have begun before age 22. For disabled adults to become entitled to this benefit, one of their parents must be receiving Social Security retirement or disability benefits; or if deceased the parent must have worked long enough under Social Security to qualify for benefits. These benefits continue as long as the adult child remains disabled.

Methodology for Adjusting Benefit Spending Data

The FY 2008 Medicaid benefit spending amounts shown in the June 2011 MACStats were calculated based on Medicaid Statistical Information System (MSIS) data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[45] 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.[46] 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 primarily used for statistical purposes.
- MSIS generally understates total Medicaid benefit spending because it excludes disproportionate share hospital (DSH) and additional types of supplemental payments made to hospitals and other providers, Medicare premium payments, and certain other amounts.[47]
- 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.[48]
- 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 13 for unadjusted benefit spending amounts in MSIS as a percentage of benefit spending in the CMS-64.

[45] Medicaid benefit spending reported here excludes the territories, administrative spending, 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.

[46] For a discussion of these data sources, see 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.

[47] Some of these amounts, including DSH and other supplemental payments, are lump sums not related to service use by an individual Medicaid enrollee. 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 (e.g., hospital). We include both types of supplemental payments in benefit spending partly because unlike DSH, states do not reliably break out their non-DSH supplemental payments separately from their regular payments for hospital and other care in the CMS-64. If accurate reports of both DSH and non-DSH supplemental payments become available, we will consider an alternative adjustment methodology that excludes them.

[48] T. Plewes, *Databases for estimating health insurance coverage for children: A workshop summary* (Washington, DC: The National Academies Press, 2010):32-37. http://www.nap.edu/catalog/13024.html.

TABLE 13. Medicaid Benefit Spending in MSIS and CMS-64 Data by State, FY 2008 (billions)

State	MSIS	CMS-64	MSIS as a Percentage of CMS-64
Total	**$293.7**	**$338.6**	**86.7%**
Alabama	3.5	4.1	86.0
Alaska	0.9	0.9	106.4
Arizona	6.6	7.5	87.7
Arkansas	3.2	3.3	96.1
California	32.0	39.0	82.1
Colorado	3.0	3.2	94.2
Connecticut	4.1	4.5	91.2
Delaware	1.1	1.1	103.2
District of Columbia	1.7	1.4	119.4
Florida	13.2	14.7	90.0
Georgia	6.9	7.3	93.5
Hawaii	1.0	1.2	80.3
Idaho	1.2	1.2	102.8
Illinois	10.1	11.6	87.3
Indiana	4.9	6.2	78.9
Iowa	2.7	2.8	94.3
Kansas	2.3	2.3	100.9
Kentucky	4.4	4.8	91.2
Louisiana	4.8	6.1	79.2
Maine	1.4	2.3	60.0
Maryland	5.4	5.7	94.0
Massachusetts	8.8	10.8	81.0
Michigan	9.2	9.8	93.5
Minnesota	6.6	7.0	95.2
Mississippi	3.1	3.8	81.9
Missouri	5.1	7.1	71.8
Montana	0.7	0.8	84.3
Nebraska	1.5	1.6	92.9
Nevada	1.1	1.3	85.8
New Hampshire	0.9	1.3	74.4
New Jersey	7.4	9.4	78.3
New Mexico	2.9	3.0	95.7
New York	43.0	47.6	90.4
North Carolina	8.8	10.2	87.0
North Dakota	0.5	0.5	101.9
Ohio	11.6	12.4	93.2
Oklahoma	3.2	3.5	90.8
Oregon	2.5	3.2	76.4
Pennsylvania	12.5	16.3	76.7
Rhode Island	1.6	1.8	85.6
South Carolina	4.3	4.4	96.1
South Dakota	0.7	0.7	99.9
Tennessee	6.3	7.2	87.8
Texas	16.7	21.5	77.6
Utah	1.6	1.5	108.3
Vermont	0.9	1.1	81.7
Virginia	4.6	5.4	86.1
Washington	5.8	6.3	92.7
West Virginia	2.4	2.3	105.5
Wisconsin	4.5	5.0	89.3
Wyoming	0.5	0.5	102.1

Note: See text for a discussion of differences between MSIS and CMS-64 data. Both sources are unadjusted. The CMS-64 amounts exclude $5.5 billion in offsetting collections from third-party liability, estate, and other recoveries.

Source: MACPAC analysis of MSIS Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS

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

- We aggregate 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 14 provides additional detail on the categories used.
- We calculate state-specific adjustment factors for each of the service categories by dividing CMS-64 benefit spending by MSIS benefit spending.
- We then multiply MSIS dollar amounts in each service category by the state-specific factors to obtain adjusted MSIS spending. For example, in a state with a fee-for-service 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.[49]

By making these adjustments to the MSIS data, we are attempting to provide comparable estimates of Medicaid benefit spending across states that can be analyzed by eligibility group and other enrollee characteristics. There are a number of areas where this methodology might be refined for future analyses—for example, with regard to the services included in the long-term services and supports category and the treatment of DSH and other supplemental payments that are not related to service use by an individual Medicaid enrollee. 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.

Managed Care Enrollment and Spending Guide

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

The Medicaid Managed Care Data Collection System (MMCDCS) provides 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*,[50] which is the source of information on Medicaid managed care most commonly cited by CMS, as well as outside analysts and researchers. CMS also uses the MMCDCS to produce an annual *National 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),[51] each of which may include several managed care plans.

[49] 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, $5.5 billion in FY 2008, are not reported by type of service in the CMS-64 and are not reported at all in MSIS.

[50] CMS, *Medicaid managed care enrollment report,* https://www.cms.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp.

[51] CMS, *Description of state programs,* https://www.cms.gov/MedicaidDataSourcesGenInfo/06_ DescStateProg.asp.

TABLE 14. Service Categories Used to Adjust Medicaid Benefit Spending in MSIS to Match CMS-64 Totals

Service Category	MSIS Service Types	CMS-64 Service Types
Hospital	▶ Inpatient hospital ▶ Outpatient hospital ▶ Inpatient psychiatric for under age 21 ▶ Mental health facility for the aged	▶ Inpatient hospital regular payments ▶ Inpatient hospital non-DSH supplemental payments ▶ Inpatient hospital DSH ▶ Mental health facility regular payments ▶ Mental health facility DSH ▶ Outpatient hospital regular payments ▶ Outpatient hospital supplemental payments ▶ Critical access hospital ▶ Emergency hospital ▶ Emergency services for aliens[1]
Non-hospital acute care	▶ Physician ▶ Dental ▶ Nurse midwife ▶ Nurse practitioner ▶ Other practitioner ▶ Non-hospital outpatient clinic ▶ Lab/X-ray ▶ Sterilizations ▶ Abortions ▶ Physical, occupational, speech, and hearing therapy	▶ Physician regular payments ▶ Physician supplemental payments ▶ Dental ▶ Nurse midwife ▶ Nurse practitioner ▶ Other practitioner regular payments ▶ Other practitioner supplemental payments ▶ Non-hospital outpatient clinic ▶ Rural health clinic ▶ Federally qualified health center ▶ Lab/X-ray ▶ Sterilizations ▶ Abortions ▶ EPSDT screenings ▶ Non-emergency transportation ▶ Physical, occupational, speech, and hearing therapy ▶ Prosthetics, dentures, and eyeglasses ▶ Diagnostic screening and preventive services ▶ School-based services ▶ Care not otherwise categorized
Drugs	▶ Drugs (gross spending)	▶ Drugs (gross spending) ▶ Drug rebates

TABLE 14, Continued

Service Category	MSIS Service Types	CMS-64 Service Types
Managed care and premium assistance	▶ HMO (i.e., comprehensive risk-based managed care; includes PACE) ▶ PHP ▶ PCCM	▶ MCO (i.e., comprehensive risk-based managed care) ▶ PAHP ▶ PIHP ▶ PCCM ▶ PACE ▶ Premium assistance for employer-sponsored coverage
LTSS non-institutional	▶ Home health ▶ Personal care ▶ Private duty nursing ▶ Targeted case management ▶ Rehabilitative services ▶ Hospice ▶ Other services (consists primarily of HCB waiver)	▶ Home health ▶ Personal care ▶ Private duty nursing ▶ Case management (excludes primary care case management) ▶ Rehabilitative services ▶ Hospice ▶ HCB waiver and state plan services
LTSS institutional	▶ Nursing facility ▶ ICF/MR	▶ Nursing facility regular payments ▶ Nursing facility supplemental payments ▶ ICF/MR regular payments ▶ ICF/MR supplemental payments
Medicare[2,3]		▶ Medicare Part A and Part B premiums ▶ Medicare coinsurance and deductibles for QMBs

Notes: EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; HCB = home and community-based; HMO = health maintenance organization; ICF/MR = intermediate care facility for the mentally retarded; LTSS = long-term services and supports; MCO = managed care organization; PACE = Program of All-Inclusive Care for the Elderly; PHP = prepaid health plan; PAHP = prepaid ambulatory health plan; PIHP = prepaid inpatient health plan; PCCM = primary care case management; QMB = Qualified Medicare Beneficiary.

Service categories and types reflect fee-for-service spending unless noted otherwise. Service types with identical names in the MSIS and CMS-64 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., DSH) are distributed across Medicaid enrollees with MSIS spending in the relevant service categories (e.g., hospital).

1 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.

2 Medicare premiums are not reported in MSIS. We distribute CMS-64 amounts across dual eligible enrollees in MSIS.

3 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 and non-hospital acute categories prior to calculating adjustment factors, based the distribution of spending for these categories among QMBs in MSIS.

Source: MACPAC analysis of MSIS and CMS-64 data

The Medicaid Statistical Information System (MSIS) provides person-level and claims-level information for all Medicaid enrollees.[52] With regard to managed care, the information collected for each enrollee includes plan ID numbers and types for up to four managed care plans (including comprehensive risk-based plans, PCCMs, and limited-benefit plans) under which the enrollee is covered; if enrolled in a 1915(b) or other waiver, the waiver ID number; claims that provide a record of each capitated payment made on behalf of the enrollee to a managed care plan (these are generally referred to as capitated claims); and, in some states, a record of each service received by the enrollee from a provider under contract with a managed care plan (these generally do not include a payment amount and are referred to as encounter or "dummy" claims). As discussed in the managed care sections of this Report and in MACPAC's March 2011 Report to the Congress, all states collect encounter data from their Medicaid managed care plans, but some do not report it 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.

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.

The Statistical Enrollment Data System (SEDS) provides aggregate statistics on CHIP enrollment and child Medicaid enrollment that include the number covered under fee for service and managed care systems. SEDS is the only comprehensive source of information on managed care participation among separate CHIP enrollees across states; however, it is generally not used to examine managed care participation among Medicaid-expansion CHIP and regular Medicaid enrollees, for which other data sources are available.

In MACStats and the managed care chapter of this Report, many of the statistics cited on managed care are from CMS's *2009 Medicaid Managed Care Enrollment Report*. However, the enrollment report does not provide information on characteristics of enrollees in managed care aside from dual eligibility status (e.g., basis of eligibility and demographics such as age, sex, and race/ethnicity) or their spending and non-managed care service use. As a result, we supplement statistics from the enrollment report with MSIS and CMS-64 data; for example, Tables 11 and 12 use MSIS data to show the percentage of child, adult, disabled, and aged Medicaid enrollees who are enrolled in managed care and the percentage of their Medicaid benefit spending that was for 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 enrollment report data cited for Tables 9 and 10 in MACStats and throughout the managed care chapter. Tables 11 and 12—which show the percentage of child, adult, disabled, and aged Medicaid enrollees who are enrolled in managed care and the percentage of their Medicaid benefit spending that was for

[52] 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.).

managed care—are based on MSIS data and exclude Medicaid-expansion CHIP enrollees.[53]

- The types of managed care reported by states may differ somewhat between the Medicaid Managed Care Enrollment Report and the MSIS. For example, in their MSIS data, Alabama, Idaho, and Utah report a small number of enrollees in comprehensive risk-based managed care (Table 11); in their enrollment report data, they report zero enrollees in this category (Table 9). Anomalies in the MSIS data are documented by CMS as it reviews each state's quarterly submission,[54] but not all issues may be identified in this process.
- The Medicaid Managed Care enrollment report provides point-in-time figures (e.g., as of June 30, 2009). 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).

[53] We generally exclude Medicaid-expansion 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.

[54] See CMS, MSIS *State Anomalies/Issues*, 2009. http://www.cms.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp.