Medicaid and CHIP Program Statistics: June 2012 MACStats

MACStats Table of Contents

Overview of MACStats

MACStats is a standing section in all MACPAC reports to the Congress. It was created because data and information on Medicaid and the State Children's Health Insurance Program (CHIP) can often be difficult to find and are spread out across a variety of sources. The June 2012 edition of MACStats is divided into five sections:

- Section 1: Trends in Medicaid Enrollment and Spending
- Section 2: Health and Other Characteristics of Medicaid/CHIP Populations
- Section 3: Medicaid Enrollment and Benefit Spending
- Section 4: Medicaid Managed Care
- Section 5: Technical Guide to the June 2012 MACStats

Key points from each section follow.

Section 1: Trends in Medicaid Enrollment and Spending

- **Federal and state policy choices, as well as economic factors, impact Medicaid and CHIP spending and enrollment.** Trends in Medicaid spending and enrollment reflect shifts in federal and state Medicaid policy—such as expansions of eligibility to new groups of individuals—in addition to changing economic conditions (Figure 1). For example, recent recessions spurred enrollment growth in both the early and late 2000s.
- **Individuals qualifying for Medicaid on the basis of a disability accounted for half of real Medicaid spending growth since fiscal year (FY) 1975.** Of the real (inflation-adjusted) growth in Medicaid spending between FY 1975 and FY 2009, 51.2 percent was attributable to individuals qualifying for Medicaid on the basis of a disability. Nearly three-quarters of the growth for this group was driven by increased enrollment, with the remainder being attributable to growth in per capita spending (Table 2).
- **Compared to the other major eligibility groups, enrollment of individuals qualifying for Medicaid on the basis of a disability experienced the largest annual growth rates.** Children (excluding those eligible on the basis of a disability) experienced the largest enrollment increase in absolute numbers, from 9.6 million in FY 1975 to 28.3 million in FY 2009. However, despite the fact that enrollment growth has generally shown greater annual fluctuations among non-disabled children

and adults under age 65, enrollment among individuals qualifying for Medicaid on the basis of a disability had the largest annual growth rate over this time period (3.9 percent, Table 2).

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

- **Medicaid/CHIP enrollees generally report being in poorer health and using more services than individuals who have other health insurance or who are uninsured.** Medicaid/CHIP enrollees were more likely to report being in fair or poor health than individuals with any other source of coverage or no insurance, across all age groups analyzed, with the exception of 19- to 64-year olds enrolled in Medicare (Tables 3B, 4B, and 5B).
- **Even within the same age group, Medicaid/CHIP enrollees are a diverse population.** For example, nearly 60 percent of Medicaid enrollees with disabilities[1] age 19 to 64 reported being in fair or poor health, compared to 20 percent of the other Medicaid enrollees in that age group (Table 4B).

Section 3: Medicaid Enrollment and Benefit Spending

- **A small share of enrollees account for a large share of spending.** Enrollees eligible on the basis of a disability and those who are age 65 and older account for 25 percent of the Medicaid population, but 67 percent of the program's spending on benefits (Tables 6 and 7).
- **Benefit spending per enrollee varies widely across populations and states.** For example, enrollees eligible on the basis of a disability and those who are age 65 and older have average per person Medicaid benefit spending that is 3 to 5 times that of other enrollees (Figure 4 and Table 8).
- **Users of long-term services and supports (LTSS) are a small but high-cost population.** LTSS users—primarily enrollees eligible on the basis of a disability and those age 65 and older—account for only about 7 percent of Medicaid enrollees, but nearly half of all Medicaid benefit spending. Acute care represents a minority of Medicaid spending for most LTSS users, and these individuals have average per person Medicaid benefit spending ($45,272 per full-year equivalent (FYE) enrollee in FY 2009) that is more than 10 times that of enrollees who are not using LTSS ($4,193 per FYE, Figures 5, 6, and 7).

Section 4: Medicaid Managed Care

- **Managed care models vary by state and range from comprehensive risk-based plans to those providing only a limited set of benefits.** All but two states report using some form of managed care that includes comprehensive risk-based plans, limited-benefit plans, or primary care case management programs. The national percentage of Medicaid enrollees in any form of managed care is more than 70 percent, and nearly half of enrollees are in comprehensive risk-based plans (Tables 9, 10, and 11).
- **Enrollment in comprehensive risk-based plans is highest among non-disabled children and adults under age 65.** The share of enrollees in comprehensive risk-based plans in FY 2009 ranged from 61 percent among non-disabled child enrollees to 12 percent

among enrollees age 65 and older. Among individuals dually enrolled in Medicaid and Medicare, 38 percent were enrolled in some form of Medicaid managed care in FY 2009, but only about 10 percent were in Medicaid comprehensive risk-based plans (Tables 9 and 11).

Section 5: Technical Guide to the June 2012 MACStats

- **Enrollment and spending numbers can vary depending on the source of data, time period examined, and other factors.** For example, based on administrative data, nearly half of children living in the United States were enrolled in Medicaid or CHIP sometime during FY 2009 (48.4 percent). However, numbers from the same data source illustrate that the number of children enrolled at a particular point in time is much smaller (36.7 percent, Tables 13A–D).
- **A complete picture of Medicaid benefit spending requires multiple sources of information, including Medicaid Statistical Information System (MSIS) and CMS-64 data.** The FY 2009 Medicaid benefit spending amounts shown in the June 2012 MACStats were calculated based on MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data. These adjustments are made in an effort to provide more complete estimates of Medicaid benefit spending across states by eligibility group and other enrollee characteristics (Tables 14 and 15).

Endnotes

1 For Tables 4A–C, Medicaid enrollees with disabilities are those who were also enrolled in Medicare (dual eligibles) or who were not dual eligibles but were receiving Supplemental Security Income.

SECTION 1

Trends in Medicaid Enrollment and Spending

Overall Medicaid spending growth is driven by increases 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. At times, this growth (or lack thereof) has been driven by broad economic changes; at other times, trends in Medicaid enrollment and spending have reflected changes in federal and state Medicaid policies.

For example, in the late 1970s and early 1980s, inflation levels were high across the entire economy, causing rapid Medicaid spending growth even during times with little growth in enrollment. 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.[1]

During the recession in the early 2000s, enrollment grew substantially, but slowed again in the mid-2000s. Medicaid spending actually declined from fiscal year (FY) 2005 to FY 2006; this was primarily because of the implementation in 2006 of Medicare Part D, which shifted spending on outpatient prescription drugs for individuals dually enrolled in Medicaid and Medicare to the Medicare program.[2] Since then, economic recession has once again spurred increased program enrollment—and thus program spending—while growth in Medicaid per capita spending has been relatively flat for the past several years.[3]

Enrollment and Spending Measures

Total Medicaid spending can be measured in different ways, as can the number of program participants. In turn, these measurement differences can affect the extent to

which spending growth is attributed to the number of people covered versus program spending per person.

Figure 2 illustrates three different ways of expressing 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 is the case today. 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 focus is not limited to health care, such as the Congressional Budget Office.[4] A second alternative, used by the Centers for Medicare & Medicaid Services, is to convert nominal historical Medicaid spending to real dollars using *health care* inflation.[5] 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.

Inflation increases the dollar amount required to purchase the same amount of goods and services over time. As a result, historical spending in nominal dollars can be difficult to interpret because it is unclear whether increases in spending are due to inflation or due to increases in the amount of goods and services being purchased. Inflation-adjusted numbers are used to address this problem by translating all purchases over a series of years into amounts that more closely reflect what they would cost if they had all been purchased in the same year. To simulate the purchase of goods and services in the health care sector in FY 1975 (or any year between FY 1975 and FY 2009) using FY 2009 dollars, the inflation-adjusted amount must be larger than the original nominal dollar amount to account for health care inflation. Since health care inflation generally exceeded economy-wide inflation over the entire period spanning FY 1975 to FY 2009, an inflation-adjusted amount that accounts only for economy-wide inflation—of which health care is just one component—would not accurately reflect the amount required to simulate a health sector purchase in any given year.

Historical Trends

Table 2 decomposes growth in Medicaid benefit spending[6] from FY 1975 to FY 2009 into two factors: the number of beneficiaries (a term described in Section 5), and per beneficiary spending. According to this MACPAC analysis, growth in the number of beneficiaries is responsible for 68.5 percent of real (i.e., health care inflation-adjusted) Medicaid benefit spending growth from FY 1975 to FY 2009.[7] The remaining 31.5 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 intensity of treatment specific to Medicaid; and state and federal policies regarding provider payments, care management, and other issues.[8]

The FY 1975–FY 2009 decomposition of growth by eligibility groups—aged, disabled, children, and adults—reveals that 51.2 percent of overall Medicaid benefit spending growth was attributable to individuals eligible on the basis of a disability. This was driven mostly by enrollment growth for this population, which has outpaced all other groups (Table 2). Children accounted for 19.2 percent of Medicaid spending growth between FY 1975 and FY 2009. Over

that period, the aged and other adults accounted for approximately 16.5 percent and 13.1 percent, respectively, of real Medicaid benefit spending growth.

By FY 2009, the number of beneficiaries eligible on the basis of a disability had risen to 9.1 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 Supplemental Security Income benefits, some is due to federal Medicaid expansions since the 1980s that increased the number of persons with disabilities enrolled in the program. These included home- and community-based waivers and the Medicare Savings Programs under which state Medicaid programs pay all or some of low-income Medicare beneficiaries' Medicare premiums and cost sharing.[9]

Despite the fact that enrollment growth has generally shown greater annual fluctuations among non-disabled children and adults under age 65 and that children have experienced the largest enrollment increase in absolute numbers, their annual growth rates have been lower than those for the disabled. In addition, because the per beneficiary spending for children is low, it has a smaller impact on overall growth in Medicaid benefit spending.

Future MACPAC analyses that decompose Medicaid spending growth may look at different eras or subpopulations, such as those dually eligible for Medicaid and Medicare, as well as spending on particular services.

Endnotes

1 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.

2 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.

3 J. Holahan and A. Yemane, Enrollment is driving Medicaid costs—but two targets can yield savings, *Health Affairs* 28 (2009): 1453–1465; and R. Garfield et al., *Enrollment-driven expenditure growth: Medicaid spending during the economic downturn, FFY2007–2010* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Issue Paper #8309, May 2012). http://www.kff.org/medicaid/upload/8309.pdf.

4 For example, see: Congressional Budget Office (CBO), *The 2012 long-term budget outlook* (Washington, DC: CBO, 2012). http://www.cbo.gov/publication/43288; 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.

5 See, for example, Table 13.10 in Centers for Medicare & Medicaid Services (CMS), *Health care financing review 2010 statistical supplement*, (Baltimore, MD: CMS, 2010). https://www.cms.gov/MedicareMedicaidStatSupp/09_2010.asp.

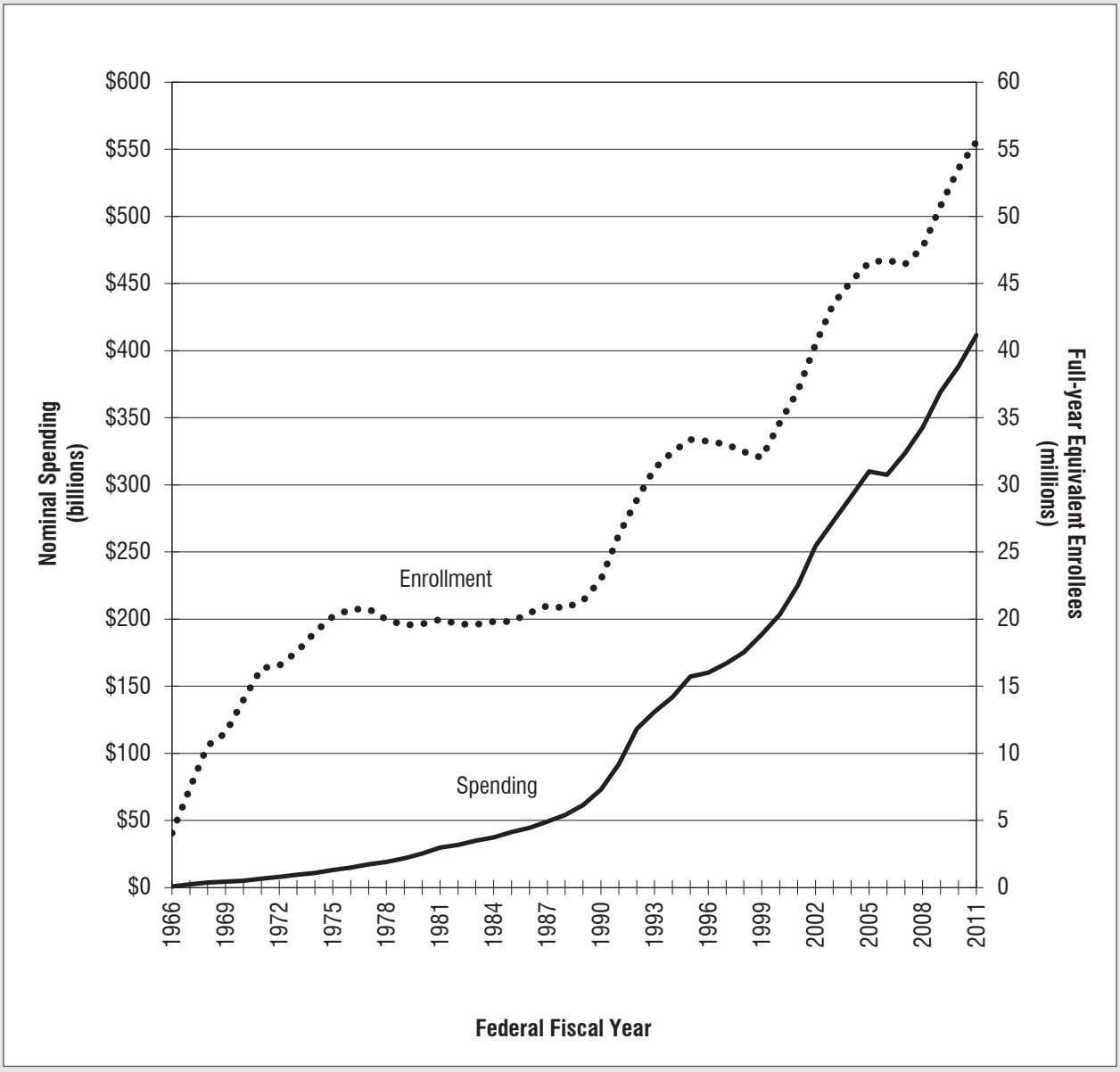
6 Benefit spending excludes administration and the Vaccines for Children program. As described in Section 5, FY 2009 benefit spending amounts are from the Medicaid Statistical Information System and have been adjusted to match totals reported by states in CMS-64 data. FY 1975 spending amounts do not need a similar adjustment because the data on which benefit spending were based in that year closely matched the CMS-64.

7 Results can differ if using different years or eras. The period FY 1975 to FY 2009 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 growth during its initial startup phase.

8 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 41.0 percent of real Medicaid benefit spending growth would be attributable to growth in the number of beneficiaries, and per-beneficiary spending would account for 59.0 percent of the growth.

9 See Social Security Administration (SSA), *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. Medicare Savings Programs—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 co-insurance) paid varies by the type of MSP.

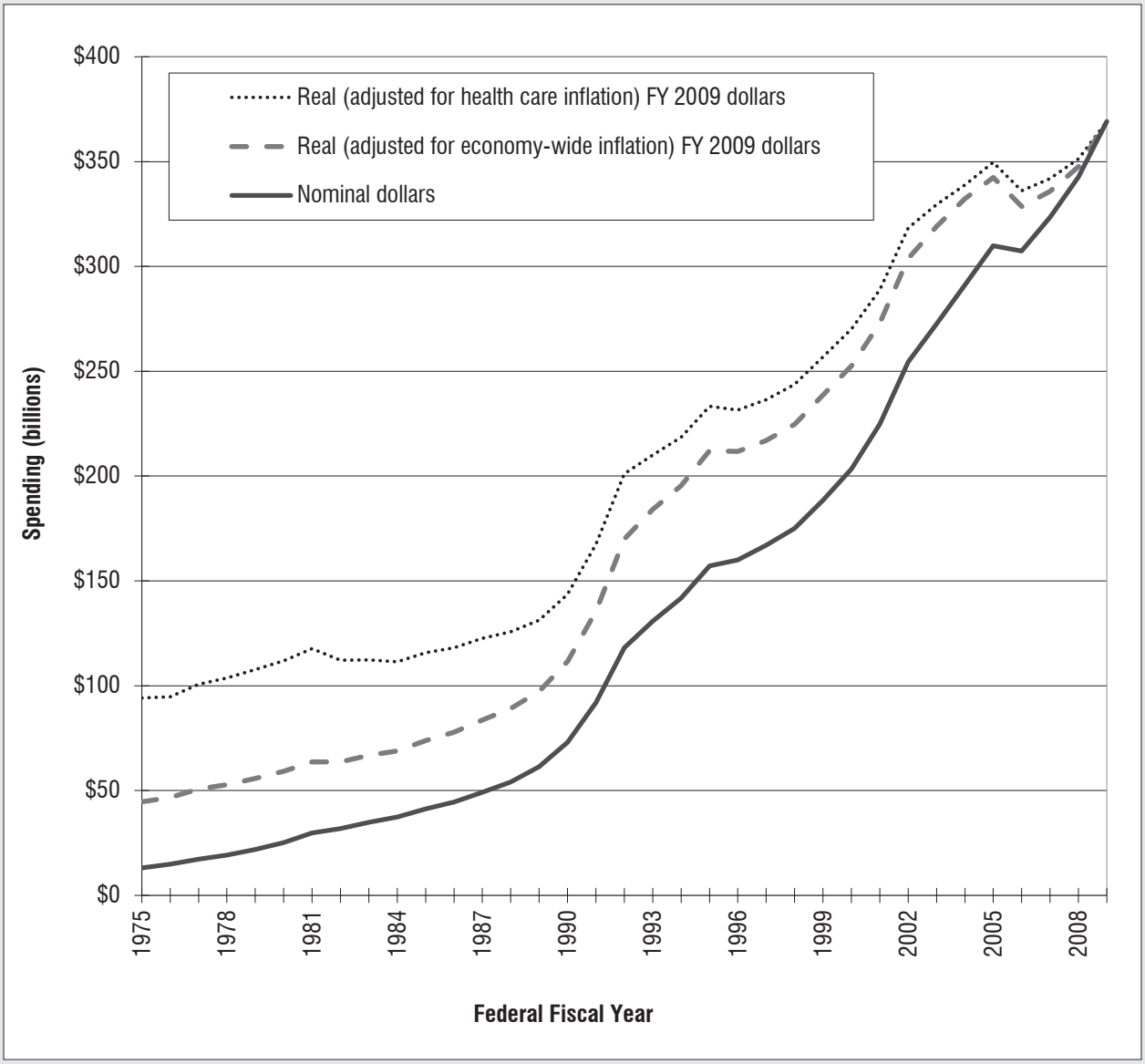
FIGURE 1. Medicaid Enrollment and Spending, FY 1966–FY 2011



Notes: Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Numbers exclude CHIP-financed coverage. Enrollment data for FY 2009–2011 are projected. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). The amounts in this figure may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Enrollment counts are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served (see Section 5 of MACStats for a discussion of how enrollees are counted).

Source: Data compilation provided to MACPAC by Office of the Actuary, CMS, April 2012

FIGURE 2. Medicaid Spending in Nominal and Real Dollars, FY 1975–FY 2009



Notes: Spending includes benefits and administrative spending. The bottom line in this figure (and in Figure 1) shows actual (nominal) spending. The middle line transforms nominal Medicaid spending to real FY 2009 dollars by adjusting for economy-wide inflation, using the Gross Domestic Product price deflator. The top line also shows real FY 2009 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 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 for Quarter 1 of 2012 from the Bureau of Economic Analysis, U.S. Department of Commerce (http://www.bea.gov/histdata/NIyear.asp)

TABLE 1. Number of Medicaid Beneficiaries (Persons Served) by Eligibility Group, FY 1975–FY 2009 (thousands)

Year	Total	Children	Adults	Disabled	Aged	Unknown
1975	22,007	9,598	4,529	2,464	3,615	1,801
1976	22,815	9,924	4,773	2,669	3,612	1,837
1977	22,832	9,651	4,785	2,802	3,636	1,958
1978	21,965	9,376	4,643	2,718	3,376	1,852
1979	21,520	9,106	4,570	2,753	3,364	1,727
1980	21,605	9,333	4,877	2,911	3,440	1,044
1981	21,980	9,581	5,187	3,079	3,367	766
1982	21,603	9,563	5,356	2,891	3,240	553
1983	21,554	9,535	5,592	2,921	3,372	134
1984	21,607	9,684	5,600	2,913	3,238	172
1985	21,814	9,757	5,518	3,012	3,061	466
1986	22,515	10,029	5,647	3,182	3,140	517
1987	23,109	10,168	5,599	3,381	3,224	737
1988	22,907	10,037	5,503	3,487	3,159	721
1989	23,511	10,318	5,717	3,590	3,132	754
1990	25,255	11,220	6,010	3,718	3,202	1,105
1991	27,967	12,855	6,703	4,033	3,341	1,035
1992	31,150	15,200	7,040	4,487	3,749	674
1993	33,432	16,285	7,505	5,016	3,863	763
1994	35,053	17,194	7,586	5,458	4,035	780
1995	36,282	17,164	7,604	5,858	4,119	1,537
1996	36,118	16,739	7,127	6,221	4,285	1,746
1997	34,872	15,791	6,803	6,129	3,955	2,195
1998	40,096	18,969	7,895	6,637	3,964	2,631
1999	39,748	18,233	7,446	6,690	3,698	3,682
2000	41,212	18,528	8,538	6,688	3,640	3,817
2001	45,164	20,181	9,707	7,114	3,812	4,349
2002	46,839	21,487	10,847	7,182	3,789	3,534
2003	50,716	23,742	11,530	7,664	4,041	3,739
2004	54,250	25,415	12,325	8,123	4,349	4,037
2005	56,276	25,979	12,431	8,205	4,395	5,266
2006	56,264	26,358	12,495	8,334	4,374	4,703
2007	55,210	26,061	12,264	8,423	4,044	4,418
2008	56,962	26,479	12,739	8,685	4,147	4,912
2009[1]	60,426	28,312	14,026	9,055	4,191	4,841

Notes: Beneficiaries (enrollees for whom payments are made) 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 5 of MACStats. The increase in FY 1998 reflects a change in how Medicaid beneficiaries are counted: beginning in FY 1998, a Medicaid-eligible person who received only coverage for managed care benefits was included in this series as a beneficiary. Excludes Medicaid-expansion CHIP children.

Children and adults who qualify for Medicaid on the basis of a disability are included in the disabled category. In addition, although disability is not a basis of eligibility for aged individuals, states may also report some enrollees age 65 and older in the disabled category. Unlike the majority of the June 2012 MACStats, this table (along with Table 2) does *not* recategorize individuals age 65 and older who are reported as disabled, due to a lack of necessary detail in the historical data. Generally, individuals whose eligibility group is unknown are persons who were enrolled in the prior year but had a Medicaid claim paid in the current year.

1 This table shows the number of beneficiaries. See Table 6 for the number of Medicaid enrollees in FY 2009 data from CMS. FY 2009 unavailable for Massachusetts; FY 2008 values used instead.

Sources: For FY 1999 to FY 2009: MACPAC analysis of Medicaid Statistical Information System (MSIS). For FY 1975 to FY 1998: CMS Medicare & Medicaid Statistical Supplement, 2010 edition, Table 13.4

TABLE 2. Components of Growth in Real Medicaid Benefit Spending, FY 1975–FY 2009

		FY 1975 (in FY 2009 dollars)	FY 2009[1]	Annual Growth Rate	Relative Contribution to Real Spending Growth, FY 1975 to FY 2009
All eligibility groups					
	Spending per beneficiary	$4,342	$6,567[2]	1.2%	31.5%
	Number of beneficiaries (millions)	20.2	55.6	3.0	68.5
	Total benefit spending (millions)	**$87,732**	**$364,827**	**4.3**	**100.0**
Children					
	Spending per beneficiary	$1,700	$2,454[2]	1.1	3.6
	Number of beneficiaries (millions)	9.6	28.3	3.2	15.6
	Total benefit spending (millions)	**$16,320**	**$69,410**	**4.3**	**19.2**
Adults					
	Spending per beneficiary	$3,399	$3,684[2]	0.2	0.5
	Number of beneficiaries (millions)	4.5	14.0	3.4	12.6
	Total benefit spending (millions)	**$15,395**	**$51,668**	**3.6**	**13.1**
Disabled					
	Spending per beneficiary	$9,529	$18,276[2]	1.9	13.1
	Number of beneficiaries (millions)	2.5	9.1	3.9	38.2
	Total benefit spending (millions)	**$23,480**	**$165,482[3]**	**5.9**	**51.2**
Aged					
	Spending per beneficiary	$9,000	$18,675[2]	2.2	14.4
	Number of beneficiaries (millions)	3.6	4.2	0.4	2.1
	Total benefit spending (millions)	**$32,537**	**$78,266[3]**	**2.6**	**16.5**

Notes: Beneficiaries (enrollees for whom payments are made) 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 5 of MACStats.

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

Children and adults who qualify for Medicaid on the basis of a disability are included in the disabled category. In addition, although disability is not a basis of eligibility for aged individuals, states may also report some enrollees age 65 and older in the disabled category. Unlike the majority of the June 2012 MACStats, this table (along with Table 1) does *not* recategorize individuals age 65 and older who are reported as disabled, due to a lack of necessary detail in the historical data.

The number of beneficiaries excludes individuals whose basis of Medicaid eligibility is unknown. 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. In this analysis, FY 1975 benefit spending for these individuals was allocated proportionally to the four eligibility groups in the table. FY 2009 benefit spending reflects MSIS data that have been adjusted to match CMS-64 totals; see Section 5 of MACStats for a discussion of the methodology used.

Results can differ if using different years or eras. The period FY 1975 to FY 2009 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 FY 2009 data unavailable for Massachusetts; FY 2008 values used instead.

2 Benefit spending per beneficiary shown here differs from the FY 2009 benefit spending per full-year equivalent enrollee shown in Table 8 and Figure 4.

3 Total benefit spending shown here differs from the FY 2009 benefit spending in Table 7 and Figure 3. Unlike the majority of the June 2012 MACStats, this table (along with Table 1) does not recategorize individuals age 65 and older who are reported as disabled.

Sources: For FY 2009: MACPAC analysis of Medicaid Statistical Information System (MSIS) and CMS-64 net financial management report data as of May 2012. For FY 1975: CMS Medicare & Medicaid Statistical Supplement, 2010 edition

Health and Other Characteristics of Medicaid/CHIP Populations

Section 2 of MACStats, including Tables 3A through 5C, uses federal survey data to describe how Medicaid and the State Children's Health Insurance Program (CHIP) enrollees differ from individuals with other types of coverage in terms of their self-reported demographic, socioeconomic, and health characteristics as well as their use of care. It also explores how, even within the same age group, individuals enrolled in Medicaid or CHIP can differ markedly from one another, based on their responses to the survey.

Source of Data for Tables 3A–5C

Every year, thousands of non-institutionalized[1] Americans are interviewed about their health insurance and health status for the National Health Interview Survey (NHIS). Individuals' responses to the NHIS questions are the basis for the results in 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.[2] Administered by the National Center for Health Statistics within the Centers for Disease Control and Prevention, the NHIS consists of a nationally representative sample from approximately 35,000 households containing about 87,500 people.[3] Tables 3A through 5C are based on NHIS data, pooling the years 2008 through 2010.[4] Although there are other federal surveys, the NHIS is used here because it is generally considered to be one of the best surveys for health insurance coverage estimates, and it captures detailed information on individuals' health status.[5] As with most surveys, information about participation in programs such as Medicaid, CHIP, Medicare, Supplemental Security Income (SSI), and Social Security Disability Income may not be accurately reported by respondents in the NHIS. As a result, they

may not match estimates of program participation computed from the programs' administrative data.

NHIS data also serve as the basis for most of the findings in Section B of this Report. For additional information on the general strengths and weaknesses of results from household survey data such as the NHIS, see Box b-2 in Section B.

Organization of Tables

For the tables in this Section, the U.S. population is divided into the three age groups that are commonly used in MACPAC analyses because they correspond to some of the key eligibility pathways in Medicaid and CHIP:

- Tables 3A–C provide estimates of children age 0 to 18;
- Tables 4A–C of adults age 19 to 64; and
- Tables 5A–C of adults age 65 and older.

The tables for each age group explore the following self-reported characteristics from the survey data:

- health insurance coverage and demographics (Tables 3A, 4A, and 5A);
- health characteristics (Tables 3B, 4B, and 5B); and
- use of health care (Tables 3C, 4C, and 5C).

All of the tables are broken into two parts—first, they compare Medicaid/CHIP[6] enrollees in that age group to individuals with other sources of health insurance; second, they provide estimates for selected subgroups of Medicaid/CHIP enrollees in that age group.[7]

The summary of findings that follows describes the survey results for each age group—first comparing results across insurance types, then among Medicaid/CHIP enrollees in that age group.

Children under Age 19

Children in Medicaid or CHIP compared to other children. According to the NHIS data used in Table 3A, 34.1 percent of children were reported to be Medicaid/CHIP enrollees at the time of the survey,[8] while 55.8 percent of children were in private coverage, and 8.7 percent were uninsured. Children enrolled in Medicaid or CHIP are more likely to be Hispanic (33.6 percent) than are privately insured children (12.3 percent) and less likely to be Hispanic than are uninsured children (38.7 percent); Medicaid/CHIP children are more likely to be non-Hispanic black (23.5 percent) than are privately insured (9.1 percent) or uninsured children (11.4 percent).

According to the survey results shown in Table 3B, which focuses on children's health characteristics, children enrolled in Medicaid or CHIP 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, autism). Table 3C, which focuses on children's health care use, shows that children enrolled in Medicaid or CHIP were more likely to have had a visit to the emergency department (ED) in the past year and to have been regularly taking prescription medications for at least three months. Analyses in Chapter 2 of MACPAC's March 2012 Report to the Congress showed that, even after controlling for differences in enrollees' health, demographic, and socioeconomic characteristics, children enrolled in Medicaid or CHIP were still significantly more likely to have had an ED visit compared to children with employer-sponsored insurance or uninsured children.

Comparisons of children within Medicaid/CHIP. For the right-hand portion of Tables 3A–C, children enrolled in Medicaid or CHIP are grouped into one of three categories:

- children who receive SSI benefits and are therefore disabled under that program's definition;[9]
- 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 as a group of children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[10] 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. Table 3A shows that only 3.2 percent of children with Medicaid or CHIP receive SSI. Therefore, the 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,[11] CSHCN are identified here 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.[12]

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.[13] 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.

Among children with Medicaid or CHIP, the three subgroups analyzed here often differ significantly from children with Medicaid or CHIP overall. Selected findings include:

Significant differences in general health exist among children enrolled in Medicaid or CHIP. Among children enrolled in Medicaid or CHIP, 19.5 percent of those receiving SSI are reported to

be in fair or poor health, compared to 13.0 percent for non-SSI CSHCN and 1.1 percent for children who are neither SSI nor CSHCN.[14]

Prevalence of specific health conditions varies among children enrolled in Medicaid or CHIP. According to the survey data, the prevalence of ADHD/ADD among Medicaid/CHIP enrolled children is 43.2 percent for SSI children, 40.3 percent for non-SSI CSHCN, and 2.0 percent for children who are neither SSI nor CSHCN. The prevalence of asthma reported by SSI children was 32.4 percent, compared to 40.3 percent for non-SSI CSHCN and 10.8 percent for children who are neither SSI nor CSHCN.

Significant differences in use of recent care exist among children enrolled in Medicaid or CHIP. SSI children and non-SSI CSHCN are each nearly twice as likely to visit health care providers four or more times within a year as are children with Medicaid or CHIP who are neither SSI nor CSHCN.

Adults Age 19 to 64

Non-elderly adults in Medicaid compared to other non-elderly adults. According to the NHIS estimates shown in Table 4A, 8.9 percent of non-institutionalized adults age 19 to 64 were enrolled in Medicaid.[15] The Medicaid enrollees in this age group are significantly more likely to be female and to be the parent of a dependent child, compared to those with private insurance, Medicare, or no insurance.

As shown in Table 4B, the non-elderly adults enrolled in Medicaid (who are generally eligible on the basis of being the parent of a dependent child, pregnant, or disabled) reported that they were in worse health than were those enrolled in private coverage or the uninsured, but were in better health than were those enrolled in Medicare (nearly all of whom are eligible for that program on the basis of a disability). This is the case for several variables—for example, whether individuals are working, are in fair or poor health, have any of several limitations in their activities of daily living (ADLs), have lost all of their natural teeth, and have any of numerous specific health conditions (e.g., hypertension, coronary heart disease, cancer, diabetes).

Table 4C, which focuses on non-elderly adults' health care use, shows that non-elderly adults enrolled in Medicaid reported they were significantly more likely than those with private insurance to have had four or more visits to a doctor or other health professional in the past 12 months. However, additional analyses suggest that these differences are mostly driven by differences in health status.[16]

Table 4C also shows that adults with Medicaid were more likely to report having visited the ED during the past year. Analyses in Section B of this Report indicate that, even after controlling for differences in enrollees' health, demographic, and socioeconomic characteristics, non-elderly adults enrolled in Medicaid are still significantly more likely to report having an ED visit than are those with employer-sponsored insurance or no insurance.

Comparisons of non-elderly adults within Medicaid. Among 19- to 64-year-olds, nearly all individuals who are dually enrolled in both Medicaid and Medicare have low incomes and qualify for these programs on the basis of a disability.[17] Among non-elderly adults enrolled in Medicaid, 12.3 percent reported they were also enrolled in Medicare (Table 4A).[18]

The right-hand portion of Tables 4A–C groups the 19- to 64-year-old Medicaid enrollees into one of three categories, the first two of which are primarily composed of persons with disabilities:

- individuals also enrolled in Medicare (dual eligibles);
- Medicaid enrollees receiving SSI who are not enrolled in Medicare; and
- Medicaid enrollees who are neither SSI nor Medicare enrollees.

Significant differences in self-reported health exist among 19- to 64-year-olds enrolled in Medicaid. Individuals dually enrolled in Medicaid and Medicare as well as non-dual SSI beneficiaries report fair or poor health (59.3 percent and 59.5 percent, respectively)[19] at much higher rates than do non-SSI, non-dual enrollees (19.9 percent).

Among 19- to 64-year-olds enrolled in Medicaid, those who were also enrolled in Medicare or SSI were more likely to report limitations in activities of daily living as well as the presence of chronic conditions such as heart disease, diabetes, depression, chronic bronchitis, and arthritis than the overall Medicaid population in this age group (Table 4B). Persons with disabilities were also reported to have higher use of care—in particular, for at-home care and visits to a doctor or other health professional in the past 12 months—than were 19- to 64-year-old Medicaid enrollees overall (Table 4C). Individuals dually enrolled in Medicaid and Medicare and non-dual SSI beneficiaries were also more likely than 19- to 64-year-old Medicaid enrollees overall to have had an ED visit in the past 12 months.

Adults Age 65 and Older

Elderly adults in Medicaid compared to other elderly adults. According to the NHIS estimates in Table 5A, 7.4 percent of non-institutionalized adults age 65 and older were enrolled in Medicaid. Medicare covered nearly all individuals age 65 and older. Among Medicaid enrollees age 65 and older, 92.1 percent reported they were also enrolled in Medicare (Table 5A).[20] Conversely, of the Medicare enrollees in this age group, 7.2 percent reported they were enrolled in Medicaid. Elderly Medicaid enrollees were more likely to report being female and less likely to report being white (non-Hispanic) than were those with Medicare or private coverage.

Compared to those enrolled in private coverage or Medicare, elderly Medicaid enrollees were more likely to report being in fair or poor health, being in worse health compared to 12 months before, and having any of several limitations in their ADLs (Table 5B). Elderly Medicaid enrollees were also more likely than those with other coverage to have any of a number of specific chronic conditions.

As shown in Table 5C, elderly Medicaid enrollees were also more likely than those with private or Medicare coverage to have received at-home care, to have had multiple visits to a doctor or other health professional, and to have visited an ED in the past 12 months.

Comparisons of elderly adults within Medicaid. The right-hand portion of Tables 5A–C groups Medicaid enrollees age 65 and older into one of two categories:

- those reporting a functional limitation; and
- those not reporting a functional limitation.

Individuals with a functional limitation are those who reported any degree of difficulty—ranging from "only a little difficult" to "can't do at all"—performing any of a dozen activities by themselves and without special equipment.[21] It should be noted that individuals with functional limitations can vary substantially in their health needs—from being bedridden in one's home[22] 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 do those with no functional limitations.

Compared to elderly Medicaid enrollees overall, Medicaid enrollees who reported no functional limitations were less likely to be 85 years old or older, to report being in fair or poor health, and to have any of several specific chronic health conditions. They were also less likely to have visited a doctor or other health professional or to have visited an ED in the past 12 months.

Future MACPAC analyses of these data may consider different subpopulations and assess how enrollees' characteristics and use of care have changed over time.

Endnotes

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

2 Centers for Disease Control and Prevention (CDC), About the National Health Interview Survey, (Atlanta, GA: CDC, 2012). http://www.cdc.gov/nchs/nhis/about_nhis.htm.

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

4 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.

5 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.

6 The NHIS asks separately about Medicaid and CHIP. However, Medicaid and CHIP estimates are not produced separately from the NHIS for several reasons; for example, many states' CHIP and Medicaid programs use the same name, so respondents would not necessarily know whether their child's coverage was funded by Medicaid or CHIP. The separate survey questions are used to reduce surveys' undercount of Medicaid and CHIP enrollees, not to produce valid estimates separately for each program. Thus, survey estimates generally combine Medicaid and CHIP into a single category, as is done here.

7 Health and other characteristics presented in Tables 3A–5C are for the Medicaid/CHIP population as a whole because the data source (NHIS) does not publish separate results for Medicaid and CHIP enrollees.

8 See MACStats Section 5 (including Tables 13A–D) for a discussion of how the percentage of individuals covered by Medicaid and CHIP can vary depending on several factors, including the source of data and the time period examined.

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

10 M. McPherson et al., A new definition of children with special health care needs, *Pediatrics* 102 (1998), 137–140.

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

12 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 2008–2010 NHIS based on an operationalization of the CSHCN screener for the 1999–2000 NHIS (A. Davidoff, 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 one could attempt to operationalize the CSHCN definition using the NHIS.

13 Children who are receiving SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that children who are reported to have SSI did not meet the criteria for CSHCN, it could be because: (1) the parent erroneously reported in the survey that the children received SSI, or (2) the parents neglected to report in the survey the children's health information related to their eligibility for SSI and thus as CSHCN.

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

15 Although CHIP covers adults in a handful of states, their numbers are so small compared to Medicaid that the discussion in this Section uses "Medicaid" to refer to adults enrolled in Medicaid or CHIP.

16 For example, see Table 6 in MACPAC Contractor Report No. 2.

17 Nearly all individuals under age 65 who are dually enrolled in Medicaid and Medicare 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 that confer automatic Medicaid eligibility in most states; they may also qualify for Medicaid via other non-SSI 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 Chapter 1 in the Commission's March 2012 Report to the Congress.

18 Conversely, of the Medicare enrollees in this age group, 31.1 percent also were enrolled in Medicaid.

19 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).

20 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 qualify for Medicaid as well.

21 The survey includes questions about the following activities: walking a quarter of a mile, walking up 10 steps without resting, standing or being on one's feet for about two hours, sitting for about two hours, stooping or kneeling, reaching up over one's head, using one's fingers to grasp or handle small objects, lifting or carrying something as heavy as 10 pounds, pushing or pulling large objects such as a living-room chair, going out to do things like shopping, participating in social activities such as visiting friends, or doing things to relax at home such as reading or watching TV.

22 Individuals in institutions such as nursing homes or assisted living facilities 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, 2008–2010

		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		**34.1%**	55.8%	8.7%	**100.0%**	3.2%	18.1%	78.7%
Age (categories sum to 100%)								
0–5	32.5%*	**38.7%**	29.6%*	26.1%*	**38.7%**	15.4%*	23.1%*	43.2%*
6–11	30.7	**31.6**	30.6	28.7*	**31.6**	36.2	38.9*	29.7*
12–18	36.9*	**29.7**	39.8*	45.2*	**29.7**	48.4*	38.0*	27.1*
Gender (categories sum to 100%)								
Male	51.2%	**51.0%**	51.2%	52.1%	**51.0%**	63.0%*	58.5%*	48.8%*
Female	48.8	**49.0**	48.8	47.9	**49.0**	37.0*	41.5*	51.2*
Race (categories sum to 100%)								
Hispanic	22.0%*	**33.6%**	12.3%*	38.7%*	**33.6%**	24.7%*	20.5%*	37.0%*
White, non-Hispanic	55.6*	**35.5**	70.2*	42.4*	**35.5**	35.6	46.8*	32.9*
Black, non-Hispanic	14.4*	**23.5**	9.1*	11.4*	**23.5**	34.4*	24.7	22.7
Other and multiple races, non-Hispanic	8.0	**7.4**	8.4	7.5	**7.4**	5.3	8.0	7.4
Health insurance								
Medicaid/CHIP	34.1%*	**100.0%**	2.3%*	–	**100.0%**	100.0%	100.0%	100.0%
Private	55.8*	**3.8**	100.0*	–	**3.8**	10.1*	6.0*	3.0

See Table 3C for source and notes.

TABLE 3B. Health Characteristics of Non-institutionalized Individuals Age 0–18 by Source of Health Insurance, 2008–2010

		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)	1.3%*	**3.2%**	0.5%*	0.4%*	**3.2%**	100.0%*	–	–
Children with special health care needs (CSHCN)[5]	15.3*	**20.7**	13.0*	10.8*	**20.7**	80.4*[6]	100.0%*	–
Current health status (categories sum to 100%)								
Excellent or very good	82.6%*	**72.4%**	89.2%*	79.0%*	**72.4%**	40.1%*	52.5%*	78.3%*
Good	15.4*	**23.7**	9.9*	19.0*	**23.7**	40.3*	34.5*	20.6*
Fair or poor	2.0*	**3.8**	0.9*	2.1*	**3.8**	19.5*	13.0*	1.1*
Impairments								
Impairment requiring special equipment	1.1%*	**1.5%**	1.1%*	0.5%*	**1.5%**	10.4%*	5.3%*	0.3%*
Impairment limits ability to crawl, walk, run, play[7]	1.9*	**2.9**	1.6*	1.4*	**2.9**	17.7*	10.0*	0.6*
Impairment lasted, or expected to last 12+ months[8]	1.7*	**2.6**	1.4*	1.3*	**2.6**	17.7*	9.1*	0.4*
Specific health conditions								
Ever told child has:								
ADHD/ADD[8]	7.8%*	**11.2%**	6.4%*	5.2%*	**11.2%**	43.2%*	40.3%*	2.0%*
Asthma	13.9*	**16.8**	12.8*	10.4*	**16.8**	32.4*	40.3*	10.8*
Autism[7]	0.9*	**1.1**	0.8*	0.4*	**1.1**	13.6*	3.8*	†
Cerebral palsy[7]	0.2	**0.4**	0.2*	†	**0.4**	5.5*	1.1*	†
Congenital heart disease	1.3	**1.6**	1.2*	0.9*	**1.6**	5.9*	4.6*	0.7*
Diabetes	0.2	**0.3**	0.2	†	**0.3**	†	1.3*	†
Down syndrome[7]	0.1	**0.2**	0.1	†	**0.2**	3.1*	0.5	†
Mental retardation[7]	0.6*	**1.2**	0.4*	†	**1.2**	13.5*	3.8*	0.1*
Other developmental delay[7]	4.4*	**6.2**	3.8*	3.0*	**6.2**	44.7*	22.2*	0.9*
Sickle cell anemia[7]	0.2*	**0.3**	0.0*	0.1*	**0.3**	1.7	0.9*	0.2*

See Table 3C for source and notes.

TABLE 3C. Use of Care by Non-institutionalized Individuals Age 0–18 by Source of Health Insurance, 2008–2010

		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]	77.9%*	**80.6%**	80.5%	49.4%*	**80.6%**	84.0%	84.8%*	79.4%
Regularly taking prescription drug(s) for 3+ months[8]	13.2*	**15.3**	13.2*	6.0*	**15.3**	48.6*	55.1*	4.7*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)								
None	10.6%*	**9.3%**	7.6%*	34.4%*	**9.3%**	4.9%*	4.4%*	10.6%*
1	20.8*	**19.4**	20.8*	24.7*	**19.4**	15.0	10.0*	21.8*
2–3	36.2	**34.9**	38.7*	25.8*	**34.9**	22.6*	27.4*	37.2*
4+	32.4*	**36.3**	32.9*	15.1*	**36.3**	57.5*	58.1*	30.4*
Number of emergency room visits in past 12 months (categories sum to 100%)								
None	78.5%*	**70.6%**	82.9%*	81.8%*	**70.6%**	65.8%	59.1%*	73.5%*
1	13.9*	**17.4**	12.1*	11.6*	**17.4**	17.8	20.0*	16.8
2–3	6.1*	**9.3**	4.3*	5.3*	**9.3**	7.6	14.5*	8.1*
4+	1.5*	**2.7**	0.7*	1.4*	**2.7**	8.8*	6.4*	1.6*

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.

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

* Statistically different from Medicaid/CHIP at the (.05) level, two-tailed test.

– 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 percent, generally children with end-stage renal disease), any type of military health plan (VA, TRICARE, and CHAMP-VA), or other government programs.

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

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

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

5 A standard screener has been developed by researchers (Bethell et al. 2002) to identify 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 2008–2010 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. For full references to Bethell and Davidoff, see endnotes in text of Section 2.

6 For a child to be eligible for SSI, one of the criteria is that the child has a medically determinable physical or mental impairment(s) that results in marked and severe functional limitations and generally is expected to last at least 12 months or result in death. Thus, children who are eligible for SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that these Medicaid/CHIP children who are reported to have SSI did not meet the criteria for CSHCN, it could be because (1) the parents erroneously reported in the survey that the children received SSI, or (2) the parents neglected to report in the survey the children's health information related to their eligibility for SSI and thus as 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 2008–2010 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, 2008–2010

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults Age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Health Insurance Coverage		**8.9%**	66.3%	3.5%	20.9%	**100.0%**	12.3%	15.6%	72.3%
Age (categories sum to 100%)									
19–24	13.5%*	**18.9%**	10.9%*	1.6%*	20.3%	**18.9%**	1.8%*	9.6%*	23.9%*
25–44	43.9*	**46.8**	42.9*	21.1*	50.0*	**46.8**	31.6*	37.3*	51.4*
45–54	23.8*	**19.4**	25.9*	28.8*	18.7	**19.4**	32.8*	27.2*	15.4*
55–64	18.7*	**15.0**	20.4*	48.5*	11.0*	**15.0**	33.7*	26.0*	9.3*
Gender (categories sum to 100%)									
Male	49.2%*	**34.5%**	48.8%*	50.3%*	55.6%*	**34.5%**	45.1%*	40.6%*	31.3%*
Female	50.8*	**65.5**	51.2*	49.7*	44.4*	**65.5**	54.9*	59.4*	68.7*
Race (categories sum to 100%)									
Hispanic	15.1%*	**21.4%**	9.7%*	8.4%*	30.2%*	**21.4%**	9.1%*	13.8%*	25.2%*
White, non-Hispanic	66.1*	**48.5**	73.8*	68.5*	49.3	**48.5**	64.3*	52.8	44.8*
Black, non-Hispanic	12.1*	**23.9**	9.6*	18.5*	14.2*	**23.9**	21.6	28.8*	23.2
Other and multiple races, non-Hispanic	6.7	**6.2**	6.9	4.6*	6.2	**6.2**	5.0	4.7	6.7
Family characteristics									
Parent of a dependent child[5]	39.0%*	**50.1%**	39.0%*	14.7%*	36.9%*	**50.1%**	13.2%*	18.9%*	63.1%*
Health insurance									
Medicaid/CHIP	8.9%*	**100.0%**	0.4%*	31.1%*	–	**100.0%**	100.0%	100.0%	100.0%
Medicare	3.5*	**12.3**	1.1*	100.0*	–	**12.3**	100.0*	–	–
Private	66.3*	**2.9**	100.0*	21.2*	–	**2.9**	2.8	2.3	3.1

See Table 4C for source and notes.

TABLE 4B. Health Characteristics of Non-institutionalized Individuals Age 19–64 by Source of Health Insurance, 2008–2010

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults Age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Disability and work status									
Receives Supplemental Security Income (SSI)	2.4%*	**20.9%**	0.3%*	22.2%	0.4%*	**20.9%**	44.3%*	100.0%*	–
Receives Social Security Disability Insurance (SSDI)	3.3*	**14.5**	1.3*	62.5*	0.6*	**14.5**	65.0*	17.4	5.3%*
Working	72.3*	**36.2**	82.2*	11.9*	63.1*	**36.2**	9.3*	9.7*	46.6*
Current health status (categories sum to 100%)									
Excellent or very good	64.0%*	**39.1%**	71.3%*	12.1%*	56.8%*	**39.1%**	10.7%*	16.0%*	48.9%*
Good	25.1*	**30.0**	22.4*	28.0	30.8	**30.0**	29.9	24.5*	31.1
Fair or poor	10.9*	**30.9**	6.3*	59.9*	12.4*	**30.9**	59.3*	59.5*	19.9*
Health compared to 12 months ago (categories sum to 100%)									
Better	19.8%	**20.7%**	20.1%	16.2%	18.4%	**20.7%**	18.3%	20.7%	21.2%
Worse	8.1*	**16.3**	6.0*	26.0*	9.5*	**16.3**	28.9*	22.0*	13.0*
Same	72.1*	**63.0**	73.9*	57.8*	72.1*	**63.0**	52.9*	57.3*	65.9*
Activities of daily living (ADLs)									
Help with any personal care needs[6]	1.2%*	**6.8%**	0.5%*	13.2%*	0.5%*	**6.8%**	19.9%*	16.2%*	2.5%*
Help with bathing/showering	0.7*	**4.5**	0.2*	8.2*	0.2*	**4.5**	13.2*	11.7*	1.4*
Help with dressing	0.7*	**3.9**	0.3*	8.1*	0.2*	**3.9**	12.8*	9.7*	1.2*
Help with eating	0.2*	**1.6**	0.1*	2.8*	0.1*	**1.6**	5.1*	4.3*	0.4*
Help with transferring (in/out of bed or chairs)	0.6*	**3.5**	0.2*	6.9*	0.2*	**3.5**	10.3*	7.8*	1.4*
Help with toileting	0.4*	**2.7**	0.1*	5.0*	0.1*	**2.7**	9.0*	6.5*	0.8*
Help getting around in home	0.5*	**2.8**	0.2*	5.4*	0.2*	**2.8**	8.6*	5.5*	1.2*
Number of above ADLs reported (categories sum to 100%)									
0	99.0%*	**94.2%**	99.6%*	88.8%*	99.6%*	**94.2%**	82.9%*	86.2%*	97.9%*
1	0.2*	**0.9**	0.1*	1.9*	0.1*	**0.9**	2.0*	2.7*	0.4*
2	0.3*	**1.4**	0.1*	2.7*	0.1*	**1.4**	3.9*	3.1*	0.6*
3	0.2*	**1.1**	0.1*	2.1*	0.0*	**1.1**	3.6*	2.0	0.5*
4+	0.4*	**2.4**	0.1*	4.6*	0.1*	**2.4**	7.6*	6.1*	0.7*

TABLE 4B, Continued

	Adults Age 19–64	Selected Sources of Insurance[1]				Medicaid[2]			
		Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Specific health conditions									
Currently pregnant	1.2%*	**4.9%**	1.0%*	†	0.5%*	**4.9%**	†	0.8%*	6.6%*
Functional limitation[7]	28.7*	**48.0**	25.3*	83.1%*	25.8*	**48.0**	83.0%*	75.7*	36.0*
Difficulty walking without equipment	3.2*	**12.1**	1.7*	32.3*	1.8*	**12.1**	34.9*	24.6*	5.6*
Health condition that requires special equipment (e.g., cane, wheelchair)	4.0*	**12.7**	2.6*	33.4*	2.0*	**12.7**	35.5*	25.0*	6.2*
Lost all natural teeth	4.7*	**9.6**	3.5*	18.6*	4.9*	**9.6**	20.0*	17.8*	6.1*
Depressed/anxious feelings[8]	12.8*	**28.4**	8.6*	36.7*	17.1*	**28.4**	43.4*	41.1*	23.3*
Ever told had hypertension	23.5*	**31.9**	23.0*	55.9*	17.6*	**31.9**	55.4*	47.7*	24.4*
Ever told had coronary heart disease	2.4*	**4.2**	2.1*	13.2*	1.4*	**4.2**	9.9*	7.8*	2.5*
Ever told had heart attack	1.9*	**4.0**	1.5*	11.2*	1.3*	**4.0**	9.3*	7.9*	2.3*
Ever told had stroke	1.6*	**4.7**	1.0*	12.0*	1.1*	**4.7**	12.1*	8.6*	2.6*
Ever told had cancer	5.2*	**6.3**	5.6	13.5*	2.9*	**6.3**	12.2*	9.7*	4.6*
Ever told had diabetes	6.7*	**12.6**	6.0*	25.9*	4.9*	**12.6**	28.3*	22.3*	7.9*
Ever told had arthritis	17.5*	**25.1**	17.4*	51.5*	10.9*	**25.1**	50.6*	40.8*	17.4*
Ever told had asthma	13.0*	**19.6**	12.4*	22.6*	11.6*	**19.6**	27.4*	25.6*	16.9*
Past 12 months, told had chronic bronchitis	4.0*	**8.2**	3.3*	13.5*	3.6*	**8.2**	15.5*	13.7*	5.7*
Past 12 months, told had liver condition	1.5*	**3.5**	1.1*	6.1*	1.4*	**3.5**	7.3*	6.7*	2.1*
Past 12 months, told had weak/failing kidneys	1.3*	**4.1**	0.8*	8.0*	1.2*	**4.1**	10.9*	6.7*	2.5*

See Table 4C for source and notes.

TABLE 4C. Use of Care by Non-institutionalized Individuals Age 19–64 by Source of Health Insurance, 2008–2010

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults Age 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults age 19–64	Medicare (duals)	Non-dual SSI	Neither SSI nor Medicare
Received at-home care in past 12 months	1.3%*	**5.1%**	0.9%*	8.9%*	0.5%*	**5.1%**	15.0%*	9.2%*	2.5%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)									
None	21.7%*	**14.0%**	15.1%	6.5%*	47.9%*	**14.0%**	4.2%*	8.4%*	16.9%*
1	17.5*	**11.9**	18.4*	5.6*	18.3*	**11.9**	3.4*	7.7*	14.3*
2–3	26.4*	**20.3**	30.4*	16.7*	16.9*	**20.3**	17.5	16.2*	21.6
4+	34.3*	**53.8**	36.1*	71.3*	16.9*	**53.8**	74.9*	67.7*	47.2*
Number of emergency room visits in past 12 months (categories sum to 100%)									
None	79.7%*	**59.6%**	83.3%*	60.3%	79.0%*	**59.6%**	54.0%*	52.9%*	61.9%
1	12.8*	**19.1**	11.8*	18.7	12.4*	**19.1**	19.7	19.3	18.9
2–3	5.4*	**12.8**	3.9*	12.7	6.2*	**12.8**	14.4	16.0*	11.9
4+	2.1*	**8.5**	1.0*	8.4	2.4*	**8.5**	11.8	11.8*	7.2

Notes: Estimates for 2008–2010 are based on household interviews of a sample of the civilian non-institutionalized population. Health insurance coverage is defined as coverage at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. 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.

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

* Statistically different from Medicaid at the (.05) level, two-tailed test.

– 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 also includes adults reporting coverage through the CHIP program or other state-sponsored health plans. Separate results for Medicaid and CHIP are generally not published from federal surveys such as NHIS. CHIP enrollment of adults is small, totaling approximately 226,000 ever enrolled during FY 2011 (March 2012 MACStats).

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

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

5 Parent of a dependent child is defined as an adult with at least one dependent child living in that health insurance unit.

6 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 prevalence (rather than the prevalence among those needing help with any personal care needs).

7 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.

8 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 2008–2010 are based on household interviews of a sample of the civilian non-institutionalized population

TABLE 5A. Health Insurance and Demographic Characteristics of Non-institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2008–2010

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults Age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Health Insurance Coverage		**7.4%**	55.8%	95.1%	**100.0%**	77.7%	22.3%
Age (categories sum to 100%)							
65–74	54.3%	**54.0%**	53.8%	53.2%	**54.0%**	52.9%	58.2%
75–84	33.8	**34.6**	34.3	34.6	**34.6**	33.8	36.8
85+	12.0	**11.4**	12.0	12.2	**11.4**	13.3	5.0*
Gender (categories sum to 100%)							
Male	43.3%*	**32.8%**	43.4%*	42.7%*	**32.8%**	28.5%	47.7%*
Female	56.7*	**67.2**	56.6*	57.3*	**67.2**	71.5	52.3*
Race (categories sum to 100%)							
Hispanic	7.1%*	**23.1%**	3.0%*	6.7%*	**23.1%**	22.4%	25.4%
White, non-Hispanic	79.7*	**48.2**	87.7*	80.7*	**48.2**	50.2	42.5
Black, non-Hispanic	8.4*	**18.7**	5.6*	8.2*	**18.7**	19.6	15.5
Other and multiple races, non-Hispanic	4.8*	**9.9**	3.7*	4.4*	**9.9**	7.8	16.6
Health insurance							
Medicaid/CHIP	7.4%*	**100.0%**	0.7%*	7.2%*	**100.0%**	100.0%	100.0%
Medicare	95.1*	**92.1**	94.3*	100.0*	**92.1**	92.2	91.9
Private	55.8*	**4.9**	100.0*	55.4*	**4.9**	4.2	7.4

See Table 5C for source and notes.

TABLE 5B. Health Characteristics of Non-institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2008–2010

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults Age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Disability and work status							
Receives Supplemental Security Income (SSI)	4.0%*	35.4%	0.5%*	3.9%*	35.4%	36.7%	29.6%
Working	15.3*	3.3	18.3*	14.0*	3.3	2.3	6.9*
Current health status (categories sum to 100%)							
Excellent or very good	41.7%*	18.0%	45.8%*	41.6%*	18.0%	12.3%*	38.4%*
Good	34.3*	31.1	35.3*	34.4*	31.1	28.5	40.9*
Fair or poor	23.9*	50.8	18.8*	24.1*	50.8	59.1*	20.8*
Health compared to 12 months ago (categories sum to 100%)							
Better	13.3%	12.6%	13.0%	13.2%	12.6%	12.3%	13.7%
Worse	12.4*	21.4	11.2*	12.6*	21.4	25.6*	6.5*
Same	74.3*	66.1	75.8*	74.2*	66.1	62.1	79.7*
Activities of daily living (ADLs)							
Help with any personal care needs[5]	6.4%*	19.6%	4.7%*	6.6%*	19.6%	24.0%*	3.8%*
Help with bathing/showering	4.8*	15.6	3.5*	4.9*	15.6	19.3	2.2*
Help with dressing	3.7*	11.6	2.7*	3.8*	11.6	14.1	2.1*
Help with eating	1.3*	4.6	0.9*	1.3*	4.6	5.6	†
Help with transferring (in/out of bed or chairs)	2.8*	9.2	2.0*	2.8*	9.2	11.0	2.1*
Help with toileting	2.1*	6.5	1.6*	2.1*	6.5	7.8	1.4*
Help getting around in home	2.5*	7.5	1.9*	2.6*	7.5	9.0	1.4*
Number of above ADLs reported (categories sum to 100%)							
0	94.2%*	82.2%	95.7%*	94.1%*	82.2%	77.9%*	97.8%*
1	1.5*	3.5	1.2*	1.5*	3.5	4.5	†
2	1.4*	5.0	1.0*	1.5*	5.0	6.4	†
3	0.8*	2.9	0.5*	0.8*	2.9	3.6	†
4+	2.1*	6.4	1.5*	2.1*	6.4	7.7	1.4*

TABLE 5B, Continued

	Adults Age 65+	Selected Sources of Insurance[1]			Medicaid[2]		
		Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Specific health conditions							
Functional limitation[4]	63.8%*	77.7%	62.3%*	64.4%*	77.7%	100.0%*	0.0%*
Difficulty walking without equipment	18.7*	36.7	16.6*	19.1*	36.7	44.9*	6.5*
Health condition that requires special equipment (e.g., cane, wheelchair)	20.4*	36.6	18.3*	20.9*	36.6	45.0*	7.4*
Lost all natural teeth	24.6*	42.9	21.2*	24.7*	42.9	46.3	31.4*
Depressed/anxious feelings[6]	9.8*	22.7	7.9*	9.9*	22.7	27.0	8.0*
Ever told had hypertension	62.4*	71.2	61.9*	62.8*	71.2	75.2	56.5*
Ever told had coronary heart disease	15.3*	18.6	15.4*	15.4*	18.6	21.1	9.9*
Ever told had heart attack	11.3*	14.7	11.1*	11.3*	14.7	16.2	9.6*
Ever told had stroke	8.8*	13.0	8.4*	9.0*	13.0	16.1	2.3*
Ever told had cancer	23.6*	18.0	26.2*	23.9*	18.0	19.4	12.3*
Ever told had diabetes	19.8*	28.9	17.9*	20.0*	28.9	32.9	14.3*
Ever told had arthritis	51.2*	57.5	52.0*	51.8*	57.5	66.7*	25.1*
Ever told had asthma	11.2*	16.0	10.8*	11.2*	16.0	17.8	9.5*
Past 12 months, told had chronic bronchitis	6.0*	9.9	5.3*	6.1*	9.9	11.5	4.3*
Past 12 months, told had liver condition	1.4*	3.6	1.1*	1.4*	3.6	3.9	†
Past 12 months, told had weak/failing kidneys	4.4*	9.0	3.8*	4.5*	9.0	10.3	4.5*

See Table 5C for source and notes.

TABLE 5C. Use of Care by Non-institutionalized Individuals Age 65 and Older by Source of Health Insurance, 2008–2010

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults Age 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults age 65+	Functional limitation[4]	No functional limitation
Received at-home care in past 12 months	7.8%*	**19.9%**	7.1%*	8.0%*	**19.9%**	24.1%*	5.2%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)							
None	5.8%	**6.3%**	4.3%*	5.4%	**6.3%**	3.8%*	14.7%*
1	9.8*	**6.7**	9.8*	9.6*	**6.7**	5.1	12.4*
2–3	25.1*	**17.1**	26.2*	24.9*	**17.1**	15.4	22.9
4+	59.3*	**69.9**	59.6*	60.1*	**69.9**	75.7*	50.0*
Number of emergency room visits in past 12 months (categories sum to 100%)							
None	76.0%*	**67.4%**	77.4%*	75.6%*	**67.4%**	64.0%	79.3%*
1	15.6	**16.1**	15.5	15.8	**16.1**	17.0	13.4
2–3	6.3*	**11.4**	5.3*	6.5*	**11.4**	13.3	4.8*
4+	2.1*	**5.1**	1.8*	2.1*	**5.1**	5.8	2.4*

Notes: Health insurance coverage is defined at the time of the survey. Totals of health insurance coverage may sum to more than 100 percent because individuals may have multiple sources of coverage. Responses to recent care questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. Not separately shown are the estimates of 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.

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

* Statistically different from Medicaid at the (.05) level, two-tailed test.

– 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 also includes adults reporting coverage through CHIP or other state-sponsored health plans.

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

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

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

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

Source: Urban Institute analysis of the National Health Interview Survey (NHIS) for MACPAC; the estimates for 2008–2010 are based on household interviews of a sample of the civilian non-institutionalized population

SECTION 3

Medicaid Enrollment and Benefit Spending

Section 3 of MACStats provides information on Medicaid enrollment and benefit spending, with various breakouts by state, eligibility group, dual-eligible status, and type of service. The source for this information is Medicaid Statistical Information System (MSIS) data for fiscal year (FY) 2009 (the most recent available for all but one state) that have been adjusted to match benefit spending totals reported by states in CMS-64 data, as discussed in Section 5 of MACStats.

As demonstrated in the following tables and figures, Medicaid benefit spending varies widely across populations:

- **Distribution of spending among eligibility groups.** Non-disabled adults and children represent the majority of Medicaid enrollees nationally and within each state (Table 6), but enrollees eligible on the basis of a disability and those who are age 65 and older account for the largest share of the program's spending on benefits (Table 7).
- **Benefit spending per enrollee.** Enrollees eligible on the basis of a disability and those who are age 65 and older have average per person Medicaid benefit spending that is 3 to 5 times that of other enrollees (Figure 4 and Table 8).
- **Individuals dually enrolled in Medicaid and Medicare.** Among dual eligibles, about 60 percent of enrollment and Medicaid benefit spending is for individuals age 65 and older (Tables 6 and 7).
- **Spending by type of service.** Spending by type of service varies among populations. A large share of spending for disabled and aged enrollees covers long-term services and supports (LTSS), while a substantial portion of spending for non-disabled children and adults is accounted for by managed care payments (Figures 3 and 4).
- **Users of LTSS.** LTSS users—primarily enrollees eligible on the basis of a disability and those age 65 and older—account for only about 7 percent of Medicaid enrollees,

but nearly half of all Medicaid spending (Figure 5). Acute care represents a minority of Medicaid spending for most LTSS users (Figure 6), and these individuals have average per person Medicaid benefit spending that is more than 10 times that of enrollees who are not using LTSS (Figure 7).

Variation across states. In addition to varying by population group, Medicaid benefit spending per enrollee also varies substantially across states (Table 8). Reasons for cross-state variation may include the breadth of benefits that states choose to cover; the proportion of enrollees receiving the full benefit package or a more limited version; enrollee case mix (based on health status and other characteristics); the underlying costs of delivering health care services in specific geographic areas; and state policies regarding provider payments, care management, and other issues.

Information reported by states in MSIS for FY 2009 indicates that the proportion of enrollees receiving limited benefits ranged from less than 5 percent in some states to more than 20 percent in others (Table 8). These percentages vary by enrollee population, but it is important to note that states may not consistently identify their limited-benefit enrollees in MSIS. For example, many states with family planning waivers report that a substantial portion of their non-disabled adult enrollees receive limited benefits; however, some states with family planning waivers report lower than expected numbers of limited-benefit enrollees.[1] Among Medicaid enrollees eligible on the basis of a disability and those age 65 and older, most individuals receiving limited benefits are dual eligibles for whom Medicaid only provides assistance with Medicare premiums and cost sharing.

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 Supplemental Security Income program) receiving full Medicaid-only benefits on a fee-for-service basis (i.e., excluding enrollees with limited benefits, those with Medicare coverage, and those in managed care) found that:[2]

- Medicaid spending per enrollee on acute care in the highest-spending state was more than double the amount in the lowest-spending state.
- In the 10 highest-spending states, 72 percent of their difference from the national average Medicaid spending per enrollee was due to the volume of services delivered, rather than the price of services; in the 10 lowest-spending states, 58 percent of their difference from the national average was due to volume.
- Compared to inpatient, physician, and prescription drug spending, there is more interstate variation in Medicaid spending per enrollee for mental health and other acute care services; in addition, there is substantially more variation in LTSS spending than in acute care spending.

Endnotes

1 As of January 31, 2009, 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, WI, and WY. See Centers for Medicare & Medicaid Services (CMS), *Section 1115 demonstrations, state profiles: Approvals through January 31, 2009* (Baltimore, MD: CMS, 2009).

2 T. Gilmer and R. Kronick, Differences in the volume of services and in prices drive big variations in Medicaid spending among U.S. states and regions, *Health Affairs* 30 (2011): 1316–1324. http://content.healthaffairs.org/content/30/7/1316.

TABLE 6. Medicaid Enrollment by State, Eligibility Group, and Dual Eligible Status, FY 2009 (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	**62,295**	**48.2%**	**26.8%**	**15.2%**	**9.8%**	**9,413**	**60.2%**	**7,264**	**60.3%**	**2,149**	**59.7%**
Alabama	955	49.0	16.8	21.5	12.7	207	57.7	99	53.4	108	61.7
Alaska	117	56.0	23.6	13.1	7.2	13	54.1	13	53.7	0	70.3
Arizona	1,721	44.7	41.3	8.1	5.9	160	59.3	123	55.5	37	71.9
Arkansas	680	52.3	17.1	20.4	10.2	118	55.0	67	60.4	52	48.1
California	10,941	38.6	43.2	9.1	9.1	1,229	70.6	1,202	70.4	27	76.3
Colorado	632	59.3	17.9	13.9	9.0	85	59.5	70	58.7	15	63.4
Connecticut	587	51.7	24.8	11.8	11.7	106	60.7	80	58.6	27	67.2
Delaware	207	41.8	40.1	11.5	6.6	25	54.7	11	54.8	13	54.6
District of Columbia	168	44.8	24.5	21.6	9.2	23	60.1	19	59.6	4	62.1
Florida	3,420	50.6	19.9	16.5	13.0	644	65.4	372	68.3	272	61.4
Georgia	1,819	57.9	16.8	15.9	9.4	272	59.1	145	59.2	126	59.0
Hawaii	243	40.7	38.5	10.8	10.0	34	68.7	30	69.4	4	62.5
Idaho	223	61.4	13.5	17.5	7.6	32	49.7	22	49.3	10	50.6
Illinois	2,660	53.7	27.0	11.4	7.8	339	56.8	299	56.0	40	63.2
Indiana	1,113	55.6	22.6	14.2	7.6	158	49.8	100	54.4	57	41.7
Iowa	514	46.7	30.1	14.9	8.3	83	51.1	69	48.5	14	64.1
Kansas	373	56.1	14.6	19.5	9.8	65	51.5	48	53.1	18	47.3
Kentucky	876	46.9	16.1	26.1	10.9	180	52.0	109	52.8	70	50.6
Louisiana	1,113	51.8	19.0	19.1	10.1	186	59.1	108	57.0	78	61.9
Maine	352	35.4	29.8	17.6	17.2	98	61.2	54	47.4	44	78.2
Maryland	841	48.9	26.9	15.5	8.6	112	57.9	75	58.3	37	57.2
Massachusetts[3]	1,489	29.0	26.5	33.6	10.9	255	53.9	248	52.7	7	95.6
Michigan	2,006	55.0	21.8	16.4	6.9	269	49.5	237	49.1	32	52.2
Minnesota	880	47.4	27.5	14.1	10.9	138	55.0	125	54.0	13	65.0
Mississippi	754	50.4	16.5	21.3	11.8	151	57.7	81	60.5	70	54.5
Missouri	1,033	52.8	18.4	19.6	9.1	181	49.7	164	49.5	17	51.9
Montana	115	55.2	18.6	17.1	9.1	19	56.0	16	54.0	3	66.7
Nebraska	242	56.5	18.4	15.2	9.9	42	53.5	38	52.7	4	60.0
Nevada	290	57.9	19.2	14.0	8.9	42	60.1	22	65.9	20	53.7
New Hampshire	159	59.5	14.1	16.7	9.7	30	47.8	21	48.2	9	46.8

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+
New Jersey	986	54.2%	13.6%	17.1%	15.1%	206	66.5%	179	65.9%	27	70.3%
New Mexico	540	61.5	20.3	11.5	6.7	58	60.4	40	60.5	18	60.2
New York	5,208	38.4	37.7	12.6	11.3	761	68.3	674	67.1	87	77.4
North Carolina	1,795	52.2	20.5	17.1	10.2	317	56.5	251	55.9	66	58.5
North Dakota	75	52.0	21.1	14.7	12.2	15	58.7	12	58.1	4	60.6
Ohio	2,114	49.0	25.0	17.6	8.3	313	51.8	215	54.3	97	46.3
Oklahoma	771	55.9	20.6	14.9	8.7	117	55.2	97	55.1	20	55.7
Oregon	564	50.8	23.4	16.1	9.7	94	56.6	63	58.1	31	53.5
Pennsylvania	2,304	45.0	20.3	24.4	10.3	400	55.6	339	54.5	61	61.1
Rhode Island	196	45.4	24.0	19.7	10.9	40	59.2	35	57.6	6	68.6
South Carolina	875	50.6	23.1	16.8	9.5	153	54.6	133	53.9	20	59.0
South Dakota	124	58.7	16.9	14.3	10.1	21	59.7	14	61.2	7	56.9
Tennessee	1,496	50.3	19.4	20.3	10.0	288	50.7	196	45.9	92	61.1
Texas	4,488	63.1	13.7	13.3	9.8	645	66.5	415	67.6	230	64.5
Utah	329	56.0	27.2	12.0	4.7	28	44.0	26	43.0	3	54.5
Vermont	182	36.8	39.8	12.6	10.9	33	59.6	25	54.6	7	76.9
Virginia	927	54.2	16.5	17.9	11.4	176	57.4	120	60.0	55	51.7
Washington	1,159	56.4	20.3	15.7	7.6	150	54.5	112	57.4	38	46.2
West Virginia	417	47.5	14.9	27.6	10.0	82	50.4	50	51.2	32	49.2
Wisconsin	1,139	39.7	34.4	13.4	12.5	213	65.4	195	65.4	18	65.6
Wyoming	82	65.4	14.7	12.9	7.0	11	53.1	7	52.1	3	55.1

Notes: Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month; however, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories.

Although state-level information is not yet available, the estimated number of individuals ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 66.7 million for FY 2010; 69.3 million for FY 2011; 70.7 million for FY 2012; and 71.0 million for FY 2013. These FY 2010–FY 2013 figures exclude about one million enrollees in the territories (MACPAC communication with CMS Office of the Actuary, February 2012).

1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged."

2 Dual eligibles are enrolled in both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing.

3 FY 2009 data unavailable for Massachusetts; FY 2008 values shown instead.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2012

TABLE 7. Medicaid Benefit Spending by State, Eligibility Group, and Dual Eligible Status, FY 2009 (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	**$364,827**	**19.0%**	**14.2%**	**42.7%**	**24.1%**	**$134,966**	**61.2%**	**$130,623**	**61.5%**	**$4,343**	**53.2%**
Alabama	4,416	26.1	8.4	37.8	27.7	1,755	68.1	1,534	69.6	222	57.9
Alaska	1,070	29.0	15.3	37.3	18.4	298	55.6	298	55.6	1	66.2
Arizona	8,665	21.6	37.0	28.8	12.6	1,645	59.0	1,589	58.8	56	64.1
Arkansas	3,452	21.6	4.5	45.7	28.2	1,509	60.8	1,321	64.1	188	37.7
California	41,390	15.8	14.8	41.6	27.7	15,298	67.8	15,226	67.8	72	68.3
Colorado	3,555	22.0	11.7	42.3	24.0	1,293	61.4	1,275	61.4	18	58.7
Connecticut	6,035	14.8	8.9	41.4	34.8	3,491	57.3	3,441	57.4	51	51.5
Delaware	1,212	18.2	29.3	34.4	18.0	362	58.4	337	59.3	25	47.2
District of Columbia	1,626	12.4	11.1	53.7	22.8	559	59.1	522	60.4	37	41.7
Florida	15,089	18.0	12.4	43.2	26.4	6,111	62.0	5,535	63.0	576	52.7
Georgia	7,693	25.7	19.0	36.1	19.2	2,126	64.4	1,941	65.4	185	53.5
Hawaii	1,308	14.3	24.9	35.5	25.3	482	67.1	474	67.3	7	54.0
Idaho	1,277	20.7	10.3	51.0	18.0	408	52.0	392	52.4	16	42.5
Illinois	13,140	23.5	17.3	41.3	17.8	3,707	56.2	3,634	56.3	73	48.8
Indiana	5,906	18.9	12.9	45.6	22.5	2,344	54.7	2,225	55.7	119	34.5
Iowa	2,960	16.9	11.7	49.0	22.4	1,322	49.7	1,296	49.6	26	55.1
Kansas	2,444	18.2	8.1	49.4	24.3	1,041	54.2	1,011	54.7	30	37.9
Kentucky	5,401	21.7	12.7	46.6	19.0	1,696	59.2	1,573	60.3	124	46.3
Louisiana	6,513	19.9	12.6	49.6	18.0	1,968	56.9	1,820	57.1	148	54.8
Maine	2,518	19.7	10.0	47.1	23.2	1,063	53.3	997	52.1	66	71.2
Maryland	6,524	18.7	14.2	44.8	22.2	2,109	61.8	2,011	62.3	98	50.8
Massachusetts[3]	10,822	17.1	13.8	44.4	24.7	4,380	57.2	4,370	57.1	11	93.8
Michigan	10,583	20.2	17.0	41.6	21.2	3,460	64.1	3,392	64.5	67	44.2
Minnesota	7,387	17.6	11.5	47.3	23.6	3,230	51.6	3,208	51.5	22	55.0
Mississippi	3,948	21.5	11.6	42.6	24.3	1,407	66.4	1,255	68.6	152	48.7
Missouri	7,748	23.4	9.4	48.1	19.1	2,603	52.9	2,568	53.1	34	41.1
Montana	876	20.9	12.2	40.2	26.7	353	65.9	345	66.2	8	53.6
Nebraska	1,616	24.1	8.9	42.4	24.6	683	54.0	677	54.0	6	45.3

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+
Nevada	$1,383	26.9%	11.3%	44.2%	17.6%	$370	61.8%	$331	63.6%	$39	46.0%
New Hampshire	1,327	25.6	8.3	37.0	29.1	610	60.3	588	60.7	22	49.6
New Jersey	9,667	14.4	7.2	44.9	33.5	4,746	63.7	4,709	63.6	37	69.3
New Mexico	3,290	40.1	18.2	34.7	7.0	481	43.9	443	42.9	38	56.1
New York	49,369	10.6	18.0	42.1	29.4	21,614	62.6	21,408	62.4	206	73.8
North Carolina	11,506	22.3	13.7	44.4	19.6	3,790	59.1	3,679	59.4	110	48.7
North Dakota	572	14.0	8.9	42.3	34.8	338	58.2	333	58.3	5	48.5
Ohio	14,150	14.0	13.0	47.0	25.9	5,626	59.7	5,414	60.5	212	37.6
Oklahoma	3,938	25.8	11.5	42.7	20.0	1,382	54.7	1,357	54.8	25	49.2
Oregon	3,678	17.0	16.0	41.3	25.7	1,410	65.2	1,364	65.8	46	45.5
Pennsylvania	17,232	16.4	9.2	46.6	27.7	6,762	67.3	6,678	67.5	84	56.1
Rhode Island	1,893	19.7	16.9	43.4	20.0	747	58.3	739	58.2	8	61.0
South Carolina	5,099	21.0	15.1	44.1	19.9	1,725	58.8	1,703	58.8	22	56.3
South Dakota	713	24.8	11.7	41.8	21.8	269	57.5	254	57.8	15	51.0
Tennessee	7,290	23.7	16.2	41.9	18.3	2,329	55.2	2,164	56.1	164	44.2
Texas	23,705	32.2	9.4	39.7	18.7	6,527	65.1	5,947	64.9	580	66.4
Utah	1,629	25.7	15.1	47.7	11.5	407	34.0	401	33.8	6	46.8
Vermont	1,191	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Virginia	5,775	22.8	9.5	45.6	22.1	2,103	56.1	2,008	56.7	95	43.8
Washington	6,603	20.2	13.3	42.6	24.0	2,290	64.3	2,203	65.2	86	42.3
West Virginia	2,434	16.0	7.8	48.1	28.1	1,003	67.2	950	68.2	53	49.4
Wisconsin	6,684	12.8	16.4	41.4	29.5	3,343	57.7	3,305	57.6	37	66.3
Wyoming	526	25.7	9.6	42.6	22.2	225	51.0	213	51.2	12	46.3

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 5 of MACStats for methodology, which differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports.

1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged."

2 Dual eligibles are enrolled in both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing.

3 FY 2009 data unavailable for Massachusetts; FY 2008 values shown instead.

4 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.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

TABLE 8. Medicaid Benefit Spending Per Full-year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2009

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	**11.3%**	**$7,322**	**$7,971**	**1.6%**	**$2,872**	**$2,896**	**28.3%**	**$4,395**	**$5,332**	**8.9%**	**$18,266**	**$19,722**	**21.9%**	**$16,364**	**$20,262**
Alabama	23.7	5,563	6,598	0.1	3,035	3,034	75.8	3,086	6,062	19.5	9,049	10,604	55.4	11,180	22,425
Alaska	0.3	11,876	11,902	-	6,102	6,102	0.0	9,192	9,184	0.6	28,688	28,838	2.3	26,130	26,691
Arizona	10.0	6,766	7,086	3.7	3,215	3,255	15.3	6,649	7,280	6.5	19,593	19,804	27.7	12,282	15,734
Arkansas	19.9	6,040	7,005	2.3	2,472	2,499	71.6	1,806	4,437	19.2	12,842	14,694	36.2	15,932	23,164
California	29.4	4,911	6,456	7.9	1,988	2,094	65.8	1,853	3,199	0.7	18,643	18,689	3.8	12,733	13,020
Colorado	3.6	7,556	7,626	0.3	2,852	2,818	5.1	5,818	5,356	6.0	19,771	20,771	16.3	17,430	20,505
Connecticut	4.6	12,163	12,649	-	3,478	3,478	-	4,593	4,593	12.2	40,356	45,520	25.9	35,196	46,923
Delaware	15.4	7,460	8,421	2.3	3,241	3,297	18.8	5,904	6,717	25.3	19,130	24,737	54.2	17,792	36,705
District of Columbia	2.6	11,211	11,094	0.0	3,075	3,075	0.7	5,305	4,751	4.0	27,448	27,858	16.4	27,451	31,397
Florida	13.1	5,836	6,173	1.0	2,069	2,022	23.3	4,692	4,439	18.2	13,216	15,430	37.0	10,394	15,176
Georgia	8.1	5,572	5,870	0.0	2,465	2,463	1.0	8,357	8,112	17.8	10,975	12,920	43.8	9,872	16,377
Hawaii	1.4	6,599	6,653	0.0	2,229	2,229	0.0	4,703	4,699	4.5	19,453	20,212	8.3	15,732	16,930
Idaho	5.0	7,425	7,715	-	2,531	2,531	0.0	7,576	7,576	11.8	18,366	20,531	30.0	15,685	21,727
Illinois	5.2	5,707	5,893	0.1	2,468	2,467	14.1	3,844	4,105	4.9	19,624	20,450	12.4	12,900	14,472
Indiana	5.5	6,485	6,727	0.0	2,160	2,160	0.0	4,320	4,320	20.2	18,742	22,817	29.3	18,274	25,039
Iowa	10.7	7,268	7,883	1.5	2,598	2,619	26.8	3,227	3,621	5.9	20,450	21,554	21.2	18,187	22,573
Kansas	5.5	8,679	9,036	0.0	2,860	2,856	0.7	6,341	6,103	12.6	18,851	21,241	23.4	19,315	24,717
Kentucky	8.8	7,526	8,050	0.0	3,498	3,497	0.4	7,598	7,541	14.7	12,128	13,846	38.0	12,097	18,408
Louisiana	14.8	6,749	7,515	0.0	2,519	2,518	45.6	5,129	7,364	13.7	16,894	19,143	43.4	11,645	19,154
Maine	13.0	8,378	9,374	0.1	4,743	4,746	0.2	2,965	2,971	14.6	20,776	23,941	56.1	10,793	22,622
Maryland	10.7	9,451	10,011	1.4	3,567	3,573	22.5	5,666	5,443	11.2	24,324	26,943	29.2	22,672	30,910
Massachusetts[3]	1.5	8,665	8,742	0.0	5,090	5,090	0.0	4,698	4,698	0.1	11,267	11,271	12.6	18,884	21,115
Michigan	5.9	6,405	6,711	1.2	2,292	2,312	18.6	5,858	6,962	4.5	14,921	15,465	13.3	19,051	21,618
Minnesota	5.2	11,029	11,511	1.0	3,976	3,992	11.9	5,272	5,827	3.7	31,159	32,156	11.8	25,175	28,124
Mississippi	16.3	6,403	7,070	0.0	2,804	2,803	41.7	5,366	6,301	20.1	11,452	13,654	43.5	11,829	19,305
Missouri	5.3	9,305	9,633	0.1	3,991	3,991	23.1	5,657	6,181	4.1	21,770	22,579	9.2	18,890	20,614
Montana	2.2	10,366	10,508	-	3,914	3,914	0.1	8,187	8,185	2.9	21,387	21,811	16.9	28,368	33,519
Nebraska	1.9	8,465	8,600	0.0	3,442	3,441	0.0	5,786	5,784	4.4	20,935	21,810	10.8	19,520	21,736

TABLE 8, Continued

State	Total			Children			Adults			Disabled			Aged		
		Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE			Benefit spending per FYE	
	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]	Percentage of FYEs with limited benefits[1]	All enrollees	Excluding those with limited benefits[2]
Nevada	8.1%	$6,595	$6,837	0.1%	$3,072	$3,059	2.2%	$4,819	$4,377	21.4%	$17,829	$21,742	40.1%	$11,134	$17,067
New Hampshire	6.0	10,598	11,081	-	4,482	4,482	-	7,827	7,827	17.4	21,652	25,598	27.8	30,376	40,886
New Jersey	3.3	11,581	11,815	0.0	3,061	3,059	1.9	7,750	7,025	5.0	27,812	29,168	13.8	24,320	27,855
New Mexico	10.3	7,336	7,736	0.0	4,728	4,719	37.7	7,351	9,120	10.8	20,330	22,445	29.1	7,222	9,250
New York	4.8	11,317	11,615	1.8	3,151	3,187	5.8	5,701	5,635	3.0	33,683	34,489	13.6	27,364	30,894
North Carolina	8.2	8,040	8,535	0.1	3,400	3,397	25.0	6,746	8,018	8.8	18,246	19,749	21.1	13,916	17,196
North Dakota	5.4	9,899	10,379	-	2,614	2,614	0.0	5,259	5,259	12.6	24,830	28,112	25.0	25,982	34,223
Ohio	4.8	8,104	8,386	-	2,271	2,271	0.0	4,679	4,679	13.7	20,204	22,959	26.0	24,564	32,470
Oklahoma	7.1	6,625	6,968	0.1	2,934	2,934	27.9	5,055	6,048	7.3	16,678	17,840	16.4	13,665	16,085
Oregon	11.1	8,513	9,324	3.4	2,970	3,056	14.3	6,340	6,838	15.5	18,658	21,728	30.7	19,892	28,067
Pennsylvania	6.3	9,018	9,505	0.2	3,316	3,312	18.7	4,625	5,301	4.3	15,733	16,330	16.3	23,411	27,652
Rhode Island	3.8	11,591	11,862	0.0	5,025	5,022	3.3	9,408	9,446	3.2	22,838	23,294	20.2	19,760	24,192
South Carolina	9.8	7,070	7,558	0.2	2,913	2,910	37.9	5,286	6,790	4.2	16,642	17,291	12.5	13,695	15,458
South Dakota	6.3	7,269	7,586	0.0	3,040	3,040	0.1	6,259	6,230	16.5	18,695	21,811	32.6	14,382	20,309
Tennessee	6.5	5,756	6,006	0.0	2,723	2,720	0.2	5,356	5,308	11.4	10,912	11,953	37.5	10,061	15,233
Texas	6.5	7,044	7,149	0.0	3,610	3,583	2.5	7,178	6,005	13.5	17,301	19,419	34.3	11,171	15,226
Utah	1.2	7,274	7,192	0.1	3,327	3,316	1.3	4,761	4,317	2.6	22,970	23,423	8.4	14,876	15,814
Vermont	4.5	8,112	[4]	-	[4]	[4]	-	[4]	[4]	6.9	[4]	[4]	29.4	[4]	[4]
Virginia	7.2	7,629	8,015	0.0	3,192	3,191	6.4	5,437	5,415	15.4	17,494	20,185	27.1	13,745	18,151
Washington	8.5	6,730	7,131	0.1	2,335	2,335	29.2	5,152	6,600	10.9	17,225	18,841	19.4	20,274	24,430
West Virginia	8.0	7,273	7,736	0.0	2,465	2,465	0.0	5,008	5,007	13.2	11,417	12,853	37.1	18,999	29,047
Wisconsin	8.8	7,342	7,872	4.8	2,352	2,419	16.7	3,904	4,314	3.9	19,723	20,390	8.2	15,671	16,853
Wyoming	5.7	8,509	8,784	0.8	3,321	3,343	4.0	6,991	7,061	13.7	24,423	27,468	34.2	24,416	35,306

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged." Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology, which differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports.

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.

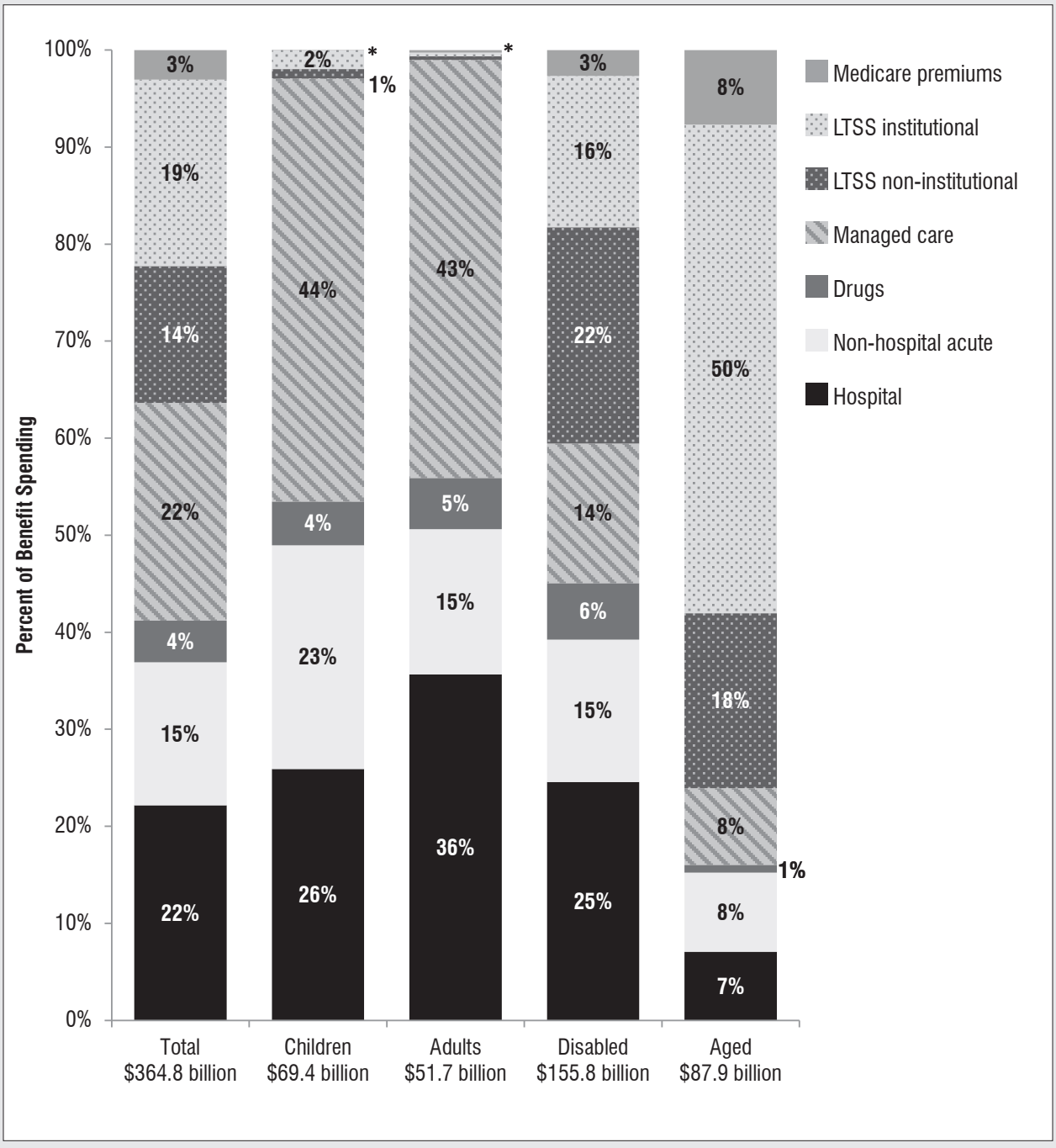
2 Calculated by removing limited-benefit enrollees and their spending.

3 FY 2009 data unavailable for Massachusetts; FY 2008 values shown instead.

4 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.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

FIGURE 3. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2009

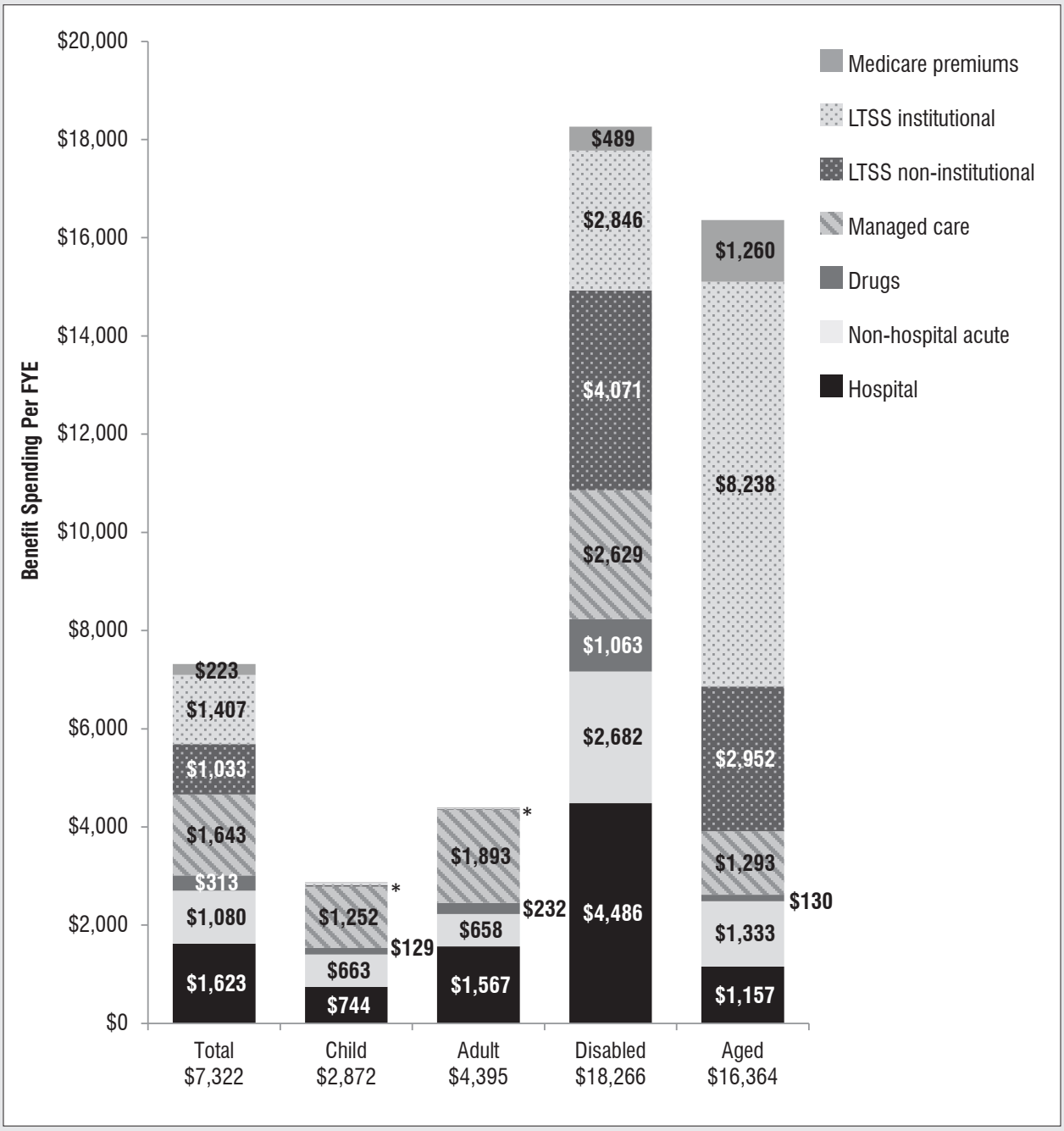


Notes: LTSS = long-term services and supports. Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged." Amounts are fee-for-service unless otherwise noted. Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category and a description of how the FY 2009 methodology differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. FY 2009 data unavailable for Massachusetts; FY 2008 values used instead.

* Values less than 1 percent not shown.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

FIGURE 4. Medicaid Benefit Spending Per Full-year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2009

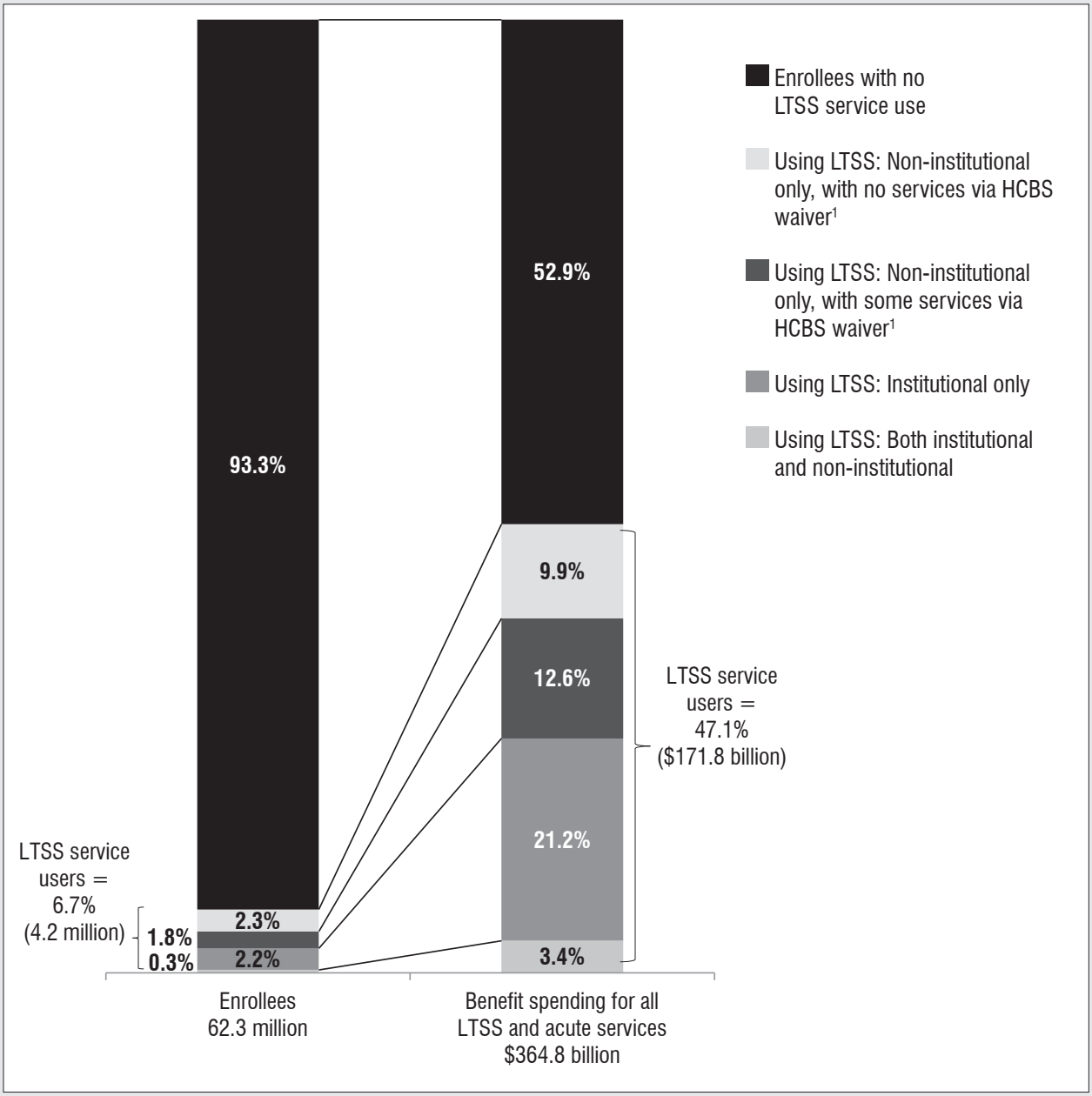


Notes: LTSS = long-term services and supports. Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged." Amounts are fee-for-service unless otherwise noted. Benefit spending from MSIS data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category and a description of how the FY 2009 methodology differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. Amounts reflect all enrollees, including those with limited benefits; see Table 8 notes for more information. FY 2009 data unavailable for Massachusetts; FY 2008 values used instead.

* Values less than $100 not shown.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

FIGURE 5. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-users of Long-term Services and Supports, FY 2009

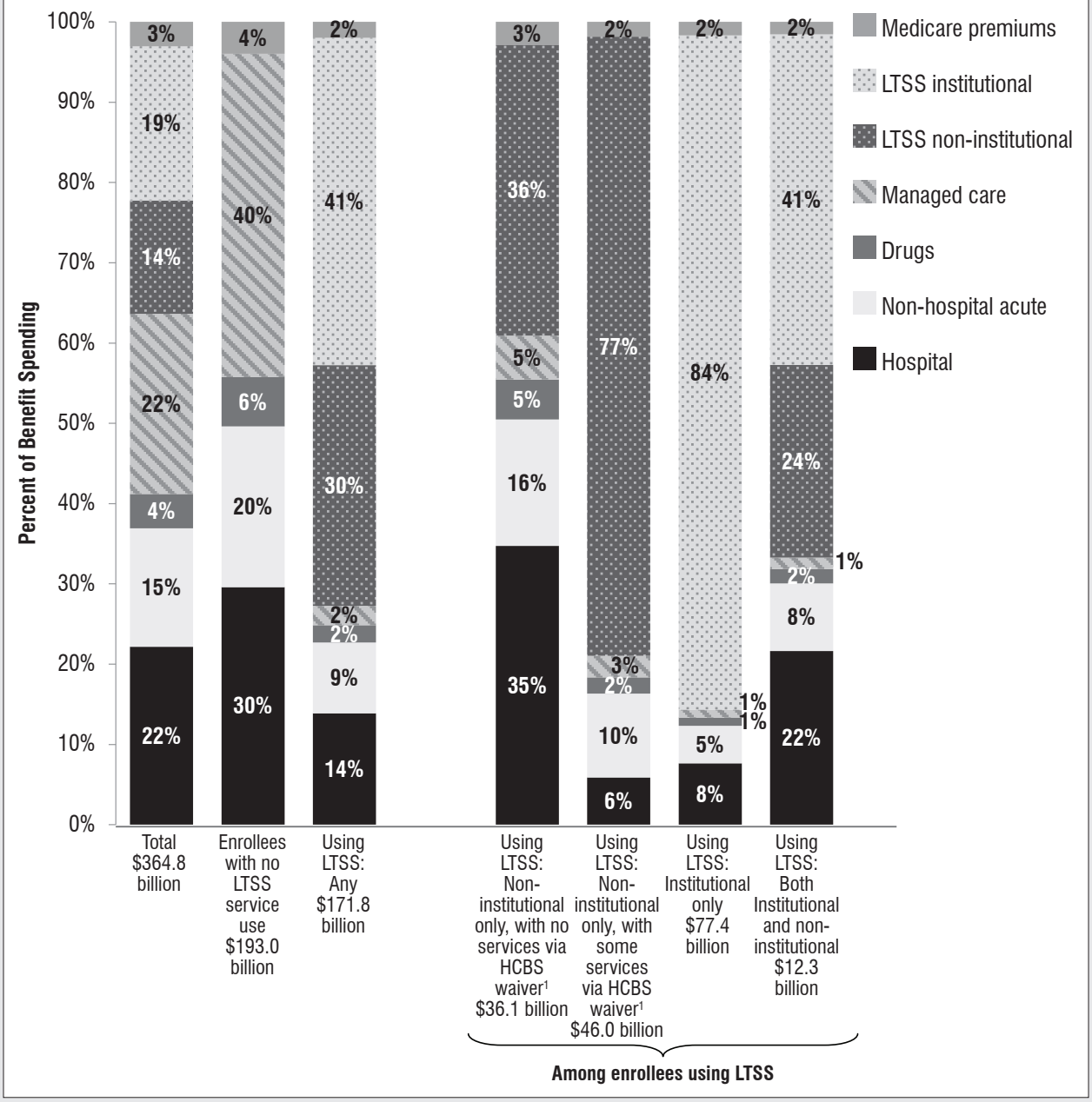


Notes: HCBS = home and community-based services; LTSS = long-term services and supports. Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category and a description of how the FY 2009 methodology differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. FY 2009 data unavailable for Massachusetts; FY 2008 values used instead. 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.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

FIGURE 6. Distribution of Medicaid Benefit Spending by Long-term Services and Supports Use and Service Category, FY 2009

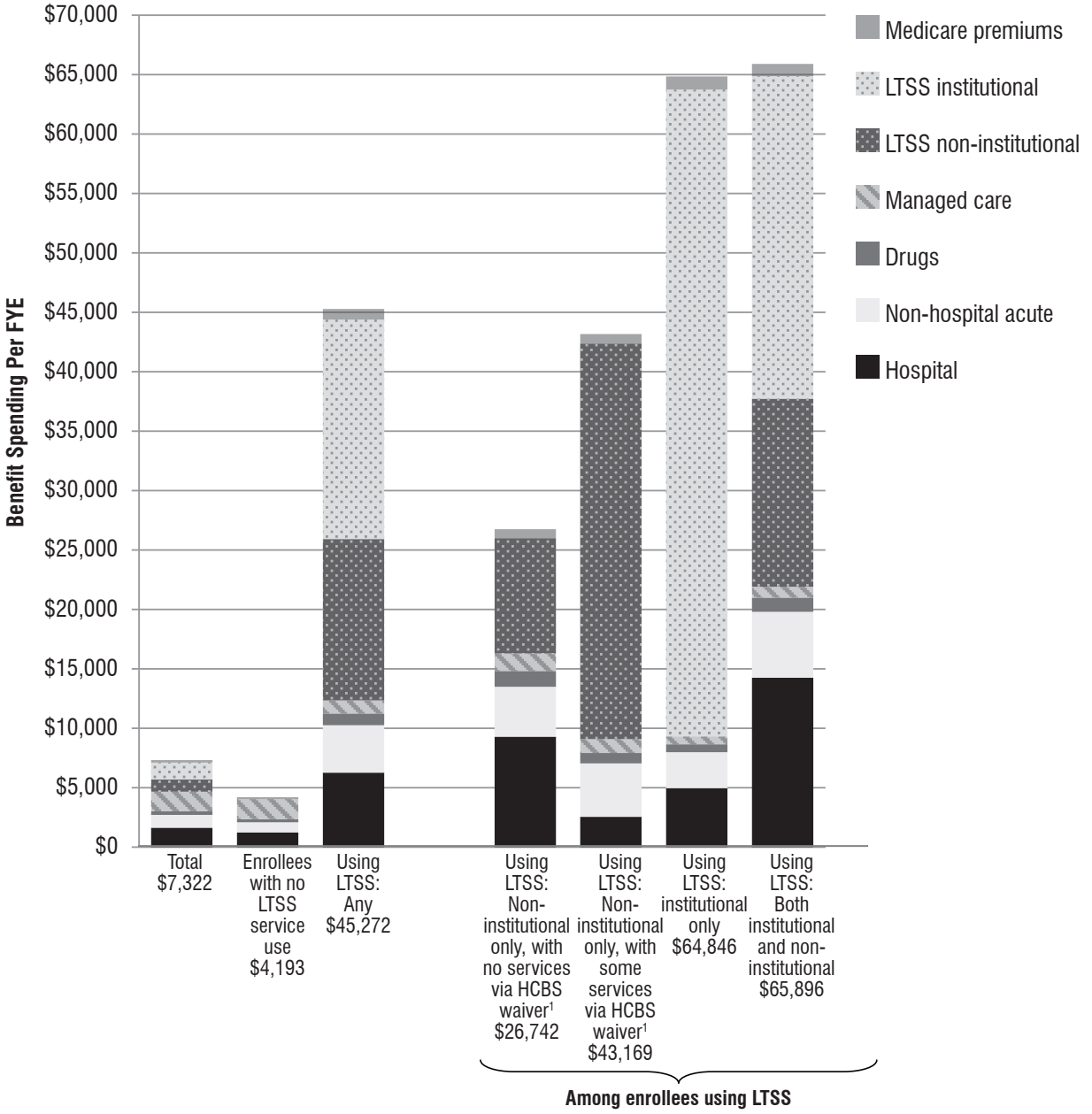


Notes: HCBS = home and community-based services; LTSS = long-term services and supports. Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category and a description of how the FY 2009 methodology differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. FY 2009 data unavailable for Massachusetts; FY 2008 values used instead. 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.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

FIGURE 7. Medicaid Benefit Spending Per Full-year Equivalent (FYE) Enrollee by Long-term Services and Supports Use and Service Category, FY 2009



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 5 of MACStats for methodology, including a list of services in each category and a description of how the FY 2009 methodology differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. FY 2009 data unavailable for Massachusetts; FY 2008 values used instead. 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.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

SECTION 4

Medicaid Managed Care

Section 4 of MACStats provides state-level information on Medicaid managed care enrollment and spending. Depending on the context in which it is used, the term "managed care" may refer to several different arrangements, including comprehensive risk-based and limited-benefit plans that provide a contracted set of services in exchange for a capitated (per member per month) payment, as well as primary care case management (PCCM) programs that typically pay primary care providers a small monthly fee to coordinate enrollees' care.[1]

The use of Medicaid managed care for non-disabled children and adults under age 65 has been common for a number of years. However, a majority of states currently use or are actively considering some form of managed care as an option for persons with disabilities in Medicaid,[2] and there is growing interest in managed care for individuals dually enrolled in Medicaid and Medicare.

- **Share of enrollees in managed care.** The national percentage of Medicaid enrollees (including Medicaid-expansion State Children's Health Insurance Program (CHIP)) in managed care ranged from less than half to more than 70 percent in 2010, depending on the definition of managed care that is used (Table 9).
- **Types of managed care.** The use of managed care varies widely by state, both in the arrangements used and the populations served. In 2010, all but two states reported using some form of managed care, including comprehensive risk-based plans, limited-benefit plans, or PCCM programs (Tables 9 and 10).
- **Variation by eligibility group.** 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 ranged from 38 percent among enrollees age 65 and older to 86 percent among non-disabled child enrollees in fiscal year 2009. Participation in comprehensive risk-based managed care plans was lowest among aged and disabled eligibility groups (12 percent and 28 percent, respectively) and highest among non-disabled adults and children (46 percent and 61 percent).[3]

- **Individuals dually enrolled in Medicaid and Medicare.** For dual eligibles, enrollment in Medicaid limited-benefit plans (which typically cover only behavioral health, transportation, or dental services) is more common than enrollment in Medicaid comprehensive risk-based plans or PCCM programs. For dual eligibles enrolled in a "comprehensive" Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state. Some individuals may receive both Medicaid and Medicare services under managed care arrangements, but the extent to which these services are coordinated by a single managed care entity varies. Thirty-eight percent of individuals dually enrolled in Medicaid and Medicare were enrolled in some form of Medicaid managed care in FY 2009 (Table 11), but only about 10 percent (9 percent using one data source for 2010 and 12 percent using another for FY 2009, Tables 9 and 11) were in Medicaid comprehensive risk-based plans.
- **Managed care spending.** Table 12 shows the share of Medicaid benefit spending that goes toward payments for managed care. The national percentage of Medicaid benefit spending on any form of managed care ranges from about 8 percent among aged enrollees to more than 40 percent among non-disabled child and adult enrollees. In states with comprehensive risk-based managed care, these plans account for the majority of managed care spending.

Endnotes

1 Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress: The evolution of managed care in Medicaid*, June 2011 (Washington, DC: MACPAC, 2011). http://www.macpac.gov/reports.

2 Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2012 (Washington, DC: MACPAC, 2012). http://www.macpac.gov/reports.

3 Readers will note that the percentages of enrollees in any form of managed care and in comprehensive risk-based managed care vary between Tables 9 and 11; as discussed in Section 5, this is due to differences between the Medicaid Statistical Information System and Medicaid managed care enrollment report data.

TABLE 9. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2010

State	All Medicaid Enrollees					Individuals Dually Enrolled in Medicaid and Medicare	
		Percentage in managed care					
	Number	Any managed care[1]	Comprehensive risk–based or PCCM[2,3]	Comprehensive risk–based[2]	PCCM	Number	Percentage in comprehensive risk–based managed care[2]
Total	**53,565,848**	**71.5%**	**63.3%**	**48.0%**	**15.3%**	**8,887,087**	**9.1%**
Alabama	872,501	59.6	57.1	–	57.1	187,130	–
Alaska	113,439	–	–	–	–	13,064	–
Arizona	1,322,359	90.5	90.5	90.5	–	147,772	68.2
Arkansas	595,556	78.4	70.3	0.0	70.3	110,894	0.0
California	7,326,862	55.0	54.6	54.6	–	1,135,406	18.9
Colorado	554,275	94.6	13.0	8.2	4.8	78,556	6.0
Connecticut	542,524	69.9	69.9	69.8	0.1	106,443	–
Delaware	180,429	77.4	73.0	73.0	–	23,185	–
District of Columbia	221,348	69.7	69.7	69.7	–	16,447	0.6
Florida	2,853,392	64.5	58.6	38.2	20.4	577,163	4.0
Georgia	1,496,733	91.0	70.4	62.2	8.3	236,983	–
Hawaii	260,457	98.0	98.0	98.0	–	29,723	89.0
Idaho	213,559	87.6	87.6	–	87.6	22,993	–
Illinois	2,429,500	56.5	56.5	7.5	49.0	649,200	–
Indiana	1,035,251	70.4	74.7	67.6	7.1	131,771	–
Iowa	429,860	90.1	46.4	0.0	46.4	74,980	0.1
Kansas	325,593	86.6	57.4	50.3	7.1	68,931	0.4
Kentucky	813,062	88.2	59.2	20.4	38.8	165,940	18.7
Louisiana	1,180,923	63.7	63.7	0.0	63.7	176,078	0.1
Maine	287,055	67.7	67.7	–	67.7	84,539	–
Maryland	901,560	79.5	74.8	74.8	–	102,557	0.1
Massachusetts	1,417,247	53.5	55.5	32.8	22.8	242,000	6.8
Michigan	1,828,749	86.2	65.5	65.5	–	239,262	0.2
Minnesota	734,366	63.8	63.8	63.8	–	121,394	41.3
Mississippi	702,775	75.9	–	–	–	152,414	–
Missouri	892,261	99.1	42.3	42.3	–	168,084	0.1
Montana[4]	100,726	74.6	74.6	0.0	74.5	19,970	0.2
Nebraska	230,498	85.6	39.4	17.5	21.9	33,223	–
Nevada	265,019	85.1	55.1	55.1	–	39,796	–
New Hampshire	131,470	–	–	–	–	26,405	–

TABLE 9, Continued

State	All Medicaid Enrollees: Number	Percentage in managed care: Any managed care[1]	Percentage in managed care: Comprehensive risk–based or PCCM[2,3]	Percentage in managed care: Comprehensive risk–based[2]	Percentage in managed care: PCCM	Individuals Dually Enrolled in Medicaid and Medicare: Number	Individuals Dually Enrolled in Medicaid and Medicare: Percentage in comprehensive risk–based managed care[2]
New Jersey	1,039,398	76.8	76.8	76.8	–	189,503	12.1
New Mexico	546,101	73.1	73.2	73.2	–	62,442	51.3
New York	4,740,518	68.1	67.4	67.1	0.3	676,143	1.3
North Carolina	1,465,190	77.5	76.2	0.0	76.2	286,798	0.0
North Dakota	62,486	67.3	67.3	0.1	67.2	14,081	0.2
Ohio	2,125,105	73.5	73.5	73.5	–	284,818	0.2
Oklahoma	669,499	90.1	67.1	0.0	67.1	101,359	0.1
Oregon	550,319	86.7	71.8	71.1	0.7	88,039	37.4
Pennsylvania	2,029,591	81.7	68.4	54.0	14.3	390,971	1.2
Rhode Island	189,286	67.4	68.7	67.4	1.3	35,752	0.5
South Carolina	807,591	100.0	62.5	48.7	13.8	131,649	0.3
South Dakota	113,274	80.3	80.3	–	80.3	18,429	–
Tennessee	1,204,239	100.0	96.4	96.4	–	233,094	57.6
Texas	3,763,896	67.0	67.0	44.4	22.6	578,134	15.5
Utah	269,643	83.3	41.4	17.1	24.3	22,947	12.4
Vermont	176,812	56.7	56.8	56.8	–	30,347	–
Virginia	883,916	59.2	65.6	59.3	6.3	161,847	0.3
Washington	1,121,278	86.7	58.9	58.4	0.6	149,182	0.8
West Virginia	335,397	48.6	51.4	48.6	2.8	70,172	–
Wisconsin	1,144,184	62.4	59.7	59.7	–	169,543	6.5
Wyoming	68,776	–	–	–	–	9,534	–

Notes: PCCM = primary care case management. Excludes the territories; unlike other tables and figures in the June 2012 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-organized 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.

3 Figure is based on the sum of enrollees reported in comprehensive risk-based plans and PCCM programs. In some states, the sum exceeds the 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 both types as of the reporting date.

4 Montana reported 144,740 PCCM enrollees and 43 PACE enrollees, but only 75,133 unduplicated enrollees in any form of managed care. PCCM figure shown here was obtained by subtracting PACE enrollees from the unduplicated total.

Source: MACPAC analysis of 2010 Medicaid Managed Care Enrollment Report data from CMS, as reported by states

TABLE 10. Number of Managed Care Entities by State and Type, July 1, 2010

State	Comprehensive Risk-based Plans				Limited-benefit Plans			
	Commercial MCO	Medicaid-only MCO	HIO	PACE	PIHP	PAHP	PCCM	Other
Total	**143**	**163**	**4**	**75**	**152**	**61**	**38**	**9**
Alabama	–	–	–	–	–	1	1	–
Alaska	–	–	–	–	–	–	–	–
Arizona	–	29	–	–	1	–	–	–
Arkansas	–	–	–	1	–	1	1	–
California	22	2	4	5	1	13	–	–
Colorado	–	2	–	3	6	–	2	–
Connecticut	1	2	–	–	–	–	1	2
Delaware	–	2	–	–	–	–	–	1
District of Columbia	–	2	–	–	1	1	–	–
Florida	21	6	–	3	27	9	1	2
Georgia	–	3	–	–	–	1	1	–
Hawaii	4	1	–	1	–	–	–	–
Idaho	–	–	–	–	–	2	1	–
Illinois	1	2	–	–	–	–	1	–
Indiana	4	1	–	–	–	–	2	1
Iowa	–	–	–	1	1	–	1	–
Kansas	–	2	–	2	1	2	1	–
Kentucky	–	1	–	–	–	1	1	–
Louisiana	–	–	–	2	–	–	1	–
Maine	–	–	–	–	–	–	1	–
Maryland	–	7	–	1	–	5	–	1
Massachusetts	2	6	–	6	1	–	1	–
Michigan	–	14	–	4	18	1	–	–
Minnesota	5	3	–	–	–	–	–	–
Mississippi	–	–	–	–	–	1	–	–
Missouri	–	6	–	1	–	1	–	–
Montana	–	–	–	1	–	–	2	–

TABLE 10, Continued

State	Comprehensive Risk-based Plans				Limited-benefit Plans			
	Commercial MCO	Medicaid-only MCO	HIO	PACE	PIHP	PAHP	PCCM	Other
Nebraska	1	–	–	–	–	–	1	1
Nevada	1	1	–	–	–	1	–	–
New Hampshire	–	–	–	–	–	–	–	–
New Jersey	1	3	–	2	–	1	–	–
New Mexico	5	1	–	1	1	–	–	–
New York	18	13	–	7	20	–	3	1
North Carolina	–	–	–	2	1	–	2	–
North Dakota	–	–	–	1	–	1	1	–
Ohio	–	7	–	2	–	–	–	–
Oklahoma	–	–	–	1	–	1	2	–
Oregon	2	13	–	1	9	6	1	–
Pennsylvania	13	–	–	12	39	2	1	–
Rhode Island	2	1	–	1	–	1	1	–
South Carolina	–	4	–	2	–	2	1	–
South Dakota	–	–	–	–	–	–	1	–
Tennessee	–	6	–	1	1	2	–	–
Texas	6	13	–	3	1	1	1	–
Utah	–	1	–	–	10	2	1	–
Vermont	–	1	–	1	–	–	–	–
Virginia	3	2	–	5	–	1	1	–
Washington	8	–	–	1	2	1	1	–
West Virginia	3	–	–	–	–	–	1	–
Wisconsin	20	6	–	1	11	–	–	–
Wyoming	–	–	–	–	–	–	–	–

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-organized 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.

Source: 2010 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 2009

	Percentage of Enrollees											
	Any managed care						Comprehensive risk-based managed care					
State	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]
Total	**70.1%**	**85.9%**	**58.7%**	**60.5%**	**38.2%**	**38.2%**	**47.3%**	**61.4%**	**45.6%**	**28.3%**	**12.2%**	**12.1%**
Alabama	68.1	97.1	21.6	65.4	21.7	20.8	3.0	–	0.0	6.0	13.8	14.0
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	89.6	95.6	84.5	94.0	74.2	79.4	83.5	89.7	77.8	88.5	69.1	74.8
Arkansas	80.3	97.4	48.5	78.9	48.4	48.3	–	–	–	–	–	–
California	58.2	77.7	27.1	92.6	88.7	92.5	37.8	63.0	22.4	26.4	15.4	17.3
Colorado	90.8	95.2	86.0	86.1	79.0	74.5	17.1	19.8	12.2	15.5	11.0	9.2
Connecticut	68.2	91.4	84.2	0.7	0.0	0.5	68.2	91.4	84.2	0.7	0.0	0.5
Delaware	88.8	97.2	89.6	78.3	48.7	51.0	76.6	88.2	83.5	51.8	4.6	7.8
District of Columbia	93.5	96.8	92.2	93.1	82.2	81.7	66.0	92.3	90.0	12.3	0.3	1.9
Florida	71.5	90.0	74.6	55.5	15.1	12.2	71.5	90.0	74.6	55.5	15.1	12.2
Georgia	87.4	95.9	88.1	75.0	54.7	53.6	67.5	91.4	82.8	4.0	0.0	0.5
Hawaii	94.1	97.0	93.6	92.3	86.6	86.6	94.1	97.0	93.6	92.3	86.6	86.6
Idaho	90.8	98.2	93.6	80.5	49.8	57.3	–	–	–	–	–	–
Illinois	70.3	83.8	76.6	35.0	8.0	4.1	7.7	10.2	8.0	0.1	0.1	0.1
Indiana	76.9	92.3	87.7	39.1	2.9	3.8	70.8	88.7	86.5	13.3	0.2	1.6
Iowa	73.9	95.0	51.6	92.1	3.5	43.9	1.1	1.7	0.9	0.1	0.1	0.1
Kansas	84.6	93.5	87.7	78.9	40.8	53.3	54.2	76.5	73.5	2.3	0.6	0.9
Kentucky	89.8	97.9	96.4	82.7	62.0	61.5	19.8	24.9	20.7	15.6	6.5	8.3
Louisiana	62.8	90.4	41.4	41.2	1.6	3.2	0.0	0.0	–	0.0	0.1	0.1
Maine	–	–	–	–	–	–	–	–	–	–	–	–
Maryland	70.7	93.7	58.0	59.2	1.4	4.2	70.7	93.7	58.0	59.2	1.4	4.2
Massachusetts[2]	54.6	82.8	73.7	29.6	10.2	9.7	31.2	58.5	37.1	10.1	8.7	6.6
Michigan	72.5	88.9	66.4	54.0	4.1	8.3	69.0	83.7	65.6	51.4	3.5	6.1
Minnesota	67.6	84.7	70.3	10.9	59.7	44.6	67.6	84.7	70.3	10.9	59.7	44.6
Mississippi	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 11, Continued

State	Percentage of Enrollees											
	Any managed care						Comprehensive risk-based managed care					
	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]
Missouri	72.4%	66.7%	60.0%	91.6%	89.4%	89.9%	46.6%	66.7%	59.7%	2.0%	0.0%	0.4%
Montana	64.4	79.7	63.6	49.9	1.3	2.4	–	–	–	–	–	–
Nebraska	36.6	46.0	39.5	19.8	3.1	1.2	18.6	23.0	20.6	10.6	1.5	0.6
Nevada	88.2	95.7	88.2	76.2	58.2	53.6	56.7	74.7	68.9	1.7	0.0	0.3
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	90.5	95.7	84.6	90.3	77.4	78.6	72.0	92.7	80.3	52.2	12.6	11.4
New Mexico	68.7	81.5	57.4	56.6	5.1	4.9	68.1	81.4	57.3	53.4	4.4	4.6
New York	64.9	78.5	72.6	46.9	13.3	11.2	64.9	78.5	72.6	46.9	13.3	11.2
North Carolina	72.1	92.6	61.0	55.7	16.6	22.8	0.0	–	–	0.0	0.0	0.0
North Dakota	51.1	69.2	70.4	1.4	–	0.3	–	–	–	–	–	–
Ohio	76.9	92.6	94.7	42.3	4.7	3.5	76.9	92.6	94.7	42.3	4.7	3.5
Oklahoma	85.4	97.3	54.3	85.8	82.4	80.2	–	–	–	–	–	–
Oregon	87.0	94.2	82.2	82.5	68.0	66.8	71.6	82.0	72.1	59.2	37.1	39.6
Pennsylvania	87.3	95.1	81.8	92.2	52.1	65.9	60.0	73.9	62.9	53.8	8.2	7.6
Rhode Island	59.7	88.0	68.5	16.9	0.1	0.9	59.7	88.0	68.5	16.9	0.1	0.9
South Carolina	90.2	98.3	71.5	94.1	85.6	86.7	49.0	64.2	46.0	34.8	0.5	2.3
South Dakota	100.0	100.0	100.0	100.0	100.0	100.0	–	–	–	–	–	–
Tennessee	92.9	96.9	97.2	92.4	65.5	75.5	92.9	96.9	97.1	92.2	65.5	75.4
Texas	73.1	91.3	53.2	46.8	19.4	21.3	46.9	60.0	33.8	21.9	14.9	15.6
Utah	88.1	99.0	62.3	95.6	89.0	91.0	0.2	0.1	0.0	1.7	0.1	1.0
Vermont	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	66.5	82.9	72.2	43.6	16.3	10.9	60.3	77.9	67.4	36.3	3.9	2.3
Washington	69.1	87.6	60.9	40.8	12.1	6.1	62.2	87.0	60.3	4.3	2.7	2.1
West Virginia	55.0	89.3	78.7	2.9	0.0	0.5	50.8	82.8	73.9	1.8	0.0	0.4
Wisconsin	63.8	84.5	70.1	32.5	14.4	17.7	61.5	84.2	69.9	25.3	4.8	8.1
Wyoming	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 11, Continued

	Percentage of Enrollees											
	Limited-benefit plan						Primary care case management					
State	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]
Total	**33.0%**	**37.3%**	**23.4%**	**37.9%**	**30.0%**	**30.7%**	**12.4%**	**17.2%**	**8.3%**	**11.5%**	**1.7%**	**2.0%**
Alabama	65.1	97.1	21.5	59.6	8.2	7.2	45.9	71.7	13.5	38.7	1.3	1.4
Alaska	-	-	-	-	-	-	-	-	-	-	-	-
Arizona	84.1	93.0	81.4	72.0	51.9	59.2	-	-	-	-	-	-
Arkansas	79.2	95.8	47.6	78.7	48.3	48.2	60.3	84.8	24.4	55.4	4.9	7.0
California	54.4	70.8	24.7	92.2	88.0	92.0	-	-	-	-	-	-
Colorado	90.4	94.7	85.9	85.8	77.5	73.3	-	-	-	-	-	-
Connecticut	-	-	-	-	-	-	-	-	-	-	-	-
Delaware	87.0	96.1	86.9	76.7	47.8	49.3	-	-	-	-	-	-
District of Columbia	29.0	5.5	2.9	84.6	82.2	80.4	-	-	-	-	-	-
Florida	-	-	-	-	-	-	-	-	-	-	-	-
Georgia	86.9	95.2	87.6	74.9	54.7	53.6	8.6	0.4	0.1	47.7	7.6	6.6
Hawaii	1.6	3.6	0.1	0.7	-	0.0	-	-	-	-	-	-
Idaho	70.6	93.2	92.7	3.7	3.6	4.3	86.0	93.4	83.2	79.2	46.8	54.1
Illinois	2.5	3.4	2.6	0.0	-	0.0	64.0	75.1	70.6	34.9	7.8	4.0
Indiana	-	-	-	-	-	-	7.7	4.4	5.3	26.9	2.7	2.3
Iowa	73.9	95.0	51.6	92.1	3.4	43.9	38.5	61.8	31.3	1.4	-	0.2
Kansas	84.6	93.5	87.6	78.8	40.3	53.0	5.7	3.4	1.3	17.8	1.7	1.3
Kentucky	89.4	97.5	96.0	82.5	61.8	61.3	46.4	68.5	67.6	12.0	2.4	2.1
Louisiana	-	-	-	-	-	-	62.8	90.4	41.4	41.2	1.5	3.1
Maine	-	-	-	-	-	-	-	-	-	-	-	-
Maryland	-	-	-	-	-	-	-	-	-	-	-	-
Massachusetts[2]	25.5	27.8	39.2	20.5	1.5	3.3	-	-	-	-	-	-
Michigan	18.7	31.0	2.2	6.7	0.6	2.4	-	-	-	-	-	-
Minnesota	-	-	-	-	-	-	-	-	-	-	-	-
Mississippi	-	-	-	-	-	-	-	-	-	-	-	-
Missouri	26.2	0.1	0.4	91.2	89.4	89.7	-	-	-	-	-	-
Montana	-	-	-	-	-	-	64.4	79.7	63.6	49.9	1.3	2.4
Nebraska	-	-	-	-	-	-	19.1	24.3	20.1	10.1	1.7	0.6
Nevada	88.2	95.7	88.2	76.2	58.2	53.6	-	-	-	-	-	-
New Hampshire	-	-	-	-	-	-	-	-	-	-	-	-
New Jersey	39.2	29.0	24.7	56.9	69.1	70.8	-	-	-	-	-	-
New Mexico	68.3	81.5	57.2	55.0	3.6	3.3	-	-	-	-	-	-
New York	-	-	-	-	-	-	-	-	-	-	-	-

TABLE 11, Continued

	Percentage of Enrollees											
	Limited-benefit plan						Primary care case management					
State	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]
North Carolina	5.5%	5.5%	5.7%	5.5%	5.0%	5.2%	71.1%	92.5%	60.0%	53.9%	12.4%	19.1%
North Dakota	-	-	-	-	-	-	51.1	69.2	70.4	1.4	-	0.3
Ohio	-	-	-	-	-	-	-	-	-	-	-	-
Oklahoma	85.4	97.3	54.3	85.8	82.4	80.2	2.0	2.7	1.2	1.3	0.1	0.1
Oregon	86.7	93.8	82.2	82.4	67.5	66.5	0.9	1.0	0.3	1.3	1.4	1.3
Pennsylvania	86.7	94.6	80.8	92.0	51.4	65.4	17.2	21.2	17.7	16.2	1.1	1.8
Rhode Island	-	-	-	-	-	-	-	-	-	-	-	-
South Carolina	90.0	98.0	71.4	94.0	85.6	86.7	13.2	16.6	8.0	13.6	6.7	8.6
South Dakota	100.0	100.0	100.0	100.0	100.0	100.0	44.1	55.6	55.2	14.6	0.4	0.9
Tennessee	59.2	57.3	56.0	74.6	43.8	54.6	-	-	-	-	-	-
Texas	10.5	12.7	5.4	9.5	4.2	4.7	25.2	32.1	19.8	16.2	0.3	1.0
Utah	88.1	99.0	62.3	95.6	89.0	91.0	-	-	-	-	-	-
Vermont	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	-	-	-	-	-	-	6.3	5.1	4.9	7.5	12.5	8.6
Washington	-	-	-	-	-	-	7.0	0.6	0.8	36.9	9.4	4.1
West Virginia	-	-	-	-	-	-	5.5	9.1	6.1	1.2	0.0	0.1
Wisconsin	5.0	3.8	2.4	9.6	11.5	12.0	-	-	-	-	-	-
Wyoming	-	-	-	-	-	-	-	-	-	-	-	-

Notes: Excludes the territories and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged." Any managed care includes comprehensive risk-based plans, limited-benefit plans, and PCCM programs. Enrollees are counted as participating in managed care if they were enrolled during the fiscal year and at least one managed care payment was made on their behalf during the fiscal year; this method underestimates participation somewhat because it does not capture enrollees who entered managed care late in the year but for whom a payment was not made until the following fiscal year. Managed care types do not sum to total because individuals are counted in every category for which a payment was made on their behalf during the year.

Figures shown here may differ from Table 9, which uses Medicaid Managed Care Enrollment Report data. Reasons for differences include differing time periods (the Medicaid Statistical Information System (MSIS) data used here include those ever enrolled in FY 2009), 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.

1 Dual eligibles are enrolled in both Medicaid and Medicare; includes those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For dual eligibles enrolled in a comprehensive Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state.

2 FY 2009 data unavailable for Massachusetts; FY 2008 values shown instead.

3 Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, managed care enrollment (which, for this table, is based on the presence of managed care spending in MSIS for a given enrollee) is not reported here.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2012

TABLE 12. Percentage of Medicaid Benefit Spending on Managed Care by State and Eligibility Group, FY 2009

	Percentage of Benefit Spending											
	Any managed care						Comprehensive risk-based managed care					
State	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]
Total	**22.4%**	**43.6%**	**43.1%**	**14.4%**	**7.9%**	**7.2%**	**20.8%**	**41.0%**	**41.1%**	**13.0%**	**6.8%**	**5.7%**
Alabama	15.2	42.1	7.9	8.6	1.0	0.9	0.1	–	0.0	0.1	0.3	0.3
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	84.9	86.0	87.2	83.5	79.5	81.7	83.9	85.0	85.7	83.1	78.8	81.1
Arkansas	0.4	1.3	0.6	0.2	0.1	0.1	–	–	–	–	–	–
California	15.4	41.7	16.7	8.6	10.0	10.5	14.7	41.0	16.4	8.2	8.4	9.2
Colorado	12.6	19.8	8.8	11.7	9.4	9.3	6.9	7.4	5.2	6.2	8.6	6.4
Connecticut	12.6	50.0	57.9	0.0	0.0	0.0	12.6	50.0	57.9	0.0	0.0	0.0
Delaware	42.0	55.7	77.6	25.7	1.4	1.5	41.9	55.5	77.5	25.6	1.2	1.4
District of Columbia	19.9	56.9	70.8	9.0	0.8	1.4	19.0	56.6	70.7	7.7	0.0	0.3
Florida	16.6	31.2	18.1	14.1	9.9	5.8	16.6	31.2	18.1	14.1	9.9	5.8
Georgia	31.2	70.3	64.1	1.8	1.3	1.5	30.5	70.2	64.1	0.7	0.0	0.2
Hawaii	55.5	78.5	77.8	33.9	50.8	42.2	55.5	78.5	77.8	33.9	50.8	42.2
Idaho	3.1	11.3	3.8	0.4	0.6	0.8	–	–	–	–	–	–
Illinois	1.8	4.4	4.4	0.1	0.2	0.1	1.4	3.2	3.4	0.0	0.2	0.1
Indiana	23.1	60.9	76.9	3.6	0.1	0.3	22.9	60.6	76.6	3.4	0.0	0.3
Iowa	4.3	8.9	6.2	4.2	0.2	1.9	0.2	0.4	0.5	0.0	0.1	0.1
Kansas	21.0	57.4	69.8	8.7	2.5	3.7	15.1	49.8	69.1	0.6	0.6	0.5
Kentucky	16.2	28.4	22.2	14.5	2.5	3.2	15.1	25.5	20.8	14.0	2.1	2.7
Louisiana	0.1	0.3	0.1	0.0	0.1	0.0	0.0	0.0	–	0.0	0.1	0.0
Maine	–	–	–	–	–	–	–	–	–	–	–	–
Maryland	33.0	56.6	72.2	26.7	0.6	1.4	33.0	56.6	72.2	26.7	0.6	1.4
Massachusetts[2]	26.0	52.7	45.3	16.5	13.7	8.8	22.2	48.7	35.4	12.8	13.6	8.5
Michigan	46.5	66.2	70.6	48.2	5.0	17.8	41.2	65.7	60.9	41.4	1.7	3.2
Minnesota	33.3	75.5	78.7	4.8	36.8	20.5	33.3	75.5	78.7	4.8	36.8	20.5
Mississippi	–	–	–	–	–	–	–	–	–	–	–	–
Missouri	15.4	47.3	40.3	0.7	1.0	0.9	14.9	47.3	40.3	0.2	0.0	0.1
Montana	0.6	2.1	0.7	0.3	0.0	0.0	–	–	–	–	–	–
Nebraska	5.8	12.0	14.9	3.4	0.7	0.1	5.8	11.8	14.8	3.4	0.7	0.1
Nevada	15.9	39.5	44.3	0.3	0.3	0.3	15.6	39.2	44.2	0.1	0.0	0.0
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 12, Continued

State	Percentage of Benefit Spending											
	Any managed care						Comprehensive risk-based managed care					
	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]	Total	Children	Adults	Disabled	Aged	Dual eligibles[1]
New Jersey	17.6%	50.9%	63.6%	11.0%	2.2%	1.3%	17.5%	50.8%	63.6%	10.9%	2.0%	1.1%
New Mexico	59.3	75.2	66.1	46.7	13.2	5.3	59.1	75.1	66.1	46.3	13.0	5.3
New York	17.6	42.1	40.4	8.3	8.3	5.7	17.6	42.1	40.4	8.3	8.3	5.7
North Carolina	1.1	1.6	0.5	1.3	0.2	0.8	0.0	–	–	0.0	0.0	0.0
North Dakota	0.5	2.5	1.3	0.0	–	0.0	–	–	–	–	–	–
Ohio	31.9	78.5	85.6	19.7	2.0	0.7	31.9	78.5	85.6	19.7	2.0	0.7
Oklahoma	3.8	7.4	2.1	2.7	2.7	2.5	–	–	–	–	–	–
Oregon	37.9	69.3	67.5	32.9	6.8	9.4	36.0	65.6	66.5	30.7	6.2	8.1
Pennsylvania	44.3	81.1	72.4	48.3	6.4	6.1	40.4	76.0	68.6	43.7	4.5	3.2
Rhode Island	27.4	68.4	54.2	11.0	0.0	0.2	27.4	68.4	54.2	11.0	0.0	0.2
South Carolina	18.1	30.3	28.5	16.1	1.8	2.2	17.3	29.0	28.0	15.7	0.2	0.9
South Dakota	0.2	0.5	0.2	0.1	0.1	0.1	–	–	–	–	–	–
Tennessee	49.2	72.6	74.5	42.0	13.1	18.8	49.2	72.6	74.5	42.0	13.1	18.8
Texas	18.9	37.0	23.9	8.4	7.8	7.7	18.6	36.5	23.7	8.0	7.8	7.6
Utah	16.6	15.8	8.5	21.9	7.3	19.9	0.4	0.2	0.0	0.8	0.0	0.7
Vermont	80.2	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	23.3	38.6	57.5	18.2	3.4	1.0	23.3	38.5	57.5	18.1	3.4	1.0
Washington	22.7	66.2	63.8	1.5	1.1	0.8	22.7	66.2	63.8	1.4	1.1	0.8
West Virginia	12.6	53.4	50.5	0.2	0.0	0.1	12.6	53.3	50.5	0.2	0.0	0.1
Wisconsin	40.4	57.7	64.5	30.3	33.8	32.2	27.7	56.6	64.3	16.4	10.5	10.9
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. About 690,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as "aged." Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to match CMS-64 totals; see Section 5 of MACStats for methodology, which differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and PCCM programs.

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

1 Dual eligibles are enrolled in both Medicaid and Medicare; includes those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For dual eligibles enrolled in a comprehensive Medicaid managed care plan, Medicare is still the primary payer of most acute care services; as a result, the Medicaid plan may only provide a subset of the comprehensive services normally covered under its contract with the state.

2 FY 2009 data unavailable for Massachusetts; FY 2008 values shown instead.

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 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 2012

SECTION 5

Technical Guide to the June 2012 MACStats

Section 5 provides supplemental information to accompany the tables and figures in Sections 1 through 4 of MACStats. It describes key issues to consider when interpreting the data and comparing numbers across tables and figures and with data from other sources.

Guide to Interpreting Medicaid and CHIP Numbers

As described in MACPAC's March 2012 Report to the Congress, there are several reasons why estimates of Medicaid and State Children's Health Insurance Program (CHIP) enrollment and spending may vary.[1] These issues are noted here in the context of the tables and figures in the June 2012 MACStats. In addition, MACPAC has made certain adjustments to the spending data in MACStats that are described in detail later in this Section.

Tables 13A–D are used to illustrate how the factors described in this Section can affect enrollment numbers. Table 13A shows enrollment numbers for the entire U.S. population in 2009.[2] Tables 13B–D divide the U.S. population into the three age groups that are commonly used in MACPAC analyses because they correspond to some of the key eligibility pathways in Medicaid and CHIP:

- children age 0 to 18;
- adults age 19 to 64; and
- adults age 65 and older.

Data sources

Medicaid and CHIP enrollment and spending numbers are available from administrative data, which states and the federal government compile in the course of administering

these programs. The latest year of available data may differ, depending on the source. The administrative data used in this edition of MACStats include the following, which are submitted by the states to the Centers for Medicare & Medicaid Services (CMS):

- Form CMS-64 for state-level Medicaid spending, which is used throughout MACStats;
- the Medicaid Statistical Information System (MSIS) for person-level detail, which is used throughout MACStats;[3] and
- Medicaid managed care enrollment reports, which are used in Tables 9 and 10.

Additional information is available from nationally representative surveys based on interviews of individuals. The survey data used in Tables 3A–5C are from the National Health Interview Survey (NHIS), which is conducted for the U.S. Department of Health and Human Services.

Tables 13A–D show 2009 survey-based estimates of Medicaid/CHIP enrollment as well as comparable (point-in-time) estimates from the administrative data. Estimates of Medicaid/CHIP enrollment from survey data tend be lower than numbers from administrative data because survey respondents tend to underreport Medicaid and CHIP, among other reasons described later in this Section.

Enrollment period examined

The number of individuals enrolled at a particular point during the year will be lower than the total number enrolled at any point during an entire year. For example, the administrative data in Table 13B show that 48.4 percent of children (38.2 million) were enrolled in Medicaid or CHIP at some time during fiscal year (FY) 2009. However, numbers from the same data source illustrate that the number of children enrolled at a particular point in time (29.9 million, or approximately 37.8 percent of children) is much smaller than the number ever enrolled during the year.

Point-in-time data may also be referred to as average monthly enrollment or full-year equivalent enrollment.[4] Full-year equivalent enrollment is often used for budget analyses, such as those by the CMS Office of the Actuary and when comparing enrollment and expenditure numbers, 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 source and the year in question, data may include slightly different numbers of individuals in Medicaid. Certain terms commonly used to refer to people with Medicaid have very specific definitions in administrative data sources provided by CMS:[5]

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

The following example illustrates the difference in these terms. In FY 2009, there were 30.0 million non-disabled child Medicaid (excluding Medicaid-expansion CHIP) *enrollees* (Table 6). However, there were 28.3 million *beneficiaries* in this eligibility group—that is, during FY 2009, a Medicaid FFS or managed care capitation payment was made on their behalf (Table 1).[7] 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.[8]

Institutionalized and limited-benefit enrollees

Administrative Medicaid data include enrollees who were in institutions such as nursing homes, as well as individuals who received only limited benefits (for example, only coverage for emergency services). Survey data tend to exclude such individuals from counts of coverage; the NHIS estimates in Tables 3A–5C do not include the institutionalized.

Table 13D shows point-in-time enrollment among those age 65 and older—5.4 million from the administrative data and 2.7 million from the survey data (NHIS). In percentage terms, the difference between the administrative data and the survey data is largest for this age group. This is primarily because the NHIS excludes the institutionalized and because, when Medicaid pays only for Medicare enrollees' cost sharing, NHIS generally does not count it as Medicaid coverage. Based on administrative data, 1.4 million Medicaid enrollees age 65 and older received only limited benefits from Medicaid.

CHIP enrollees

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

Methodology for Adjusting Benefit Spending Data

The FY 2009 Medicaid benefit spending amounts shown in the June 2012 MACStats were calculated based on MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[9] 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.[10] We adjust the MSIS amounts for several reasons:

- CMS-64 data provide an official accounting of state spending on Medicaid for purposes of receiving federal matching dollars; in contrast, MSIS data are used primarily for statistical purposes.
- MSIS generally understates total Medicaid benefit spending because it excludes disproportionate share hospital payments and additional types of supplemental payments made to hospitals and other providers, Medicare premium payments, and certain other amounts.[11]
- MSIS generally overstates net spending on prescribed drugs, because it excludes rebates from drug manufacturers.

TABLE 13A. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2009

Medicaid and CHIP Enrollment (All Ages)	Administrative Data: Ever enrolled during the year	Administrative Data: Point in time	Survey Data (NHIS): Point in time
Medicaid	62.3 million	49.8 million	Not available
CHIP	8.1 million	5.2 million	Not available
Totals for Medicaid and CHIP	70.4 million	55.1 million	45.1 million
U.S. Population	**Census Bureau**		**Survey Data (NHIS)**
	307.5 million	306.3 million	301.4 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	22.9% (70.4/307.5)	18.0% (55.1/306.3)	15.0% (45.1/301.4)

See Table 13D for sources and notes.

TABLE 13B. Medicaid and CHIP Enrollment as a Percentage of Children Under Age 19, 2009

Medicaid and CHIP Enrollment Among Children Under Age 19	Administrative Data: Ever enrolled during the year	Administrative Data: Point in time	Survey Data (NHIS): Point in time
Medicaid	30.5 million	24.9 million	Not available
CHIP	7.7 million	5.0 million	Not available
Totals for Medicaid and CHIP	38.2 million	29.9 million	26.6 million
Children Under Age 19	**Census Bureau**		**Survey Data (NHIS)**
	79.0 million	78.9 million	78.5 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Children Under 19			
	48.4% (38.2/79.0)	37.8% (29.9/78.9)	33.9% (26.6/78.5)

See Table 13D for sources and notes.

TABLE 13C. Medicaid and CHIP Enrollment as a Percentage of Adults Age 19–64, 2009

Medicaid and CHIP Enrollment Among Adults Age 19–64	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	25.7 million	19.6 million	Not available
CHIP	0.4 million	0.3 million	Not available
Totals for Medicaid and CHIP	26.1 million	19.8 million	15.8 million
Adults Age 19–64	**Census Bureau**		**Survey Data (NHIS)**
	188.8 million	188.0 million	184.9 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 19–64			
	13.8%	10.5%	8.5%
	(26.1/188.8)	(19.8/188.0)	(15.8/184.9)

See Table 13D for sources and notes.

TABLE 13D. Medicaid and CHIP Enrollment as a Percentage of Adults Age 65 and Older, 2009

Medicaid and CHIP Enrollment Among Adults Age 65 and Older	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	6.1 million	5.4 million	Not available
CHIP	–	–	Not available
Totals for Medicaid and CHIP	6.1 million	5.4 million	2.7 million
Adults Age 65 and Older	**Census Bureau**		**Survey Data (NHIS)**
	39.7 million	39.4 million	38.0 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 65 and Older			
	15.4%	13.7%	7.2%
	(6.1/39.7)	(5.4/39.4)	(2.7/38.0)

Notes: Excludes U.S. territories. Medicaid enrollment numbers obtained from administrative data include 7.8 million individuals ever enrolled during the year who received limited benefits (e.g., emergency services only, Medicaid payment only for Medicare enrollees' cost sharing), of whom 0.6 million were under age 19, 5.8 million were age 19 to 64, and 1.4 million were 65 or older. In the event individuals were reported to be in both Medicaid and CHIP during the year, individuals are to be counted only once in the administrative data, based on their most recent source of coverage. Overcounting of enrollees in the administrative data may occur because individuals may move and be enrolled in two states' Medicaid programs during the year. The NHIS excludes individuals in institutions, such as nursing homes, and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage. Administrative data (with the exception of Massachusetts, for which FY 2008 values were used) and Census Bureau data are for FY 2009 (October 2008 through September 2009); the NHIS data are for sources of insurance at the time of the survey in calendar year 2009. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of September 2009 (the month in FY 2009 with the largest count); a number of residents ever living in the U.S. during the year is not available. The Census Bureau point-in-time number is the average estimated monthly number of U.S. residents for FY 2009.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from the Centers for Medicare & Medicaid Services (CMS) as of May 2012; CHIP Statistical Enrollment Data System (SEDS) from CMS as of May 2012, as reported by states; the National Health Interview Survey (NHIS); and U.S. Census Bureau data, Monthly Postcensal Resident Population, by single year of age, sex, race, and Hispanic origin (http://www.census.gov/popest/data/national/asrh/2009/2009-nat-res.html)

- Even after accounting for differences in their scope and design, MSIS still tends to produce lower total benefit spending than the CMS-64.[12]
- 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 14 for unadjusted benefit spending amounts in MSIS as a percentage of benefit spending in the CMS-64.

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

- 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 15 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 FFS hospital factor of 1.2, each Medicaid enrollee with hospital spending in MSIS would have that spending multiplied by 1.2; doing so makes the sum of adjusted hospital spending amounts among individual Medicaid enrollees in MSIS total the aggregate hospital spending reported by states in the CMS-64.[13]

By making these adjustments to the MSIS data, we are attempting to provide more complete estimates of Medicaid benefit spending across states that can be analyzed by eligibility group and other enrollee characteristics. Other organizations, including the Office of the Actuary at CMS, the Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute use methodologies that are similar to MACPAC's but may differ in various ways—for example, by using different service categories or producing estimates for future years based on actual data for earlier years.

Readers should note that MACPAC refined its methodology for adjusting MSIS benefit spending data following the publication of its March 2012 Report to the Congress. As a result, the current methodology used to produce FY 2009 spending figures presented in the June 2012 MACStats differs from the one used to produce FY 2008 spending figures presented in prior MACPAC reports. Key differences between the current and previous methodologies include:

- Separation of the "other" service type in MSIS into spending on: (1) home and community-based services (HCBS) waivers, and (2) non-HCBS waiver items and services. Since all spending on "other" in MSIS was previously categorized as "LTSS non-institutional," this change substantially reduced the number of non-disabled children and adults identified as having long-term services and supports (LTSS) spending.
- Shifting inpatient psychiatric services for individuals under age 21 and mental health facility services for individuals age 65 and older out of the hospital category and into the LTSS institutional category. Although some of these services may be provided in response to an acute episode, many are provided on a longer-term basis and are thus more appropriately categorized as LTSS.

TABLE 14. Medicaid Benefit Spending in MSIS and CMS-64 Data by State, FY 2009 (billions)

State	MSIS	CMS-64	MSIS as a Percentage of CMS-64
Total	**$321.7**	**$364.8**	**88.2%**
Alabama	3.6	4.4	82.1
Alaska	1.0	1.1	96.9
Arizona	8.6	8.7	99.4
Arkansas	3.5	3.5	100.9
California	35.0	41.4	84.5
Colorado	3.3	3.6	92.5
Connecticut	5.3	6.0	87.6
Delaware	1.3	1.2	104.3
District of Columbia	1.9	1.6	118.6
Florida	14.1	15.1	93.1
Georgia	7.4	7.7	95.9
Hawaii	1.2	1.3	89.5
Idaho	1.3	1.3	104.1
Illinois	11.7	13.1	88.7
Indiana	5.3	5.9	89.8
Iowa	2.9	3.0	96.9
Kansas	2.3	2.4	94.8
Kentucky	4.9	5.4	91.1
Louisiana	5.2	6.5	80.2
Maine	1.5	2.5	58.8
Maryland	6.1	6.5	93.8
Massachusetts[1]	8.8	10.8	81.0
Michigan	10.1	10.6	95.9
Minnesota	7.0	7.4	95.2
Mississippi	3.2	3.9	81.0
Missouri	5.7	7.7	73.2
Montana	0.7	0.9	81.6
Nebraska	1.5	1.6	95.2
Nevada	1.2	1.4	86.5
New Hampshire	1.0	1.3	74.9
New Jersey	7.9	9.7	81.4
New Mexico	2.6	3.3	78.7
New York	44.9	49.4	90.9
North Carolina	9.6	11.5	83.3
North Dakota	0.6	0.6	101.5
Ohio	13.6	14.2	96.3
Oklahoma	3.4	3.9	87.2
Oregon	2.8	3.7	76.1
Pennsylvania	14.2	17.2	82.4
Rhode Island	1.5	1.9	78.4
South Carolina	4.6	5.1	90.9
South Dakota	0.7	0.7	100.0
Tennessee	7.2	7.3	98.8
Texas	18.5	23.7	78.2
Utah	1.9	1.6	114.7
Vermont	1.0	1.2	81.4
Virginia	5.5	5.8	95.4
Washington	5.7	6.6	86.8
West Virginia	2.6	2.4	106.4
Wisconsin	5.7	6.7	85.9
Wyoming	0.6	0.5	104.9

Note: See text for a discussion of differences between MSIS and CMS-64 data. Both sources reflect unadjusted amounts as reported by states. Includes federal and state funds. Both sources exclude administrative spending, the territories, and Medicaid-expansion CHIP; in addition, the CMS-64 amounts exclude $7.3 billion in offsetting collections from third-party liability, estate, and other recoveries.

1 FY 2009 data unavailable for Massachusetts; FY 2008 values shown instead.

Sources: MACPAC analysis of MSIS Annual Person Summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2012

TABLE 15. Service Categories Used to Adjust FY 2009 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 hospital non-DSH ▶ Inpatient hospital DSH ▶ Outpatient 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 ▶ Hospice ▶ Targeted case management ▶ Physical, occupational, speech, and hearing therapy ▶ Non-emergency transportation ▶ Private duty nursing ▶ Rehabilitative services ▶ Other care, excluding HCBS waiver	▶ Physician ▶ Dental ▶ Other practitioner ▶ Non-hospital outpatient clinic ▶ Rural health clinic ▶ Federally qualified health center ▶ Lab/X-ray ▶ Sterilizations ▶ Abortions ▶ Hospice ▶ Targeted case management ▶ EPSDT screenings ▶ Care not otherwise categorized
Drugs	▶ Drugs (gross spending)	▶ Drugs (gross spending) ▶ Drug rebates
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) ▶ PACE ▶ PAHP ▶ PIHP ▶ PCCM ▶ Premium assistance for employer-sponsored coverage
LTSS non-institutional	▶ Home health ▶ Personal care ▶ HCBS waiver	▶ Home health ▶ Personal care ▶ HCBS waiver

TABLE 15, Continued

Service Category	MSIS Service Types	CMS-64 Service Types
LTSS institutional	▶ Nursing facility ▶ ICF-ID ▶ Inpatient psychiatric for under age 21 ▶ Mental health facility for the aged	▶ Nursing facility ▶ ICF-ID ▶ Mental health facility for under age 21 or age 65+ non-DSH ▶ Mental health facility for under age 21 or age 65+ DSH
Medicare[2, 3]		▶ Medicare Part A and Part B premiums ▶ Medicare coinsurance and deductibles for QMBs

Notes: DSH = disproportionate share hospital; EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; HCBS = home and community-based services; HMO = health maintenance organization; ICF-ID = intermediate care facility for persons with intellectual disabilities; LTSS = long-term services and supports; MCO = managed care organization; PACE = Program of All-Inclusive Care for the Elderly; PAHP = prepaid ambulatory health plan; PIHP = prepaid inpatient health plan; PHP = prepaid health plan, either a PAHP or a PIHP; 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 on the distribution of spending for these categories among QMBs in MSIS.

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

- Shifting rehabilitation, private duty nursing, targeted case management, and hospice out of the LTSS non-institutional category and into the non-hospital acute care category. After a review of the definitions used in various analyses and in recent legislation and regulations, MACPAC determined that these four services were not consistently referred to as LTSS and therefore adjusted its LTSS categorization to exclude them.

Managed Care Enrollment and Spending Guide

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

- **Medicaid Managed Care Data Collection System (MMCDCS).** The 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,[14] 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),[15] each of which may include several managed care plans.

- **MSIS.** The MSIS provides person-level and claims-level information for all Medicaid enrollees.[16] With regard to managed care, the information collected for each enrollee includes: (1) plan ID numbers and types for up to four managed care plans (including comprehensive risk-based plans, primary care case management programs, and limited-benefit plans) under which the enrollee is covered, (2) the waiver ID number, if enrolled in a 1915(b) or other waiver, (3) claims that provide a record of each capitated payment made on behalf of the enrollee to a managed care plan (these are generally referred to as capitated claims), and (4) in some states, a record of each service received by the enrollee from a provider under contract with a managed care plan (these generally do not include a payment amount and are referred to as encounter or "dummy" claims). As discussed in MACPAC's March 2011 and June 2011 Reports to the Congress, all states collect encounter data from their Medicaid managed care plans, but some do not report them in MSIS. Managed care enrollees may also have FFS claims in MSIS if they used services that were not included in their managed care plan's contract with the state.
- **CMS-64.** The CMS-64 provides aggregate spending information for Medicaid by major benefit categories, including managed care. The spending amounts reported by states on the CMS-64 are used to calculate their federal matching dollars.
- **Statistical Enrollment Data System (SEDS).** The SEDS provides aggregate statistics on CHIP enrollment and child Medicaid enrollment that include the number covered under FFS and managed care systems. SEDS is the only comprehensive source of information on managed care participation among separate CHIP enrollees across states; 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 Tables 9 and 10, the statistics cited on managed care are from CMS's 2010 Medicaid managed care enrollment report. However, this enrollment report does not provide information on characteristics of enrollees in managed care aside from dual eligibility for Medicare (e.g., basis of eligibility and demographics such as age, sex, and race/ethnicity). It also does not include information on their spending and service use outside of managed care. 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 various populations in managed care and the percentage of their Medicaid benefit spending accounted for by managed care.

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

- Figures in the annual Medicaid managed care enrollment report published by CMS include Medicaid-expansion CHIP enrollees. Although we generally exclude these children (about 2 million, depending on the time period) from Medicaid analyses, it is not possible to do so with the enrollment report data cited for Tables 9 and 10. Tables 11 and 12—which show the percentage of child, adult, disabled, aged, and dual-eligible enrollees who are enrolled in Medicaid managed care and the percentage of their Medicaid benefit spending that was for managed care—are based on MSIS data and exclude Medicaid-expansion CHIP enrollees.[17]
- The types of managed care reported by states may differ somewhat between the Medicaid managed care enrollment report and the

MSIS. For example, some states report a small number of enrollees in comprehensive risk-based managed care in one data source but not the other (Tables 9 and 11). Anomalies in the MSIS data are documented by CMS as it reviews each state's quarterly submission,[18] 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 July 1, 2010). 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).

Endnotes

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

2 Table 13A is modeled after Table 1 in the March 2012 edition of MACStats (Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2012 (Washington, DC: MACPAC, 2012), 87. http://www.macpac.gov/reports/). Table 1 of the March 2012 MACStats shows estimates for 2011 and is partly based on projections by the CMS Office of the Actuary that use administrative data. To produce the age breaks used in Tables 13B–D, however, numbers were calculated by MACPAC directly from the MSIS. FY 2009 is the latest year for which data are available in MSIS for all but one state.

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

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

5 See, for example, Centers for Medicare & Medicaid Services (CMS), Brief summaries and glossary in *Health care financing review 2010 statistical supplement* (Baltimore, MD: CMS, 2010). https://www.cms.gov/MedicareMedicaidStatSupp/LT/list.-asp.

6 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 was 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, regardless of whether or not they have any health service use.

7 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.

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

9 Medicaid benefit spending reported here excludes Medicaid-expansion CHIP, 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.

10 For a discussion of these data sources, see Medicaid and CHIP Payment and Access Commission (MACPAC), Improving Medicaid and CHIP data for policy analysis and program accountability, in *Report to the Congress on Medicaid and CHIP,* March 2011 (Washington, DC: MACPAC, 2011). http://www.macpac.gov/reports/MACPAC_ March2011_ web.pdf.

11 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.

12 Some of these amounts, including disproportionate share hospital (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.

13 The sum of adjusted MSIS benefit spending amounts for all service categories totals CMS-64 benefit spending, exclusive of offsetting collections from third-party liability, estate, and other recoveries. These collections, 7.3 billion in FY 2009, are not reported by type of service in the CMS-64 and are not reported at all in MSIS.

14 Centers for Medicare & Medicaid Services (CMS), *Medicaid managed care enrollment report* (Baltimore, MD: CMS). https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MdManCrEnrllRep.html.

15 Centers for Medicare & Medicaid Services (CMS), *Description of state programs* (Baltimore, MD: CMS). https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/DescStateProg.html.

16 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.).

17 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.

18 See Centers for Medicare & Medicaid Services (CMS), *MSIS state anomalies/issues: All states*, January 28, 2009, (Baltimore, MD: CMS, 2009). http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads//anomalies1.pdf.