MACStats: Medicaid and CHIP Program Statistics

MACStats Table of Contents

Overview

MACStats, a standing section in all MACPAC reports to the Congress, presents data and information on Medicaid and the State Children's Health Insurance Program (CHIP) that otherwise can be difficult to find and are spread out across multiple sources. The June 2013 edition of MACStats is divided into five sections, each prefaced by key points.

Section 1: Trends in Medicaid Enrollment and Spending

- Growth in Medicaid spending and enrollment has varied over the years, reflecting shifts in federal and state policy along with changing economic conditions (Figure 1).
- Individuals qualifying for Medicaid on the basis of a disability accounted for half of real Medicaid spending growth since fiscal year (FY) 1975 (Table 2). Over the same period, non-disabled children accounted for the largest Medicaid enrollment increase in absolute numbers.

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

- The characteristics of individuals enrolled in Medicaid and CHIP differ from those with other types of coverage, but there is also great diversity within the Medicaid/CHIP population (Tables 3–11).
- Medicaid/CHIP enrollees generally report being in poorer health and using more services than individuals who have other health insurance or who are uninsured (Tables 4, 7, and 10).

Section 3: Medicaid Enrollment and Benefit Spending

- Individuals eligible on the basis of a disability and those aged 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Tables 12 and 13).
- Medicaid spending per enrollee is affected by large numbers of individuals with limited benefits in some states (Table 14).
- Users of Medicaid long-term services and supports are a small but high-cost population (Figures 5–7).

Section 4: Medicaid Managed Care

- About half of Medicaid enrollees are in comprehensive risk-based managed care plans. When limited-benefit plans and primary care case management programs are also included, more than 70 percent of enrollees are in some form of managed care (Tables 15 and 17).
- The share of enrollees in comprehensive risk-based plans in FY 2010 was 62 percent among non-disabled children, 47 percent among non-disabled adults, 29 percent among individuals eligible on the basis of a disability, and 12 percent among those aged 65 and older (Table 17).

Section 5: Technical Guide to the June 2013 MACStats

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

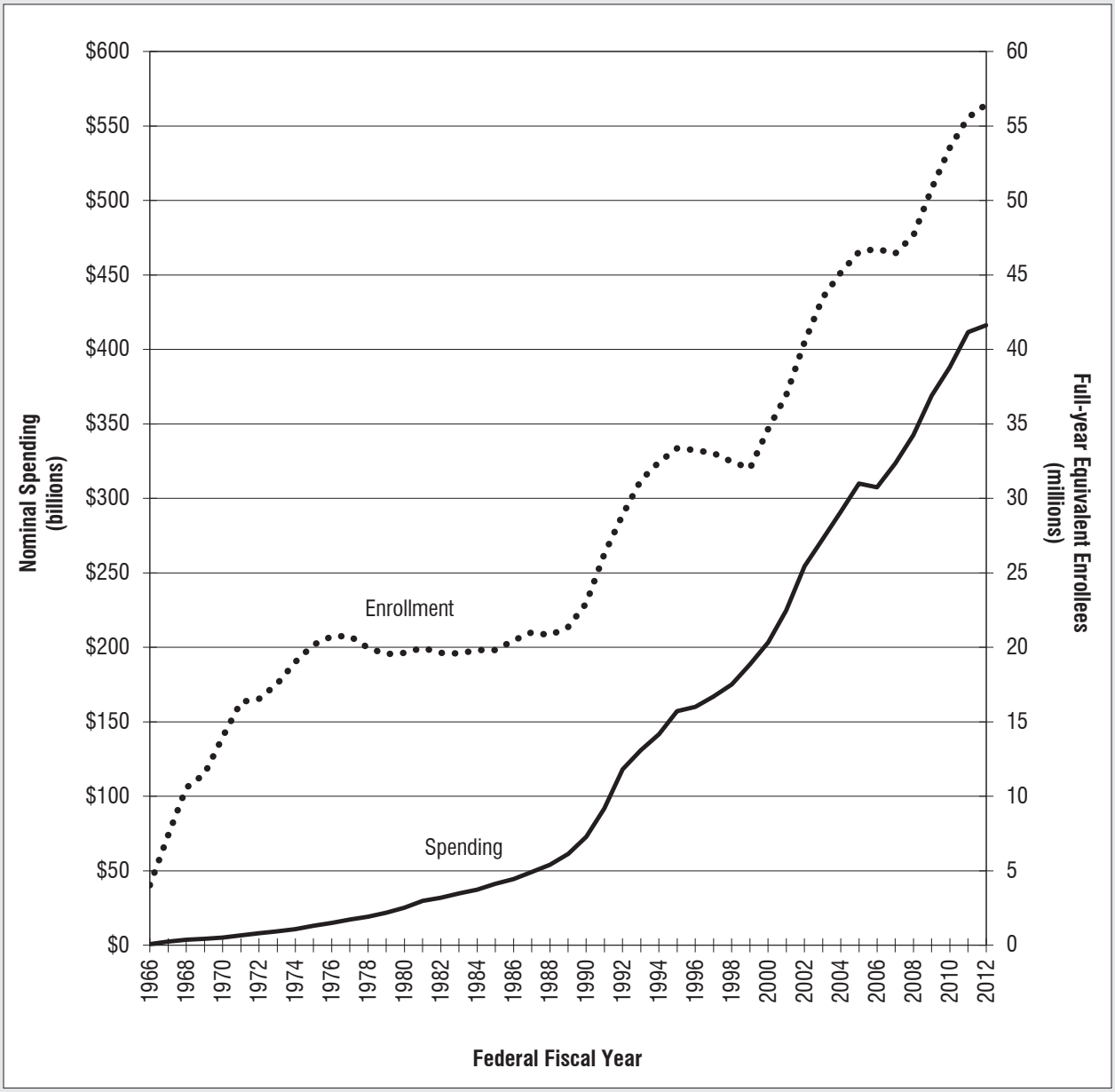
SECTION 1

Key Points

Trends in Medicaid Enrollment and Spending

- Medicaid spending and enrollment are affected by both federal and state policy choices and economic factors. For example, the Congress made a number of changes that expanded eligibility for pregnant women and children between 1984 and 1990, with delayed effective dates or phase-in provisions that resulted in substantial enrollment growth through the mid-1990s (Figure 1). Economic recessions spurred enrollment growth at the beginning and end of the first decade of the 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 (adjusted for health care inflation) growth in Medicaid spending between FY 1975 and FY 2010, 50.9 percent was attributable to individuals qualifying for Medicaid on the basis of a disability. About 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).
- Enrollment trends vary by eligibility group. Children (excluding those eligible on the basis of a disability) experienced the largest enrollment increase in absolute numbers, from 9.6 million in FY 1975 to 30.0 million in FY 2010 (Table 2). However, enrollment among the smaller group of individuals qualifying for Medicaid on the basis of a disability showed the largest annual growth rate over this time period (3.9 percent).

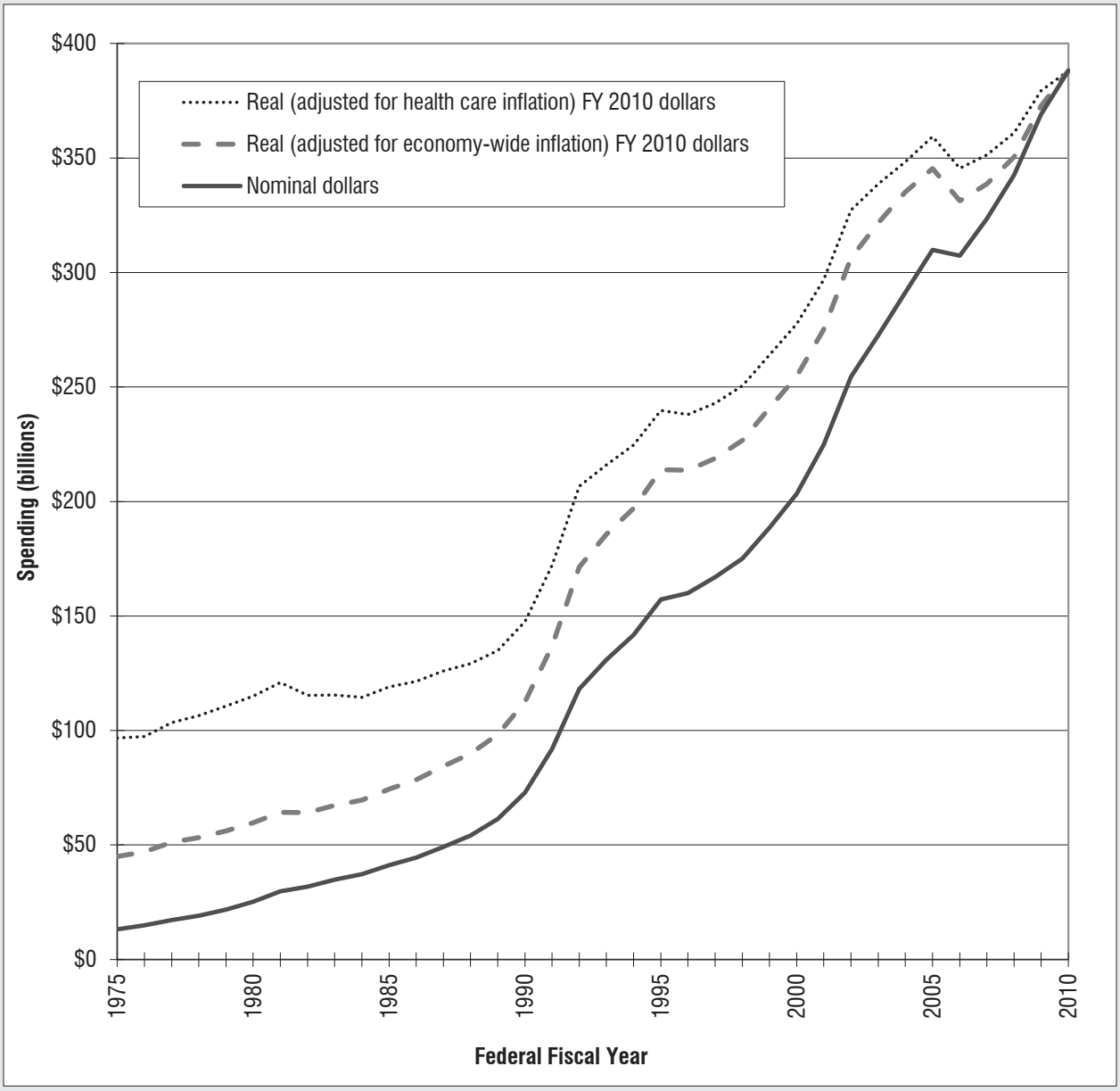
FIGURE 1. Medicaid Enrollment and Spending, FY 1966–FY 2012



Notes: Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Numbers exclude coverage financed by CHIP. Enrollment data for fiscal year (FY) 2010–2012 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 Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, April 2013.

FIGURE 2. Medicaid Spending in Nominal and Real Dollars, FY 1975–FY 2010



Notes: Spending includes benefits and administrative spending. The bottom line in the figure shows actual (nominal) spending. The middle line transforms nominal Medicaid spending to real fiscal year (FY) 2010 dollars by adjusting for economy-wide inflation, using the gross domestic product (GDP) price deflator. The top line also shows real FY 2010 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 based on data compilation from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, April 2013; real spending based on MACPAC analysis of nominal spending and quarterly National Income and Product Account (NIPA) historical tables for Quarter 4 of 2012 from the Bureau of Economic Analysis, U.S. Department of Commerce (http://www.bea.gov/histdata/Nlyear.asp).

TABLE 1. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FY 1975–FY 2010 (thousands)

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

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

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 aged 65 and older in the disabled category. Unlike the majority of the June 2013 MACStats, this table (along with Table 2) does not recode individuals aged 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 12 for the number of Medicaid enrollees in FY 2010, which is larger than the number of beneficiaries. FY 2010 unavailable for Idaho and Missouri; FY 2009 values used instead.

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

TABLE 2. Components of Growth in Real Medicaid Benefit Spending, FY 1975–FY 2010

		FY 1975 (in FY 2010 dollars)	FY 2010[1]	Annual Growth Rate	Relative Contribution to Real Spending Growth, FY 1975 to FY 2010
All eligibility groups					
	Spending per beneficiary	$4,463	$6,588[2]	1.1%	29.7%
	Number of beneficiaries (millions)	20.2	59.0	3.1	70.3
	Total benefit spending (millions)	**$90,181**	**$388,611**	**4.3**	**100.0**
Children					
	Spending per beneficiary	$1,748	$2,481[2]	1.0	3.2
	Number of beneficiaries (millions)	9.6	30.0	3.3	16.1
	Total benefit spending (millions)	**$16,776**	**$74,398**	**4.3**	**19.3**
Adults					
	Spending per beneficiary	$3,494	$3,726[2]	0.2	0.4
	Number of beneficiaries (millions)	4.5	15.4	3.6	13.5
	Total benefit spending (millions)	**$15,825**	**$57,256**	**3.7**	**13.9**
Disabled					
	Spending per beneficiary	$9,795	$18,857[2]	1.9	12.7
	Number of beneficiaries (millions)	2.5	9.3	3.9	38.3
	Total benefit spending (millions)	**$24,136**	**$176,143[3]**	**5.8**	**50.9**
Aged					
	Spending per beneficiary	$9,252	$18,841[2]	2.1	13.4
	Number of beneficiaries (millions)	3.6	4.3	0.5	2.4
	Total benefit spending (millions)	**$33,445**	**$80,815[3]**	**2.6**	**15.9**

Notes: Beneficiaries are shown here because they provide the only historical time series data available prior to fiscal year (FY) 1990. Most current analyses of individuals in Medicaid reflect enrollees, as shown in Table 12. 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 (GDP) price deflator for health care. In this table, real Medicaid spending growth is attributed to spending per beneficiary and number of beneficiaries. The effect of the interaction between these two factors is allocated between them in proportion to each factor's contribution to spending growth.

The number of beneficiaries excludes individuals whose basis of Medicaid eligibility is unknown. In this analysis, FY 1975 benefit spending for these individuals with an unknown basis of eligibility was allocated proportionally to the four eligibility groups in the table. FY 2010 benefit spending reflects Medicaid Statistical Information System (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 2010 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 2010 data unavailable for Idaho and Missouri; FY 2009 values used instead.

[2] Benefit spending per beneficiary shown here differs from the FY 2010 benefit spending per full-year equivalent (FYE) enrollee shown in Table 14 and Figure 4. Per beneficiary numbers are used here because they are the only readily available data prior to FY 1990; they reflect the average amount spent on individuals for whom at least one Medicaid payment was made during the year. Per FYE numbers reflect the average amount spent on individuals enrolled in Medicaid for the entire year.

[3] Total benefit spending shown here differs from the FY 2010 benefit spending in Table 13 and Figure 3. Unlike the majority of the June 2013 MACStats, this table (along with Table 1) does not recode individuals aged 65 and older who are reported as eligible on the basis of a disability.

Sources: MACPAC analysis of CMS 2012 Medicare and Medicaid Statistical Supplement data from Tables 13.4 and 13.10 (for FY 1975) and Medicaid Statistical Information System (MSIS) annual person summary (APS) and CMS-64 net financial management report data as of May 2013 (for FY 2010).

Health and Other Characteristics of Medicaid/CHIP Populations

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

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

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

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

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

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

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

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

Key Points

Health and Other Characteristics of Medicaid/CHIP Populations

Children under age 19 (Tables 3-5)

- More than a third (36.2 percent) of children were reported to be Medicaid or CHIP enrollees at the time of the survey, while 54.5 percent of children were in private coverage, and 8 percent were uninsured.
- Children enrolled in Medicaid or CHIP were more likely to be Hispanic (34.4 percent) than are privately insured children (12.5 percent) and less likely to be Hispanic than are uninsured children (39.3 percent); Medicaid/CHIP children were more likely to be non-Hispanic black (23.7 percent) than are privately insured (10 percent) or uninsured children (12.3 percent).
- Children enrolled in Medicaid or CHIP were more likely than privately insured or uninsured children to be in fair or poor health and to have certain impairments and health conditions (e.g., attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD), asthma, autism).
- Children enrolled in Medicaid or CHIP were more likely to have had a visit to the emergency department (ED) in the past year and to have been regularly taking prescription medications for at least three months.
- Differences in self-reported health status exist among children enrolled in Medicaid or CHIP. Among these children, 22.7 percent of those receiving Supplemental Security Income (SSI) were reported to be in fair or poor health, compared to 13.8 percent for non-SSI children with special health care needs (CSHCN) and less than 1 percent for children who are neither SSI nor CSHCN.
- Prevalence of specific health conditions varies among children enrolled in Medicaid or CHIP. The prevalence of ADHD/ADD among children enrolled in Medicaid or CHIP was 38.8 percent for children receiving SSI, 38.2 percent for non-SSI CSHCN, and 2.1 percent for children who were neither receiving SSI nor CSHCN. The prevalence of asthma for children receiving SSI was 32.3 percent, compared to 40.2 percent for non-SSI CSHCN and 11.1 percent for children who were neither SSI nor CSHCN.
- SSI children and non-SSI CSHCN were each nearly twice as likely to visit health care providers four or more times within a year as are children with Medicaid or CHIP who are neither SSI nor CSHCN.

Adults aged 19 to 64 (Tables 6-8)

- Nearly 1 in 10 (9.5 percent) of non-institutionalized adults aged 19 to 64 reported that they were enrolled in Medicaid.
- Medicaid enrollees in this age group were more likely to be female and to be the parent of a dependent child, compared to those with private insurance, Medicare, or no insurance.
- Adults younger than 65 enrolled in Medicaid (who are generally eligible on the basis of being the parent of a dependent child, pregnant, or disabled) reported that they were in worse health than were those enrolled in private coverage or the uninsured, but were in better health than those enrolled in Medicare (nearly all of whom are eligible for that program on the basis of a disability).
- Adults younger than 65 enrolled in Medicaid were more likely than those with private insurance to have had four or more visits to a doctor or other health professional in the past 12 months.
- Adults with Medicaid were more likely than those with private insurance or no insurance to have visited the ED during the past year. Even after controlling for differences in enrollees' health, demographic, and socioeconomic characteristics, adults younger than 65 enrolled in Medicaid were still more likely to have had an ED visit.
- Among 19- to 64-year-olds, nearly all individuals who are dually enrolled in both Medicaid and Medicare qualify for these programs on the basis of a disability.
- Among adults younger than 65 enrolled in Medicaid, 11.3 percent reported they were also enrolled in Medicare. Conversely, of the Medicare enrollees in this age group, 30.3 percent also were enrolled in Medicaid.
- Differences in self-reported health exist among 19- to 64-year-olds enrolled in Medicaid. Individuals dually enrolled in Medicaid and Medicare, as well as non-dual SSI beneficiaries report fair or poor health (61.2 and 56.5 percent, respectively) 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 have limitations in activities of daily living (ADLs)—as well as the presence of chronic conditions such as heart disease, diabetes, depression, chronic bronchitis, and arthritis—than the overall Medicaid population for this age group.
- Persons with disabilities also had higher use of care—in particular, for at-home care and visits to a doctor or other health professional in the past 12 months—than 19- to 64-year-old Medicaid enrollees overall. 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 aged 65 and older (Tables 9-11)

- Among non-institutionalized adults aged 65 and older, 7.5 percent reported being enrolled in Medicaid. Most of these Medicaid enrollees (92.1 percent) reported being dually eligible for Medicare, which covered nearly all individuals aged 65 and older.
- Medicaid enrollees aged 65 and older were more likely to be female and less likely to be white (non-Hispanic) than were those with Medicare or private coverage.
- Compared to those enrolled in private coverage or Medicare, Medicaid enrollees aged 65 and older were more likely to report being in fair or poor health, being in worse health compared to 12 months before, and having any of several limitations in their ADLs. Medicaid enrollees aged 65 and older were also more likely to have lost all of their natural teeth, or have any of a number of specific chronic conditions (e.g., depression, diabetes, chronic bronchitis).
- Medicaid enrollees aged 65 and older were also more likely than those with private or Medicare coverage to have received at-home care, to have had multiple visits to a doctor or other health professional, and to have visited an ED in the past 12 months.
- Because more than three-quarters of Medicaid enrollees aged 65 and older had functional limitations, these individuals drive the overall characteristics of enrollees in this age range, and thus do not show significant differences from the total as often as do those with no functional limitations.
- Compared to the overall group of Medicaid enrollees aged 65 and older, Medicaid enrollees who had no functional limitations were less likely to be 85 years old or older, to report being in fair or poor health, and to have any of several specific chronic health conditions. They were also less likely to have visited a doctor or other health professional, or to have visited an ED in the past 12 months.

TABLE 3. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Aged 0–18 by Source of Health Insurance, 2009–2011

		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		**36.2%**	54.5%	8.0%	**100.0%**	3.3%	17.9%	78.8%
Age (categories sum to 100%)								
0–5	32.5%*	**39.1%**	29.3%*	23.7%*	**39.1%**	17.2%*	26.5%*	42.9%*
6–11	30.9	**30.9**	31.0	29.7	**30.9**	38.1*	36.1*	29.4
12–18	36.6*	**30.0**	39.6*	46.6*	**30.0**	44.7*	37.4*	27.7*
Gender (categories sum to 100%)								
Male	51.3%	**50.9%**	51.6%	52.4%	**50.9%**	61.7%*	59.2%*	48.6%*
Female	48.7	**49.1**	48.4	47.6	**49.1**	38.3*	40.8*	51.4*
Race (categories sum to 100%)								
Hispanic	22.7%*	**34.4%**	12.5%*	39.3%*	**34.4%**	24.3%*	23.4%*	37.4%*
White, non-Hispanic	56.3*	**37.7**	71.2*	41.4*	**37.7**	37.8	47.5*	35.4
Black, non-Hispanic	15.3*	**23.7**	10.0*	12.3*	**23.7**	34.7*	26.9*	22.4
Other and multiple races, non-Hispanic	5.6*	**4.3**	6.3*	6.9*	**4.3**	3.3	2.2*	4.8
Health insurance								
Medicaid/CHIP	36.2%*	**100.0%**	2.4%*	–	**100.0%**	100.0%	100.0%	100.0%
Private	54.5*	**3.6**	100.0*	–	**3.6**	7.9*	6.1*	2.9

See Table 5 for notes.

Source: MACPAC analysis of the 2009-2011 National Health Interview Survey (NHIS).

TABLE 4. Health Characteristics of Non-Institutionalized Individuals Aged 0–18 by Source of Health Insurance, 2009–2011

		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)	1.4%*	**3.3%**	0.4%*	0.4%*	**3.3%**	100.0%*	–	–
Children with special health care needs (CSHCN)[5]	15.3*	**20.4**	13.0*	10.7*	**20.4**	76.4*[6]	100.0%*	–
Current health status (categories sum to 100%)								
Excellent or very good	82.7%*	**73.2%**	89.2%*	79.1%*	**73.2%**	42.0%*	53.6%*	79.0%*
Good	15.2*	**22.8**	9.9*	19.0*	**22.8**	35.3*	32.6*	20.1*
Fair or poor	2.1*	**3.9**	1.0*	2.0*	**3.9**	22.7*	13.8*	0.9*
Impairments								
Impairment requiring special equipment	1.2%*	**1.6%**	1.1%*	0.7%*	**1.6%**	11.2%*	5.0%*	0.4%*
Impairment limits ability to crawl, walk, run, play[7]	2.0*	**3.1**	1.5*	1.3*	**3.1**	19.9*	10.8*	0.5*
Impairment lasted, or expected to last 12+ months[8]	1.8*	**2.8**	1.3*	1.1*	**2.8**	19.9*	9.9*	0.4*
Specific health conditions								
Ever told child has:								
ADHD/ADD[8]	7.9%*	**10.7%**	6.8%*	5.2%*	**10.7%**	38.8%*	38.2%*	2.1%*
Asthma	13.9*	**17.0**	12.4*	11.0*	**17.0**	32.3*	40.2*	11.1*
Autism[7]	1.0*	**1.3**	0.9*	0.5*	**1.3**	14.0*	4.0*	0.0*
Cerebral palsy[7]	0.3*	**0.4**	0.2*	†	**0.4**	6.2*	1.3*	†
Congenital heart disease	1.3*	**1.7**	1.1*	0.8*	**1.7**	7.1*	5.0*	0.8*
Diabetes	0.2	**0.3**	0.2	†	**0.3**	†	1.4*	†
Down syndrome[7]	0.1*	**0.2**	0.1*	†	**0.2**	3.6*	0.6*	†
Intellectual disability (mental retardation)[7]	0.8*	**1.4**	0.5*	†	**1.4**	16.2*	4.6*	0.0*
Other developmental delay[7]	4.3*	**5.8**	3.8*	3.1*	**5.8**	43.1*	19.9*	0.9*
Sickle cell anemia[7]	0.1*	**0.3**	0.0*	†	**0.3**	1.6	0.8*	0.1*

See Table 5 for notes.

Source: MACPAC analysis of the 2009-2011 National Health Interview Survey (NHIS).

TABLE 5. Use of Care by Non-Institutionalized Individuals Aged 0–18 by Source of Health Insurance, 2009–2011

		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]	79.4%*	**81.1%**	82.1%	51.6%*	**81.1%**	81.6%	85.1%*	80.2%
Regularly taking prescription drug(s) for 3+ months[8]	13.4*	**15.7**	13.3*	5.7*	**15.7**	45.0*	54.3*	5.3*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)								
None	10.1%*	**8.8%**	7.4%*	32.9%*	**8.8%**	5.6%*	3.4%*	10.2%*
1	20.5*	**18.8**	20.8*	24.9*	**18.8**	11.6*	10.1*	21.1*
2–3	36.7	**35.5**	38.8*	27.5*	**35.5**	24.7*	26.8*	38.0*
4+	32.7*	**36.8**	33.0*	14.7*	**36.8**	58.2*	59.7*	30.8*
Number of emergency room visits in past 12 months (categories sum to 100%)								
None	79.4%*	**72.1%**	83.7%*	83.4%*	**72.1%**	67.8%	57.6%*	75.6%*
1	13.5*	**16.5**	11.9*	10.5*	**16.5**	16.8	18.7*	16.0
2–3	5.7*	**8.6**	3.8*	4.8*	**8.6**	8.5	16.3*	6.9*
4+	1.5*	**2.8**	0.6*	1.3*	**2.8**	7.0*	7.4*	1.6*

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

† 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.

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

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

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

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

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

[6] For a child to be eligible for SSI, one of the criteria is that the child has a medically determinable physical or mental impairment(s) that results in marked and severe functional limitations and generally is expected to last at least 12 months or result in death. Thus, children who are eligible for SSI should meet the criteria for being a CSHCN; however, some do not. While we do not have enough information to assess the reasons that these Medicaid/CHIP children who are reported to have SSI did not meet the criteria for CSHCN, it could be because: (1) the 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 aged 0 to 17.

[8] Question only asked for children aged 2 to 17.

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

TABLE 6. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Aged 19–64 by Source of Health Insurance, 2009–2011

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults Aged 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults aged 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Health Insurance Coverage		**9.5%**	65.2%	3.5%	21.3%	**100.0%**	11.4%	15.0%	73.6%
Age (categories sum to 100%)									
19–24	13.6%*	**19.7%**	11.0%*	1.8%*	19.7%	**19.7%**	2.6%*	11.5%*	23.9%*
25–44	43.5*	**46.8**	42.2*	20.8*	49.9*	**46.8**	30.8*	36.1*	51.6*
45–54	23.7*	**19.2**	25.6*	28.6*	19.2	**19.2**	33.6*	27.9*	15.2*
55–64	19.2*	**14.4**	21.2*	48.8*	11.3*	**14.4**	33.0*	24.5*	9.4*
Gender (categories sum to 100%)									
Male	49.2%*	**35.5%**	49.0%*	49.0%*	54.6%*	**35.5%**	43.1%*	42.4%*	32.9%*
Female	50.8*	**64.5**	51.0*	51.0*	45.4*	**64.5**	56.9*	57.6*	67.1*
Race (categories sum to 100%)									
Hispanic	15.3%*	**21.1%**	9.7%*	8.7%*	30.1%*	**21.1%**	9.0%*	13.5%*	24.7%*
White, non-Hispanic	66.3*	**49.5**	74.4*	69.4*	49.5	**49.5**	64.3*	54.0	46.4*
Black, non-Hispanic	12.5*	**24.0**	9.6*	19.5*	14.9*	**24.0**	24.7	28.0	23.0
Other and multiple races, non-Hispanic	5.9	**5.3**	6.3*	2.4*	5.5	**5.3**	2.0*	4.6	6.0
Family characteristics									
Parent of a dependent child[5]	38.0%*	**49.2%**	38.0%*	13.3%*	35.7%*	**49.2%**	13.7%*	16.5%*	61.5%*
Health insurance									
Medicaid/CHIP	9.5%*	**100.0%**	0.4%*	30.3%*	–	**100.0%**	100.0%	100.0%	100.0%
Medicare	3.5*	**11.3**	1.1*	100.0*	–	**11.3**	100.0*	–	–
Private	65.2*	**2.6**	100.0*	21.2*	–	**2.6**	2.2	2.7	2.7

See Table 8 for notes.

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

TABLE 7. Health Characteristics of Non-Institutionalized Individuals Aged 19–64 by Source of Health Insurance, 2009–2011

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults Aged 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults aged 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Disability and work status									
Receives Supplemental Security Income (SSI)	2.4%*	**19.9%**	0.3%*	21.1%	0.4%*	**19.9%**	42.7%*	100.0%*	–
Receives Social Security Disability Insurance (SSDI)	3.5*	**14.4**	1.4*	63.9*	0.5*	**14.4**	67.2*	18.2*	5.5%*
Working	70.3*	**33.5**	81.2*	10.9*	59.8*	**33.5**	8.2*	7.2*	42.8*
Current health status (categories sum to 100%)									
Excellent or very good	63.6%*	**40.5%**	71.3%*	12.9%*	55.5%*	**40.5%**	10.8%*	16.4%*	50.1%*
Good	25.3*	**29.4**	22.5*	27.9	31.7*	**29.4**	28.0	27.1	30.0
Fair or poor	11.1*	**30.1**	6.3*	59.2*	12.8*	**30.1**	61.2*	56.5*	19.9*
Health compared to 12 months ago (categories sum to 100%)									
Better	19.2%*	**20.6%**	19.5%	16.8%*	18.0%*	**20.6%**	20.0%	19.5%	21.0%
Worse	8.1*	**15.2**	5.9*	26.0*	9.6*	**15.2**	26.4*	21.4*	12.2*
Same	72.7*	**64.2**	74.6*	57.2*	72.3*	**64.2**	53.6*	59.1*	66.9*
Activities of daily living (ADLs)									
Help with any personal care needs[6]	1.3%*	**6.3%**	0.5%*	13.1%*	0.6%*	**6.3%**	19.6%*	17.0%*	2.2%*
Help with bathing/showering	0.7*	**4.3**	0.2*	7.7*	0.3*	**4.3**	12.5*	12.8*	1.3*
Help with dressing	0.7*	**3.7**	0.3*	7.5*	0.3*	**3.7**	11.4*	10.9*	1.1*
Help with eating	0.3*	**1.7**	0.1*	3.0*	0.1*	**1.7**	5.7*	5.3*	0.4*
Help with transferring (in/out of bed or chairs)	0.6*	**3.1**	0.2*	6.6*	0.3*	**3.1**	10.2*	7.9*	1.1*
Help with toileting	0.4*	**2.5**	0.2*	4.5*	0.1*	**2.5**	7.7*	7.2*	0.7*
Help getting around in home	0.5*	**2.8**	0.2*	5.7*	0.2*	**2.8**	9.3*	6.6*	1.0*
Number of above ADLs reported (categories sum to 100%)									
0	98.7%*	**93.7%**	99.5%*	86.9%*	99.4%*	**93.7%**	80.4%*	83.0%*	97.9%*
1	0.2*	**0.8**	0.1*	2.1*	0.2*	**0.8**	3.0*	1.7	0.3*
2	0.2*	**1.0**	0.1*	1.8*	0.1*	**1.0**	2.2*	3.1*	0.3*
3	0.3*	**1.2**	0.1*	3.1*	0.1*	**1.2**	4.3*	2.7*	0.4*
4+	0.6*	**3.3**	0.2*	6.0*	0.2*	**3.3**	10.0*	9.4*	1.1*

TABLE 7, Continued

	Adults Aged 19–64	Selected Sources of Insurance[1]				Medicaid[2]			
		Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults aged 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Specific health conditions									
Currently pregnant[7]	3.5%*	**9.7%**	2.8%*	†	1.6%*	**9.7%**	†	3.1%*	11.2%
Functional limitation[8]	29.7*	**47.7**	26.1*	84.5%*	27.6*	**47.7**	84.9%*	76.8*	36.0*
Difficulty walking without equipment	3.2*	**11.5**	1.7*	31.3*	2.0*	**11.5**	32.6*	24.6*	5.6*
Health condition that requires special equipment (e.g., cane, wheelchair)	4.1*	**11.8**	2.7*	32.8*	2.4*	**11.8**	32.8*	24.7*	6.0*
Lost all natural teeth	4.5*	**8.8**	3.3*	18.5*	5.0*	**8.8**	20.7*	16.7*	5.4*
Depressed/anxious feelings[9]	13.1*	**27.9**	8.6*	37.9*	18.0*	**27.9**	44.5*	41.1*	22.8*
Ever told had hypertension	23.5*	**30.9**	23.1*	57.0*	18.0*	**30.9**	53.8*	47.2*	24.1*
Ever told had coronary heart disease	2.5*	**4.4**	2.3*	14.0*	1.4*	**4.4**	11.7*	7.9*	2.6*
Ever told had heart attack	1.8*	**3.8**	1.4*	11.6*	1.4*	**3.8**	9.9*	6.5*	2.3*
Ever told had stroke	1.5*	**4.2**	1.0*	11.1*	1.1*	**4.2**	11.6*	8.6*	2.2*
Ever told had cancer	5.2	**5.8**	5.6	13.1*	2.8*	**5.8**	11.3*	9.5*	4.2*
Ever told had diabetes	6.8*	**12.5**	6.1*	25.2*	5.0*	**12.5**	27.2*	21.6*	8.5*
Ever told had arthritis	17.7*	**24.5**	17.6*	53.5*	11.3*	**24.5**	53.2*	39.5*	17.0*
Ever told had asthma	13.1*	**20.0**	12.2*	23.5*	12.1*	**20.0**	28.9*	27.2*	17.1*
Past 12 months, told had chronic bronchitis	4.0*	**8.2**	3.1*	15.0*	3.5*	**8.2**	17.4*	14.2*	5.6*
Past 12 months, told had liver condition	1.4*	**3.4**	1.0*	6.1*	1.2*	**3.4**	7.2*	7.3*	2.1*
Past 12 months, told had weak/failing kidneys	1.3*	**4.1**	0.8*	8.8*	1.3*	**4.1**	11.6*	6.3*	2.5*

See Table 8 for notes.

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

TABLE 8. Use of Care by Non-Institutionalized Individuals Aged 19–64 by Source of Health Insurance, 2009–2011

		Selected Sources of Insurance[1]				Medicaid[2]			
	Adults Aged 19–64	Medicaid[2]	Private[3]	Medicare	Uninsured[4]	Medicaid adults aged 19–64	Medicare (dual eligibles)	Non-dual SSI	Neither SSI nor Medicare
Received at-home care in past 12 months	1.2%*	**4.7%**	0.9%*	9.1%*	0.4%*	**4.7%**	15.4%*	8.2%*	2.3%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)									
None	21.9%*	**14.0%**	15.3%*	6.0%*	47.6%*	**14.0%**	4.9%*	8.9%*	16.3%*
1	17.8*	**12.6**	19.0*	4.9*	17.7*	**12.6**	4.2*	8.7*	14.7*
2–3	26.1*	**20.6**	29.9*	17.0*	17.1*	**20.6**	17.2	15.0*	22.2
4+	34.2*	**52.9**	35.8*	72.1*	17.5*	**52.9**	73.7*	67.4*	46.8*
Number of emergency room visits in past 12 months (categories sum to 100%)									
None	79.8%*	**60.3%**	83.6%*	59.6%	78.5%*	**60.3%**	53.2%*	54.5%*	62.5%*
1	12.7*	**18.6**	11.6*	17.8	12.5*	**18.6**	17.7	19.3	18.6
2–3	5.3*	**13.0**	3.7*	13.4	6.2*	**13.0**	17.3*	14.5	12.0
4+	2.3*	**8.1**	1.0*	9.1	2.8*	**8.1**	11.9*	11.7*	6.8*

Notes: SSI is Supplemental Security Income.

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

[2] Medicaid also includes adults reporting coverage through the CHIP program or other state-sponsored health plans. Medicaid and CHIP cannot be distinguished from each other in the National Health Interview Survey. CHIP enrollment of adults is small, totaling approximately 218,000 ever enrolled during FY 2012. (See March 2013 MACStats Table 3.)

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

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

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

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

[7] Question only asked for females aged 18 to 49.

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

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

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

TABLE 9. Health Insurance and Demographic Characteristics of Non-Institutionalized Individuals Aged 65 and Older by Source of Health Insurance, 2009–2011

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults Aged 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults aged 65+	Functional limitation[4]	No functional limitation
Health Insurance Coverage		**7.5%**	54.4%	94.9%	**100.0%**	80.0%	20.0%
Age (categories sum to 100%)							
65–74	54.9%	**54.1%**	54.3%	53.9%	**54.1%**	52.4%	60.9%*
75–84	33.3	**34.9**	33.9	34.0	**34.9**	35.2	33.9
85+	11.8	**11.0**	11.8	12.1	**11.0**	12.4	5.1*
Gender (categories sum to 100%)							
Male	43.6%*	**33.3%**	43.4%*	43.0%*	**33.3%**	30.8%	42.9%*
Female	56.4*	**66.7**	56.6*	57.0*	**66.7**	69.2	57.1*
Race (categories sum to 100%)							
Hispanic	7.2%*	**22.1%**	3.1%*	6.6%*	**22.1%**	21.0%	26.4%
White, non-Hispanic	80.0*	**49.6**	88.3*	81.3*	**49.6**	51.0	44.3
Black, non-Hispanic	8.6*	**18.4**	5.9*	8.2*	**18.4**	19.3	14.7
Other and multiple races, non-Hispanic	4.2*	**9.8**	2.8*	3.9*	**9.8**	8.6	14.5
Health insurance							
Medicaid/CHIP	7.5%*	**100.0%**	0.7%*	7.2%*	**100.0%**	100.0%	100.0%
Medicare	94.9*	**90.8**	94.1*	100.0*	**90.8**	91.7	87.5
Private	54.4*	**5.3**	100.0*	53.9*	**5.3**	4.7	7.8

See Table 11 for notes.

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

TABLE 10. Health Characteristics of Non-Institutionalized Individuals Aged 65 and Older by Source of Health Insurance, 2009–2011

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults Aged 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults aged 65+	Functional limitation[4]	No functional limitation
Disability and work status							
Receives Supplemental Security Income (SSI)	3.9%*	**32.5%**	0.7%*	3.8%*	**32.5%**	35.3%	20.5%*
Working	15.7*	**3.5**	19.2*	14.3*	**3.5**	2.5	7.6*
Current health status (categories sum to 100%)							
Excellent or very good	42.6%*	**19.4%**	47.4%*	42.5%*	**19.4%**	13.4%*	43.8%*
Good	33.9*	**29.9**	34.5*	33.9*	**29.9**	28.8	35.0
Fair or poor	23.4*	**50.7**	18.1*	23.6*	**50.7**	57.9*	21.1*
Health compared to 12 months ago (categories sum to 100%)							
Better	13.4%	**13.2%**	12.9%	13.3%	**13.2%**	13.6%	11.9%
Worse	12.5*	**21.5**	11.2*	12.6*	**21.5**	25.3*	6.1*
Same	74.1*	**65.3**	75.9*	74.0*	**65.3**	61.1*	82.0*
Activities of daily living (ADLs)							
Help with any personal care needs[5]	6.7%*	**20.2%**	4.8%*	6.7%*	**20.2%**	24.5%*	2.9%*
Help with bathing/showering	4.9*	**15.9**	3.5*	5.0*	**15.9**	19.2*	2.5*
Help with dressing	3.9*	**13.2**	2.6*	3.9*	**13.2**	16.0	2.2*
Help with eating	1.4*	**5.0**	0.8*	1.4*	**5.0**	5.9	1.7*
Help with transferring (in/out of bed or chairs)	2.9*	**9.2**	2.1*	2.9*	**9.2**	11.0	2.2*
Help with toileting	2.1*	**6.8**	1.6*	2.2*	**6.8**	8.0	2.0*
Help getting around in home	2.7*	**8.5**	1.9*	2.7*	**8.5**	10.0	2.0*
Number of above ADLs reported (categories sum to 100%)							
0	93.4%*	**79.8%**	95.2%*	93.3%*	**79.8%**	75.5%*	97.1%*
1	0.7*	**2.3**	0.6*	0.7*	**2.3**	2.8	†
2	1.4*	**2.7**	1.1*	1.5*	**2.7**	3.3	†
3	1.5*	**4.9**	1.1*	1.5*	**4.9**	6.1	0.0*
4+	2.9*	**10.3**	2.0*	3.0*	**10.3**	12.3	2.2*

TABLE 10, Continued

	Adults Aged 65+	Selected Sources of Insurance[1]			Medicaid[2]		
		Medicaid[2]	Private[3]	Medicare	All Medicaid adults aged 65+	Functional limitation[4]	No functional limitation
Specific health conditions							
Functional limitation[4]	65.3%*	**80.0%**	63.8%*	66.0%*	**80.0%**	100.0%*	0.0%*
Difficulty walking without equipment	18.7*	**37.5**	16.1*	19.1*	**37.5**	45.0*	6.5*
Health condition that requires special equipment (e.g., cane, wheelchair)	20.7*	**37.8**	18.1*	21.2*	**37.8**	45.3*	7.8*
Lost all natural teeth	23.8*	**42.3**	19.9*	23.9*	**42.3**	45.5	29.0*
Depressed/anxious feelings[6]	9.9*	**22.0**	8.1*	9.8*	**22.0**	26.1*	5.9*
Ever told had hypertension	62.2*	**70.0**	61.5*	62.5*	**70.0**	73.5	55.4*
Ever told had coronary heart disease	15.8*	**18.8**	15.9*	16.1*	**18.8**	20.9	10.2*
Ever told had heart attack	10.6*	**14.1**	10.1*	10.8*	**14.1**	15.6	8.2*
Ever told had stroke	8.5*	**13.8**	7.6*	8.6*	**13.8**	16.4	3.2*
Ever told had cancer	24.3*	**17.4**	26.9*	24.7*	**17.4**	18.8	10.7*
Ever told had diabetes	20.5*	**30.1**	18.7*	20.6*	**30.1**	33.7	16.4*
Ever told had arthritis	50.8*	**57.0**	51.6*	51.5*	**57.0**	65.1*	23.7*
Ever told had asthma	10.9*	**15.8**	10.2*	11.1*	**15.8**	17.1	10.2*
Past 12 months, told had chronic bronchitis	6.3*	**10.3**	5.8*	6.4*	**10.3**	11.8	4.1*
Past 12 months, told had liver condition	1.3*	**2.9**	1.1*	1.3*	**2.9**	3.3	†
Past 12 months, told had weak/failing kidneys	4.6*	**9.9**	3.8*	4.7*	**9.9**	11.8	2.5*

See Table 11 for notes.

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

TABLE 11. Use of Care by Non-Institutionalized Individuals Aged 65 and Older by Source of Health Insurance, 2009–2011

		Selected Sources of Insurance[1]			Medicaid[2]		
	Adults Aged 65+	Medicaid[2]	Private[3]	Medicare	All Medicaid adults aged 65+	Functional limitation[4]	No functional limitation
Received at-home care in past 12 months	8.1%*	**19.1%**	7.3%*	8.3%*	**19.1%**	22.8%	4.1%*
Number of times saw a doctor or other health professional in past 12 months (categories sum to 100%)							
None	5.9%	**7.2%**	4.5%*	5.5%*	**7.2%**	4.8%*	16.5%*
1	10.2*	**7.0**	9.8*	9.9*	**7.0**	5.3	13.8*
2–3	25.3*	**17.8**	26.2*	25.1*	**17.8**	16.3	23.5
4+	58.7*	**68.1**	59.5*	59.5*	**68.1**	73.6*	46.3*
Number of emergency room visits in past 12 months (categories sum to 100%)							
None	76.1%*	**67.4%**	77.1%*	75.7%*	**67.4%**	63.8%	81.7%*
1	16.0	**17.5**	15.8	16.2	**17.5**	18.8	12.3*
2–3	6.0*	**10.4**	5.4*	6.0*	**10.4**	11.8	4.6*
4+	2.0*	**4.7**	1.7*	2.0*	**4.7**	5.5	1.4*

Notes:

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

[2] Medicaid also includes adults reporting coverage through CHIP or other state-sponsored health plans.

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

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

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

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

Source: MACPAC analysis of the 2009–2011 National Health Interview Survey (NHIS).

SECTION 3

Key Points

Medicaid Enrollment and Benefit Spending

- Individuals eligible on the basis of a disability and those aged 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Tables 12 and 13).
- Medicaid spending per enrollee is affected by large numbers of individuals with limited benefits in some states (Table 14).
- Among individuals dually enrolled in Medicaid and Medicare, those aged 65 and older account for about 60 percent of enrollment and Medicaid benefit spending (Tables 12 and 13).
- A large share of Medicaid spending for enrollees eligible on the basis of a disability and enrollees aged 65 and older is for long-term services and supports (LTSS), while a substantial portion of spending for non-disabled children and adults is for capitation payments to managed care plans (Figures 3 and 4).
- Long-term services and supports (LTSS) users account for only about 6 percent of Medicaid enrollees, but nearly half of all Medicaid spending (Figure 5). Acute care represents a minority of Medicaid spending for most LTSS users (Figure 6), and average Medicaid benefit spending for these individuals is more than 10 times that of enrollees who are not using LTSS (Figure 7).
- Medicaid benefit spending per enrollee varies substantially across states (Table 14). Reasons for this variation may include the breadth of benefits that states choose to cover; the proportion of enrollees receiving the full benefit package or a more limited version; enrollee case mix (based on health status and other characteristics); the underlying costs of delivering health care services in specific geographic areas; and state policies regarding provider payments, care management, and other program features.

TABLE 12. Medicaid Enrollment by State, Eligibility Group, and Dual Eligible Status, FY 2010 (thousands)

State	Total	Percentage of Enrollees in Eligibility Group[1]				Dual Eligible Status[2]					
						All dual eligibles		Dual eligibles with full benefits		Dual eligibles with limited benefits	
		Children	Adults	Disabled	Aged	Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
Total	**66,024**	**48.1%**	**27.8%**	**14.5%**	**9.5%**	**9,755**	**59.6%**	**7,366**	**59.8%**	**2,389**	**58.9%**
Alabama	**1,016**	50.1	17.3	20.9	11.6	**206**	56.3	**97**	52.7	**109**	59.5
Alaska	**126**	55.4	24.4	13.2	7.0	**14**	53.8	**14**	53.4	**0**	67.2
Arizona	**1,531**	44.5	40.3	8.9	6.2	**153**	58.4	**119**	54.6	**34**	71.7
Arkansas	**699**	52.1	17.0	20.9	10.0	**125**	53.9	**70**	59.6	**55**	46.7
California	**11,335**	38.3	43.7	9.1	9.0	**1,262**	70.3	**1,231**	70.2	**31**	76.2
Colorado	**700**	58.3	19.7	13.7	8.3	**89**	58.8	**66**	61.1	**23**	52.2
Connecticut	**712**	44.4	32.5	10.2	12.9	**133**	65.3	**79**	58.3	**54**	75.6
Delaware	**225**	40.8	41.6	11.1	6.4	**26**	53.6	**12**	54.4	**14**	52.9
District of Columbia	**213**	37.9	36.6	17.4	8.1	**26**	60.2	**20**	59.4	**6**	63.2
Florida	**3,703**	51.1	20.8	15.4	12.7	**676**	65.2	**369**	69.1	**307**	60.5
Georgia	**1,870**	59.2	16.3	15.2	9.3	**272**	58.9	**138**	59.1	**135**	58.6
Hawaii	**261**	41.5	38.7	10.4	9.4	**35**	68.2	**31**	68.7	**4**	63.9
Idaho[3]	**223**	61.4	13.5	17.5	7.6	**32**	49.7	**22**	49.3	**10**	50.6
Illinois	**2,780**	53.6	27.7	11.0	7.6	**346**	56.3	**307**	55.5	**39**	62.5
Indiana	**1,174**	55.2	22.3	14.8	7.6	**166**	48.9	**106**	53.8	**60**	40.4
Iowa	**555**	47.2	30.5	14.5	7.8	**86**	50.2	**71**	47.4	**15**	63.3
Kansas	**394**	56.4	14.4	19.6	9.6	**68**	50.8	**48**	52.9	**20**	45.8
Kentucky	**907**	47.8	15.9	25.7	10.6	**185**	50.8	**110**	51.7	**75**	49.4
Louisiana	**1,177**	52.0	19.4	18.9	9.7	**191**	58.3	**109**	56.2	**81**	61.0
Maine	**411**	30.7	27.3	25.8	16.3	**105**	60.2	**57**	46.0	**48**	76.9
Maryland	**952**	47.7	29.1	15.2	8.0	**120**	56.8	**80**	56.7	**40**	57.1
Massachusetts	**1,654**	29.2	44.4	16.2	10.2	**270**	53.0	**248**	49.1	**22**	96.8
Michigan	**2,257**	52.0	26.0	15.6	6.3	**275**	47.6	**240**	47.1	**35**	50.9
Minnesota	**936**	47.4	28.3	14.0	10.4	**143**	54.1	**129**	53.1	**14**	63.3
Mississippi	**772**	51.8	15.0	21.7	11.6	**158**	56.2	**83**	58.6	**74**	53.5
Missouri[3]	**1,033**	52.8	18.4	19.6	9.1	**181**	49.7	**164**	49.5	**17**	51.8
Montana	**133**	56.8	16.4	17.3	9.6	**24**	53.2	**16**	53.7	**8**	52.4
Nebraska	**250**	57.5	18.1	15.3	9.1	**41**	51.4	**38**	50.5	**3**	62.2
Nevada	**340**	59.5	19.6	12.8	8.0	**45**	59.4	**23**	65.4	**22**	53.1
New Hampshire	**167**	59.2	14.1	17.3	9.4	**33**	45.6	**22**	45.8	**10**	45.1

TABLE 12, Continued

State	Total	Percentage of Enrollees in Eligibility Group[1]				Dual Eligible Status[2]					
						All dual eligibles		Dual eligibles with full benefits		Dual eligibles with limited benefits	
		Children	Adults	Disabled	Aged	Total	Percentage age 65+	Total	Percentage age 65+	Total	Percentage age 65+
New Jersey	**1,026**	55.3%	12.9%	17.1%	14.8%	**210**	66.1%	**183**	65.5%	**27**	69.8%
New Mexico	**576**	60.4	20.1	12.1	7.5	**70**	59.9	**39**	60.2	**30**	59.6
New York	**5,570**	37.6	39.1	12.2	11.1	**797**	67.9	**694**	66.6	**103**	76.9
North Carolina	**1,876**	52.3	20.8	17.0	9.8	**324**	55.6	**253**	55.2	**71**	57.2
North Dakota	**82**	52.9	21.5	14.1	11.5	**16**	58.0	**13**	57.4	**3**	60.4
Ohio	**2,246**	49.6	25.0	17.3	8.1	**326**	50.4	**222**	52.9	**104**	45.0
Oklahoma	**829**	55.5	21.9	14.6	8.0	**120**	53.7	**99**	53.6	**21**	54.2
Oregon	**644**	50.1	25.9	15.0	9.0	**100**	56.3	**65**	58.1	**35**	52.8
Pennsylvania	**2,417**	44.6	20.8	24.6	10.0	**415**	54.5	**348**	53.3	**68**	60.8
Rhode Island	**205**	44.8	20.9	20.1	14.1	**42**	58.3	**36**	57.0	**6**	66.3
South Carolina	**909**	51.0	22.9	16.9	9.2	**155**	53.9	**135**	53.3	**20**	58.0
South Dakota	**131**	58.6	17.1	14.5	9.8	**22**	59.1	**14**	60.8	**8**	55.8
Tennessee	**1,502**	51.9	20.7	17.9	9.5	**269**	52.1	**157**	50.0	**111**	55.2
Texas	**4,844**	63.9	13.7	13.1	9.2	**666**	65.5	**421**	67.0	**245**	63.0
Utah	**352**	58.0	25.3	12.1	4.7	**32**	45.1	**29**	44.3	**4**	51.2
Vermont	**196**	34.8	41.6	12.2	11.4	**36**	60.1	**28**	55.9	**8**	75.5
Virginia	**1,007**	54.7	16.8	17.6	10.9	**184**	56.6	**124**	59.4	**60**	50.7
Washington	**1,353**	56.1	21.5	15.3	7.1	**172**	54.3	**129**	57.4	**43**	45.3
West Virginia	**430**	47.5	15.0	27.7	9.8	**84**	49.6	**51**	50.6	**33**	48.1
Wisconsin	**1,232**	39.1	36.1	13.1	11.8	**222**	64.3	**202**	64.2	**20**	64.7
Wyoming	**87**	64.9	15.6	12.8	6.8	**11**	52.3	**7**	51.8	**4**	53.5

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

Although state-level information is not yet available, the estimated number of individuals ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 70.7 million for fiscal year (FY) 2011 and 71.6 million for FY 2012. These FY 2011–FY 2012 figures exclude about 1 million enrollees in the territories (MACPAC communication with Centers for Medicare & Medicaid Services Office of the Actuary, February 2013).

[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 aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 65 and older, MACPAC recodes these enrollees as aged.

[2] Dual eligibles are individuals who are enrolled in both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing. Zeroes indicate enrollment counts less than 500 that round to zero.

[3] FY 2010 data unavailable for Idaho and Missouri; FY 2009 values shown instead.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2013.

TABLE 13. Medicaid Benefit Spending by State, Eligibility Group, and Dual Eligible Status, FY 2010 (millions)

State	Total	Percentage of Benefit Spending Attributable to Eligibility Group[1]				Dual Eligible Status[2]					
						All dual eligibles		Dual eligibles with full benefits		Dual eligibles 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	**$388,611**	**19.1%**	**14.7%**	**42.8%**	**23.3%**	**$140,573**	**60.5%**	**$135,406**	**60.8%**	**$5,166**	**52.5%**
Alabama	**4,749**	27.2	9.1	38.6	25.1	**1,757**	65.9	**1,516**	67.7	**242**	55.2
Alaska	**1,207**	28.2	15.9	38.0	17.8	**335**	54.2	**334**	54.2	**1**	70.5
Arizona	**9,384**	20.9	36.9	29.0	13.3	**1,913**	59.3	**1,852**	59.1	**61**	64.4
Arkansas	**3,940**	21.2	4.8	46.5	27.5	**1,736**	59.8	**1,510**	63.3	**226**	37.0
California	**42,142**	15.9	15.2	41.5	27.4	**15,358**	67.9	**15,272**	67.9	**87**	69.9
Colorado	**4,052**	22.6	12.8	42.3	22.3	**1,371**	60.8	**1,337**	61.2	**34**	45.4
Connecticut	**5,744**	15.3	12.6	36.4	35.6	**3,091**	62.7	**2,994**	62.8	**96**	60.4
Delaware	**1,289**	19.0	30.6	33.2	17.2	**369**	57.8	**340**	58.9	**29**	45.8
District of Columbia	**1,792**	11.9	12.6	54.2	21.3	**544**	60.8	**523**	61.2	**21**	49.4
Florida	**17,390**	17.9	13.4	42.2	26.6	**6,894**	62.9	**6,168**	64.2	**726**	51.5
Georgia	**7,785**	22.3	14.1	43.1	20.6	**2,228**	62.7	**1,998**	64.0	**230**	51.7
Hawaii	**1,428**	15.9	26.5	29.7	27.8	**536**	72.4	**528**	72.6	**8**	61.1
Idaho[3]	**1,277**	20.7	10.3	51.0	18.0	**408**	52.0	**392**	52.4	**16**	42.5
Illinois	**15,336**	24.8	18.5	40.1	16.6	**3,992**	55.5	**3,904**	55.8	**88**	45.1
Indiana	**5,921**	18.1	11.7	45.2	25.1	**2,581**	55.9	**2,454**	57.1	**127**	33.2
Iowa	**3,119**	17.3	12.1	48.0	22.6	**1,385**	50.4	**1,355**	50.3	**30**	55.6
Kansas	**2,438**	19.5	8.5	48.6	23.4	**1,020**	53.2	**986**	53.7	**34**	38.9
Kentucky	**5,606**	23.4	12.4	45.7	18.5	**1,781**	57.1	**1,644**	58.1	**137**	45.3
Louisiana	**6,964**	19.7	12.4	50.5	17.5	**2,044**	56.5	**1,882**	56.7	**162**	54.3
Maine	**2,296**	16.2	10.4	47.6	25.8	**1,062**	54.6	**988**	53.1	**74**	74.3
Maryland	**7,082**	18.9	16.8	44.6	19.7	**2,127**	59.1	**2,016**	59.5	**111**	50.1
Massachusetts	**11,781**	13.6	19.3	42.4	24.6	**4,864**	55.9	**4,826**	55.6	**38**	95.9
Michigan	**11,655**	19.0	15.7	45.1	20.2	**3,822**	58.7	**3,741**	59.0	**81**	43.0
Minnesota	**7,589**	17.5	12.2	47.5	22.8	**3,278**	50.5	**3,255**	50.5	**23**	52.3
Mississippi	**4,146**	21.7	11.5	42.9	23.8	**1,484**	65.5	**1,308**	67.9	**176**	47.4
Missouri[3]	**7,748**	23.4	9.4	48.1	19.1	**2,603**	52.9	**2,568**	53.1	**35**	40.9
Montana	**936**	23.7	11.9	39.1	25.4	**375**	63.8	**356**	64.8	**20**	46.7
Nebraska	**1,730**	23.6	10.0	42.8	23.6	**697**	53.9	**693**	53.9	**4**	60.4

TABLE 13, Continued

State	Total	Percentage of Benefit Spending Attributable to Eligibility Group[1]				Dual Eligible Status[2]					
						All dual eligibles		Dual eligibles with full benefits		Dual eligibles 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	**1,509**	28.5%	12.8%	41.9%	16.9%	**383**	62.1%	**340**	64.1%	**43**	46.6%
New Hampshire	**1,332**	24.8	8.4	38.1	28.7	**622**	58.4	**598**	58.8	**24**	49.1
New Jersey	**10,224**	16.2	7.1	44.6	32.0	**4,770**	63.8	**4,727**	63.7	**43**	69.4
New Mexico	**3,443**	45.7	19.3	31.6	3.4	**339**	30.4	**286**	25.5	**53**	56.7
New York	**52,122**	10.5	18.8	42.2	28.5	**22,770**	60.9	**22,517**	60.8	**253**	72.5
North Carolina	**10,907**	21.8	14.2	45.0	19.1	**3,518**	58.6	**3,397**	59.0	**121**	48.0
North Dakota	**688**	15.4	9.9	42.5	32.2	**382**	57.0	**378**	57.1	**5**	52.6
Ohio	**15,262**	13.6	13.6	47.2	25.6	**6,051**	58.7	**5,801**	59.7	**250**	36.6
Oklahoma	**4,119**	26.9	12.3	42.0	18.8	**1,366**	53.7	**1,338**	53.7	**28**	50.8
Oregon	**4,007**	17.5	17.7	40.6	24.2	**1,457**	64.7	**1,399**	65.5	**58**	45.7
Pennsylvania	**18,766**	16.7	9.0	49.5	24.8	**7,122**	62.0	**7,018**	62.0	**104**	56.7
Rhode Island	**1,926**	22.2	12.1	46.4	19.2	**695**	51.4	**688**	51.4	**8**	53.3
South Carolina	**5,173**	20.5	15.7	43.9	20.0	**1,743**	59.3	**1,719**	59.4	**24**	53.4
South Dakota	**784**	24.9	11.8	41.2	22.1	**294**	58.3	**276**	59.0	**18**	48.8
Tennessee	**8,518**	24.6	17.3	40.9	17.2	**2,503**	56.5	**2,286**	57.9	**217**	41.4
Texas	**27,200**	32.2	9.5	40.3	18.0	**7,213**	64.8	**6,542**	64.7	**671**	65.2
Utah	**1,716**	25.9	14.3	48.8	11.1	**470**	37.5	**462**	37.5	**8**	40.9
Vermont	**1,250**	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Virginia	**6,467**	23.3	10.3	45.0	21.3	**2,274**	55.6	**2,158**	56.3	**116**	43.1
Washington	**7,063**	22.7	15.3	40.8	21.3	**2,319**	62.8	**2,220**	63.7	**99**	41.1
West Virginia	**2,553**	16.2	7.6	47.7	28.5	**1,076**	66.7	**1,018**	67.8	**59**	47.7
Wisconsin	**6,521**	11.9	17.9	41.1	29.1	**3,163**	58.5	**3,133**	58.6	**30**	53.8
Wyoming	**538**	22.9	10.5	43.1	23.6	**240**	52.6	**224**	53.1	**16**	45.3

Notes: Includes federal and state funds. Excludes administrative spending, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology.

[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 aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 65 and older, MACPAC recodes these enrollees as aged.

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

[3] Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 values shown instead.

[4] Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, MACPAC's adjustment methodology is only applied to total Medicaid spending.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2013.

TABLE 14. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2010

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	**11.5%**	**$7,264**	**$7,915**	**1.5%**	**$2,848**	**$2,871**	**27.7%**	**$4,343**	**$5,259**	**9.9%**	**$19,166**	**$20,889**	**23.0%**	**$16,430**	**$20,549**
Alabama	22.8	5,613	6,572	0.1	3,071	3,070	74.3	3,355	6,747	19.9	9,637	11,316	55.0	11,216	22,140
Alaska	0.3	12,016	12,041	0.0	5,954	5,953	0.0	9,350	9,348	0.6	30,857	31,027	2.5	27,651	28,271
Arizona	7.9	7,161	7,436	2.5	3,320	3,358	11.1	6,913	7,381	7.0	20,851	21,317	26.7	13,937	17,921
Arkansas	19.9	6,697	7,736	2.4	2,680	2,709	71.5	2,186	5,391	19.7	14,196	16,284	36.9	17,700	25,896
California	29.0	4,773	6,256	7.2	1,937	2,032	64.8	1,828	3,162	0.8	18,399	18,465	3.9	12,550	12,859
Colorado	4.3	7,584	7,687	0.2	2,942	2,910	3.8	5,804	5,330	10.8	20,567	22,635	19.9	17,886	21,861
Connecticut	6.8	10,010	10,559	–	3,222	3,222	0.0	4,467	4,467	16.3	32,003	37,552	38.6	27,982	44,274
Delaware	14.8	7,129	7,999	2.1	3,280	3,333	17.7	5,626	6,385	26.0	18,514	24,093	52.3	17,199	33,871
District of Columbia	3.0	10,969	11,074	–	3,013	3,013	0.6	5,099	4,773	5.0	29,002	30,195	19.9	25,645	31,107
Florida	10.3	6,164	6,453	0.2	2,079	2,062	5.9	5,543	5,308	20.9	14,650	17,531	39.1	11,362	17,006
Georgia	8.3	5,345	5,593	0.0	1,991	1,988	0.8	6,191	5,838	19.2	13,126	15,689	45.6	10,443	17,709
Hawaii	1.4	6,423	6,476	0.0	2,365	2,365	0.0	4,761	4,755	4.6	17,027	17,723	9.1	18,259	19,825
Idaho[3]	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	6,295	6,501	0.1	2,882	2,881	13.9	4,369	4,684	4.8	21,931	22,824	11.5	13,581	15,103
Indiana	5.4	6,158	6,371	–	1,955	1,955	0.0	3,764	3,764	19.9	17,194	20,775	28.1	19,755	26,705
Iowa	10.5	7,037	7,576	1.1	2,532	2,546	26.3	3,172	3,397	6.3	20,137	21,294	22.3	19,196	24,112
Kansas	5.7	7,884	8,210	0.0	2,712	2,708	0.6	5,953	5,737	14.0	17,530	20,031	24.7	18,015	23,380
Kentucky	9.0	7,500	8,024	0.0	3,660	3,657	0.4	7,473	7,422	15.8	12,146	13,991	39.2	12,176	18,838
Louisiana	15.3	6,738	7,552	0.0	2,478	2,477	47.5	4,918	7,381	14.3	17,407	19,851	44.4	11,805	19,705
Maine	12.9	6,927	7,700	0.1	3,409	3,412	0.4	2,605	2,610	13.1	14,974	16,945	57.1	10,291	21,768
Maryland	7.9	8,987	9,301	0.9	3,471	3,464	12.0	5,775	5,422	11.0	24,115	26,642	29.9	21,103	28,865
Massachusetts	6.6	8,527	9,026	3.4	4,054	4,169	9.0	3,898	4,167	0.3	19,717	19,762	16.6	19,590	23,007
Michigan	6.1	6,247	6,538	1.0	2,203	2,216	17.2	4,307	4,944	4.6	16,547	17,161	13.2	19,677	22,258
Minnesota	5.2	10,395	10,841	0.9	3,737	3,752	11.7	4,967	5,473	3.9	30,498	31,526	11.8	24,671	27,493
Mississippi	15.3	6,517	7,104	0.0	2,783	2,782	36.3	5,771	6,439	21.0	11,912	14,280	44.3	12,295	20,223
Missouri[3]	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	6.5	9,037	9,461	–	3,763	3,763	–	7,845	7,845	15.9	18,403	21,246	33.5	22,308	32,229
Nebraska	1.1	8,740	8,807	0.0	3,362	3,362	0.2	6,665	6,620	2.2	21,791	22,242	7.8	24,653	26,602
Nevada	7.4	5,922	6,077	0.1	2,816	2,802	2.0	4,642	4,253	22.3	16,905	20,738	41.3	10,930	16,867
New Hampshire	6.3	9,924	10,405	–	4,073	4,073	–	7,379	7,379	18.8	20,515	24,661	29.6	29,207	40,177

TABLE 14, Continued

State	Total			Children			Adults			Disabled			Aged		
	Percentage of FYEs with limited benefits[1]	Benefit spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit spending per FYE		Percentage of FYEs with limited benefits[1]	Benefit spending per FYE	
		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]		All enrollees	Excluding those with limited benefits[2]
New Jersey	3.2%	$11,645	$11,866	0.0%	$3,374	$3,373	1.8%	$8,081	$7,376	5.0%	$28,228	$29,570	13.7%	$24,188	$27,639
New Mexico	12.3	7,055	7,549	0.0	5,247	5,239	38.8	7,641	9,548	17.0	17,266	20,329	40.9	3,092	3,908
New York	5.5	11,139	11,500	2.2	3,136	3,184	6.5	5,647	5,616	3.5	34,495	35,508	15.0	26,814	30,703
North Carolina	8.9	7,197	7,676	0.1	2,941	2,938	28.0	6,072	7,494	9.3	16,887	18,350	21.9	12,763	15,879
North Dakota	4.6	10,821	11,262	–	3,084	3,084	0.0	6,125	6,124	11.1	28,518	31,806	22.8	28,228	36,153
Ohio	4.7	7,987	8,248	–	2,138	2,138	0.0	4,707	4,707	14.5	20,853	23,859	26.3	25,418	33,672
Oklahoma	7.5	6,227	6,575	0.1	2,889	2,889	28.0	4,531	5,484	7.6	16,034	17,199	17.1	13,346	15,795
Oregon	10.7	8,083	8,807	3.0	2,796	2,868	14.3	6,621	7,213	16.4	18,572	21,785	31.9	19,346	27,597
Pennsylvania	7.5	9,267	9,866	0.2	3,486	3,481	24.3	4,494	5,390	4.5	17,185	17,881	17.1	22,357	26,574
Rhode Island	3.4	11,126	11,356	0.0	5,519	5,490	3.9	7,120	7,121	3.3	23,427	24,005	13.8	15,061	17,085
South Carolina	8.7	6,822	7,249	0.1	2,705	2,702	32.4	5,334	6,669	5.0	16,169	16,898	12.8	13,856	15,683
South Dakota	6.3	7,512	7,829	0.0	3,141	3,141	0.1	6,424	6,401	17.0	19,231	22,505	33.7	15,759	22,563
Tennessee	7.6	6,639	6,975	0.0	3,099	3,094	0.1	6,019	5,916	18.1	14,711	17,304	43.1	11,752	19,399
Texas	9.6	7,365	7,663	0.0	3,698	3,670	38.0	7,524	9,120	14.0	18,937	21,311	34.9	12,199	16,676
Utah	1.6	6,941	6,918	0.0	3,075	3,069	1.1	4,674	4,333	4.4	22,763	23,615	12.7	13,980	15,610
Vermont	4.4	7,792	[4]	–	[4]	[4]	–	[4]	[4]	7.4	[4]	[4]	26.7	[4]	[4]
Virginia	7.2	7,842	8,225	0.0	3,289	3,288	6.6	5,903	5,956	16.1	18,421	21,390	27.6	14,475	19,169
Washington	11.1	6,426	6,781	0.2	2,500	2,486	43.4	5,527	7,051	11.2	16,028	17,572	19.7	18,208	21,905
West Virginia	8.1	7,319	7,785	0.0	2,488	2,488	0.0	4,824	4,823	13.8	11,432	12,922	37.9	20,052	31,036
Wisconsin	9.2	6,289	6,754	4.7	1,944	1,986	16.5	3,228	3,510	4.3	18,060	18,721	8.7	14,858	16,130
Wyoming	6.7	7,971	8,200	0.8	2,776	2,794	12.2	6,576	6,700	14.6	23,778	26,833	35.0	25,971	37,698

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 aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology.

In this table, enrollees with limited benefits are defined as those reported by states in MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services. Additional individuals may receive limited benefits for other reasons, but are not broken out here.

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

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

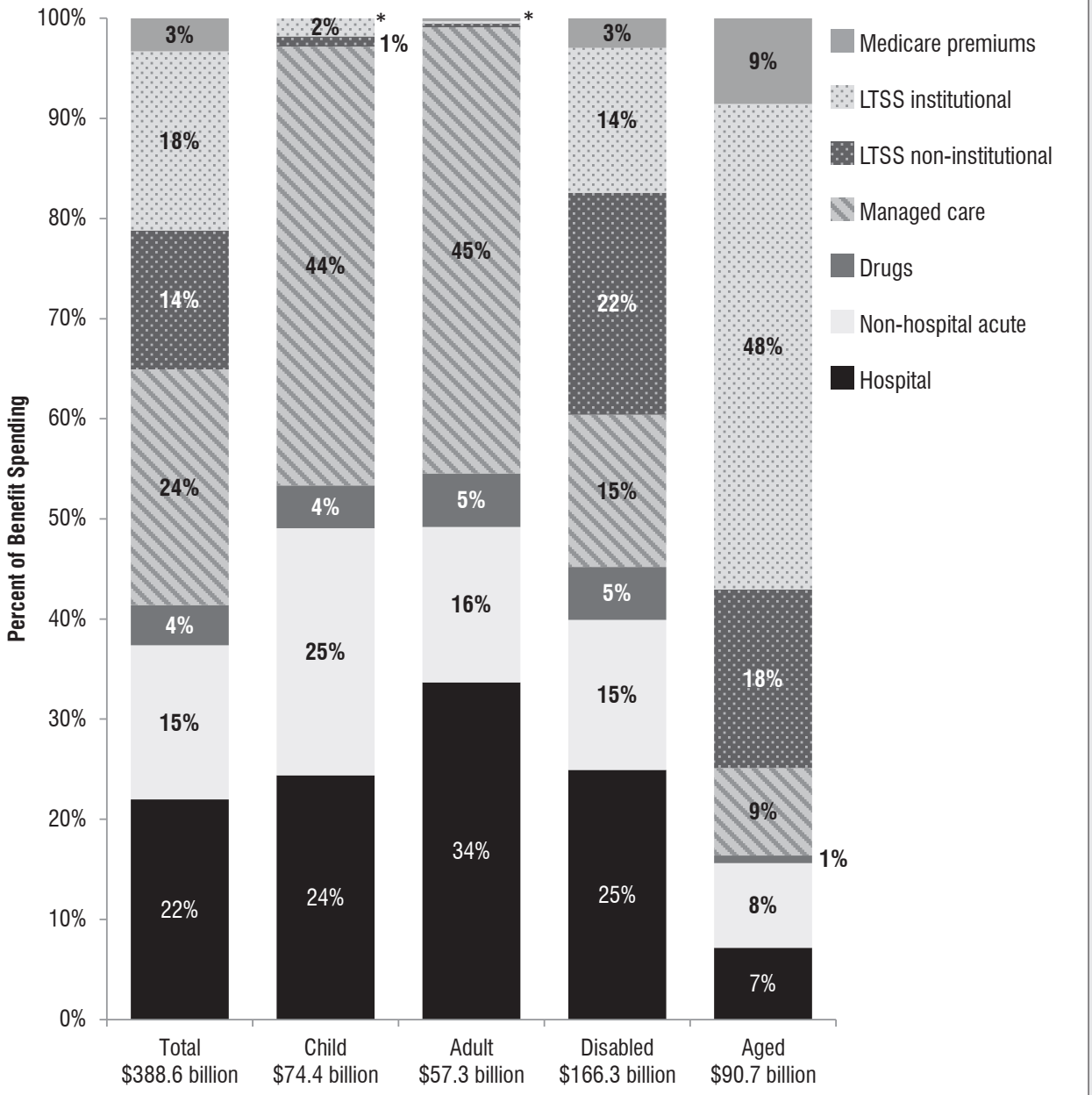
[2] Calculated by removing limited-benefit enrollees and their spending.

[3] Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 values shown instead.

[4] Due to large differences in the way managed care spending is reported by Vermont in CMS-64 and MSIS data, MACPAC's adjustment methodology is only applied to total Medicaid spending.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2013.

FIGURE 3. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2010

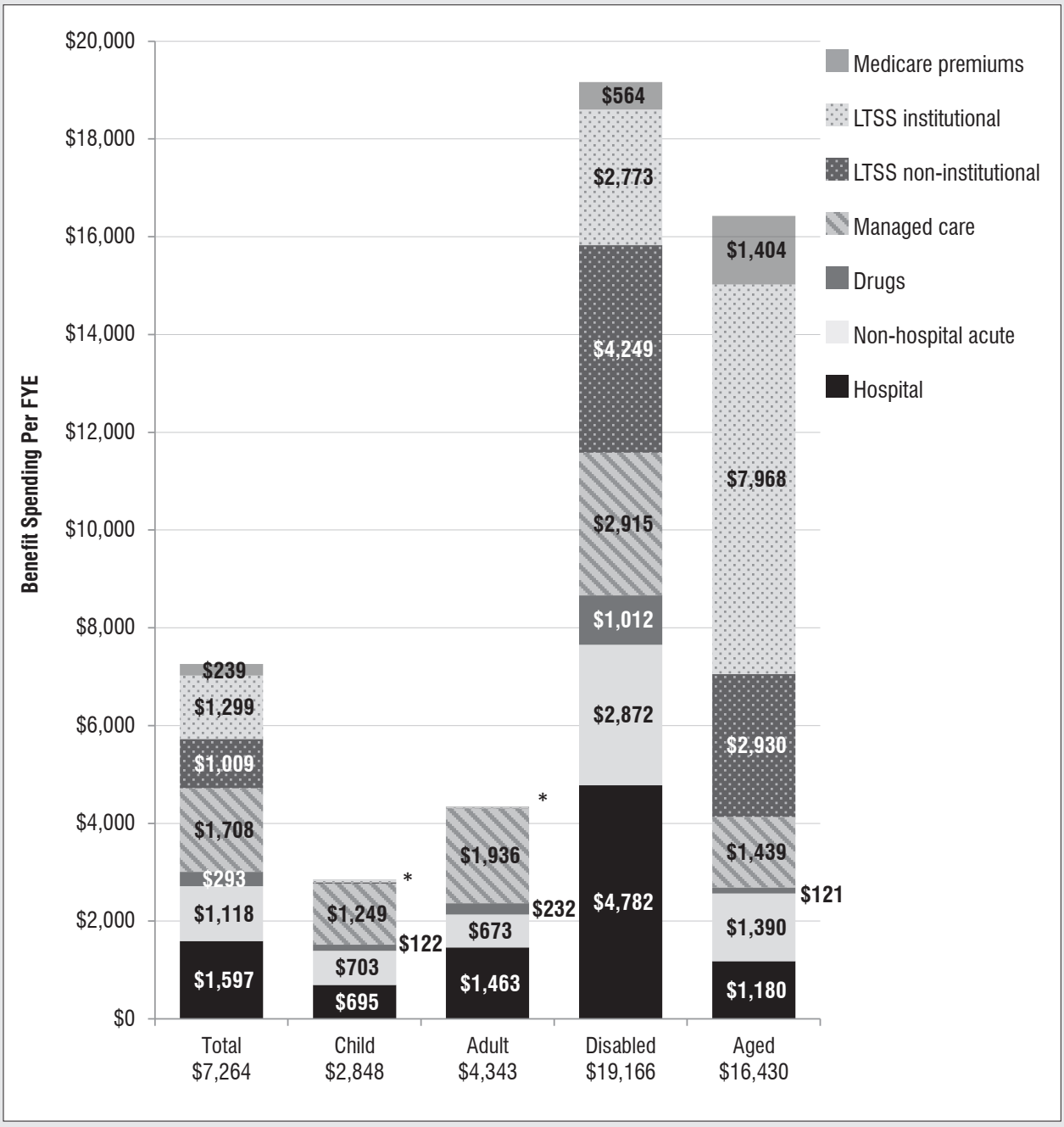


Notes: LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category. Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 values used instead.

* Values less than 1 percent are 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 2013.

FIGURE 4. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2010

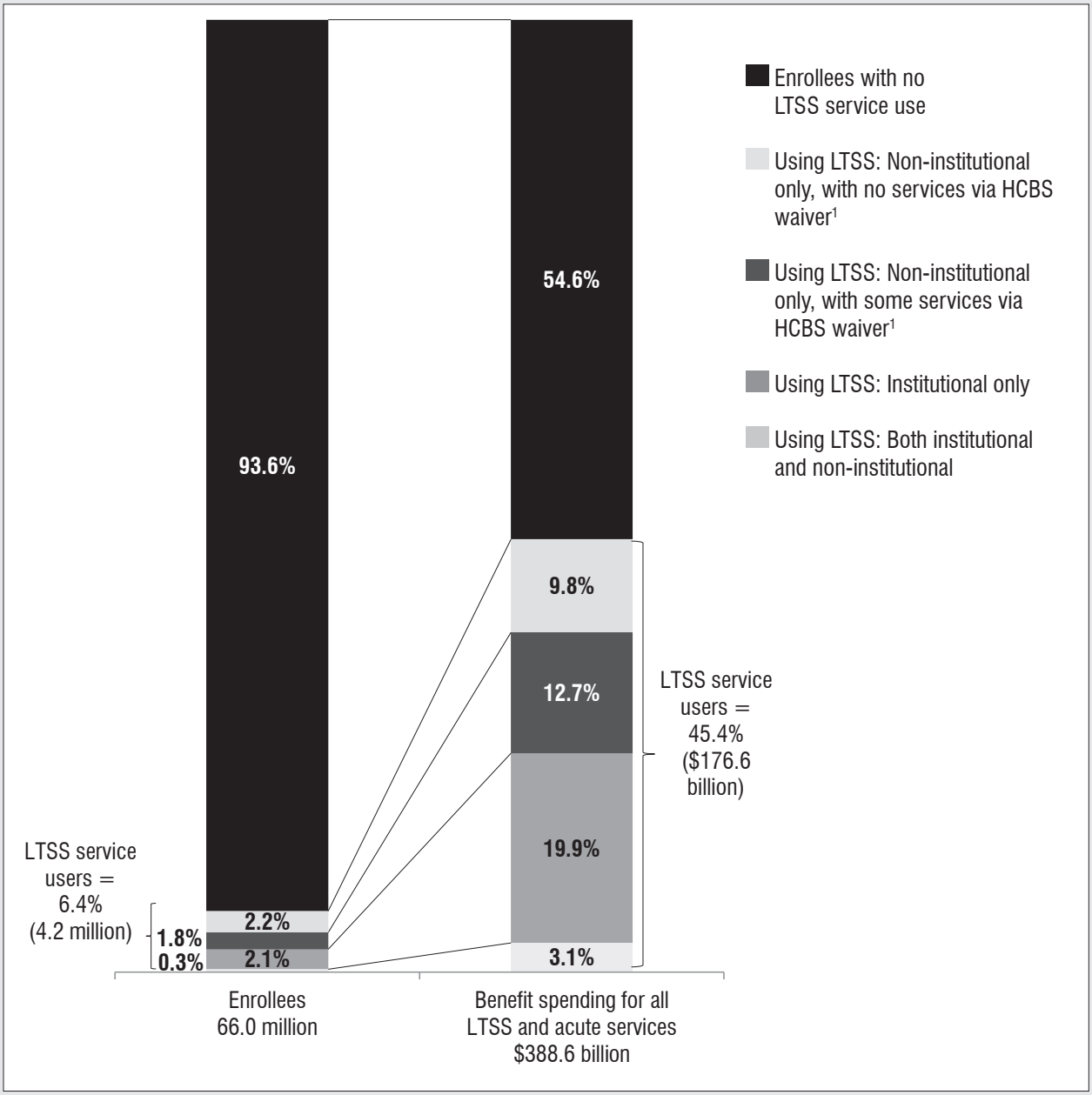


Notes: LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. About 690,000 enrollees aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category. Amounts reflect all enrollees, including those with limited benefits; see Table 14 notes for more information. Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 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 2013.

FIGURE 5. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2010

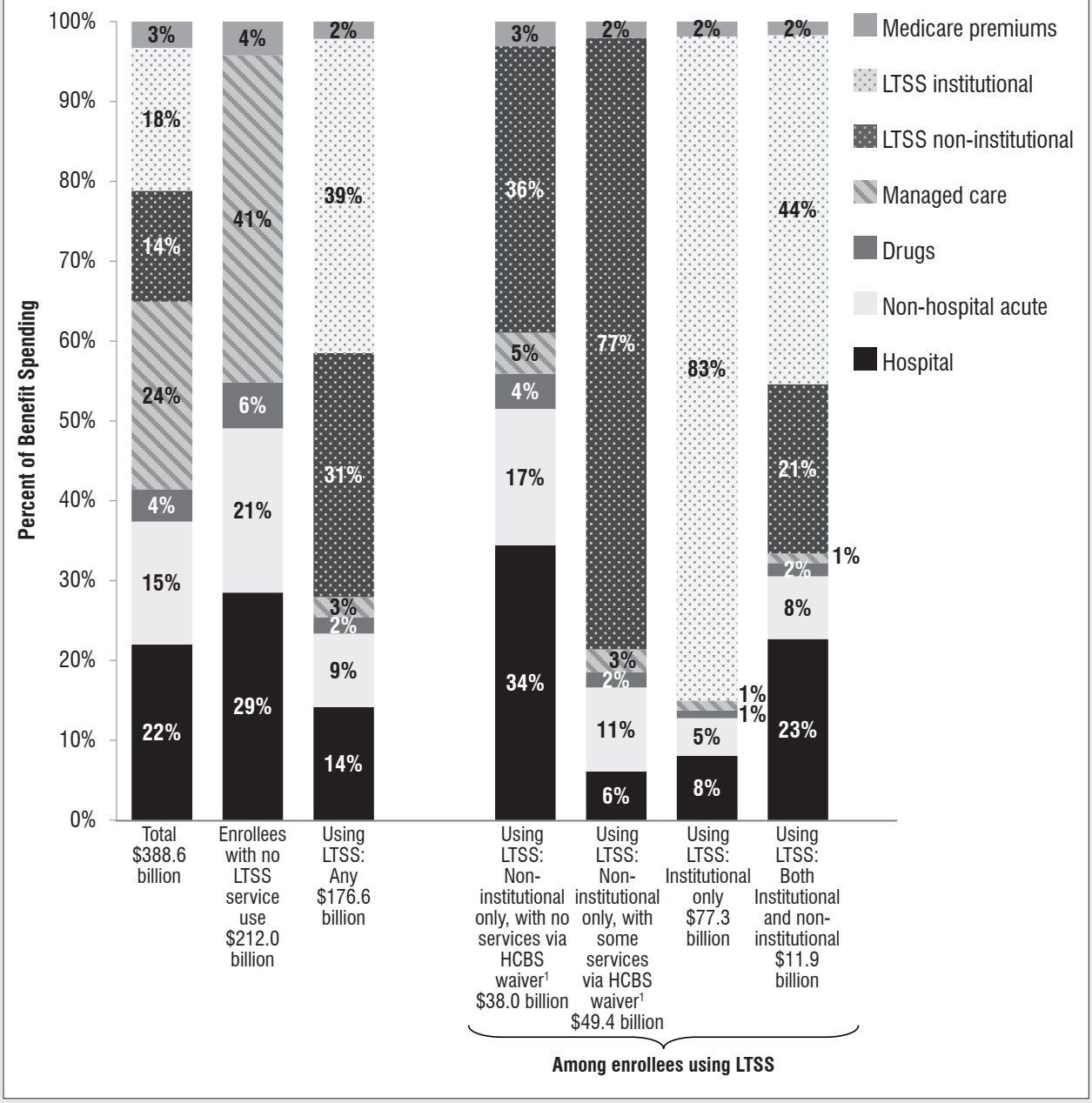


Notes: HCBS is home and community-based services; LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to match CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category. Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 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 2013.

FIGURE 6. Distribution of Medicaid Benefit Spending by Long-Term Services and Supports Use and Service Category, FY 2010

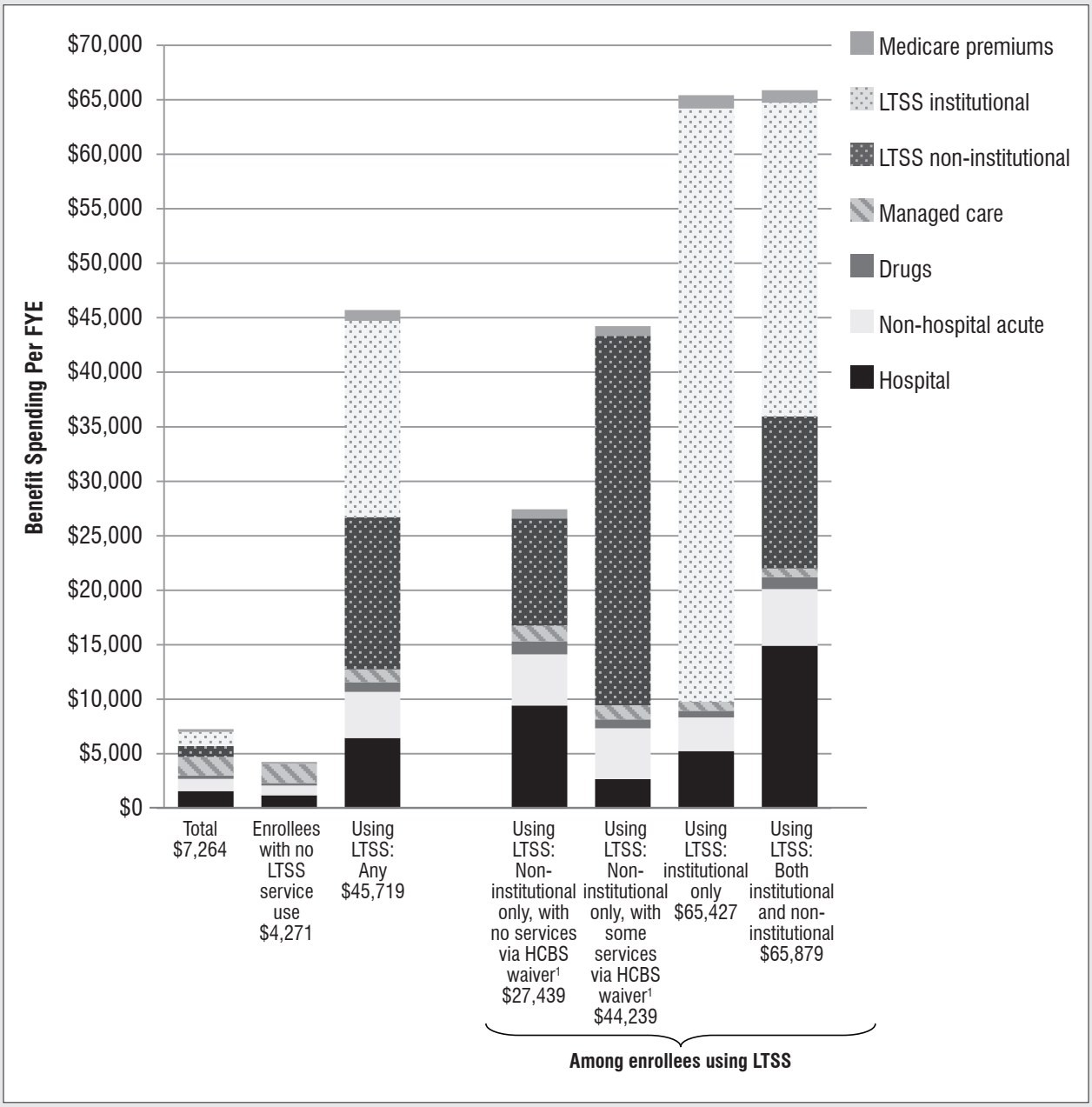


Notes: HCBS is home and community-based services, LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to match CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category. Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 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 2013.

FIGURE 7. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Long-Term Services and Supports Use and Service Category, FY 2010



Notes: HCBS is home and community-based services, LTSS is long-term services and supports. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to match CMS-64 totals; see Section 5 of MACStats for methodology, including a list of services in each category. Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 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 2013.

Key Points

Medicaid Managed Care

- The term managed care may refer to several different arrangements, including comprehensive risk-based and limited-benefit plans that provide a contracted set of services in exchange for a capitated (per member per month) payment, as well as primary care case management (PCCM) programs that typically pay primary care providers a small monthly fee to coordinate enrollees' care. Depending on the definition that is used, the national percentage of Medicaid enrollees in managed care ranges from about half (reflecting individuals in comprehensive risk-based plans) to more than 70 percent (Tables 15 and 17).
- The use of managed care varies widely by state, both in the arrangements used and the populations served. In 2011, all but three states reported using some form of managed care, including comprehensive risk-based plans, limited-benefit plans, or PCCM programs (Tables 15 and 16).
- The national percentage of Medicaid enrollees in any form of managed care ranged from 41 percent among enrollees aged 65 and older to 87 percent among non-disabled child enrollees in fiscal year (FY) 2010 (Table 17). Participation in comprehensive risk-based managed care plans was lowest among the aged and disabled eligibility groups (12 and 29 percent, respectively) and highest among non-disabled adults and children (47 and 62 percent).
- For individuals dually enrolled in Medicaid and Medicare, enrollment in Medicaid limited-benefit plans (which typically cover only behavioral health, transportation, or dental services) is more common than enrollment in Medicaid comprehensive risk-based plans or PCCM programs. Forty-one percent of individuals dually enrolled in Medicaid and Medicare were enrolled in some form of Medicaid managed care in FY 2010 (Table 17).
- The national percentage of Medicaid benefit spending on any form of managed care ranges from about 9 percent among enrollees aged 65 and older to more than 40 percent among non-disabled child and adult enrollees (Table 18). In states with comprehensive risk-based managed care, these plans account for the majority of managed care spending.

TABLE 15. Medicaid Enrollees in Managed Care by State, July 1, 2011

	All Medicaid Enrollees					Individuals Dually Enrolled in Medicaid and Medicare	
		Percentage in managed care					
State	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	56,006,959	74.1%	65.9%	50.2%	15.8%	8,922,794	10.5%
Alabama	930,736	61.1	58.7	–	58.7	196,313	–
Alaska	120,611	–	–	–	–	13,879	–
Arizona	1,351,988	88.7	88.7	88.7	–	153,637	69.9
Arkansas	608,332	78.4	61.8	–	61.8	116,855	0.1
California	7,580,978	60.1	59.7	59.7	–	1,188,551	23.3
Colorado	583,618	94.6	16.7	8.3	8.3	82,104	5.5
Connecticut	578,620	68.6	68.6	68.5	0.1	121,149	–
Delaware	200,810	80.5	77.1	77.1	–	24,403	–
District of Columbia[4]	201,777	67.4	68.1	68.1	–	14,458	0.6
Florida	3,069,456	63.8	60.5	40.7	19.8	637,738	4.7
Georgia	1,548,090	91.3	71.9	61.5	10.5	233,374	–
Hawaii	272,218	98.7	98.0	98.0	–	30,839	87.8
Idaho	230,725	100.0	91.1	–	91.1	19,054	–
Illinois[4]	2,787,200	67.8	67.8	7.7	60.1	327,851	–
Indiana	1,055,779	70.3	70.1	66.8	3.3	145,859	–
Iowa	440,993	91.1	44.6	–	44.5	77,874	–
Kansas	354,664	87.4	58.8	51.3	7.5	72,505	0.3
Kentucky	823,133	89.4	64.7	20.8	43.9	174,351	7.9
Louisiana	1,208,859	65.3	63.4	–	63.4	181,277	0.1
Maine	357,706	49.3	49.3	–	49.3	93,914	–
Maryland	986,304	74.6	74.6	74.6	–	110,648	0.1
Massachusetts[4]	1,566,222	53.1	53.4	32.8	20.7	254,449	7.2
Michigan	1,818,312	88.4	66.7	66.7	–	263,576	0.2
Minnesota	847,638	65.7	65.7	65.7	–	127,651	41.0
Mississippi	621,607	87.2	8.3	8.3	–	144,764	–
Missouri	895,998	97.7	45.4	45.4	–	168,335	0.1
Montana[5]	106,493	76.1	76.1	–	76.1	21,314	–
Nebraska	237,484	85.1	45.6	42.5	3.1	33,994	–
Nevada	297,640	83.6	56.7	56.7	–	43,522	–
New Hampshire	135,092	–	–	–	–	28,153	–

TABLE 15, Continued

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]
New Jersey	1,098,608	77.7%	77.7%	77.7%	–	195,802	14.1%
New Mexico[4]	551,017	72.8	72.9	72.9	–	65,637	50.5
New York	4,925,236	76.7	76.0	75.7	0.3%	706,454	1.3
North Carolina	1,488,263	83.2	77.2	–	77.2	301,493	0.1
North Dakota[4]	66,698	63.6	63.7	0.1	63.6	14,226	0.4
Ohio	2,129,706	75.4	75.4	75.4	–	301,063	0.2
Oklahoma	684,387	86.5	64.2	–	64.2	105,532	0.1
Oregon	652,846	98.2	76.7	76.3	0.5	96,210	37.5
Pennsylvania	2,134,956	81.5	68.2	54.1	14.2	322,835	1.6
Rhode Island[4]	197,248	68.6	69.5	68.6	1.0	37,280	0.5
South Carolina	862,145	100.0	66.3	49.8	16.5	143,325	0.2
South Dakota	120,474	75.8	75.8	–	75.8	17,846	–
Tennessee	1,218,676	100.0	96.4	96.4	–	236,408	57.9
Texas	3,943,189	70.7	70.7	47.5	23.2	615,435	22.0
Utah	269,643	99.8	45.7	19.1	26.6	33,767	0.6
Vermont	177,108	58.5	58.5	58.5	–	33,453	1.1
Virginia[4]	915,038	58.2	64.2	58.2	5.9	168,354	0.4
Washington	1,182,587	88.1	61.8	61.8	–	158,096	1.2
West Virginia[4]	326,749	51.0	52.6	51.0	1.6	74,765	–
Wisconsin	1,173,355	63.7	60.7	60.7	–	182,499	7.2
Wyoming	69,947	–	–	–	–	9,923	–

Notes: PCCM is primary care case management. Excludes the territories. Unlike most other tables and figures in the June 2013 MACStats (with the exception of those in Section 2), this table includes Medicaid-expansion CHIP enrollees.

– Quantity zero.

[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 the Centers for Medicare & Medicaid Services (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 individuals who are dually eligible for Medicare and Medicaid.

[3] Figure is based on the sum of enrollees reported in comprehensive risk-based plans and PCCM programs.

[4] The number of enrollees reported by the state for the managed care types shown 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 more than one of the plan types shown (e.g., both comprehensive risk-based and PCCM) as of the reporting date.

[5] Montana reported 153,588 PCCM enrollees, which exceeds the total Medicaid enrollment reported by the state (106,493) and the unduplicated enrollees in any form of managed care (81,085). PCCM figure shown here was capped at 81,085.

Source: Source: MACPAC analysis of data from CMS, *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

TABLE 16. Number of Managed Care Entities by State and Type, July 1, 2011

State	Comprehensive Risk-based Plans				Limited-benefit Plans			
	Commercial MCO	Medicaid-only MCO	HIO	PACE	PIHP	PAHP	PCCM	Other
Total	148	175	5	79	162	63	40	11
Alabama	–	–	–	–	–	1	1	–
Alaska	–	–	–	–	–	–	–	–
Arizona	–	29	–	–	1	–	–	–
Arkansas	–	–	–	1	–	1	1	–
California	21	3	5	5	10	13	–	–
Colorado	–	1	–	3	6	–	3	–
Connecticut	1	2	–	–	–	–	1	2
Delaware	–	2	–	–	–	–	–	1
District of Columbia	–	2	–	–	1	1	–	–
Florida	22	6	–	3	27	6	1	2
Georgia	–	3	–	–	–	1	1	–
Hawaii	4	1	–	–	–	–	–	–
Idaho	–	–	–	–	–	3	1	–
Illinois	2	3	–	–	–	–	1	–
Indiana	6	–	–	–	–	–	2	1
Iowa	–	–	–	1	1	1	1	–
Kansas	–	2	–	2	1	2	1	–
Kentucky	–	1	–	–	–	1	1	–
Louisiana	–	–	–	2	–	–	1	1
Maine	–	–	–	–	–	–	1	–
Maryland	–	7	–	1	–	5	–	1
Massachusetts	3	6	–	6	1	–	1	–
Michigan	–	14	–	4	18	1	–	–
Minnesota	5	3	–	–	–	–	–	–
Mississippi	–	2	–	–	–	1	–	–
Missouri	–	12	–	1	–	1	–	–
Montana	–	–	–	–	–	–	2	1
Nebraska	2	–	–	–	–	–	1	1

TABLE 16, Continued

State	Comprehensive Risk-based Plans				Limited-benefit Plans			
	Commercial MCO	Medicaid-only MCO	HIO	PACE	PIHP	PAHP	PCCM	Other
Nevada	1	1	–	–	–	1	–	–
New Hampshire	–	–	–	–	–	–	–	–
New Jersey	–	4	–	3	–	1	–	–
New Mexico	6	–	–	1	1	–	–	–
New York	20	13	–	7	22	–	3	–
North Carolina	–	–	–	4	1	–	2	–
North Dakota	–	–	–	1	–	1	1	–
Ohio	–	7	–	2	–	–	–	–
Oklahoma	–	–	–	1	–	1	2	–
Oregon	2	13	–	1	10	8	1	–
Pennsylvania	12	–	–	15	37	2	1	–
Rhode Island	1	1	–	1	–	1	1	–
South Carolina	–	4	–	2	–	2	3	–
South Dakota	–	–	–	–	–	–	1	–
Tennessee	–	6	–	1	1	2	–	–
Texas	6	14	–	3	1	1	1	–
Utah	1	1	–	–	10	2	1	–
Vermont	–	1	–	1	–	–	–	–
Virginia	3	2	–	5	–	1	1	–
Washington	8	–	–	1	2	2	–	1
West Virginia	3	–	–	–	–	–	1	–
Wisconsin	19	9	–	1	11	–	–	–
Wyoming	–	–	–	–	–	–	–	–

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

Comprehensive risk-based managed care includes plans categorized by the Centers for Medicare & Medicaid Services (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 individuals who are dually eligible for Medicare and Medicaid. 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.

Source: MACPAC analysis of data from CMS, *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

TABLE 17. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2010

	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	**71.7%**	**87.0%**	**60.5%**	**63.1%**	**40.6%**	**40.7%**	**48.3%**	**62.2%**	**46.8%**	**28.7%**	**12.4%**	**11.9%**
Alabama	**72.8**	97.2	44.0	66.1	23.0	22.2	**3.0**	–	0.0	6.5	14.3	14.9
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	**91.3**	96.8	87.5	93.8	73.5	79.0	**85.1**	90.9	80.5	88.3	68.0	74.1
Arkansas	**79.8**	97.1	47.9	78.5	47.3	47.9	–	–	–	–	–	–
California	**58.8**	79.0	28.1	92.3	89.0	92.4	**38.5**	64.3	22.9	26.9	15.9	17.7
Colorado	**90.8**	95.0	87.6	85.7	78.0	73.2	**13.3**	14.1	11.7	13.6	10.8	8.9
Connecticut	**62.3**	94.8	61.7	1.0	0.0	0.6	**62.3**	94.8	61.7	1.0	0.0	0.6
Delaware	**88.0**	96.8	88.6	75.9	49.1	49.0	**76.5**	88.5	82.8	49.1	6.3	5.6
District of Columbia	**90.7**	95.1	88.6	92.5	76.3	76.5	**68.2**	88.8	87.2	14.9	0.2	1.8
Florida	**71.7**	90.3	71.6	55.8	16.0	11.3	**71.7**	90.3	71.6	55.8	16.0	11.3
Georgia	**88.9**	97.1	89.8	77.5	53.6	51.5	**69.4**	93.1	84.9	3.2	0.1	0.4
Hawaii	**95.8**	97.6	95.7	94.8	89.6	89.4	**95.8**	97.6	95.7	94.8	89.6	89.4
Idaho[2]	**90.8**	98.2	93.6	80.5	49.8	57.3	–	–	–	–	–	–
Illinois	**71.7**	84.4	78.1	37.6	9.1	3.7	**7.2**	9.6	7.3	0.1	0.1	0.1
Indiana	**77.7**	93.1	88.0	43.1	3.3	4.2	**70.7**	89.3	87.2	13.1	0.3	1.9
Iowa	**78.1**	94.9	49.6	90.8	64.7	74.7	**0.0**	–	–	0.1	0.1	0.1
Kansas	**84.0**	92.1	85.5	78.1	46.1	55.9	**53.6**	75.8	72.0	2.1	0.6	0.9
Kentucky	**90.2**	98.4	96.8	83.0	61.1	60.5	**20.1**	25.2	20.8	15.7	6.5	8.1
Louisiana	**62.1**	88.4	41.1	42.1	1.7	3.3	**0.0**	0.0	–	0.0	0.2	0.1
Maine	–	–	–	–	–	–	–	–	–	–	–	–
Maryland	**72.9**	95.6	63.7	56.9	1.4	4.1	**72.9**	95.6	63.7	56.9	1.4	4.1
Massachusetts	**72.6**	89.2	81.6	54.7	14.2	13.1	**48.5**	60.6	58.4	22.2	12.6	9.6
Michigan	**88.9**	95.9	75.6	90.7	81.6	85.0	**70.9**	85.5	68.8	53.2	3.4	7.1
Minnesota	**67.6**	84.4	70.5	11.4	58.8	43.6	**67.6**	84.4	70.5	11.4	58.8	43.6
Mississippi	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 17, 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[2]	**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	**66.0**	82.4	69.9	44.6	1.1	2.4	–	–	–	–	–	–
Nebraska	**42.3**	51.8	46.9	23.9	3.8	1.6	**38.1**	47.4	39.4	21.9	3.5	0.9
Nevada	**89.2**	96.5	89.6	75.1	56.6	51.5	**60.8**	77.8	72.6	2.0	0.0	0.4
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	**93.4**	96.1	90.0	93.9	85.3	85.8	**72.8**	93.0	81.0	52.5	13.4	12.4
New Mexico	**67.3**	82.4	58.3	46.3	3.5	4.0	**67.3**	82.4	58.3	46.2	3.5	4.0
New York	**65.9**	78.9	73.1	48.8	15.0	12.8	**65.9**	78.9	73.1	48.8	15.0	12.8
North Carolina	**80.9**	96.4	72.8	72.7	30.2	37.6	**0.0**	–	–	0.0	0.1	0.0
North Dakota	**56.1**	75.1	75.1	1.8	–	0.3	–	–	–	–	–	–
Ohio	**75.7**	91.2	92.2	40.3	4.9	3.6	**75.7**	91.2	92.2	40.3	4.9	3.6
Oklahoma	**81.1**	94.6	46.0	83.6	79.8	77.7	**0.0**	–	–	0.0	0.1	0.0
Oregon	**87.0**	95.1	80.3	83.2	67.5	66.1	**74.6**	86.0	73.2	62.0	36.3	38.4
Pennsylvania	**86.8**	95.5	78.9	92.1	51.1	65.4	**59.7**	74.2	60.5	53.7	8.2	7.6
Rhode Island	**59.2**	88.0	78.2	16.7	0.1	1.1	**59.2**	88.0	78.2	16.7	0.1	1.1
South Carolina	**91.9**	99.1	77.0	93.7	86.0	87.0	**53.3**	69.4	54.3	32.3	0.6	2.5
South Dakota	**92.1**	93.3	88.4	91.7	91.5	92.5	–	–	–	–	–	–
Tennessee	**92.7**	97.4	97.7	89.5	62.0	70.8	**92.7**	97.4	97.7	89.5	62.0	70.8
Texas	**74.1**	92.4	52.0	46.7	19.5	21.1	**48.1**	61.4	32.8	22.1	14.9	15.5
Utah	**89.6**	98.6	67.5	94.2	85.4	88.6	**0.3**	0.1	–	1.8	0.1	1.0
Vermont	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	**66.5**	83.1	71.1	42.4	15.1	9.7	**60.8**	78.4	66.7	35.7	4.0	2.0
Washington	**68.7**	90.5	61.8	24.7	12.1	12.1	**67.5**	89.9	61.1	20.8	11.5	11.7
West Virginia	**54.5**	90.0	73.4	2.6	0.0	0.4	**51.8**	85.7	70.8	1.8	0.0	0.4
Wisconsin	**64.5**	82.5	71.0	36.0	16.1	20.5	**58.7**	82.4	71.0	4.8	2.3	3.5
Wyoming	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 17, Continued. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2010

	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	**36.4%**	**41.6%**	**26.1%**	**42.1%**	**31.2%**	**32.0%**	**12.5%**	**17.3%**	**8.3%**	**11.5%**	**2.0%**	**2.4%**
Alabama	**69.9**	97.1	44.0	59.8	9.0	7.7	**46.4**	71.5	14.0	38.2	1.4	1.4
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	**87.8**	96.5	87.1	71.6	53.3	60.4	–	–	–	–	–	–
Arkansas	**78.7**	95.3	47.0	78.4	47.3	47.7	**60.7**	85.9	24.6	54.7	3.9	5.2
California	**55.2**	72.4	25.8	91.9	88.2	91.8	–	–	–	–	–	–
Colorado	**90.6**	95.0	87.6	85.5	76.1	71.8	–	–	–	–	–	–
Connecticut	–	–	–	–	–	–	–	–	–	–	–	–
Delaware	**87.1**	95.9	87.4	75.5	49.0	48.8	–	–	–	–	–	–
District of Columbia	**24.0**	7.0	2.0	83.1	76.3	75.3	–	–	–	–	–	–
Florida	–	–	–	–	–	–	–	–	–	–	–	–
Georgia	**88.5**	96.5	89.4	77.4	53.6	51.5	**8.7**	0.4	0.1	50.1	8.2	6.7
Hawaii	**0.5**	1.1	–	0.6	–	–	–	–	–	–	–	–
Idaho[2]	**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	**2.7**	3.7	2.6	0.0	0.0	0.0	**65.4**	75.8	72.0	37.5	9.0	3.6
Indiana	–	–	–	–	–	–	**11.8**	4.9	18.8	31.8	3.1	3.1
Iowa	**78.0**	94.9	49.2	90.8	64.7	74.6	**38.9**	62.3	30.5	1.5	0.0	0.3
Kansas	**83.9**	92.1	85.5	78.0	45.6	55.6	**5.2**	3.0	1.1	16.6	1.6	1.2
Kentucky	**89.9**	98.1	96.4	82.8	61.0	60.3	**46.2**	68.6	67.6	9.8	0.8	0.9
Louisiana	–	–	–	–	–	–	**62.0**	88.4	41.1	42.0	1.5	3.1
Maine	–	–	–	–	–	–	–	–	–	–	–	–
Maryland	–	–	–	–	–	–	–	–	–	–	–	–
Massachusetts	**29.6**	35.4	29.8	36.1	1.8	3.8	–	–	–	–	–	–
Michigan	**88.7**	95.6	75.4	90.6	81.3	84.8	**0.0**	–	–	0.0	0.0	0.0
Minnesota	–	–	–	–	–	–	–	–	–	–	–	–
Mississippi	–	–	–	–	–	–	–	–	–	–	–	–
Missouri[2]	**26.2**	0.1	0.4	91.2	89.4	89.7	–	–	–	–	–	–
Montana	–	–	–	–	–	–	**66.0**	82.4	69.9	44.6	1.1	2.4
Nebraska	–	–	–	–	–	–	**21.7**	27.3	22.2	11.8	2.0	0.8
Nevada	**89.2**	96.5	89.6	75.1	56.6	51.5	–	–	–	–	–	–
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	**70.7**	66.6	62.7	81.2	81.3	82.2	–	–	–	–	–	–
New Mexico	**67.0**	82.4	58.1	44.7	1.9	2.3	–	–	–	–	–	–
New York	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 17, 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	**69.8%**	88.6%	65.4%	54.4%	5.8%	8.4%	**74.8%**	93.6%	60.1%	62.9%	26.7%	34.2%
North Dakota	–	–	–	–	–	–	**56.1**	75.1	75.1	1.8	–	0.3
Ohio	–	–	–	–	–	–	–	–	–	–	–	–
Oklahoma	**81.1**	94.6	46.0	83.6	79.7	77.7	**2.0**	2.9	1.0	1.4	0.1	0.1
Oregon	**86.9**	94.9	80.3	83.2	67.5	66.1	**0.6**	0.6	0.2	0.9	1.1	1.0
Pennsylvania	**86.2**	95.1	77.8	91.9	50.2	64.8	**17.0**	21.2	17.0	16.1	1.0	1.7
Rhode Island	–	–	–	–	–	–	–	–	–	–	–	–
South Carolina	**91.7**	98.8	76.9	93.6	86.0	87.0	**14.8**	18.6	9.7	14.4	7.2	9.4
South Dakota	**87.3**	88.0	79.3	91.0	91.5	92.4	**44.8**	56.7	55.3	14.3	0.4	0.8
Tennessee	**8.5**	5.2	9.9	19.4	2.5	10.8	–	–	–	–	–	–
Texas	**10.8**	13.1	5.4	9.7	4.3	4.8	**25.2**	31.9	19.6	16.0	0.3	1.0
Utah	**89.6**	98.6	67.5	94.2	85.4	88.6	–	–	–	–	–	–
Vermont	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	–	–	–	–	–	–	**5.9**	4.9	4.6	7.0	11.2	7.7
Washington	–	–	–	–	–	–	**1.6**	1.1	1.1	4.7	0.8	0.6
West Virginia	–	–	–	–	–	–	**3.5**	5.7	3.5	0.9	0.0	0.0
Wisconsin	**5.9**	0.2	0.1	32.1	13.8	17.1	–	–	–	–	–	–
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 aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 65 and older, MACPAC recodes these enrollees as aged. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs. Enrollees are counted as participating in managed care if they were enrolled during the fiscal year and at least one managed care payment was made on their behalf during the fiscal year; this method underestimates participation somewhat because it does not capture enrollees who entered managed care late in the year but for whom a payment was not made until the following fiscal year. Managed care types do not sum to total because individuals are counted in every category for which a payment was made on their behalf during the year.

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 fiscal year (FY) 2010), 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 15). 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.

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

[1] Dual eligibles are individuals who are enrolled in both Medicaid and Medicare; these figures include those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For 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 2010 data unavailable for Idaho and Missouri; FY 2009 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 2013.

TABLE 18. Percentage of Medicaid Benefit Spending on Managed Care by State and Eligibility Group, FY 2010

	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	**23.5%**	**43.9%**	**44.6%**	**15.2%**	**8.8%**	**8.0%**	**21.6%**	**41.1%**	**42.7%**	**13.3%**	**7.5%**	**6.1%**
Alabama	**15.8**	38.3	24.0	7.6	1.0	0.9	**0.2**	–	0.0	0.2	0.3	0.4
Alaska	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	**87.0**	88.7	90.1	84.4	81.3	82.5	**86.0**	87.6	88.5	84.1	80.7	82.0
Arkansas	**0.4**	1.3	0.6	0.2	0.1	0.1	–	–	–	–	–	–
California	**15.5**	42.3	16.8	8.8	9.4	10.0	**14.8**	41.8	16.6	8.5	7.7	8.6
Colorado	**11.4**	16.5	8.5	10.4	9.8	9.6	**5.9**	5.4	4.6	4.9	9.0	6.6
Connecticut	**12.7**	47.2	43.2	0.1	0.0	0.0	**12.7**	47.2	43.2	0.1	0.0	0.0
Delaware	**46.6**	63.0	80.4	28.7	2.7	2.1	**46.5**	62.8	80.3	28.6	2.5	1.9
District of Columbia	**22.8**	62.8	78.6	9.6	0.8	1.6	**21.8**	62.3	78.6	8.4	0.0	0.3
Florida	**17.0**	33.1	18.5	13.9	10.4	5.9	**17.0**	33.1	18.5	13.9	10.4	5.9
Georgia	**28.7**	77.5	75.8	1.2	1.2	1.3	**28.0**	77.4	75.8	0.3	0.0	0.1
Hawaii	**76.0**	74.4	81.2	62.2	86.6	75.4	**76.0**	74.4	81.2	62.2	86.6	75.4
Idaho[2]	**3.1**	11.3	3.8	0.4	0.6	0.8	–	–	–	–	–	–
Illinois	**2.2**	4.8	5.2	0.1	0.3	0.2	**1.6**	3.3	3.9	0.0	0.2	0.2
Indiana	**21.5**	63.0	73.2	3.5	0.1	0.2	**21.0**	62.2	73.0	2.8	0.0	0.2
Iowa	**4.3**	8.2	5.8	4.2	0.5	2.1	**0.1**	–	–	0.1	0.1	0.1
Kansas	**23.3**	60.2	72.3	9.8	3.0	4.3	**16.8**	52.8	71.5	0.6	0.7	0.6
Kentucky	**13.4**	22.1	19.8	11.9	2.0	2.4	**12.5**	19.8	18.7	11.4	1.7	2.0
Louisiana	**0.1**	0.4	0.1	0.0	0.2	0.1	**0.0**	0.0	–	0.0	0.2	0.1
Maine	–	–	–	–	–	–	–	–	–	–	–	–
Maryland	**35.7**	55.4	76.5	27.5	0.6	1.5	**35.7**	55.4	76.5	27.5	0.6	1.5
Massachusetts	**27.2**	51.1	55.9	14.5	13.4	8.0	**24.1**	45.8	50.8	11.3	13.3	7.9
Michigan	**49.5**	65.7	73.2	53.1	7.5	25.7	**41.2**	63.8	66.7	40.4	1.7	4.1
Minnesota	**34.5**	77.1	80.2	5.3	38.3	21.5	**34.5**	77.1	80.2	5.3	38.3	21.5
Mississippi	–	–	–	–	–	–	–	–	–	–	–	–
Missouri[2]	**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	**0.7**	2.2	0.9	0.3	0.0	0.0	–	–	–	–	–	–
Nebraska	**6.2**	11.3	16.2	4.0	0.9	0.2	**6.2**	11.3	16.2	4.0	0.9	0.2
Nevada	**19.2**	44.2	49.8	0.4	0.3	0.4	**18.9**	43.9	49.6	0.2	0.0	0.1
New Hampshire	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 18, 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	**18.7%**	48.6%	61.4%	12.1%	3.4%	2.3%	**18.3%**	48.4%	61.3%	11.7%	2.6%	1.4%
New Mexico	**64.8**	76.3	68.8	49.6	28.1	8.9	**64.7**	76.3	68.8	49.6	28.1	8.9
New York	**18.7**	44.3	42.9	8.3	8.7	5.8	**18.7**	44.3	42.9	8.3	8.7	5.8
North Carolina	**2.5**	3.8	2.2	2.7	0.6	1.5	**0.0**	–	–	0.0	0.1	0.1
North Dakota	**0.5**	2.3	1.2	0.0	–	0.0	–	–	–	–	–	–
Ohio	**29.7**	71.3	79.3	18.4	2.1	0.8	**29.7**	71.3	79.3	18.4	2.1	0.8
Oklahoma	**4.2**	6.5	1.5	3.5	4.4	3.8	**0.2**	–	–	0.0	0.8	0.2
Oregon	**42.4**	76.5	75.7	34.7	6.0	8.2	**40.7**	73.6	74.6	32.7	5.4	7.1
Pennsylvania	**45.5**	82.4	71.5	47.4	7.3	6.5	**41.5**	76.4	69.1	42.9	5.1	3.4
Rhode Island	**29.2**	63.7	83.5	10.5	0.0	0.2	**29.2**	63.7	83.5	10.5	0.0	0.2
South Carolina	**24.9**	44.8	43.3	19.6	1.9	2.6	**24.0**	43.3	42.8	19.2	0.3	1.3
South Dakota	**0.2**	0.6	0.2	0.1	0.1	0.1	–	–	–	–	–	–
Tennessee	**57.9**	70.6	89.9	47.1	33.3	32.9	**57.9**	70.6	89.9	47.1	33.3	32.9
Texas	**18.1**	34.9	21.7	8.6	7.7	7.6	**17.8**	34.4	21.5	8.2	7.6	7.5
Utah	**20.7**	19.4	10.5	26.8	10.4	24.2	**0.5**	0.2	–	0.9	0.1	0.7
Vermont	**81.2**	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	**25.9**	43.0	60.9	19.4	3.8	0.9	**25.8**	42.9	60.9	19.4	3.8	0.9
Washington	**25.8**	71.5	53.0	3.0	1.4	1.3	**25.8**	71.5	53.0	2.9	1.4	1.3
West Virginia	**12.7**	53.1	52.3	0.2	0.0	0.1	**12.6**	53.1	52.3	0.2	0.0	0.1
Wisconsin	**39.6**	53.4	55.0	33.0	33.9	34.9	**19.2**	52.1	54.8	3.4	6.3	5.6
Wyoming	–	–	–	–	–	–	–	–	–	–	–	–

Notes: 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 aged 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals aged 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. Any managed care includes comprehensive risk-based plans, limited-benefit plans, and primary care case management programs.

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

[1] Dual eligibles are individuals who are enrolled in both Medicaid and Medicare; these figures include those with full Medicaid benefits and those with limited benefits who only receive Medicaid assistance with Medicare premiums and cost sharing. For 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] Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 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 2013.

SECTION 5

Technical Guide to the June 2013 MACStats

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

Interpreting Medicaid and CHIP Enrollment and Spending Numbers

Previous MACPAC reports have discussed reasons why estimates of Medicaid and State Children's Health Insurance Program (CHIP) enrollment and spending may vary.[1] Here, Tables 19–22 are used to illustrate how various factors can affect enrollment numbers. Table 19 shows enrollment numbers for the entire U.S. population in 2010.[2] Tables 20–22 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 aged 0 to 18; adults aged 19 to 64; and adults aged 65 and older.

Data sources

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

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

TABLE 19. Medicaid and CHIP Enrollment by Data Source and Enrollment Period, 2010

	Administrative Data		Survey Data (NHIS)
Medicaid and CHIP Enrollment (All Ages)	**Ever enrolled during the year**	**Point in time**	**Point in time**
Medicaid	66.0 million	53.5 million	Not available
CHIP	7.9 million	5.3 million	Not available
Totals for Medicaid and CHIP	74.0 million	58.8 million	47.7 million
U.S. Population	**Census Bureau**		**Survey Data (NHIS)**
	310.3 million	308.8 million	304.1 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	23.8%	19.1%	15.7%

See Table 22 for notes.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2013, CHIP Statistical Enrollment Data System (SEDS) data from CMS as of May 2013, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau data on the monthly postcensal resident population, by single year of age, sex, race, and Hispanic origin.

TABLE 20. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Children Under Age 19, 2010

	Administrative Data		Survey Data (NHIS)
Medicaid and CHIP Enrollment Among Children Under Age 19	**Ever enrolled during the year**	**Point in time**	**Point in time**
Medicaid	32.1 million	26.7 million	Not available
CHIP	7.7 million	5.1 million	Not available
Totals for Medicaid and CHIP	39.8 million	31.8 million	28.2 million
Children Under Age 19	**Census Bureau**		**Survey Data (NHIS)**
	79.1 million	78.8 million	79.0 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Children Under 19			
	50.3%	40.4%	35.7%

See Table 22 for notes.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2013, CHIP Statistical Enrollment Data System (SEDS) data from CMS as of May 2013, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau data on the monthly postcensal resident population, by single year of age, sex, race, and Hispanic origin.

TABLE 21. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Adults Aged 19-64, 2010

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	27.7 million	21.2 million	Not available
CHIP	0.2 million	0.2 million	Not available
Totals for Medicaid and CHIP	27.9 million	21.4 million	16.5 million
Adults Age 19–64	**Census Bureau**		**Survey Data (NHIS)**
	190.6 million	189.7 million	186.4 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 19–64			
	14.6%	11.3%	8.9%

See Table 22 for notes.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2013, CHIP Statistical Enrollment Data System (SEDS) data from CMS as of May 2013, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau data on the monthly postcensal resident population, by single year of age, sex, race, and Hispanic origin.

TABLE 22. Medicaid and CHIP Enrollment by Data Source and Enrollment Period Among Adults Aged 65 and Older, 2010

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	6.3 million	5.5 million	Not available
CHIP	–	–	Not available
Totals for Medicaid and CHIP	6.3 million	5.5 million	3.0 million
Adults Age 65 and Older	**Census Bureau**		**Survey Data (NHIS)**
	40.7 million	40.2 million	38.7 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of All Adults Age 65 and Older			
	15.5%	13.8%	7.7%

Notes: Excludes U.S. territories. Medicaid enrollment numbers obtained from administrative data include 8.5 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, 6.4 million were aged 19 to 64, and 1.5 million were aged 65 or older. In the event individuals were reported to be in both Medicaid and CHIP during the year, individuals were counted only once in the administrative data, based on their most recent source of coverage. Overcounting of enrollees in the administrative data may occur because individuals may move and be enrolled in two states' Medicaid programs during the year. The National Health Interview Survey (NHIS) excludes individuals in institutions (such as nursing homes) and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage. Administrative data (with the exception of Idaho and Missouri, for which fiscal year (FY) 2009 values were used) and Census Bureau data are for FY 2010 (October 2009 through September 2010); the NHIS data are for sources of insurance at the time of the survey in calendar year 2010. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population in the month in FY 2010 with the largest count; the number of residents ever living in the United States during the year is not available. The Census Bureau point-in-time number is the average estimated monthly number of U.S. residents for FY 2010.

Sources: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2013, CHIP Statistical Enrollment Data System (SEDS) data from CMS as of May 2013, data from the National Health Interview Survey (NHIS), and U.S. Census Bureau data on the monthly postcensal resident population, by single year of age, sex, race, and Hispanic origin.

- Medicaid Statistical Information System (MSIS) data for person-level detail, which is used throughout MACStats;
- Medicaid managed care enrollment reports, which are used in Tables 15 and 16;[3] and
- Statistical Enrollment Data System (SEDS) data for CHIP enrollment, used in Tables 19–22.

Additional information is available from nationally representative surveys based on interviews of individuals. The survey data used in Tables 3–11 are from the federal National Health Interview Survey (NHIS), which is described below in more detail.

Tables 19–22 show 2010 survey-based estimates of Medicaid/CHIP enrollment as well as comparable (point-in-time) estimates from the administrative data. Estimates of Medicaid/CHIP enrollment from survey data tend to be lower than numbers from administrative data because survey respondents tend to underreport Medicaid and CHIP, among other reasons described later in this section.

Enrollment period examined

The number of individuals enrolled at a particular point during the year will be lower than the total number enrolled at any point during an entire year. For example, the administrative data in Table 20 show that 50.3 percent of children (39.8 million) were enrolled in Medicaid or CHIP at some time during fiscal year (FY) 2010. However, numbers from the same data source illustrate that the number of children enrolled at a particular point in time (31.8 million, or approximately 40.4 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 (such as in Figure 1). Per enrollee spending levels based on full-year equivalents (Table 14) 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 (less commonly referred to as eligibles) are individuals who are eligible for and enrolled in Medicaid or CHIP. Prior to FY 1990, CMS did not track the number of Medicaid enrollees, only beneficiaries. For some historical numbers, CMS has estimated the number of enrollees prior to 1990 (Figure 1).
- Beneficiaries or persons served (less commonly referred to as recipients) are enrollees who receive covered services or for whom Medicaid or CHIP payments are made. Prior to FY 1998, individuals were not counted as beneficiaries if managed care payments were the only Medicaid payments made on their behalf. Beginning in FY 1998, however, Medicaid managed care enrollees with no fee-for-service (FFS) spending were also counted as beneficiaries, which had a large impact on the numbers (Table 1).[6]

The following example illustrates the difference in these terms. In FY 2010, there were 31.8 million non-disabled child Medicaid enrollees (Table 12). However, there were 30 million beneficiaries in this eligibility group—that is, during FY 2010, 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 3–11 do not include the institutionalized.

Table 22 shows point-in-time enrollment among those aged 65 and older—5.5 million from the administrative data and 3.0 million from the survey data (NHIS). In percentage terms, the difference between the administrative data and the survey data is largest for this age group. This is primarily because the NHIS excludes the institutionalized and because, when Medicaid pays only for Medicare enrollees' cost sharing, the NHIS generally does not count it as Medicaid coverage. Based on administrative data, 1.5 million Medicaid enrollees aged 65 and older received only limited benefits from Medicaid.

State Children's Health Insurance Program Enrollees

Medicaid-expansion CHIP enrollees are children who are entitled to the covered services of a state's Medicaid program, but whose Medicaid coverage is generally funded with CHIP dollars. Depending on the data source, Medicaid enrollment and spending figures may include both Medicaid enrollees funded with Medicaid dollars and Medicaid-expansion CHIP enrollees funded with CHIP dollars. We generally exclude Medicaid-expansion CHIP enrollees from Medicaid analyses where possible in MACStats, but in some cases data sources do not allow these children to be broken out separately.

Methodology for Adjusting Benefit Spending Data

The FY 2010 Medicaid benefit spending amounts shown in the June 2013 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.
- 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 23 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 24 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.

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

Section 2 of MACStats, which encompasses Tables 3–11, uses data from the federal National Health Interview Survey to describe Medicaid and CHIP enrollees in terms of their self-reported demographic, socioeconomic, and health characteristics as well as their use of care. Background information on the NHIS is provided here, along with information on how children with special health care needs are identified in Tables 3–5 using this data source.

National Health Interview Survey data

Every year, thousands of non-institutionalized Americans are interviewed about their health insurance and health status for the NHIS.[14] Individuals' responses to the NHIS questions are the basis for the results in Tables 3–11.

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.[15] 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.[16] Tables 3–11

TABLE 23. Medicaid Benefit Spending in MSIS and CMS-64 Data by State, FY 2010 (billions)

State	MSIS	CMS-64	MSIS as a Percentage of CMS-64
Total	**$339.9**	**$388.6**	**87.5%**
Alabama	4.0	4.7	85.1
Alaska	1.2	1.2	96.8
Arizona	9.5	9.4	101.4
Arkansas	3.7	3.9	93.7
California	34.4	42.1	81.7
Colorado	3.3	4.1	81.4
Connecticut	5.4	5.7	93.8
Delaware	1.3	1.3	104.1
District of Columbia	1.8	1.8	100.1
Florida	16.1	17.4	92.7
Georgia	7.0	7.8	89.5
Hawaii	1.3	1.4	92.3
Idaho[1]	1.3	1.3	104.1
Illinois	11.5	15.3	75.1
Indiana	5.7	5.9	95.6
Iowa	3.0	3.1	96.0
Kansas	2.3	2.4	94.1
Kentucky	5.2	5.6	92.5
Louisiana	5.3	7.0	75.9
Maine	1.5	2.3	63.8
Maryland	6.6	7.1	93.6
Massachusetts	10.8	11.8	92.0
Michigan	11.4	11.7	97.5
Minnesota	7.1	7.6	94.0
Mississippi	3.4	4.1	81.1
Missouri[1]	5.7	7.7	73.2
Montana	0.8	0.9	81.4
Nebraska	1.5	1.7	88.5
Nevada	1.3	1.5	86.2
New Hampshire	1.0	1.3	75.7
New Jersey	8.0	10.2	78.7
New Mexico	2.4	3.4	70.6
New York	47.4	52.1	90.9
North Carolina	9.5	10.9	87.2
North Dakota	0.7	0.7	97.9
Ohio	14.1	15.3	92.5
Oklahoma	3.6	4.1	86.6
Oregon	3.2	4.0	79.5
Pennsylvania	15.9	18.8	84.7
Rhode Island	1.5	1.9	77.3
South Carolina	5.0	5.2	96.7
South Dakota	0.8	0.8	96.5
Tennessee	9.0	8.5	105.5
Texas	20.7	27.2	76.2
Utah	2.0	1.7	116.3
Vermont	1.0	1.3	79.9
Virginia	5.8	6.5	89.9
Washington	6.3	7.1	89.4
West Virginia	2.7	2.6	105.4
Wisconsin	5.4	6.5	82.2
Wyoming	0.6	0.5	106.3

Note: See text for a discussion of differences between Medicaid Statistical Information System (MSIS) and CMS-64 data. Both sources reflect unadjusted amounts as reported by states. Includes federal and state funds. Both sources exclude spending on administration, the territories, and Medicaid-expansion CHIP enrollees; in addition, the CMS-64 amounts exclude $6.7 billion in offsetting collections from third-party liability, estate, and other recoveries.

[1] Fiscal year (FY) 2010 data unavailable for Idaho and Missouri; FY 2009 values shown instead.

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 2013.

TABLE 24. Service Categories Used to Adjust FY 2010 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 ▶ Inpatient hospital non-DSH supplemental payments ▶ Inpatient hospital GME payments ▶ Outpatient hospital non-DSH ▶ Outpatient hospital non-DSH supplemental payments ▶ Emergency services for aliens[1] ▶ Emergency hospital services ▶ Critical access hospitals
Non-hospital acute care	▶ Physician ▶ Dental ▶ Nurse midwife ▶ Nurse practitioner ▶ Other practitioner ▶ Non-hospital outpatient clinic ▶ Lab and 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 ▶ Physician services supplemental payments ▶ Dental ▶ Nurse midwife ▶ Nurse practitioner ▶ Other practitioner ▶ Other practitioner supplemental payments ▶ Non-hospital clinic ▶ Rural health clinic ▶ Federally qualified health center ▶ Lab and X-ray ▶ Sterilizations ▶ Abortions ▶ Hospice ▶ Targeted case management ▶ Statewide case management ▶ Physical therapy ▶ Occupational therapy ▶ Services for speech, hearing, and language ▶ Non-emergency transportation ▶ Private duty nursing ▶ Rehabilitative services (non-school-based) ▶ School-based services ▶ EPSDT screenings ▶ Diagnostic screening and preventive services ▶ Prosthetic devices, dentures, eyeglasses ▶ Care not otherwise categorized

TABLE 24, Continued

Service Category	MSIS Service Types	CMS-64 Service Types
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) ▶ MCO drug rebates ▶ PACE ▶ PAHP ▶ PIHP ▶ PCCM ▶ Premium assistance for private coverage
LTSS non-institutional	▶ Home health ▶ Personal care ▶ HCBS waiver	▶ Home health ▶ Personal care ▶ Personal care – 1915(j) ▶ HCBS waiver ▶ HCBS – 1915(i) ▶ HCBS – 1915(j)
LTSS institutional	▶ Nursing facility ▶ ICF/ID ▶ Inpatient psychiatric for individuals under age 21 ▶ Mental health facility for individuals aged 65 and older	▶ Nursing facility ▶ Nursing facility supplemental payments ▶ ICF/ID ▶ ICF/ID supplemental payments ▶ Mental health facility for under age 21 or aged 65+ non-DSH ▶ Mental health facility for under age 21 or aged 65+ DSH
Medicare[2, 3]		▶ Medicare Part A and Part B premiums ▶ Medicare coinsurance and deductibles for QMBs

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

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

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

are based on NHIS data, pooling the years 2009 through 2011.[17] 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.[18]

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

Children with special health care needs

Tables 3–5 in MACStats present figures for children with special health care needs (CSHCN) who are enrolled in Medicaid or CHIP. As described here, MACPAC uses NHIS data to construct a CSHCN indicator based on responses to a number of questions contained in the survey.

CSHCN are defined by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration as a group of children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[19] This definition is used by all states for policy and program planning purposes for CSHCN and encompasses children with disabilities and also children with chronic conditions (e.g., asthma, juvenile diabetes, sickle cell anemia) that range from mild to severe. Children with special health care needs are a broader group than children with conditions severe enough and family incomes so low as to qualify for SSI.[20] Table 3 shows that only 3.3 percent of children with Medicaid or CHIP receive SSI.

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

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

health and to be able to function appropriately for their age.

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

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

The NHIS varies from year to year in the diagnoses and health conditions that parents are asked about, so establishing a consistent definition across the 2009–2011 NHIS data in this analysis required modifying the survey items used in the CAHMI construct of CSHCN. Estimates for CSHCN in this analysis are not directly comparable to those in prior MACPAC reports because the definition of CSHCN used here differs slightly from the one used previously.[26]

Understanding Managed Care Enrollment and Spending Data

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

- **Medicaid Managed Care Data Collection System (MMCDCS).** The MMCDCS provides state-reported aggregate enrollment statistics and other basic information for each managed care plan within a state. CMS uses the MMCDCS to create an annual Medicaid managed care enrollment report, which is the source of information on Medicaid managed care most commonly cited by CMS, as well as by outside analysts and researchers.[27] CMS also uses the MMCDCS to produce an annual summary of state Medicaid managed care programs that describes the managed care programs within a state (generally defined by the statutory authority under which they operate), each of which may include several managed care plans.[28]
- **Medicaid Statistical Information System (MSIS).** The MSIS provides person-level and claims-level information for all Medicaid enrollees.[29] With regard to managed care, the information collected for each enrollee includes: (1) plan ID numbers and types for up to four managed care plans (including comprehensive risk-based plans, primary care case management programs, and limited-benefit plans) under which the enrollee is covered, (2) the waiver ID number, if enrolled in a 1915(b) or other waiver, (3) claims that provide a record of each capitated payment made on behalf of the enrollee to a managed care plan (generally referred to as capitated claims), and (4) in some states, a record of each service received by the enrollee from a provider under contract with a managed care plan (which generally do not include a payment amount and are referred to as encounter or

"dummy" claims). As discussed in Chapter 4, 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.

In Tables 15 and 16, the statistics cited on managed care are from CMS's annual 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, race, and 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 17 and 18 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 15 and 16. Tables 17 and 18—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.[30]
- 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 15 and 17). Anomalies in the MSIS data are documented by CMS as it reviews each state's quarterly submission, but not all issues may be identified in this process.[31]
- The Medicaid managed care enrollment report provides point-in-time figures (e.g., as of July 1, 2011). 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] 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 19 is modeled after Table 1 in the March 2013 edition of MACStats (Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP,* March 2013 (Washington, DC: MACPAC, 2013): 75. http://www.macpac.gov/reports/). Table 1 of the March 2013 MACStats shows estimates for 2012 and is partly based on projections by the CMS Office of the Actuary. To produce the age breaks used in Tables 19–22, however, numbers were calculated by MACPAC directly from the MSIS. FY 2010 is the latest year for which data are available in MSIS for all but two states.

[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). http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Medicare-and-Medicaid-Statistical-Supplement-List.html.

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

[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 amounts for Medicaid-expansion CHIP enrollees, the territories, administrative activities, the Vaccines for Children program (which is authorized by the Medicaid statute but operates as a separate program), and offsetting collections from third-party liability, estate, and other recoveries.

[10] For a discussion of these data sources, see Chapter 4 and 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] 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).

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

[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, $6.8 billion in FY 2010, are not reported by type of service in the CMS-64 and are not reported at all in MSIS.

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

[15] 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.

[16] 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.

[17] 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.

[18] 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.

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

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

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

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

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

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

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

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

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

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

[29] 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.).

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

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