MACStats: Medicaid and CHIP Data Book

December 2015

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 USC 1396, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

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Table of Contents

Medicaid Benefits

Medicaid Managed Care

Medicaid Program Administration

CHIP

Introduction

The Medicaid and CHIP Payment and Access Commission is pleased to introduce the inaugural edition of the *MACStats: Medicaid and CHIP Data Book.*

In past years MACPAC has published Medicaid and State Children's Health Insurance Program (CHIP) data in our semi-annual reports to Congress. This section, known as MACStats, has provided a comprehensive resource for a broad range of data on Medicaid and CHIP, which often can be difficult to find. Now MACPAC is making Medicaid and CHIP information even more accessible. Instead of publishing MACStats in two parts, we will publish tables and figures on the MACPAC website as soon as new data become available. At the end of each year, MACPAC will compile the most current Medicaid and CHIP program statistics in a stand-alone data book.

The December 2015 data book presents the most current data available on Medicaid and CHIP. Divided into six sections, it includes an overview with key statistics on Medicaid and CHIP; trends in Medicaid; Medicaid and CHIP enrollment and spending with information on benefits, managed care, and program administration; Medicaid and CHIP eligibility; and measures of beneficiary health, use of services, and access to care.

The data describe two programs that provide a safety net for low-income populations who otherwise would not have access to coverage and that cover services other payers often do not cover. The data book also provides a picture of these programs in context. For example, Medicaid and CHIP combined accounted for a smaller share of total health care spending than Medicare in fiscal year 2014, despite covering more people.

The final section of the data book contains a technical guide that describes the data sources used in MACStats, the methods that MACPAC uses to analyze these data, and guidance in interpreting how specific data—such as those on enrollment and spending—may differ from each other or from those published elsewhere.

We would like to thank the many individuals at the Centers for Medicare & Medicaid Services and our contractors—Social & Scientific Systems, and Acumen, LLC—who provided their insights and assistance. We would also like to thank Paula Gordon and GKV Communications, who provided valuable support in copyediting, formatting, and producing this data book.

SECTION 1

Overview—
Key Statistics

Section 1: Overview—Key Statistics

Key Points

- In 2014, more than one-quarter of the U.S. population was enrolled in Medicaid or CHIP for at least part of the year. The estimated number of people ever enrolled in Medicaid was 78.6 million in fiscal year (FY) 2014 (including 1 million individuals in the territories); for CHIP, the figure was 8.3 million (Exhibit 1).
- Nearly half of all individuals enrolled in Medicaid in 2014 had family incomes below the federal poverty level. People enrolled in Medicaid or CHIP were more likely to be Hispanic or black than those enrolled in other types of coverage, and they were more likely to be in fair or poor health than either privately insured or uninsured individuals (Exhibit 2).
- Medicaid and CHIP together accounted for 15.9 percent of national health expenditures in calendar year 2013; Medicare accounted for 20.1 percent; and private insurance accounted for 32.9 percent (Exhibit 3).
- The share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965, but Medicaid continues to account for a smaller share (8.6 percent in FY 2014) than Medicare (14.4 percent) (Exhibit 4).
- Medicaid spending as a share of state budgets varies depending on whether federal funds are included. Looking only at the state-funded portion of state budgets (that is, the portion states must finance on their own through taxes and other means), Medicaid's share was 15.1 percent in state fiscal year (SFY) 2013. After including federal funds in state budgets, a typical practice in other data sources, Medicaid's share was 24.5 percent in SFY 2013 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2014 (millions)

Population	Ever during FY 2014	Point in time during FY 2014	Point in time during CY 2014
	Estimates based on administrative data (CMS)[1]		Survey data (NHIS)[2]
Medicaid enrollees	77.6[3]	63.8	Not available
CHIP enrollees	8.3	5.5	Not available
Totals for Medicaid and CHIP	**85.9**[3]	**69.3**	**55.4**
	Census Bureau data		Survey data (NHIS)[2]
U.S. population	319.3[4]	318.2[4]	313.0
	Administrative and Census Bureau data		Survey data (NHIS)[2]
Medicaid and CHIP enrollment as a percentage of U.S. population	26.9%[1]	21.8%	17.7%

Notes: FY is fiscal year. CY is calendar year. NHIS is National Health Interview Survey. Excludes the territories. For more detailed discussion of why Medicaid and CHIP enrollment numbers can vary, see https://www.macpac.gov/macstats/data-sources-and-methods/. As noted in this exhibit, reasons include differences in the sources of data (e.g., administrative records versus survey interviews), the individuals included in the data (e.g., those receiving full versus limited benefits, those who are living in the community versus an institution such as a nursing home), and the enrollment period examined (e.g., ever during the year versus at a point in time).

[1] Estimates based on administrative data are from the President's budget for FY 2016. Medicaid and CHIP enrollment numbers obtained from administrative data include individuals who received limited benefits (e.g., emergency services only). Combining administrative totals from Medicaid and CHIP may cause some individuals to be double counted if they were enrolled in both programs during the year. Overcounting of enrollees in the administrative data may occur for other reasons—for example, individuals may move and be enrolled in two states' Medicaid programs during the year. Excludes about 1 million individuals in the territories. All other figures in the table exclude individuals in the territories, but the number of excluded individuals is not available.

[2] NHIS data exclude individuals in institutions, such as nursing homes, and active-duty military; in addition, surveys such as the NHIS generally do not classify limited benefits as Medicaid or CHIP coverage and respondents are known to underreport Medicaid and CHIP coverage.

[3] Ever enrolled estimate was not available from CMS for the group of new adults enrolled under state expansions of Medicaid that began in January 2014 and beyond; total reflects the point-in-time estimate for this group instead. As a result, the total is an underestimate of the number of people ever enrolled.

[4] The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of October 2014 (the month with the largest count in FY 2014); 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 2014.

Source: MACPAC, 2015, analysis of CMS, Office of the Actuary, 2015, email to MACPAC staff, April 17; analysis of NHIS data; and analysis of Bureau of the Census, 2015, *Monthly population estimates for the United States: April 1, 2010 to December 1, 2015,* National totals: vintage 2014, http://www.census.gov/popest/data/national/totals/2014/index.html.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2014

Characteristic	Selected coverage sources at time of interview, all ages[1]					Selected coverage sources at time of interview, age 0-18[1]			
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]	Total	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	100.0%	15.5%	60.9%	17.7%	11.4%	100.0%	53.7%	38.3%	5.7%
Coverage									
Length of time with any coverage during year									
Full year	**84.1***	98.7*	95.1*	90.2	–	**90.7***	96.8*	94.3	–
Part year	**7.5***	1.3*	4.9*	9.8	22.6*	**6.1**	3.2*	5.7	40.1*
No coverage during year	**8.4***	–	–	–	77.4*	**3.2***	–	–	59.9*
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/CHIP combination[6]	**1.7***	10.8*	0.2*	9.4	–	**†**	–	†	–
Yes, any private and Medicaid/CHIP combination	**†**	–	0.8*	2.6	–	**1.2***	2.3*	3.2	–
Yes, any other combination	**8.1**	49.8*	11.5*	0.3	–	**†**	0.3	†	–
No	**89.7***	39.4*	87.6	87.7	100.0	**98.5***	97.4*	96.5	100.0
Demographics									
Age									
0–18	**24.8***	0.5*	21.9*	53.8	12.4*	**100.0**	100.0	100.0	100.0
19–64	**60.8***	13.1*	66.6*	39.9	86.5*	**–**	–	–	–
65 or older	**14.3***	86.3*	11.6*	6.3	1.0*	**–**	–	–	–
Gender									
Male	**48.9***	44.4	49.1*	44.5	54.6*	**51.1**	51.1	50.5	53.6
Female	**51.1***	55.6	50.9*	55.5	45.4*	**48.9**	48.9	49.5	46.4
Race									
Hispanic	**17.4***	7.7*	11.3*	29.9	36.5*	**24.3***	14.3*	35.5	43.6*
White, non-Hispanic	**63.4***	78.2*	72.3*	41.5	44.3*	**54.2***	68.4*	36.6	39.5
Black, non-Hispanic	**12.8***	10.0*	9.6*	22.7	13.2*	**15.1***	9.9*	23.0	9.7*
Other non-white, non-Hispanic	**6.4**	4.1*	6.9*	6.0	6.1	**6.4***	7.4*	4.8	7.2

EXHIBIT 2. (continued)

Characteristic	Selected coverage sources at time of interview, age 19-64[1]					Selected coverage sources at time of interview, age 65 and older[1]			
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid/ CHIP[3]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.4%**	**66.7%**	**11.7%**	**16.2%**	**100.0%**	**93.3%**	**49.0%**	**7.8%**
Coverage									
Length of time with any coverage during year									
Full year	**78.0***	96.7*	93.8*	83.3	–	**98.3**	99.1	99.3*	98.3
Part year	**9.6***	3.3*	6.2*	16.7	20.2*	**1.1**	0.9	0.7*	1.7
No coverage during year	**12.5***	–	–	–	79.8*	**0.6***	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/CHIP combination[6]	**1.1***	31.6*	0.1*	9.1	–	**7.0***	7.5*	0.9*	89.4
Yes, any private and Medicaid/CHIP combination	**0.3***	–	0.4*	2.2	–	**–**	–	†	†
Yes, any other combination	**1.1***	20.6*	1.4*	0.5	–	**51.2***	54.6*	91.0*	†
No	**97.5***	47.8*	98.2*	88.2	100.0	**41.7***	37.9*	8.0*	10.2
Demographics									
Age									
0–18	**–**	–	–	–	–	**–**	–	–	–
19–64	**100.0**	100.0	100.0	100.0	100.0	**–**	–	–	–
65 or older	**–**	–	–	–	–	**100.0**	100.0	100.0	100.0
Gender									
Male	**49.0***	48.1*	49.3*	37.7	54.9*	**44.4***	43.8*	44.4*	36.4
Female	**51.0***	51.9*	50.7*	62.3	45.1*	**55.6***	56.2*	55.6*	63.6
Race									
Hispanic	**16.9***	9.1*	11.6*	23.1	35.3*	**7.7***	7.2*	3.6*	24.1
White, non-Hispanic	**63.5***	67.8*	71.0*	47.1	45.2	**78.9***	80.1*	87.1*	48.0
Black, non-Hispanic	**12.7***	19.8*	10.1*	22.8	13.7*	**8.7***	8.5*	6.1*	18.3
Other non-white, non-Hispanic	**6.9**	3.3*	7.3	6.9	5.8*	**4.6***	4.2*	3.2*	9.5

EXHIBIT 2. (continued)

Characteristic	Selected coverage sources at time of interview, all ages[1]					Selected coverage sources at time of interview, age 0-18[1]			
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]	Total	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Education[7]									
Less than high school	**12.8%***	18.6%*	6.4%*	30.1%	26.2%*	–	–	–	–
High school diploma/GED	**26.8***	31.9*	22.8*	34.6	35.4	–	–	–	–
Some college	**30.4***	25.1	32.0*	25.9	28.0*	–	–	–	–
College or graduate degree	**29.9***	24.3*	38.8*	9.4	10.4	–	–	–	–
Marital status[7]									
Married	**55.1***	54.6*	62.1*	32.5	40.5*	–	–	–	–
Widowed	**5.9**	23.0*	4.5*	6.4	1.7*	–	–	–	–
Divorced or separated	**10.6***	13.5*	8.6*	16.9	12.0*	–	–	–	–
Living with partner	**7.5***	2.4*	6.2*	10.2	14.7*	–	–	–	–
Never married	**20.9***	6.5*	18.6*	34.0	31.1*	–	–	–	–
Family income									
Less than 138 percent FPL	**23.4***	20.3*	7.6*	66.1	43.6*	**32.8%***	7.1%*	68.2%	42.7%*
Has income in ranges below									
Less than 100 percent FPL	**15.3***	11.3*	4.1*	47.7	28.3*	**22.5***	3.7*	49.1	26.1*
100–199 percent FPL	**20.0***	24.7*	12.3*	33.8	34.7	**23.0***	12.9*	35.1	37.3
200–399 percent FPL	**29.4***	33.2*	33.3*	14.3	27.4*	**28.1***	38.1*	13.3	29.5*
400 percent FPL or higher	**35.3***	30.8*	50.4*	4.1	9.7*	**26.4***	45.3*	2.5	7.0*
Other demographic characteristics									
Citizen of United States	**92.9**	98.2*	95.6*	93.3	74.4*	**97.3**	98.6*	97.5	84.4*
Parent of a dependent child[7]	**29.7***	2.2*	31.6*	36.9	35.3	–	–	–	–
Currently working[7]	**61.8***	14.1*	73.2*	35.5	65.4*	–	–	–	–
Veteran[7]	**9.0***	20.9*	7.8*	3.1	3.0	–	–	–	–
Receives SSI or SSDI	**4.0***	12.8	1.1*	13.2	0.7*	**1.6***	0.5*	3.6	0.5*
Health									
Current health status									
Excellent or very good	**66.5***	41.2*	73.2*	59.5	59.2	**84.2***	89.8*	76.7	78.9
Good	**23.7***	32.2*	21.0*	25.2	30.3*	**14.1***	9.3*	20.5	19.4
Fair or poor	**9.8***	26.7*	5.8*	15.3	10.4*	**1.7***	0.9*	2.9	1.7*

EXHIBIT 2. (continued)

Characteristic	Selected coverage sources at time of interview, age 19-64[1]					Selected coverage sources at time of interview, age 65 and older[1]			
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid/ CHIP[3]
Education[7]									
Less than high school	**11.6%***	24.2%*	5.4%*	27.7%	25.9%	**18.0%***	17.8%*	12.2%*	45.4%
High school diploma/GED	**25.9***	36.4	21.4*	35.9	35.5	**30.9***	31.3*	30.7*	26.0
Some college	**31.8***	29.2	33.2*	27.6	28.2	**24.3***	24.5*	25.3*	14.8
College or graduate degree	**30.7***	10.2	40.1*	8.7	10.3*	**26.8***	26.5*	31.8*	13.8
Marital status[7]									
Married	**54.6***	39.1*	62.1*	32.9	40.4*	**57.3***	57.0*	62.0*	30.2
Widowed	**1.4***	6.2*	1.1*	2.3	1.5*	**25.0***	25.5*	23.9*	32.3
Divorced or separated	**10.4***	26.9*	8.5*	15.9	11.9*	**11.6***	11.4*	9.2*	23.4
Living with partner	**8.8***	6.1*	7.0*	11.5	14.8*	**1.8**	1.9	1.6	2.3
Never married	**24.8***	21.8*	21.3*	37.4	31.3*	**4.3***	4.1*	3.2*	11.8
Family income									
Less than 138 percent FPL	**21.3***	46.4*	7.7*	63.8	43.7*	**16.3***	16.1*	7.8*	61.9
Has income in ranges below									
Less than 100 percent FPL	**13.9***	30.1*	4.4*	46.9	28.5*	**8.5***	8.2*	2.8*	41.6
100–199 percent FPL	**18.1***	35.1*	11.1*	31.8	34.3*	**22.7***	23.0*	17.6*	35.7
200–399 percent FPL	**28.7***	23.0*	31.3*	15.8	27.2*	**34.4***	34.9*	36.0*	14.1
400 percent FPL or higher	**39.2***	11.7*	53.2*	5.5	10.0*	**34.4***	33.9*	43.6*	8.6
Other demographic characteristics									
Citizen of United States	**90.2***	98.4*	94.1*	88.5	73.4*	**97.1***	98.1*	99.0*	88.3
Parent of a dependent child[7]	**36.6***	12.6*	37.0*	42.6	35.7*	**0.7**	0.6	0.5	1.0
Currently working[7]	**72.6***	10.4*	82.2*	40.4	65.9*	**16.4***	14.7*	21.3*	5.0
Veteran[7]	**5.8***	9.4*	5.2*	2.3	3.0*	**22.7***	22.7*	22.9*	7.8
Receives SSI or SSDI	**5.0***	71.5*	1.4*	23.2	0.8*	**3.8***	3.7*	0.8*	31.7
Health									
Current health status									
Excellent or very good	**64.3***	14.5*	71.5*	42.4	56.7*	**44.9***	45.0*	51.6*	22.4
Good	**25.4***	25.8*	22.9*	30.5	31.9	**33.3**	33.2	32.3	31.7
Fair or poor	**10.3***	59.7*	5.6*	27.2	11.5*	**21.7***	21.7*	16.1*	45.9

EXHIBIT 2. (continued)

Notes: FPL is federal poverty level. SSDI is Social Security Disability Insurance. SSI is Supplemental Security Income. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/publication/characteristics-of-non-institutionalized-individuals-by-source-of-health-insurance/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized individuals, regardless of coverage source. In this exhibit, the sum of values across health insurance coverage types may not add to 100 percent for each age group because individuals may have multiple sources of coverage and because not all types of coverage are displayed. Other MACStats exhibits apply a hierarchy to assign individuals with multiple coverage sources to a primary source, and may therefore have different results than those shown here. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[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] Components may not sum to 100 percent because individuals may have multiple sources of coverage and because not all types of coverage are displayed.

[6] NHIS and other survey data underestimate the number of individuals dually enrolled in Medicare and Medicaid, in part because most surveys do not count those whose only Medicaid benefit is payment of Medicare premiums and cost sharing as having Medicaid coverage.

[7] Information is limited to those age 19 or older.

Source: MACPAC, 2015, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2013

Type of expenditure	Payer amount (millions)							
	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Total	**$2,919,137**	**$449,389**	**$13,493**	**$585,701**	**$961,741**	**$92,570**	**$476,818**	**$339,422**
Hospital care	**936,867**	163,534	3,478	242,670	348,021	50,955	95,559	32,650
Physician and clinical services	**586,675**	50,123	3,534	130,302	267,601	20,594	59,170	55,350
Dental services	**110,970**	7,506	1,497	475	52,624	1,204	542	47,123
Other professional services[3]	**80,247**	5,011	254	18,045	29,306	–	7,039	20,592
Home health care	**79,772**	29,103	33	34,381	6,336	1,079	2,412	6,428
Other non-durable medical products[4]	**55,892**	–	–	2,667	–	–	2	53,223
Prescription drugs	**271,096**	21,173	1,415	74,647	117,937	7,500	2,513	45,911
Durable medical equipment[5]	**42,987**	4,904	132	7,692	4,977	–	625	24,656
Nursing care facilities and continuing care retirement communities[6]	**155,829**	46,867	11	34,555	12,580	4,475	11,519	45,822
Other health, residential, and personal care services[7]	**148,230**	82,560	954	5,108	6,611	3,514	41,815	7,668
Administration[8]	**210,588**	38,607	2,185	35,157	115,749	3,248	15,641	–
Public health activity	**75,388**	–	–	–	–	–	75,388	–
Investment	**164,594**	–	–	–	–	–	164,594	–

EXHIBIT 3. (continued)

Type of expenditure	Share of total							
	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Total	**100.0%**	**15.4%**	**0.5%**	**20.1%**	**32.9%**	**3.2%**	**16.3%**	**11.6%**
Hospital care	**100.0**	17.5	0.4	25.9	37.1	5.4	10.2	3.5
Physician and clinical services	**100.0**	8.5	0.6	22.2	45.6	3.5	10.1	9.4
Dental services	**100.0**	6.8	1.3	0.4	47.4	1.1	0.5	42.5
Other professional services[3]	**100.0**	6.2	0.3	22.5	36.5	–	8.8	25.7
Home health care	**100.0**	36.5	0.0	43.1	7.9	1.4	3.0	8.1
Other non-durable medical products[4]	**100.0**	–	–	4.8	–	–	0.0	95.2
Prescription drugs	**100.0**	7.8	0.5	27.5	43.5	2.8	0.9	16.9
Durable medical equipment[5]	**100.0**	11.4	0.3	17.9	11.6	–	1.5	57.4
Nursing care facilities and continuing care retirement communities[6]	**100.0**	30.1	0.0	22.2	8.1	2.9	7.4	29.4
Other health, residential, and personal care services[7]	**100.0**	55.7	0.6	3.4	4.5	2.4	28.2	5.2
Administration[8]	**100.0**	18.3	1.0	16.7	55.0	1.5	7.4	–
Public health activity	**100.0**	–	–	–	–	–	100.0	–
Investment	**100.0**	–	–	–	–	–	100.0	–

Notes: Figures for nursing care facilities and continuing retirement communities and other health, residential, and personal care reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40 percent of nursing home expenditures and about three-quarters of other personal health care expenditures.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

EXHIBIT 3. (continued)

[1] U.S. Department of Defense and U.S. Department of Veterans Affairs.

[2] Includes all other public and private programs and expenditures except for out-of-pocket amounts.

[3] The other professional services category includes services provided in establishments operated by health practitioners other than physicians and dentists, including those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational, and speech therapists, among others.

[4] The other non-durable medical products category includes the retail sales of non-prescription drugs and medical sundries.

[5] The durable medical equipment category includes retail sales of items such as contact lenses, eyeglasses, and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals.

[6] The nursing care facilities and continuing care retirement communities category includes nursing and rehabilitative services provided in freestanding nursing home facilities that are generally provided for an extended period of time by registered or licensed practical nurses and other staff.

[7] The other health, residential, and personal care category includes spending for Medicaid home and community-based waivers, care provided in residential facilities for people with intellectual disabilities or mental health and substance abuse disorders, ambulance services, school health, and worksite health care.

[8] The administration category includes the administrative cost of health care programs (e.g., Medicare and Medicaid) and the net cost of private health insurance (administrative costs, as well as additions to reserves, rate credits and dividends, premium taxes, and plan profits or losses).

Sources: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2014, *National health expenditures by type of service and source of funds: Calendar years 1960–2013,* Baltimore, MD: OACT, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2013.zip. OACT, 2014, *National health expenditure accounts: Methodology paper, 2013,* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-13.pdf.

EXHIBIT 4. Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2014

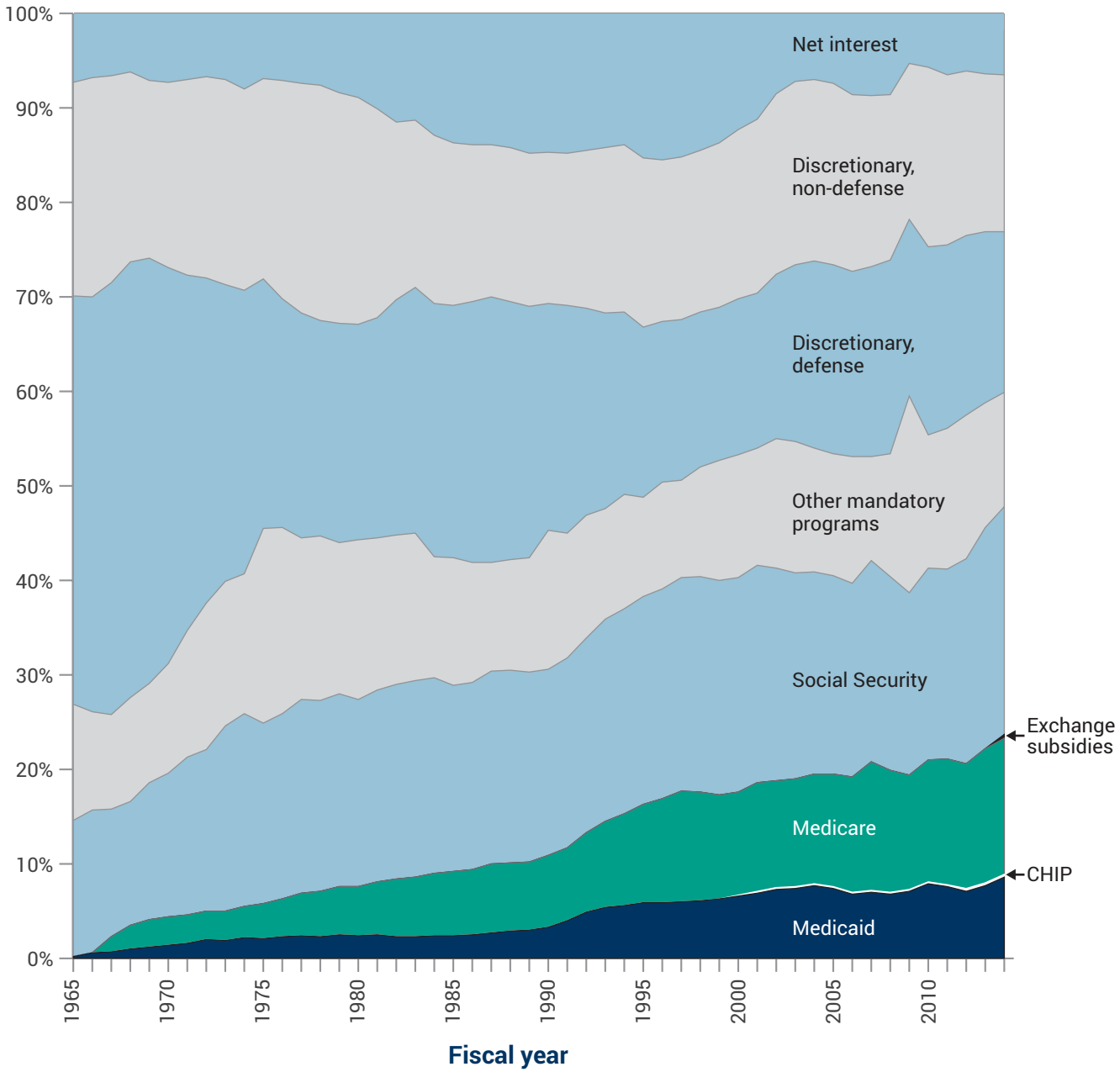


EXHIBIT 4. (continued)

Fiscal year	Mandatory programs						Discretionary programs		Net interest
	Medicaid	CHIP	Medicare	Exchange subsidies	Social Security	Other	Defense	Non-defense	
1965	0.2%	–	–	–	14.4%	12.3%	43.2%	22.6%	7.3%
1970	1.4	–	3.0%	–	15.2	11.6	41.9	19.6	7.3
1975	2.1	–	3.7	–	19.1	20.6	26.4	21.2	7.0
1980	2.4	–	5.2	–	19.8	16.9	22.8	24.0	8.9
1985	2.4	–	6.8	–	19.7	13.5	26.7	17.2	13.7
1990	3.3	–	7.6	–	19.7	14.7	24.0	16.0	14.7
1991	4.0	–	7.7	–	20.1	13.2	24.1	16.1	14.7
1992	4.9	–	8.4	–	20.6	13.0	21.9	16.7	14.4
1993	5.4	–	9.1	–	21.4	11.7	20.7	17.5	14.1
1994	5.6	–	9.7	–	21.7	12.1	19.3	17.7	13.9
1995	5.9	–	10.4	–	22.0	10.5	18.0	17.9	15.3
1996	5.9	–	11.0	–	22.2	11.3	17.0	17.1	15.4
1997	6.0	–	11.7	–	22.6	10.3	17.0	17.2	15.2
1998	6.1	0.0%	11.5	–	22.8	11.6	16.4	17.1	14.6
1999	6.3	0.0	11.0	–	22.7	12.7	16.2	17.4	13.5
2000	6.6	0.1	10.9	–	22.7	13.0	16.5	17.9	12.5
2001	6.9	0.2	11.5	–	23.0	12.4	16.4	18.4	11.1
2002	7.3	0.2	11.3	–	22.5	13.7	17.4	19.1	8.5
2003	7.4	0.2	11.4	–	21.8	13.9	18.7	19.4	7.1
2004	7.7	0.2	11.6	–	21.4	13.1	19.8	19.2	7.0
2005	7.4	0.2	11.9	–	21.0	12.9	20.0	19.2	7.4
2006	6.8	0.2	12.2	–	20.5	13.4	19.6	18.7	8.5
2007	7.0	0.2	13.6	–	21.3	11.0	20.1	18.1	8.7
2008	6.8	0.2	12.9	–	20.5	13.0	20.5	17.5	8.5
2009	7.1	0.2	12.1	–	19.3	20.8	18.7	16.5	5.3
2010	7.9	0.2	12.9	–	20.3	14.1	19.9	19.0	5.7
2011	7.6	0.2	13.3	–	20.1	14.9	19.4	18.0	6.4
2012	7.1	0.3	13.2	–	21.7	15.2	19.0	17.4	6.2
2013	7.7	0.3	14.2	–	23.4	13.2	18.1	16.7	6.4
2014	8.6	0.3	14.4	0.4%	24.1	12.1	17.0	16.6	6.5

Notes: FY is fiscal year.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

Source: MACPAC, 2015, analysis of Office of Management and Budget (OMB), *Fiscal year 2016 historical tables: Budget of the U.S. government,* Tables 6.1, 8.5, and 8.7, Washington, DC: OMB, http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=BUDGET-2016-TAB.

EXHIBIT 5. Medicaid as a Share of State Budgets Including and Excluding Federal Funds by State, SFY 2013

State	Total budget (including all state and federal funds)				State-funded budget (no federal funds)			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
Total	**$1,689,542**	**24.5%**	**19.8%**	**10.3%**	**$1,186,805**	**15.1%**	**23.9%**	**13.0%**
Alabama	24,520	22.8	20.4	19.9	15,038	11.7	26.9	24.6
Alaska	11,838	12.2	13.7	9.2	9,108	6.7	15.4	10.6
Arizona	28,297	29.8	18.6	14.3	16,289	16.4	25.4	20.3
Arkansas	21,445	21.0	15.6	15.4	15,363	8.7	18.4	21.5
California	211,432	25.1	21.4	6.6	141,001	17.5	27.6	6.5
Colorado	29,035	22.0	26.0	8.3	21,612	16.6	32.1	9.1
Connecticut	27,852	21.8	14.1	10.6	25,239	24.0	13.7	10.3
Delaware	9,162	17.2	24.3	4.6	7,379	9.6	27.3	4.8
District of Columbia[2]	–	–	–	–	–	–	–	–
Florida	63,971	31.8	19.3	8.5	39,699	21.4	25.8	13.6
Georgia	42,444	21.3	24.1	19.0	29,398	10.6	26.8	27.2
Hawaii	11,584	14.4	15.5	10.9	9,672	8.2	15.6	12.9
Idaho	6,691	28.0	24.2	8.1	4,043	15.7	34.1	13.4
Illinois	65,287	23.8	13.3	3.7	49,815	15.9	13.2	4.3
Indiana	28,171	31.2	30.8	6.1	17,814	15.9	42.8	9.6
Iowa	19,531	19.8	16.4	26.0	13,804	12.6	20.0	33.2
Kansas	13,969	18.5	26.8	18.2	10,079	11.5	32.4	19.1
Kentucky	25,673	21.9	19.6	26.7	17,672	9.6	23.6	33.4
Louisiana	27,317	25.1	19.3	10.3	17,076	12.5	24.7	15.5
Maine	7,679	32.7	16.9	3.6	5,116	19.4	21.4	5.4
Maryland	36,255	21.0	19.2	14.5	27,071	13.8	22.1	18.2
Massachusetts	57,541	18.7	11.2	10.1	42,011	9.0	12.9	13.8
Michigan	47,398	26.4	27.2	4.2	29,974	14.4	37.2	6.2
Minnesota	33,074	24.3	29.2	4.7	24,639	16.3	36.2	6.3
Mississippi	18,512	26.1	16.4	16.1	10,757	11.2	21.7	26.2

EXHIBIT 5. (continued)

State	Total budget (including all state and federal funds)				State-funded budget (no federal funds)			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
Missouri	$22,943	35.8%	22.8%	4.8%	$15,734	25.2%	27.2%	7.0%
Montana	6,040	17.9	15.5	10.1	3,925	8.8	19.7	14.2
Nebraska	10,162	17.9	14.6	23.3	7,148	11.5	16.2	28.3
Nevada	8,897	22.7	22.3	8.5	5,979	14.3	26.7	12.7
New Hampshire	5,017	25.6	23.4	2.2	3,413	19.9	28.5	3.3
New Jersey	50,811	20.4	24.9	7.9	38,770	12.4	30.4	10.3
New Mexico	14,696	25.0	19.5	19.3	8,897	12.6	27.6	24.5
New York	133,097	29.1	19.3	7.6	94,523	16.3	23.5	10.4
North Carolina	43,105	30.0	24.8	12.4	30,414	14.8	30.5	17.5
North Dakota	5,712	13.7	15.0	19.0	4,176	8.6	17.2	23.2
Ohio	58,268	29.2	17.0	4.3	45,621	28.3	17.3	5.5
Oklahoma	21,430	23.0	16.2	22.7	14,507	13.7	19.4	30.0
Oregon	25,803	21.4	14.3	1.1	18,352	11.1	17.0	1.2
Pennsylvania	85,378	26.9	14.9	2.1	61,433	17.2	16.8	2.9
Rhode Island	7,866	24.8	14.9	13.0	5,346	17.8	17.9	19.1
South Carolina	22,208	22.0	17.6	19.5	14,408	9.5	20.9	25.8
South Dakota	4,098	19.9	14.1	22.3	2,604	12.1	15.6	32.0
Tennessee	30,491	30.8	17.8	13.9	17,959	18.3	23.7	22.5
Texas	93,244	31.7	27.4	15.7	62,360	19.3	33.1	19.6
Utah	12,679	17.2	23.6	11.5	9,233	8.1	27.8	15.6
Vermont	4,965	28.3	32.0	1.8	3,270	19.2	44.9	2.8
Virginia	45,737	16.7	15.1	15.3	36,191	10.7	16.3	15.9
Washington	33,996	11.9	23.4	14.3	25,896	7.9	27.4	18.6
West Virginia	22,320	13.5	10.5	13.7	18,245	4.7	11.0	15.2
Wisconsin	42,769	17.2	16.2	14.3	31,954	9.1	19.3	13.6
Wyoming	9,132	6.6	10.9	4.8	6,778	4.4	14.3	6.4

EXHIBIT 5. (continued)

Notes: SFY is state fiscal year. Total budget includes federal and all other funds. State-funded budget includes state general funds, other state funds, and bonds. Medicaid, elementary and secondary education, and higher education represent the largest total budget shares among functions broken out separately by the National Association of State Budget Officers (NASBO). Functions not shown here are transportation, corrections, public assistance, and all other. Medicaid spending amounts exclude administrative costs but include Medicare Part D phased-down state contribution (also referred to as clawback) payments.

[1] Total and state-funded budget shares should be viewed with caution because they reflect varying state practices. For example, Connecticut reports all of its Medicaid spending as state-funded spending due to the direct deposit of federal funds into the state treasury. In addition, some functions—particularly elementary and secondary education—may be partially funded outside of the state budget by local governments.

[2] NASBO does not collect information for the District of Columbia.

Source: National Association of State Budget Officers (NASBO), 2014, *State expenditure report: Examining fiscal 2012–2014 state spending,* Washington, DC: NASBO, https://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202012-2014%29S.pdf.

EXHIBIT 6. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, FYs 2012–2016

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2012	FY 2013	FY 2014[1]	FY 2015[1]	FY 2016[1]	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[2]
Alabama	68.62%	68.53%	68.12%	68.99%	69.87%	78.03%	77.97%	77.68%	78.29%	100.00%
Alaska	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Arizona	67.30	65.68	67.23	68.46	68.92	77.11	75.98	77.06	77.92	100.00
Arkansas	70.71	70.17	70.10	70.88	70.00	79.50	79.12	79.07	79.62	100.00
California	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Colorado	50.00	50.00	50.00	51.01	50.72	65.00	65.00	65.00	65.71	88.50
Connecticut	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Delaware	54.17	55.67	55.31	53.63	54.83	67.92	68.97	68.72	67.54	91.38
District of Columbia	70.00	70.00	70.00	70.00	70.00	79.00	79.00	79.00	79.00	100.00
Florida	56.04	58.08	58.79	59.72	60.67	69.23	70.66	71.15	71.80	95.47
Georgia	66.16	65.56	65.93	66.94	67.55	76.31	75.89	76.15	76.86	100.00
Hawaii	50.48	51.86	51.85	52.23	53.98	65.34	66.30	66.30	66.56	90.79
Idaho	70.23	71.00	71.64	71.75	71.24	79.16	79.70	80.15	80.23	100.00
Illinois	50.00	50.00	50.00	50.76	50.89	65.00	65.00	65.00	65.53	88.62
Indiana	66.96	67.16	66.92	66.52	66.60	76.87	77.01	76.84	76.56	99.62
Iowa	60.71	59.59	57.93	55.54	54.91	72.50	71.71	70.55	68.88	91.44
Kansas	56.91	56.51	56.91	56.63	55.96	69.84	69.56	69.84	69.64	92.17
Kentucky	71.18	70.55	69.83	69.94	70.32	79.83	79.39	78.88	78.96	100.00
Louisiana[3]	69.78	65.51	62.11	62.05	62.21	72.76	72.87	72.69	73.44	96.55
Maine	63.27	62.57	61.55	61.88	62.67	74.29	73.80	73.09	73.32	96.87
Maryland	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Michigan	66.14	66.39	66.32	65.54	65.60	76.30	76.47	76.42	75.88	98.92
Minnesota	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Mississippi	74.18	73.43	73.05	73.58	74.17	81.93	81.40	81.14	81.51	100.00
Missouri	63.45	61.37	62.03	63.45	63.28	74.42	72.96	73.42	74.42	97.30
Montana	66.11	66.00	66.33	65.90	65.24	76.28	76.20	76.43	76.13	98.67
Nebraska	56.64	55.76	54.74	53.27	51.16	69.65	69.03	68.32	67.29	88.81

EXHIBIT 6. (continued)

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2012	FY 2013	FY 2014[1]	FY 2015[1]	FY 2016[1]	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016[2]
Nevada	56.20%	59.74%	63.10%	64.36%	64.93%	69.34%	71.82%	74.17%	75.05%	98.45%
New Hampshire	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
New Jersey	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
New Mexico	69.36	69.07	69.20	69.65	70.37	78.55	78.35	78.44	78.76	100.00
New York	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
North Carolina	65.28	65.51	65.78	65.88	66.24	75.70	75.86	76.05	76.12	99.37
North Dakota	55.40	52.27	50.00	50.00	50.00	68.78	66.59	65.00	65.00	88.00
Ohio	64.15	63.58	63.02	62.64	62.47	74.91	74.51	74.11	73.85	96.73
Oklahoma	63.88	64.00	64.02	62.30	60.99	74.72	74.80	74.81	73.61	95.69
Oregon	62.91	62.44	63.14	64.06	64.38	74.04	73.71	74.20	74.84	98.07
Pennsylvania	55.07	54.28	53.52	51.82	52.01	68.55	68.00	67.46	66.27	89.41
Rhode Island	52.12	51.26	50.11	50.00	50.42	66.48	65.88	65.08	65.00	88.29
South Carolina	70.24	70.43	70.57	70.64	71.08	79.17	79.30	79.40	79.45	100.00
South Dakota	59.13	56.19	53.54	51.64	51.61	71.39	69.33	67.48	66.15	89.13
Tennessee	66.36	66.13	65.29	64.99	65.05	76.45	76.29	75.70	75.49	98.54
Texas	58.22	59.30	58.69	58.05	57.13	70.75	71.51	71.08	70.64	92.99
Utah	70.99	69.61	70.34	70.56	70.24	79.69	78.73	79.24	79.39	100.00
Vermont	57.58	56.04	55.11	54.01	53.90	70.31	69.23	68.58	67.81	90.73
Virginia	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Washington	50.00	50.00	50.00	50.03	50.00	65.00	65.00	65.00	65.02	88.00
West Virginia	72.62	72.04	71.09	71.35	71.42	80.83	80.43	79.76	79.95	100.00
Wisconsin	60.53	59.74	59.06	58.27	58.23	72.37	71.82	71.34	70.79	93.76
Wyoming	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
American Samoa	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Guam	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
N. Mariana Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Puerto Rico	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Virgin Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50

EXHIBIT 6. (continued)

Notes: FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. ACA is Patient Protection and Affordable Care Act (P.L. 111-148, as amended). The federal government's share of most Medicaid service costs is determined by the FMAP, with some exceptions. For Medicaid administrative costs, the federal share does not vary by state and is generally 50 percent. The E-FMAP determines the federal share of both service and administrative costs for CHIP, subject to the availability of funds from a state's federal allotments for CHIP.

FMAPs for Medicaid are generally calculated based on a formula that compares each state's per capita income relative to U.S. per capita income and provides a higher federal match for states with lower per capita incomes, subject to a statutory minimum (50 percent) and maximum (83 percent). The general formula for a given state is: FMAP = 1 — [(state per capita income)^2 / (U.S. per capita income)^2 × 0.45].

Medicaid exceptions to this formula include the District of Columbia (set in statute at 70 percent) and the territories (set in statute at 55 percent). Other Medicaid exceptions apply to certain services, providers, or situations (e.g., services provided through an Indian Health Service facility receive an FMAP of 100 percent). Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent and adding 23 percentage points (see note 2).

[1] For certain newly eligible individuals under the Medicaid expansion beginning in 2014, there is an increased FMAP (100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and subsequent years). An increased FMAP is also available for certain states that previously expanded eligibility to low-income parents and non-pregnant adults without children prior to enactment of the ACA.

[2] Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAP is increased by 23 percentage points, not to exceed 100 percent, for all states.

[3] Louisiana received a disaster-recovery state FMAP adjustment for the fourth quarter of FY 2011 and FYs 2012–2014.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for various years.

SECTION 2

Trends

Section 2: Trends

Key Points

- Trends in Medicaid spending and enrollment over time, shown in Exhibits 8–10, are affected by federal and state policy choices as well as economic factors. Recent examples include growth around the recessions of 2001 and 2007–2009, which slowed as economic conditions subsequently improved; the fiscal year (FY) 2006 decrease in Medicaid spending driven by the implementation of Medicare Part D, which shifted dually eligible beneficiaries' outpatient prescription drug costs from Medicaid to Medicare; and the FY 2014 increase in Medicaid spending driven in part by expanded eligibility under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).
- Medicaid enrollment trends vary by eligibility group. Children (excluding those eligible on the basis of disability) experienced the largest enrollment increase in absolute numbers between FY 1975 and FY 2012, from 9.6 million to 30.5 million. Individuals qualifying for Medicaid on the basis of disability—the smallest eligibility group in terms of absolute numbers—had the largest percentage increase in enrollment, almost quadrupling over this period (Exhibit 7).
- Medicaid's share of both state-funded budgets (excluding federal funds) and total state budgets (including federal funds) has grown substantially since state fiscal year (SFY) 1987. In SFYs 2009 and 2010, the program's share of state-funded budgets remained stable or dropped, while its share of total state budgets continued to increase. This divergence was due to a temporary increase in federal matching rates, which effectively allowed states to maintain their programs with a smaller state contribution (Exhibit 13).
- Between 2013 and 2015, the number of individuals enrolled in full-benefit Medicaid and CHIP grew by more than 14 million, largely due to changes made by the ACA. Enrollment in July 2014 was 14.4 percent higher than average monthly enrollment during July to September 2013, a baseline period that precedes the start of open enrollment for exchange plans and state expansions of Medicaid for adults under the ACA. Between July 2014 and July 2015, enrollment grew by an additional 7.3 percent. Because not all states have chosen to expand Medicaid, state-specific growth rates vary substantially (Exhibit 11).
- Medicaid and CHIP are projected to maintain a steady share of national health expenditures at about 17 percent through 2024, and Medicare's share is projected to increase from about 20 percent to 22.5 percent (Exhibit 12).

EXHIBIT 7. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FYs 1975–2012 (thousands)

Fiscal 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

EXHIBIT 7. (continued)

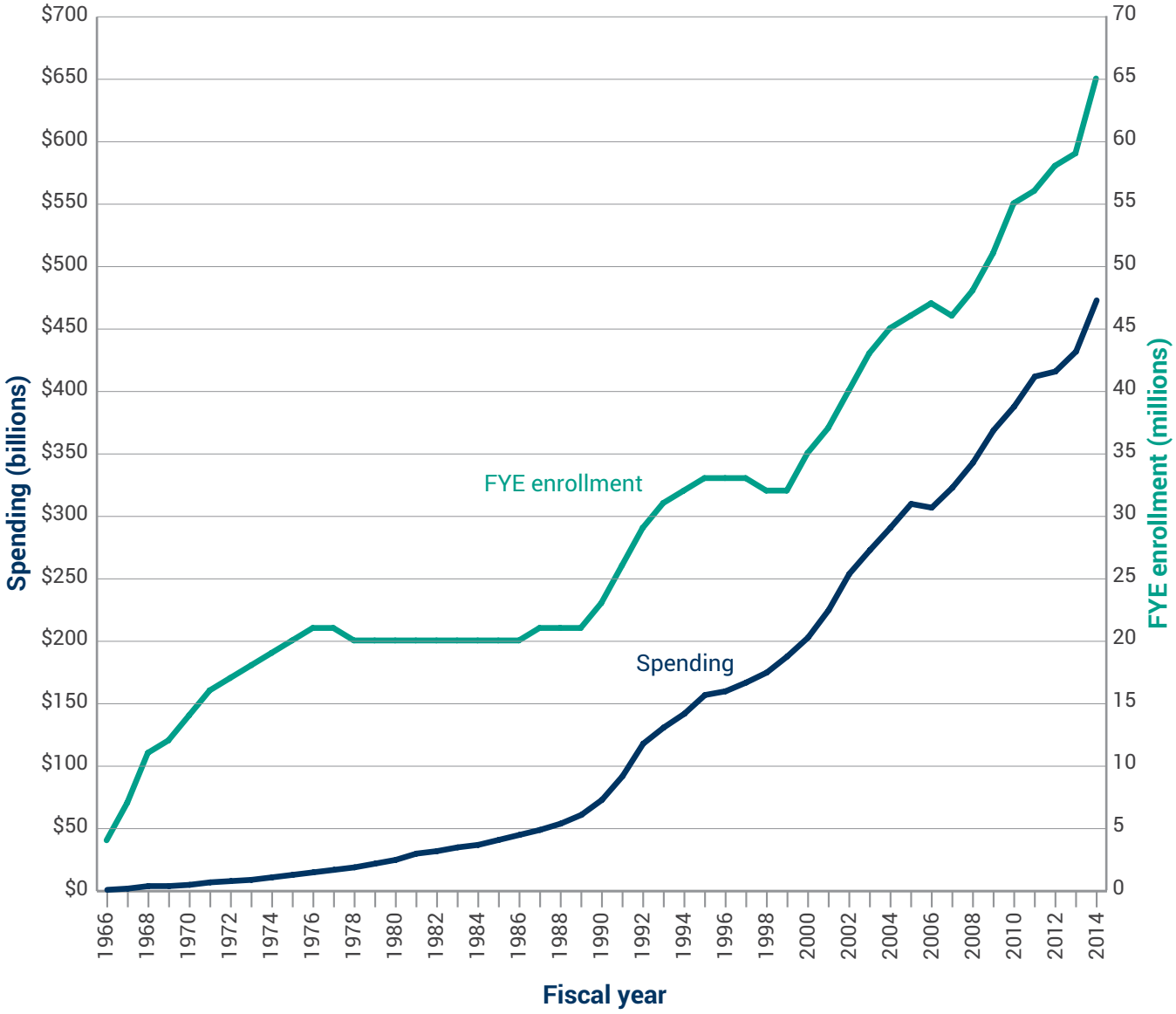
Fiscal year	Total	Children	Adults	Disabled	Aged	Unknown
2003	**50,716**	23,742	11,530	7,664	4,041	3,739
2004	**54,250**	25,415	12,325	8,123	4,349	4,037
2005	**56,276**	25,979	12,431	8,205	4,395	5,266
2006	**56,264**	26,358	12,495	8,334	4,374	4,703
2007	**55,210**	26,061	12,264	8,423	4,044	4,418
2008	**56,962**	26,479	12,739	8,685	4,147	4,912
2009	**60,880**	28,344	14,245	9,031	4,195	5,066
2010	**63,730**	30,024	15,368	9,341	4,289	4,709
2011	**65,831**	30,175	16,069	9,609	4,331	5,646
2012	**65,584**	30,467	16,483	9,836	4,376	4,423

Notes: FY is fiscal year. Beneficiaries (enrollees for whom payments are made) are shown here because they provide the only historical time series data directly available prior to FY 1990. Most current analyses of individuals in Medicaid reflect enrollees. For additional discussion, see https://www.macpac.gov/macstats/data-sources-and-methods/. The increase in FY 1998 reflects a change in how Medicaid beneficiaries are counted: beginning in FY 1998, a Medicaid-eligible person who received only coverage for managed care benefits was included in this series as a beneficiary. Excludes Medicaid-expansion CHIP and the territories. Children and adults who qualify for Medicaid on the basis of a disability are included in the disabled category. In addition, although disability is not a basis of eligibility for aged individuals, states may report some enrollees age 65 and older in the disabled category. Unlike the majority of MACStats, this exhibit does not recode individuals age 65 and older who are reported as disabled, due to lack of 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.

Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year FY 2012, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID.

Sources: For FYs 1999–2012: MACPAC, 2015, analysis of MSIS data for FYs 1975–1998: Centers for Medicare & Medicaid Services, *Medicare & Medicaid statistical supplement, 2010 edition,* Table 13.4, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2010_Section13.pdf#Table%2013.4.

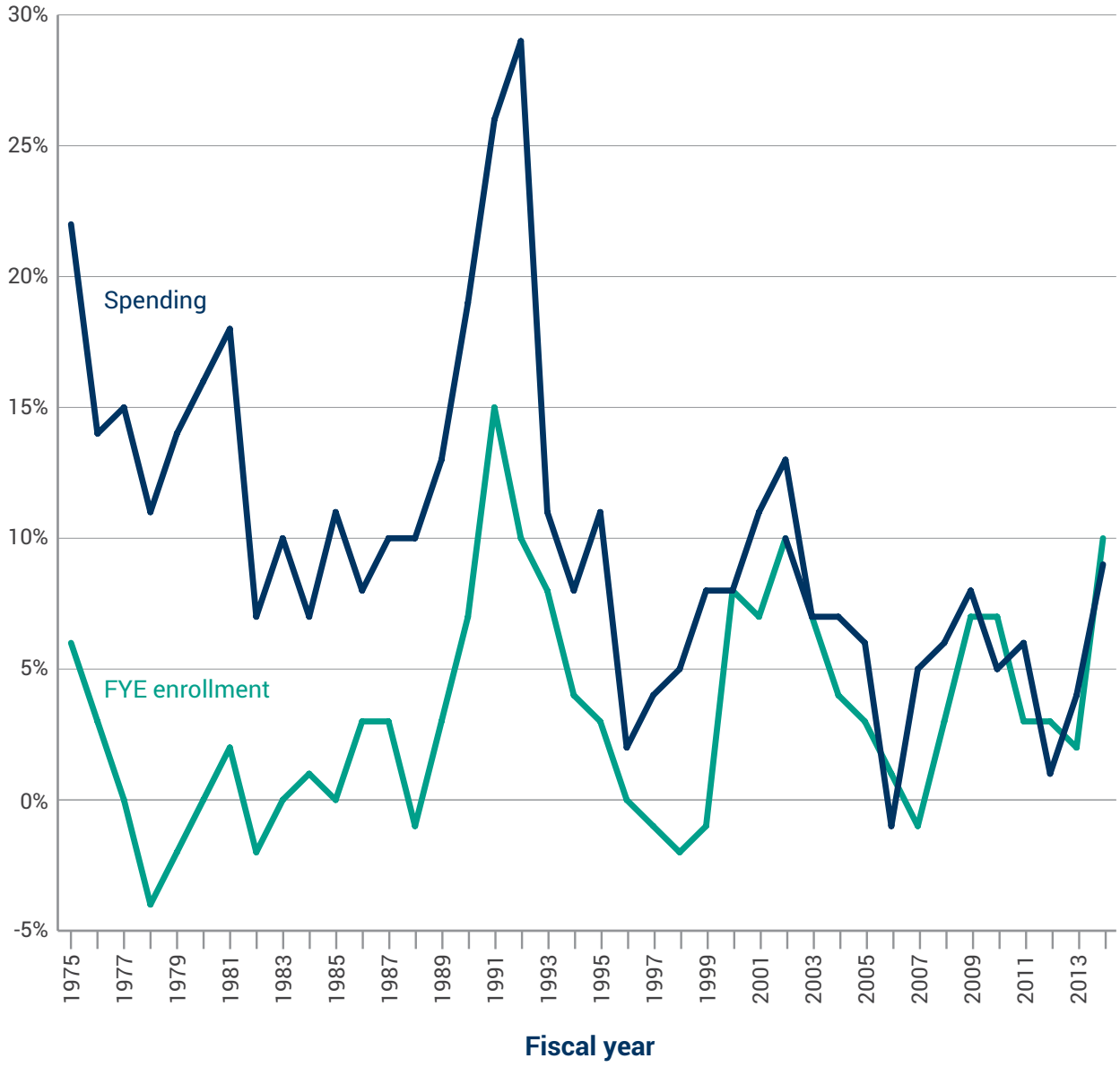
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1966–2014



Notes: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as average monthly payment. All numbers exclude CHIP-financed coverage. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). The amounts shown in this exhibit may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served (see https://www.macpac.gov/macstats/data-sources-and-methods/ for a discussion of how enrollees are counted). Enrollment data for FYs 2012–2014 are projected; those for FYs 1999–2014 include estimates for Puerto Rico and the Virgin Islands.

Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2015, data compilation provided to MACPAC staff, April 17.

EXHIBIT 9. Annual Growth in Medicaid Enrollment and Spending, FYs 1975–2014



Notes: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as average monthly enrollment. All numbers exclude CHIP-financed coverage. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 to September 30). The amounts shown in this exhibit may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served (see https://www.macpac.gov/macstats/data-sources-and-methods/ for a discussion of how enrollees are counted). Enrollment data for FYs 2012–2014 are projected; those for FYs 1999–2014 include estimates for Puerto Rico and the Virgin Islands.

Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2015, data compilation provided to MACPAC staff, April 17.

EXHIBIT 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1966–2014

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	Full-year equivalent enrollment	Spending per FYE enrollee
1966	$1	4.0	$198	–	–	–
1967	2	7.4	321	197.4%	83.3%	62.2%
1968	4	10.6	343	52.4	42.9	6.7
1969	4	11.5	382	21.2	8.9	11.3
1970	5	14.0	365	15.9	21.3	-4.4
1971	7	16.3	401	28.5	16.9	9.9
1972	8	16.5	484	22.4	1.3	20.9
1973	9	17.6	534	17.0	6.2	10.2
1974	11	19.0	567	15.1	8.3	6.3
1975	13	20.2	651	21.8	6.1	14.8
1976	15	20.7	720	13.6	2.7	10.6
1977	17	20.7	830	15.3	0.1	15.3
1978	19	20.0	959	11.2	-3.8	15.6
1979	22	19.6	1,115	14.0	-2.0	16.3
1980	25	19.6	1,285	15.7	0.4	15.2
1981	30	20.0	1,493	18.2	1.7	16.2
1982	32	19.6	1,620	6.7	-1.7	8.5
1983	35	19.6	1,779	9.6	-0.2	9.8
1984	37	19.8	1,883	7.1	1.2	5.8
1985	41	19.8	2,080	10.5	0.0	10.5
1986	45	20.5	2,176	7.9	3.2	4.6
1987	49	21.0	2,339	10.4	2.6	7.5
1988	54	20.8	2,598	10.1	-0.9	11.0
1989	61	21.4	2,871	13.4	2.6	10.5
1990	73	22.9	3,177	18.9	7.4	10.7
1991	92	26.3	3,495	26.0	14.6	10.0
1992	118	28.9	4,092	28.6	9.8	17.1

EXHIBIT 10. (continued)

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	Full-year equivalent enrollment	Spending per FYE enrollee
1993	$131	31.2	$4,190	10.7%	8.1%	2.4%
1994	142	32.4	4,371	8.3	3.9	4.3
1995	157	33.4	4,710	10.9	2.9	7.7
1996	160	33.2	4,815	1.8	-0.4	2.2
1997	167	33.0	5,054	4.3	-0.6	5.0
1998	175	32.5	5,393	4.9	-1.7	6.7
1999	188	32.1	5,878	7.7	-1.2	9.0
2000	203	34.5	5,888	7.9	7.7	0.2
2001	225	36.9	6,099	10.6	6.7	3.6
2002	254	40.5	6,286	13.2	9.8	3.1
2003	273	43.5	6,272	7.2	7.4	-0.2
2004	291	45.2	6,449	6.8	3.9	2.8
2005	310	46.3	6,690	6.4	2.6	3.7
2006	307	46.7	6,587	-0.8	0.7	-1.5
2007	323	46.4	6,968	5.2	-0.5	5.8
2008	343	47.7	7,188	5.9	2.7	3.1
2009	369	50.9	7,256	7.7	6.7	1.0
2010	388	54.6	7,111	5.2	7.3	-2.0
2011	412	56.5	7,290	6.1	3.5	2.5
2012	416	58.0	7,177	1.1	2.7	-1.5
2013	432	58.9	7,342	3.9	1.6	2.3
2014	473	64.8	7,294	9.3	10.0	-0.7

Notes: FY is fiscal year. FYE is full-year equivalent, which may also be referred to as average monthly enrollment. All numbers exclude CHIP-financed coverage. Data prior to FY 1977 have been adjusted to the current federal fiscal year basis (October 1 through September 30). The amounts shown in this exhibit may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are full-year equivalents and, for fiscal years prior to FY 1990, have been estimated from counts of persons served (see https://www.macpac.gov/macstats/data-sources-and-methods/ for a discussion of how enrollees are counted). Enrollment data for FYs 2012–2014 are projected; those for FYs 1999–2014 include estimates for Puerto Rico and the Virgin Islands.

Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2015, data compilation provided to MACPAC staff, April 17.

EXHIBIT 11. Full-Benefit Medicaid and CHIP Enrollment, Selected Months, 2013–2015

State	Number of individuals enrolled			Annual and cumulative growth		
	July–September 2013 average	July 2014	July 2015	July–September 2013 average to July 2014	July 2014 to July 2015	July–September 2013 average to July 2015
Total	**57,794,096**[1]	**67,147,446**	**72,046,111**	**14.4%**[2]	**7.3%**	**22.9%**[2]
Alabama	799,176[3]	868,174	878,270	8.6	1.2	9.9
Alaska	122,334	125,254	122,406	2.4	-2.3	0.1
Arizona	1,201,770	1,463,723	1,595,617	21.8	9.0	32.8
Arkansas	556,851	784,335	823,741	40.9	5.0	47.9
California	9,157,000	10,900,000[4]	12,648,637	19.0	16.0	38.1
Colorado	783,420	1,106,134	1,265,537	41.2	14.4	61.5
Connecticut	–	749,159	753,927	–	0.6	–
Delaware	223,324	233,706	241,749	4.6	3.4	8.3
District of Columbia[5]	235,786	250,446	255,660	6.2	2.1	8.4
Florida	3,104,996	3,343,988[6]	3,558,092[6]	7.7	6.4	14.6
Georgia	1,535,090	1,739,141	1,731,306	13.3	-0.5	12.8
Hawaii	288,357	318,838	332,027	10.6	4.1	15.1
Idaho	238,150	283,129	277,213	18.9	-2.1	16.4
Illinois	2,626,943[7]	3,021,195	3,120,581	15.0	3.3	18.8
Indiana[8]	1,120,674	1,211,125	1,327,909	8.1	9.6	18.5
Iowa	493,515	565,593	599,305	14.6	6.0	21.4
Kansas	378,160	401,980	397,144	6.3	-1.2	5.0
Kentucky	606,805	1,048,285	1,119,198	72.8	6.8	84.4
Louisiana	1,019,787	1,037,136	1,075,652	1.7	3.7	5.5
Maine	–	296,206	280,241	–	-5.4	–
Maryland	856,297	1,151,270	1,167,003	34.4	1.4	36.3
Massachusetts	1,296,359	1,476,184[9]	1,639,259	13.9	11.0	26.5
Michigan	1,912,009	2,218,845	2,284,761	16.0	3.0	19.5
Minnesota	873,040[10]	1,068,305	1,006,444	22.4	-5.8	15.3
Mississippi	637,229	693,425	702,327	8.8	1.3	10.2
Missouri	846,084	812,785	932,026	-3.9	14.7	10.2
Montana	148,974	163,551	176,714	9.8	8.0	18.6

EXHIBIT 11. (continued)

State	Number of individuals enrolled			Annual and cumulative growth		
	July–September 2013 average	July 2014	July 2015	July–September 2013 average to July 2014	July 2014 to July 2015	July–September 2013 average to July 2015
Nebraska	244,600	238,609	232,088	-2.4%	-2.7%	-5.1%
Nevada	332,560[5]	527,929[5]	566,017	58.7	7.2	70.2
New Hampshire	127,082	137,934	181,182	8.5	31.4	42.6
New Jersey	1,283,851	1,562,483	1,749,110	21.7	11.9	36.2
New Mexico	457,678	705,128	717,189	54.1	1.7	56.7
New York	5,678,417	6,143,909	6,452,876	8.2	5.0	13.6
North Carolina	1,595,952	1,737,117	1,911,334	8.8	10.0	19.8
North Dakota	69,980[11]	79,076	88,719	13.0	12.2	26.8
Ohio	2,341,481	2,708,484	2,988,934	15.7	10.4	27.7
Oklahoma	790,051	803,577	821,867	1.7	2.3	4.0
Oregon	626,356	997,762	1,028,349	59.3	3.1	64.2
Pennsylvania	2,386,046	2,417,392	2,635,481	1.3	9.0	10.5
Rhode Island	190,833	259,183[12]	276,028	35.8	6.5	44.6
South Carolina	889,744	868,487	999,438	-2.4	15.1	12.3
South Dakota	115,501	116,174	118,715	0.6	2.2	2.8
Tennessee	1,244,516	1,352,243	1,504,952	8.7	11.3	20.9
Texas[8]	4,441,605	4,575,968	4,634,046	3.0	1.3	4.3
Utah[8]	294,029	301,311	302,560	2.5	0.4	2.9
Vermont	161,081	208,699	185,242	29.6	-11.2	15.0
Virginia	935,434	937,493	962,183	0.2	2.6	2.9
Washington	1,117,576	1,542,789	1,721,645	38.0	11.6	54.1
West Virginia	354,544	519,672	542,077	46.6	4.3	52.9
Wisconsin	985,531[13]	1,006,257[13]	1,048,817	2.1	4.2	6.4
Wyoming	67,518	67,858	64,516	0.5	-4.9	-4.5

Notes: Enrollment excludes individuals with limited benefits, such as those who only receive Medicaid coverage of Medicare premiums and cost sharing, family planning services, or emergency coverage due to non-citizen status (state-specific exceptions are noted below). The July–September 2013 period shown here serves as a pre-Affordable Care Act baseline, representing the number of people covered by Medicaid and CHIP prior to the start of open enrollment for exchange plans in October 2013 and the state expansions of Medicaid for adults that began in January 2014 and beyond. Some data are preliminary or estimated, and all data are subject to change as states may revise their submissions at any time. See source documents below for full details.

EXHIBIT 11. (continued)

– Dash indicates that state did not report data.

[1] Excludes two states not reporting data.

[2] Percentage calculated based on states reporting data for both periods.

[3] Data are for September 2013 only.

[4] Includes applicants likely eligible for Medicaid or CHIP, but whose applications were still pending verification.

[5] Includes limited-benefit individuals who are dually eligible for Medicare and Medicaid, and individuals enrolled in the locally funded DC Health Alliance.

[6] Excludes Supplemental Security Income beneficiaries enrolled in Medicaid.

[7] Includes retroactive enrollment.

[8] Includes limited-benefit individuals who are dually eligible for Medicare and Medicaid.

[9] Excludes individuals receiving temporary transitional coverage.

[10] May include duplicates.

[11] Data are for July 2013 only.

[12] Includes only enrollments based on determinations through new Modified Adjusted Gross Income (MAGI) system.

[13] Excludes retroactive enrollment.

Source: MACPAC, 2015, analysis of Centers for Medicare & Medicaid Services (CMS), 2015, *Medicaid & CHIP June and July 2015 application, eligibility, and enrollment data,* http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/june-and-july-2015-enrollment-data.zip and CMS, 2014, *Medicaid & CHIP August and September 2014 application, eligibility, and enrollment data,* http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/august-and-september-2014-enrollment-data.zip.

EXHIBIT 12. Historical and Projected National Health Expenditures by Payer for Selected Years, 1970–2024

Calendar year	Payer amount (billions) and share of total												
	Total (billions)	Medicaid and CHIP		Medicare		Private insurance		Other health insurance[1]		Other third party payers[2]		Out of pocket	
Historical													
1970	**$75**	$5	7.1%	$8	10.2%	$15	20.6%	$3	4.4%	$18	24.2%	$25	33.4%
1975	**134**	13	10.1	16	12.2	30	22.8	6	4.5	30	22.5	37	28.0
1980	**256**	26	10.2	37	14.6	69	27.0	10	3.8	55	21.6	58	22.8
1985	**445**	41	9.2	72	16.2	131	29.5	15	3.4	89	20.1	96	21.6
1990	**724**	74	10.2	110	15.2	234	32.3	21	3.0	146	20.2	139	19.1
1995	**1,027**	145	14.1	184	17.9	327	31.8	27	2.6	198	19.3	146	14.2
2000	**1,378**	203	14.8	225	16.3	460	33.4	33	2.4	255	18.5	201	14.6
2005	**2,035**	317	15.6	340	16.7	703	34.6	57	2.8	351	17.2	267	13.1
2010	**2,604**	409	15.7	520	20.0	862	33.1	84	3.2	422	16.2	306	11.8
2011	**2,705**	419	15.5	545	20.1	899	33.2	89	3.3	436	16.1	317	11.7
2012	**2,817**	436	15.5	567	20.1	936	33.2	90	3.2	459	16.3	329	11.7
2013	**2,919**	463	15.9	586	20.1	962	32.9	93	3.2	477	16.3	339	11.6
Projected													
2014	**$3,080**	$517	16.8%	$617	20.0%	$1,020	33.1%	$96	3.1%	$486	15.8%	$344	11.2%
2015	**3,244**	560	17.3	646	19.9	1,085	33.5	99	3.1	502	15.5	351	10.8
2016	**3,403**	585	17.2	685	20.1	1,140	33.5	105	3.1	527	15.5	361	10.6
2017	**3,587**	616	17.2	728	20.3	1,198	33.4	112	3.1	557	15.5	376	10.5
2018	**3,785**	650	17.2	775	20.5	1,258	33.2	118	3.1	590	15.6	393	10.4
2019	**4,020**	688	17.1	838	20.8	1,329	33.1	125	3.1	625	15.5	415	10.3
2020	**4,274**	729	17.0	906	21.2	1,406	32.9	133	3.1	662	15.5	438	10.2
2021	**4,543**	771	17.0	977	21.5	1,488	32.8	142	3.1	701	15.4	463	10.2

EXHIBIT 12. (continued)

Calendar year	Payer amount (billions) and share of total												
	Total (billions)	Medicaid and CHIP		Medicare		Private insurance		Other health insurance[1]		Other third party payers[2]		Out of pocket	
2022	**$4,825**	$816	16.9%	$1,054	21.8%	$1,572	32.6%	$152	3.1%	$742	15.4%	$489	10.1%
2023	**5,119**	864	16.9	1,135	22.2	1,658	32.4	161	3.2	785	15.3	515	10.1
2024	**5,425**	915	16.9	1,221	22.5	1,746	32.2	171	3.2	829	15.3	543	10.0

Notes: Components may not sum to total due to rounding. Historical data were released in 2014; projected data were released in 2015.

[1] U.S. Department of Defense and U.S. Department of Veterans Affairs.

[2] Includes all other public and private programs and expenditures except for out-of-pocket amounts.

Sources: For historical data: MACPAC, 2015, analysis of Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2014, *National health expenditures by type of service and source of funds: Calendar years 1960–2013*, as of December 2014, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2013.zip. For projected data: MACPAC, 2015, analysis of OACT, 2015, *National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1960–2024 in projections format*, as of July 2015, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe60-24.zip; and analysis of OACT, 2015, *Table 17: Health and insurance enrollment and enrollment growth rates, calendar years 2008–2024,* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2014tables.zip.

EXHIBIT 13. Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2013

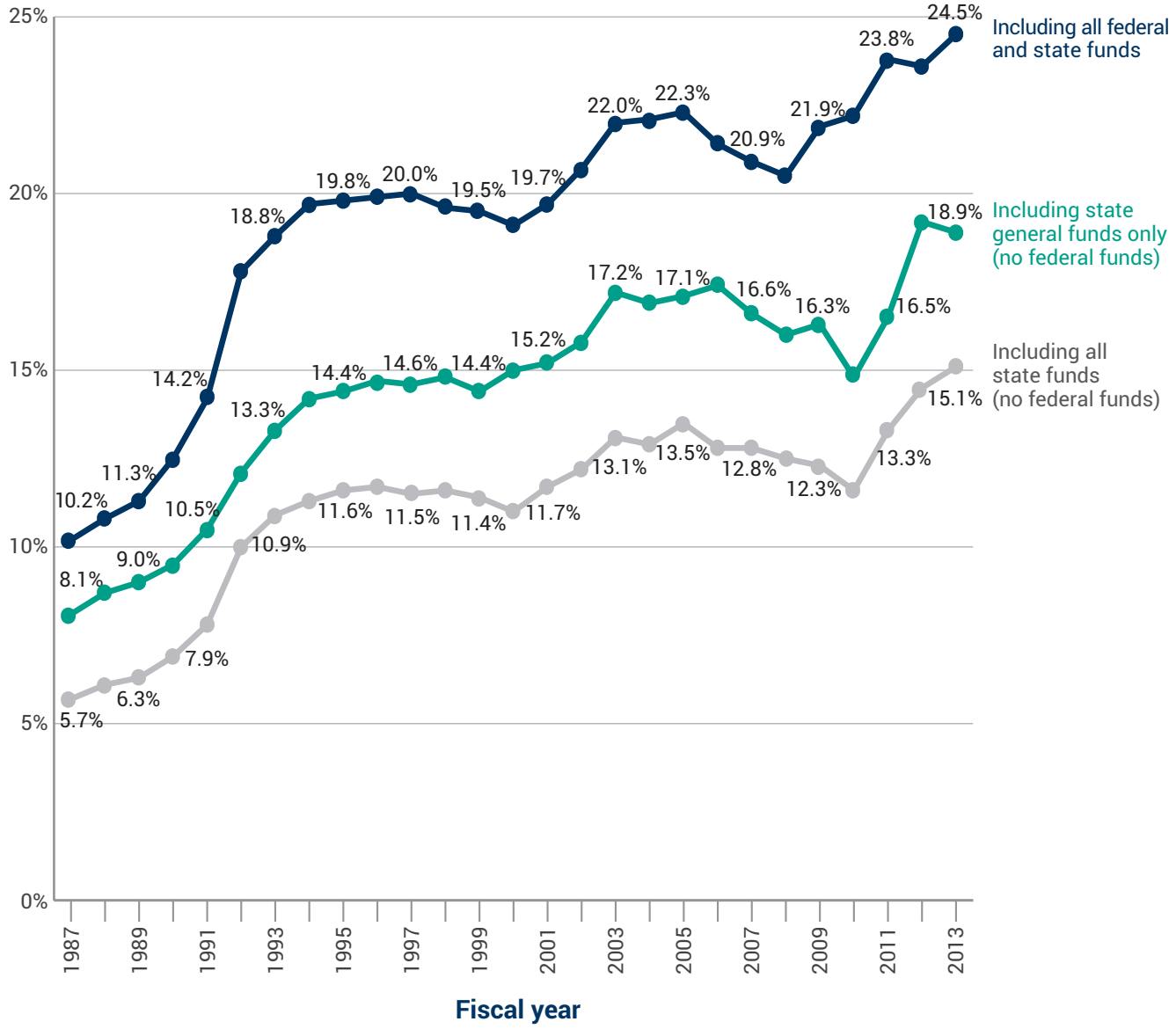


EXHIBIT 13. (continued)

State fiscal year	Including all federal and state funds	Including state general funds only (no federal funds)	Including all state funds (no federal funds)
1987	10.2%	8.1%	5.7%
1988	10.8	8.7	6.1
1989	11.3	9.0	6.3
1990	12.5	9.5	6.9
1991	14.2	10.5	7.9
1992	17.8	12.1	10.0
1993	18.8	13.3	10.9
1994	19.7	14.2	11.3
1995	19.8	14.4	11.6
1996	19.9	14.7	11.7
1997	20.0	14.6	11.5
1998	19.6	14.8	11.6
1999	19.5	14.4	11.4
2000	19.1	15.0	11.0
2001	19.7	15.2	11.7
2002	20.7	15.8	12.2
2003	22.0	17.2	13.1
2004	22.1	16.9	12.9
2005	22.3	17.1	13.5
2006	21.4	17.4	13.3
2007	20.9	16.6	12.8
2008	20.5	16.0	12.5
2009	21.9	16.3	12.3
2010	22.2	14.8	11.6
2011	23.8	16.5	13.3
2012	23.6	19.2	14.5
2013	24.5	18.9	15.1

Notes: SFY is state fiscal year. Amounts shown here reflect the most recent information available in cases where data for a given year were published and then updated in a subsequent report.

The all federal and state funds category reflects amounts from any source. The state general funds category reflects amounts from revenues raised through income, sales, and other broad-based state taxes. The all state funds category reflects amounts from any non-federal source; these include state general funds, other state funds (amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects).

Source: MACPAC, 2015, analysis of state expenditure reports from the National Association of State Budget Officers, http://www.nasbo.org/publications-data/state-expenditure-report/archives.

SECTION 3

Program Enrollment and Spending

Section 3: Program Enrollment and Spending

Key Points

- Total Medicaid spending was $498.3 billion in fiscal year (FY) 2014, an 8 percent increase from the prior year (Exhibit 16). Total CHIP spending decreased by about 1 percent, to $13.0 billion (Exhibit 32).
- The share of Medicaid benefit spending on capitation payments for managed care reached about 38 percent of all Medicaid benefit spending in FY 2014, an increase of 6 percentage points over the prior year (Exhibit 17).
- Individuals eligible on the basis of disability and those age 65 and older account for about a quarter of Medicaid enrollees, but about two-thirds of program spending (Exhibits 14 and 21). Many of these individuals are users of long-term services and supports (LTSS). This group accounts for only about 6 percent of Medicaid enrollees, but nearly half of all Medicaid spending (Exhibit 20).
- A large share of Medicaid spending for enrollees eligible on the basis of disability and enrollees age 65 and older is for LTSS, while more than half of spending for children and adults eligible on a basis other than disability is for capitation payments to managed care plans (Exhibit 18).
- Medicaid benefit spending per enrollee varies substantially across states (Exhibit 22). This variation may reflect several factors, including the underlying costs of delivering health care services in specific geographic areas, the breadth of benefit packages offered by states, and the health status and other characteristics of enrollees.
- Almost half (47 percent) of Medicaid gross spending for drugs occurred under managed care in FY 2014 (Exhibit 25). Drug rebates reduced gross drug spending by about 47 percent in FY 2014 (Exhibit 27).
- Disproportionate share hospital (DSH), upper payment limit (UPL), and other types of supplemental payments accounted for more than 40 percent of fee-for-service payments to hospitals in FY 2014 (Exhibit 23).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2012 (thousands)

State	Total	Basis of eligibility[1]				Dually eligible status[2]					
						All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Total	**68,680**	**31,880**	**19,934**	**10,203**	**6,664**	**10,622**	**6,181**	**7,840**	**4,564**	**2,782**	**1,616**
Alabama	**1,104**	558	198	228	119	**218**	118	**96**	50	**121**	68
Alaska	**139**	75	35	18	10	**16**	9	**15**	8	**1**	0
Arizona[3]	**1,713**	783	646	170	114	**183**	106	**143**	78	**40**	28
Arkansas	**695**	354	112	156	72	**133**	70	**71**	42	**62**	28
California	**12,005**	4,363	5,447	1,083	1,112	**1,394**	977	**1,349**	943	**45**	33
Colorado	**826**	463	181	121	62	**99**	57	**72**	43	**27**	14
Connecticut	**823**	325	304	79	115	**165**	111	**84**	48	**82**	63
Delaware	**255**	100	111	27	16	**29**	15	**13**	7	**16**	8
District of Columbia	**225**	79	91	37	19	**25**	15	**24**	15	**0**	0
Florida	**4,145**	2,078	896	636	536	**776**	503	**390**	270	**386**	233
Georgia[3]	**1,640**	932	230	309	169	**289**	166	**143**	82	**146**	84
Hawaii	**296**	121	115	33	27	**38**	26	**34**	23	**5**	3
Idaho	**279**	170	43	45	20	**41**	19	**27**	12	**14**	7
Illinois	**3,005**	1,603	834	328	239	**387**	219	**344**	193	**43**	26
Indiana	**1,228**	668	254	207	99	**185**	88	**117**	60	**68**	27
Iowa	**622**	283	207	87	45	**90**	44	**71**	33	**19**	12
Kansas	**430**	251	60	80	39	**73**	36	**48**	25	**25**	11
Kentucky	**926**	445	144	238	99	**318**	97	**233**	56	**86**	41
Louisiana	**1,311**	670	278	243	121	**211**	119	**115**	63	**96**	56
Maine	**446**	131	113	134	68	**106**	63	**60**	28	**46**	35
Maryland	**1,098**	510	357	148	82	**135**	75	**86**	48	**49**	27
Massachusetts	**1,549**	386	646	356	161	**266**	137	**244**	116	**22**	21
Michigan	**2,297**	1,167	588	389	153	**305**	140	**256**	116	**49**	25
Minnesota	**1,145**	463	443	140	99	**153**	80	**137**	71	**16**	9
Mississippi	**781**	401	116	172	91	**166**	91	**85**	49	**81**	42

EXHIBIT 14. (continued)

State	Total	Basis of eligibility[1]				Dually eligible status[2]					
						All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri	**1,135**	575	241	222	97	**192**	91	**180**	84	**13**	8
Montana	**136**	77	21	25	13	**26**	13	**17**	9	**9**	5
Nebraska	**264**	149	50	42	24	**45**	23	**40**	20	**5**	3
Nevada	**405**	241	79	52	33	**54**	32	**25**	16	**30**	16
New Hampshire	**168**	96	23	32	17	**36**	16	**23**	10	**13**	6
New Jersey	**1,184**	624	203	196	162	**239**	150	**209**	129	**30**	21
New Mexico	**652**	354	178	74	46	**76**	45	**42**	25	**34**	20
New York	**5,865**	2,096	2,395	706	669	**872**	589	**741**	492	**131**	97
North Carolina	**1,976**	1,028	407	351	192	**347**	188	**264**	141	**83**	46
North Dakota	**87**	47	18	12	9	**16**	9	**13**	7	**3**	2
Ohio	**2,474**	1,130	775	370	198	**370**	183	**247**	128	**123**	55
Oklahoma	**931**	491	244	128	68	**126**	66	**102**	53	**24**	13
Oregon	**751**	366	211	109	66	**115**	64	**71**	40	**45**	23
Pennsylvania	**2,562**	1,107	500	699	256	**457**	245	**374**	195	**82**	49
Rhode Island	**185**	80	40	40	24	**39**	22	**33**	18	**6**	4
South Carolina	**1,044**	526	257	172	88	**167**	88	**142**	74	**25**	14
South Dakota	**134**	77	24	20	13	**22**	13	**14**	8	**8**	4
Tennessee	**1,545**	794	323	278	150	**288**	148	**157**	80	**131**	68
Texas[3]	**4,641**	2,979	557	654	451	**686**	443	**412**	273	**274**	170
Utah	**388**	225	98	47	19	**38**	17	**33**	15	**5**	3
Vermont	**205**	69	87	26	23	**38**	22	**29**	16	**8**	6
Virginia	**1,093**	580	208	190	115	**199**	109	**130**	75	**69**	34
Washington	**1,408**	795	286	222	105	**189**	102	**135**	78	**54**	24
West Virginia	**439**	208	64	124	44	**89**	44	**52**	26	**38**	18
Wisconsin	**1,264**	493	452	174	145	**213**	125	**190**	110	**23**	15
Wyoming	**89**	58	13	12	6	**12**	6	**7**	4	**5**	2

EXHIBIT 14. (continued)

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

Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for FY 2012, the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. Categories may not sum to total for each state due to rounding. In addition, the sum of the state totals exceeds the national total because individuals may be enrolled in more than one state during the year.

[1] Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

[2] Dually eligible enrollees are covered by both Medicaid and Medicare; those with limited benefits receive only Medicaid assistance with Medicare premiums and cost sharing.

[3] State had a change in total enrollment of 10 percent or more over the prior year. These data may reflect data anomalies in the submission of MSIS data and may be updated in future MSIS submissions by states. MSIS data anomalies have been compiled and reported by Mathematica Policy Research; the data anomalies report may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

Source: MACPAC, 2015, analysis of MSIS data as of September 2014.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2012 (thousands)

State	Total		Child		Adult		Disabled		Aged	
	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]
Total	**56,995**	**50,019**	**27,027**	**26,704**	**14,707**	**10,591**	**9,347**	**8,293**	**5,913**	**4,430**
Alabama	**943**	**718**	473	473	153	38	207	160	109	46
Alaska	**110**	**110**	61	61	24	24	16	16	9	8
Arizona[2]	**1,385**	**1,277**	642	630	486	429	156	144	101	75
Arkansas	**594**	**472**	307	300	83	23	140	110	63	38
California	**9,475**	**6,900**	3,563	3,358	3,893	1,579	1,008	998	1,012	965
Colorado	**651**	**625**	368	368	129	127	100	89	54	42
Connecticut	**695**	**623**	283	283	238	237	72	56	102	47
Delaware	**209**	**180**	84	83	86	73	25	18	14	6
District of Columbia[3]	**157**	**157**	55	55	61	61	27	27	14	13
Florida	**3,248**	**2,801**	1,672	1,664	545	446	562	427	469	264
Georgia[2]	**1,243**	**1,087**	682	682	139	109	272	220	150	77
Hawaii	**249**	**245**	106	106	90	90	30	28	24	21
Idaho	**223**	**211**	139	139	26	26	41	35	17	11
Illinois	**2,672**	**2,532**	1,447	1,447	711	610	302	287	212	188
Indiana	**1,007**	**947**	565	565	177	177	181	146	84	59
Iowa	**499**	**446**	232	230	147	113	81	75	38	28
Kansas	**349**	**327**	207	207	38	37	72	59	33	23
Kentucky	**770**	**692**	371	371	92	92	217	177	89	52
Louisiana	**1,114**	**942**	565	565	217	134	222	185	110	58
Maine[2]	**371**	**326**	112	112	97	96	100	90	60	28
Maryland	**915**	**848**	430	429	277	253	136	118	72	47
Massachusetts	**1,080**	**1,011**	251	242	422	384	279	277	128	107
Michigan	**1,885**	**1,760**	984	976	421	347	350	330	130	108
Minnesota	**889**	**850**	374	372	313	292	129	123	73	64
Mississippi	**655**	**553**	332	331	83	55	158	122	83	45

EXHIBIT 15. (continued)

State	Total		Child		Adult		Disabled		Aged	
	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]
Missouri	**931**	**834**	485	485	180	93	187	182	80	74
Montana	**108**	**100**	62	62	13	13	22	18	11	7
Nebraska	**208**	**204**	122	122	30	30	37	35	19	17
Nevada	**306**	**280**	185	185	48	47	44	33	28	15
New Hampshire	**137**	**126**	80	80	15	15	28	21	14	9
New Jersey	**971**	**943**	533	533	118	117	178	170	142	124
New Mexico	**557**	**478**	307	307	143	94	67	54	40	23
New York	**4,951**	**4,668**	1,765	1,731	1,921	1,802	666	634	600	501
North Carolina	**1,620**	**1,470**	873	873	263	187	314	281	169	128
North Dakota	**65**	**62**	36	36	11	11	11	10	8	6
Ohio	**2,106**	**1,928**	1,007	1,004	602	535	329	269	168	120
Oklahoma	**723**	**646**	393	393	155	99	115	105	59	48
Oregon	**618**	**552**	293	286	168	149	99	80	57	37
Pennsylvania	**2,145**	**1,953**	919	918	379	261	627	596	220	178
Rhode Island	**162**	**155**	69	69	33	31	37	36	22	19
South Carolina	**853**	**742**	425	423	195	107	155	145	78	66
South Dakota	**107**	**100**	63	63	15	15	18	15	11	7
Tennessee	**1,322**	**1,207**	687	687	252	252	251	197	132	72
Texas	**4,073**	**3,661**	2,606	2,606	394	245	646	544	426	266
Utah	**281**	**276**	165	165	59	59	41	39	15	13
Vermont	**168**	**160**	58	58	65	65	24	22	20	15
Virginia	**898**	**806**	485	485	142	110	170	139	101	71
Washington	**1,158**	**1,029**	676	675	197	116	194	168	90	70
West Virginia	**355**	**323**	166	166	40	40	111	94	38	23
Wisconsin	**1,062**	**950**	414	397	361	286	161	153	126	113
Wyoming	**68**	**63**	45	44	8	7	10	9	5	3

EXHIBIT 15. (continued)

Notes: FY is fiscal year. Full-year equivalent (FYE) may also be referred to as average monthly enrollment. 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. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year FY 2012, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. Categories may not sum to total for each state due to rounding. In addition, the sum of the state totals exceeds the national total because individuals may be enrolled in more than one state during the year.

[1] In this exhibit, full benefit enrollees columns excludes enrollees reported by states in the MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

[2] State had a change in FYE enrollees of 10 percent or more over the prior year. These data may reflect anomalies in the MSIS data and may be updated in future MSIS submissions by states. MSIS data anomalies have been compiled and reported by Mathematica Policy Research; the data anomalies report may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

[3] The District of Columbia had a slight increase in total enrollees but a large decrease in total enrolled months, thus creating a decrease in FYE enrollees and number of months per enrollee of 10 percent or more over the prior year. These data may reflect anomalies in the MSIS data and may be updated in future MSIS submissions. MSIS data anomalies have been compiled and reported by Mathematica Policy Research; the data anomalies report may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

Source: MACPAC, 2015, analysis of MSIS data as of December 2014.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2014 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$5,213**	$3,599	$1,614	**$212**	$136	$76	**$5,425**	$3,735	$1,690
Alaska	**1,412**	832	580	**134**	85	50	**1,547**	917	630
Arizona	**9,185**	6,565	2,620	**268**	195	73	**9,453**	6,760	2,693
Arkansas	**4,840**	3,615	1,225	**314**	211	104	**5,154**	3,826	1,328
California	**63,384**	35,756	27,628	**4,864**	2,724	2,140	**68,248**	38,480	29,769
Colorado	**5,919**	3,335	2,584	**346**	224	122	**6,265**	3,559	2,706
Connecticut	**6,821**	3,879	2,942	**347**	215	132	**7,168**	4,094	3,074
Delaware	**1,692**	1,004	688	**113**	80	33	**1,805**	1,084	721
District of Columbia	**2,368**	1,721	647	**157**	100	57	**2,524**	1,821	704
Florida	**20,303**	12,151	8,152	**747**	471	276	**21,050**	12,623	8,428
Georgia	**9,397**	6,347	3,050	**461**	312	150	**9,858**	6,659	3,199
Hawaii	**1,950**	1,125	824	**100**	76	24	**2,050**	1,201	848
Idaho	**1,586**	1,137	448	**107**	77	30	**1,692**	1,214	478
Illinois	**16,616**	8,940	7,676	**1,106**	669	438	**17,723**	9,609	8,114
Indiana	**9,094**	6,145	2,949	**506**	324	182	**9,600**	6,469	3,131
Iowa	**3,922**	2,460	1,462	**189**	137	51	**4,110**	2,597	1,513
Kansas	**2,728**	1,562	1,165	**205**	136	69	**2,933**	1,699	1,234
Kentucky	**7,793**	5,935	1,858	**223**	157	66	**8,016**	6,092	1,924
Louisiana	**7,056**	4,408	2,647	**282**	177	105	**7,338**	4,586	2,752
Maine	**2,365**	1,471	895	**163**	117	47	**2,529**	1,587	941
Maryland	**9,210**	5,255	3,955	**415**	268	147	**9,626**	5,523	4,102
Massachusetts	**14,251**	7,321	6,929	**702**	422	280	**14,952**	7,743	7,209
Michigan	**13,503**	9,270	4,233	**645**	439	206	**14,148**	9,709	4,439
Minnesota	**9,918**	5,481	4,437	**595**	370	225	**10,513**	5,851	4,663
Mississippi	**4,865**	3,585	1,280	**151**	102	49	**5,016**	3,687	1,330
Missouri	**8,829**	5,545	3,284	**410**	271	139	**9,239**	5,816	3,423
Montana	**1,072**	729	343	**72**	52	21	**1,145**	781	363
Nebraska	**1,772**	979	793	**136**	91	45	**1,907**	1,070	838
Nevada	**2,281**	1,589	692	**151**	109	42	**2,432**	1,698	734
New Hampshire	**1,323**	678	645	**98**	66	32	**1,421**	744	677
New Jersey	**12,470**	7,099	5,371	**724**	408	316	**13,194**	7,507	5,687
New Mexico	**4,169**	3,140	1,029	**180**	121	59	**4,349**	3,261	1,088

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
New York	**$51,806**	$27,622	$24,184	**$1,792**	$1,074	$719	**$53,599**	$28,696	$24,903
North Carolina	**11,993**	7,945	4,047	**663**	440	222	**12,655**	8,386	4,269
North Dakota	**402**	206	195	**49**	32	17	**451**	239	212
Ohio	**19,439**	13,068	6,371	**784**	502	282	**20,223**	13,570	6,653
Oklahoma	**4,666**	3,038	1,629	**259**	178	81	**4,925**	3,215	1,710
Oregon	**6,784**	4,952	1,832	**507**	281	226	**7,291**	5,233	2,058
Pennsylvania	**23,462**	12,705	10,757	**953**	602	351	**24,415**	13,306	11,109
Rhode Island	**2,437**	1,410	1,027	**129**	88	42	**2,566**	1,498	1,069
South Carolina	**5,321**	3,771	1,550	**276**	185	90	**5,597**	3,956	1,640
South Dakota	**778**	455	323	**63**	42	21	**841**	497	344
Tennessee	**9,205**	6,064	3,141	**449**	282	167	**9,654**	6,346	3,308
Texas	**31,385**	18,790	12,595	**1,446**	884	562	**32,831**	19,674	13,157
Utah	**2,064**	1,459	606	**170**	124	46	**2,235**	1,583	652
Vermont	**1,526**	901	625	**44**	39	5	**1,570**	940	630
Virginia	**7,547**	3,843	3,704	**433**	299	134	**7,980**	4,142	3,838
Washington	**10,250**	6,434	3,816	**596**	361	235	**10,846**	6,794	4,051
West Virginia	**3,331**	2,454	877	**157**	105	52	**3,488**	2,559	929
Wisconsin	**7,396**	4,448	2,949	**387**	241	146	**7,783**	4,689	3,094
Wyoming	**539**	276	263	**55**	37	18	**595**	313	281
Subtotal (states)	**$467,639**	**$282,500**	**$185,139**	**$24,337**	**$15,136**	**$9,201**	**$491,976**	**$297,636**	**$194,340**
American Samoa	**25**	14	11	**1**	0	0	**26**	15	11
Guam	**74**	42	32	**5**	3	1	**78**	45	33
Northern Mariana Islands	**34**	19	14	**1**	0	0	**34**	20	14
Puerto Rico	**1,842**	1,139	703	**87**	62	26	**1,929**	1,201	728
Virgin Islands	**71**	40	31	**9**	8	1	**80**	47	32
Subtotal (states and territories)	**$469,683**	**$283,754**	**$185,929**	**$24,440**	**$15,209**	**$9,230**	**$494,123**	**$298,964**	**$195,159**
State Medicaid Fraud Control Units (MFCUs)	–	–	–	**285**	214	71	**285**	214	71
Medicaid survey and certification of nursing and intermediate care facilities	–	–	–	**293**	220	73	**293**	220	73
Vaccines for Children (VFC) program	–	–	–	–	–	–	**3,557**	3,557	–
Total	**$469,683**	**$283,754**	**$185,929**	**$25,018**	**$15,643**	**$9,375**	**$498,258[2]**	**$302,954[2]**	**$195,304**

EXHIBIT 16. (continued)

Notes: FY is fiscal year. Total federal spending shown here ($302,954 million) will differ from total federal outlays shown in FY 2016 budget documents due to slight differences in the timing of data for the states and the treatment of certain adjustments. Federal spending in the territories is capped; however, territories report their total spending regardless of whether they have reached their caps. As a result, federal spending shown here may exceed the amounts actually paid to the territories. State shares for MFCUs and survey and certification are MACPAC estimates based on 75 percent federal match. State-level estimates for these items are available but are not shown here. The VFC program is authorized in the Medicaid statute but is operated as a separate program; 100 percent federal funding finances the purchase of vaccines for children who are enrolled in Medicaid, uninsured, or privately insured without vaccine coverage. Spending on administration is only for state programs; federal oversight spending is not included.

– Dash indicates zero; $0 indicates an amount less than $0.5 million that rounds to zero.

[1] Not all states have certified their CMS-64 FMR submissions as of February 25, 2015. California's and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; Rhode Island's fourth quarter submission is not certified. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] Amounts exceed the sum of benefits and state program administration columns due to the inclusion of the VFC program.

Sources: For state and territory spending: MACPAC, 2015, analysis of CMS-64 FMR net expenditure data as of February 25, 2015. For all other spending (MCFUs, survey and certification, VFC): Centers for Medicare & Medicaid Services, 2015, *Fiscal year 2016 justification of estimates for Appropriations Committees,* Baltimore, MD, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2014 (millions)

State[1]	Total spending on benefits	Fee for service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			
Alabama	**$5,213**	$1,909	$503	$84	$49	$89	$499	$293	$1,003	$459	$96	$258	-$30
Alaska	**1,412**	308	119	74	21	208	112	39	159	363	0	24	-15
Arizona	**9,185**	1,175	37	5	5	148	264	5	72	5	7,300	225	-54
Arkansas	**4,840**	1,009	339	74	22	49	903	185	998	489	529	299	-56
California	**63,384**	13,274	1,446	593	25	2,485	5,835	1,408	5,682	9,010	21,838	2,257	-469
Colorado	**5,919**	1,910	493	146	–	154	250	280	710	1,064	843	109	-41
Connecticut	**6,821**	1,972	396	171	116	264	471	467	1,613	1,380	0	380	-411
Delaware	**1,692**	54	13	34	1	58	64	106	37	108	1,218	35	-34
District of Columbia	**2,368**	379	46	24	3	149	117	79	372	408	769	37	-13
Florida	**20,303**	4,942	1,330	184	42	184	1,446	417	1,836	1,224	7,459	1,361	-123
Georgia	**9,397**	2,139	431	39	32	15	714	277	1,380	932	3,194	334	-89
Hawaii	**1,950**	114	3	36	0	37	4	3	10	106	1,628	53	-45
Idaho	**1,586**	434	111	-0	18	22	184	62	272	299	165	41	-23
Illinois	**16,616**	6,722	892	183	109	288	1,189	414	2,508	1,733	2,286	401	-110
Indiana	**9,094**	1,906	320	184	11	394	357	463	2,358	1,059	1,907	172	-36
Iowa	**3,922**	802	196	54	23	79	368	126	941	745	559	144	-116
Kansas[2]	**2,728**	146	21	0	3	5	46	-1	82	139	2,240	85	-37
Kentucky	**7,793**	458	57	3	4	113	386	36	1,148	735	4,769	198	-115
Louisiana	**7,056**	2,212	328	82	–	89	314	234	1,334	835	1,659	271	-303
Maine	**2,365**	510	102	27	43	233	384	75	428	439	3	213	-92
Maryland	**9,210**	1,210	128	125	25	57	936	291	1,338	1,103	3,892	267	-162
Massachusetts	**14,251**	2,257	387	227	23	332	1,002	339	1,901	2,368	5,339	427	-352
Michigan	**13,503**	1,486	440	71	9	230	513	288	2,034	799	7,315	397	-79
Minessota	**9,918**	642	237	36	192	63	647	118	1,003	2,387	4,554	177	-138
Mississippi	**4,865**	1,661	198	4	23	95	375	147	1,096	315	763	207	-19
Missouri	**8,829**	2,881	42	14	12	445	819	648	1,389	1,298	1,055	320	-95
Montana	**1,072**	302	56	28	19	20	190	41	193	175	25	36	-13
Nebraska	**1,772**	186	33	34	3	5	67	59	421	340	566	103	-45
Nevada	**2,281**	514	126	33	16	32	202	98	275	187	697	120	-19
New Hampshire[2]	**1,323**	163	38	21	7	5	145	-9	404	301	243	27	-21

EXHIBIT 17. (continued)

State[1]	Total spending on benefits	Fee for service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home and community-based LTSS			
New Jersey	**$12,470**	$1,776	$71	$8	$3	$196	$838	$19	$2,967	$1,057	$5,307	$333	-$104
New Mexico[2]	**4,169**	360	35	11	38	28	41	-14	34	321	3,236	91	-13
New York[2]	**51,806**	7,707	388	76	216	1,263	5,101	-1,489	9,661	6,117	23,861	1,302	-2,398
North Carolina	**11,993**	3,471	730	318	320	247	1,046	610	1,377	860	2,697	421	-105
North Dakota	**402**	63	26	6	5	6	26	10	163	92	8	6	-7
Ohio	**19,439**	2,459	387	53	26	118	1,539	77	2,859	2,603	9,078	385	-143
Oklahoma	**4,666**	1,673	491	116	43	389	359	297	770	526	157	146	-300
Oregon	**6,784**	514	31	2	23	78	540	65	411	1,235	3,762	169	-47
Pennsylvania	**23,462**	1,822	105	28	2	103	346	14	4,896	3,530	12,203	574	-161
Rhode Island	**2,437**	365	16	10	1	29	567	3	239	2	1,177	43	-14
South Carolina	**5,321**	1,089	159	94	22	241	325	6	812	488	2,140	178	-232
South Dakota	**778**	193	64	15	2	91	57	32	165	136	2	28	-7
Tennessee	**9,205**	856	53	142	1	40	235	485	259	684	6,163	346	-58
Texas	**31,385**	5,471	1,690	85	237	38	4,542	346	3,692	2,445	12,634	1,023	-817
Utah	**2,064**	303	76	19	3	11	93	63	275	238	975	37	-30
Vermont[2]	**1,526**	44	2	0	0	1	1,428	-74	120	8	-0	6	-9
Virginia	**7,547**	992	202	128	33	50	1,006	44	1,246	1,326	2,356	228	-64
Washington	**10,250**	1,080	193	155	29	536	380	59	910	1,710	5,022	331	-154
West Virginia	**3,331**	622	199	40	18	47	261	156	747	586	552	121	-18
Wisconsin	**7,396**	779	130	44	23	312	676	321	956	899	3,033	322	-99
Wyoming	**539**	117	46	14	13	36	28	18	133	128	2	14	-8
Subtotal	$467,639	$85,432	$13,960	$3,955	$1,912	$10,209	$38,235	$8,034	$65,687	$55,795	$177,277	$15,084	-$7,941
American Samoa	**25**	23	–	–	–	–	1	0	–	–	–	–	–
Guam	**74**	15	9	2	0	1	27	17	1	0	–	1	–
N. Mariana Islands	**34**	22	–	1	–	3	3	2	–	1	0	1	–
Puerto Rico	**1,842**	–	–	–	–	–	30	–	–	–	1,811	–	1
Virgin Islands	**71**	44	4	1	1	3	-2	6	5	0	–	8	-0
Total	$469,683	$85,537	$13,973	$3,960	$1,913	$10,216	$38,294	$8,059	$65,692	$55,796	$179,089	$15,094	-$7,940
Percent of total, exclusive of collections	–	17.9%	2.9%	0.8%	0.4%	2.1%	8.0%	1.7%	13.8%	11.7%	37.5%	3.2%	–

EXHIBIT 17. (continued)

Notes: LTSS is long-term services and supports. Includes federal and state funds. Service category definitions and spending amounts shown here may differ from other CMS data sources, such as the Medicaid Statistical Information System (MSIS). The specific services included in each category have changed over time and therefore may not be directly comparable to earlier editions of MACStats. Collections include third-party liability, estate, and other recoveries.

– Dash indicates zero; $0 or -$0 indicates an amount between $0.5 and -$0.5 million that rounds to zero.

Additional detail on categories:

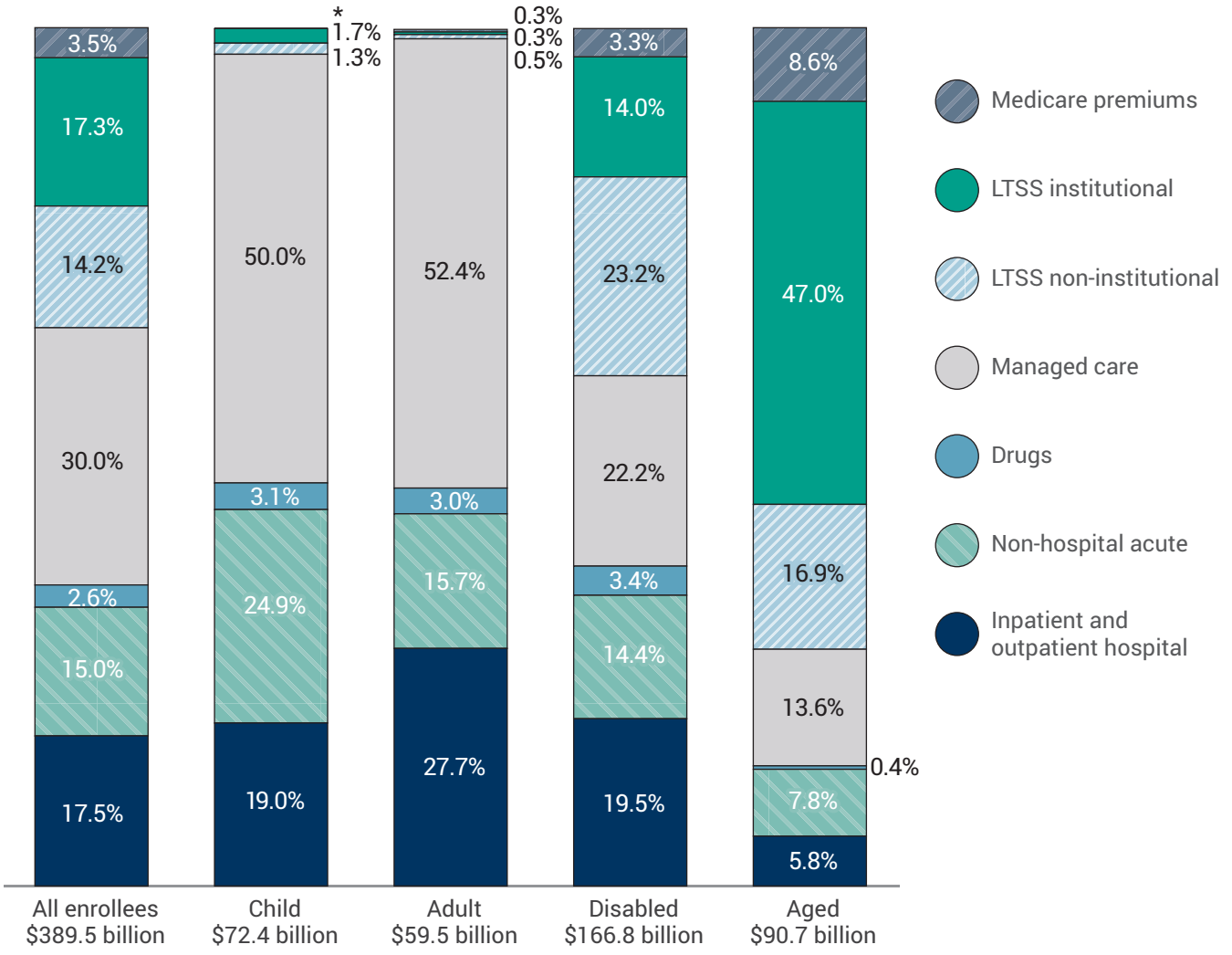
- Hospital includes inpatient, outpatient, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments.
- Physician includes physician and surgical services, both regular payments and those associated with the primary care physician payment increase.
- Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center, and freestanding birth center.
- Other acute includes lab or X-ray; sterilizations; abortions; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; preventive services with U.S. Preventive Services Task Force (USPSTF) Grade A or B and Advisory Committee on Immunization Practices (ACIP) vaccines; other diagnostic screening and preventive services; school-based services; health home with chronic conditions; tobacco cessation for pregnant women; private duty nursing; case management (excluding primary care case management); rehabilitative services; hospice; and other care not otherwise categorized.
- Drugs are net of rebates.
- Institutional LTSS includes nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility.
- Home and community-based LTSS includes home health, waiver and state plan services, and personal care.
- Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management (PCCM), employer-sponsored premium assistance programs, and Programs of All-inclusive Care for the Elderly (PACE). Comprehensive plans account for about 90 percent of spending in the managed care category. Managed care also includes rebates for drugs provided by managed care plans, and managed care payments associated with the primary care physician payment increase, Community First Choice option, and preventive services with USPSTF Grade A or B, and ACIP vaccines.

[1] Not all states had certified their CMS-64 FMR submissions as of February 25, 2015. California's and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; Rhode Island's fourth quarter submission is not certified. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] State reports negative fee-for-service (FFS) drug spending after the application of drug rebates. The negative net amount may reflect a shift of some FFS drug spending into Medicaid managed care or the state not separately reporting the FFS and managed care drug rebates. Vermont shows negative drug spending because it reports most of its benefit spending under other care services in its CMS-64 submission.

Source: MACPAC, 2015, analysis of CMS-64 FMR net expenditure data as of February 25, 2015.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2012

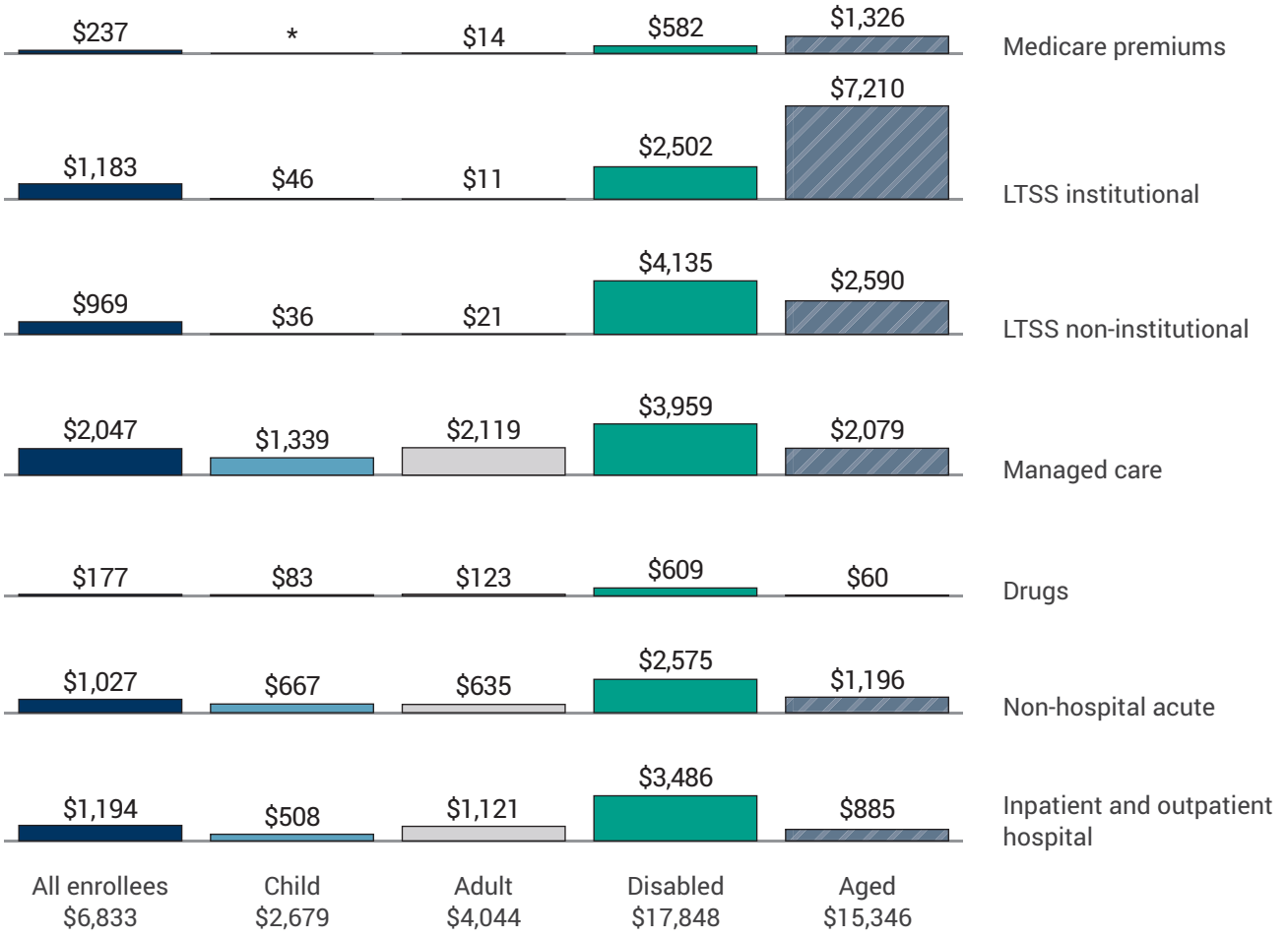


Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for FY 2012, the source used in prior editions of this exhibit, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

* Values less than 0.1 percent are not shown.

Sources: MACPAC, 2015, analysis of MSIS data as of December 2014 and analysis of CMS-64 FMR net expenditure data from CMS as of June 2015.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2012

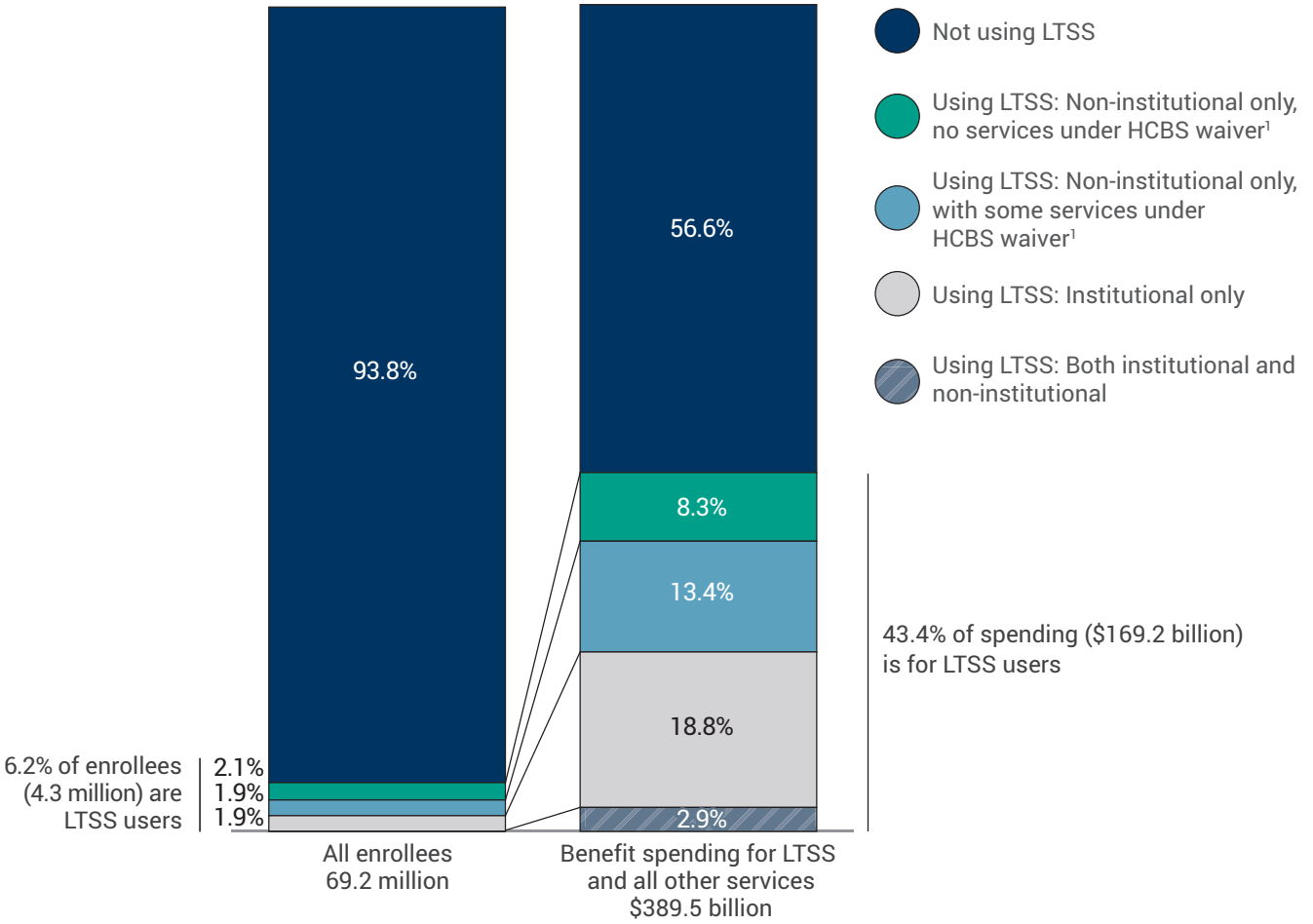


Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for FY 2012, the source used in prior editions of this exhibit, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

* Values less than $1 are not shown.

Sources: MACPAC, 2015, analysis of MSIS data as of December 2014 and analysis of CMS-64 FMR net expenditure data from CMS as of June 2015.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2012



Notes: FY is fiscal year. LTSS is long-term services and supports. HCBS is home and community-based services. Includes federal and state funds. Excludes administrative spending and spending and enrollees in the territories and in Medicaid-expansion CHIP. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals, and enrollment counts are unduplicated using unique national identification numbers. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) payments and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for FY 2012, the source used in prior editions of this exhibit, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement. (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 waiver programs that provide a range of LTSS for targeted populations of non-institutionalized 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 the MSIS.

Source: MACPAC, 2015, analysis of MSIS data as of December 2014 and CMS-64 FMR net expenditure data from CMS as of June 2015.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2012 (millions)

State	Total	Basis of eligibilty[1]				Dually eligible status[2]					
						All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Total	$389,456	18.6%	15.3%	42.8%	23.3%	$144,690	59.1%	$138,174	59.4%	$6,515	53.1%
Alabama	4,569	23.8	10.4	41.0	24.8	1,643	67.6	1,419	69.6	224	54.7
Alaska	1,331	26.9	16.0	38.2	19.0	392	54.7	391	54.7	1	70.6
Arizona	7,516	22.7	32.1	31.6	13.6	1,590	57.4	1,530	57.1	60	63.6
Arkansas	4,093	24.7	5.3	46.8	23.3	1,486	62.0	1,344	64.5	142	38.1
California	45,504	17.0	16.4	39.8	26.8	16,181	68.2	15,684	68.2	497	68.4
Colorado	4,534	21.2	14.8	42.3	21.7	1,510	61.4	1,472	61.8	39	45.0
Connecticut	6,281	16.8	23.3	31.5	28.4	2,863	59.0	2,710	58.7	153	64.2
Delaware	1,472	19.7	32.8	32.1	15.4	395	55.3	363	56.1	32	46.6
District of Columbia	2,050	11.3	19.8	48.3	20.6	548	62.2	547	62.3	2	27.4
Florida	16,602	18.3	13.4	41.3	27.0	6,584	64.1	5,833	65.5	751	53.4
Georgia	8,110	23.6	11.7	43.5	21.3	2,562	65.7	2,262	67.7	300	50.1
Hawaii	1,465	15.0	26.6	31.3	27.1	534	71.7	524	71.9	10	62.4
Idaho	1,428	19.0	11.5	50.0	19.5	532	50.1	504	50.6	27	41.2
Illinois	12,949	23.0	16.9	40.2	19.9	4,062	55.6	3,988	55.7	74	48.8
Indiana	7,487	17.8	13.6	45.4	23.2	2,939	56.5	2,719	58.2	220	35.1
Iowa	3,439	17.2	11.4	48.4	23.0	1,550	50.7	1,513	50.6	37	56.8
Kansas	2,593	22.3	8.8	43.5	25.3	1,030	61.4	988	62.3	42	39.2
Kentucky	5,493	23.4	11.5	46.9	18.2	3,413	29.0	3,295	28.5	118	43.9
Louisiana	6,625	19.7	11.9	50.2	18.2	2,092	56.1	1,925	56.3	167	53.0
Maine	2,372	12.3	12.6	47.1	28.0	1,197	54.6	1,093	53.1	104	70.2
Maryland	7,650	19.1	19.4	42.0	19.5	2,299	58.8	2,173	59.4	126	48.9
Massachusetts	11,994	12.3	13.3	47.4	26.9	5,353	56.7	5,312	56.4	41	95.8
Michigan	12,184	19.2	15.6	45.9	19.3	3,727	58.8	3,526	58.4	201	65.0
Minnesota	8,846	16.0	22.8	40.8	20.5	3,458	50.4	3,430	50.4	28	50.6
Mississippi	4,255	20.7	10.8	43.7	24.8	1,617	64.9	1,421	67.6	196	45.3
Missouri	7,971	22.3	9.0	49.4	19.3	2,728	51.7	2,703	51.8	25	49.1
Montana	955	24.4	11.2	39.1	25.2	376	64.2	354	65.2	21	48.8
Nebraska	1,680	18.5	11.2	45.5	24.7	731	52.3	722	52.4	10	48.8
Nevada	1,653	28.1	12.7	43.6	15.6	394	59.9	337	61.9	57	48.0
New Hampshire	1,145	22.6	6.4	39.9	31.1	592	57.5	567	57.8	24	48.9
New Jersey	9,146	16.0	8.3	46.3	29.4	4,440	56.9	4,397	56.8	43	67.3

EXHIBIT 21. (continued)

State	Total	Basis of eligibilty[1]				Dually eligible status[2]					
						All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
New Mexico	**$3,374**	39.3%	26.4%	31.0%	3.3%	**$346**	30.1%	**$297**	25.8%	**$50**	55.8%
New York	**49,668**	10.4	20.4	40.5	28.8	**21,658**	62.1	**21,370**	62.0	**288**	71.4
North Carolina	**11,972**	23.6	15.0	44.6	16.8	**3,480**	57.3	**3,340**	57.7	**140**	47.1
North Dakota	**743**	16.5	8.8	43.1	31.5	**412**	56.1	**407**	56.2	**5**	45.9
Ohio	**15,808**	15.6	17.5	43.2	23.7	**5,953**	57.0	**5,651**	57.7	**302**	42.3
Oklahoma	**4,606**	28.9	15.5	39.5	16.1	**1,306**	53.1	**1,274**	53.2	**32**	50.9
Oregon	**4,518**	17.1	23.5	37.6	21.8	**1,518**	63.0	**1,438**	63.9	**80**	46.6
Pennsylvania	**19,232**	16.5	7.1	52.8	23.6	**7,147**	61.1	**7,023**	61.2	**124**	55.6
Rhode Island	**1,727**	17.0	14.6	44.6	23.8	**728**	54.3	**719**	54.3	**10**	49.1
South Carolina	**4,391**	20.6	16.5	42.0	20.9	**1,547**	59.4	**1,519**	59.5	**28**	55.1
South Dakota	**749**	23.9	11.7	43.1	21.3	**279**	56.2	**262**	56.7	**18**	48.2
Tennessee	**7,520**	23.4	16.3	40.0	20.4	**2,667**	56.3	**2,458**	57.6	**209**	42.0
Texas	**24,375**	32.7	7.5	40.4	19.5	**7,226**	64.1	**6,480**	64.3	**746**	62.6
Utah	**1,870**	28.0	17.3	44.4	10.3	**477**	39.1	**469**	39.1	**8**	37.8
Vermont	**1,311**	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Virginia	**6,692**	21.0	11.1	46.1	21.8	**2,422**	54.7	**2,301**	55.4	**121**	41.4
Washington	**7,168**	23.2	14.6	42.5	19.8	**2,247**	61.4	**2,135**	62.4	**113**	41.4
West Virginia	**2,714**	15.8	8.9	49.8	25.5	**1,097**	62.2	**1,033**	63.1	**64**	46.6
Wisconsin	**7,096**	11.6	16.5	42.6	29.3	**3,521**	57.8	**3,487**	57.9	**34**	55.4
Wyoming	**528**	19.6	9.0	44.9	26.6	**264**	52.9	**247**	53.6	**17**	42.1

Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals exclude disproportionate share hospital (DSH) payments and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for FY 2012, the source used in prior editions of this exhibit, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

[1] Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

[2] Dually eligible enrollees are covered by both Medicaid and Medicare; those with limited benefits receive only Medicaid assistance with Medicare premiums and cost sharing.

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

Sources: MACPAC, 2015, analysis of MSIS data as of December 2014 and analysis of CMS-64 FMR net expenditure data as of June 2015.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2012

State	Total		Child		Adult		Disabled		Aged	
	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]
Total	**$6,833**	**$7,482**	**$2,679**	**$2,696**	**$4,044**	**$4,960**	**$17,848**	**$19,660**	**$15,346**	**$19,563**
Alabama	**4,847**	**5,679**	2,297	2,297	3,113	5,579	9,027	11,032	10,399	21,805
Alaska	**12,047**	**12,086**	5,829	5,829	8,752	8,746	31,583	31,831	29,066	30,090
Arizona[2]	**5,429**	**5,597**	2,657	2,676	4,971	5,261	15,290	15,776	10,040	12,608
Arkansas	**6,889**	**8,187**	3,288	3,325	2,600	6,213	13,649	16,530	15,011	23,527
California	**4,803**	**6,141**	2,174	2,271	1,918	3,258	17,963	17,923	12,052	12,141
Colorado	**6,967**	**7,073**	2,614	2,597	5,166	4,884	19,263	21,210	18,338	23,121
Connecticut	**9,042**	**9,839**	3,721	3,721	6,155	6,157	27,324	34,537	17,595	36,252
Delaware	**7,035**	**7,851**	3,466	3,502	5,583	6,265	18,770	25,117	16,280	33,187
District of Columbia[3]	**13,039**	**13,003**	4,170	4,170	6,612	6,504	36,725	36,752	31,271	31,429
Florida	**5,111**	**5,453**	1,816	1,797	4,077	3,935	12,196	15,161	9,560	15,336
Georgia[2]	**6,524**	**7,082**	2,806	2,806	6,809	7,737	12,936	15,315	11,507	20,535
Hawaii	**5,876**	**5,925**	2,066	2,066	4,329	4,326	15,561	16,179	16,779	18,494
Idaho	**6,412**	**6,630**	1,959	1,957	6,202	6,067	17,570	20,221	16,267	23,893
Illinois	**4,846**	**5,008**	2,058	2,058	3,079	3,300	17,231	17,999	12,150	13,432
Indiana	**7,434**	**7,674**	2,362	2,362	5,755	5,755	18,714	22,334	20,787	27,999
Iowa	**6,897**	**7,407**	2,548	2,552	2,657	2,619	20,603	22,029	20,643	27,402
Kansas	**7,420**	**7,773**	2,794	2,793	6,062	5,871	15,724	18,605	19,968	27,657
Kentucky	**7,138**	**7,739**	3,455	3,452	6,812	6,733	11,880	14,130	11,289	18,412
Louisiana	**5,949**	**6,707**	2,310	2,310	3,628	4,839	14,978	17,521	11,003	19,324
Maine[2]	**6,401**	**6,941**	2,596	2,599	3,077	3,096	11,127	12,042	10,980	21,285
Maryland	**8,361**	**8,628**	3,399	3,388	5,352	5,061	23,576	26,694	20,766	30,115
Massachusetts	**11,105**	**11,752**	5,892	6,085	3,784	4,039	20,419	20,483	25,148	29,594
Michigan	**6,462**	**6,753**	2,383	2,397	4,500	5,248	15,981	16,731	18,104	20,509
Minnesota	**9,950**	**10,298**	3,780	3,792	6,431	6,773	27,956	29,116	24,943	28,031
Mississippi	**6,499**	**7,101**	2,652	2,650	5,582	5,979	11,784	14,375	12,746	21,672

EXHIBIT 22. (continued)

State	Total		Child		Adult		Disabled		Aged	
	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]	All enrollees	Full benefit enrollees[1]
Missouri	**$8,558**	**$9,311**	$3,664	$3,664	$3,977	$5,891	$21,111	$21,502	$19,297	$20,709
Montana	**8,840**	**9,318**	3,778	3,778	7,942	8,020	17,355	20,184	21,315	32,143
Nebraska	**8,082**	**8,173**	2,545	2,543	6,321	6,202	20,638	21,562	22,114	24,629
Nevada	**5,410**	**5,595**	2,509	2,497	4,360	4,065	16,287	20,602	9,177	15,553
New Hampshire	**8,374**	**8,913**	3,224	3,224	4,972	4,972	16,477	20,759	25,399	36,798
New Jersey	**9,415**	**9,590**	2,741	2,740	6,456	6,198	23,785	24,821	18,914	21,434
New Mexico	**6,055**	**6,631**	4,313	4,310	6,246	7,916	15,679	18,911	2,750	3,586
New York	**10,031**	**10,398**	2,919	2,942	5,262	5,290	30,190	31,466	23,868	27,874
North Carolina	**7,391**	**7,911**	3,238	3,236	6,815	8,552	16,984	18,685	11,900	15,161
North Dakota	**11,469**	**11,834**	3,451	3,451	5,975	5,973	30,085	32,999	31,016	37,610
Ohio	**7,508**	**7,972**	2,457	2,459	4,597	4,941	20,742	24,731	22,264	30,081
Oklahoma	**6,370**	**6,886**	3,389	3,389	4,600	5,948	15,765	17,080	12,481	15,013
Oregon	**7,314**	**7,948**	2,642	2,693	6,319	6,834	17,082	20,596	17,202	25,870
Pennsylvania	**8,967**	**9,672**	3,459	3,457	3,613	4,546	16,188	16,900	20,591	25,039
Rhode Island	**10,689**	**10,978**	4,256	4,254	7,677	7,726	20,625	21,321	18,357	21,304
South Carolina	**5,148**	**5,630**	2,131	2,133	3,706	5,092	11,908	12,561	11,747	13,669
South Dakota	**6,969**	**7,292**	2,830	2,830	5,895	5,865	17,780	21,147	14,316	20,969
Tennessee	**5,690**	**6,056**	2,561	2,560	4,863	4,866	11,976	14,619	11,601	20,153
Texas	**5,985**	**6,307**	3,056	3,045	4,610	5,957	15,248	17,410	11,138	15,845
Utah	**6,657**	**6,668**	3,164	3,156	5,464	5,184	20,246	21,297	12,491	14,372
Vermont	**7,816**	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Virginia	**7,452**	**7,998**	2,889	2,886	5,255	5,996	18,166	21,431	14,464	19,733
Washington	**6,190**	**6,547**	2,455	2,442	5,291	6,669	15,714	17,574	15,698	19,568
West Virginia	**7,642**	**8,200**	2,587	2,587	6,010	6,006	12,222	14,050	18,041	28,587
Wisconsin	**6,680**	**7,262**	1,994	2,028	3,255	3,667	18,731	19,525	16,421	18,130
Wyoming	**7,713**	**8,024**	2,312	2,326	5,820	6,211	22,712	26,183	27,131	41,818

EXHIBIT 22. (continued)

Notes: FY is fiscal year. Full year equivalent (FYE) may also be referred to as average monthly enrollment. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals exclude disproportionate share hospital (DSH) payments and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included. In addition, due to the unavailability of several states' MSIS Annual Person Summary (APS) data for FY 2012, the sources used in prior editions of this exhibit, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

[1] In this table, the full benefit columns exclude enrollees reported by states in the MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

[2] State had a change in FYE enrollees of 10 percent or more over the prior year. These data may reflect anomalies in the MSIS data and may be updated in future MSIS submissions by states. MSIS data anomalies have been compiled and reported by Mathematica Policy Research; the data anomalies report may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

[3] The District of Columbia had a slight increase in total enrollees but a large decrease in total enrolled months, thus creating a decrease in FYE enrollees and number of months per enrollee of 10 percent or more over the prior year. These data may reflect anomalies in the MSIS data and may be updated in future MSIS submissions. MSIS data anomalies have been compiled and reported by Mathematica Policy Research; the data anomalies report may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/anomalies1.pdf.

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

Source: MACPAC, 2015, analysis of MSIS data as of December 2014 and CMS-64 FMR net expenditure data as of June 2015.

EXHIBIT 23. Medicaid Supplemental Payments to Hospital Providers by State, FY 2014 (millions)

State[1]	Inpatient and outpatient hospitals[2]				
	Total Medicaid payments	DSH payments	Non-DSH supplemental payments	Section 1115 waiver authority payments	Supplemental payments as % of total
Total	**$89,260.4**	**$15,204.2**	**$13,669.7**	**$10,545.6**	**44.2%**
Alabama	**1,909.4**	481.2	619.1	–	57.6
Alaska	**308.0**	8.8	–	–	2.8
Arizona[3]	**1,174.8**	114.9	159.4	338.6	52.2
Arkansas	**1,009.0**	36.8	295.3	–	32.9
California[3, 4]	**14,777.9**	2,481.9	2,176.8	2,797.6	50.5
Colorado	**1,909.8**	197.3	737.8	–	49.0
Connecticut	**1,972.2**	43.5	253.7	–	15.1
Delaware	**53.8**	8.4	–	–	15.7
District of Columbia	**378.6**	48.3	20.5	–	18.2
Florida[3]	**4,941.6**	240.2	–	992.5	24.9
Georgia	**2,139.0**	435.1	69.1	–	23.6
Hawaii[3]	**114.5**	–	0.3	93.2	81.7
Idaho	**434.4**	24.1	10.8	–	8.0
Illinois	**6,722.2**	369.6	2,898.3	–	48.6
Indiana	**1,905.9**	260.5	38.1	–	15.7
Iowa[3]	**802.3**	43.7	31.0	0.3	9.3
Kansas[3]	**145.6**	51.8	6.6	81.0	95.8
Kentucky	**458.0**	173.7	25.2	–	43.4
Louisiana	**2,212.2**	1,047.7	497.2	–	69.8
Maine	**510.0**	–	10.6	–	2.1
Maryland	**1,209.9**	47.2	47.6	–	7.8
Massachusetts[3, 4]	**2,257.0**	–	418.9	447.8	38.4
Michigan	**1,486.1**	304.6	570.3	–	58.9
Minnesota[5]	**641.6**	43.4	51.6	70.9	25.9
Mississippi	**1,660.7**	222.6	487.1	–	42.7
Missouri	**2,881.4**	521.7	119.2	–	22.2
Montana	**302.2**	18.1	1.5	–	6.5
Nebraska	**186.2**	39.2	–	–	21.0
Nevada	**514.2**	78.2	59.1	–	26.7
New Hampshire	**162.8**	83.4	0.4	–	51.4
New Jersey[4, 5]	**1,776.2**	856.5	0.0	225.0	60.9
New Mexico[3]	**359.6**	2.4	78.0	68.9	41.5
New York[4]	**7,732.9**	2,821.0	–	25.8	36.8
North Carolina	**3,471.3**	249.1	1,405.1	–	47.7
North Dakota	**63.0**	0.2	1.2	–	2.3
Ohio	**2,458.7**	579.2	492.0	–	43.6

EXHIBIT 23. (continued)

State[1]	Inpatient and outpatient hospitals[2]				
	Total Medicaid payments	DSH payments	Non-DSH supplemental payments	Section 1115 waiver authority payments	Supplemental payments as % of total
Oklahoma	**$1,673.0**	$40.3	$590.9	–	37.7%
Oregon	**513.7**	12.2	138.3	–	29.3
Pennsylvania	**1,822.0**	643.9	665.4	–	71.9
Rhode Island	**364.7**	138.3	13.9	–	41.8
South Carolina	**1,089.4**	446.3	96.7	–	49.8
South Dakota	**193.3**	0.9	2.8	–	1.9
Tennessee[3, 5]	**856.0**	–	–	$832.8	97.3
Texas[3, 4]	**7,769.4**	1,409.2	32.4	4,571.3	77.4
Utah	**302.8**	30.8	47.5	–	25.9
Vermont	**44.2**	37.4	–	–	84.8
Virginia	**992.2**	169.3	301.6	–	47.5
Washington	**1,079.6**	234.4	–	–	21.7
West Virginia	**622.4**	55.5	158.8	–	34.4
Wisconsin	**778.5**	50.8	22.3	–	9.4
Wyoming	**116.6**	0.5	17.2	–	15.2

Notes: FY is fiscal year. DSH is disproportionate share hospital. Includes federal and state funds. Excludes payments made under managed care arrangements. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; amounts include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported by states for any given category (e.g., inpatient hospital) sometimes show substantial annual fluctuations. CMS only began to require separate reporting of non-DSH supplemental payments in FY 2010 and is continuing to work with states to standardize this reporting. As a result, the information presented may not reflect a consistent classification of supplemental payment spending across states. Reporting is expected to improve over time.

– Dash indicates zero; $0.0 indicates an amount less than $0.05 million that rounds to zero.

[1] Not all states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 25, 2015. California's and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; Rhode Island's and Washington's fourth quarter submissions are not certified. Figures presented in this table may change if states revise their expenditure data after this date.

[2] Includes inpatient, outpatient, critical access hospital, and emergency hospital categories in the CMS-64 data. The CMS-64 instructions to states note that DSH payments are those made in accordance with Section 1923 of the Social Security Act. Non-DSH supplemental payments are described in the CMS-64 instructions to states as those made in addition to the standard fee schedule or other standard payment for a given service. They include payments made under institutional upper payment limit rules and payments to hospitals for graduate medical education. Section 1115 waiver expenditure authority payments include those made under uncompensated care pools, delivery system reform incentive payments (DSRIP), and other non-DSH supplemental payments that have been authorized under Section 1115 waivers. Because the majority of DSRIP payments go to hospitals, DSRIP payments that were reported as other care services on the CMS-64 were included in the Section 1115 waiver expenditure category and the total hospital payment category.

[3] State made supplemental payments through an uncompensated care pool under Section 1115 waiver expenditure authority.

[4] State made supplemental payments through a DSRIP under Section 1115 waiver expenditure authority.

[5] State made other supplemental payments, including graduate medical education, under Section 1115 waiver expenditure authority.

Source: MACPAC, 2015, analysis of CMS-64 FMR net expenditure data as of February 25, 2015 and CMS-64 Schedule C waiver report data as of August 18, 2015.

EXHIBIT 24. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2014 (millions)

State[1]	Mental health facilities[2]			Nursing facilities and ICFs/ID[3]			Physicians and other practitioners[4]		
	Total Medicaid payments	Supplemental payments	Supplemental payments as % of total	Total Medicaid payments	Supplemental payments	Supplemental payments as % of total	Total Medicaid payments	Supplemental payments	Supplemental payments as % of total
Total	**$5,462.6**	**$3,111.2**	**57.0%**	**$60,224.4**	**$2,997.4**	**5.0%**	**$15,370.4**	**$1,554.4**	**10.1%**
Alabama	**72.2**	0.2	0.2	**931.1**	–	–	**525.7**	–	–
Alaska	**31.8**	14.3	45.1	**127.2**	–	–	**140.1**	–	–
Arizona	**30.5**	28.5	93.2	**41.1**	3.8	9.2	**39.7**	–	–
Arkansas	**153.4**	0.8	0.5	**845.1**	–	–	**359.2**	35.0	9.7
California[5]	**390.2**	0.6	0.2	**5,291.8**	261.1	4.9	**1,468.2**	478.8	32.6
Colorado	**5.0**	–	–	**704.7**	98.2	13.9	**492.9**	5.9	1.2
Connecticut	**220.2**	105.6	47.9	**1,393.2**	–	–	**511.6**	–	–
Delaware	**6.0**	5.8	95.9	**30.8**	–	–	**13.4**	–	–
District of Columbia	**24.9**	5.9	23.8	**346.9**	–	–	**47.3**	8.1	17.1
Florida	**127.4**	95.9	75.3	**1,708.6**	4.5	0.3	**1,367.2**	168.0	12.3
Georgia	**38.8**	–	–	**1,341.3**	93.8	7.0	**462.2**	39.2	8.5
Hawaii	**–**	–	–	**9.6**	–	–	**3.3**	–	–
Idaho	**3.1**	–	–	**268.4**	64.7	24.1	**129.4**	–	–
Illinois	**196.8**	87.9	44.7	**2,311.5**	–	–	**974.3**	–	–
Indiana	**55.2**	–	–	**2,302.4**	745.6	32.4	**330.6**	122.7	37.1
Iowa[6, 7]	**15.5**	–	–	**925.3**	0.1	0.0	**212.0**	0.0	0.0
Kansas	**27.1**	25.5	94.2	**54.5**	–	–	**23.7**	18.0	76.0
Kentucky	**40.3**	37.4	93.0	**1,107.4**	0.6	0.0	**58.4**	14.2	24.2
Louisiana	**79.6**	78.0	97.9	**1,254.7**	–	–	**328.2**	28.5	8.7
Maine	**92.7**	39.3	42.4	**335.5**	–	–	**126.6**	–	–
Maryland	**152.0**	53.7	35.3	**1,185.6**	–	–	**146.8**	–	–
Massachusetts[5, 7, 8]	**113.0**	221.8	196.3	**1,787.8**	2.8	0.2	**403.4**	29.4	7.3
Michigan[8]	**255.5**	257.9	101.0	**1,778.5**	346.6	19.5	**445.2**	211.4	47.5
Minnesota	**78.7**	0.0	0.0	**924.3**	–	–	**398.1**	42.0	10.6
Mississippi	**76.2**	–	–	**1,020.2**	23.6	2.3	**200.5**	–	–
Missouri	**235.2**	207.2	88.1	**1,154.2**	–	–	**53.7**	–	–
Montana	**20.3**	–	–	**172.6**	–	–	**73.7**	–	–
Nebraska	**5.5**	2.1	37.6	**415.1**	–	–	**35.2**	–	–
Nevada	**54.0**	–	–	**221.3**	–	–	**138.7**	3.2	2.3
New Hampshire	**28.4**	25.9	91.4	**375.2**	–	–	**40.6**	–	–

EXHIBIT 24. (continued)

State[1]	Mental health facilities[2]			Nursing facilities and ICFs/ID[3]			Physicians and other practitioners[4]		
	Total Medicaid payments	Supplemental payments	Supplemental payments as % of total	Total Medicaid payments	Supplemental payments	Supplemental payments as % of total	Total Medicaid payments	Supplemental payments	Supplemental payments as % of total
New Jersey	**$464.0**	$357.4	77.0%	**$2,503.1**	–	–	**$72.5**	–	–
New Mexico	**1.7**	–	–	**32.7**	–	–	**71.8**	$6.3	8.7%
New York	**1,000.0**	545.5	54.6	**8,660.8**	$477.3	5.5%	**603.6**	37.5	6.2
North Carolina	**158.2**	157.8	99.7	**1,218.4**	–	–	**755.3**	51.7	6.8
North Dakota	**5.4**	0.5	9.1	**157.3**	0.7	0.4	**28.0**	–	–
Ohio[9]	**-46.6**	93.4	-200.4	**2,905.6**	–	–	**411.8**	–	–
Oklahoma	**97.0**	3.3	3.4	**673.1**	–	–	**531.8**	–	–
Oregon	**25.3**	20.0	79.0	**386.2**	–	–	**51.7**	–	–
Pennsylvania	**372.9**	312.4	83.8	**4,523.3**	725.2	16.0	**106.6**	–	–
Rhode Island	**4.5**	–	–	**234.1**	–	–	**17.1**	–	–
South Carolina	**104.2**	49.1	47.1	**707.9**	21.2	3.0	**178.5**	36.8	20.6
South Dakota	**4.2**	0.8	17.9	**160.9**	1.7	1.0	**66.0**	–	–
Tennessee	**37.2**	–	–	**221.6**	–	–	**53.2**	–	–
Texas[7]	**133.5**	117.1	87.7	**3,558.2**	39.7	1.1	**1,914.9**	55.3	2.9
Utah	**23.1**	0.9	4.0	**252.1**	14.2	5.6	**79.8**	13.0	16.3
Vermont	**–**	–	–	**119.8**	0.1	0.1	**2.1**	0.0	2.1
Virginia	**145.4**	9.4	6.5	**1,100.7**	3.0	0.3	**235.3**	37.5	16.0
Washington	**159.6**	130.6	81.8	**750.0**	–	–	**220.7**	83.8	38.0
West Virginia	**112.7**	18.9	16.8	**634.4**	–	–	**212.9**	28.3	13.3
Wisconsin	**15.9**	–	–	**939.8**	38.4	4.1	**151.3**	–	–
Wyoming	**15.0**	–	–	**118.4**	30.5	25.8	**55.3**	–	–

Notes: FY is fiscal year. ICF/ID is intermediate care facility for persons with intellectual disabilities. Includes federal and state funds. Excludes payments made under managed care arrangements. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; amounts include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported by states for any given category (e.g., nursing facility) sometimes show substantial annual fluctuations.

– Dash indicates zero; $0.0 indicates an amount less than $0.05 million that rounds to zero.

[1] Not all states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 25, 2015. California's and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; Rhode Island's and Washington's fourth quarter submissions are not certified. Figures presented in this table may change if states revise their expenditure data after this date.

EXHIBIT 24. (continued)

[2] Includes inpatient psychiatric services for individuals under age 21 and inpatient hospital or nursing facility services for individuals age 65 and older in an institution for mental diseases. Supplemental payments include DSH payments made in accordance with Section 1923 of the Social Security Act as well as uncompensated care pool and other non-DSH supplemental payments made under Section 1115 waiver expenditure authority. States are not instructed to break out non-DSH supplemental payments for mental health facilities.

[3] Includes nursing facilities and intermediate care facilities for persons with intellectual disabilities (ICF/ID). Supplemental payments include those payments that are made in addition to the standard fee schedule or other standard payments for a given service, including payments made under institutional upper payment limit rules and uncompensated care pools made under Section 1115 waiver expenditure authority.

[4] Includes the physician and other practitioner categories in CMS-64 data; excludes additional categories (e.g., dental, nurse-midwife, nurse practitioner) for which states are not instructed to break out supplemental payments. Supplemental payments include those payments that are made in addition to the standard fee schedule payment as well as uncompensated care pool payments made under Section 1115 waiver expenditure authority. Unlike for institutional providers, there is not a regulatory upper payment limit for physicians and other practitioners.

[5] State made non-DSH payments to mental health facilities through an uncompensated care pool or made other non-DSH supplemental payments under Section 1115 waiver expenditure authority.

[6] State made payments to nursing facilities through an uncompensated care pool under Section 1115 waiver expenditure authority.

[7] State made payments to physicians and other practitioners through an uncompensated care pool under Section 1115 waiver expenditure authority.

[8] Massachusetts and Michigan reported supplemental payments that were greater than the total payments, creating a percentage above 100 percent.

[9] Ohio reported negative non-DSH payments to mental health facilities that were greater than the DSH payments, creating a negative total payment and a negative percentage.

Source: MACPAC, 2015, analysis of CMS-64 FMR net expenditure data as of February 25, 2015 and CMS-64 Schedule C waiver report data as of August 18, 2015.

EXHIBIT 25. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2014 (millions)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Total	$42,747.6	76.4%	23.2%	0.5%	$22,607.5	79.5%	20.4%	0.2%	$20,140.1	72.9%	26.3%	0.8%
Alabama	596.2	75.8	24.1	0.1	596.2	75.8	24.1	0.1	–	–	–	–
Alaska	75.6	72.7	27.0	0.3	75.6	72.7	27.0	0.3	–	–	–	–
Arizona	721.5	68.0	31.7	0.2	11.2	83.4	16.1	0.4	710.3	67.8	32.0	0.2
Arkansas	363.6	72.4	27.5	0.1	363.6	72.4	27.5	0.1	–	–	–	–
California	4,737.3	78.4	21.6	0.0	3,414.9	84.9	15.1	0.0	1,322.4	61.8	38.2	0.0
Colorado	549.9	73.4	26.2	0.4	549.9	73.4	26.2	0.4	–	–	–	–
Connecticut	867.6	81.7	18.2	0.1	867.6	81.7	18.2	0.1	–	–	–	–
Delaware	217.5	83.1	16.9	0.0	189.3	82.0	18.0	0.0	28.2	90.2	9.8	0.0
District of Columbia	143.8	75.1	24.9	0.0	72.3	81.1	18.9	0.0	71.5	69.0	31.0	0.0
Florida	2,340.8	79.2	20.7	0.1	1,400.1	82.7	17.3	0.1	940.7	74.1	25.8	0.1
Georgia	987.3	74.5	25.5	0.0	615.4	80.7	19.3	0.0	371.9	64.2	35.8	0.0
Hawaii[4]	411.8	47.2	20.6	32.2	1.0	76.6	23.3	0.1	410.8	47.1	20.6	32.2
Idaho	171.7	76.5	23.4	0.1	171.7	76.5	23.4	0.1	–	–	–	–
Illinois	1,206.2	72.7	27.2	0.0	936.1	73.2	26.8	0.0	270.1	71.3	28.7	0.0
Indiana	1,089.9	80.6	18.2	1.2	1,077.0	80.4	18.4	1.2	12.9	96.0	3.4	0.5
Iowa	349.2	77.2	22.8	0.0	349.1	77.2	22.8	0.0	0.1	95.2	4.8	0.0
Kansas	443.2	77.8	22.2	0.1	1.5	82.8	17.0	0.2	441.7	77.8	22.2	0.1
Kentucky	742.9	70.0	29.8	0.2	77.0	74.5	24.7	0.9	665.9	69.5	30.4	0.1
Louisiana	765.3	73.4	26.4	0.1	483.9	74.0	25.9	0.1	281.4	72.6	27.3	0.1
Maine	224.6	82.8	17.2	0.0	224.6	82.8	17.2	0.0	–	–	–	–
Maryland	810.4	82.1	17.9	0.0	428.9	87.7	12.3	0.0	381.5	75.7	24.3	0.0
Massachusetts	979.9	73.5	26.3	0.2	472.9	72.3	27.5	0.2	507.1	74.6	25.1	0.3
Michigan	1,285.5	77.2	22.7	0.1	778.3	82.7	17.3	0.1	507.3	68.8	31.0	0.1
Minnesota	845.4	72.2	27.6	0.2	261.9	73.5	26.3	0.2	583.4	71.6	28.2	0.2
Mississippi	459.3	69.4	30.6	0.0	261.4	75.5	24.5	0.0	198.0	61.4	38.6	0.0
Missouri	1,139.7	74.4	25.3	0.3	1,139.7	74.4	25.3	0.3	–	–	–	–
Montana	105.9	80.3	19.6	0.1	105.9	80.3	19.6	0.1	–	–	–	–
Nebraska	193.9	79.0	20.9	0.0	183.1	78.5	21.5	0.0	10.8	87.3	12.4	0.2

EXHIBIT 25. (continued)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Nevada	$263.5	79.3%	20.5%	0.2%	$204.5	81.5%	18.3%	0.2%	$59.0	71.5%	28.2%	0.3%
New Hampshire	114.8	79.3	20.5	0.3	41.6	82.8	16.7	0.5	73.1	77.2	22.6	0.2
New Jersey	892.9	76.8	23.2	0.0	76.0	78.5	21.5	0.0	816.9	76.6	23.4	0.0
New Mexico	219.5	69.9	30.0	0.2	11.2	71.2	28.8	0.0	208.3	69.8	30.0	0.2
New York	4,848.3	79.6	20.4	0.0	722.6	85.0	15.0	0.0	4,125.8	78.6	21.4	0.0
North Carolina	1,525.2	78.8	21.1	0.1	1,525.2	78.8	21.1	0.1	–	–	–	–
North Dakota	51.8	73.6	26.3	0.0	43.8	72.4	27.6	0.0	8.0	80.3	19.7	0.0
Ohio	1,803.8	73.1	26.0	0.9	541.9	76.3	23.2	0.5	1,261.8	71.8	27.2	1.0
Oklahoma	504.5	75.0	25.0	0.1	504.5	75.0	25.0	0.1	–	–	–	–
Oregon	438.6	71.9	28.1	0.0	147.5	68.6	31.4	0.0	291.2	73.5	26.4	0.0
Pennsylvania	1,913.8	76.5	23.4	0.1	67.8	76.7	23.1	0.2	1,846.1	76.5	23.5	0.1
Rhode Island	10.1	86.0	14.0	0.1	10.1	86.0	14.0	0.1	–	–	–	–
South Carolina	461.3	73.6	26.3	0.1	141.5	80.3	19.5	0.2	319.8	70.6	29.3	0.1
South Dakota	66.4	76.5	23.5	0.0	66.4	76.5	23.5	0.0	–	–	–	–
Tennessee	895.7	80.0	19.9	0.2	850.0	79.3	20.6	0.1	45.7	91.7	7.1	1.2
Texas	2,797.9	79.4	20.6	0.0	734.8	82.7	17.3	0.0	2,063.2	78.2	21.8	0.0
Utah	202.0	77.2	22.8	0.0	115.8	79.7	20.3	0.0	86.2	73.9	26.1	0.0
Vermont	156.6	76.9	23.1	0.1	156.6	76.9	23.1	0.1	–	–	–	–
Virginia[5]	843.0	61.6	37.5	1.0	148.3	73.0	25.4	1.6	694.7	59.1	40.0	0.8
Washington	550.2	75.6	24.3	0.1	120.4	72.7	27.1	0.2	429.8	76.3	23.5	0.1
West Virginia	455.1	78.4	21.5	0.1	366.5	79.6	20.3	0.1	88.6	73.5	26.3	0.2
Wisconsin	861.3	78.4	21.6	0.1	855.4	78.4	21.5	0.1	5.9	67.5	32.2	0.2
Wyoming	44.9	79.4	20.5	0.1	44.9	79.4	20.5	0.1	–	–	–	–

Notes: FY is fiscal year. Amounts include federal and state funds. Gross spending reflects expenditures prior to the application of manufacturer rebates. Drug expenditures in this exhibit use information from the state drug utilization data that states submit to CMS for rebate purposes and are different from the CMS-64 Financial Management Report (FMR) and Medicaid Statistical Information System (MSIS) data that serve as our usual sources of expenditure data. Spending shown in the drug utilization data may differ from these other sources due to differences in timing and run-out of data used. In addition, the drug utilization data may include physician-administered drugs for which rebates are available; these drugs are typically reported under the physician services category instead of the outpatient prescription drug category in other data. The state drug utilization data provide both fee-for-service and managed care drug utilization and spending information at the national drug code (NDC) level. To assign brand and generic status, we linked the quarterly state drug utilization data to the quarterly Medicaid drug product data from CMS using the NDC code. Brand and generic status was assigned

EXHIBIT 25. (continued)

using the drug category indicator from the drug product file. The state drug utilization data are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-programs-data-and-resources.html and the drug product data are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html. The different brand and generic proportions under fee for service and managed care may reflect differences in the populations and specific drugs covered under each delivery system (e.g., behavioral health drugs carved out of managed care) as well as differences in how the state and participating health plans managed the drug benefit.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] For this exhibit, brand drugs were defined as single source drugs and innovator, multiple source drugs as indicated in that quarter's Medicaid drug product data.

[2] For this exhibit, generic drugs were defined as non-innovator, multiple source drugs as indicated in that quarter's Medicaid drug product file.

[3] For this exhibit, unknown drugs were those drugs whose NDC did not have a match in that quarter's Medicaid drug product file.

[4] Hawaii reports a large amount of spending in managed care under an unidentifiable NDC code and drug name, which accounts for the high percentage of spending on drugs in the unknown category.

[5] Virginia data were corrected for an apparent error in fee-for-service spending in the second quarter of 2014.

Source: MACPAC, 2015, analysis of Medicaid drug product data and state drug rebate utilization data as of October 2015.

EXHIBIT 26. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2014 (thousands)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Total	**588,624**	**18.9%**	**80.7%**	**0.4%**	**261,956**	**21.5%**	**78.0%**	**0.5%**	**326,668**	**16.8%**	**82.8%**	**0.3%**
Alabama	7,662	21.9	77.9	0.2	7,662	21.9	77.9	0.2	–	–	–	–
Alaska	961	21.6	77.7	0.7	961	21.6	77.7	0.7	–	–	–	–
Arizona	13,804	13.6	86.0	0.4	103	15.3	84.0	0.7	13,701	13.6	86.0	0.4
Arkansas	5,067	20.1	79.5	0.4	5,067	20.1	79.5	0.4	–	–	–	–
California	61,811	18.4	81.5	0.0	26,148	26.0	73.9	0.1	35,663	12.9	87.1	0.0
Colorado	6,473	18.7	81.1	0.2	6,473	18.7	81.1	0.2	–	–	–	–
Connecticut	7,971	26.4	73.3	0.3	7,971	26.4	73.3	0.3	–	–	–	–
Delaware	2,421	23.4	76.5	0.1	2,256	22.6	77.3	0.1	165	33.9	65.9	0.2
District of Columbia	2,356	17.6	82.4	0.1	936	20.6	79.3	0.0	1,420	15.6	84.3	0.1
Florida	27,697	19.6	80.2	0.1	13,543	23.0	76.9	0.1	14,154	16.5	83.4	0.1
Georgia	16,661	18.2	81.8	0.0	8,068	19.4	80.6	0.0	8,593	16.9	83.0	0.0
Hawaii	2,699	14.5	83.3	2.2	10	7.8	91.9	0.3	2,689	14.5	83.3	2.2
Idaho	2,201	20.5	79.4	0.1	2,201	20.5	79.4	0.1	–	–	–	–
Illinois	19,805	17.2	82.8	0.0	15,221	17.6	82.4	0.0	4,584	16.1	83.9	0.0
Indiana	12,011	21.8	77.1	1.1	11,858	21.7	77.2	1.1	153	30.1	69.2	0.7
Iowa	5,616	20.6	79.4	0.0	5,616	20.6	79.4	0.0	0	81.0	19.0	0.0
Kansas	5,651	21.6	78.3	0.1	15	23.8	76.0	0.2	5,636	21.6	78.3	0.1
Kentucky	15,635	15.2	84.3	0.5	1,375	14.0	83.7	2.2	14,261	15.3	84.4	0.3
Louisiana	10,510	21.2	78.6	0.2	5,957	24.0	75.8	0.2	4,553	17.6	82.2	0.2
Maine	2,962	24.7	75.3	0.0	2,962	24.7	75.3	0.0	–	–	–	–
Maryland	12,359	19.0	81.0	0.0	3,691	25.1	74.9	0.0	8,668	16.4	83.6	0.0
Massachusetts	13,186	16.8	81.3	1.9	6,684	15.5	82.0	2.5	6,502	18.0	80.6	1.3
Michigan	22,319	16.7	82.7	0.5	8,076	22.3	77.3	0.4	14,243	13.6	85.8	0.6
Minnesota	11,571	16.7	82.9	0.4	3,035	18.6	81.0	0.4	8,537	16.0	83.5	0.4
Mississippi	5,692	20.8	79.1	0.0	2,878	27.0	73.0	0.0	2,814	14.5	85.4	0.0
Missouri	11,684	21.3	78.4	0.2	11,684	21.3	78.4	0.2	–	–	–	–
Montana	1,136	22.0	77.8	0.2	1,136	22.0	77.8	0.2	–	–	–	–
Nebraska	2,663	18.2	81.7	0.1	2,540	17.7	82.2	0.1	123	26.8	72.2	0.9
Nevada	3,756	18.9	79.9	1.1	2,426	22.1	76.6	1.3	1,330	13.2	85.9	0.9
New Hampshire	1,523	21.5	77.5	1.0	540	20.8	76.9	2.4	983	21.9	77.8	0.3
New Jersey	12,815	17.9	82.0	0.0	1,103	19.6	80.4	0.0	11,712	17.8	82.2	0.0
New Mexico	4,251	15.4	84.3	0.3	161	20.0	79.9	0.2	4,090	15.3	84.4	0.3
New York	67,582	17.6	82.4	0.0	10,372	16.6	83.4	0.0	57,209	17.8	82.2	0.0

EXHIBIT 26. (continued)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
North Carolina	16,939	26.4%	73.4%	0.2%	16,939	26.4%	73.4%	0.2%	–	–	–	–
North Dakota	705	19.8	80.1	0.1	599	20.2	79.7	0.1	106	17.2%	82.7%	0.1%
Ohio	30,007	17.0	80.1	2.9	8,345	17.4	77.6	5.1	21,662	16.9	81.1	2.0
Oklahoma	6,274	18.9	81.0	0.1	6,274	18.9	81.0	0.1	–	–	–	–
Oregon	7,666	14.9	85.0	0.0	2,035	14.0	86.0	0.0	5,631	15.3	84.7	0.0
Pennsylvania	25,494	18.3	81.5	0.2	1,854	13.9	86.0	0.1	23,641	18.6	81.2	0.2
Rhode Island	384	21.6	78.2	0.1	384	21.6	78.2	0.1	–	–	–	–
South Carolina	6,908	19.3	80.3	0.3	1,725	23.7	75.6	0.7	5,183	17.9	81.9	0.2
South Dakota	821	21.9	78.1	0.0	821	21.9	78.1	0.0	–	–	–	–
Tennessee	13,159	18.2	81.4	0.3	12,694	17.9	81.9	0.2	466	27.8	67.9	4.3
Texas	35,150	22.9	77.0	0.0	6,152	28.7	71.2	0.0	28,998	21.7	78.3	0.0
Utah	3,011	19.7	80.3	0.0	1,347	21.1	78.9	0.0	1,665	18.6	81.4	0.0
Vermont	1,365	28.0	71.8	0.1	1,365	28.0	71.8	0.1	–	–	–	–
Virginia	10,317	17.9	79.7	2.4	2,665	17.7	74.6	7.6	7,652	17.9	81.5	0.6
Washington	10,381	14.5	84.9	0.5	2,452	14.4	84.7	0.9	7,929	14.6	85.0	0.4
West Virginia	7,852	19.9	80.0	0.1	6,001	19.8	80.1	0.1	1,851	20.2	79.6	0.2
Wisconsin	11,153	21.9	77.9	0.2	11,053	22.0	77.8	0.1	101	11.4	87.2	1.4
Wyoming	526	21.0	79.0	0.1	526	21.0	79.0	0.1	–	–	–	–

Notes: FY is fiscal year. Drug utilization in this exhibit reflects the number of prescriptions reported in the state drug utilization data that states submit to CMS for rebate purposes and are different from the Medicaid Statistical Information System (MSIS) data that serve as our usual source of utilization data. Utilization shown in the drug utilization data may differ from other sources due to differences in timing and run-out of data used. In addition, the drug utilization data may include physician-administered drugs for which rebates are available; these drugs are typically reported under the physician services category instead of the outpatient prescription drug category in other data. The state drug utilization data provide both fee-for-service and managed care drug utilization and spending information at the national drug code (NDC) level. To assign brand and generic status, we linked the quarterly state drug utilization data to the quarterly Medicaid drug product data from CMS using the NDC code. Brand and generic status was assigned using the drug category indicator from the drug product file. The state drug utilization data are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-programs-data-and-resources.html and the drug product data are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html. The different brand and generic proportions under fee for service and managed care may reflect differences in the populations and specific drugs covered under each delivery system (e.g., behavioral health drugs carved out of managed care) as well as differences in how the state and participating health plans managed the drug benefit.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] For this exhibit, brand drugs were defined as single source drugs and innovator, multiple source drugs as indicated in that quarter's Medicaid drug product data.

[2] For this exhibit, generic drugs were defined as non-innovator, multiple source drugs as indicated in that quarter's Medicaid drug product file.

[3] For this exhibit, unknown drugs were those drugs whose NDC did not have a match in that quarter's Medicaid drug product file.

Source: MACPAC, 2015, analysis of Medicaid drug product data and state drug rebate utilization data as of October 2015.

EXHIBIT 27. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2014 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total	**$42,747.6**	**$22,607.5**	**$20,140.1**	**-$19,944.1**	**-$13,323.3**	**-$6,620.7**
Alabama	**596.2**	596.2	–	**-276.0**	-276.0	–
Alaska	**75.6**	75.6	–	**-33.0**	-33.0	–
Arizona	**721.5**	11.2	710.3	**-305.3**	-5.4	-299.9
Arkansas	**363.6**	363.6	–	**-137.2**	-137.2	–
California	**4,737.3**	3,414.9	1,322.4	**-2,246.2**	-1,545.2	-701.0
Colorado	**549.9**	549.9	–	**-224.7**	-224.7	–
Connecticut	**867.6**	867.6	–	**-388.2**	-388.2	–
Delaware	**217.5**	189.3	28.2	**-122.5**	-116.6	-5.9
District of Columbia	**143.8**	72.3	71.5	**-66.1**	-39.3	-26.8
Florida	**2,340.8**	1,400.1	940.7	**-1,109.9**	-821.5	-288.4
Georgia	**987.3**	615.4	371.9	**-439.1**	-321.7	-117.4
Hawaii[1]	**411.8**	1.0	410.8	**-54.8**	-0.3	-54.5
Idaho	**171.7**	171.7	–	**-92.3**	-92.3	–
Illinois	**1,206.2**	936.1	270.1	**-493.4**	-420.6	-72.7
Indiana	**1,089.9**	1,077.0	12.9	**-497.0**	-493.7	-3.3
Iowa	**349.2**	349.1	0.1	**-190.4**	-190.4	-0.0
Kansas[2]	**443.2**	1.5	441.7	**-163.7**	-1.9	-161.8
Kentucky	**742.9**	77.0	665.9	**-260.5**	-36.5	-224.0
Louisiana[3]	**765.3**	483.9	281.4	**-340.2**	-331.5	-8.7
Maine	**224.6**	224.6	–	**-136.4**	-136.4	–
Maryland	**810.4**	428.9	381.5	**-331.8**	-190.7	-141.1
Massachusetts	**979.9**	472.9	507.1	**-401.7**	-210.0	-191.7
Michigan	**1,285.5**	778.3	507.3	**-732.4**	-459.8	-272.7
Minnesota	**845.4**	261.9	583.4	**-492.8**	-131.1	-361.7
Mississippi	**459.3**	261.4	198.0	**-175.5**	-113.8	-61.7
Missouri	**1,139.7**	1,139.7	–	**-473.5**	-455.2	-18.4
Montana	**105.9**	105.9	–	**-56.0**	-56.0	–

EXHIBIT 27. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Nebraska[4]	**$193.9**	$183.1	$10.8	**-$113.8**	-$113.8	–
Nevada	**263.5**	204.5	59.0	**-110.2**	-91.8	-$18.4
New Hampshire[2, 3]	**114.8**	41.6	73.1	**-41.8**	-41.8	–
New Jersey[2]	**892.9**	76.0	816.9	**-471.8**	-67.3	-404.5
New Mexico[2]	**219.5**	11.2	208.3	**-155.9**	-26.5	-129.4
New York[3]	**4,848.3**	722.6	4,125.8	**-2,194.5**	-2,194.5	–
North Carolina	**1,525.2**	1,525.2	–	**-834.5**	-834.5	–
North Dakota[2]	**51.8**	43.8	8.0	**-11.9**	-11.9	–
Ohio	**1,803.8**	541.9	1,261.8	**-796.8**	-357.8	-439.1
Oklahoma	**504.5**	504.5	–	**-237.0**	-237.0	–
Oregon	**438.6**	147.5	291.2	**-217.6**	-85.5	-132.1
Pennsylvania[2]	**1,913.8**	67.8	1,846.1	**-885.8**	-57.6	-828.2
Rhode Island[5]	**10.1**	10.1	–	**-58.9**	-13.9	-45.0
South Carolina[2]	**461.3**	141.5	319.8	**-210.9**	-124.4	-86.5
South Dakota	**66.4**	66.4	–	**-26.9**	-26.9	–
Tennessee[4]	**895.7**	850.0	45.7	**-393.6**	-393.6	–
Texas	**2,797.9**	734.8	2,063.2	**-1,525.0**	-425.1	-1,099.9
Utah	**202.0**	115.8	86.2	**-98.0**	-56.7	-41.3
Vermont	**156.6**	156.6	–	**-77.7**	-77.7	–
Virginia[6]	**843.0**	148.3	694.7	**-301.4**	-80.3	-221.2
Washington	**550.2**	120.4	429.8	**-217.5**	-97.5	-120.0
West Virginia	**455.1**	366.5	88.6	**-220.7**	-179.0	-41.7
Wisconsin	**861.3**	855.4	5.9	**-476.2**	-474.4	-1.8
Wyoming	**44.9**	44.9	–	**-24.9**	-24.9	–

Notes: FY is fiscal year. Amounts include federal and state funds. Gross spending reflects expenditures prior to the application of manufacturer rebates. The gross drug expenditures in this exhibit use information from the state drug utilization data that states submit to CMS for rebate purposes and are different from the CMS-64 Financial Management Report (FMR) and Medicaid Statistical Information System (MSIS) data that serve as our usual sources of expenditure data. Spending shown in the drug utilization data may differ from these other sources due to differences in timing and run-out of data used. In addition, the drug rebate data may include physician-administered

EXHIBIT 27. (continued)

drugs for which rebates are available; the spending for these drugs are typically reported under the physician services category instead of the outpatient prescription drug category in other data. The state drug utilization data provide both fee-for-service and managed care drug utilization and spending information at the national drug code (NDC) level, which is not available in CMS-64 data. The state drug utilization data are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-programs-data-and-resources.html. The drug rebate information comes from the CMS-64 and does allow states to separately identify fee-for-service and managed care drug rebates. The rebate totals shown here include federal rebates, state supplemental rebates, and the rebate increases attributable to the Affordable Care Act.

Due to the time it takes to collect the drug utilization information and invoice drug manufacturers for the rebate, the rebates collected in any particular quarter are generally attributable to drugs purchased in prior quarters; thus, the gross spending and rebate dollars for a given time period are not necessarily aligned. Changes in covered populations or benefit design (e.g., managed care expansion or pharmacy carve-in) can create distortions in the data, because changes will be reflected in gross spending before they are reflected in rebates collected.

– Dash indicates zero; -$0.0 indicates an amount between zero and -$0.5 million that rounds to zero.

[1] Hawaii shows wide quarterly variations in their managed care drug spending; this is due in part due to the state's practice of reporting a large amount of spending under an unidentifiable NDC code and drug name.

[2] State recently implemented or expanded managed care. This change creates a large difference between gross spending and rebate collections for fee-for-service and managed care, resulting in anomalous rebate percentages at the delivery system level.

[3] State reports little or no managed care rebates in CMS-64 data. The rebates for these managed care expenditures appears to be reported with the fee-for-service rebates.

[4] State generally carves out prescription drugs from the managed care program. State managed care spending may reflect physician-administered drugs; however, rebates for these managed care expenditures are not reported separately in the CMS-64 data and appear to be reported with the fee-for-service rebates.

[5] Rhode Island has not reported any managed care drug utilization since the second quarter of FY 2013.

[6] Virginia data were corrected for an apparent error in fee-for-service spending in the second quarter of FY 2014.

Sources: MACPAC, 2015, analysis of Medicaid state drug rebate utilization data as of October 2015 and CMS-64 FMR net expenditure data as of February 25, 2015.

EXHIBIT 28. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2013

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care						
			Limited-benefit plans					
		Comprehensive managed care[1]	MLTSS	BHO (PIHP and/or PAHP)	Dental	Transportation	Other	PCCM
Total	**60,512**	**55.3%**	**0.3%**	**15.9%**	**10.8%**	**11.7%**	**1.9%**	**13.2%**
Alabama	**960**	0.0	–	–	–	–	2.4	57.1
Alaska	**145**	–	–	–	–	–	–	–
Arizona	**1,271**	84.4	–	–	–	–	–	–
Arkansas	**614**	0.0	–	–	–	75.3	–	71.6
California	**8,469**	67.2	–	–	7.8	–	0.0	–
Colorado	**740**	10.6	–	94.9	–	–	2.9	48.0
Connecticut	**622**	–	–	–	–	–	–	–
Delaware	**216**	84.4	–	–	–	–	–	–
District of Columbia	**253**	62.4	–	–	–	20.3	–	–
Florida	**3,384**	44.8	0.6	17.3	38.9	–	0.2	17.4
Georgia	**1,814**	63.3	–	–	–	–	–	–
Hawaii	**307**	93.9	–	–	–	–	–	–
Idaho[2]	**255**	–	–	0.0	94.5	94.6	0.3	85.6
Illinois	**2,931**	9.6	–	–	–	–	–	63.8
Indiana	**1,126**	64.9	–	–	–	–	–	3.1
Iowa	**434**	7.0	–	96.9	–	93.2	–	47.6
Kansas	**399**	82.5	–	–	–	–	–	–
Kentucky	**847**	84.6	–	–	–	–	–	–
Louisiana	**1,257**	34.1	–	82.5	–	–	–	41.1
Maine	**262**	–	–	–	–	–	–	68.0
Maryland	**1,089**	79.4	–	–	–	–	–	–
Massachusetts	**1,410**	31.6	–	4.8	–	–	–	25.6
Michigan	**1,816**	71.1	–	88.2	23.7	–	–	–
Minnesota	**902**	70.2	–	–	–	–	–	–
Mississippi	**689**	22.5	–	–	–	–	–	–

EXHIBIT 28. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care						
			Limited-benefit plans					
		Comprehensive managed care[1]	MLTSS	BHO (PIHP and/or PAHP)	Dental	Transportation	Other	PCCM
Missouri	868	47.9%	–	–	–	49.4%	–	–
Montana	119	–	–	–	–	–	–	65.5%
Nebraska[3]	244	75.7	–	86.9%	–	–	–	–
Nevada	329	54.9	–	–	–	54.9	–	–
New Hampshire[2]	146	0.0	–	–	–	–	–	–
New Jersey	1,201	87.9	–	–	–	84.5	–	–
New Mexico	555	74.5	–	67.6	–	–	–	–
New York	5,353	73.6	1.9%	–	–	–	–	–
North Carolina	1,589	0.0	–	76.2	–	–	–	96.2
North Dakota	77	0.1	–	0.4	–	–	–	54.8
Ohio	2,390	69.8	–	–	–	–	–	–
Oklahoma	736	0.0	–	–	–	93.7	–	100.0
Oregon[4]	695	78.8	–	3.5	86.7%	–	–	0.1
Pennsylvania	3,447	47.2	–	53.8	–	14.3	–	–
Rhode Island	197	71.3	–	–	32.5	–	–	0.8
South Carolina	1,002	45.9	–	–	–	100.0	–	17.9
South Dakota	122	–	–	–	–	–	–	74.8
Tennessee[4]	1,216	100.0	–	–	60.7	–	88.7%	–
Texas	3,879	77.3	–	12.3	63.8	48.6	0.3	–
Utah[3]	266	70.1	–	98.0	–	81.4	–	–
Vermont	182	56.5	–	–	–	–	–	–
Virginia	938	67.8	–	–	–	–	–	–
Washington	1,173	67.3	–	65.3	–	2.2	–	0.7
West Virginia	330	51.6	–	–	–	–	–	1.2
Wisconsin	1,179	59.5	3.2	0.1	–	–	–	–
Wyoming	66	0.0	–	–	–	–	–	–

EXHIBIT 28. (continued)

Notes: PCCM is primary care case management. MLTSS is managed long-term services and supports. BHO is behavioral health organization. PIHP is prepaid inpatient health plan. PAHP is prepaid ambulatory health plan. Excludes the territories. This exhibit includes Medicaid-expansion CHIP enrollees. Medicaid beneficiaries may be enrolled concurrently in more than one type of managed care program (e.g., a comprehensive plan and a BHO), so the sum of enrollment in each program type as a percentage of total Medicaid enrollment may be greater than 100 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Includes comprehensive managed care and Programs of All-Inclusive Care for the Elderly (PACE).

[2] State operated a Medicaid managed care program in 2013 but the program either ended before July 1, 2013 or began after that date. Idaho had a BHO program and New Hampshire had a comprehensive managed care program in 2013, but both had zero enrollment on July 1, 2013.

[3] The total for BHO plans published by CMS was greater than the total number of Medicaid enrollees due to the state having two behavioral health programs that allowed for concurrent enrollment. The value shown here uses the enrollment total from the largest of the two types of BHO programs.

[4] The total for comprehensive managed care plans published by CMS was greater than the total number of Medicaid enrollees due to an apparent classification error; some plans that appear to be limited-benefit plans (dental, BHO, or other managed care) were classified as comprehensive managed care. The values shown here use plan-level information in the CMS report to separate enrollment in the limited plans from the comprehensive managed care total and categorize enrollment in those limited-benefit plans as BHO, dental, or other managed care.

Source: MACPAC, 2015, analysis of CMS, 2015, *Medicaid managed care enrollment and program characteristics, 2013,* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2013-medicaid-managed-care-enrollment-report.pdf.

EXHIBIT 29. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2012

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care														
		Comprehensive managed care[1]					Limited-benefit plans					PCCM				
		Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Total	68,680	52.5%	66.2%	50.1%	37.3%	17.0%	48.0%	56.3%	35.6%	52.0%	39.0%	15.9%	22.0%	10.8%	14.9%	3.5%
Alabama	1,104	3.0	–	0.0	6.9	14.6	–	–	–	–	–	61.9	93.2	22.2	51.5	1.5
Alaska	139	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	1,713	79.1	88.1	77.3	65.6	47.2	88.4	94.3	84.1	89.6	70.3	–	–	–	–	–
Arkansas	695	0.0	–	0.0	0.0	0.2	78.7	98.1	46.9	75.1	41.2	63.8	90.7	28.0	56.1	3.8
California	12,005	47.8	72.1	28.8	62.4	30.6	68.8	93.8	36.9	99.8	96.6	–	–	–	–	–
Colorado	826	12.1	12.9	11.5	10.4	10.3	95.1	99.2	95.5	89.1	75.2	3.9	3.4	3.1	6.3	5.1
Connecticut	823	48.8	81.9	44.4	0.7	0.0	–	–	–	–	–	–	–	–	–	–
Delaware	255	84.8	93.9	87.0	66.2	43.9	89.4	98.8	90.2	74.7	49.3	3.0	3.0	3.3	3.2	0.6
District of Columbia	225	71.4	89.6	89.7	22.3	2.9	36.7	20.6	26.2	79.0	71.9	–	–	–	–	–
Florida	4,145	40.0	53.5	37.0	27.9	7.1	27.0	41.0	11.3	23.7	2.7	25.1	35.2	14.3	25.9	3.5
Georgia	1,640	63.1	89.2	85.0	2.8	0.0	82.6	93.5	77.0	73.1	47.9	–	–	–	–	–
Hawaii	296	98.0	99.7	99.0	95.6	89.4	1.2	2.1	0.0	3.3	0.2	–	–	–	–	–
Idaho	279	–	–	–	–	–	94.8	100.0	97.4	85.6	66.7	86.2	94.2	83.6	77.1	45.3
Illinois	3,005	–	–	–	–	–	10.6	12.2	9.4	9.8	4.4	65.3	77.9	72.6	29.4	4.9
Indiana	1,228	70.6	92.2	89.1	11.7	0.2	–	–	–	–	–	3.9	2.2	0.1	15.3	1.8
Iowa	622	1.6	2.6	1.1	0.1	0.2	79.4	99.1	47.9	92.7	74.9	56.3	71.0	70.0	4.5	1.0
Kansas	430	59.2	82.0	78.9	1.7	0.6	92.5	100.0	96.9	86.5	49.8	7.4	3.9	2.0	24.8	2.3
Kentucky	926	84.8	99.1	95.0	72.7	34.6	90.8	99.9	99.7	81.7	58.7	22.5	35.4	25.7	5.7	0.5
Louisiana	1,311	0.0	–	–	0.0	0.2	75.9	59.1	90.8	96.1	94.2	64.3	91.0	38.5	46.8	10.5
Maine	446	–	–	–	–	–	–	–	–	–	–	98.2	97.1	97.9	99.2	98.8
Maryland	1,098	81.3	97.3	86.1	60.1	2.1	–	–	–	–	–	–	–	–	–	–
Massachusetts	1,549	45.1	53.4	57.3	27.0	16.0	28.3	38.3	24.7	36.7	0.2	24.1	30.2	24.4	27.8	0.2
Michigan	2,297	71.4	86.5	69.1	54.3	8.4	93.4	98.7	83.9	95.2	85.7	–	–	–	–	–
Minnesota	1,145	76.1	86.4	80.5	40.4	59.2	–	–	–	–	–	–	–	–	–	–
Mississippi	781	8.2	0.4	0.2	35.5	0.7	87.5	99.8	82.7	79.4	55.2	–	–	–	–	–

EXHIBIT 29. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care														
		Comprehensive managed care[1]					Limited-benefit plans					PCCM				
		Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Missouri	1,135	45.2%	67.8%	49.0%	2.0%	0.2%	–	–	–	–	–	–	–	–	–	–
Montana	136	–	–	–	–	–	0.7%	–	0.0%	3.6%	0.1%	74.6%	92.7%	83.0%	51.0%	1.6%
Nebraska	264	65.8	82.7	69.0	37.6	5.1	85.7	96.0%	84.7	74.8	43.2	–	–	–	–	–
Nevada	405	60.3	77.9	71.1	1.8	0.0	87.6	95.6	89.5	71.9	50.0	–	–	–	–	–
New Hampshire	168	0.0	0.0	–	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	1,184	83.8	95.5	63.1	84.5	63.9	96.6	99.7	95.9	95.2	87.1	–	–	–	–	–
New Mexico	652	68.1	84.1	63.3	42.9	2.6	68.1	84.1	40.0	67.6	53.9	–	–	–	–	–
New York	5,865	75.0	87.8	88.4	49.0	14.5	1.0	0.0	0.0	1.3	7.5	0.3	0.3	0.2	0.6	0.0
North Carolina	1,976	0.0	–	–	0.0	0.2	81.1	96.5	78.8	67.3	27.9	80.3	96.2	61.2	74.7	45.8
North Dakota	87	2.4	4.3	0.1	0.1	0.8	0.4	0.3	0.2	1.5	0.2	54.5	72.6	72.1	1.8	0.0
Ohio	2,474	74.3	93.5	80.9	38.7	5.5	–	–	–	–	–	–	–	–	–	–
Oklahoma	931	0.0	–	–	0.0	0.2	81.5	96.4	50.5	85.1	78.8	68.3	88.0	61.4	42.1	1.2
Oregon	751	77.6	87.8	80.0	63.5	36.6	88.5	96.6	86.4	80.2	63.5	0.5	0.5	0.2	0.8	0.9
Pennsylvania	2,562	62.2	78.5	61.2	57.4	7.4	87.7	97.6	77.8	93.0	49.8	16.6	20.9	16.2	15.6	1.1
Rhode Island	185	59.8	88.2	81.4	16.6	1.0	27.2	59.3	–	6.9	0.0	–	–	–	–	–
South Carolina	1,044	50.7	65.5	49.7	31.8	1.3	90.2	99.8	70.0	94.2	84.0	19.2	23.3	13.8	20.1	8.1
South Dakota	134	–	–	–	–	–	–	–	–	–	–	73.0	92.0	88.4	29.3	0.7
Tennessee	1,545	92.0	100.0	100.0	79.8	55.1	92.0	100.0	100.0	79.8	54.9	–	–	–	–	–
Texas	4,641	79.7	94.1	55.9	67.5	34.9	11.7	14.2	7.0	9.9	4.2	18.5	23.5	12.6	13.7	0.3
Utah	388	22.9	26.9	18.2	17.2	15.1	90.0	98.8	70.3	92.4	82.2	27.6	31.0	21.2	28.8	18.6
Vermont	205	0.1	–	–	0.1	0.6	–	–	–	–	–	68.0	86.9	78.6	39.3	3.3
Virginia	1,093	66.5	87.1	64.9	42.4	5.2	–	–	–	–	–	5.3	5.9	5.2	6.3	0.4
Washington	1,408	66.6	87.4	60.7	30.5	1.3	91.3	99.9	73.9	88.8	78.5	0.7	0.8	0.9	0.5	0.0
West Virginia	439	53.2	88.3	76.8	1.5	0.0	–	–	–	–	–	1.4	2.2	1.7	0.5	0.0
Wisconsin	1,264	59.5	83.3	72.8	4.5	2.5	84.6	92.8	88.4	93.2	35.0	–	–	–	–	–
Wyoming	89	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

EXHIBIT 29. (continued)

Notes: FY is fiscal year. PCCM is primary care case management. 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. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 737,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, individuals are counted as participating in managed care if they had at least one month indicating plan enrollment; previously, individuals were counted as participating if at least one managed care payment was made on their behalf during the fiscal year. In addition, due to the unavailability of a states' MSIS Annual Person Summary (APS) data for FY 2012, the source used in prior editions of this exhibit, MACPAC calculated spending and enrollment from the full MSIS data files that are used to create the APS files. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. The sum of the state totals exceeds the national total because individuals may be enrolled in more than one state during the year. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Medicaid enrollees may be enrolled concurrently in more than one type of managed care program (e.g., a comprehensive plan and a limited-benefit plan), so the sum of enrollment in each program type as a percentage of total Medicaid enrollment may be greater than 100 percent.

Figures shown here, which are based on MSIS data, may differ from those that use Medicaid managed care enrollment report data. Reasons for differences include differing time periods, state reporting anomalies, and the treatment of Medicaid-expansion CHIP enrollees (excluded here but included in enrollment report data). Although the enrollment report is a commonly cited source, it does not provide information on the characteristics of enrollees in managed care (e.g., eligibility group).

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Includes comprehensive managed care plans and Programs of All-Inclusive Care for the Elderly (PACE).

Source: MACPAC, 2015, analysis of MSIS data as of December 2014.

EXHIBIT 30. Total Medicaid Administrative Spending by State and Category, FY 2014 (millions)

State[1]	Total spending on administration	Spending by category					Collections
		MMIS[2]	Eligibility system[2]	EHR incentive program[3]	Other functions, federal match, above 50%[4]	Other functions, federal match of 50%[5]	
Alabama	$212	$35	$19	$26	$10	$122	-$0
Alaska	134	16	10	16	6	87	–
Arizona	268	30	125	45	8	60	-0
Arkansas	314	48	47	17	48	154	–
California	4,864	399	87	250	262	3,866	–
Colorado	346	45	44	44	6	207	–
Connecticut	347	40	55	23	7	222	–
Delaware	113	27	23	7	6	52	–
District of Columbia	157	25	23	9	5	95	–
Florida	747	70	49	90	48	489	–
Georgia	461	101	76	76	3	206	-0
Hawaii	100	14	34	19	2	30	–
Idaho	107	23	24	17	6	37	–
Illinois	1,106	44	36	144	72	810	–
Indiana	506	88	31	53	18	316	–
Iowa	189	59	72	27	5	26	–
Kansas	205	25	40	24	4	112	-0
Kentucky	223	43	13	46	23	98	–
Louisiana	282	35	13	40	11	183	–
Maine	163	56	18	23	8	58	–
Maryland	415	28	57	46	60	226	–
Massachusetts	702	91	14	66	34	497	–
Michigan	645	199	46	66	15	319	–
Minnesota	595	67	91	69	8	361	–
Mississippi	151	31	6	33	9	71	–
Missouri	410	48	47	57	32	226	-0
Montana	72	7	26	10	3	27	-0
Nebraska	136	26	32	16	6	56	–
Nevada	151	34	50	16	11	40	–

EXHIBIT 30. (continued)

State[1]	Total spending on administration	Spending by category					Collections
		MMIS[2]	Eligibility system[2]	EHR incentive program[3]	Other functions, federal match, above 50%[4]	Other functions, federal match of 50%[5]	
New Hampshire	$98	$16	$42	$6	$2	$31	–
New Jersey	724	55	19	32	29	589	–
New Mexico	180	22	52	11	9	86	–
New York	1,792	197	32	174	86	1,304	–
North Carolina	663	87	167	71	27	311	–
North Dakota	49	11	5	5	1	27	–
Ohio	784	108	88	92	13	482	–
Oklahoma	259	57	17	37	29	119	–
Oregon	507	26	17	27	8	429	-0
Pennsylvania	953	98	184	71	22	577	–
Rhode Island	129	23	29	8	5	65	-0
South Carolina	276	75	21	41	11	127	-0
South Dakota	63	6	2	15	2	37	–
Tennessee	449	61	45	52	14	278	-1
Texas	1,446	256	50	147	25	975	-8
Utah	170	31	40	29	11	59	–
Vermont	44	16	11	12	1	4	–
Virginia	433	32	174	51	25	151	–
Washington	596	63	23	62	26	421	–
West Virginia	157	38	6	17	21	75	–
Wisconsin	387	19	13	46	10	299	–
Wyoming	55	13	12	5	2	22	–
Subtotal (states)	$24,337	$3,065	$2,260	$2,386	$1,111	$15,524	-$9
American Samoa	1	–	–	0	–	1	–
Guam	5	–	–	2	0	3	–
Northern Mariana Islands	1	–	–	0	–	0	–
Puerto Rico	87	1	–	35	–	51	–
Virgin Islands	9	8	0	0	-0	1	–
Subtotal (states and territories)	$24,440	$3,075	$2,260	$2,423	$1,111	$15,580	-$9

EXHIBIT 30. (continued)

State[1]	Total spending on administration	Spending by category					Collections
		MMIS[2]	Eligibility system[2]	EHR incentive program[3]	Other functions, federal match, above 50%[4]	Other functions, federal match of 50%[5]	
Medicaid Fraud Control Units[6]	$285	–	–	–	$285	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	293	–	–	–	293	–	–
Total	$25,018	$3,075	$2,260	$2,423	$1,690	$15,580	-$9
Percent of total, exclusive of collections	–	12.3%	9.0%	9.7%	6.8%	62.3%	–

Notes: FY is fiscal year. MMIS is Medicaid management information system. EHR is electronic health record. Includes federal and state funds. Excludes administrative activities performed by Medicaid managed care plans (which are included in the capitation payments that states make to these plans) and activities that are exclusively federal, such as program oversight by CMS staff. Collections may include, for example, donations made by hospitals to compensate for the cost of on-site stationing of state or local Medicaid agency personnel to determine eligibility or provide outreach. For more information on specific items noted in this exhibit, see CMS, 2010, MBES CBES category of service line definitions for the 64.10 base form, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/CMS6410Base.pdf.

– Dash indicates zero; $0 or -$0 indicates an amount between $0.5 and -$0.5 million that rounds to zero.

[1] Not all states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 25, 2015. California's and Colorado's second, third, and fourth quarter submissions are not certified; North Dakota's third and fourth quarter submissions are not certified; South Carolina's second quarter submission is not certified; Rhode Island's fourth quarter submission is not certified. Figures presented in this table may change if states revise their expenditure data after this date.

[2] Includes design and development of systems (90 percent federal match), operation of approved systems (75 percent), and other costs (50 percent).

[3] Includes EHR incentive payments to providers (100 percent federal match) and administration of payments (90 percent).

[4] Includes skilled medical professionals, preadmission screening and resident review, medical and utilization review, external independent review, survey and certification, and MFCU operations (all at 75 percent federal match); translation and interpretation services for children and planning activities for the Health Home benefit (both at match equal to a state's federal medical assistance percentage); eligibility changes associated with the Temporary Assistance for Needy Families program (75 or 90 percent); administration of family planning services (90 percent); and immigration status verification systems (100 percent). Excludes MMIS and eligibility system spending, which have their own categories.

[5] Excludes MMIS and eligibility system spending, which have their own categories.

[6] State-level estimates for MFCUs and survey and certification are available but are not included in the CMS-64 data that MACPAC typically uses to analyze Medicaid spending.

Sources: For state and territory spending: MACPAC, 2015, analysis of CMS-64 FMR net expenditure data as of February 25, 2015; for MCFUs and survey and certification: CMS, 2015, *Fiscal year 2016 justification of estimates for Appropriations Committees,* Baltimore, MD: CMS, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf.

EXHIBIT 31. Child Enrollment in CHIP and Medicaid by State, FY 2014

State	Total	CHIP-funded coverage	Medicaid-funded coverage
Total	**43,689,824**	**8,129,426**	**36,133,260**
Alabama	**743,241**	105,491	637,750
Alaska	**96,232**	9,661	86,571
Arizona[1]	**1,006,893**	54,361	952,532
Arkansas	**506,290**	100,112	406,178
California[2]	**5,904,347**	1,874,939	4,602,270
Colorado	**593,440**	125,471	467,969
Connecticut	**352,626**	19,927	332,699
Delaware	**119,594**	18,650	100,944
District of Columbia	**98,234**	7,085	91,149
Florida	**2,710,000**	423,351	2,286,649
Georgia[3]	**1,472,524**	231,270	1,241,254
Hawaii	**174,062**	30,505	143,557
Idaho	**220,383**	30,615	189,768
Illinois	**1,912,477**	295,844	1,616,633
Indiana	**868,556**	153,523	715,033
Iowa	**404,006**	83,411	320,595
Kansas	**306,335**	73,574	232,761
Kentucky[3]	**596,706**	61,473	535,233
Louisiana	**799,554**	136,263	663,291
Maine	**206,631**	27,461	179,170
Maryland	**651,768**	137,192	514,576
Massachusetts[4]	**673,190**	126,384	546,806
Michigan	**1,278,297**	104,127	1,174,170
Minnesota	**542,382**	3,590	538,792
Mississippi	**533,140**	80,575	452,565
Missouri	**632,734**	86,828	545,906
Montana	**139,603**	49,671	89,932
Nebraska	**214,638**	56,476	158,162
Nevada	**343,608**	45,870	297,738
New Hampshire	**110,676**	16,523	94,153
New Jersey	**920,515**	211,371	709,144
New Mexico	**400,961**	16,037	384,924
New York	**2,797,987**	604,566	2,193,421

EXHIBIT 31. (continued)

State	Total	CHIP-funded coverage	Medicaid-funded coverage
North Carolina	**1,404,270**	236,893	1,167,377
North Dakota	**59,108**	5,032	54,076
Ohio[5]	**1,386,824**	136,169	1,250,655
Oklahoma	**698,690**	164,831	533,859
Oregon[3]	**540,194**	109,085	431,109
Pennsylvania[3]	**1,572,275**	258,455	1,313,820
Rhode Island	**120,825**	22,136	98,689
South Carolina	**688,155**	79,740	608,415
South Dakota[6]	**82,271**	15,870	66,401
Tennessee	**888,306**	112,826	775,480
Texas	**4,721,457**	1,041,482	3,679,975
Utah	**380,762**	76,533	304,229
Vermont	**79,490**	5,953	73,537
Virginia	**842,607**	186,513	656,094
Washington	**762,451**	42,637	719,814
West Virginia[1]	**330,901**	40,864	290,037
Wisconsin	**734,922**	183,115	551,807
Wyoming	**64,686**	9,095	55,591

Notes: FY is fiscal year. Total column reflects children ever enrolled in CHIP or Medicaid during the year, even if for a single month. Most states counted children who were enrolled in multiple categories during the year (for example, in Medicaid-funded coverage for the first half of the year but in CHIP-funded coverage for the second half) in the most recent category (state-specific exceptions to this rule are noted below). Medicaid-funded child enrollment shown here includes all children, regardless of disability status; in other MACStats exhibits that break enrollment out by eligibility group, children qualifying on the basis of disability may be counted in the disabled category rather than the child category. Data were reported by individual states as of May 13, 2015, and may be revised at a later date.

[1] Children who transitioned between CHIP and Medicaid were reported in both programs rather than the program in which they were last enrolled. Therefore, enrollment totals are artificially high.

[2] The total reflects unduplicated enrollment and is accurate; however, the data reported for each program contain duplicates and are artificially high.

[3] Due to eligibility and enrollment system challenges, some CHIP-funded Medicaid enrollees were included in Medicaid enrollment counts, rather than CHIP.

[4] Due to eligibility and enrollment system challenges, certain members who should have been assigned to CHIP were assigned to Medicaid-funded coverage beginning in the second quarter of 2014.

[5] Due to eligibility and enrollment system challenges, certain members who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FY 2014.

[6] Due to the exclusion of certain Medicaid enrollees in reporting, data are artificially low.

Source: Centers for Medicare & Medicaid Services (CMS), 2015, *FY 2014 unduplicated number of children ever enrolled in Medicaid and CHIP,* http://www.medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

EXHIBIT 32. CHIP Spending by State, FY 2014 (millions)

State	Total CHIP			Benefits						State program administration			Section 2105(g) spending[2]
				Medicaid-expansion CHIP			Separate CHIP programs and coverage of pregnant women[1]						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
Alabama	$181.6	$141.1	$40.5	$22.6	$17.5	$5.0	$152.1	$118.2	$33.9	$6.9	$5.4	$1.5	–
Alaska	30.0	19.5	10.5	28.9	18.8	10.1	–	–	–	1.1	0.7	0.4	–
Arizona	85.4	65.8	19.6	50.8	39.2	11.7	32.8	25.2	7.5	1.8	1.4	0.4	–
Arkansas	97.0	76.7	20.3	72.9	57.6	15.3	20.6	16.3	4.3	3.5	2.8	0.7	–
California	2,189.2	1,423.1	766.1	1,829.9	1,189.4	640.5	276.3	179.6	96.6	83.1	54.0	29.1	–
Colorado	196.9	128.0	68.9	59.3	38.5	20.8	130.7	85.0	45.8	6.9	4.5	2.4	–
Connecticut	30.6	39.2	-8.6	–	–	–	27.5	17.9	9.6	3.1	2.0	1.1	$19.3
Delaware	24.0	16.5	7.5	0.1	0.1	0.0	23.0	15.8	7.2	1.0	0.7	0.3	–
District of Columbia	20.8	16.4	4.4	19.9	15.7	4.2	–	–	–	0.8	0.7	0.2	–
Florida	646.5	460.0	186.6	126.7	90.2	36.6	472.3	336.0	136.3	47.5	33.8	13.7	–
Georgia	439.5	334.7	104.8	–	–	–	408.8	311.3	97.5	30.7	23.4	7.3	–
Hawaii	57.0	37.6	19.5	54.6	36.0	18.6	–	–	–	2.4	1.6	0.8	–
Idaho	67.4	54.0	13.4	27.2	21.8	5.4	35.6	28.5	7.1	4.6	3.7	0.9	–
Illinois	453.7	294.9	158.8	122.1	79.1	43.0	287.4	187.0	100.3	44.2	28.8	15.4	–
Indiana	172.9	132.9	40.1	106.0	81.5	24.6	60.9	46.8	14.1	6.0	4.6	1.4	–
Iowa	145.7	102.8	42.9	32.7	23.0	9.6	102.0	72.0	30.0	11.1	7.8	3.3	–
Kansas	99.4	69.5	30.0	–	–	–	89.9	62.8	27.1	9.6	6.7	2.9	–
Kentucky	177.8	140.3	37.6	102.8	81.1	21.7	71.3	56.2	15.1	3.8	3.0	0.8	–
Louisiana	202.2	147.0	55.2	171.0	124.3	46.7	15.4	11.2	4.2	15.8	11.5	4.3	–
Maine	30.6	22.3	8.2	17.3	12.7	4.6	12.3	9.0	3.3	0.9	0.7	0.2	–
Maryland	294.1	191.2	102.9	271.3	176.3	95.0	–	–	–	22.8	14.8	8.0	–
Massachusetts	519.4	337.6	181.8	243.8	158.5	85.3	223.7	145.4	78.3	51.9	33.7	18.2	–
Michigan	126.6	96.7	29.9	22.3	17.0	5.3	97.8	74.7	23.1	6.6	5.0	1.5	–
Minnesota	16.7	33.5	-16.8	0.1	0.1	0.0	16.4	10.7	5.7	0.2	0.1	0.1	22.6
Mississippi	227.4	184.5	42.9	–	–	–	223.2	181.1	42.1	4.3	3.5	0.8	–
Missouri	181.4	133.1	48.2	113.8	83.6	30.3	50.0	36.7	13.3	17.6	12.9	4.7	–
Montana	97.4	74.5	23.0	26.0	19.9	6.1	65.6	50.1	15.5	5.8	4.5	1.4	–
Nebraska	82.8	56.6	26.2	68.5	46.8	21.7	12.1	8.3	3.8	2.2	1.5	0.7	–
Nevada	47.3	35.1	12.2	6.3	4.6	1.6	38.9	28.9	10.1	2.1	1.6	0.5	–

EXHIBIT 32. (continued)

State	Total CHIP			Benefits						State program administration			Section 2105(g) spending[2]
				Medicaid-expansion CHIP			Separate CHIP programs and coverage of pregnant women[1]						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
New Hampshire	$15.7	$16.3	-$0.6	$15.6	$10.1	$5.4	$0.0	$0.0	$0.0	$0.1	$0.1	$0.1	$6.1
New Jersey	433.7	281.3	152.4	208.1	135.3	72.8	195.3	126.4	68.8	30.3	19.6	10.7	–
New Mexico	76.6	60.1	16.5	75.2	59.0	16.2	–	–	–	1.6	1.3	0.3	–
New York	1,221.0	793.7	427.2	619.9	402.9	217.0	581.0	377.8	203.3	20.0	13.0	7.0	–
North Carolina	423.2	321.9	101.4	184.7	140.4	44.2	227.5	173.0	54.5	11.0	8.4	2.6	–
North Dakota	25.5	16.6	8.9	11.4	7.4	4.0	12.7	8.2	4.4	1.5	0.9	0.5	–
Ohio	377.3	279.7	97.6	367.0	272.1	95.0	–	–	–	10.3	7.6	2.7	–
Oklahoma	187.4	140.2	47.2	170.4	127.5	42.9	10.9	8.2	2.7	6.0	4.5	1.5	–
Oregon	212.8	157.9	54.9	–	–	–	199.5	148.0	51.5	13.4	9.9	3.5	–
Pennsylvania	448.8	302.8	146.0	35.8	24.1	11.6	397.2	268.0	129.2	15.8	10.7	5.2	–
Rhode Island	57.6	37.5	20.1	42.7	27.8	14.9	12.0	7.8	4.2	2.9	1.9	1.0	–
South Carolina	146.6	116.2	30.4	134.0	106.4	27.6	–	–	–	12.6	9.8	2.8	–
South Dakota	22.6	15.2	7.4	16.6	11.1	5.4	5.7	3.8	1.8	0.4	0.3	0.1	–
Tennessee	213.5	161.6	51.9	49.5	37.5	12.0	147.4	111.6	35.8	16.6	12.6	4.0	–
Texas	1,217.9	865.6	352.3	165.2	117.4	47.8	957.8	680.7	277.1	94.8	67.4	27.4	–
Utah	60.4	47.9	12.5	16.0	12.7	3.3	39.2	31.1	8.1	5.2	4.1	1.1	–
Vermont	9.2	12.7	-3.6	6.7	4.7	2.0	1.9	1.3	0.6	0.6	0.4	0.2	6.3
Virginia	309.9	201.4	108.5	130.7	84.9	45.7	163.4	106.2	57.2	15.8	10.3	5.5	–
Washington	104.8	104.7	0.1	17.2	11.2	6.0	82.5	53.7	28.8	5.1	3.3	1.8	36.5
West Virginia	56.5	45.1	11.4	3.2	2.6	0.6	49.3	39.3	10.0	4.0	3.2	0.8	–
Wisconsin	240.9	180.5	60.4	111.4	79.3	32.1	118.3	84.4	33.9	11.2	8.0	3.2	8.8
Wyoming	14.2	9.2	5.0	0.7	0.5	0.3	12.9	8.4	4.5	0.5	0.3	0.2	–
Subtotal	$12,817.5	$9,033.0	$3,784.4	$5,978.7	$4,108.0	$1,870.7	$6,160.9	$4,352.7	$1,808.3	$678.1	$472.9	$205.2	$99.7
American Samoa	1.7	1.4	0.3	1.7	1.4	0.3	–	–	–	–	–	–	–
Guam	6.7	4.8	1.9	6.7	4.8	1.9	–	–	–	–	–	–	–
N. Mariana Islands	1.1	0.9	0.1	1.1	0.9	0.1	–	–	–	–	–	–	–
Puerto Rico	214.9	149.5	65.4	214.9	149.5	65.4	–	–	–	–	–	–	–
Virgin Islands	5.8	4.0	1.7	5.8	4.0	1.7	–	–	–	–	–	–	–
Total	$13,047.6	$9,193.7	$3,853.9	$6,208.9	$4,268.7	$1,940.1	$6,160.9	$4,352.7	$1,808.3	$678.1	$472.9	$205.2	$99.7

EXHIBIT 32. (continued)

Notes: FY is fiscal year. Components may not add to total due to rounding. Federal CHIP spending on administration is generally limited to 10 percent of a state's total federal CHIP spending for the year. States with a Medicaid-expansion CHIP program may elect to receive reimbursement for administrative spending from Medicaid rather than CHIP funds; Medicaid funds are not shown in this exhibit.

[1] Three states (Colorado, New Jersey, and Rhode Island) use CHIP funds to provide coverage for pregnant women.

[2] Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level. Although these are CHIP funds, they effectively reduce state spending on children in Medicaid and do not require a state match within the CHIP program. In cases where the sum of 2105(g) federal CHIP spending (for Medicaid enrollees) and regular federal CHIP spending (for CHIP enrollees) exceeds total spending for CHIP enrollees, states are shown in this exhibit as having negative state CHIP spending (Connecticut, Minnesota, New Hampshire, and Vermont).

Source: MACPAC, 2015, analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data from the Centers for Medicare & Medicaid Services as of March 6, 2015.

EXHIBIT 33. Federal CHIP Allotments, FY 2015 (millions)

State	FY 2014 federal CHIP spending A	FY 2015 allotment increase factor B	Full year FY 2015 amount based on rebased amount[1] C = A × B	First half FY 2015 allotment[2] D = C × 86.5%	Second half FY 2015 allotment[3] E = 2.850 billion × (D / column D total)	FY 2015 federal CHIP allotments F = D + E
Alabama	$141.1	1.0595	$149.5	$129.2	$43.7	$172.9
Alaska	19.5	1.0609	20.7	17.9	6.0	23.9
Arizona	65.8	1.0596	69.7	60.3	20.4	80.7
Arkansas	76.7	1.0595	81.2	70.2	23.7	94.0
California	1,423.1	1.0595	1,507.7	1,303.7	440.4	1,744.1
Colorado	128.0	1.0639	136.2	117.7	39.8	157.5
Connecticut	39.2	1.0595	41.6	35.9	12.1	48.1
Delaware	16.5	1.0595	17.5	15.1	5.1	20.3
District of Columbia	16.4	1.0921	17.9	15.5	5.2	20.7
Florida	460.0	1.0638	489.3	423.1	142.9	566.0
Georgia	334.7	1.0605	354.9	306.9	103.7	410.6
Hawaii	37.6	1.0652	40.0	34.6	11.7	46.3
Idaho	54.0	1.0600	57.2	49.5	16.7	66.2
Illinois	294.9	1.0595	312.4	270.1	91.3	361.4
Indiana	132.9	1.0595	140.8	121.7	41.1	162.9
Iowa	102.8	1.0598	108.9	94.2	31.8	126.0
Kansas	69.5	1.0595	73.6	63.6	21.5	85.1
Kentucky	140.3	1.0595	148.6	128.5	43.4	171.9
Louisiana	147.0	1.0595	155.7	134.6	45.5	180.1
Maine	22.3	1.0595	23.7	20.5	6.9	27.4
Maryland	191.2	1.0595	202.5	175.1	59.2	234.3
Massachusetts	337.6	1.0595	357.7	309.3	104.5	413.8
Michigan	96.7	1.0595	102.5	88.6	29.9	118.6
Minessota	33.5	1.0609	35.6	30.7	10.4	41.1
Mississippi	184.5	1.0595	195.5	169.1	57.1	226.2
Missouri	133.1	1.0595	141.1	122.0	41.2	163.2
Montana	74.5	1.0650	79.3	68.6	23.2	91.7
Nebraska	56.6	1.0646	60.2	52.1	17.6	69.7
Nevada	35.1	1.0614	37.3	32.2	10.9	43.1
New Hampshire	16.3	1.0595	17.3	15.0	5.1	20.0
New Jersey	281.3	1.0595	298.1	257.7	87.1	344.8
New Mexico	60.1	1.0595	63.7	55.0	18.6	73.6
New York	793.7	1.0595	840.9	727.1	245.7	972.8

EXHIBIT 33. (continued)

State	FY 2014 federal CHIP spending A	FY 2015 allotment increase factor B	Full year FY 2015 amount based on rebased amount[1] C = A × B	First half FY 2015 allotment[2] D = C × 86.5%	Second half FY 2015 allotment[3] E = 2.850 billion × (D / column D total)	FY 2015 federal CHIP allotments F = D + E
North Carolina	$321.9	1.0609	$341.5	$295.3	$99.8	$395.0
North Dakota	16.6	1.0966	18.2	15.7	5.3	21.0
Ohio	279.7	1.0595	296.3	256.2	86.6	342.8
Oklahoma	140.2	1.0674	149.6	129.4	43.7	173.1
Oregon	157.9	1.0595	167.3	144.7	48.9	193.5
Pennsylvania	302.8	1.0595	320.8	277.4	93.7	371.1
Rhode Island	37.5	1.0595	39.8	34.4	11.6	46.0
South Carolina	116.2	1.0627	123.5	106.8	36.1	142.9
South Dakota	15.2	1.0714	16.3	14.1	4.8	18.9
Tennessee	161.6	1.0595	171.2	148.1	50.0	198.1
Texas	865.6	1.0674	923.9	798.8	269.9	1,068.7
Utah	47.9	1.0678	51.1	44.2	14.9	59.1
Vermont	12.7	1.0595	13.5	11.6	3.9	15.6
Virginia	201.4	1.0626	214.0	185.1	62.5	247.6
Washington	104.7	1.0649	111.5	96.4	32.6	129.0
West Virginia	45.1	1.0595	47.8	41.3	14.0	55.2
Wisconsin	180.5	1.0595	191.3	165.4	55.9	221.2
Wyoming	9.2	1.0673	9.8	8.5	2.9	11.4
Subtotal	**$9,033.0**		**$9,586.1**	**$8,288.9**	**$2,800.3**	**$11,089.2**
American Samoa	1.4	1.0595	1.5	1.3	0.4	1.7
Guam	4.8	1.0595	5.1	4.4	1.5	5.9
N. Mariana Islands	0.9	1.0636	1.0	0.9	0.3	1.2
Puerto Rico	149.5	1.0595	158.4	137.0	46.3	183.2
Virgin Islands	4.0	1.0595	4.3	3.7	1.3	5.0
Total	**$9,193.7**		**$9,756.3**	**$8,436.1**	**$2,850.0**	**$11,286.1**

Notes: FY is fiscal year. For odd-numbered years (e.g., FY 2015), federal CHIP allotments are based on each state's prior-year spending.

[1] Column C contains the full year amount based on rebased amount described in Section 2104(m)(3)(C) of the Social Security Act.

[2] The first half allotment is calculated by multiplying the full year amount in Column C by the first half ratio described in Section 2104(m)(3)(D) of the Social Security Act, which is equal to 86.467879%.

[3] The second half allotment is calculated by multiplying the $2.850 billion provided in section 2104(a)(18)(B) of the Social Security Act by the ratio equal to each state's proportion of the total amount awarded for the first half FY 2015 CHIP allotments in Column D.

Source: Centers for Medicare & Medicaid Services (CMS), 2015, email to MACPAC staff, February 9.

SECTION 4

Medicaid and CHIP Eligibility

Section 4: Medicaid and CHIP Eligibility

Key Points

- More than half of states are now covering low-income adults, for whom a new Medicaid eligibility group was added in 2014. Most of these new adults are eligible at incomes up to 138 percent of the federal poverty level (FPL), which amounts to $16,243 for a single individual (Exhibits 35 and 37).
- Beginning in 2014, Medicaid and CHIP eligibility levels for most child and adult populations reflect the application of uniform modified adjusted gross income (MAGI) rules across states. A maintenance of effort provision also prevents states from lowering their existing eligibility levels for children through the end of FY 2019 (Exhibits 34 and 35).
- Eligibility criteria for individuals eligible for Medicaid on the basis of disability and for individuals age 65 and older, who are not subject to MAGI rules, were largely unchanged between 2014 and 2015 (Exhibit 36).
- In the lower 48 states and the District of Columbia, 100 percent of the 2015 FPL is $11,770 for an individual, plus $4,160 for each additional family member (Exhibit 37).

EXHIBIT 34. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State, September 2015

State	Medicaid coverage						CHIP program type[2] (as of May 1, 2015)	Separate CHIP coverage		Medicaid/CHIP coverage
	Infants under age 1		Age 1–5		Age 6–18			Birth through age 18	Unborn children[3]	Pregnant women and deemed newborns[4]
	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]				
Alabama	141%	–	141%	–	141%	107–141%	Combination	312%	–	141%
Alaska	177	159–203%	177	159–203%	177	124–203	Medicaid expansion	–	–	200
Arizona[5]	147	–	141	–	133	104–133	Combination	200	–	156
Arkansas	142	–	142	–	142	107–142	Combination	211	209%	209
California	208	208–261	142	142–261	133	108–261	Combination	317[6]	317	208
Colorado	142	–	142	–	142	108–142	Combination	260	–	195/260
Connecticut	196	–	196	–	196	–	Separate	318	–	258
Delaware	212	194–212	142	–	133	110–133	Combination	212	–	212
District of Columbia	319	206–319	319	146–319	319	112–319	Medicaid expansion	–	–	319
Florida	206	192–206	140	–	133	112–133	Combination	210[7]	–	191
Georgia	205	–	149	–	133	113–133	Combination	247	–	220
Hawaii	191	191–308	139	139–308	133	105–308	Medicaid expansion	–	–	191
Idaho	142	–	142	–	133	107–133	Combination	185	–	133
Illinois	142	–	142	–	142	108–142	Combination	313	208	208
Indiana	208	157–208	158	141–158	158	106–158	Combination	250	–	208
Iowa	375	240–375	167	–	167	122–167	Combination	302	–	375
Kansas	166	–	149	–	133	113–133	Combination	239	–	166
Kentucky	195	–	142	142–159	133	109–159	Combination	213	–	195
Louisiana	142	142–212	142	142–212	142	108–212	Combination	250	209	133
Maine	191	–	157	140–157	157	132–157	Combination	208	–	209
Maryland	194	194–317	138	138–317	133	109–317	Medicaid expansion	–	–	259
Massachusetts	200	185–200	150	133–150	150	114–150	Combination	300	200	200
Michigan	195	–	160	143–160	160	109–160	Combination	212	195	195
Minnesota[8]	275	275-283	275	–	275	–	Combination	–	278	278
Mississippi	194	–	143	–	133	107–133	Combination	209	–	194
Missouri	196	–	148	148–150	148	110–150	Combination	300	–	196
Montana	143	–	143	–	133	109–143	Combination	261	–	157
Nebraska	162	162–213	145	145–213	133	109–213	Combination	–	197	194
Nevada	160	–	160	–	133	122–133	Combination	200	–	160
New Hampshire	196	196–318	196	196–318	196	196–318	Medicaid expansion	–	–	196
New Jersey	194	–	142	–	142	107–142	Combination	350	–	194/200
New Mexico	240	200–300	240	200–300	190	138–240	Medicaid expansion	–	–	250

EXHIBIT 34. (continued)

State	Medicaid coverage						CHIP program type[2] (as of May 1, 2015)	Separate CHIP coverage		Medicaid/CHIP coverage
	Infants under age 1		Age 1–5		Age 6–18			Birth through age 18	Unborn children[3]	Pregnant women and deemed newborns[4]
	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]				
New York	218%	196–218%	149%	–	149%	110–149%	Combination	400%	–	218%
North Carolina	210	194–210	210	141–210%	133	107–133	Combination	211[9]	–	196
North Dakota	147	–	147	–	133	111–133	Combination	170	–	147
Ohio	156	141–206	156	141–206	156	107–206	Medicaid expansion	–	–	200
Oklahoma	205	169–205	205	151–205	205	115–205	Combination	–	205%	133
Oregon	185	133–185	133	–	133	100–133	Combination	300	185	185
Pennsylvania	215	–	157	–	133	119–133	Combination	314	–	215
Rhode Island	190	190–261	142	142–261	133	109–261	Combination	–	253	190/253
South Carolina	194	194–208	143	143–208	133	107–208	Medicaid expansion	–	–	194
South Dakota	182	177–182	182	177–182	182	124–182	Combination	204	–	133
Tennessee[10]	195	–	142	–	133	109–133	Combination	250	250	195
Texas	198	–	144	–	133	109–133	Combination	201	202	198
Utah	139	–	139	–	133	105–133	Combination	200	–	139
Vermont	312	237–312	312	237–312	312	237–312	Medicaid expansion	–	–	208
Virginia	143	–	143	–	143	109–143	Combination	200	–	143/200
Washington	210	–	210	–	210	–	Separate	312	193	193
West Virginia	158	–	141	–	133	108–133	Combination	300	–	158
Wisconsin	301	–	186	–	133	101–151	Combination	301	301	301
Wyoming	154	–	154	–	133	119–133	Combination	200	–	154

Notes: FPL is federal poverty level. In 2015, 100 percent FPL is $11,770 for an individual plus $4,160 for each additional family member in the lower 48 states and the District of Columbia. When determining Medicaid and CHIP eligibility prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing. Beginning in 2014, uniform modified adjusted gross income (MAGI) rules must be used to determine Medicaid and CHIP eligibility for most non-disabled children and adults under age 65, including the groups shown in this table. As a result, states are now required to use MAGI-converted eligibility levels that account for the change in income-counting rules. The eligibility levels shown in this table reflect these MAGI-converted levels or another MAGI-based income limit in effect in each state for these groups as of September 2015. Under federal regulations, the effective income limits may be higher by 5 percent of the FPL than those shown on this table to account for a general income disregard that applies to an individual's determination of eligibility for Medicaid and CHIP overall, rather than for particular eligibility groups within Medicaid or CHIP.

Medicaid coverage of children under age 19 with incomes below states' eligibility levels in effect as of March 31, 1997, continues to be financed by Medicaid (Title XIX) funding. Any expansion of eligibility to uninsured children above those levels—through expansions of Medicaid or through separate CHIP programs—is generally financed by CHIP (Title XXI) funding. CHIP funding is not permitted for children with other coverage. Thus, where Medicaid coverage in this table shows overlapping eligibility levels for Medicaid funding and CHIP funding, children with no other coverage are funded by CHIP, while children with other coverage are funded by Medicaid. Pregnant women can receive Medicaid- or CHIP-funded services through regular state plan eligibility pathways or through Section 1115 waivers; in addition, the unborn children of pregnant women may receive CHIP-funded coverage under a state plan option. Deemed newborns are infants up to age 1 who are deemed eligible for Medicaid or CHIP—with no separate application or eligibility determination required—if their mother was enrolled at the time of their birth.

EXHIBIT 34. (continued)

[1] Under Medicaid funded, there is no lower bound for income eligibility. The eligibility levels listed under Medicaid funded are the highest income levels under which each age group of children is covered under the Medicaid state plan, where either all or just insured children are claimed with Medicaid funding. The eligibility levels listed under CHIP funded are the income levels to which Medicaid has expanded with CHIP funding since its creation in 1997. For states that have different CHIP-funded eligibility levels for children age 6 through 13 and age 14 through 18, this table shows only the levels for children age 6 through 13. In addition, Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed uninsured children whose family income exceeds 133 percent FPL (not separately noted on this table).

[2] Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches. Nine states (including the District of Columbia) are Medicaid expansions and 2 states are separate CHIP only (Connecticut and Washington). Forty states are combination programs—and among those, 11 consider themselves to have separate programs but are technically combinations due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, Wyoming).

[3] Separate CHIP eligibility for children birth through age 18 generally begins where Medicaid coverage ends (as shown in the previous columns). For unborn children, there is no lower bound for income eligibility if the mother is not eligible for Medicaid.

[4] Pregnant women can be covered with Medicaid or CHIP funding. Under CHIP, coverage can be through a state plan option for targeted low-income pregnant women or through continuation of an existing Section 1115 waiver. When two values are shown in this column, the first is for Medicaid and the second is for CHIP.

[5] Although Arizona's separate CHIP program up to 200 percent FPL (KidsCare) has been closed to new enrollment since January 2010, thousands of children were added to the state's CHIP-funded coverage through the state's KidsCare II waiver, which was in effect from May 2012 until January 2014.

[6] California has a separate CHIP program in three counties only that covers children up to 317 percent FPL.

[7] Florida's separate CHIP program covers children age 1–18.

[8] In Minnesota, only infants (defined by the state as being under age 2) are eligible for the Medicaid-expansion CHIP program.

[9] North Carolina's separate CHIP program covers children age 6–18.

[10] While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

Sources: MACPAC, 2015, analysis of Centers for Medicare & Medicaid Services (CMS), 2014, *State Medicaid and CHIP income eligibility standards (For MAGI Groups, based on state decisions as of October 1, 2014),* http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf; MACPAC, 2015, analysis of CMS, 2015, MAGI conversion plans and SIPP-based MAGI conversion results, http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html; MACPAC, 2015, analysis of CMS, 2015, Medicaid state plan amendments, http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html; MACPAC, 2015, analysis of CMS, 2015, CHIP state plan amendments, http://www.medicaid.gov/chip/state-program-information/chip-state-program-information.html; MACPAC, 2015, analysis of CMS, 2015, *Children's Health Insurance Program: Plan activity as of May 1, 2015,* http://www.medicaid.gov/chip/downloads/chip-map.pdf; MACPAC, 2015, analysis of state websites; and MACPAC, 2015, analysis of CMS, 2015, email to MACPAC staff, October 29.

EXHIBIT 35. Medicaid Income Eligibility Levels as a Percentage of the FPL for Non-Aged, Non-Disabled, Non-Pregnant Adults by State, September 2015

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	143	133% (143 only for those age 19–20)
Arizona	106	133
Arkansas	17	133
California	109	133
Colorado	68	133
Connecticut	150	133
Delaware	87	133
District of Columbia	216	210 (216 only for those age 19–20)
Florida	29	29 only for those age 19–20
Georgia	34	–
Hawaii	105	133
Idaho	24[3]	–[4]
Illinois	133	133
Indiana	19	133
Iowa	54	133
Kansas	33	–
Kentucky	23	133
Louisiana	19[3]	–[4]
Maine	100	156 only for those age 19–20[4]
Maryland	123	133
Massachusetts	133	133 (150 only for those age 19–20)
Michigan	54	133
Minnesota	133[5]	133[5]
Mississippi	23	–
Missouri	18[3]	–[4]
Montana	46	–[4]
Nebraska	58	–
Nevada	33	133

EXHIBIT 35. (continued)

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
New Hampshire	68%	133%
New Jersey	32	133
New Mexico	46	133
New York	133	133
North Carolina	44	44 only for those age 19–20
North Dakota	53	133
Ohio	90	133
Oklahoma	42[3]	–[4]
Oregon	41	133
Pennsylvania	33	133
Rhode Island	116	133
South Carolina	62	–
South Dakota	57	–
Tennessee	104	–
Texas	15	–
Utah	45[3]	–[4]
Vermont	53	133
Virginia	49	–
Washington	40	133
West Virginia	19	133
Wisconsin	95	95
Wyoming	56	–

Notes: FPL is federal poverty level. In 2015, 100 percent FPL is $11,770 for an individual plus $4,160 for each additional family member in the lower 48 states and the District of Columbia. When determining Medicaid and CHIP eligibility prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing. Beginning in 2014, uniform modified adjusted gross income (MAGI) rules must be used to determine Medicaid and CHIP eligibility for most non-disabled children and adults under age 65, including the groups shown in this table. As a result, states are now required to use MAGI-converted eligibility levels that account for the change in income-counting rules. The eligibility levels shown in this table reflect these MAGI-converted levels or another MAGI-based income limit in effect in each state for these groups as of September 2015. Under federal regulations, the effective income limits may be higher by 5 percentage points of the FPL than those shown on this table to account for a general income disregard that applies to an individual's determination of eligibility for Medicaid and CHIP overall, rather than for particular eligibility groups within Medicaid or CHIP.

EXHIBIT 35. (continued)

States are required to provide Medicaid coverage for parents and other caretaker relatives (and their dependent children), at a minimum, at their 1988 Aid to Families with Dependent Children (AFDC) eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents and caretaker relatives; children age 19 or 20; and other individuals aged 19–64 who are not pregnant, not eligible for Medicare, and have incomes at or below 133 percent of the federal poverty level. States may also provide coverage under Section 1115 waivers, which allow them to operate their Medicaid programs without regard to certain statutory requirements. As noted in this table, the covered benefits under these waivers may be more limited than those provided under regular state plan rules and may not be available to all individuals at the income levels shown.

[1] In states that use dollar amounts rather than percentages of the FPL to determine eligibility for parents, those amounts were converted to a percent of the FPL for 2015, and the highest percentage was selected to reflect eligibility level for the group.

[2] Reflects state plan coverage under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act for individuals who are age 19–64, not pregnant, not eligible for Medicare, and have income at or below 133 percent FPL; state plan coverage for children age 19 or 20 where indicated; and Section 1115 waiver coverage that is not subject to the limitations indicated in note 4.

[3] Reflects parent coverage under the Medicaid state plan. The state has some additional coverage above state plan eligibility standards through a Section 1115 demonstration or a pending demonstration proposal. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap.

[4] The state has a Section 1115 demonstration or a pending demonstration proposal that provides Medicaid coverage to some low-income adults. The demonstration includes limitations on eligibility or benefits, is not offered to all residents of the state, or includes an enrollment cap.

[5] Minnesota implemented a Basic Health Program (BHP) in January 2015. Individuals with incomes between 133 and 200 percent FPL who were previously covered under a Medicaid Section 1115 waiver are now covered under the BHP.

Sources: MACPAC, 2015, analysis of Centers for Medicare & Medicaid Services (CMS), 2014, *State Medicaid and CHIP income eligibility standards (For MAGI Groups, based on state decisions as of October 1, 2014),* http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf; MACPAC, 2015, analysis of CMS, 2015, Medicaid state plan amendments, http://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/medicaid-state-plan-amendments.html; MACPAC, 2015, analysis of state websites; and MACPAC, 2015, analysis of CMS, 2015, email to MACPAC staff, October 29, 2015.

EXHIBIT 36. Medicaid Income Eligibility Levels as a Percentage of the FPL for Individuals Age 65 and Older and Persons with Disabilities by State, 2015

State	State eligibility type[1]	SSI recipients	209(b) eligibility	Poverty level[2]	Medically needy[3]	Special income level[4]
Alabama	1634	75%	–	–	–	224%
Alaska	SSI criteria	60[5]	–	–	–	179
Arizona	1634	75	–	100%	–	224
Arkansas	1634	75	–	80 (aged only)	11%	224
California	1634	75	–	100	61	–
Colorado	1634	75	–	–	–	224
Connecticut	209(b)	–	62%	–	62	224
Delaware	1634	75	–	–	–	187
District of Columbia	1634	75	–	100	64	224
Florida	1634	75	–	88	18	224
Georgia	1634	75	–	–	32	224
Hawaii	209(b)	–	65	100	42	–
Idaho	SSI criteria	75	–	–	–	224
Illinois	209(b)	–	100	100	100	–
Indiana[6]	1634	75	–	100	–	224
Iowa	1634	75	–	–	49	224
Kansas	SSI criteria	75	–	–	48	224
Kentucky	1634	75	–	–	22	224
Louisiana	1634	75	–	75	10	224
Maine	1634	75	–	100	32	224
Maryland	1634	75	–	–	36	224
Massachusetts[7]	1634	75	–	100 (aged)/ 133 (disabled)	53	224
Michigan	1634	75	–	100	42	224
Minnesota	209(b)	–	75	100	75	224
Mississippi	1634	75	–	–	–	224
Missouri	209(b)	–	85	85	85	131
Montana	1634	75	–	–	64	–
Nebraska	SSI criteria	75	–	100	40	–
Nevada	SSI criteria	75	–	–	–	224

EXHIBIT 36. (continued)

State	State eligibility type[1]	SSI recipients	209(b) eligibility	Poverty level[2]	Medically needy[3]	Special income level[4]
New Hampshire	209(b)	–	76%	–	60%	224%
New Jersey	1634	75%	–	100%	37	224
New Mexico	1634	75	–	–	–	224
New York	1634	75	–	84	84	–
North Carolina	1634	75	–	100	25	–
North Dakota	209(b)	–	83	–	83	–
Ohio	209(b)	–	64	–	64	224
Oklahoma[6]	SSI criteria	75	–	100	–	224
Oregon	SSI criteria	75	–	–	–	224
Pennsylvania	1634	75	–	100	43	224
Rhode Island	1634	75	–	100	87	224
South Carolina	1634	75	–	100	–	224
South Dakota	1634	75	–	–	–	224
Tennessee	1634	75	–	–	–	224
Texas	1634	75	–	–	–	224
Utah	SSI criteria	75	–	100	100	224
Vermont	1634	75	–	–	110	224
Virginia	209(b)	–	75	80	47	224
Washington	1634	75	–	–	75	224
West Virginia	1634	75	–	–	20	224
Wisconsin	1634	75	–	–	60	224
Wyoming	1634	75	–	–	–	224

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. In 2015, 100 percent FPL is $11,770 for an individual and $4,160 for each additional family member in the lower 48 states and the District of Columbia. Eligibility levels shown here apply to countable income; as a result, states that use optional income disregards to reduce countable income effectively allow a larger number of people to qualify at a given eligibility level (e.g., 100 percent FPL) relative to states that do not. The eligibility levels listed in this exhibit are for individuals; the eligibility levels for couples differ for certain categories. In addition, income eligibility levels for individuals who qualify based on blindness may be higher than for individuals who qualify based on other disabilities or being age 65 or older.

In most states, enrollment in the SSI program for individuals age 65 and older and persons with disabilities automatically qualifies them for Medicaid. However, 209(b) states may use more restrictive criteria (related to income and assets, disability, or both) than SSI when determining Medicaid eligibility. All states have the option of covering additional people with low incomes or high medical expenses through other eligibility pathways, such as poverty level, medically needy, and special income level.

EXHIBIT 36. (continued)

– Dash indicates that state does not use this eligibility pathway.

[1] SSI criteria are used to determine Medicaid eligibility in both Section 1634 and SSI-criteria states. In Section 1634 states, the federal eligibility determination process for SSI automatically qualifies an individual for Medicaid; in SSI-criteria states, individuals must submit information to the state for a separate eligibility determination. Section 209(b) states may use eligibility criteria (related to income and assets, disability, or both) more restrictive than the SSI program but may not use more restrictive criteria than those in effect in the state on January 1, 1972. If a Section 209(b) state does not have a separate medically needy standard, it must allow individuals with higher incomes to spend down to the 209(b) income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes.

[2] Under the poverty level option, states may choose to provide Medicaid coverage to persons who are aged or disabled and whose income is above the SSI or 209(b) level, but is at or below the FPL.

[3] Under the medically needy option, individuals with higher incomes can spend down to the medically needy income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes. Five states (Connecticut, Louisiana, Michigan, Vermont, and Virginia) have a medically needy income standard that varies by location; the highest income standard is listed for each of these states.

[4] Under the special income level option, states have the option to provide Medicaid benefits to people who require at least 30 days of nursing home or other institutional care and have incomes up to 300 percent of the SSI benefit rate (which was about 224 percent FPL in 2015). The income standard listed in this column may be for institutional services, home and community-based waiver services, or both.

[5] The dollar amount that equals the upper income eligibility level for SSI does not vary by state; however, the dollar amount that equals the FPL is higher in Alaska, resulting in a lower percentage.

[6] Indiana was a 209(b) state until June 1, 2014, at which point it became a 1634 state; the state's poverty level group also took effect on June 1, 2014. Oklahoma was a 209(b) state until October 1, 2015, at which point it became an SSI-criteria state.

[7] Massachusetts provides medically needy coverage for individuals age 65 and older and those who are eligible on the basis of disability, but the rules for counting income and spend-down expenses vary for these groups.

Source: MACPAC, 2015, analysis of eligibility information from state websites and Medicaid state plans as of July 2015.

EXHIBIT 37. Income as a Percentage of the FPL for Various Family Sizes, 2015

State	FPL	Annual amount					Monthly amount				
		Family size					Family size				
		1	2	3	4	Each additional person	1	2	3	4	Each additional person
Lower 48 states and DC	100%	$11,770	$15,930	$20,090	$24,250	$4,160	$981	$1,328	$1,674	$2,021	$347
	133	15,654	21,187	26,720	32,253	5,533	1,305	1,766	2,227	2,688	461
	138	16,243	21,983	27,724	33,465	5,741	1,354	1,832	2,310	2,789	478
	150	17,655	23,895	30,135	36,375	6,240	1,471	1,991	2,511	3,031	520
	185	21,775	29,471	37,167	44,863	7,696	1,815	2,456	3,097	3,739	641
	200	23,540	31,860	40,180	48,500	8,320	1,962	2,655	3,348	4,042	693
	250	29,425	39,825	50,225	60,625	10,400	2,452	3,319	4,185	5,052	867
	300	35,310	47,790	60,270	72,750	12,480	2,943	3,983	5,023	6,063	1,040
	400	47,080	63,720	80,360	97,000	16,640	3,923	5,310	6,697	8,083	1,387
Alaska	100%	$14,720	$19,920	$25,120	$30,320	$5,200	$1,227	$1,660	$2,093	$2,527	$433
	133	19,578	26,494	33,410	40,326	6,916	1,631	2,208	2,784	3,360	576
	138	20,314	27,490	34,666	41,842	7,176	1,693	2,291	2,889	3,487	598
	150	22,080	29,880	37,680	45,480	7,800	1,840	2,490	3,140	3,790	650
	185	27,232	36,852	46,472	56,092	9,620	2,269	3,071	3,873	4,674	802
	200	29,440	39,840	50,240	60,640	10,400	2,453	3,320	4,187	5,053	867
	250	36,800	49,800	62,800	75,800	13,000	3,067	4,150	5,233	6,317	1,083
	300	44,160	59,760	75,360	90,960	15,600	3,680	4,980	6,280	7,580	1,300
	400	58,880	79,680	100,480	121,280	20,800	4,907	6,640	8,373	10,107	1,733

EXHIBIT 37. (continued)

State	FPL	Annual amount					Monthly amount				
		Family size					Family size				
		1	2	3	4	Each additional person	1	2	3	4	Each additional person
Hawaii	100%	$13,550	$18,330	$23,110	$27,890	$4,780	$1,129	$1,528	$1,926	$2,324	$398
	133	18,022	24,379	30,736	37,094	6,357	1,502	2,032	2,561	3,091	530
	138	18,699	25,295	31,892	38,488	6,596	1,558	2,108	2,658	3,207	550
	150	20,325	27,495	34,665	41,835	7,170	1,694	2,291	2,889	3,486	598
	185	25,068	33,911	42,754	51,597	8,843	2,089	2,826	3,563	4,300	737
	200	27,100	36,660	46,220	55,780	9,560	2,258	3,055	3,852	4,648	797
	250	33,875	45,825	57,775	69,725	11,950	2,823	3,819	4,815	5,810	996
	300	40,650	54,990	69,330	83,670	14,340	3,388	4,583	5,778	6,973	1,195
	400	54,200	73,320	92,440	111,560	19,120	4,517	6,110	7,703	9,297	1,593

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services 2015 federal poverty guidelines. These differ slightly from the U.S. Census Bureau's federal poverty thresholds, which are used mainly for statistical purposes. The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period.

Source: U.S. Department of Health and Human Services (HHS), 2015, Annual update of the HHS poverty guidelines, *Federal Register* 80, no. 14 (January 22): 3237.

SECTION 5

Beneficiary Health, Service Use, and Access to Care

Section 5: Beneficiary Health, Service Use, and Access to Care

Key Points

- Children whose primary coverage source is Medicaid or CHIP report being in poorer health than those who have private coverage or are uninsured (Exhibit 38). However, their use of services relative to other groups varies depending on the type of care and data source. For example, both National Health Interview Survey (NHIS) and Medical Expenditures Panel Survey (MEPS) data indicate that children with Medicaid or CHIP are less likely than those with private coverage and more likely than those who are uninsured to have seen a dentist in the last 12 months. However, the percentage of children with Medicaid or CHIP reported as having seen a dentist differs substantially between the NHIS (77.0 percent in 2014) and MEPS (41.5 percent in 2013), with similar differences observed for children who have private coverage or are uninsured (Exhibits 39 and 40).
- As with children, adults age 19–64 whose primary coverage source is Medicaid or CHIP generally report being in poorer health, and comparisons of their service use relative to other groups varies by data source. Those whose primary coverage source is Medicare, who must meet federal disability criteria to receive coverage, report the poorest health and highest service use among adults age 19–64 (Exhibits 42–44).
- Children whose primary coverage source is Medicaid or CHIP report having seen a general doctor or had a well-child checkup at rates similar to those with private coverage. However, they are more likely to have had trouble finding a doctor or delayed care than those with private coverage; reports of unmet need due to cost vary depending on the type of care in question (Exhibit 41). Relative to those with private coverage, adults age 19–64 with Medicaid report having a usual source of care at a similar rate, but are more likely to report having difficulties with access to care. Among adults age 19–64, those whose primary coverage source is Medicare report the highest rates of delayed care and unmet need due to cost (Exhibit 45).
- The measures reported in Exhibits 38–45 should be interpreted with caution due to the limitations of survey data, and the characteristics of the populations examined. For example, the results shown are unadjusted for differences in age, health, income, race, ethnicity, and family and household characteristics that are known to explain some of the differences in access and use observed between individuals with different coverage sources. In addition, Exhibits 38–45 reflect an individual's primary payer of care because those with multiple coverage sources are assigned to a single source based on a hierarchy. For selected characteristics of individuals without the application of this hierarchy, see Exhibit 2. For information on individuals who are dually eligible for Medicare and Medicaid, see the latest joint data book published by MACPAC and the Medicare Payment Advisory Commission (MedPAC).

EXHIBIT 38. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2014

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**53.5%**	**37.6%**	**5.6%**
Coverage				
Length of time with any coverage during the year				
Full year	**90.8***	96.9*	93.9	–
Part year	**6.1**	3.1*	6.1	39.6*
No coverage during year	**3.2**	–	–	60.4
Demographics				
Age				
0–5	**30.9 ***	28.4 *	35.6	22.1 *
6–11	**31.3**	31.0	31.8	29.5
12–18	**37.8 ***	40.6 *	32.6	48.4 *
Gender				
Male	**51.1**	51.1	50.6	54.2
Female	**48.9**	48.9	49.4	45.8
Race				
Hispanic	**24.3 ***	14.3 *	36.3	42.8 *
White, non-Hispanic	**54.1 ***	68.3 *	35.6	39.4
Black, non-Hispanic	**15.3 ***	10.1 *	23.3	10.7 *
Other non-white, non-Hispanic	**6.3 ***	7.3 *	4.8	7.1
Parents present in family				
Mother, no father	**24.0 ***	13.7 *	39.0	23.4 *
Father, no mother	**3.9**	3.6	4.3	5.3
Both present	**68.4 ***	81.0 *	50.8	65.8 *
No parents	**3.6 ***	1.7 *	6.0	5.6
Family income				
Has income less than 138 percent FPL	**32.9 ***	7.2 *	69.1	41.9 *
Has income in ranges shown below				
Less than 100 percent FPL	**22.7***	3.9*	50.1	25.1*
100–299 percent FPL	**23.0***	12.7*	34.8	38.9
300–399 percent FPL	**27.9***	38.1*	12.8	28.0*
400 percent FPL or higher	**26.3***	45.3*	2.3	7.9*

EXHIBIT 38. (continued)

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Other demographic characteristics				
Citizen of United States	**97.4%**	98.7%*	97.5%	84.6%*
Receives SSI[6]	**1.5***	0.6*	3.0	0.3*
Family receives WIC	**7.6***	1.8*	16.3	5.1*
Health				
Current health status				
Excellent or very good	**84.5***	89.9*	77.2	80.2
Good	**13.8***	9.1*	20.0	17.7
Fair or poor	**1.7***	1.0*	2.8	2.2
BMI[7]				
Healthy weight (BMI less than 25)	**77.6***	81.8*	72.7	65.2
Overweight (BMI 25–29)	**14.1**	11.6*	16.8	22.7
Obese (BMI 30 or higher)	**8.3**	6.6*	10.5	12.1
Special needs, impairments, and health conditions				
Has special health care needs[8]	**14.4***	12.2*	18.2	9.8*
Receives special education or early intervention services	**7.2***	5.7*	9.1	5.5*
Has impairment requiring special equipment	**1.3**	1.3	1.5	†
Has impairment limiting ability to crawl, walk, run, or play[9]	**1.6**	1.3*	2.0	†
Has impairment limiting ability to crawl, walk, run, or play that is expected to last 12+ months[9]	**1.3**	1.1*	1.8	†
Ever been told he or she has selected conditions				
ADHD/ADD[10]	**8.4***	6.8*	11.1	4.2*
Asthma	**13.5***	12.4*	15.4	11.9
Autism[9]	**2.2**	2.1	2.3	†
Cerebral palsy[9]	**0.3**	†	0.4	†
Congenital heart disease	**1.0**	0.9	1.0	†
Diabetes	**0.1**	†	0.2	†
Down syndrome[9]	**0.2**	†	0.1	†
Intellectual disability (mental retardation)[9]	**1.0**	0.8	1.2	†
Other developmental delay[9]	**3.3**	2.8*	3.8	2.3*

EXHIBIT 38. (continued)

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. WIC is Supplemental Nutrition Program for Women, Infants, and Children. BMI is body mass index. ADHD is attention deficit hyperactivity disorder. ADD is attention deficit disorder. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized children under age 19, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other government-sponsored programs. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Characteristic is listed under demographics because low income is one of the criteria for SSI eligibility. However, SSI receipt is also an indicator of disability. For a child to be eligible for SSI, he or she must have a medically determinable physical or mental impairment that results in marked and severe functional limitations and that is generally expected to last at least 12 months or result in death.

[7] Survey information is limited to children age 2 or older.

[8] Due in part to changes in the 2011 National Health Interview Survey (NHIS) questionnaire, the definition of children with special health care needs differs slightly from the definition MACPAC used in reports before 2013. The 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, 2012, *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; Davidoff, A.J., 2004, "Identifying children with special health care needs in the National Health Interview Survey: A new resource for policy analysis," *Health Services Research* 39, no. 1: 53–71.) Under the children with special health care needs definition applied here, a child must have at least one diagnosed or parent-reported condition expected to be an ongoing health condition and also must 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 children with special health care needs, see https://www.macpac.gov/macstats/data-sources-and-methods/.

[9] Survey information is limited to children age 0 to 17.

[10] Survey information is limited to children age 2 to 17.

Source: MACPAC, 2015, analysis of NHIS data.

EXHIBIT 39. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2014, Data from National Health Interview Survey

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**53.5%**	**37.6%**	**5.6%**
Contact with health care professionals (past 12 months)				
Number of times saw a doctor or other health professional, excluding dental visits and inpatient hospital stays				
None	**9.4**	8.0	8.3	30.7*
At least 1	**90.6**	92.0	91.7	69.3*
1	**26.0**	26.6	24.9	28.2
2–3	**37.3**	37.9	37.9	28.8*
4 or more	**27.2**	27.5	29.0	12.3*
Saw selected health professionals in an office-based or clinic setting[6]				
General doctor	**83.2**	85.1	84.6	58.3*
General doctor, nurse practitioner, physician assistant, midwife, or ob-gyn	**84.5**	86.5	85.7	61.4*
Medical specialist	**13.5**	15.0*	12.3	6.5*
Eye doctor	**24.0***	26.4*	21.6	17.7
Mental health professional	**7.1***	6.2*	8.9	†
Doctor, for emotional or behavioral problem	**4.2***	3.0*	6.2	†
Dentist	**79.0***	82.7*	77.0	56.8*
Any health professional, excluding dental[7]	**88.4**	90.4*	88.8	67.7*
Any health professional, including dental	**96.7**	98.1*	96.9	82.3*
Had at least 1 overnight hospital stay[8]	**4.9***	4.5*	6.1	2.5*
Received care at home	**1.0**	0.8*	1.3	†
Receipt of appropriate care (past 12 months)				
Had well-child checkup[9]	**83.8**	85.8	84.9	56.3 *
Had more than 15 office or clinic visits	**1.9**	2.0	2.0	†
Number of emergency room visits				
None	**83.0***	87.3*	76.8	84.1*
At least 1	**17.0***	12.7*	23.2	15.9*
1	**11.8***	9.8*	15.2	9.0*
2–3	**4.0***	2.4*	6.2	4.3
4 or more	**1.1***	0.4*	1.8	†
Had at least 1 emergency room visit, and most recent visit was for a serious health problem	**9.9***	8.1*	13.0	6.9*

EXHIBIT 39. (continued)

Notes: Ob-gyn is obstetrician-gynecologist. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized children under age 19, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other government-sponsored programs. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Parents may report encounters with a broad range of health professionals (e.g., speech therapist or social worker) but the question is limited to visits in a doctor's office or clinic.

[7] Percentages are lower than for a measure shown earlier in this exhibit because the measure shown in this row is limited to office and clinic settings.

[8] Includes stays for newborns.

[9] Survey information is limited to children age 0 to 17.

Source: MACPAC, 2015, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2013, Data from Medical Expenditures Panel Survey

Characteristics	Primary coverage source at time of most recent interview[1]			
	Total	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**54.5%**	**35.5%**	**8.7%**
Contact with health care professionals (past 12 months)				
Number of times saw a doctor or other health professional, excluding dental visits and inpatient hospital stays				
None	**23.4**	18.9*	25.5	43.5*
At least 1	**76.6**	81.1*	74.5	56.5*
1	**23.3**	22.6	23.7	26.4
2–3	**25.6**	27.0	25.8	16.9*
4 or more	**27.7***	31.6*	25.1	13.3*
Had at least 1 overnight hospital stay	**2.4***	2.1*	3.2	†
Received care at home	**0.9**	0.7	1.4	†
Saw a general dentist	**45.9***	52.2*	41.5	24.2*
Saw an orthodontist	**9.2***	13.0*	4.5	4.4
Receipt of appropriate care (past 12 months)				
Had dental cleaning, prophylaxis, or polishing	**43.1***	50.0*	37.9	20.9*
Had more than 15 office or clinic visits[6]	**3.9**	4.6	3.1	†
Number of emergency room visits				
None	**87.8***	89.7*	84.0	91.3*
At least 1	**12.2***	10.3*	16.0	8.7*
1	**9.7***	8.6*	12.1	6.5*
2–3	**2.2***	1.4*	3.4	†
4 or more	**0.4**	†	†	†

Notes: Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

EXHIBIT 40. (continued)

[1] Total includes all non-institutionalized children under age 19, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other government-sponsored programs. Coverage source is defined as of the time of the most recent survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Reflects information from the office-based and hospital outpatient department files in MEPS.

Source: MACPAC, 2015, analysis of MEPS data.

EXHIBIT 41. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2014

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**53.5%**	**37.6%**	**5.6%**
Timeliness of care (past 12 months)				
Has a usual source of care	**95.9**	98.0*	96.6	70.8*
Had the same usual source of medical care 12 months ago	**89.2**	91.5*	89.7	66.3*
Does not have a usual source of care, and access barrier is the reason[6]	**1.1***	0.3	0.6	12.3*
Had trouble finding a doctor or was told that coverage or new patients were not accepted[7]	**3.0***	1.7*	4.6	5.0
Timeliness of care (past 12 months)				
Delayed medical care due to any access barrier indicated below	**9.7***	6.5*	12.1	24.3*
Delayed because of costs	**2.8***	1.8	2.1	17.9*
Delayed for provider-related reasons[8]	**6.6***	4.9*	8.8	8.2
Delayed due to lack of transportation	**1.6***	0.2*	3.4	†
Unmet need for selected types of care due to cost				
Medical care	**1.6***	0.9	1.1	13.5*
Mental health care or counseling[9]	**0.8**	0.8	0.5	1.9*
Dental care	**4.3**	2.7*	4.9	16.6*
Prescription drugs	**1.6**	0.9*	2.0	5.7*
Eyeglasses	**1.8**	1.0*	2.1	7.8*
Specialist care	**1.2**	0.7	1.2	6.2*
Follow-up care	**1.1**	0.6*	1.2	6.4*

Notes: Percentage calculations for each item in the table exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

EXHIBIT 41. (continued)

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized children under age 19, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other government-sponsored programs. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Reasons given by those who reported no usual place of care that were classified as access barriers include the following: too expensive/cost, previous doctor not available, parent does not know where to go, and speaks a different language.

[7] Parent reported one of these barriers in the past 12 months: trouble finding a doctor or provider, doctor's office/clinic did not accept child's insurance coverage, or office/clinic did not accept the child as a new patient.

[8] Includes any of the following: parent could not get an appointment, had to wait too long to see doctor, could not go when open, could not get through on phone, parent speaks a different language.

[9] Survey information is limited to children age 2 or older.

Source: MACPAC, 2015, analysis of NHIS data.

EXHIBIT 42. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2014

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.6%***	**66.2%***	**10.5%**	**16.3%***
Coverage					
Length of time with any coverage during year					
Full year	**77.3***	96.0*	93.6*	79.9	–
Part year	**10.0***	4.0*	6.4*	20.1	20.6
No coverage during year	**12.6**	–	–	–	79.4
Demographics					
Age					
19–25	**13.5 ***	†	12.2 *	20.4	15.9 *
26–44	**43.0 ***	14.7 *	42.4 *	47.2	51.8 *
45–54	**22.5 ***	26.5 *	23.8 *	17.8	19.7
55–64	**20.9 ***	57.3 *	21.7 *	14.5	12.6
Gender					
Male	**49.0 ***	49.3 *	49.7 *	36.1	54.3 *
Female	**51.0 ***	50.7 *	50.3 *	63.9	45.7 *
Race					
Hispanic	**16.9 ***	8.5 *	11.5 *	25.1	36.0 *
White, non-Hispanic	**63.6 ***	69.1 *	71.0 *	46.0	44.1
Black, non-Hispanic	**12.7 ***	18.9	10.1 *	22.1	13.9 *
Other non-white, non-Hispanic	**6.9**	3.5 *	7.4	6.8	5.9
Marital status					
Married	**53.3 ***	37.6 *	61.3 *	31.6	39.0 *
Widowed	**25.0 ***	20.6 *	21.4 *	38.0	31.8 *
Divorced or separated	**11.2 ***	29.4 *	9.1 *	15.9	12.4 *
Living with partner	**1.6**	6.5 *	1.2 *	2.0	1.7
Never married	**8.7 ***	5.8 *	6.9 *	12.3	15.0 *
Family income					
Less than 138 percent FPL	**21.8 ***	49.2 *	7.9 *	65.5	43.8 *
Has income in ranges below					
Less than 100 percent FPL	**14.6***	31.6*	4.7*	47.5	29.8*
100–299 percent FPL	**18.1***	36.7	11.2*	32.8	32.2
200–399 percent FPL	**28.8***	22.4*	31.4*	15.2	28.2*
400 percent FPL or higher	**38.5***	9.3*	52.8*	4.4	9.7*

EXHIBIT 42. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Education					
Less than high school	**11.6%***	24.2%	5.2%*	26.3%	26.2%
High school diploma/GED	**24.9***	33.8	20.0*	36.1	34.8
Some college	**32.3***	33.3*	33.4*	28.0	28.8
College or graduate degree	**31.3***	8.7	41.5*	9.6	10.2
Other demographic characteristics					
Citizen of United States	**89.9***	98.8*	93.8*	88.1	72.2*
Parent of a dependent child	**37.3***	12.2*	37.6*	48.6	36.5*
Currently working	**72.4***	10.1*	83.2*	43.3	63.9*
Veteran	**6.2***	10.1*	5.5*	2.0	3.8*
Receives SSI or SSDI[6]	**5.5***	76.5*	0.8*	17.8	0.8*
Receives SSI	**2.6***	18.9*	0.3*	14.4	0.3*
Receives SSDI	**3.6***	66.7*	0.5*	6.6	0.6*
Health					
Current health status					
Excellent or very good	**64.2***	14.1*	72.2*	44.9	56.3*
Good	**24.9***	21.2*	22.4*	31.3	31.2
Fair or poor	**10.9***	64.7*	5.4*	23.7	12.4*
BMI					
Healthy weight (BMI less than 25)	**35.8***	25.5*	36.9*	32.9	35.8
Overweight (BMI 25–30)	**34.0***	28.8	34.7*	29.6	34.9*
Obese (BMI 30 or higher)	**30.1***	45.7*	28.4*	37.5	29.3*
Smoking status					
Current smoker	**18.9***	32.1	14.1*	29.6	28.2
Former smoker	**18.4***	28.1*	19.5*	14.4	13.8
Never smoked	**62.7***	39.7*	66.4*	56.0	58.0
Limitations and health conditions					
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[7]	**24.9***	86.4*	18.7*	40.1	24.8*
Any complex activity limitation[8]	**11.6***	84.1*	5.2*	28.8	8.9*
Either one	**26.6***	92.4*	19.7*	44.4	26.2*
Has functional limitation[9]	**27.0***	85.3*	21.9*	39.9	25.2*

EXHIBIT 42. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Has difficulty walking without equipment	**3.3%***	34.3%*	1.2%*	7.7%	1.7%*
Has health condition requiring special equipment	**4.0***	35.0*	1.8*	8.3	2.6*
Needs help with any of the following ADLs					
Personal care	**1.3***	12.5*	0.4*	4.6	0.5*
Bathing	**0.8***	8.0*	0.2*	3.2	†
Eating	**0.2***	2.3*	†	0.8	†
Transferring	**0.6***	6.5*	0.2*	1.9	†
Toileting	**0.4***	4.2*	0.1*	1.3	†
Getting around in home	**0.5***	5.5*	0.1*	1.7	†
Number of ADLs needing assistance					
None	**98.9***	89.2*	99.7*	96.0	99.6*
1–2	**0.6***	5.0*	†	2.4	†
3–4	**0.3***	2.7*	†	0.8	†
5–6	**0.3***	3.1*	†	0.8	†
Unable to work now due to health problem	**7.1***	70.8*	2.1*	19.6	4.3*
Limited in amount or kind of work due to health	**10.1***	80.0*	4.0*	26.4	7.1*
Lost all natural teeth	**4.4***	18.9*	3.0*	6.8	4.7*
Has depressed or anxious feelings	**12.6***	35.2*	8.5*	23.2	16.9*
Currently pregnant[10]	**4.4***	†	3.9*	7.8	2.5*
Ever been told he or she has selected conditions					
Hypertension	**24.2***	62.0*	22.3*	29.7	18.7*
Coronary heart disease	**2.0**	11.5*	1.5*	2.7	1.6*
Heart attack	**1.9***	11.0*	1.2*	3.5	1.3*
Stroke	**1.6***	10.5*	0.9*	3.6	0.9*
Cancer	**3.8**	12.0*	3.7	4.2	2.2*
Diabetes	**6.7***	27.1*	5.3*	10.0	5.1*
Arthritis	**16.8***	56.8*	15.3*	19.2	11.5*
Asthma	**13.2***	25.5*	12.5*	17.0	10.6*
Chronic bronchitis (past 12 months)	**3.3***	13.1*	2.5*	5.8	3.0*
Liver condition (past 12 months)	**1.3***	5.9*	1.0*	2.8	0.8*
Weak or failing kidneys (past 12 months)	**1.1***	6.9*	0.6*	2.6	1.2*

EXHIBIT 42. (continued)

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. BMI is body mass index. ADL is activity of daily living. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized individuals age 19–64, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by Medicare, any type of military health plan, or other government-sponsored programs. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see earlier note), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Characteristic is listed under demographics because low income is one of the criteria for SSI eligibility, and the inability to engage in a specified level of work activity and earnings (referred to as substantial gainful activity in federal statute) is one of the criteria for SSDI eligibility. However, SSI or SSDI receipt is also an indicator of disability. For an adult to be eligible for SSI or SSDI, he or she must have a medically determinable physical or mental impairment that is expected to last at least 12 months or result in death.

[7] Captures limitations or difficulties in movement (walking, standing, bending or kneeling, reaching overhead, and using the hands and fingers) and sensory, emotional (i.e., feelings that interfere with accomplishing daily activities), or mental (i.e., difficulties with remembering or experiencing confusion) functioning that are associated with some health problem.

[8] Reflects a limitation in the tasks and organized activities that, when executed, make up numerous social roles, such as working, attending school, or maintaining a household. Adults are defined as having a complex activity limitation if they have one or more of the following types of limitations: self-care limitation, social limitation, or work limitation.

[9] Functional limitation is defined as “very difficult” or “cannot do” for the following activities: grasp small objects; reach above one’s head; sit more than 2 hours; lift or carry 10 pounds; climb a flight of stairs; push a heavy object; walk a 1/4 mile; stand more than 2 hours; stoop, bend, or kneel.

[10] Information is limited to women age 19–44.

Source: MACPAC, 2015, analysis of NHIS data.

EXHIBIT 43. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2014, Data from National Health Interview Survey

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.6%**	**66.2%**	**10.5%**	**16.3%**
Contact with health care professionals (past 12 months)					
Number of times saw a doctor or other health professional, excluding dental visits and inpatient hospital stays					
None	**21.1***	6.0*	16.2	17.0	48.6*
At least 1	**78.9***	94.0*	83.8	83.0	51.4*
1	**21.0***	7.5*	22.7*	15.9	20.4*
2–3	**27.0***	14.9*	30.6*	24.3	16.5*
4 or more	**30.9***	71.6*	30.4*	42.8	14.5*
Saw selected health professionals in an office-based or clinic setting[6]					
General doctor	**66.1***	86.0*	70.4	72.1	38.2*
General doctor, nurse practitioner, physician assistant, midwife, or ob-gyn	**73.7***	88.9*	78.5	80.0	44.8*
Medical specialist	**21.6**	54.0*	23.2	22.3	7.4*
Eye doctor	**33.0***	41.0*	38.2*	26.3	14.4*
Mental health professional	**8.0***	25.2*	6.6*	13.6	4.1*
Dentist	**61.7***	47.2	71.7*	49.2	31.6*
Any health professional, excluding dental[7]	**78.9***	94.9*	84.1*	81.6	51.3*
Any health professional, including dental	**87.9**	97.1*	93.1*	89.5	62.9*
Had at least 1 overnight hospital stay	**7.2***	22.5*	5.7*	14.2	5.2*
Received care at home	**1.2***	11.0*	0.7*	2.6	†
Receipt of appropriate care (past 12 months)					
Had cholesterol checked					
All individuals	**69.1**	87.3*	73.1	71.2	44.9*
Men age 35–64	**73.6***	86.7	77.0	81.3	44.6*
Individuals with elevated risk of cardiac disease[8]	**72.6**	87.2*	77.2	75.0	45.9*
Had flu shot					
All individuals	**35.8***	53.7*	40.0*	30.5	15.7*

EXHIBIT 43. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Individuals age 50–64	**45.4%**	57.2%*	47.8%*	42.5%	20.9%*
Individuals who have a chronic condition or are pregnant	**43.3***	56.9*	47.2*	36.6	20.1*
Had any test for colorectal cancer (age 50–64)	**20.7**	25.1	21.6	23.2	7.1*
Had Pap smear or test for cervical cancer (women age 21–60)	**55.9**	43.6*	61.8*	54.1	33.3*
Had professional counseling about smoking (current smokers)	**50.9***	68.2*	54.3	60.3	30.4*
Had more than 15 office or clinic visits	**4.9***	23.0*	4.1*	8.3	1.7*
Number of emergency room visits					
None	**82.1***	58.0*	85.9*	65.8	83.5*
At least 1	**17.9***	42.0*	14.1*	34.2	16.5*
1	**11.4***	19.7	10.2*	16.6	10.7*
2–3	**4.4***	12.6	2.9*	11.7	3.9*
4 or more	**2.0***	9.8*	1.0*	5.9	1.9*
Had at least 1 emergency room visit, and most recent visit was for a serious health problem	**12.2***	31.6*	9.8*	23.0	10.1*

Notes: Ob-gyn is obstetrician-gynecologist. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized individuals age 19–64, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other government-sponsored programs. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

EXHIBIT 43. (continued)

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Individuals may report encounters with a broad range of health professionals (e.g., speech therapist or social worker) but the question is limited to visits in a doctor's office or clinic.

[7] Percentages are lower than for a measure shown earlier in this exhibit because the measure shown in this row is limited to office and clinic settings.

[8] Individuals of any age or sex who report hypertension or diabetes, or who currently smoke.

Source: MACPAC, 2015, analysis of NHIS data.

EXHIBIT 44. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2013, Data from Medical Expenditures Panel Survey

Characteristics	Primary coverage source at time of most recent interview[1]				
	Total	Medicare	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.4%**	**63.7%**	**7.6%**	**24.0%**
Contact with health care professionals (past 12 months)					
Number of times saw a doctor or other health professional, excluding dental visits and inpatient hospital stays					
None	**27.7***	5.1*	21.8	21.1	48.9*
At least 1	**72.3***	94.9*	78.2	78.9	51.1*
1	**15.7***	6.4*	15.9*	11.8	17.9*
2–3	**18.3**	10.4*	20.4*	17.8	13.8*
4 or more	**38.4***	78.1*	41.9*	49.3	19.4*
Had at least 1 overnight hospital stay	**6.7***	19.1	5.8*	16.0	4.3*
Received care at home	**1.6***	12.9*	0.8*	5.1	0.7*
Saw a general dentist	**35.8***	27.9*	45.5*	21.4	15.9*
Saw an orthodontist	**1.2**	†	1.3	1.3	0.8
Receipt of appropriate care (past 12 months)					
Had dental cleaning, prophylaxis, or polishing	**31.0***	17.2	41.2*	15.0	11.2*
Had more than 15 office or clinic visits[6]	**8.8***	30.4*	9.1*	13.3	3.5*
Number of emergency room visits					
None	**86.6***	67.0	89.5*	70.9	87.2*
At least 1	**13.4***	33.0	10.5*	29.1	12.8*
1	**9.6***	19.2	8.3*	16.6	9.3*
2–3	**3.2***	10.9	2.0*	10.2	3.0*
4 or more	**0.5***	2.9	†	2.3	0.5*

Notes: Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

EXHIBIT 44. (continued)

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized individuals age 19–64, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other government-sponsored programs. Coverage source is defined as of the time of the most recent survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Reflects information from the office-based and hospital outpatient department files in MEPS.

Source: MACPAC, 2015, analysis of MEPS data.

EXHIBIT 45. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2014

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.6%**	**66.2%**	**10.5%**	**16.3%**
Connection to the health care system (past 12 months)					
Has a usual source of care	**82.6***	93.6*	89.3	87.7	48.2*
Had the same usual source of medical care 12 months ago	**75.3***	83.6*	81.1*	78.4	46.6*
Does not have a usual source of care, and access barrier is the reason[6]	**6.2***	2.1	1.5*	3.3	28.9*
Had trouble finding a doctor or was told that coverage or new patients were not accepted[7]	**5.0***	7.8	4.0*	8.4	6.6*
Timeliness of care (past 12 months)					
Delayed medical care due to any access barrier indicated below	**18.4***	31.1*	13.6*	21.6	33.8*
Delayed because of costs	**10.8**	18.0*	6.7*	9.5	28.0*
Delayed for provider-related reasons[8]	**8.6***	14.1	7.8*	11.9	8.1*
Delayed due to lack of transportation	**1.7***	7.8*	0.5*	5.2	2.7*
Unmet need for selected types of care due to cost					
Medical care	**8.1**	13.4*	4.1*	8.3	23.9*
Mental health care or counseling	**2.3***	5.1*	1.2*	3.3	5.2*
Dental care	**12.8***	28.0*	7.0*	20.1	28.4*
Prescription drugs	**7.8***	19.4*	4.1*	11.5	17.8*
Eyeglasses	**7.2***	19.4*	3.7*	11.1	16.4*
Specialist care	**5.0***	11.0*	2.6*	6.9	12.4*
Follow-up care	**4.3**	8.1*	2.1*	5.0	11.8*

Notes: Percentage calculations for each item in the table exclude individuals with missing and unknown values. Standard errors are available online in downloadable Excel files at https://www.macpac.gov/macstats/health-and-other-characteristics-of-beneficiaries-service-use-and-access-to-care/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

EXHIBIT 45. (continued)

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

† Estimate is unreliable because it has a relative standard error greater than 30 percent.

– Dash indicates zero; 0.0% indicates an amount less than 0.05% that rounds to zero.

[1] Total includes all non-institutionalized individuals age 19–64, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid/CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other government-sponsored programs. Coverage source is defined as of the time of the survey interview. Since an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

[4] Individuals were defined as uninsured if they did not have any private health insurance, Medicaid, CHIP, Medicare, state- 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 to the fact that a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid/CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Reasons given by those who reported no usual place of care that were classified as access barriers include the following: too expensive/cost, previous doctor not available, parent does not know where to go, and speaks a different language.

[7] Individual reported one of these barriers in the past 12 months: trouble finding a doctor or provider, doctor's office/clinic did not accept child's insurance coverage, or office/clinic did not accept the child as a new patient.

[8] Includes any of the following: individual could not get an appointment, had to wait too long to see doctor, could not go when open, could not get through on phone, individual speaks a different language.

Source: MACPAC, 2015, analysis of NHIS data.

SECTION 6

Technical Guide to MACStats

This technical guide provides supplementary information to help readers interpret the exhibits in this data book as well as to understand the data sources and methods used. In addition, we explain why MACPAC's statistics, particularly those on enrollment and spending, may differ from each other or from those published elsewhere.[1]

Interpreting Medicaid and CHIP Enrollment and Spending Numbers

Published numbers for enrollment in Medicaid and the State Children's Health Insurance Program (CHIP) can vary substantially depending on the source of data, the enrollment period examined, and the individuals included in the data.

Data sources

Medicaid and CHIP enrollment and spending numbers are available from data which states and the federal government compile in the course of administering these programs. Program data are updated on different schedules, so the latest year of available data may differ depending on the source. MACPAC commonly uses the following types of administrative data, which are submitted by the states to the Centers for Medicare & Medicaid Services (CMS):

- Form CMS-64 data for state-level Medicaid spending;
- Medicaid Statistical Information System (MSIS) data for person-level detail;
- Medicaid managed care enrollment reports; and
- Statistical Enrollment Data System (SEDS) data for CHIP enrollment.

In addition, CMS recently began compiling two new administrative data sources, referred to here as performance indicator enrollment data and CMS-64 enrollment data.[2] Notable differences between these sources include that the performance indicator enrollment data are published monthly by CMS and only include full-benefit Medicaid and CHIP enrollees, while CMS-64 enrollment data are published quarterly and include those with limited benefits but exclude CHIP enrollees. Both sources provide more up-to-date information than the MSIS. Although timelier reporting is expected under a new version of the MSIS, referred to as the transformed MSIS (T-MSIS), full implementation has been delayed and states are still in the process of transitioning to T-MSIS reporting.

MACStats also uses nationally representative surveys based on interviews of individuals including the National Health Interview Survey (NHIS) and the Medical Expenditures Panel Survey (MEPS). Estimates of Medicaid and CHIP enrollment from survey data tend to be lower those generated from administrative data, in part because survey respondents tend to underreport Medicaid and CHIP coverage. However, survey data provide many more details on individual and family circumstances (for example, health status, ease in accessing services, reasons for delaying care) and can therefore provide a richer picture of the individuals enrolled in Medicaid and CHIP.

Enrollment period examined

Characterizations of the size of the Medicaid and CHIP populations may vary based on the 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. Point-in-time numbers are sometimes referred to as average, full-year equivalent, or person-year enrollment. These statistics are often used for budget analyses (such as those by the CMS Office of the Actuary) and when comparing enrollment and expenditure

numbers. Per enrollee spending levels based on full-year equivalents 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 reflect different ways of characterizing individuals in Medicaid. Certain terms commonly used to refer to people with Medicaid coverage have extremely specific definitions in administrative data sources provided by CMS:[3]

- Enrollees (less commonly referred to as eligibles) are individuals who are eligible for and enrolled in Medicaid or CHIP. Prior to fiscal year (FY) 1990, CMS did not track the number of Medicaid enrollees, and tracked only beneficiaries (see below). In some cases, CMS has estimated the number of enrollees prior to 1990.
- 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 increased the number of individuals reflected in enrollment statistics. 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.[4] (In common usage outside of statistical publications from CMS, the term beneficiaries typically is synonymous with enrollees.)

Institutionalized and limited-benefit enrollees

Administrative Medicaid data include enrollees who are in institutions such as nursing homes, as well as individuals who receive only limited benefits (for example, only coverage for emergency services). Survey data tend to exclude such individuals from counts of coverage. In percentage terms, the difference between estimates from administrative data versus survey data tends to be largest among older beneficiaries, who are more likely to be living in institutions (in which case they are excluded from most surveys) and receiving limited Medicaid benefits that pay only for their Medicare premiums and cost sharing (which may not be counted as Medicaid coverage in some surveys).

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 not only Medicaid enrollees funded with Medicaid dollars, but also Medicaid-expansion CHIP enrollees funded with CHIP dollars. For MACStats, we generally exclude Medicaid-expansion CHIP enrollees from Medicaid analyses, but some data sources do not allow these children to be broken out separately.

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

MACStats uses data from the federal National Health Interview Survey and the Medical Expenditures Panel 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 these surveys is provided here, along with information on how children with special health care needs are identified using NHIS data.

National Health Interview Survey and Medical Expenditures Panel Survey data

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.[5] A subsample of households that participated in the previous year's NHIS undergo further interviews for the household component of the MEPS, which collects more detailed information on use of health care services and expenditures.[6]

Although other surveys are available, the NHIS is the main survey data source used in MACStats because it provides relatively timely estimates and because its sample size is large enough to produce reliable subgroup estimates and to detect meaningful differences between them. In addition, 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.[7]

However, the NHIS is known to produce higher estimates of service use than the MEPS.[8] As a result, MACStats includes estimates of service use from both sources. For purposes of comparing groups of individuals, the NHIS has the advantage of providing the most recent information available; for other purposes, such as measuring levels of service use relative to a particular benchmark or goal, consulting estimates from the MEPS or another source might be more appropriate.

The NHIS and MEPS have some limitations. As in most surveys, respondents do not always accurately report information about participation in programs such as Medicaid, CHIP, Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI). As a result, survey data may not match estimates of program participation computed from the programs' own administrative data. In addition, although surveys typically ask about participation in Medicaid and CHIP in two different questions, program participation estimates are not reported separately. One reason for this is that many states' CHIP and Medicaid programs use the same name, so respondents may not necessarily know which program funds their children's coverage. Even when the programs have different names, it may be difficult for respondents and interviewers to correctly categorize the coverage. As a result, separate survey questions regarding participation in Medicaid and CHIP are generally used to minimize the undercounting of Medicaid and CHIP enrollees, not to produce valid estimates separately for each program. Thus, survey data analyses typically combine Medicaid and CHIP into a single category.

Children with special health care needs

The term, children with special health care needs (CSHCN), is defined by the U.S. Department of Health and Human Services' Maternal and Child Health Bureau (MCHB) 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."[9] This definition is used by all states for policy and program planning purposes 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. The category of CSHCN covers a broader range of children than the category of children with conditions severe enough and family incomes low enough to qualify for SSI.[10]

MACPAC uses responses to several questions on the NHIS to identify such children. This definition includes children with at least one diagnosed or parent-reported condition expected to be an ongoing health condition, who also meet at least

one of five criteria related to elevated service use or elevated need:

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

Estimates for the category of CSHCN in this edition of MACStats are not directly comparable to those in MACPAC reports prior to 2013, which used a slightly different definition.[11]

Methodology for Adjusting Benefit Spending Data

The FY 2012 Medicaid benefit spending amounts presented in this data book were calculated based on MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[12] Although the CMS-64 provides a more complete accounting of spending than the MSIS and is preferred when examining state or federal spending totals, it cannot be used for analysis of benefit spending by eligibility group and other enrollee characteristics.[13] Thus, we adjust 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.
- The 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.[14]
- The 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, the MSIS still tends to produce lower total benefit spending than the CMS-64.[15]
- The extent to which the 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 Exhibit 46 for unadjusted benefit spending amounts in the MSIS as a percentage of benefit spending in the CMS-64.

The methodology MACPAC uses for adjusting 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 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. Exhibit 47 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 an FFS hospital factor of 1.2, each Medicaid enrollee with

hospital spending in the MSIS would have that spending multiplied by 1.2; doing so makes the sum of adjusted hospital spending amounts among individual Medicaid enrollees in the MSIS total the aggregate hospital spending reported by states in the CMS-64 (as noted later, MACPAC excludes some amounts from the CMS-64 hospital total).[16]

These adjustments to MSIS data are meant 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 CMS Office of the Actuary, the Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute, use similar methodologies although these may differ in some ways—for example, by using different service categories or producing estimates for future years based on actual data for earlier years.

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

- In the 2014 and 2015 editions of MACStats, we excluded disproportionate share hospital (DSH) payments from CMS-64 totals used to adjust MSIS spending. In earlier editions, DSH payments were included in CMS-64 totals. The rationale for doing so was that DSH payments are used to support hospitals that serve a large number of low-income and Medicaid patients, and could therefore be partially attributed to Medicaid enrollees in the MSIS. However, an examination of annual DSH report data submitted by states indicates that for some hospitals, Medicaid DSH payments far exceed their uncompensated care costs for Medicaid patients and may therefore be attributed largely to uninsured patients.[17] As a result, we now exclude DSH payments from CMS-64 totals when we adjust MSIS spending.
- In the 2015 edition, we exclude incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority from CMS-64 totals used to adjust MSIS spending.[18] In earlier editions, these payments were included in CMS-64 totals. Because these payments may be made for purposes other than Medicaid patient costs, we now exclude them when we adjust MSIS spending.
- In the 2015 edition, we shifted a portion of drug rebate amounts in the CMS-64 from fee for service to managed care for a small number of states that, despite reporting drug utilization data for managed care, reported little or no drug rebates for managed care.
- In the 2014 and 2015 editions, we obtained a more precise separation of home- and community-based services (HCBS) waiver spending in the MSIS, due to the use of more detailed MSIS data files than in editions of MACStats prior to 2014.

With regard to changes in data, complete MSIS Annual Person Summary (APS) files have not been available in a timely manner for use in the 2014 and 2015 editions of MACStats. Therefore, we calculated spending and enrollment from the full MSIS data files that are used to create APS files. In general, our calculations closely match those used to create the APS. However, our development of enrollment counts is a notable exception. In MACPAC's analysis of the full MSIS data files, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts were then unduplicated using this national ID, which results in MACPAC reporting slightly lower enrollment counts than would be the case had we used APS files.

EXHIBIT 46. Medicaid Benefit Spending in MSIS and CMS-64 Data by State, FY 2012 (millions)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted MSIS	CMS-64	MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
Total	**$365,746**	**$389,456**	**93.9%**	**$17,076**	**$8,624**
Alabama	4,107	4,569	89.9	458	–
Alaska	1,294	1,331	97.3	20	–
Arizona	8,223	7,516	109.4	195	194
Arkansas	3,457	4,093	84.5	61	5
California	35,154	45,504	77.3	2,102	2,560
Colorado	3,688	4,534	81.3	189	–
Connecticut	5,882	6,281	93.6	478	–
Delaware	1,569	1,472	106.6	13	–
District of Columbia	2,197	2,050	107.2	61	–
Florida	18,865	16,602	113.6	365	939
Georgia	9,098	8,110	112.2	416	–
Hawaii	1,448	1,465	98.8	–	27
Idaho	1,459	1,428	102.1	23	–
Illinois	13,274	12,949	102.5	444	–
Indiana	6,453	7,487	86.2	-1	–
Iowa	3,391	3,439	98.6	52	4
Kansas	2,559	2,593	98.7	74	–
Kentucky	5,529	5,493	100.7	208	–
Louisiana	5,587	6,625	84.3	733	–
Maine	1,902	2,372	80.2	41	–
Maryland	7,214	7,650	94.3	36	–
Massachusetts	10,609	11,994	88.5	–	931
Michigan	11,750	12,184	96.4	276	–
Minnesota	8,654	8,846	97.8	48	–
Mississippi	3,732	4,255	87.7	211	–
Missouri	6,464	7,971	81.1	756	–
Montana	807	955	84.5	17	–
Nebraska	1,630	1,680	97.0	42	–
Nevada	1,377	1,653	83.3	86	–
New Hampshire	1,047	1,145	91.4	42	–
New Jersey	8,752	9,146	95.7	1,243	–
New Mexico	2,520	3,374	74.7	56	–

EXHIBIT 46. (continued)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted MSIS	CMS-64	MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
New York	$48,151	$49,668	96.9%	$3,250	$387
North Carolina	9,919	11,972	82.9	310	–
North Dakota	766	743	103.0	1	–
Ohio	15,752	15,808	99.7	544	–
Oklahoma	3,732	4,606	81.0	36	–
Oregon	3,756	4,518	83.1	69	–
Pennsylvania	17,793	19,232	92.5	1,162	–
Rhode Island	1,497	1,727	86.7	128	1
South Carolina	4,644	4,391	105.8	457	–
South Dakota	744	749	99.4	1	–
Tennessee	12,216	7,520	162.5	102	1,176
Texas	22,117	24,375	90.7	1,516	2,394
Utah	2,365	1,870	126.5	33	–
Vermont	1,077	1,311	82.1	37	5
Virginia	6,005	6,692	89.7	215	–
Washington	6,255	7,168	87.3	392	–
West Virginia	3,049	2,714	112.3	75	–
Wisconsin	5,641	7,096	79.5	0	–
Wyoming	582	528	110.1	0	–

Notes: MSIS is Medicaid Statistical Information System. FY is fiscal year. DSH is disproportionate share hospital. Includes federal and state funds. MSIS and CMS-64 data reflect unadjusted amounts as reported by states. Both sources exclude spending on administration, the territories, and Medicaid-expansion CHIP enrollees; in addition, CMS-64 amounts exclude $8.0 billion in offsetting collections from third-party liability, estate, and other recoveries. See https://www.macpac.gov/macstats/data-sources-and-methods/ for a discussion of differences between MSIS and CMS-64 data. Beginning with the 2014 edition of MACStats, DSH payments were excluded from CMS-64 totals used to adjust MSIS spending; beginning with the 2015 edition, incentive and uncompensated care pool payments made under Section 1115 waiver authority were also excluded. For informational purposes, the DSH and waiver expenditure amounts that were excluded are shown here.

– Dash indicates zero; $0 indicates an amount less than $0.5 million that rounds to zero; negative sign indicates that state reported an amount less than zero (which may reflect, for example, a correction to an amount reported in a prior period).

Source: MACPAC, 2015, analysis of MSIS data as of December 2014 and CMS-64 Financial Management Report (FMR) net expenditure data as of June 2015.

EXHIBIT 47. Service Categories Used to Adjust FY 2012 Medicaid Benefit Spending in the MSIS to Match CMS-64 Totals

Service category	MSIS service types[1]	CMS-64 service types
Hospital	• Inpatient hospital • Outpatient hospital	• Inpatient hospital non-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[2] • 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 • Freestanding birth center • Health home with chronic conditions • Tobacco cessation for pregnant women • Care not otherwise categorized
Drugs	• Drugs (gross spending)	• Drugs (gross spending) • Drug rebates

EXHIBIT 47. (continued)

Service category	MSIS service types[1]	CMS-64 service types
Managed care and premium assistance	• HMO (i.e., comprehensive risk based managed care; includes PACE) • PHP • PCCM	• MCO (i.e., comprehensive risk-based managed care) • 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 age 65 and older	• Nursing facility • Nursing facility supplemental payments • ICF/ID • ICF/ID supplemental payments • Mental health facility for individuals under age 21 or age 65 and older, non-DSH
Medicare[3, 4]		• Medicare Part A and Part B premiums • Medicare coinsurance and deductibles for QMBs

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

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

[1] Claims in the MSIS include both a service type (such as inpatient hospital, physician, personal care, etc.) and a program type (including HCBS waiver). When adjusting MSIS data to match CMS-64 totals, we count all claims with an HCBS waiver program type as HCBS waiver, regardless of their specific service type. Among claims with an HCBS waiver program type, the most common service types are other, home health, rehabilitation, and personal care.

[2] Emergency services for aliens are reported under individual service types throughout the MSIS, but primarily inpatient and outpatient hospital. As a result, we include this CMS-64 amount in the hospital category.

[3] Medicare premiums are not reported in the MSIS. We distribute CMS-64 amounts proportionately across dually eligible enrollees in the MSIS for each state.

[4] Medicare coinsurance and deductibles are reported under individual service types throughout the MSIS. We distribute CMS-64 amount for QMBs across CMS-64 spending in the hospital, non-hospital acute, and LTSS institutional categories prior to calculating state-level adjustment factors, based on the distribution of Medicare cost sharing for hospital, Part B, and skilled nursing facility services among QMBs in 2010 Medicare data. See MedPAC and MACPAC, 2015, *Data book: Beneficiaries dually eligible for Medicare and Medicaid,* Table 4, fee-for-service Medicare Part A and Part B cost sharing incurred by dually eligible and non-dually eligible Medicare beneficiaries, https://www.macpac.gov/wp-content/uploads/2015/01/Duals_DataBook_2015-01.pdf.

Source: MACPAC, 2015, analysis of MSIS and CMS-64 Financial Management Report (FMR) net expenditure data.

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.
- **MSIS.** The MSIS provides person-level and claims-level information for all Medicaid enrollees. For managed care, MSIS claims include records of each capitated payment made on behalf of an enrollee to a managed care plan (generally referred to as capitated claims), as well as records of each service received by the enrollee from a provider under contract with a managed care plan (which generally do not include payment amounts and may be referred to as encounter or dummy claims). All states collect encounter data from their Medicaid managed care plans, but some do not report them in the MSIS. Managed care enrollees may also have FFS claims in the MSIS if they used services beyond those covered by a managed care plan's contract with the state.
- **CMS-64.** The CMS-64 Financial Management Report (FMR) 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. The SEDS is the only comprehensive source of information on managed care participation among separate CHIP enrollees across states.

Although the annual Medicaid managed care enrollment report generally contains the most recent information available from CMS on Medicaid managed care for all states, it does not provide information on many characteristics of enrollees in managed care (e.g., basis of eligibility and demographics such as age, sex, race, and ethnicity). It does provide information on whether individuals are dually eligible for Medicare. As a result, MACStats also includes statistics based on MSIS and CMS-64 data, such as the percentage of individuals enrolled in managed care by eligibility group and the percentage of Medicaid benefit spending attributable to 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 in MACStats, it is not possible to do so with CMS's annual Medicaid managed care enrollment report data.[19]
- The types of managed care reported by states may differ somewhat between the Medicaid managed care enrollment report and the MSIS. For example, some states report a small number of enrollees in comprehensive risk-based managed care in one data source but not the other. Anomalies in MSIS data are documented by CMS as it reviews each state's quarterly submission, but all issues may not be identified in this process.
- The Medicaid managed care enrollment report provides point-in-time figures. In contrast, MSIS data allow for reporting on the number of enrollees ever in managed care during a fiscal year or other period of time.

Endnotes

[1] For technical guides to earlier editions of MACStats, see MACPAC's June reports to Congress, which are accessible through the publications page of the MACPAC website; https://www.macpac.gov/publication/.

[2] CMS has been collecting Medicaid and CHIP performance indicator data on key processes related to eligibility and enrollment since late 2013. In part because the new Medicaid and CHIP performance indicator enrollment data do not identify newly eligible individuals for whom there is a higher federal matching rate, CMS is using a separate process to collect monthly Medicaid enrollment by eligibility category when states submit their CMS-64 quarterly expenditures. Specifically, a new CMS-64 enrollment form has been created to accompany the current expenditure forms. While enrollment is submitted at the same time as expenditures, there is not a direct link between the amount of federal expenditures claimed by states and the number of enrollees reported. Instead, CMS uses CMS-64 enrollment data for monitoring and oversight purposes.

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

[4] 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 currently are counted as beneficiaries or persons served, regardless of whether or not they have any health service use.

[5] Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, 2015, About the National Health Interview Survey, http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[6] Agency for Health Care Research and Quality (AHRQ), U.S. Department of Health and Human Services, 2015, Medical Expenditures Panel Survey: Survey background, http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp.

[7] Kenney, G., and V. Lynch, 2010, 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.J. Plewes, Washington, DC: The National Academies Press. http://www.nap.edu/catalog/13024.html.

[8] Rhoades, J.A., J.W. Cohen, and S.R. Machlin, 2010, Methodological comparison of estimates of ambulatory health care use from the Medical Expenditure Panel Survey and other data sources, in *JSM Proceedings,* Section on Health Policy, Alexandria, VA: American Statistical Association, 2828–2837, https://www.amstat.org/sections/srms/proceedings/y2010/Files/307444_58577.pdf.

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

[10] For children under age 18 to be determined disabled under SSI rules, the child must have at least one medically determinable physical or mental impairment 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).

[11] For full details on the definition of CSHCN, see Medicaid and CHIP Payment and Access Commission (MACPAC), 2014, Technical guide to the June 2014 MACStats, in *Report to the Congress on Medicaid and CHIP,* June 2014, Washington, DC: MACPAC, https://www.macpac.gov/wp-content/uploads/2015/03/June-2014-MACStats.pdf.

[12] 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.

[13] For a discussion of these data sources, see Medicaid and CHIP Payment and Access Commission (MACPAC), 2011, 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, https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_March2011_web.pdf.

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

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

[16] 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 are not reported by type of service in the CMS-64 and are not reported at all in the MSIS.

[17] See Centers for Medicare & Medicaid Services (CMS), 2015, Medicaid disproportionate share hospital (DSH) payments, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html.

[18] For more on these payments, see Medicaid and CHIP Payment and Access Commission (MACPAC), 2015, Using Medicaid supplemental payments to drive delivery system reform, in *Report to Congress on Medicaid and CHIP,* June 2015, Washington, DC: MACPAC, https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf.

[19] We generally exclude children enrolled in Medicaid-expansion CHIP 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.

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