MACStats: Medicaid and CHIP Data Book

December 2016

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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Introduction

This 2016 edition of the *MACStats: Medicaid and CHIP Data Book* presents the most current data available on Medicaid and the State Children's Health Insurance Program (CHIP), two programs that provide a safety net for low-income populations who otherwise would not have access to health care coverage and that cover services other payers often do not cover.

The MACStats data book compiles the broad range of Medicaid and CHIP statistics that MACPAC regularly updates on macpac.gov into a single, end-of-year publication. Our purpose is to bring together in one place federal and state data on Medicaid and CHIP that come from multiple data sources and are often difficult to find.

The data book provides context for understanding these programs and how they fit in the larger health care system. For example: Medicaid and CHIP combined still account for a smaller share of total health care spending than Medicare, despite covering more people (Section 1). After experiencing high rates of growth in 2014 and 2015, Medicaid and CHIP enrollment grew less than 1 percent in 2016 (Exhibit 11). Managed care enrollment and spending continue to climb (Exhibits 17 and 28). And children whose primary coverage source is Medicaid or CHIP are reported to have well-child checkups at rates similar to those with private coverage (Exhibit 39).

The December 2016 data book is divided into six sections:

- an overview with key statistics on Medicaid and CHIP;
- trends in Medicaid spending, enrollment, and share of state budgets;
- Medicaid and CHIP enrollment and spending, with information provided by state, service category, and eligibility group;
- Medicaid and CHIP eligibility;
- measures of beneficiary health, use of services, and access to care; and
- a technical guide.

The technical guide describes the data sources used in MACStats and the methods that MACPAC uses to analyze these data. It also provides guidance in interpreting the exhibits and 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—the State Health Access Data Assistance Center (SHADAC) and Acumen, LLC—who provided their insights and assistance. We would also like to thank Paula Gordon and GKV Communications for providing valuable support in copyediting, formatting, and producing this data book.

SECTION 1

Overview—
Key Statistics

Section 1: Overview—Key Statistics

Key Points

- In 2015, more than one-quarter of the U.S. population was enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) at some point during the year. The estimated number of people ever enrolled in Medicaid was 81.0 million in fiscal year (FY) 2015; for CHIP, the figure was 8.9 million (Exhibit 1).
- Nearly half (45.9 percent) of all individuals enrolled in Medicaid in 2015 had family incomes below 100 percent of the federal poverty level (FPL). Nearly two-thirds (63.8 percent) of all individuals enrolled in Medicaid had incomes less than 138 percent FPL (Exhibit 2).
- People enrolled in Medicaid or CHIP were more likely to be Hispanic or black than those enrolled in other types of coverage. Additionally, Medicaid and CHIP enrollees 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 16.8 percent of national health expenditures in calendar year 2014, Medicare accounted for 20.4 percent, and private insurance accounted for 32.7 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 (9.5 percent in FY 2015) than Medicare (14.6 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 15.3 percent in state fiscal year (SFY) 2014. After including federal funds in state budgets, Medicaid's share was 25.6 percent in SFY 2014 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Share of the U.S. Population, 2015 (millions)

Population	Ever during FY 2015	Point in time during FY 2015	Point in time during CY 2015
	Estimates based on administrative data (CMS)[1]		Survey data (NHIS)[2]
Medicaid enrollees	81.0[3]	67.3	Not available
CHIP enrollees	8.9	5.8	Not available
Totals for Medicaid and CHIP	**89.9**[3]	**73.1**	**56.3**
	Census Bureau data		Survey data (NHIS)[2]
U.S. population	321.9[4]	320.7[4]	316.0
	Administrative and Census Bureau data		Survey data (NHIS)[2]
Medicaid and CHIP enrollment as a percentage of U.S. population	27.9%[1]	22.8%	17.8%

Notes: FY is fiscal year. CY is calendar year. CMS is Centers for Medicare & Medicaid Services. 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 2017. 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 1.5 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 September 2015 (the month with the largest count in FY 2015); 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 2015.

Source: MACPAC, 2016, analysis of Office of the Actuary, CMS, 2016, email to MACPAC staff, August 15; analysis of NHIS data; and analysis of Bureau of the Census, 2016, *Monthly population estimates for the United States: April 1, 2010 to December 1, 2016,* National totals: vintage 2015, http://www.census.gov/popest/data/national/totals/2015/index.html.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2015

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%	16.3%	62.9%	17.9%	9.0%	100.0%	54.9%	37.6%	4.7%
Coverage									
Length of time with any coverage during year									
Full year	**87.2***	98.7*	95.8*	92.3	–	**92.7***	97.5*	95.6	–
Part year	**6.6***	1.3*	4.2*	7.7	27.0	**4.9***	2.5*	4.4	41.4
No coverage during year	**6.1**	–	–	–	73.0	**2.5**	–	–	58.6
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/CHIP combination[6]	**1.7***	10.4	–	9.5	–	**†**	–	†	–
Yes, any private and Medicaid/CHIP combination	**0.5***	–	0.8*	2.8	–	**1.1***	2.0*	2.9	–
Yes, any other combination	**7.0***	43.4*	11.3*	0.4	–	**†**	0.0	–	–
No	**90.8***	46.2*	87.9	87.4	100.0*	**98.9***	98.0*	97.0	100.0*
Demographics									
Age									
0–18	**24.6***	†	21.5*	51.7	12.9*	**100.0**	100.0	100.0	100.0
19–64	**60.7***	14.4*	67.0*	41.8	86.3*	**–**	–	–	–
65 or older	**14.7***	85.3*	11.5*	6.5	†	**–**	–	–	–
Gender									
Male	**48.9**	45.1	48.9*	44.9	54.8*	**51.0***	50.4	51.9	49.7
Female	**51.1**	54.9	51.1*	55.1	45.2*	**49.0***	49.6	48.1	50.3
Race									
Hispanic	**17.7***	7.9*	11.8*	31.5	38.3*	**24.6***	14.7*	36.7	43.1
White, non-Hispanic	**62.7***	77.4*	70.9*	40.2	42.8	**53.7***	67.4*	35.7	42.9*
Black, non-Hispanic	**12.6***	10.0*	9.9*	21.8	13.3*	**14.6***	9.9*	21.9	8.3*
Other non-white, non-Hispanic	**7.0***	4.8*	7.4	6.5	5.7	**7.1***	8.0*	5.7	5.7

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]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.9%**	**69.6%**	**12.4%**	**12.8%**	**100.0%**	**94.2%**	**48.9%**	**7.9%**
Coverage									
Length of time with any coverage during year									
Full year	**82.2***	95.7*	94.6*	87.2	–	**98.7**	99.2	99.4	99.2
Part year	**8.8***	4.3*	5.4*	12.8	25.2*	**0.9**	0.8	0.6	†
No coverage during year	**9.1**	–	–	–	74.8	**0.4**	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/CHIP combination[6]	**1.2***	30.3*	–	9.5	–	**6.6***	7.0*	–	83.9
Yes, any private and Medicaid/CHIP combination	**0.4***	–	0.5*	3.0	–	**†**	–	†	†
Yes, any other combination	**0.7***	17.3*	1.0*	†	–	**45.1***	48.0*	92.4*	4.5
No	**97.8***	52.4*	98.5*	87.3	100.0*	**48.2***	45.0*	7.5*	11.4
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***	50.0*	49.4*	38.0	55.7*	**44.5***	44.3*	43.5*	34.7
Female	**51.0***	50.0*	50.6*	62.0	44.3*	**55.5***	55.7*	56.5*	65.3
Race									
Hispanic	**17.2***	9.5*	12.3*	25.6	37.7*	**8.0***	7.6*	3.7*	27.9
White, non-Hispanic	**62.7***	69.1*	69.4*	45.2	42.7	**78.1***	78.9*	86.0*	44.4
Black, non-Hispanic	**12.7***	17.5*	10.5*	22.3	14.0*	**8.8***	8.7*	6.5*	17.2
Other non-white, non-Hispanic	**7.4***	3.9*	7.8	7.0	5.5	**5.1***	4.8*	3.9*	10.5

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	**12.1%***	17.3%*	6.1%*	28.2%	27.7%	–	–	–	–
High school diploma/GED	**24.5**	29.9	21.0*	31.7	33.1	–	–	–	–
Some college	**31.3***	26.9*	32.0	31.3	28.1*	–	–	–	–
College or graduate degree	**32.1***	25.9*	40.8*	8.7	11.1*	–	–	–	–
Marital status[7]									
Married	**54.0***	52.2*	60.6*	31.9	39.5*	–	–	–	–
Widowed	**6.2***	22.6*	4.6*	6.1	2.0*	–	–	–	–
Divorced or separated	**11.7***	15.1*	9.6*	17.3	13.6*	–	–	–	–
Living with partner	**7.4***	2.9*	6.4*	11.1	13.3*	–	–	–	–
Never married	**20.7***	7.2*	18.7*	33.6	31.5	–	–	–	–
Family income									
Has income less than 138 percent FPL	**22.5***	20.8*	8.3*	63.8	39.7*	**31.1%***	8.5%*	63.5%	38.9%*
Has income in ranges shown below									
Less than 100 percent FPL	**14.5***	11.1*	4.3*	45.9	26.4*	**21.1***	4.2*	45.8	22.9*
100–199 percent FPL	**19.4***	23.1*	12.0*	35.1	31.5*	**23.0***	12.6*	36.1	35.2
200–399 percent FPL	**28.7***	32.2*	31.5*	15.1	31.0*	**27.6***	35.5*	14.9	33.0*
400 percent FPL or higher	**37.2***	33.4*	52.1*	3.7	10.9*	**28.1**	47.6*	3.0	8.5*
Other demographic characteristics									
Citizen of United States	**93.1***	97.6*	95.2*	93.6	73.5*	**97.5***	98.2	97.8	86.9*
Parent of a dependent child[7]	**29.6***	2.2*	31.1*	37.9	36.3	–	–	–	–
Currently working[7]	**61.8***	13.7*	73.6*	35.2	64.6*	–	–	–	–
Veteran[7]	**8.9***	20.5*	7.3*	3.8	2.8	–	–	–	–
Receives SSI or SSDI	**4.2**	13.6	1.3*	13.4	0.8*	**1.2***	0.5*	2.6	†
Health									
Current health status									
Excellent or very good	**65.8***	40.6*	72.1*	57.6	61.2*	**84.2***	89.9*	76.1	80.9*
Good	**23.9***	33.0*	21.6*	25.6	28.1*	**14.0***	9.2*	20.7	17.7
Fair or poor	**10.3***	26.4*	6.3*	16.8	10.8*	**1.9***	0.9*	3.3	†

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	**11.0%***	22.8%	5.2%*	25.7%	27.7%	**16.6%***	16.4%*	11.3%*	44.6%
High school diploma/GED	**23.4***	35.3	19.7*	32.8	33.2	**28.9**	29.0	28.9	24.9
Some college	**32.5***	30.0	33.0	33.4	28.1*	**26.4***	26.4*	26.5*	18.1
College or graduate degree	**33.0***	11.9*	42.1*	8.2	11.0*	**28.2***	28.2*	33.4*	12.4
Marital status[7]									
Married	**53.8***	36.6	60.7*	32.3	39.5*	**54.9***	54.9*	60.4*	29.0
Widowed	**1.6***	5.2*	1.3*	2.3	1.7	**25.1***	25.6*	23.6*	30.7
Divorced or separated	**11.3***	26.3*	9.5*	15.6	13.5*	**13.4***	13.2*	10.6*	28.0
Living with partner	**8.6***	7.6*	7.1*	12.4	13.5	**2.1**	2.1	2.2	†
Never married	**24.6***	24.3*	21.4*	37.4	31.8*	**4.5***	4.3*	3.3*	9.5
Family income									
Has income less than 138 percent FPL	**20.5***	46.4*	8.3*	63.9	39.9*	**16.5***	16.3*	7.6*	65.9
Has income in ranges shown below									
Less than 100 percent FPL	**13.3***	29.0*	4.6*	46.0	26.9*	**8.5***	8.1*	3.2*	45.5
100–199 percent FPL	**17.6**	34.1	11.3*	34.4	31.1*	**20.5***	21.0*	14.7*	32.3
200–399 percent FPL	**28.1***	25.2*	29.7*	15.5	30.8*	**33.2***	33.5*	34.5*	14.6
400 percent FPL or higher	**40.9***	11.7*	54.4*	3.9	11.1*	**37.6***	37.2*	47.5*	7.2
Other demographic characteristics									
Citizen of United States	**90.3***	96.7*	93.6*	89.2	71.7*	**96.9***	97.8*	98.6*	88.1
Parent of a dependent child[7]	**36.6***	12.6*	36.3*	43.8	36.7*	**0.5**	0.4	†	†
Currently working[7]	**73.0***	10.0*	82.9*	40.1	64.9*	**15.7***	14.4*	19.2*	3.6
Veteran[7]	**5.7***	9.0*	4.6*	3.3	2.8	**22.4***	22.4*	22.5*	7.1
Receives SSI or SSDI	**5.6***	74.7*	1.7*	24.1	0.8*	**3.6***	3.4*	0.7*	30.7
Health									
Current health status									
Excellent or very good	**63.3***	11.9*	70.0*	40.5	58.5*	**45.3***	45.2*	51.1*	21.3
Good	**25.7**	30.4	23.6*	31.1	29.6	**33.4**	33.6	33.1	29.5
Fair or poor	**11.0***	57.8*	6.4*	28.5	11.9*	**21.3***	21.2*	15.9*	49.2

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 the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/characteristics-of-non-institutionalized-individuals-by-source-of-health-insurance/. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent. 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, 2016, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2014

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	**$3,031,292**	**$495,766**	**$13,183**	**$618,706**	**$990,988**	**$98,245**	**$484,585**	**$329,819**
Hospital care	**971,836**	168,012	3,362	250,323	362,097	56,999	99,669	31,373
Physician and clinical services	**603,655**	63,993	3,169	138,366	254,656	22,065	67,371	54,035
Dental services	**113,549**	10,068	1,458	410	54,070	1,333	485	45,726
Other professional services[3]	**84,398**	6,266	250	19,617	29,713	–	7,259	21,292
Home health care	**83,198**	29,645	36	34,728	8,278	429	2,714	7,369
Other non-durable medical products[4]	**56,936**	–	–	2,251	–	–	–	54,685
Prescription drugs	**297,698**	27,333	1,413	86,388	127,288	8,514	2,040	44,722
Durable medical equipment[5]	**46,355**	6,120	124	7,739	8,174	–	607	23,592
Nursing care facilities and continuing care retirement communities[6]	**155,586**	49,594	10	35,704	13,083	4,731	11,306	41,159
Other health, residential, and personal care services[7]	**150,396**	83,878	1,017	5,184	11,441	948	42,061	5,867
Administration[8]	**234,830**	50,858	2,346	37,996	122,187	3,226	18,217	–
Public health activity	**78,993**	–	–	–	–	–	78,992	–
Investment	**153,862**	–	–	–	–	–	153,862	–

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%**	**16.4%**	**0.4%**	**20.4%**	**32.7%**	**3.2%**	**16.0%**	**10.9%**
Hospital care	**100.0**	17.3	0.3	25.8	37.3	5.9	10.3	3.2
Physician and clinical services	**100.0**	10.6	0.5	22.9	42.2	3.7	11.2	9.0
Dental services	**100.0**	8.9	1.3	0.4	47.6	1.2	0.4	40.3
Other professional services[3]	**100.0**	7.4	0.3	23.2	35.2	–	8.6	25.2
Home health care	**100.0**	35.6	0.0	41.7	9.9	0.5	3.3	8.9
Other non-durable medical products[4]	**100.0**	–	–	4.0	–	–	–	96.0
Prescription drugs	**100.0**	9.2	0.5	29.0	42.8	2.9	0.7	15.0
Durable medical equipment[5]	**100.0**	13.2	0.3	16.7	17.6	–	1.3	50.9
Nursing care facilities and continuing care retirement communities[6]	**100.0**	31.9	0.0	22.9	8.4	3.0	7.3	26.5
Other health, residential, and personal care services[7]	**100.0**	55.8	0.7	3.4	7.6	0.6	28.0	3.9
Administration[8]	**100.0**	21.7	1.0	16.2	52.0	1.4	7.8	–
Public health activity	**100.0**	–	–	–	–	–	100.0	–
Investment	**100.0**	–	–	–	–	–	100.0	–

Notes: Every five years the national health expenditure accounts undergo a comprehensive revision that includes the incorporation of newly available source data, methodological and definitional changes, and benchmark estimates from the U.S. Census Bureau's quinquennial economic census. As a result of this revision in 2014, the figures shown here may reflect methodological and definitional shifts within payer and service categories from prior publications of MACStats. For example, the 2014 methodology implements a new method for allocating Medicaid managed care premiums to the goods and services categories for states that have a large percentage of Medicaid managed care spending. This change caused a downward revision for hospitals and home health care and an upward revision for other service categories.

– 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 work site health care.

[8] The administrative 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, 2015, *National health expenditures by type of service and source of funds: Calendar years 1960–2014*, Baltimore, MD: OACT, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2014.zip. OACT, 2014, *National health expenditure accounts: Methodology paper,* 2014, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-14.pdf. OACT, 2014, *Summary of 2014 comprehensive revision to the national health expenditure accounts*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/benchmark2014.pdf.

EXHIBIT 4. Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2015

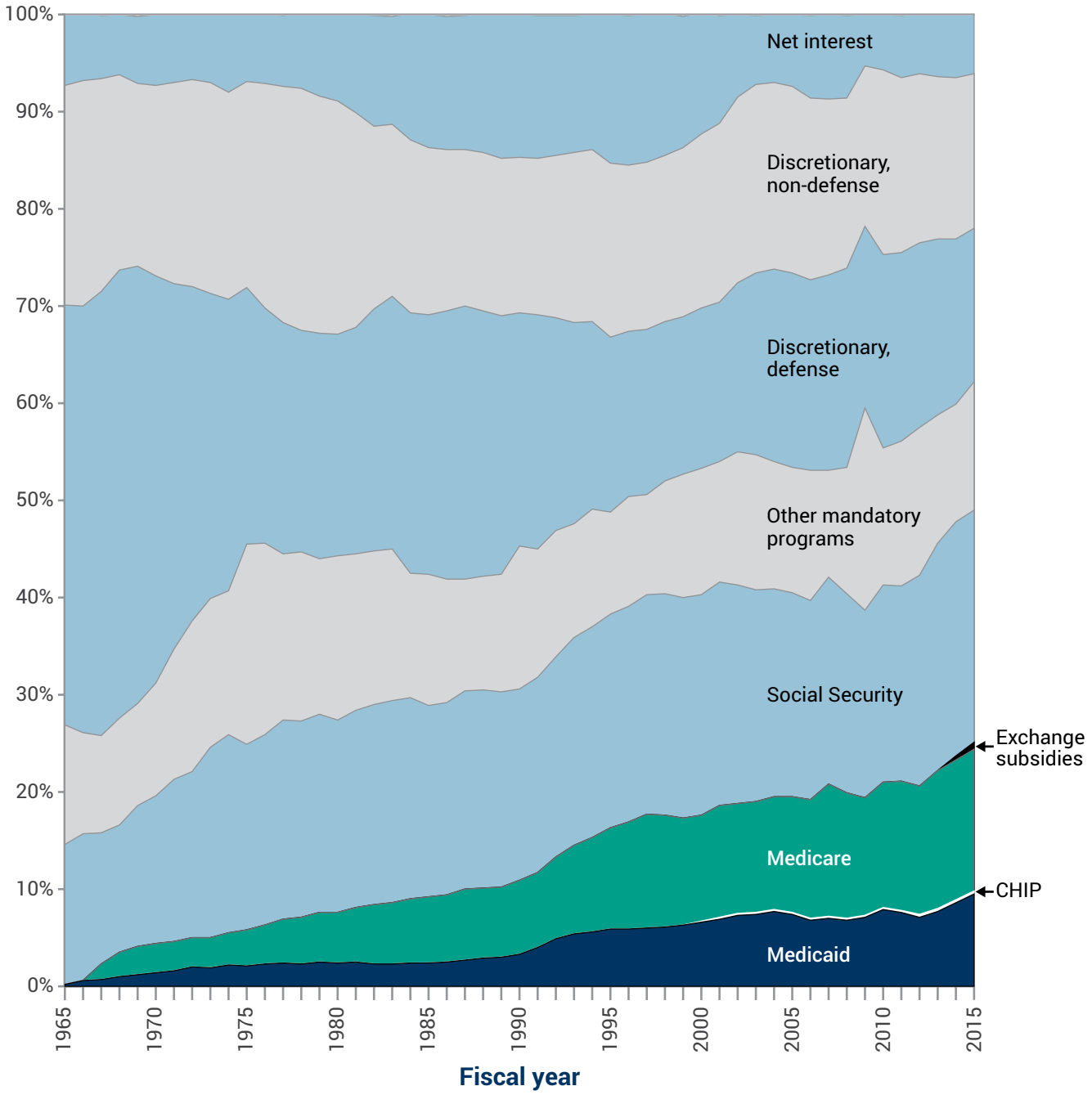


EXHIBIT 4. (continued)

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
2015	9.5	0.3	14.6	0.7	23.9	13.2	15.8	15.9	6.1

Notes: FY is fiscal year.

– Dash indicates zero; 0.0% indicates amounts less than 0.05% that round to zero.

Source: MACPAC, 2016, analysis of Office of Management and Budget (OMB), *Fiscal year 2017 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-2017-TAB.

EXHIBIT 5. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, SFY 2014

State	Total budget (including state and federal funds)				State-funded budget (no federal funds)			
		Total spending as a share of total budget[1]				State-funded spending as a share of state-funded budget[1]		
	Dollars (millions)	Medicaid	Elementary and secondary education	Higher education	Dollars (millions)	Medicaid	Elementary and secondary education	Higher education
Total	**$1,736,546**	**25.6%**	**19.8%**	**10.5%**	**$1,214,527**	**15.3%**	**24.1%**	**13.2%**
Alabama	24,963	23.3	20.5	20.6	15,603	12.1	26.9	24.6
Alaska	11,397	11.1	14.1	8.0	8,692	5.1	16.0	9.1
Arizona	29,103	31.0	18.3	16.9	16,266	16.5	26.2	25.7
Arkansas	22,765	22.1	15.1	15.6	16,261	7.5	18.0	21.7
California	215,393	24.3	21.3	7.5	142,810	15.0	27.8	7.7
Colorado	31,346	23.0	25.4	8.0	23,487	15.9	31.4	9.1
Connecticut	29,193	23.2	14.2	10.6	23,784	15.9	15.4	11.5
Delaware	9,608	17.3	24.1	4.5	7,705	8.6	27.4	4.8
District of Columbia[2]	–	–	–	–	–	–	–	–
Florida	68,033	32.0	19.2	7.0	43,679	20.8	25.5	10.7
Georgia	43,444	21.6	24.3	18.8	30,260	13.7	27.0	26.8
Hawaii	12,603	15.5	15.0	9.8	10,437	8.1	15.2	11.8
Idaho	6,865	28.0	24.0	8.1	4,251	15.5	33.2	12.9
Illinois	61,039	26.1	14.6	4.1	47,477	16.4	14.2	4.7
Indiana	27,260	32.0	32.0	6.6	17,282	14.4	44.8	10.4
Iowa	20,346	20.9	16.6	26.7	14,418	12.9	20.3	34.4
Kansas	14,723	22.4	25.9	17.6	10,823	15.9	30.9	18.9
Kentucky	28,941	24.0	17.4	23.9	19,344	9.8	21.9	31.2
Louisiana	27,279	26.8	18.9	10.4	18,286	14.4	22.5	14.9
Maine	8,088	34.4	17.0	3.5	5,392	18.8	21.9	5.3
Maryland	38,036	22.5	18.8	14.4	27,522	13.6	22.1	18.6
Massachusetts	56,250	21.4	12.0	10.4	47,569	13.7	11.9	12.3
Michigan	49,656	27.6	26.9	4.3	31,504	14.0	36.4	6.4
Minnesota	32,673	29.8	28.2	4.4	23,773	19.4	35.6	6.0
Mississippi	18,558	24.6	16.3	18.9	10,996	11.4	21.7	30.0

EXHIBIT 5. (continued)

State	Total budget (including 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	$23,172	35.8%	22.8%	4.8%	$15,971	25.4%	27.2%	6.9%
Montana	6,188	17.0	15.7	10.4	4,039	8.4	20.0	14.7
Nebraska	10,542	17.6	14.4	23.5	7,631	11.2	16.0	28.1
Nevada	9,409	21.5	19.6	8.1	6,550	10.1	24.3	11.6
New Hampshire	5,144	24.9	22.2	2.5	3,443	20.9	27.7	3.7
New Jersey	53,103	22.5	23.6	7.7	39,731	12.6	29.5	10.3
New Mexico	16,198	25.8	18.3	18.0	10,090	11.0	25.4	22.2
New York	137,526	29.1	19.3	7.6	96,355	16.3	23.5	10.6
North Carolina	43,793	30.4	22.4	14.6	30,281	16.1	25.7	20.9
North Dakota	6,592	12.9	15.8	17.3	5,069	7.8	18.1	20.1
Ohio	61,222	35.8	16.8	4.2	48,176	32.4	17.4	5.3
Oklahoma	22,381	23.2	15.6	23.3	14,977	14.0	19.1	31.5
Oregon	32,383	20.9	17.9	1.3	24,281	8.8	21.4	1.6
Pennsylvania	68,814	33.3	18.7	2.6	44,920	22.9	23.3	3.9
Rhode Island	8,944	24.8	13.4	12.0	6,268	16.4	15.9	17.1
South Carolina	22,040	24.6	18.4	23.6	14,498	10.5	21.7	30.8
South Dakota	4,099	20.3	14.0	21.6	2,696	12.4	15.1	30.3
Tennessee	30,702	30.6	18.3	14.2	18,502	19.0	23.8	22.5
Texas	110,146	30.1	25.0	14.0	68,798	19.7	33.1	16.6
Utah	12,184	19.5	25.7	12.7	8,687	9.1	31.2	17.6
Vermont	5,271	26.8	31.7	1.8	3,511	17.5	44.2	2.6
Virginia	45,858	17.2	15.1	15.2	36,290	10.8	16.5	15.9
Washington	36,867	16.5	23.4	13.7	27,236	8.8	28.3	18.5
West Virginia	23,888	14.8	9.8	12.1	19,476	4.7	10.3	13.7
Wisconsin	44,893	18.4	16.1	14.2	33,887	10.2	18.7	13.7
Wyoming	7,625	8.0	10.0	3.9	5,543	5.2	13.8	5.4

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, until SFY 2014, Connecticut reported 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: NASBO, 2015, State expenditure report: *Examining fiscal 2013-2015 state spending*, Washington, DC: NASBO, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202013-2015)S.pdf.

EXHIBIT 6. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, FYs 2013–2017

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2013	FY 2014[1]	FY 2015[1]	FY 2016[1]	FY 2017[1]	FY 2013	FY 2014	FY 2015	FY 2016[2]	FY 2017[2]
Alabama	68.53%	68.12%	68.99%	69.87%	70.16%	77.97%	77.68%	78.29%	100.00%	100.00%
Alaska	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Arizona	65.68	67.23	68.46	68.92	69.24	75.98	77.06	77.92	100.00	100.00
Arkansas	70.17	70.10	70.88	70.00	69.69	79.12	79.07	79.62	100.00	100.00
California	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Colorado	50.00	50.00	51.01	50.72	50.02	65.00	65.00	65.71	88.50	88.01
Connecticut	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Delaware	55.67	55.31	53.63	54.83	54.20	68.97	68.72	67.54	91.38	90.94
District of Columbia	70.00	70.00	70.00	70.00	70.00	79.00	79.00	79.00	100.00	100.00
Florida	58.08	58.79	59.72	60.67	61.10	70.66	71.15	71.80	95.47	95.77
Georgia	65.56	65.93	66.94	67.55	67.89	75.89	76.15	76.86	100.00	100.00
Hawaii	51.86	51.85	52.23	53.98	54.93	66.30	66.30	66.56	90.79	91.45
Idaho	71.00	71.64	71.75	71.24	71.51	79.70	80.15	80.23	100.00	100.00
Illinois	50.00	50.00	50.76	50.89	51.30	65.00	65.00	65.53	88.62	88.91
Indiana	67.16	66.92	66.52	66.60	66.74	77.01	76.84	76.56	99.62	99.72
Iowa	59.59	57.93	55.54	54.91	56.74	71.71	70.55	68.88	91.44	92.72
Kansas	56.51	56.91	56.63	55.96	56.21	69.56	69.84	69.64	92.17	92.35
Kentucky	70.55	69.83	69.94	70.32	70.46	79.39	78.88	78.96	100.00	100.00
Louisiana[3]	65.51	62.11	62.05	62.21	62.28	72.87	72.69	73.44	96.55	96.60
Maine	62.57	61.55	61.88	62.67	64.38	73.80	73.09	73.32	96.87	98.07
Maryland	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Michigan	66.39	66.32	65.54	65.60	65.15	76.47	76.42	75.88	98.92	98.61
Minnesota	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Mississippi	73.43	73.05	73.58	74.17	74.63	81.40	81.14	81.51	100.00	100.00
Missouri	61.37	62.03	63.45	63.28	63.21	72.96	73.42	74.42	97.30	97.25
Montana	66.00	66.33	65.90	65.24	65.56	76.20	76.43	76.13	98.67	98.89
Nebraska	55.76	54.74	53.27	51.16	51.85	69.03	68.32	67.29	88.81	89.30

EXHIBIT 6. (continued)

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2013	FY 2014[1]	FY 2015[1]	FY 2016[1]	FY 2017[1]	FY 2013	FY 2014	FY 2015	FY 2016[2]	FY 2017[2]
Nevada	59.74%	63.10%	64.36%	64.93%	64.67%	71.82%	74.17%	75.05%	98.45%	98.27%
New Hampshire	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
New Jersey	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
New Mexico	69.07	69.20	69.65	70.37	71.13	78.35	78.44	78.76	100.00	100.00
New York	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
North Carolina	65.51	65.78	65.88	66.24	66.88	75.86	76.05	76.12	99.37	99.82
North Dakota	52.27	50.00	50.00	50.00	50.00	66.59	65.00	65.00	88.00	88.00
Ohio	63.58	63.02	62.64	62.47	62.32	74.51	74.11	73.85	96.73	96.62
Oklahoma	64.00	64.02	62.30	60.99	59.94	74.80	74.81	73.61	95.69	94.96
Oregon	62.44	63.14	64.06	64.38	64.47	73.71	74.20	74.84	98.07	98.13
Pennsylvania	54.28	53.52	51.82	52.01	51.78	68.00	67.46	66.27	89.41	89.25
Rhode Island	51.26	50.11	50.00	50.42	51.02	65.88	65.08	65.00	88.29	88.71
South Carolina	70.43	70.57	70.64	71.08	71.30	79.30	79.40	79.45	100.00	100.00
South Dakota	56.19	53.54	51.64	51.61	54.94	69.33	67.48	66.15	89.13	91.46
Tennessee	66.13	65.29	64.99	65.05	64.96	76.29	75.70	75.49	98.54	98.47
Texas	59.30	58.69	58.05	57.13	56.18	71.51	71.08	70.64	92.99	92.33
Utah	69.61	70.34	70.56	70.24	69.90	78.73	79.24	79.39	100.00	100.00
Vermont	56.04	55.11	54.01	53.90	54.46	69.23	68.58	67.81	90.73	91.12
Virginia	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
Washington	50.00	50.00	50.03	50.00	50.00	65.00	65.00	65.02	88.00	88.00
West Virginia	72.04	71.09	71.35	71.42	71.80	80.43	79.76	79.95	100.00	100.00
Wisconsin	59.74	59.06	58.27	58.23	58.51	71.82	71.34	70.79	93.76	93.96
Wyoming	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	88.00	88.00
American Samoa	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	91.50	91.50
Guam	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	91.50	91.50
N. Mariana Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	91.50	91.50
Puerto Rico	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	91.50	91.50
Virgin Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	91.50	91.50

EXHIBIT 6. (continued)

Notes: FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. FY is fiscal year. 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 squared / U.S. per capita income squared × 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.

[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 will be 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.

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

SECTION 2

Trends

Section 2: Trends

Key Points

- Medicaid spending and enrollment are affected by federal and state policy choices as well as economic factors (Exhibits 8–10). For example, spending and enrollment both grew around the recessions of 2001 and 2007–2009, and slowed as economic conditions subsequently improved. More recently, Medicaid spending in fiscal year (FY) 2014 and beyond grew in part due to 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 FYs 1975 and 2013, from 9.6 million to 30.8 million. Individuals qualifying for Medicaid on the basis of disability—the smallest eligibility group in FY 1975 in terms of absolute numbers—had the largest percentage increase in enrollment, quadrupling over this nearly 40-year 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 due to a temporary increase in federal matching rates, which effectively allowed states to maintain their programs with a smaller state contribution (Exhibit 13). In SFY 2014, Medicaid's share of total state budgets increased, but its share of state-funded budgets remained unchanged due to 100 percent federal funding available for non-disabled adults, newly eligible for Medicaid under the ACA adult group.
- After experiencing high rates of growth in 2014 and 2015, Medicaid and CHIP enrollment grew less than 1 percent in 2016. Enrollment in July 2014 was 17.2 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 8.2 percent. However, enrollment growth from 2015 to 2016 grew by 0.2 percent as enrollment began to level off after the initial increase in expansion states. Because not all states have chosen to expand Medicaid, state-specific growth rates varied substantially (Exhibit 11).
- Medicaid and the State Children's Health Insurance Program (CHIP) are projected to maintain a steady share of national health expenditures at about 17.7 percent through 2025, and Medicare's share is projected to increase from 20.2 percent to 22.8 percent (Exhibit 12).

EXHIBIT 7. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FYs 1975–2013 (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)

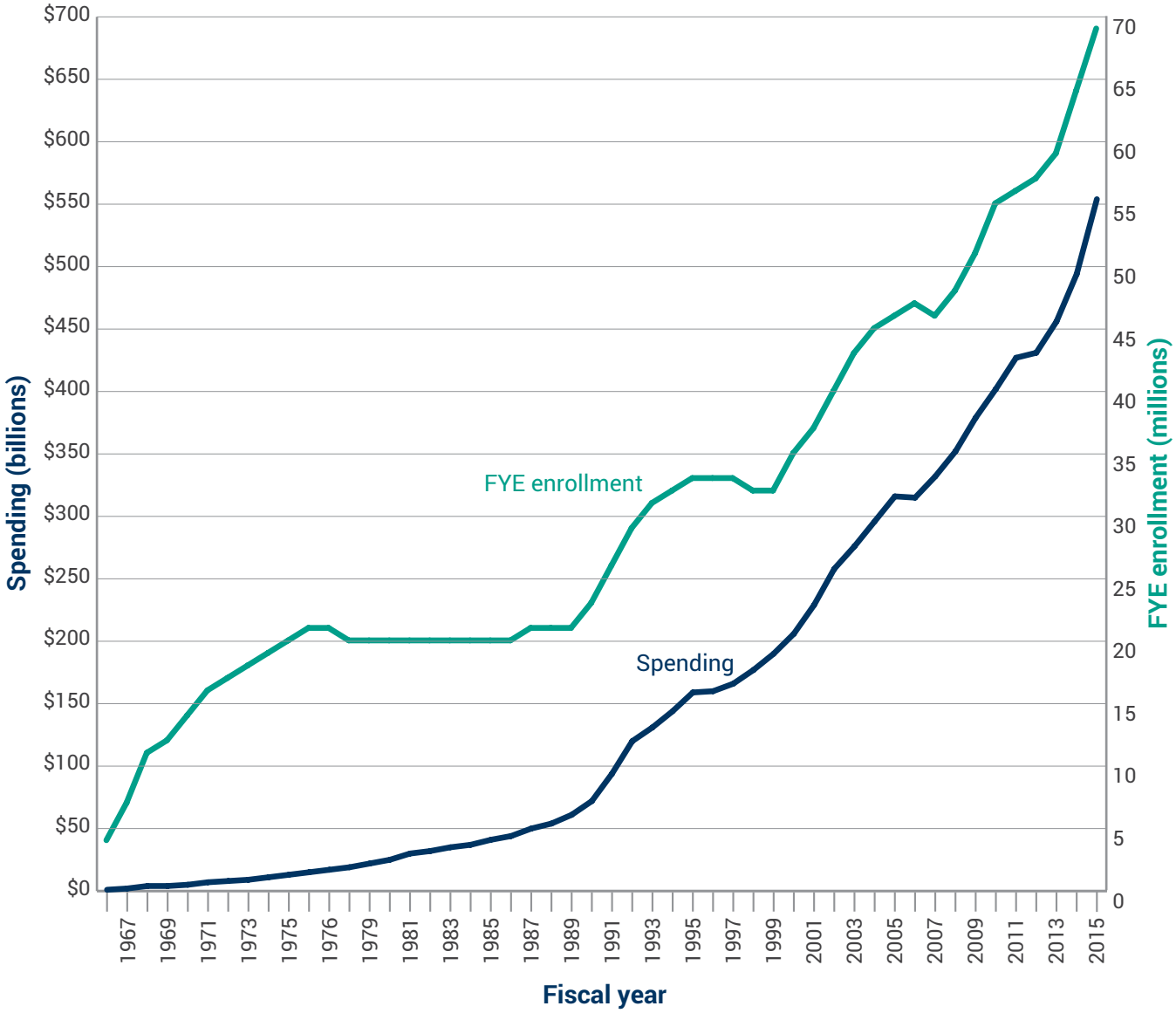
Fiscal year	Total	Children	Adults	Disabled	Aged	Unknown
2003	**50,716**	23,742	11,530	7,664	4,041	3,739
2004	**54,250**	25,415	12,325	8,123	4,349	4,037
2005	**56,276**	25,979	12,431	8,205	4,395	5,266
2006	**56,264**	26,358	12,495	8,334	4,374	4,703
2007	**55,210**	26,061	12,264	8,423	4,044	4,418
2008	**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
2013	**67,497**	30,810	16,898	10,121	4,499	5,169

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.

For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The national enrollment counts shown here are unduplicated using this national ID.

Source: For FYs 1999–2013: MACPAC, 2016, analysis of Medicaid Statistical Information System (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.

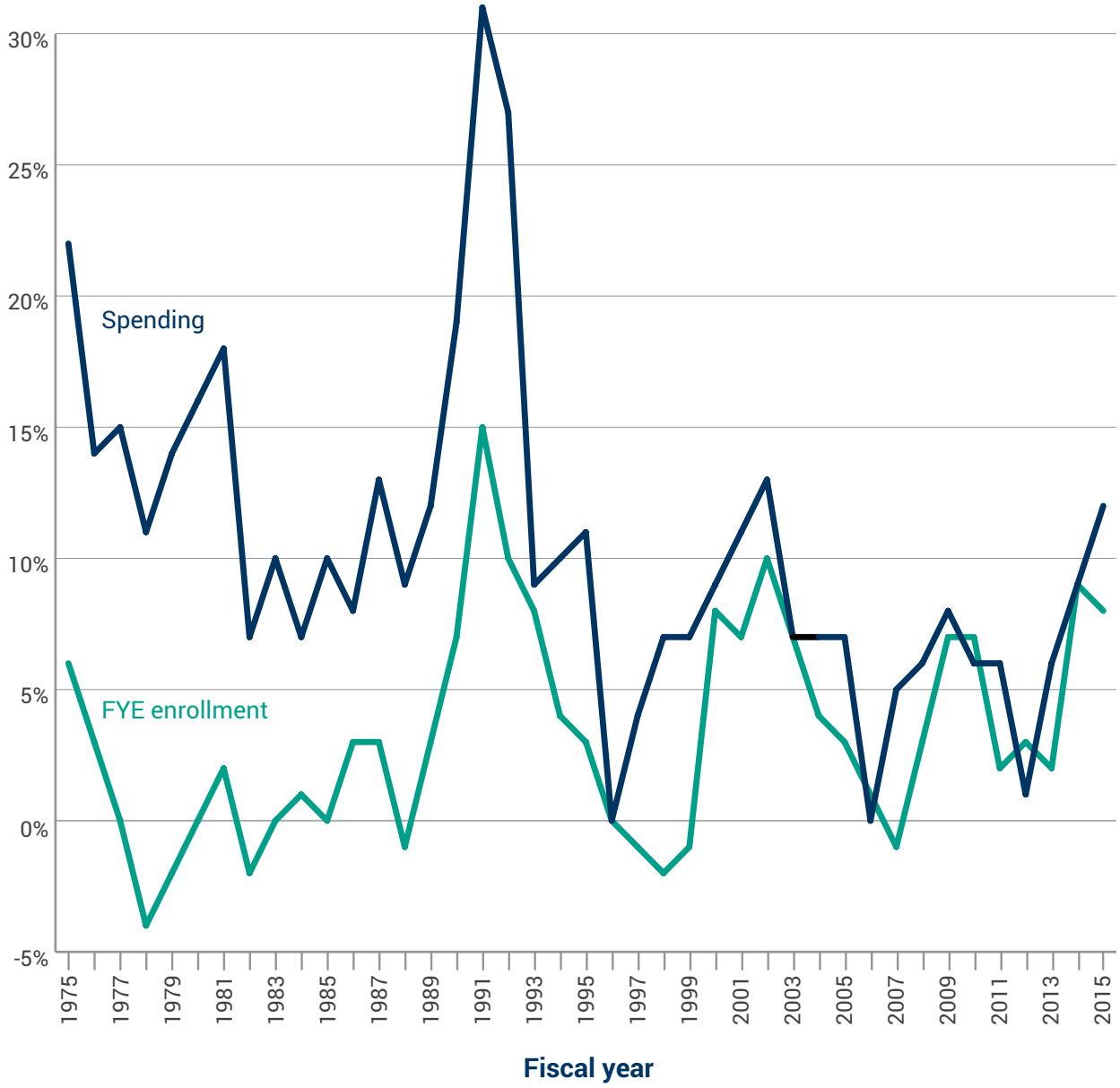
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1966–2015



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. The amounts may also differ from prior versions of MACStats due to changes in methodology by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT). See https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf for more information. 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 2012–2015 are projected; those for FYs 1999–2015 include estimates for Puerto Rico and the Virgin Islands.

Source: OACT, CMS, 2016, data compilation provided to MACPAC staff August 15.

EXHIBIT 9. Annual Growth in Medicaid Enrollment and Spending, FYs 1975–2015



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. The amounts may also differ from prior versions of MACStats due to changes in methodology by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT). See https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf for more information. 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 2012–2015 are projected; those for FYs 1999–2015 include estimates for Puerto Rico and the Virgin Islands.

Source: OACT, CMS, 2016, data compilation provided to MACPAC staff August 15.

EXHIBIT 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1966–2015

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	$222	–	–	–
1967	2	7.4	321	165.4%	83.3%	44.8%
1968	4	10.6	343	52.4	42.9	6.7
1969	4	11.5	381	21.1	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	9.9
1984	37	19.8	1,890	7.4	1.2	6.2
1985	41	19.8	2,081	10.2	0.0	10.2
1986	44	20.5	2,172	7.7	3.2	4.4
1987	50	21.0	2,382	12.5	2.6	9.6
1988	54	20.8	2,609	8.6	-0.9	9.5
1989	61	21.4	2,850	12.1	2.6	9.3
1990	72	22.9	3,147	18.6	7.4	10.4
1991	94	26.3	3,587	30.6	14.6	14.0
1992	120	28.9	4,161	27.4	9.8	16.0

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	$4,182	8.7%	8.1%	0.5%
1994	144	32.4	4,434	10.1	3.9	6.0
1995	159	33.4	4,779	10.9	2.9	7.8
1996	160	33.2	4,804	0.1	-0.4	0.5
1997	166	33.0	5,025	3.9	-0.6	4.6
1998	177	32.5	5,462	6.8	-1.7	8.7
1999	190	32.1	5,924	7.1	-1.2	8.5
2000	206	34.5	5,972	8.6	7.7	0.8
2001	229	36.9	6,213	11.0	6.7	4.0
2002	258	40.5	6,380	12.8	9.8	2.7
2003	276	43.5	6,352	6.9	7.4	-0.4
2004	296	45.2	6,560	7.3	3.9	3.3
2005	316	46.3	6,819	6.6	2.6	3.9
2006	315	46.7	6,751	-0.3	0.7	-1.0
2007	332	46.4	7,157	5.4	-0.5	6.0
2008	352	47.7	7,383	5.9	2.7	3.2
2009	379	50.9	7,443	7.6	6.7	0.8
2010	402	54.5	7,361	6.1	7.2	-1.1
2011	427	55.8	7,660	6.4	2.3	4.1
2012	431	57.3	7,525	0.9	2.7	-1.8
2013	456	58.6	7,773	5.7	2.3	3.3
2014	494	64.0	7,724	8.5	9.2	-0.6
2015	554	68.9	8,042	12.1	7.7	4.1

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 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. The amounts may also differ from prior versions of MACStats due to changes in methodology by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT). See https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2015.pdf for more information. 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 2012–2015 are projected; those for FYs 1999–2015 include estimates for Puerto Rico and the Virgin Islands.

Source: OACT, CMS, 2016, data compilation provided to MACPAC staff August 15.

EXHIBIT 11. Full-Benefit Medicaid and CHIP Enrollment, Selected Months, 2013–2016

State	Number of individuals enrolled				Annual and cumulative growth			
	July–September 2013 average	July 2014	July 2015	July 2016	July–September 2013 average to July 2014	July 2014 to July 2015	July 2015 to July 2016	July–September 2013 average to July 2016
Total	**56,392,477**[1]	**67,147,446**	**72,672,694**	**72,810,267**	**17.2%**[2]	**8.2%**	**0.2%**	**27.3%**[2]
Alabama	799,176[3]	868,174	891,912	885,046	8.6	2.7	-0.8	10.7
Alaska	122,334	125,254	127,401	158,453	2.4	1.7	24.4	29.5
Arizona	1,201,770	1,463,723	1,595,617	1,699,635	21.8	9.0	6.5	41.4
Arkansas	556,851	784,335	823,741	889,082	40.9	5.0	7.9	59.7
California[4]	7,755,381	10,900,000[5,6]	12,648,637	11,902,445	40.5	16.0	-5.9	53.5
Colorado	783,420	1,106,134	1,274,849	1,353,757	41.2	15.3	6.2	72.8
Connecticut	–	749,159	754,054	753,413	–	0.7	-0.1	–
Delaware	223,324	233,706	241,749	236,248	4.6	3.4	-2.3	5.8
District of Columbia[7]	235,786	250,446	255,660	258,918	6.2	2.1	1.3	9.8
Florida	3,104,996	3,343,988[8]	3,558,092[8]	3,620,085[8]	7.7	6.4	1.7	16.6
Georgia	1,535,090	1,739,141	1,781,537	1,744,095	13.3	2.4	-2.1	13.6
Hawaii	288,357	318,838	332,027	340,829	10.6	4.1	2.7	18.2
Idaho	238,150	283,129	278,268	289,858	18.9	-1.7	4.2	21.7
Illinois	2,626,943[6]	3,021,195	3,162,522	3,088,044	15.0	4.7	-2.4	17.6
Indiana[9]	1,120,674	1,211,125	1,389,519	1,473,414	8.1	14.7	6.0	31.5
Iowa	493,515	565,593	599,305	613,386	14.6	6.0	2.3	24.3
Kansas	378,160	401,980	398,007	422,549	6.3	-1.0	6.2	11.7
Kentucky	606,805	1,048,285	1,119,198	1,223,869	72.8	6.8	9.4	101.7
Louisiana	1,019,787	1,037,136	1,075,652	1,308,428	1.7	3.7	21.6	28.3
Maine	–	296,206	280,241	270,827	–	-5.4	-3.4	–
Maryland	856,297	1,151,270	1,179,937	1,226,309	34.4	2.5	3.9	43.2
Massachusetts	1,296,359	1,476,184[10]	1,649,423[10]	1,660,518	13.9	11.7	0.7	28.1
Michigan	1,912,009	2,218,845	2,352,127	2,273,394	16.0	6.0	-3.3	18.9
Minnesota	873,040[11]	1,068,305	1,028,161	1,026,023	22.4	-3.8	-0.2	17.5
Mississippi	637,229	693,425	709,510	687,219	8.8	2.3	-3.1	7.8
Missouri	846,084	812,785	932,026	961,073	-3.9	14.7	3.1	13.6
Montana	148,974	163,551	176,714	239,250	9.8	8.0	35.4	60.6

EXHIBIT 11. (continued)

State	Number of individuals enrolled				Annual and cumulative growth			
	July–September 2013 average	July 2014	July 2015	July 2016	July–September 2013 average to July 2014	July 2014 to July 2015	July 2015 to July 2016	July–September 2013 average to July 2016
Nebraska	244,600	238,609	237,243	234,836	-2.4%	-0.6%	-1.0%	-4.0%
Nevada	332,560	527,929[9]	566,017	609,435	58.7	7.2	7.7	83.3
New Hampshire	127,082	137,934	184,266	185,735	8.5	33.6	0.8	46.2
New Jersey	1,283,851	1,562,483	1,789,264	1,749,400	21.7	14.5	-2.2	36.3
New Mexico	457,678	705,128	717,189	761,033	54.1	1.7	6.1	66.3
New York	5,678,417	6,143,909[6]	6,512,137[6]	6,372,384[6]	8.2	6.0	-2.1	12.2
North Carolina	1,595,952	1,737,117	1,982,496	1,984,599	8.8	14.1	0.1	24.4
North Dakota	69,980[12]	79,076	88,719	89,460	13.0	12.2	0.8	27.8
Ohio	2,341,481	2,708,484	2,988,934	2,941,236	15.7	10.4	-1.6	25.6
Oklahoma	790,051	803,577	821,867	787,331	1.7	2.3	-4.2	-0.3
Oregon	626,356[13]	997,762	1,055,685	1,019,340	59.3	5.8	-3.4	62.7
Pennsylvania	2,386,046	2,417,392	2,665,455	2,834,129	1.3	10.3	6.3	18.8
Rhode Island	190,833	259,183[14]	277,232	283,838	35.8	7.0	2.4	48.7
South Carolina	889,744	868,487	999,438	987,147	-2.4	15.1	-1.2	11.0
South Dakota	115,501	116,174	118,715	119,252	0.6	2.2	0.5	3.3
Tennessee	1,244,516	1,352,243	1,512,658	1,628,196	8.7	11.9	7.6	30.8
Texas	4,441,605	4,575,968[9]	4,678,394	4,708,051	3.0	2.2	0.6	6.0
Utah[9]	294,029	301,311	310,273	306,857	2.5	3.0	-1.1	4.4
Vermont	161,081	208,699	185,991	178,142	29.6	-10.9	-4.2	10.6
Virginia	935,434	937,493	980,591	966,932	0.2	4.6	-1.4	3.4
Washington	1,117,576	1,542,789	1,728,834	1,775,882	38.0	12.1	2.7	58.9
West Virginia	354,544	519,672	542,077	572,107	46.6	4.3	5.5	61.4
Wisconsin	985,531[15]	1,006,257[15]	1,048,817	1,045,160	2.1	4.2	-0.3	6.1
Wyoming	67,518	67,858	64,516	63,618	0.5	-4.9	-1.4	-5.8

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 individuals transferred from the Low-Income Health Program Section 1115 demonstration.

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

[6] Includes retroactive enrollment.

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

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

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

[10] Excludes individuals receiving temporary transitional coverage.

[11] May include duplicates.

[12] Data are for July 2013 only.

[13] Includes emergency Medicaid population.

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

[15] Excludes retroactive enrollment.

Source: MACPAC, 2016, analysis of Centers for Medicare & Medicaid Services (CMS), 2016, *Medicaid & CHIP June and July 2016 application, eligibility, and enrollment data*, https://www.medicaid.gov/medicaid/program-information/downloads/june-and-july-2016-enrollment-data.zip; CMS, 2015, *Medicaid & CHIP August and September 2015 application, eligibility, and enrollment data*, https://www.medicaid.gov/medicaid/program-information/downloads/august-and-september-2015-enrollment-data.zip; and CMS, 2014, *Medicaid & CHIP August and September 2014 application, eligibility, and enrollment data*, https://www.medicaid.gov/medicaid/program-information/downloads/august-and-september-2014-enrollment-data.zip.

EXHIBIT 12. Historical and Projected National Health Expenditures by Payer for Selected Years, FYs 1970–2025

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	10.3%	$15	20.8%	$3	4.4%	$18	23.9%	$25	33.5%
1975	**133**	13	10.1	16	12.3	31	22.9	6	4.5	30	22.3	37	28.0
1980	**255**	26	10.2	37	14.6	69	27.1	10	3.8	55	21.5	58	22.8
1985	**443**	41	9.2	72	16.2	131	29.6	15	3.4	88	19.9	96	21.6
1990	**721**	74	10.2	110	15.3	234	32.4	21	3.0	144	20.0	138	19.1
1995	**1,022**	145	14.2	184	18.0	325	31.8	27	2.6	195	19.1	145	14.2
2000	**1,370**	203	14.8	225	16.4	458	33.5	33	2.4	251	18.3	199	14.5
2005	**2,025**	317	15.6	340	16.8	702	34.7	56	2.8	346	17.1	264	13.0
2010	**2,596**	409	15.7	521	20.1	863	33.3	84	3.2	420	16.2	299	11.5
2011	**2,697**	418	15.5	546	20.3	903	33.5	88	3.3	432	16.0	310	11.5
2012	**2,799**	435	15.5	569	20.3	934	33.4	90	3.2	453	16.2	319	11.4
2013	**2,880**	460	16.0	586	20.4	949	33.0	92	3.2	467	16.2	325	11.3
2014	**3,031**	509	16.8	619	20.4	991	32.7	98	3.2	485	16.0	330	10.9
Projected													
2015	**$3,197**	$563	17.6%	$647	20.2%	$1,042	32.6%	$101	3.2%	$505	15.8%	$338	10.6%
2016	**3,351**	593	17.7	681	20.3	1,093	32.6	106	3.2	527	15.7	350	10.4
2017	**3,522**	622	17.7	721	20.5	1,149	32.6	112	3.2	552	15.7	365	10.4
2018	**3,731**	659	17.7	770	20.6	1,217	32.6	119	3.2	583	15.6	383	10.3
2019	**3,959**	700	17.7	828	20.9	1,286	32.5	126	3.2	616	15.6	403	10.2
2020	**4,198**	742	17.7	893	21.3	1,350	32.2	134	3.2	651	15.5	427	10.2
2021	**4,457**	787	17.7	962	21.6	1,425	32.0	143	3.2	689	15.5	451	10.1

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	**$4,733**	$835	17.6%	$1,036	21.9%	$1,505	31.8%	$151	3.2%	$729	15.4%	$476	10.1%
2023	**5,022**	885	17.6	1,117	22.2	1,587	31.6	160	3.2	771	15.3	502	10.0
2024	**5,322**	940	17.7	1,200	22.5	1,671	31.4	169	3.2	814	15.3	528	9.9
2025	**5,631**	999	17.7	1,282	22.8	1,756	31.2	178	3.2	859	15.3	556	9.9

Notes: Components may not sum to total due to rounding. The latest projections begin after the latest historical year (2014) and go through 2025.

[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, 2016, analysis of Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2015, *National health expenditures by type of service and source of funds: Calendar years 1960–2014*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2014.zip. For projected data: MACPAC, 2016, analysis of OACT, 2016, *National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1960–2025 in projections format*, as of July 2016, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe60-25.zip; and analysis of OACT, 2016, *Table 17: Health insurance enrollment and enrollment growth rates, calendar years 2009–2025*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2015Tables.zip.

EXHIBIT 13. Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014

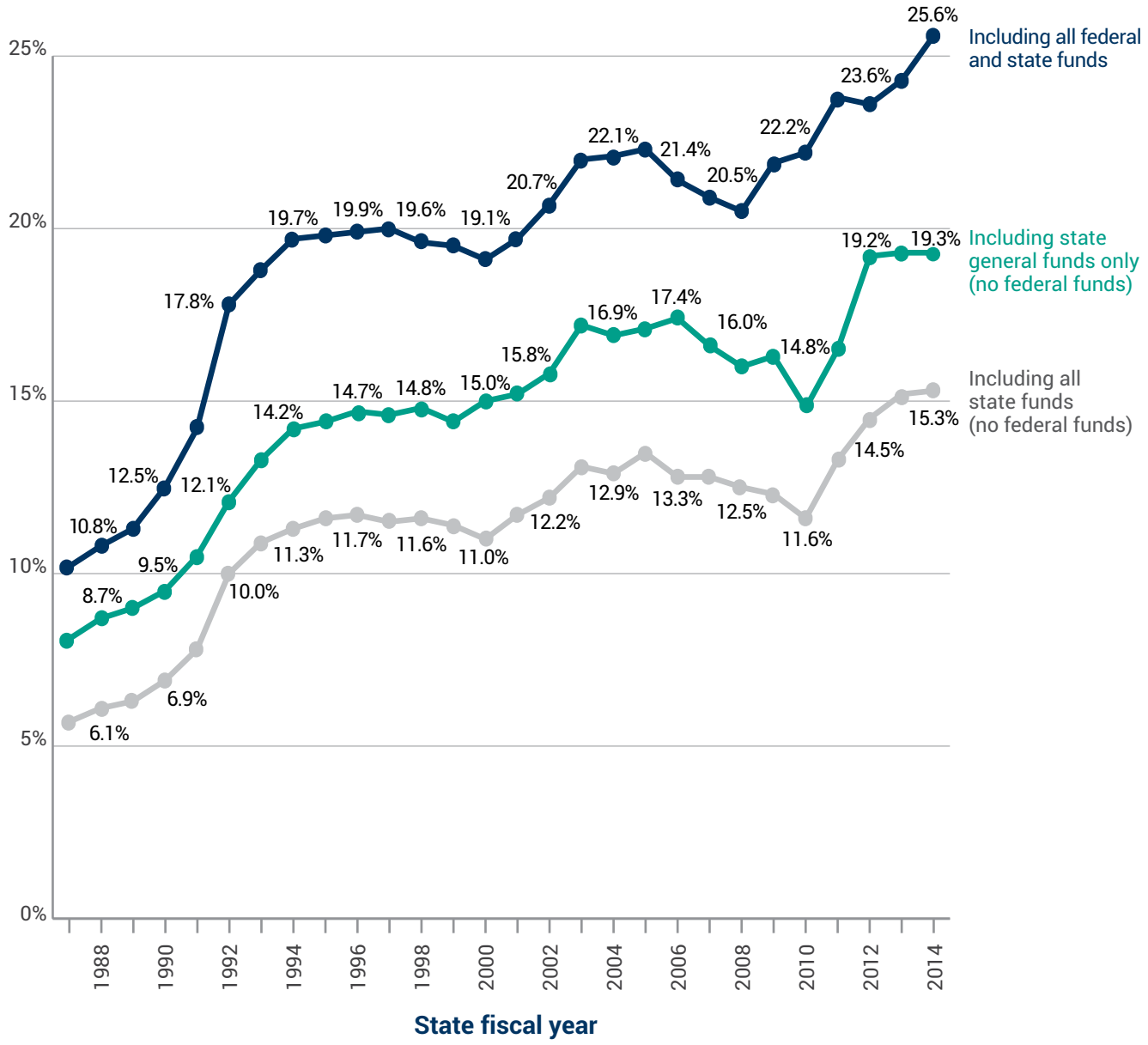


EXHIBIT 13. (continued)

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	24.3	19.3	15.2
2014	25.6	19.3	15.3

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, 2016, analysis of state expenditure reports from the National Association of State Budget Officers, http://www.nasbo.org/mainsite/reports-data/state-expenditure-report/state-expenditure-archives.

SECTION 3

Program Enrollment and Spending

Section 3: Program Enrollment and Spending

Key Points

- Total Medicaid spending was $556 billion in fiscal year (FY) 2015, an 11.6 percent increase from the prior year (Exhibit 16). Total State Children's Health Insurance Program (CHIP) spending increased by about 4.7 percent, to $13.7 billion (Exhibit 32).
- The share of Medicaid benefit spending on capitation payments for managed care reached 43.1 percent of all Medicaid benefit spending in FY 2015, up from 37.5 percent in the prior year (Exhibit 17).
- In FY 2013, individuals eligible on the basis of disability and those age 65 and older accounted for about one-quarter of Medicaid enrollees, but about two-thirds of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports (LTSS). This group accounted for only 5.9 percent of Medicaid enrollees, but over 41.8 percent of all Medicaid spending (Exhibit 20).
- The majority of FY 2013 Medicaid spending for enrollees eligible on the basis of disability and enrollees age 65 and older was for LTSS, while more than half of spending for children and adults eligible on a basis other than disability was for capitation payments to managed care plans (Exhibit 18).
- Medicaid benefit spending per enrollee varies substantially across states (Exhibit 22). This variation reflects many factors, including the underlying costs of delivering health care services in specific geographic areas, the breadth of covered benefits, and the health status and other characteristics of enrollees that affect their use of health care services.
- Drug rebates reduced gross drug spending by about 45.3 percent in FY 2015 (Exhibit 27). Net drug spending (i.e., after rebates) increased by 27.3 percent from FY 2014. Over half (54.8 percent) of Medicaid gross spending for outpatient prescription drugs occurred under managed care in FY 2015 (Exhibit 25).
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for almost half of fee-for-service payments to hospitals in FY 2015 (Exhibit 23).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2013 (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	**70,134**	**32,261**	**20,468**	**10,512**	**6,893**	**10,842**	**6,357**	**7,870**	**4,643**	**2,973**	**1,714**
Alabama[3]	**1,212**	597	244	242	129	**236**	128	**104**	54	**132**	74
Alaska	**136**	74	35	17	10	**16**	9	**15**	8	**1**	0
Arizona	**1,681**	805	579	176	121	**193**	113	**148**	82	**46**	31
Arkansas	**696**	355	109	160	73	**135**	71	**71**	41	**65**	29
California	**11,742**	4,027	5,483	1,094	1,138	**1,429**	1,004	**1,386**	971	**43**	32
Colorado	**896**	500	194	137	65	**104**	59	**74**	44	**30**	16
Connecticut	**858**	331	325	81	122	**174**	117	**84**	49	**90**	68
Delaware	**260**	102	114	28	16	**29**	16	**13**	7	**16**	9
District of Columbia	**246**	84	102	39	21	**29**	18	**28**	17	**0**	0
Florida	**4,313**	2,145	943	662	563	**817**	529	**402**	279	**416**	250
Georgia[3]	**2,013**	1,129	350	340	194	**326**	189	**158**	92	**168**	97
Hawaii	**300**	121	108	43	28	**40**	27	**35**	23	**5**	3
Idaho	**275**	168	40	47	20	**36**	16	**20**	8	**15**	8
Illinois	**3,039**	1,585	883	326	245	**394**	223	**349**	196	**45**	27
Indiana	**1,250**	667	260	221	102	**190**	89	**123**	61	**66**	28
Iowa	**634**	286	212	90	46	**93**	45	**73**	33	**20**	12
Kansas	**442**	262	61	81	39	**75**	36	**48**	25	**27**	12
Kentucky	**927**	450	139	238	99	**192**	96	**104**	55	**88**	42
Louisiana	**1,284**	623	293	245	122	**217**	120	**116**	63	**100**	58
Maine[3]	**371**	132	104	72	63	**106**	62	**61**	29	**45**	34
Maryland	**1,139**	515	389	149	85	**142**	80	**90**	50	**52**	29
Massachusetts	**1,527**	436	512	393	186	**299**	158	**274**	134	**26**	24
Michigan	**2,291**	1,149	594	392	156	**315**	145	**267**	122	**48**	24
Minnesota	**1,154**	469	442	142	101	**156**	81	**140**	72	**17**	10
Mississippi	**786**	400	118	175	93	**170**	93	**86**	49	**84**	43

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	**1,122**	571	238	218	94	**189**	89	**164**	76	**25**	13
Montana	**142**	81	23	25	14	**27**	14	**17**	9	**10**	5
Nebraska	**262**	147	47	43	25	**46**	23	**40**	20	**5**	3
Nevada	**422**	248	83	55	35	**57**	34	**25**	16	**31**	17
New Hampshire	**166**	92	23	33	17	**37**	16	**23**	10	**14**	6
New Jersey	**1,190**	635	195	198	162	**239**	150	**210**	131	**29**	19
New Mexico	**660**	354	186	74	46	**78**	46	**42**	25	**35**	20
New York	**6,002**	2,120	2,485	710	687	**892**	602	**756**	503	**137**	99
North Carolina	**2,000**	1,058	389	360	193	**352**	188	**267**	141	**84**	47
North Dakota	**87**	47	18	13	10	**17**	9	**13**	7	**3**	2
Ohio	**2,645**	1,133	890	417	203	**383**	188	**249**	129	**134**	58
Oklahoma	**951**	499	253	130	68	**127**	66	**103**	53	**24**	13
Oregon	**760**	367	210	114	69	**121**	67	**72**	41	**49**	25
Pennsylvania	**2,567**	1,097	487	722	261	**469**	249	**385**	200	**85**	50
Rhode Island	**170**	71	38	38	23	**37**	20	**31**	16	**6**	3
South Carolina	**1,091**	562	267	174	89	**169**	89	**143**	74	**27**	15
South Dakota	**134**	77	23	21	13	**23**	13	**14**	8	**9**	5
Tennessee	**1,557**	796	325	283	152	**293**	150	**156**	79	**137**	71
Texas[4]	**5,240**	3,274	727	742	497	**764**	485	**449**	294	**315**	191
Utah	**389**	225	96	49	19	**39**	18	**34**	15	**6**	3
Vermont	**206**	69	88	26	23	**38**	22	**29**	16	**9**	6
Virginia	**1,136**	591	234	192	118	**204**	111	**133**	76	**71**	35
Washington	**1,421**	794	286	232	109	**195**	106	**137**	79	**58**	27
West Virginia	**437**	208	62	124	44	**89**	44	**51**	26	**38**	18
Wisconsin	**1,254**	492	440	179	143	**178**	87	**154**	71	**24**	16
Wyoming	**89**	58	13	12	6	**12**	6	**7**	4	**5**	3

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.

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.

0 indicates an amount less than 500 that rounds to zero.

[1] Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 746,000 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 Medicaid Statistical Information System (MSIS) data for the current or prior years 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.

[4] When compared to the December 2015 edition of this table, Texas had a change in total enrollment of 10 percent or more over the prior year. However, Texas has since updated its 2012 enrollment total and no longer has a change of 10 percent or more.

Source: MACPAC, 2016, analysis of MSIS data as of December 2015.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2013 (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	**56,777**	**49,655**	**26,640**	**26,338**	**14,809**	**10,567**	**9,379**	**8,295**	**5,949**	**4,454**
Alabama	**968**	**728**	480	480	165	39	212	162	110	46
Alaska	**111**	**110**	61	61	25	25	16	16	9	9
Arizona	**1,359**	**1,235**	648	636	442	373	161	147	108	78
Arkansas	**601**	**478**	310	304	82	23	144	113	65	38
California	**9,307**	**6,761**	3,340	3,160	3,907	1,599	1,023	1,013	1,036	990
Colorado[2]	**718**	**690**	406	406	145	142	111	99	56	43
Connecticut	**731**	**649**	291	291	257	255	75	56	108	47
Delaware	**213**	**184**	85	84	88	74	26	18	14	7
District of Columbia[3]	**215**	**215**	74	74	85	85	37	37	19	19
Florida	**3,386**	**2,909**	1,727	1,719	581	478	586	440	492	272
Georgia[2]	**1,593**	**1,387**	894	894	221	164	307	244	171	85
Hawaii	**252**	**248**	107	107	82	82	39	37	25	22
Idaho	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Illinois	**2,677**	**2,555**	1,412	1,412	746	666	302	285	217	192
Indiana	**1,030**	**954**	564	564	184	168	197	161	85	61
Iowa	**516**	**458**	236	234	157	119	83	77	39	28
Kansas	**352**	**328**	209	209	38	38	72	59	33	23
Kentucky	**770**	**692**	375	375	90	90	217	176	88	51
Louisiana	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Maine[2]	**322**	**280**	115	114	85	84	65	55	56	26
Maryland	**963**	**891**	448	447	305	278	137	117	74	48
Massachusetts[3]	**1,293**	**1,197**	367	355	402	348	358	356	166	138
Michigan	**1,877**	**1,753**	971	963	418	345	355	334	132	111
Minnesota	**901**	**863**	383	380	314	293	131	125	74	65
Mississippi	**654**	**549**	328	328	84	55	159	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	**917**	**812**	480	480	176	91	183	173	77	68
Montana	**114**	**103**	65	65	15	13	22	18	11	7
Nebraska	**213**	**208**	124	124	30	30	38	36	21	18
Nevada	**318**	**292**	191	191	52	51	47	35	29	15
New Hampshire	**136**	**124**	79	79	14	14	28	22	14	9
New Jersey	**986**	**959**	541	541	122	120	181	172	143	125
New Mexico	**566**	**476**	307	307	150	91	67	54	41	23
New York	**5,115**	**4,821**	1,815	1,783	2,010	1,886	672	637	617	516
North Carolina	**1,646**	**1,502**	902	901	250	182	325	291	169	128
North Dakota	**65**	**62**	36	36	10	10	11	10	8	6
Ohio	**2,211**	**1,913**	978	973	689	515	373	305	170	120
Oklahoma	**745**	**661**	405	405	164	101	117	107	60	48
Oregon	**625**	**557**	295	289	167	147	104	83	60	38
Pennsylvania	**2,159**	**1,964**	914	913	375	257	646	613	225	182
Rhode Island	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
South Carolina	**926**	**805**	489	488	201	104	157	147	79	66
South Dakota	**107**	**100**	63	63	14	14	19	15	11	7
Tennessee	**1,320**	**1,200**	682	682	249	249	255	198	133	71
Texas	**4,081**	**3,674**	2,590	2,590	389	252	669	564	433	268
Utah	**286**	**280**	170	170	58	57	42	40	16	14
Vermont	**170**	**162**	58	58	67	67	24	22	20	15
Virginia	**935**	**822**	496	496	163	114	173	141	102	71
Washington	**1,168**	**1,038**	678	677	195	116	202	174	94	71
West Virginia	**354**	**322**	166	166	40	40	110	93	38	23
Wisconsin	**1,049**	**931**	413	398	346	266	165	157	125	111
Wyoming	**68**	**62**	44	44	8	7	11	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 746,000 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.

For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification 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] In this exhibit, full-benefit enrollees columns excludes enrollees reported by states in the Medicaid Statistical Information System (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 total FYE enrollees of 10 percent or more over the prior year. These data may reflect data anomalies in the submission of MSIS data for the current or prior years 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] When compared to the December 2015 edition of this table, District of Columbia and Massachusetts had a change in total FYE enrollees of 10 percent or more over the prior year. However, both states have since updated their 2012 enrollment total and no longer has a change of 10 percent or more.

[4] States were excluded due to data reliability concerns regarding completeness of monthly claims and enrollment data.

Source: MACPAC, 2016, analysis of MSIS data as of December 2015.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2015 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$5,265**	$3,663	$1,602	**$231**	$152	$79	**$5,496**	$3,815	$1,681
Alaska	**1,405**	826	580	**130**	79	51	**1,535**	904	631
Arizona	**10,618**	7,897	2,721	**277**	199	78	**10,895**	8,096	2,799
Arkansas	**5,470**	4,302	1,168	**383**	264	119	**5,853**	4,566	1,287
California	**84,983**	53,209	31,774	**5,631**	3,509	2,122	**90,614**	56,718	33,896
Colorado	**7,301**	4,410	2,891	**385**	244	141	**7,686**	4,654	3,032
Connecticut	**7,183**	4,211	2,972	**414**	278	135	**7,597**	4,490	3,107
Delaware	**1,860**	1,115	745	**163**	120	43	**2,024**	1,235	788
District of Columbia	**2,370**	1,759	611	**151**	94	57	**2,521**	1,853	668
Florida	**21,320**	12,877	8,443	**703**	431	272	**22,023**	13,308	8,715
Georgia	**9,665**	6,526	3,139	**580**	398	183	**10,245**	6,924	3,321
Hawaii	**1,958**	1,259	699	**119**	92	27	**2,077**	1,351	726
Idaho	**1,715**	1,234	481	**105**	72	33	**1,820**	1,306	514
Illinois	**16,938**	10,182	6,756	**1,024**	602	422	**17,962**	10,784	7,178
Indiana	**9,250**	6,366	2,884	**472**	285	186	**9,722**	6,651	3,070
Iowa	**4,476**	2,859	1,617	**196**	140	56	**4,672**	2,999	1,673
Kansas	**3,011**	1,714	1,297	**183**	120	62	**3,194**	1,834	1,360
Kentucky	**9,423**	7,506	1,918	**243**	173	70	**9,666**	7,679	1,987
Louisiana	**7,863**	4,923	2,940	**289**	192	97	**8,152**	5,116	3,037
Maine	**2,477**	1,549	928	**143**	99	44	**2,620**	1,648	973
Maryland	**9,410**	5,632	3,779	**471**	306	166	**9,882**	5,937	3,944
Massachusetts	**15,378**	8,632	6,746	**786**	485	300	**16,164**	9,117	7,047
Michigan	**15,867**	11,538	4,329	**694**	479	215	**16,561**	12,017	4,544
Minnesota	**10,705**	6,275	4,429	**590**	357	233	**11,295**	6,633	4,662
Mississippi	**5,136**	3,807	1,330	**177**	117	60	**5,314**	3,924	1,390
Missouri	**9,518**	6,099	3,419	**350**	219	132	**9,869**	6,318	3,551
Montana	**1,132**	767	366	**75**	53	21	**1,207**	820	387
Nebraska	**1,846**	990	856	**127**	87	40	**1,974**	1,077	896
Nevada	**3,106**	2,341	765	**160**	113	47	**3,266**	2,454	812
New Hampshire	**1,716**	1,011	705	**124**	91	33	**1,841**	1,102	738
New Jersey	**14,049**	8,631	5,418	**780**	455	326	**14,830**	9,086	5,744
New Mexico	**4,920**	3,898	1,023	**163**	107	56	**5,083**	4,005	1,078

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
New York	**$57,897**	$31,757	$26,140	**$1,784**	$1,040	$745	**$59,681**	$32,797	$26,884
North Carolina	**13,213**	8,743	4,470	**665**	486	180	**13,878**	9,228	4,650
North Dakota	**534**	319	215	**16**	9	6	**549**	329	221
Ohio	**21,423**	14,787	6,636	**860**	546	315	**22,284**	15,333	6,951
Oklahoma	**4,703**	2,987	1,716	**245**	158	87	**4,948**	3,146	1,802
Oregon	**8,027**	6,251	1,776	**541**	327	215	**8,569**	6,578	1,991
Pennsylvania	**23,224**	12,978	10,246	**876**	557	319	**24,100**	13,535	10,565
Rhode Island	**2,585**	1,530	1,054	**144**	99	45	**2,729**	1,629	1,100
South Carolina	**5,768**	4,083	1,685	**260**	172	88	**6,028**	4,255	1,773
South Dakota	**806**	452	354	**55**	37	18	**861**	489	372
Tennessee	**9,094**	5,917	3,177	**412**	251	162	**9,507**	6,168	3,339
Texas	**34,691**	20,430	14,261	**1,456**	972	484	**36,148**	21,403	14,745
Utah	**2,148**	1,523	625	**152**	108	44	**2,300**	1,631	669
Vermont	**1,633**	987	646	**33**	30	3	**1,666**	1,017	649
Virginia	**8,033**	4,070	3,963	**478**	330	148	**8,511**	4,400	4,111
Washington	**10,494**	6,818	3,676	**581**	358	223	**11,075**	7,176	3,899
West Virginia	**3,647**	2,801	845	**189**	128	61	**3,836**	2,929	907
Wisconsin	**7,894**	4,644	3,249	**319**	207	112	**8,212**	4,851	3,361
Wyoming	**559**	285	274	**62**	44	18	**621**	329	292
Subtotal (states)	**$523,709**	**$329,371**	**$194,338**	**$25,451**	**$16,271**	**$9,180**	**$549,160**	**$345,642**	**$203,518**
American Samoa	**30**	17	13	**4**	3	0	**34**	21	13
Guam	**73**	47	26	**3**	2	1	**76**	49	27
N. Mariana Islands	**27**	15	11	**1**	0	0	**27**	16	11
Puerto Rico	**2,280**	1,467	813	**82**	54	28	**2,362**	1,522	841
Virgin Islands	**39**	23	16	**8**	5	3	**47**	28	19
Subtotal (states and territories)	**$526,159**	**$330,942**	**$195,217**	**$25,547**	**$16,336**	**$9,212**	**$551,706**	**$347,277**	**$204,429**
State Medicaid Fraud Control Units (MFCUs)	–	–	–	**145**	109	36	**145**	109	36
Medicaid survey and certification of nursing and intermediate care facilities	–	–	–	**326**	245	82	**326**	245	82
Vaccines for Children (VFC) program	–	–	–	–	–	–	**3,845**	3,845	–
Total	**$526,159**	**$330,942**	**$195,217**	**$26,019**	**$16,689**	**$9,330**	**$556,023[2]**	**$351,476[2]**	**$204,547**

EXHIBIT 16. (continued)

Notes: FY is fiscal year. Total federal spending shown here ($351,476 million) will differ from total federal outlays shown in FY 2017 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 had certified their CMS-64 Financial Management Report (FMR) submissions as of May 24, 2016. California's first, second, third, and fourth quarter submissions are not certified; Colorado and North Dakota's second, third, and fourth quarter submissions are not certified; New Jersey's third and fourth quarter submissions are 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, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016. For all other spending (MCFUs, survey and certification, VFC): Centers for Medicare & Medicaid Services, 2016, *Fiscal year 2017 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2015 (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	**$5,265**	$1,992	$427	$80	$50	$94	$621	$283	$1,021	$467	-$2	$261	-$29
Alaska	**1,405**	317	121	69	25	201	117	29	198	323	0	21	-16
Arizona	**10,618**	1,143	45	5	6	148	315	8	75	2	8,649	246	-23
Arkansas	**5,470**	1,021	334	79	23	39	927	155	957	526	1,170	305	-67
California	**84,983**	19,447	1,038	1,032	25	3,461	5,886	1,388	4,072	7,714	39,105	2,362	-548
Colorado	**7,301**	2,419	673	256	–	164	293	317	741	1,214	1,160	121	-57
Connecticut	**7,183**	1,865	407	184	179	298	544	617	1,739	1,613	0	406	-670
Delaware[2]	**1,860**	66	15	36	0	42	69	-64	36	117	1,508	36	-2
District of Columbia	**2,370**	332	40	18	3	176	54	96	354	403	874	38	-17
Florida	**21,320**	3,617	545	19	19	166	556	104	970	1,117	13,022	1,343	-156
Georgia	**9,665**	2,228	373	33	30	19	678	369	1,371	1,036	3,269	345	-85
Hawaii	**1,958**	114	1	31	2	19	5	1	9	107	1,671	52	-54
Idaho	**1,715**	394	119	-0	21	26	203	70	317	322	206	53	-16
Illinois	**16,938**	5,155	600	124	114	248	1,013	287	2,345	1,640	5,101	411	-101
Indiana	**9,250**	1,221	197	160	12	400	559	196	2,312	1,153	2,901	219	-79
Iowa	**4,476**	949	230	54	29	98	432	176	930	794	720	150	-87
Kansas[2]	**3,011**	148	13	0	2	4	78	-1	81	3	2,630	83	-30
Kentucky	**9,423**	388	33	2	4	119	368	39	1,159	785	6,392	210	-76
Louisiana	**7,863**	1,891	182	1	–	63	246	199	1,475	820	2,904	277	-195
Maine	**2,477**	563	94	27	45	240	412	96	450	448	3	202	-103
Maryland	**9,410**	1,107	117	130	29	100	1,014	243	1,353	1,183	4,005	271	-143
Massachusetts	**15,378**	2,025	412	250	27	101	1,455	344	1,661	2,972	5,879	440	-186
Michigan	**15,867**	1,752	462	56	12	264	484	387	1,816	777	9,526	412	-82
Minnesota	**10,705**	650	197	42	203	73	712	16	1,031	2,633	5,201	179	-231
Mississippi	**5,136**	1,684	172	5	21	81	360	104	1,099	345	1,074	212	-20
Missouri	**9,518**	3,095	27	14	12	493	922	705	1,395	1,433	1,171	341	-90
Montana	**1,132**	319	60	33	22	17	200	51	198	214	-1	37	-17
Nebraska	**1,846**	142	21	36	2	3	64	84	416	382	635	103	-42
Nevada	**3,106**	573	153	42	21	46	303	124	288	205	1,245	125	-22
New Hampshire[2]	**1,716**	138	18	24	3	5	151	-6	399	300	669	32	-16

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	**$14,049**	$1,818	$56	$6	$3	$239	$763	$29	$2,634	$1,035	$7,313	$341	-$186
New Mexico	**4,920**	368	33	11	43	7	52	9	29	337	3,955	89	-13
New York	**57,897**	9,854	574	67	209	1,341	4,848	1,059	7,783	6,709	26,053	1,310	-1,909
North Carolina	**13,213**	4,663	995	315	66	180	1,095	738	1,346	833	2,843	407	-271
North Dakota	**534**	79	29	6	6	6	25	14	169	108	91	6	-3
Ohio	**21,423**	2,300	286	44	16	55	1,657	109	2,555	3,325	10,862	388	-175
Oklahoma	**4,703**	1,751	473	103	41	360	362	367	769	546	89	136	-294
Oregon	**8,027**	481	35	2	25	118	357	85	415	1,619	4,734	195	-40
Pennsylvania	**23,224**	1,431	86	28	2	108	369	24	4,797	3,915	12,037	598	-171
Rhode Island	**2,585**	356	10	11	1	36	548	2	181	1	1,404	49	-14
South Carolina	**5,768**	1,079	131	114	19	205	380	49	796	516	2,494	181	-196
South Dakota	**806**	206	62	19	3	88	56	32	172	146	2	28	-7
Tennessee	**9,094**	841	37	160	0	43	226	424	272	675	6,109	358	-50
Texas	**34,691**	6,919	509	54	645	35	4,992	230	2,993	2,146	16,228	1,055	-1,116
Utah	**2,148**	288	82	18	4	11	144	63	274	258	1,016	39	-48
Vermont[2]	**1,633**	45	2	0	0	1	1,546	-93	120	8	0	7	-2
Virginia	**8,033**	853	162	147	30	46	1,001	77	1,241	1,383	2,933	231	-71
Washington	**10,494**	954	147	182	24	653	469	170	930	1,814	4,936	342	-127
West Virginia	**3,647**	732	239	29	26	83	281	188	780	592	600	124	-29
Wisconsin	**7,894**	775	65	44	23	322	596	496	887	966	3,563	237	-81
Wyoming	**559**	127	42	14	20	33	30	23	136	126	2	14	-7
Subtotal	**$523,709**	**$92,676**	**$11,181**	**$4,214**	**$2,148**	**$11,178**	**$38,838**	**$10,507**	**$59,548**	**$58,107**	**$227,956**	**$15,426**	**-$8,070**
American Samoa	**30**	19	-4	-0	–	-2	16	1	-0	–	–	–	–
Guam	**73**	12	8	3	0	1	27	21	1	0	–	1	–
N. Mariana Islands	**27**	18	–	0	–	1	6	1	–	0	-0	0	–
Puerto Rico	**2,280**	–	–	–	–	–	16	–	–	–	2,264	–	–
Virgin Islands	**39**	19	4	2	1	1	2	6	3	0	–	1	–
Total	**$526,159**	**$92,745**	**$11,189**	**$4,218**	**$2,150**	**$11,180**	**$38,905**	**$10,535**	**$59,552**	**$58,107**	**$230,220**	**$15,428**	**-$8,070**
Percent of total, exclusive of collections	–	17.4%	2.1%	0.8%	0.4%	2.1%	7.3%	2.0%	11.1%	10.9%	43.1%	2.9%	–

EXHIBIT 17. (continued)

Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Service category definitions and spending amounts shown here may differ from other Centers for Medicare & Medicaid Services 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:

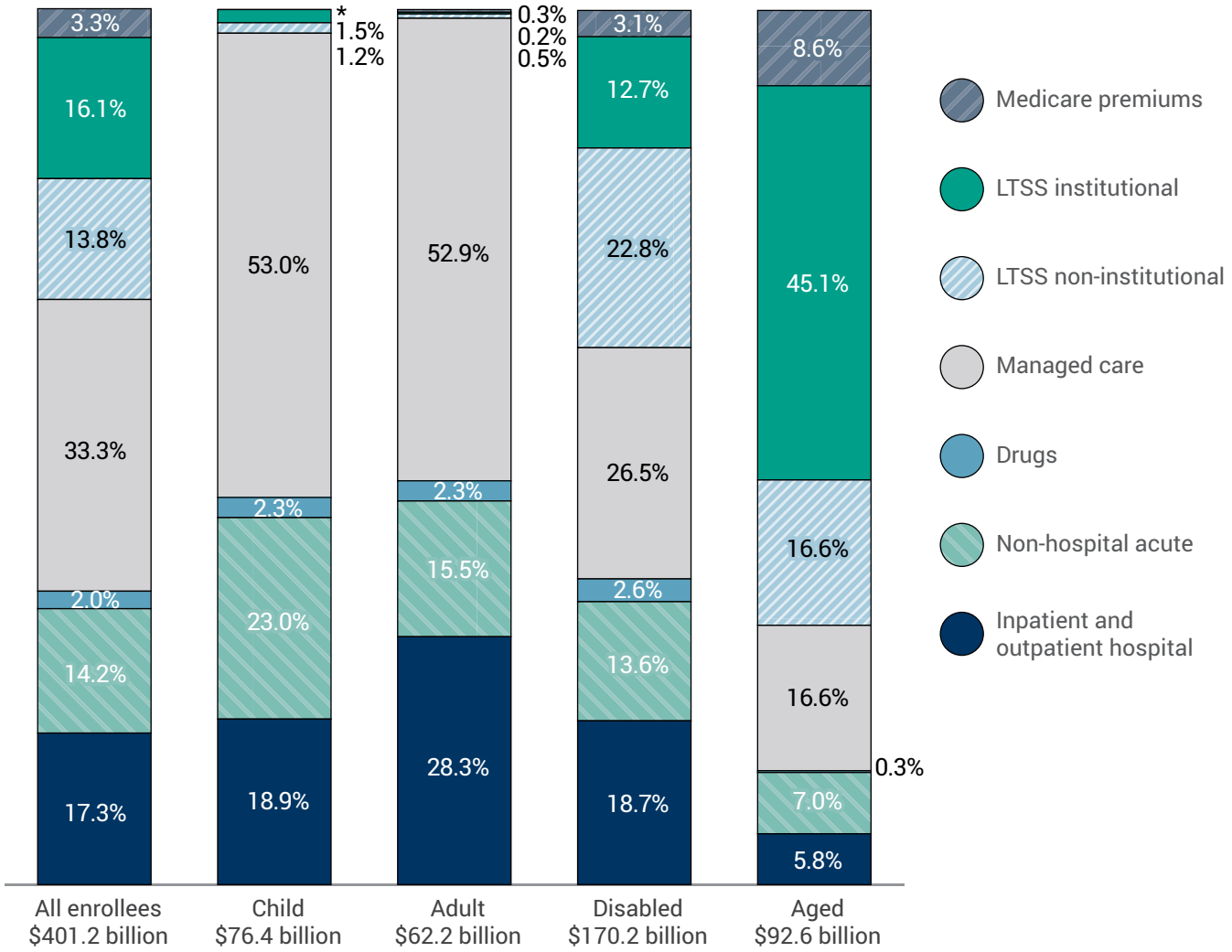
- Hospital includes inpatient, outpatient, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments.
- Physician includes physician and surgical services, both regular payments and those associated with the primary care physician payment 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 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, employer-sponsored premium assistance programs, and Programs of All-inclusive Care for the Elderly. Comprehensive plans account for over 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 Financial Management Report (FMR) submissions as of May 24, 2016. California's first, second, third, and fourth quarter submissions are not certified; Colorado and North Dakota's second, third, and fourth quarter submissions are not certified; New Jersey's third and fourth quarter submissions are 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, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2013

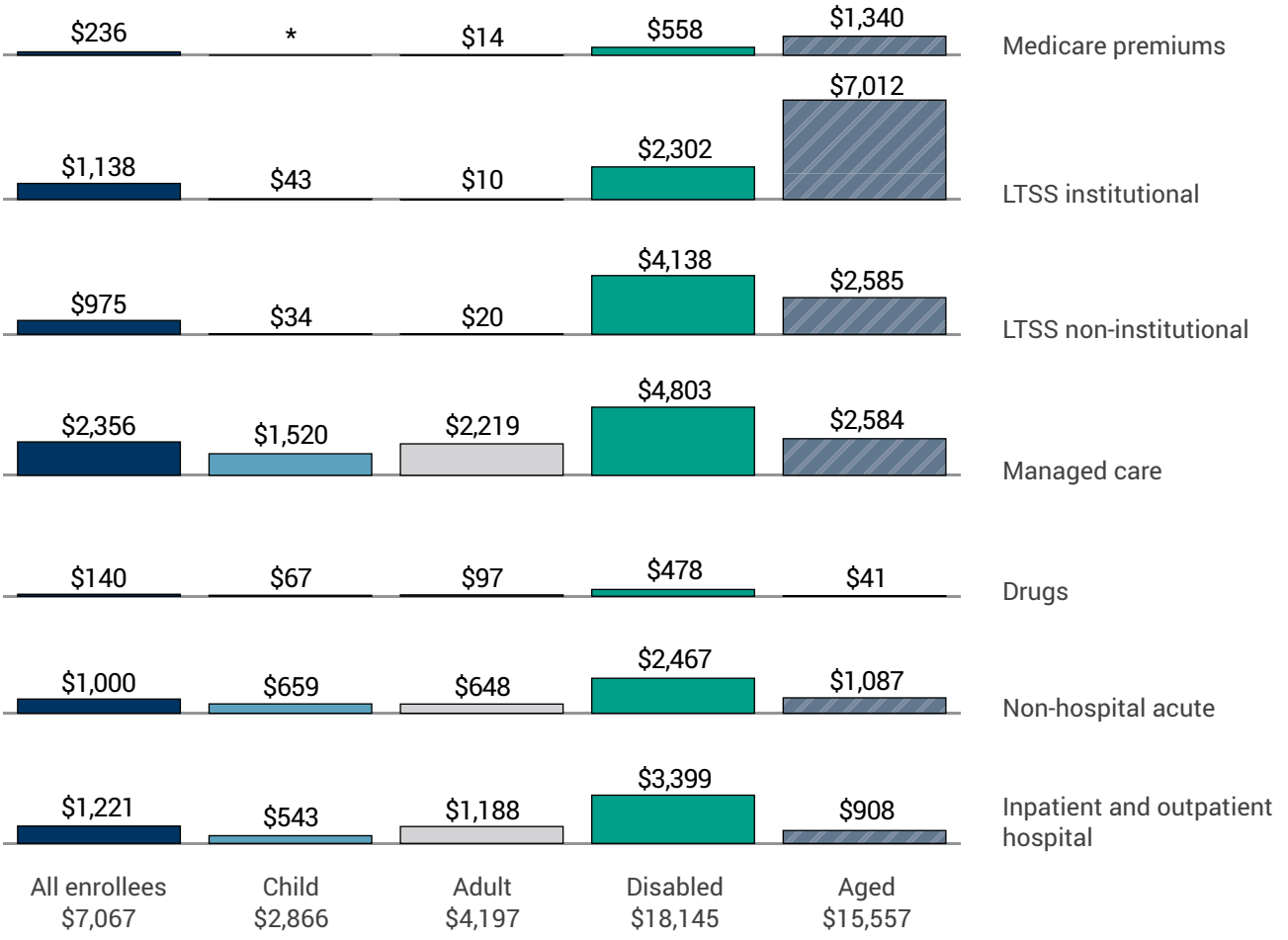


Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 746,000 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) and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.

* Values less than 0.1 percent are not shown.

Sources: MACPAC, 2016, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2013

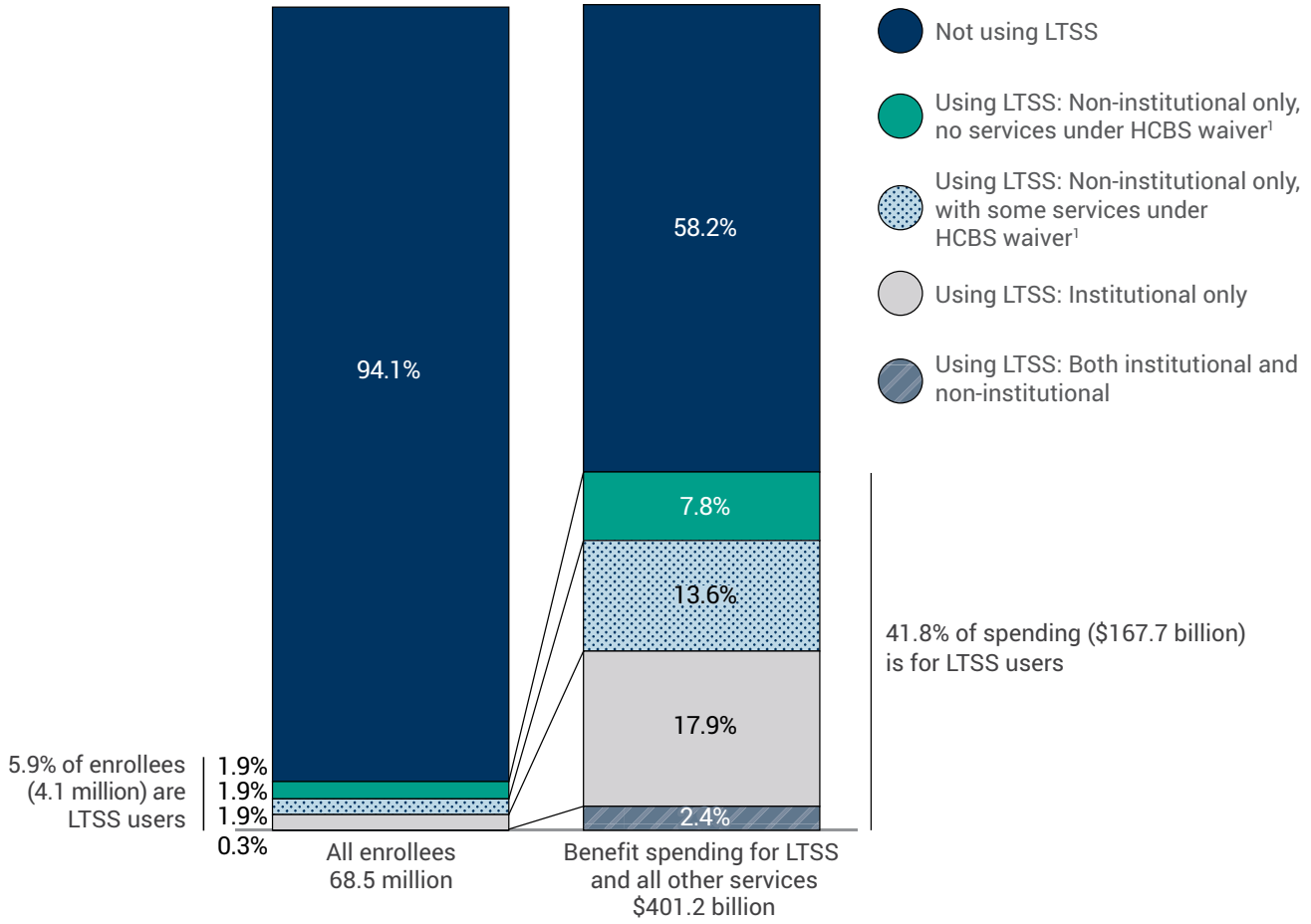


Notes: FY is fiscal year. LTSS is long-term services and supports. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 746,000 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 prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.

* Values less than $1 are not shown.

Sources: MACPAC, 2016, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2013



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 spending on 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, 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 prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

LTSS users are defined here as enrollees having at least one LTSS claim 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. Excludes Idaho, Louisiana, and Rhode Island due to data reliability concerns regarding completeness of monthly claims and enrollment data.

[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, 2016, analysis of MSIS data as of December 2015 and CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2013 (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	$401,238	19.0%	15.5%	42.4%	23.1%	$143,337	60.5%	$137,292	60.8%	$6,044	53.7%
Alabama	4,568	23.7	9.9	41.9	24.6	1,651	67.1	1,414	69.2	237	54.7
Alaska	1,335	27.4	16.3	36.1	20.1	399	57.2	398	57.2	1	69.3
Arizona	7,586	24.0	28.5	33.7	13.7	1,611	57.3	1,553	57.1	57	62.4
Arkansas	4,141	25.0	4.9	47.4	22.7	1,494	60.9	1,346	63.4	148	38.0
California	57,297	18.1	17.7	40.3	23.9	17,994	67.4	17,525	67.4	469	68.8
Colorado	4,898	21.4	15.0	42.5	21.1	1,585	61.3	1,544	61.7	41	46.5
Connecticut	6,452	15.6	24.0	31.3	29.0	2,985	59.2	2,810	58.8	175	65.1
Delaware	1,552	19.1	31.5	32.0	17.4	465	56.0	431	56.8	34	46.0
District of Columbia	2,232	11.2	20.9	47.9	20.0	610	61.3	609	61.3	1	36.2
Florida	17,232	19.0	14.0	40.9	26.1	6,706	63.0	5,867	64.4	839	53.2
Georgia	8,530	24.1	13.0	41.4	21.5	2,634	67.2	2,372	68.9	262	51.8
Hawaii	1,524	14.1	22.0	35.3	28.6	578	71.8	568	72.0	10	62.8
Idaho	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Illinois	15,211	24.1	17.6	38.0	20.4	4,725	57.8	4,637	58.0	88	49.5
Indiana	7,630	16.8	12.4	46.0	24.9	3,145	57.8	2,947	59.3	198	35.7
Iowa	3,649	17.3	10.6	49.3	22.7	1,682	48.9	1,643	48.7	39	56.6
Kansas	2,441	22.9	7.8	46.6	22.8	945	55.5	893	56.6	52	37.4
Kentucky	5,606	22.9	11.0	47.3	18.8	1,678	60.6	1,517	62.3	161	45.4
Louisiana	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
Maine	2,850	14.2	16.1	44.8	24.8	1,264	55.3	1,149	54.0	115	67.5
Maryland	7,647	19.2	20.3	41.0	19.5	2,323	59.4	2,188	60.1	135	49.0
Massachusetts	12,338	12.1	13.8	47.0	27.2	5,463	57.6	5,421	57.3	42	94.9
Michigan	11,998	18.6	16.1	45.8	19.5	3,804	58.8	3,699	59.1	105	48.0
Minnesota	8,873	15.9	22.3	41.6	20.2	3,428	50.1	3,400	50.1	27	51.0
Mississippi	4,518	20.3	9.9	45.5	24.4	1,711	64.0	1,504	66.7	207	44.2
Missouri	8,248	23.6	9.2	49.3	17.9	2,695	49.7	2,637	49.8	58	46.6
Montana	989	25.2	10.7	39.0	25.1	387	64.0	363	65.1	24	47.1
Nebraska	1,788	18.6	10.6	46.2	24.6	787	51.3	778	51.3	9	52.5
Nevada	1,742	29.6	12.9	42.7	14.8	384	60.3	329	62.1	54	50.0
New Hampshire	1,162	23.5	6.1	38.0	32.4	607	59.0	585	59.7	22	40.5
New Jersey	9,266	16.2	8.3	46.3	29.3	4,472	57.0	4,429	56.9	43	66.1

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	$3,270	39.4%	25.3%	31.7%	3.5%	$350	31.1%	$300	27.2%	$49	54.7%
New York	50,354	10.6	21.6	38.9	28.9	21,470	63.3	21,169	63.2	301	70.7
North Carolina	11,298	23.1	13.6	45.6	17.8	3,499	56.7	3,361	57.1	138	47.5
North Dakota	783	16.7	8.4	43.2	31.6	429	56.9	424	57.0	5	46.1
Ohio	16,154	15.0	17.1	44.8	23.0	5,899	56.9	5,627	57.8	272	38.1
Oklahoma	4,754	28.8	15.6	38.9	16.7	1,380	53.7	1,348	53.8	33	51.3
Oregon	4,782	16.9	22.7	37.8	22.6	1,637	63.8	1,551	64.9	86	44.3
Pennsylvania	20,245	16.1	6.7	52.9	24.3	7,719	61.5	7,588	61.6	131	54.8
Rhode Island	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]	[3]
South Carolina	4,449	23.0	15.8	41.4	19.7	1,500	58.5	1,470	58.5	29	56.0
South Dakota	765	23.4	11.7	44.2	20.8	284	54.9	265	55.6	20	44.9
Tennessee	7,617	23.2	14.4	39.5	22.9	2,885	59.1	2,684	60.1	201	45.2
Texas	24,417	30.2	6.9	43.4	19.6	7,330	63.5	6,596	63.6	733	62.6
Utah	2,101	28.8	17.1	43.8	10.2	559	36.8	551	36.7	8	40.3
Vermont	1,431	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Virginia	7,105	21.1	11.4	45.7	21.8	2,575	54.4	2,446	55.0	129	41.7
Washington	7,805	22.2	15.0	44.0	18.8	2,338	61.2	2,215	62.2	123	41.8
West Virginia	2,949	16.8	9.6	50.1	23.6	1,120	61.1	1,054	62.1	66	46.4
Wisconsin	7,105	11.9	15.7	43.7	28.8	3,522	56.3	3,484	56.3	39	57.6
Wyoming	554	20.4	8.8	45.3	25.6	277	50.7	257	51.3	19	41.4

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 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 prior to the December 2015 data book. 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 746,000 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] States were excluded due to data reliability concerns regarding completeness of monthly claims and enrollment data.

[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, 2016, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data as of June 2016.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2013

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	**$7,067**	**$7,766**	**$2,866**	**$2,884**	**$4,197**	**$5,138**	**$18,145**	**$20,091**	**$15,557**	**$19,912**
Alabama	**4,717**	**5,598**	2,252	2,252	2,731	5,077	9,001	11,092	10,173	21,493
Alaska	**12,061**	**12,102**	5,957	5,957	8,879	8,869	30,736	31,013	29,998	31,101
Arizona	**5,582**	**5,821**	2,810	2,844	4,894	5,337	15,920	16,495	9,666	12,321
Arkansas	**6,890**	**8,206**	3,338	3,374	2,472	6,076	13,599	16,603	14,555	23,224
California	**6,156**	**7,893**	3,107	3,240	2,594	4,474	22,581	22,541	13,199	13,284
Colorado[2]	**6,819**	**6,922**	2,574	2,558	5,072	4,823	18,778	20,628	18,399	23,590
Connecticut	**8,830**	**9,671**	3,463	3,465	6,036	6,075	26,992	35,009	17,353	37,286
Delaware	**7,272**	**8,110**	3,476	3,500	5,547	6,206	19,352	25,982	18,766	38,639
District of Columbia[3]	**10,366**	**10,338**	3,373	3,373	5,466	5,382	29,100	29,127	23,326	23,401
Florida	**5,090**	**5,420**	1,899	1,880	4,155	3,978	12,038	15,048	9,120	14,733
Georgia[2]	**5,355**	**5,819**	2,301	2,300	5,000	5,633	11,530	13,929	10,713	19,895
Hawaii	**6,046**	**6,097**	2,017	2,015	4,066	4,058	13,961	14,403	17,696	19,529
Idaho	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Illinois	**5,683**	**5,854**	2,595	2,595	3,582	3,794	19,133	20,049	14,305	15,856
Indiana	**7,409**	**7,743**	2,270	2,270	5,128	5,361	17,836	20,940	22,231	29,935
Iowa	**7,078**	**7,647**	2,674	2,679	2,471	2,405	21,626	23,183	21,130	28,469
Kansas	**6,944**	**7,249**	2,671	2,669	5,004	4,771	15,782	18,719	16,956	23,750
Kentucky	**7,279**	**7,848**	3,422	3,416	6,835	6,749	12,236	14,527	11,953	19,362
Louisiana	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
Maine[2]	**8,856**	**9,754**	3,538	3,542	5,392	5,422	19,495	22,395	12,556	24,275
Maryland	**7,937**	**8,195**	3,278	3,266	5,094	4,851	22,912	26,128	20,151	29,613
Massachusetts[3]	**9,541**	**10,161**	4,054	4,162	4,244	4,641	16,170	16,221	20,203	23,818
Michigan	**6,394**	**6,729**	2,301	2,315	4,615	5,375	15,482	16,252	17,646	20,479
Minnesota	**9,843**	**10,181**	3,688	3,698	6,304	6,613	28,119	29,394	24,389	27,414
Mississippi	**6,904**	**7,624**	2,792	2,791	5,305	5,864	12,902	15,904	13,238	22,685

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	**$8,993**	**$9,844**	$4,056	$4,057	$4,310	$6,303	$22,183	$23,268	$19,046	$21,326
Montana	**8,712**	**9,309**	3,811	3,811	7,139	8,031	17,630	20,683	21,624	33,225
Nebraska	**8,415**	**8,553**	2,688	2,688	6,443	6,434	21,633	22,598	20,859	23,663
Nevada	**5,471**	**5,673**	2,701	2,685	4,356	4,089	15,979	20,184	8,753	14,971
New Hampshire	**8,560**	**9,163**	3,458	3,458	4,894	4,896	15,604	19,755	26,629	39,061
New Jersey	**9,394**	**9,561**	2,769	2,768	6,314	6,064	23,704	24,726	19,019	21,439
New Mexico	**5,781**	**6,453**	4,196	4,194	5,531	7,503	15,381	18,636	2,821	3,798
New York	**9,845**	**10,208**	2,943	2,964	5,412	5,463	29,115	30,495	23,594	27,536
North Carolina	**6,864**	**7,322**	2,893	2,891	6,126	7,631	15,867	17,404	11,853	15,128
North Dakota	**12,053**	**12,544**	3,662	3,662	6,303	6,298	31,115	34,815	31,199	39,329
Ohio	**7,307**	**8,175**	2,483	2,488	4,010	4,989	19,415	23,046	21,856	30,057
Oklahoma	**6,377**	**6,953**	3,385	3,385	4,509	6,100	15,796	17,128	13,360	16,099
Oregon	**7,649**	**8,340**	2,747	2,793	6,505	7,039	17,429	21,218	17,991	27,696
Pennsylvania	**9,377**	**10,128**	3,563	3,561	3,603	4,560	16,591	17,337	21,911	26,665
Rhode Island	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]	[4]
South Carolina	**4,803**	**5,267**	2,094	2,095	3,499	5,121	11,740	12,406	11,127	13,054
South Dakota	**7,117**	**7,445**	2,831	2,831	6,198	6,124	18,024	21,554	14,191	20,838
Tennessee	**5,771**	**6,180**	2,594	2,594	4,411	4,413	11,776	14,620	13,078	23,318
Texas	**5,982**	**6,307**	2,846	2,835	4,306	5,381	15,820	18,117	11,045	15,884
Utah	**7,356**	**7,365**	3,573	3,566	6,227	5,903	21,796	22,904	13,382	15,346
Vermont	**8,427**	[5]	[5]	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Virginia	**7,603**	**8,319**	3,021	3,019	4,970	6,316	18,762	22,254	15,115	20,760
Washington	**6,679**	**6,989**	2,554	2,539	6,000	6,884	17,010	19,124	15,688	19,816
West Virginia	**8,332**	**8,957**	2,972	2,972	7,143	7,140	13,423	15,467	18,278	29,247
Wisconsin	**6,775**	**7,423**	2,041	2,078	3,214	3,742	18,821	19,622	16,393	18,208
Wyoming	**8,142**	**8,489**	2,550	2,567	6,134	6,548	23,675	27,442	26,898	42,921

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 a disability are included in the disabled category. About 746,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged. Benefit spending from Medicaid Statistical Information System (MSIS) data has been adjusted to reflect CMS-64 totals. Due to changes in both methods and data, figures shown here are not directly comparable to earlier years. With regard to methods, spending totals now exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority, which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

[1] In this table, full-benefit enrollees excludes those reported by states in 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 data anomalies in the submission of 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.

[3] When compared to the December 2015 edition of this table, District of Columbia and Massachusetts had a change in total FYE enrollees of 10 percent or more over the prior year. However, both states have since updated their 2012 enrollment total and no longer has a change of 10 percent or more.

[4] States were excluded due to data reliability concerns regarding completeness of monthly claims and enrollment data.

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

Source: MACPAC, 2016, analysis of MSIS data as of December 2015 and CMS-64 Financial Management Report net expenditure data as of June 2016.

EXHIBIT 23. Medicaid Supplemental Payments to Hospital Providers by State, FY 2015 (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	**$97,278.9**	**$15,663.2**	**$20,249.9**	**$11,931.6**	**49.2%**
Alabama	**1,991.8**	482.9	579.4	–	53.3
Alaska	**317.0**	9.0	–	–	2.8
Arizona[3]	**1,142.6**	142.6	156.3	155.7	39.8
Arkansas	**1,021.0**	64.0	318.5	–	37.5
California[3, 4]	**20,768.1**	2,390.1	7,650.4	2,299.7	59.4
Colorado	**2,418.6**	196.5	1,011.6	–	50.0
Connecticut	**1,865.2**	23.5	86.4	–	5.9
Delaware	**66.1**	8.4	–	–	12.7
District of Columbia	**332.0**	30.6	16.1	–	14.1
Florida[3]	**3,617.1**	239.7	79.9	1,872.6	60.6
Georgia	**2,227.9**	435.0	233.1	–	30.0
Hawaii[3]	**114.0**	–	0.8	94.1	83.3
Idaho	**393.7**	24.2	9.1	–	8.4
Illinois	**5,154.8**	359.5	1,596.5	–	37.9
Indiana	**1,220.9**	232.1	18.4	–	20.5
Iowa	**949.1**	47.1	30.9	–	8.2
Kansas[3]	**148.1**	52.9	2.2	72.8	86.4
Kentucky	**388.1**	188.9	19.2	–	53.6
Louisiana	**1,891.4**	1,203.5	240.8	–	76.4
Maine	**563.2**	–	12.5	–	2.2
Maryland	**1,107.4**	52.0	36.6	–	8.0
Massachusetts[3, 5]	**2,024.8**	–	309.7	45.0	17.5
Michigan	**1,751.8**	336.5	753.8	–	62.2
Minnesota[5]	**649.5**	32.0	12.0	71.6	17.8
Mississippi	**1,684.0**	224.5	533.1	–	45.0
Missouri	**3,094.6**	473.6	132.9	–	19.6
Montana	**318.8**	18.6	47.9	–	20.9
Nebraska	**141.6**	37.0	–	–	26.1
Nevada	**573.4**	78.0	156.8	–	40.9
New Hampshire	**137.8**	68.3	6.8	–	54.5
New Jersey[4, 5]	**1,818.1**	731.8	–	273.4	55.3
New Mexico	**368.5**	22.7	105.4	–	34.8
New York[4, 5]	**10,680.8**	2,820.3	1,082.9	827.3	44.3
North Carolina	**4,663.3**	371.0	2,375.1	–	58.9
North Dakota	**78.8**	0.4	0.1	–	0.6
Ohio	**2,300.5**	593.5	597.5	–	51.8

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	**$1,751.4**	$40.2	$848.4	–	50.7%
Oregon	**481.1**	40.8	153.3	–	40.3
Pennsylvania	**1,431.2**	519.2	339.5	–	60.0
Rhode Island	**356.0**	140.5	11.4	–	42.7
South Carolina	**1,078.6**	435.5	179.4	–	57.0
South Dakota	**205.8**	0.8	2.8	–	1.8
Tennessee[3, 5]	**841.4**	81.7	–	$737.7	97.4
Texas[3, 4]	**9,374.7**	2,026.5	31.1	5,481.6	80.4
Utah	**288.3**	24.5	54.7	–	27.5
Vermont	**45.1**	37.4	–	–	83.1
Virginia	**853.2**	9.1	172.7	–	21.3
Washington	**954.1**	230.4	–	–	24.1
West Virginia	**732.0**	53.7	167.1	–	30.2
Wisconsin	**775.1**	31.4	57.6	–	11.5
Wyoming	**126.5**	0.5	18.9	–	15.3

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. The Centers for Medicare & Medicaid Services 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 May 24, 2016. California's first, second, third, and fourth quarter submissions are not certified; Colorado and North Dakota's second, third, and fourth quarter submissions are not certified; New Jersey's third and fourth quarter submissions are not certified. Figures presented in this exhibit 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, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016 and CMS-64 Schedule C waiver report data as of August 2, 2016.

EXHIBIT 24. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2015 (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	**$5,166.2**	**$3,015.5**	**58.4%**	**$54,382.0**	**$2,802.5**	**5.2%**	**$13,072.8**	**$988.8**	**7.6%**
Alabama	**74.6**	–	–	**946.5**	–	–	**448.4**	–	–
Alaska	**26.5**	10.9	41.2	**171.7**	–	–	**146.4**	–	–
Arizona	**30.4**	28.5	93.7	**44.4**	5.6	12.7	**48.8**	–	–
Arkansas	**117.4**	0.8	0.7	**839.9**	–	–	**355.7**	38.0	10.7
California	**36.8**	0.0	0.1	**4,034.9**	275.6	6.8	**1,060.3**	108.3	10.2
Colorado	**7.2**	–	–	**733.9**	97.8	13.3	**673.1**	4.9	0.7
Connecticut	**195.8**	105.6	53.9	**1,543.5**	–	–	**586.2**	–	–
Delaware	**6.1**	6.0	99.0	**29.6**	–	–	**15.4**	–	–
District of Columbia	**29.6**	6.3	21.3	**324.3**	–	–	**41.5**	–	–
Florida[5]	**151.2**	119.1	78.8	**818.5**	–	–	**561.6**	204.5	36.4
Georgia	**30.6**	–	–	**1,340.0**	97.3	7.3	**402.1**	35.7	8.9
Hawaii	**–**	–	–	**9.2**	–	–	**2.4**	–	–
Idaho	**1.7**	–	–	**315.6**	101.7	32.2	**140.5**	–	–
Illinois	**181.7**	82.7	45.5	**2,163.0**	–	–	**691.5**	–	–
Indiana	**49.1**	–	–	**2,263.3**	641.0	28.3	**207.6**	25.7	12.4
Iowa[5, 6]	**13.6**	–	–	**916.2**	0.0	0.0	**249.9**	0.0	0.0
Kansas	**26.1**	26.0	99.8	**54.7**	–	–	**14.5**	10.5	72.1
Kentucky	**44.4**	37.7	84.8	**1,114.8**	0.6	0.0	**35.3**	3.7	10.5
Louisiana	**129.6**	125.6	96.9	**1,345.7**	–	–	**182.4**	20.5	11.3
Maine	**93.2**	42.1	45.1	**356.7**	–	–	**121.4**	2.6	2.1
Maryland	**158.7**	56.0	35.3	**1,194.0**	5.1	0.4	**138.4**	–	–
Massachusetts[7]	**129.1**	96.4	74.7	**1,531.7**	–	–	**429.0**	28.0	6.5
Michigan	**29.8**	0.1	0.3	**1,786.5**	342.4	19.2	**469.2**	134.3	28.6
Minnesota	**130.5**	25.1	19.2	**900.9**	–	–	**369.7**	11.0	3.0
Mississippi	**74.4**	–	–	**1,024.9**	19.5	1.9	**173.5**	–	–
Missouri	**230.3**	207.2	90.0	**1,164.8**	–	–	**38.9**	–	–
Montana	**23.4**	–	–	**174.6**	15.5	8.9	**80.5**	–	–
Nebraska	**2.9**	1.4	49.3	**412.7**	–	–	**23.0**	–	–
Nevada	**56.2**	–	–	**232.2**	84.6	36.4	**168.3**	3.7	2.2
New Hampshire	**48.1**	40.4	83.9	**350.7**	–	–	**19.4**	–	–

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	**$463.2**	$357.4	77.2%	**$2,170.4**	–	–	**$57.3**	–	–
New Mexico	**1.7**	–	–	**27.1**	–	–	**75.2**	$6.6	8.8%
New York	**941.4**	610.8	64.9	**6,841.8**	$71.7	1.0%	**783.1**	30.6	3.9
North Carolina	**160.6**	160.3	99.8	**1,185.6**	–	–	**1,017.6**	43.9	4.3
North Dakota	**7.9**	0.5	6.3	**161.0**	0.8	0.5	**31.0**	–	–
Ohio	**93.4**	93.4	100.0	**2,462.0**	–	–	**302.3**	–	–
Oklahoma	**94.6**	3.3	3.5	**674.6**	–	–	**511.4**	–	–
Oregon	**29.0**	19.9	68.7	**385.6**	–	–	**56.4**	–	–
Pennsylvania	**310.3**	231.8	74.7	**4,486.8**	714.1	15.9	**86.8**	–	–
Rhode Island	**4.5**	–	–	**176.8**	–	–	**11.1**	–	–
South Carolina	**76.5**	52.3	68.4	**719.1**	19.8	2.8	**148.4**	35.9	24.2
South Dakota	**3.6**	0.8	21.1	**168.3**	2.7	1.6	**64.2**	–	–
Tennessee	**51.0**	–	–	**221.0**	–	–	**37.0**	–	–
Texas[5]	**321.7**	303.5	94.3	**2,671.6**	200.9	7.5	**1,142.4**	98.9	8.7
Utah	**15.8**	0.9	5.9	**258.6**	22.2	8.6	**85.2**	19.8	23.3
Vermont	**0.0**	–	–	**119.6**	–	–	**2.1**	–	–
Virginia	**164.2**	11.6	7.0	**1,077.0**	11.1	1.0	**191.7**	32.5	16.9
Washington	**162.6**	132.2	81.3	**767.5**	–	–	**171.5**	54.4	31.7
West Virginia	**105.8**	18.9	17.8	**674.2**	–	–	**258.5**	34.7	13.4
Wisconsin	**16.0**	–	–	**870.8**	41.9	4.8	**86.2**	–	–
Wyoming	**13.1**	–	–	**123.3**	30.6	24.8	**58.4**	–	–

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 May 24, 2016. California's first, second, third, and fourth quarter submissions are not certified; Colorado and North Dakota's second, third, and fourth quarter submissions are not certified; New Jersey's third and fourth quarter submissions are not certified. Figures presented in this exhibit 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 disproportionate share hospital (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 ICF/IDs. 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 payments to physicians and other practitioners through an uncompensated care pool 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 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.

Source: MACPAC, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016 and CMS-64 Schedule C waiver report data as of August 2, 2016.

EXHIBIT 25. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2015 (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[4]	$53,036.3	76.9%	23.1%	0.1%	$23,961.7	80.2%	19.8%	0.1%	$29,074.6	74.1%	25.8%	0.1%
Alabama	605.7	75.3	24.6	0.1	605.7	75.3	24.6	0.1	–	–	–	–
Alaska	67.4	66.1	33.5	0.3	67.4	66.1	33.5	0.3	–	–	–	–
Arizona	909.0	68.9	30.9	0.2	9.9	86.9	12.5	0.6	899.1	68.7	31.1	0.2
Arkansas	358.8	71.1	28.8	0.1	358.8	71.1	28.8	0.1	–	–	–	–
California	6,404.1	78.6	21.3	0.0	4,056.8	86.0	14.0	0.0	2,347.3	65.9	34.0	0.0
Colorado	674.8	72.9	26.8	0.2	674.8	72.9	26.8	0.2	–	–	–	–
Connecticut	1,116.6	82.3	17.7	0.0	1,116.6	82.3	17.7	0.0	–	–	–	–
Delaware	202.9	81.7	18.3	0.0	49.5	79.9	20.1	0.0	153.4	82.3	17.7	0.0
District of Columbia	130.6	77.0	22.9	0.0	72.1	84.7	15.3	0.0	58.5	67.6	32.4	0.0
Florida	2,615.5	80.0	19.9	0.0	563.5	84.2	15.7	0.2	2,051.9	78.9	21.1	0.0
Georgia	1,054.7	75.0	25.0	0.0	651.3	82.0	18.0	–	403.5	63.7	36.3	0.0
Hawaii[5]	881.8	60.0	39.9	0.1	0.2	74.6	25.4	–	881.6	60.0	39.9	0.1
Idaho	171.1	78.2	21.8	0.0	171.1	78.2	21.8	0.0	–	–	–	–
Illinois	1,188.3	73.4	26.6	0.0	671.0	72.6	27.4	0.0	517.4	74.6	25.4	0.0
Indiana	1,097.5	77.6	22.3	0.1	829.3	78.6	21.3	0.2	268.2	74.4	25.6	0.1
Iowa	432.6	76.5	23.5	0.0	431.6	76.4	23.6	0.0	1.0	96.3	3.7	–
Kansas	289.6	75.4	24.6	0.0	0.4	80.1	19.9	0.0	289.2	75.4	24.6	0.0
Kentucky	1,042.0	68.5	31.4	0.1	63.8	76.0	23.6	0.4	978.2	68.0	31.9	0.0
Louisiana	703.1	70.3	29.7	0.0	226.9	72.7	27.3	0.0	476.2	69.1	30.9	0.0
Maine	227.5	82.1	17.9	0.0	227.5	82.1	17.9	0.0	–	–	–	–
Maryland	993.1	83.6	16.4	0.0	502.5	87.7	12.3	0.0	490.6	79.4	20.6	0.0
Massachusetts	1,113.6	75.4	24.5	0.1	524.9	74.8	25.0	0.1	588.7	75.9	23.9	0.1
Michigan	1,552.2	74.7	25.2	0.0	894.8	78.8	21.2	0.0	657.4	69.2	30.7	0.1
Minnesota	864.5	72.2	27.7	0.0	224.5	73.2	26.8	0.0	640.0	71.9	28.1	0.0
Mississippi	507.6	69.5	30.5	0.0	203.9	71.7	28.3	0.0	303.6	68.1	31.9	0.0
Missouri	1,199.0	72.3	27.7	0.1	1,199.0	72.3	27.7	0.1	–	–	–	–
Montana	97.8	80.2	19.8	0.0	97.8	80.2	19.8	0.0	–	–	–	–
Nebraska	168.5	74.9	25.1	0.0	162.6	74.5	25.5	0.0	5.9	85.7	14.2	0.0

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	$333.6	77.3%	22.7%	0.1%	$212.3	81.6%	18.3%	0.0%	$121.3	69.6%	30.2%	0.1%
New Hampshire	105.8	75.5	24.5	0.0	7.5	78.9	21.0	0.2	98.3	75.3	24.7	0.0
New Jersey	1,352.6	76.3	23.7	0.0	47.6	79.0	21.0	0.0	1,305.0	76.2	23.8	0.0
New Mexico	261.6	71.1	28.9	0.0	5.4	65.9	34.1	0.0	256.2	71.2	28.8	0.0
New York	5,306.6	79.8	20.2	0.0	678.9	82.5	17.5	0.0	4,627.7	79.4	20.6	0.0
North Carolina	1,656.1	80.8	19.2	0.0	1,656.1	80.8	19.2	0.0	–	–	–	–
North Dakota	53.4	73.8	26.1	0.1	31.2	70.2	29.8	0.0	22.2	78.8	20.9	0.3
Ohio	2,418.4	73.5	26.3	0.2	375.5	77.8	21.8	0.4	2,042.9	72.7	27.1	0.2
Oklahoma	465.3	76.1	23.9	0.0	465.3	76.1	23.9	0.0	–	–	–	–
Oregon	589.5	74.4	25.6	0.0	152.8	70.1	29.9	0.0	436.7	75.9	24.1	0.0
Pennsylvania	2,120.7	76.8	23.1	0.1	67.2	75.8	24.2	0.0	2,053.5	76.8	23.1	0.1
Rhode Island	4.0	92.3	7.7	–	4.0	92.3	7.7	–	–	–	–	–
South Carolina	475.8	72.0	28.0	0.0	92.5	79.2	20.8	0.1	383.3	70.2	29.7	0.0
South Dakota	81.2	68.1	31.9	0.0	81.2	68.1	31.9	0.0	–	–	–	–
Tennessee	931.3	79.4	20.5	0.1	876.7	78.5	21.5	0.0	54.6	93.9	5.1	1.0
Texas	3,155.1	79.9	20.1	0.0	679.5	83.8	16.2	0.0	2,475.7	78.8	21.2	0.0
Utah	180.0	74.5	25.5	–	112.6	75.9	24.1	–	67.4	72.0	28.0	–
Vermont	158.8	74.6	25.4	0.0	158.8	74.6	25.4	0.0	–	–	–	–
Virginia	900.0	58.1	40.6	1.3	100.4	73.4	26.0	0.6	799.6	56.2	42.5	1.3
Washington	794.4	76.3	23.6	0.1	128.9	78.3	21.6	0.1	665.5	75.9	24.0	0.0
West Virginia	528.8	76.7	23.2	0.1	433.4	77.4	22.6	0.1	95.5	73.8	26.2	0.0
Wisconsin	978.3	78.2	21.8	0.0	977.0	78.2	21.8	0.0	1.3	71.0	29.0	0.0
Wyoming	34.2	78.5	21.4	0.1	34.2	78.5	21.4	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 the Centers for Medicare & Medicaid Services (CMS) for rebate purposes, and are different from the CMS-64 Financial Management Report 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.

EXHIBIT 25. (continued)

Brand and generic status was assigned using the drug category indicator from the drug product file. The state drug utilization data are available at https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html and the drug product data are available at https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/data/index.html. Beginning in October 2016, CMS, as obligated by the Privacy Act of 1974 (5 U.S.C. § 552a) and the Health Insurance Portability and Accountability Act privacy rule (45 CFR Parts 160 and 164), has suppressed all records in the state drug utilization data that are less than 11 counts. 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] The national total does not equal the sum of the states due to the suppression of records (as described in the Notes above). Records for drugs that were suppressed at the state level were not necessarily suppressed once the individual state data were rolled up into the national summary file. While we do not know how much spending has been suppressed in the national summary file, comparison of the updated FY 2014 files with data suppression to last year's MACStats indicate that about $370 million dollars (0.9 percent) have been suppressed in the FY 2014 data.

[5] Hawaii's managed care spending more than doubled from FY 2014 while prescription volume remained about the same.

Source: MACPAC, 2016, analysis of Medicaid drug product data and state drug rebate utilization data as of October 2016.

EXHIBIT 26. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2015 (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[4]	**672,756**	**18.1%**	**81.5%**	**0.4%**	**244,524**	**21.2%**	**78.4%**	**0.4%**	**428,232**	**16.3%**	**83.3%**	**0.4%**
Alabama	7,477	22.1	77.8	0.2	7,477	22.1	77.8	0.2	–	–	–	–
Alaska	871	20.3	79.5	0.2	871	20.3	79.5	0.2	–	–	–	–
Arizona	16,697	13.8	85.7	0.5	89	17.7	81.4	0.9	16,609	13.7	85.7	0.5
Arkansas	4,962	19.8	80.0	0.2	4,962	19.8	80.0	0.2	–	–	–	–
California	79,445	17.0	82.7	0.3	26,532	26.0	73.8	0.2	52,913	12.5	87.2	0.3
Colorado	7,641	18.7	81.2	0.2	7,641	18.7	81.2	0.2	–	–	–	–
Connecticut	9,099	25.3	74.6	0.2	9,099	25.3	74.6	0.2	–	–	–	–
Delaware	2,464	21.5	78.3	0.1	642	21.7	78.3	0.0	1,822	21.5	78.4	0.2
District of Columbia	2,120	17.1	82.9	0.0	829	20.3	79.7	0.0	1,291	15.0	85.0	0.1
Florida	29,897	19.6	80.3	0.1	3,834	26.2	73.5	0.3	26,063	18.7	81.3	0.1
Georgia	17,032	17.5	82.5	0.0	7,661	18.8	81.2	–	9,372	16.4	83.6	0.0
Hawaii	2,601	14.2	84.0	1.9	5	4.0	96.0	–	2,596	14.2	84.0	1.9
Idaho	2,150	20.7	79.2	0.1	2,150	20.7	79.2	0.1	–	–	–	–
Illinois	19,792	16.7	83.3	0.0	10,541	17.5	82.5	0.0	9,251	15.7	84.3	0.0
Indiana	12,543	20.3	79.5	0.2	8,863	21.7	78.1	0.3	3,680	17.1	82.8	0.2
Iowa	6,738	19.7	80.3	0.0	6,680	19.6	80.4	0.0	58	29.8	70.2	–
Kansas	3,722	20.9	79.0	0.1	6	18.0	81.4	0.6	3,716	20.9	79.0	0.1
Kentucky	20,951	14.6	84.9	0.5	1,190	13.5	82.8	3.7	19,761	14.7	85.0	0.3
Louisiana	11,245	18.9	81.0	0.1	3,049	23.0	77.0	0.0	8,197	17.4	82.5	0.1
Maine	2,673	24.7	75.2	0.0	2,673	24.7	75.2	0.0	–	–	–	–
Maryland	13,817	18.3	81.7	0.0	4,256	24.6	75.4	0.0	9,561	15.4	84.5	0.0
Massachusetts	14,380	16.6	81.9	1.5	7,009	15.5	82.2	2.3	7,371	17.6	81.6	0.8
Michigan	27,100	15.5	84.1	0.4	8,988	20.2	79.5	0.2	18,111	13.1	86.4	0.5
Minnesota	11,803	16.1	83.7	0.2	2,714	18.2	81.7	0.2	9,089	15.5	84.3	0.2
Mississippi	6,097	20.7	79.3	0.0	2,293	25.5	74.5	0.0	3,804	17.8	82.2	0.0
Missouri	12,327	20.9	78.8	0.3	12,327	20.9	78.8	0.3	–	–	–	–
Montana	1,138	21.9	78.0	0.1	1,138	21.9	78.0	0.1	–	–	–	–
Nebraska	2,505	18.2	81.7	0.2	2,419	17.8	82.1	0.2	85	30.0	69.9	0.2
Nevada	5,041	15.3	84.3	0.5	2,396	18.5	81.2	0.3	2,645	12.4	87.1	0.6
New Hampshire	1,652	20.1	79.6	0.3	194	17.2	81.5	1.3	1,458	20.5	79.3	0.2
New Jersey	19,732	16.4	83.6	0.0	734	18.2	81.8	0.0	18,998	16.3	83.6	0.0
New Mexico	5,147	15.2	84.8	0.0	118	18.0	81.8	0.2	5,029	15.1	84.8	0.0
New York	70,760	16.7	83.3	0.0	10,117	15.5	84.4	0.1	60,643	16.9	83.1	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	17,220	26.6%	73.3%	0.1%	17,220	26.6%	73.3%	0.1%	–	–	–	–
North Dakota	725	18.4	81.3	0.3	474	18.9	80.9	0.2	251	17.4%	81.9%	0.7%
Ohio	38,777	16.2	81.5	2.3	5,142	17.4	76.4	6.3	33,635	16.1	82.2	1.7
Oklahoma	6,023	19.8	80.2	0.0	6,023	19.8	80.2	0.0	–	–	–	–
Oregon	10,021	14.9	85.1	0.0	2,280	12.0	88.0	0.0	7,741	15.7	84.3	0.0
Pennsylvania	27,994	17.3	82.3	0.4	1,828	12.4	87.4	0.2	26,167	17.6	81.9	0.4
Rhode Island	230	16.5	83.5	–	230	16.5	83.5	–	–	–	–	–
South Carolina	7,459	17.7	82.0	0.3	1,115	21.8	77.8	0.4	6,344	17.0	82.7	0.2
South Dakota	726	24.4	75.6	0.0	726	24.4	75.6	0.0	–	–	–	–
Tennessee	13,142	19.1	80.5	0.3	12,683	18.7	81.2	0.1	459	30.2	63.1	6.7
Texas	37,073	22.9	77.1	0.0	4,886	31.5	68.5	0.0	32,187	21.6	78.4	0.0
Utah	2,783	18.6	81.4	–	1,289	19.6	80.4	–	1,494	17.7	82.3	–
Vermont	1,538	24.8	75.2	0.0	1,538	24.8	75.2	0.0	–	–	–	–
Virginia	9,917	17.5	81.1	1.4	1,945	17.7	76.8	5.5	7,972	17.5	82.1	0.4
Washington	14,776	14.1	85.5	0.5	2,224	13.5	85.5	1.0	12,552	14.2	85.5	0.4
West Virginia	9,382	17.6	82.2	0.2	7,350	17.3	82.5	0.2	2,032	18.8	81.0	0.1
Wisconsin	11,820	21.3	78.7	0.1	11,741	21.3	78.6	0.1	79	9.8	90.1	0.1
Wyoming	455	21.0	78.9	0.1	455	21.0	78.9	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 the Centers for Medicare & Medicaid Services (CMS) for rebate purposes, and are different from 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 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 using the drug category indicator from the drug product file. The state drug utilization data are available at https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html and the drug product data are available at https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/data/index.html. Beginning in October 2016, CMS, as obligated by the Privacy Act of 1974 (5 U.S.C. § 552a) and the Health Insurance Portability and Accountability Act privacy rule (45 CFR Parts 160 and 164), suppressed all records in the state drug utilization data that are less than 11 counts. 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] The national total does not equal the sum of the states due to the suppression of records (as described in the Notes above). Records for drugs that were suppressed at the state level were not necessarily suppressed once the individual state data were rolled up into the national summary file. While we do not know how many prescriptions has been suppressed in the national summary file, comparison of the updated FY 2014 files with data suppression to last year's MACStats indicate that about 4 million prescriptions (0.7 percent) have been suppressed in the FY 2014 data.

Source: MACPAC, 2016, analysis of Medicaid drug product data and state drug rebate utilization data as of October 2016.

EXHIBIT 27. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2015 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total[1]	**$53,036.3**	**$23,961.7**	**$29,074.6**	**-$24,012.8**	**-$12,135.5**	**-$11,877.3**
Alabama	**605.7**	605.7	–	**-330.8**	-330.8	–
Alaska	**67.4**	67.4	–	**-37.8**	-37.8	–
Arizona	**909.0**	9.9	899.1	**-395.3**	-8.5	-386.8
Arkansas	**358.8**	358.8	–	**-216.8**	-216.8	–
California	**6,404.1**	4,056.8	2,347.3	**-2,633.3**	-2,127.2	-506.1
Colorado	**674.8**	674.8	–	**-376.6**	-373.0	-3.6
Connecticut	**1,116.6**	1,116.6	–	**-583.5**	-583.5	–
Delaware[2]	**202.9**	49.5	153.4	**-129.5**	-123.1	-6.4
District of Columbia	**130.6**	72.1	58.5	**-83.7**	-45.4	-38.3
Florida	**2,615.5**	563.5	2,051.9	**-1,316.0**	-445.8	-870.2
Georgia	**1,054.7**	651.3	403.5	**-486.6**	-315.3	-171.3
Hawaii[3]	**881.8**	0.2	881.6	**-61.0**	-0.3	-60.7
Idaho	**171.1**	171.1	–	**-104.5**	-104.5	–
Illinois	**1,188.3**	671.0	517.4	**-577.7**	-408.3	-169.3
Indiana[2]	**1,097.5**	829.3	268.2	**-615.7**	-587.1	-28.6
Iowa	**432.6**	431.6	1.0	**-258.8**	-258.8	-0.0
Kansas	**289.6**	0.4	289.2	**-224.7**	-1.8	-222.9
Kentucky	**1,042.0**	63.8	978.2	**-431.1**	-45.6	-385.5
Louisiana	**703.1**	226.9	476.2	**-385.2**	-100.5	-284.7
Maine	**227.5**	227.5	–	**-141.2**	-141.2	–
Maryland	**993.1**	502.5	490.6	**-504.6**	-259.2	-245.4
Massachusetts	**1,113.6**	524.9	588.7	**-541.9**	-283.0	-258.9
Michigan	**1,552.2**	894.8	657.4	**-813.5**	-519.4	-294.1
Minnesota	**864.5**	224.5	640.0	**-436.9**	-232.1	-204.8
Mississippi[2]	**507.6**	203.9	303.6	**-237.8**	-143.3	-94.4
Missouri[4]	**1,199.0**	1,199.0	–	**-542.2**	-560.6	18.4
Montana	**97.8**	97.8	–	**-60.9**	-60.9	–

EXHIBIT 27. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Nebraska[5]	**$168.5**	$162.6	$5.9	**-$98.5**	-$98.5	–
Nevada	**333.6**	212.3	121.3	**-181.0**	-115.6	-$65.4
New Hampshire	**105.8**	7.5	98.3	**-97.2**	-18.2	-79.0
New Jersey	**1,352.6**	47.6	1,305.0	**-632.4**	-38.7	-593.7
New Mexico	**261.6**	5.4	256.2	**-200.8**	-4.8	-196.0
New York[6]	**5,306.6**	678.9	4,627.7	**-2,204.4**	306.4	-2,510.9
North Carolina	**1,656.1**	1,656.1	–	**-906.1**	-906.1	–
North Dakota[2]	**53.4**	31.2	22.2	**-13.8**	-10.3	-3.5
Ohio	**2,418.4**	375.5	2,042.9	**-1,068.0**	-323.8	-744.2
Oklahoma	**465.3**	465.3	–	**-228.9**	-228.9	–
Oregon	**589.5**	152.8	436.7	**-284.0**	-84.5	-199.5
Pennsylvania	**2,120.7**	67.2	2,053.5	**-996.0**	-57.1	-938.9
Rhode Island[7]	**4.0**	4.0	–	**-85.4**	-13.3	-72.1
South Carolina	**475.8**	92.5	383.3	**-244.7**	-59.3	-185.4
South Dakota	**81.2**	81.2	–	**-33.8**	-33.8	–
Tennessee[5]	**931.3**	876.7	54.6	**-608.5**	-608.5	–
Texas	**3,155.1**	679.5	2,475.7	**-1,870.3**	-502.3	-1,367.9
Utah	**180.0**	112.6	67.4	**-111.9**	-67.3	-44.5
Vermont	**158.8**	158.8	–	**-96.9**	-96.9	–
Virginia	**900.0**	100.4	799.6	**-322.3**	-23.9	-298.4
Washington	**794.4**	128.9	665.5	**-390.6**	-83.6	-307.0
West Virginia	**528.8**	433.4	95.5	**-305.1**	-252.4	-52.8
Wisconsin	**978.3**	977.0	1.3	**-479.4**	-475.0	-4.4
Wyoming	**34.2**	34.2	–	**-25.1**	-25.1	–

EXHIBIT 27. (continued)

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 the Centers for Medicare & Medicaid Services (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 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 level, which is not available in CMS-64 data. The state drug utilization data are available at https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html. Beginning in October 2016, CMS, as obligated by the Privacy Act of 1974 (5 U.S.C. § 552a) and the Health Insurance Portability and Accountability Act privacy rule (45 CFR Parts 160 and 164), has suppressed all records in the state drug utilization data that are less than 11 counts. 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] The national total for gross spending does not equal the sum of the states due to the suppression of records (as described in the Notes above). Records for drugs that were suppressed at the state level were not necessarily suppressed once the individual state data were rolled up into the national summary file. While we do not know how much spending has been suppressed in the national summary file, comparison of the updated FY 2014 files with data suppression to last year's MACStats indicate that about $370 million dollars (0.9 percent) have been suppressed in the FY 2014 data.

[2] State recently carved the pharmacy benefit into managed care, implemented a new managed care program, or expanded their managed care program. 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] Hawaii's managed care spending more than doubled from FY 2014 while prescription volume and rebates remained about the same.

[4] Missouri reports a positive managed care rebate amount. The state made prior period adjustments to offset the managed care drug rebates reported in FY 2014.

[5] 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.

[6] New York reports a positive fee-for-service rebate amount. The state made prior period adjustments to reclassify some fee-for-service drug rebates as managed care.

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

Source: MACPAC, 2016, analysis of Medicaid state drug rebate utilization data as of October 2016 and CMS-64 FMR net expenditure data as of May 24, 2016.

EXHIBIT 28. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2014

State	Total Medicaid enrollees	Percentage of enrollees in managed care						
			Limited-benefit plans					
		Comprehensive managed care[1]	MLTSS	BHO (PIHP and/or PAHP)	Dental	Transportation	Other	PCCM
Total	**70,246,197**	**59.7%**	**0.3%**	**15.5%**	**9.3%**	**11.3%**	**1.7%**	**10.3%**
Alabama	1,054,941	0.0	–	–	–	–	1.9	58.8
Alaska	132,556	–	–	–	–	–	–	–
Arizona	1,548,325	85.1	–	–	–	–	–	–
Arkansas	595,807	0.0	–	–	–	86.3	–	81.7
California	11,522,853	67.8	–	0.0	7.0	–	0.0	–
Colorado	1,079,699	6.1	–	95.1	–	–	2.5	60.7
Connecticut	724,741	–	–	–	–	–	–	–
Delaware	227,554	86.2	–	–	–	–	–	–
District of Columbia	257,450	66.9	–	–	–	20.4	–	–
Florida[2]	3,531,945	75.3	2.4	0.0	0.0	–	0.0	0.0
Georgia	1,961,085	68.6	–	–	–	–	0.6	–
Hawaii	321,027	98.5	–	–	–	–	–	–
Idaho	266,172	0.3	–	96.0	99.7	98.6	–	91.5
Illinois	3,249,835	13.5	–	–	–	–	–	53.1
Indiana	1,176,447	62.7	–	–	–	–	–	3.1
Iowa	593,572	9.9	–	89.6	–	71.1	–	52.1
Kansas	399,299	89.3	–	–	–	–	–	–
Kentucky	1,209,552	89.4	–	–	–	–	–	–
Louisiana	1,305,671	32.1	–	78.7	79.2	–	–	37.0
Maine	262,334	–	–	–	–	–	–	61.5
Maryland	1,309,260	82.8	–	–	–	–	–	–
Massachusetts	1,878,120	42.8	–	16.3	–	–	–	16.3
Michigan	3,871,806	47.3	–	50.2	13.3	–	–	–
Minnesota	1,112,174	71.1	–	–	–	–	–	–
Mississippi	699,153	22.2	–	–	–	–	–	–

EXHIBIT 28. (continued)

State	Total Medicaid enrollees	Percentage of enrollees in managed care						
		Comprehensive managed care[1]	Limited-benefit plans					PCCM
			MLTSS	BHO (PIHP and/or PAHP)	Dental	Transportation	Other	
Missouri	825,974	47.1%	–	–	–	49.5%	–	–
Montana	131,923	–	–	–	–	–	–	69.0%
Nebraska	242,578	75.7	–	94.7%	–	–	–	–
Nevada	533,734	67.5	–	–	–	86.9	–	7.1
New Hampshire	142,315	85.1	–	–	–	–	–	–
New Jersey	1,542,022	85.3	–	–	–	92.0	–	–
New Mexico	727,214	79.8	–	–	–	–	–	–
New York	5,845,589	73.4	2.1%	–	–	–	–	–
North Carolina	1,717,658	0.1	–	95.1	–	–	–	81.6
North Dakota	79,031	14.9	–	–	–	–	0.3%	57.1
Ohio	2,796,017	72.5	–	–	–	–	–	–
Oklahoma	826,434	0.0	–	–	–	89.2	–	64.3
Oregon[3]	1,051,645	78.8	–	0.4	22.6%	–	–	–
Pennsylvania	2,152,846	77.7	–	91.6	–	22.1	–	–
Rhode Island	263,574	82.6	–	–	29.0	–	–	3.7
South Carolina	1,089,973	66.1	–	–	–	–	–	0.0
South Dakota	122,352	–	–	–	–	–	–	74.6
Tennessee[3]	1,288,631	100.0	–	–	59.6	–	89.3	–
Texas	4,137,121	78.1	–	10.7	65.7	41.6	–	0.3
Utah	287,754	70.0	–	98.1	46.3	81.5	–	–
Vermont[4]	188,337	42.3	–	–	–	–	–	–
Virginia	961,843	67.2	–	–	–	–	–	–
Washington	1,245,322	100.0	–	100.0	–	100.0	–	–
West Virginia	486,839	41.8	–	–	–	–	–	0.7
Wisconsin	1,199,773	55.1	3.2	0.1	–	–	0.1	–
Wyoming	68,320	0.1	–	–	–	–	–	–

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. Comprehensive managed care organizations (MCOs) cover acute, primary, and specialty medical care services; they may also cover behavioral health, long-term services and supports, and other benefits in some states.

[2] Florida reported enrollment as of August 1, 2014.

[3] Some plans that appear to be limited-benefit plans (dental, BHO, or other managed care) were classified as comprehensive managed care in the Centers for Medicare & Medicaid Services (CMS) report. The values shown here use plan-level information in the CMS report to recategorize enrollment in those limited-benefit plans as BHO, dental, or other managed care.

[4] The Department of Vermont Health Access, a state agency, acts as Vermont's single MCO entity.

Source: MACPAC, 2016, analysis of data from CMS, 2016, *Medicaid managed care enrollment and program characteristics, 2014*, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf.

EXHIBIT 29. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2013

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care														
		Comprehensive managed care[1]					Limited-benefit plans					Primary care case management				
		Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Total	70,134	53.9%	67.8%	50.9%	40.2%	18.1%	49.5%	58.8%	35.9%	53.1%	40.7%	12.7%	17.4%	9.3%	11.3%	2.5%
Alabama	1,212	2.4	–	0.0	5.6	12.4	–	–	–	–	–	46.0	69.7	13.4	44.4	1.4
Alaska	136	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Arizona	1,681	81.1	91.4	77.9	66.9	48.1	90.6	97.6	84.6	91.3	71.3	–	–	–	–	–
Arkansas	696	0.0	–	0.0	–	0.2	78.7	98.4	46.3	74.3	40.4	64.1	91.3	27.7	56.0	3.5
California	11,742	49.6	76.5	29.4	67.2	34.7	68.2	94.1	37.1	99.6	96.5	–	–	–	–	–
Colorado	896	11.6	12.7	11.2	9.1	9.8	95.4	99.5	96.2	89.7	73.2	2.9	2.7	2.3	4.1	4.4
Connecticut	858	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Delaware	260	85.9	95.0	87.8	67.6	47.8	89.4	98.9	90.2	74.2	49.5	2.1	1.7	2.5	2.6	0.5
District of Columbia	246	73.9	92.1	93.3	22.1	3.0	37.3	20.1	28.3	80.5	69.9	–	–	–	–	–
Florida	4,313	39.6	53.2	37.2	26.8	6.3	46.6	78.3	13.0	29.5	2.5	24.2	33.9	14.2	24.9	3.4
Georgia	2,013	68.3	93.9	87.3	2.8	0.0	85.2	96.9	78.6	74.4	48.2	–	–	–	–	–
Hawaii	300	98.2	99.8	99.6	96.4	88.9	2.2	2.0	0.0	8.9	1.5	–	–	–	–	–
Idaho	275	–	–	–	–	–	94.4	99.9	97.6	84.7	64.9	85.5	93.6	84.9	74.5	44.6
Illinois	3,039	11.0	9.8	14.5	11.8	4.8	4.3	5.9	4.3	0.1	0.0	61.9	76.1	64.4	29.0	5.0
Indiana	1,250	69.1	92.4	85.1	11.3	0.2	–	–	–	–	–	3.9	2.1	0.1	15.2	1.7
Iowa	634	6.7	10.5	5.7	0.3	0.3	78.9	99.2	46.8	92.6	74.1	59.7	73.8	72.0	14.4	3.5
Kansas	442	46.6	66.0	52.1	1.7	0.7	75.0	82.4	66.4	74.5	39.4	5.7	2.9	1.0	19.6	2.1
Kentucky	927	85.1	99.7	97.3	71.5	34.9	89.6	99.1	97.6	80.2	57.4	–	–	–	–	–
Louisiana	1,284	0.0	–	–	0.0	0.3	83.6	66.1	100.0	100.0	100.0	36.7	52.6	23.8	24.3	11.5
Maine	371	–	–	–	–	–	–	–	–	–	–	54.4	78.1	74.1	29.0	0.7
Maryland	1,139	81.7	97.5	86.7	59.6	2.1	–	–	–	–	–	–	–	–	–	–
Massachusetts	1,527	43.3	55.8	50.5	30.7	20.8	34.8	42.8	37.3	38.6	1.4	29.7	33.8	36.7	29.6	1.4
Michigan	2,291	73.1	87.5	70.7	58.9	11.5	93.8	98.9	85.0	95.2	85.7	–	–	–	–	–
Minnesota	1,154	76.5	87.0	80.8	40.7	59.4	–	–	–	–	–	–	–	–	–	–
Mississippi	786	25.6	10.9	69.9	42.3	1.0	87.3	99.9	82.9	78.6	54.8	–	–	–	–	–

EXHIBIT 29. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care														
		Comprehensive managed care[1]					Limited-benefit plans					Primary care case management				
		Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged	Total	Children	Adults	Disabled	Aged
Missouri	1,122	45.5%	67.7%	50.0%	2.0%	0.2%	–	–	–	–	–	–	–	–	–	–
Montana	142	–	–	–	–	–	0.6%	–	0.0%	3.6%	0.1%	73.3%	92.0%	75.8%	49.8%	1.4%
Nebraska	262	73.9	91.9	83.9	40.6	5.8	93.3	98.2%	89.6	91.2	74.7	–	–	–	–	–
Nevada	422	59.9	77.4	71.3	1.7	0.0	87.6	95.7	90.0	72.1	49.1	–	–	–	–	–
New Hampshire	166	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
New Jersey	1,190	84.2	95.0	62.9	85.5	65.5	96.8	98.7	99.4	95.1	87.8	–	–	–	–	–
New Mexico	660	66.8	84.4	58.6	43.2	2.6	67.3	84.3	38.0	68.6	53.3	–	–	–	–	–
New York	6,002	76.9	90.5	90.0	50.6	15.0	2.0	0.0	0.1	2.5	15.0	0.0	0.0	0.0	0.0	–
North Carolina	2,000	0.0	–	–	0.0	0.4	91.3	99.1	81.3	89.1	72.3	80.0	96.0	60.2	72.4	46.6
North Dakota	87	2.5	4.5	0.1	0.1	0.8	2.1	3.4	0.3	1.4	0.2	53.9	71.9	72.4	1.3	0.0
Ohio	2,645	73.0	94.1	74.2	46.4	5.6	–	–	–	–	–	–	–	–	–	–
Oklahoma	951	0.0	–	–	0.0	0.2	88.2	96.7	75.6	85.2	79.2	70.2	90.2	64.3	41.3	1.2
Oregon	760	79.9	91.4	82.6	63.9	36.3	87.6	96.0	85.7	79.0	62.3	0.4	0.4	0.1	0.6	0.7
Pennsylvania	2,567	75.3	95.5	74.3	69.6	8.1	87.7	97.8	77.7	92.8	49.6	8.1	10.5	7.6	7.5	0.4
Rhode Island	170	58.8	88.0	81.0	15.8	1.0	31.6	70.0	0.0	9.5	–	–	–	–	–	–
South Carolina	1,091	48.7	63.4	45.0	30.8	1.3	89.1	99.8	65.5	93.9	83.0	19.5	23.4	14.0	20.9	8.4
South Dakota	134	–	–	–	–	–	–	–	–	–	–	72.3	91.8	87.5	28.6	0.9
Tennessee	1,557	91.6	100.0	100.0	78.6	54.2	91.6	100.0	100.0	78.6	54.0	–	–	–	–	–
Texas	5,240	81.5	96.2	62.3	67.0	34.8	11.8	14.3	7.8	10.0	4.2	0.0	0.0	–	0.0	–
Utah	389	23.8	27.8	18.8	18.3	15.8	90.1	98.7	70.6	92.2	81.8	28.1	31.5	21.6	28.9	19.1
Vermont	206	0.1	–	–	0.1	0.5	–	–	–	–	–	67.1	86.7	77.1	37.7	3.1
Virginia	1,136	63.5	84.4	59.1	40.0	5.5	–	–	–	–	–	–	–	–	–	–
Washington	1,421	69.7	87.6	59.8	52.2	2.3	90.9	99.9	73.1	88.3	77.4	0.8	0.9	0.9	1.1	0.0
West Virginia	437	54.1	89.1	80.2	1.4	0.0	–	–	–	–	–	1.2	1.8	1.5	0.5	0.0
Wisconsin	1,254	59.1	85.4	70.7	3.8	2.4	89.0	98.0	93.7	93.3	38.6	–	–	–	–	–
Wyoming	89	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

EXHIBIT 29. (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. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. About 746,000 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 over time, figures shown here may not be 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; prior to the 2015 data book, individuals were counted as participating if at least one managed care payment was made on their behalf during the fiscal year. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification 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 on methods and data. 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 Medicaid Statistical Information System (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 and Programs of All-Inclusive Care for the Elderly.

Source: MACPAC, 2016, analysis of MSIS data as of December 2015.

EXHIBIT 30. Total Medicaid Administrative Spending by State and Category, FY 2015 (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	$231	$32	$39	$28	$10	$123	-$0
Alaska	130	8	25	9	5	84	–
Arizona	277	27	138	44	8	60	-0
Arkansas	383	85	56	19	48	175	–
California	5,631	641	1,626	166	240	2,958	–
Colorado	385	71	46	28	9	231	–
Connecticut	414	40	156	14	34	169	–
Delaware	163	34	56	5	6	62	–
District of Columbia	151	20	22	7	3	98	–
Florida	703	73	102	54	34	440	–
Georgia	580	130	164	49	8	230	-0
Hawaii	119	14	55	19	3	28	–
Idaho	105	27	21	10	5	41	–
Illinois	1,024	58	44	79	66	777	–
Indiana	472	76	28	25	18	325	–
Iowa	196	57	76	24	5	33	–
Kansas	183	28	48	15	3	88	-0
Kentucky	243	49	45	38	15	95	–
Louisiana	289	44	58	39	10	138	–
Maine	143	44	14	18	10	57	–
Maryland	471	35	89	35	62	250	–
Massachusetts	786	110	133	29	31	483	–
Michigan	694	289	52	63	47	242	–
Minnesota	590	62	97	50	7	374	–
Mississippi	177	45	12	28	9	83	-0
Missouri	350	52	65	29	10	195	-0
Montana	75	6	34	6	3	27	-0
Nebraska	127	22	40	14	9	43	–
Nevada	160	26	78	9	10	38	–

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	$124	$37	$49	$3	$4	$31	–
New Jersey	780	55	104	28	33	561	–
New Mexico	163	26	44	11	11	75	-$3
New York	1,784	196	21	140	69	1,357	–
North Carolina	665	70	339	52	25	180	–
North Dakota	16	3	1	1	0	10	–
Ohio	860	89	171	69	14	518	–
Oklahoma	245	40	10	29	34	132	–
Oregon	541	36	98	24	7	376	-0
Pennsylvania	876	107	231	48	23	468	–
Rhode Island	144	29	34	9	4	69	–
South Carolina	260	71	48	20	13	109	–
South Dakota	55	9	2	10	2	31	–
Tennessee	412	68	64	39	15	228	-1
Texas	1,456	282	599	75	43	466	-8
Utah	152	29	39	20	12	52	–
Vermont	33	8	15	8	0	1	–
Virginia	478	31	244	30	31	141	–
Washington	581	82	68	46	7	377	–
West Virginia	189	68	6	13	22	79	–
Wisconsin	319	78	44	30	9	167	-10
Wyoming	62	16	17	8	2	20	–
Subtotal (states)	**$25,451**	**$3,636**	**$5,667**	**$1,665**	**$1,110**	**$13,396**	**-$23**
American Samoa	4	–	–	3	–	1	–
Guam	3	–	–	0	0	2	–
N. Mariana Islands	1	–	–	0	–	0	–
Puerto Rico	82	2	–	25	–	55	–
Virgin Islands	8	1	0	2	–	5	–
Subtotal (states and territories)	**$25,547**	**$3,639**	**$5,668**	**$1,696**	**$1,110**	**$13,458**	**-$23**

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 (MFCU)[6]	$145	–	–	–	$145	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	326	–	–	–	326	–	–
Total	$26,019	$3,639	$5,668	$1,696	$1,581	$13,458	-$23
Percent of total, exclusive of collections	–	14.0%	21.8%	6.5%	6.1%	51.7%	–

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 Centers for Medicare & Medicaid Services (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, 2014, MBES CBES category of service line definitions for the 64.10 base form, https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/cms-6410-admin-category-of-services-definition-2-14.pdf.

– Dash indicates zero; $0 or -$0 indicate 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 May 24, 2016. California's first, second, third, and fourth quarter submissions are not certified; Colorado and North Dakota's second, third, and fourth quarter submissions are not certified; New Jersey's third and fourth quarter submissions are not certified. Figures presented in this exhibit 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 systems, which are included in their own categories.

[5] Excludes MMIS and eligibility systems, which are included in 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, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016; for MCFUs and survey and certification: CMS, 2016, *Fiscal year 2017 justification of estimates for appropriations committees*, Baltimore, MD: CMS, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2017-CJ-Final.pdf.

EXHIBIT 31. Child Enrollment in CHIP and Medicaid by State, FY 2015

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total[1]	Total
Total	**45,231,315**	**4,702,185**	**3,689,817**	**8,397,651**	**36,833,664**
Alabama	**791,285**	45,697	87,346	**133,043**	**658,242**
Alaska	**97,719**	10,182	–	**10,182**	**87,537**
Arizona	**981,357**	37,412	1,399	**38,811**	**942,546**
Arkansas	**476,893**	108,706	3,365	**112,071**	**364,822**
California[2]	**6,800,802**	1,787,470	124,658	**1,912,128**	**4,888,674**
Colorado	**588,343**	23,687	62,446	**86,133**	**502,210**
Connecticut	**390,560**	–	24,884	**24,884**	**365,676**
Delaware	**116,637**	238	16,141	**16,379**	**100,258**
District of Columbia	**99,886**	10,676	–	**10,676**	**89,210**
Florida	**2,692,438**	134,708	293,386	**428,094**	**2,264,344**
Georgia	**1,572,483**	53,906	176,909	**230,815**	**1,341,668**
Hawaii	**170,314**	27,239	–	**27,239**	**143,075**
Idaho	**236,703**	8,937	25,576	**34,513**	**202,190**
Illinois	**1,871,265**	113,105	217,466	**330,571**	**1,540,694**
Indiana	**790,232**	69,462	31,098	**100,560**	**689,672**
Iowa	**417,076**	21,777	60,880	**82,657**	**334,419**
Kansas	**327,223**	54	77,085	**77,139**	**250,084**
Kentucky	**612,492**	50,926	36,050	**86,976**	**525,516**
Louisiana	**820,777**	122,878	12,736	**135,614**	**685,163**
Maine	**189,181**	13,440	8,870	**22,310**	**166,871**
Maryland	**674,417**	142,327	–	**142,327**	**532,090**
Massachusetts[3]	**737,387**	79,299	89,642	**168,941**	**568,446**
Michigan[4]	**1,259,681**	29,226	90,473	**119,699**	**1,139,982**
Minnesota	**603,565**	474	3,361	**3,835**	**599,730**
Mississippi	**534,988**	30,819	56,286	**87,105**	**447,883**
Missouri	**657,363**	38,600	39,744	**78,344**	**579,019**
Montana	**139,807**	16,008	29,253	**45,261**	**94,546**
Nebraska	**227,399**	55,515	6,703	**62,218**	**165,181**
Nevada	**414,418**	17,763	44,145	**61,908**	**352,510**
New Hampshire	**111,139**	16,651	–	**16,651**	**94,488**
New Jersey	**970,667**	100,826	114,365	**215,191**	**755,476**
New Mexico	**416,059**	17,155	40	**17,195**	**398,864**
New York	**2,924,440**	235,945	394,787	**630,732**	**2,293,708**
North Carolina	**1,380,629**	134,413	100,241	**234,654**	**1,145,975**
North Dakota	**66,480**	–	4,955	**4,955**	**61,525**

EXHIBIT 31. (continued)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total[1]	Total
Ohio	1,544,429	181,100	–	181,100	1,363,329
Oklahoma	710,552	174,167	16,691	190,858	519,694
Oregon[5]	608,882	–	121,869	121,869	487,013
Pennsylvania	1,535,591	64,638	229,704	294,342	1,241,249
Rhode Island	131,036	29,948	1,376	31,324	99,712
South Carolina	718,195	98,336	–	98,336	619,859
South Dakota	96,980	12,441	3,775	16,216	80,764
Tennessee	925,671	17,971	88,244	106,215	819,456
Texas	4,585,378	336,769	712,854	1,049,623	3,535,755
Utah	310,061	27,762	27,523	55,285	254,776
Vermont	79,484	4,766	–	4,766	74,718
Virginia	865,234	86,551	102,815	189,366	675,868
Washington	833,523	–	46,037	46,037	787,486
West Virginia[6]	345,728	15,242	33,036	48,278	297,450
Wisconsin	715,155	96,973	71,603	168,576	546,579
Wyoming[7]	63,311	[8]	[8]	5,649	57,662

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 2, 2016, and may be revised at a later date.

– Dash indicates zero.

[1] Total exceeds the sum of Medicaid expansion and separate CHIP columns due to only total CHIP enrollment being reported for Wyoming.

[2] Due to reporting system updates, CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

[3] Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

[4] CHIP-funded Medicaid enrollees are included in Medicaid enrollment counts, rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low and the Medicaid enrollment totals are artificially high.

[5] Certain enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FY 2014 and FY 2015.

[6] Enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

[7] The Centers for Medicare & Medicaid Services (CMS) FY 2015 children's enrollment report considers these values to be estimates.

[8] Due to inconsistencies between the Statistical Enrollment Data System (SEDS) data and the CMS FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in the CMS FY 2015 children's enrollment report.

Source: CMS, 2016, *FY 2015 number of children ever enrolled in Medicaid and CHIP*, http://www.medicaid.gov/chip/downloads/fy-2015-childrens-enrollment-report.pdf and MACPAC, 2016, analysis of CHIP SEDS data.

EXHIBIT 32. CHIP Spending by State, FY 2015 (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	**$267.4**	$209.0	$58.4	**$118.7**	$92.6	$26.1	**$141.3**	$110.6	$30.7	**$7.4**	$5.8	$1.6	–
Alaska	**22.1**	14.3	7.7	**21.4**	13.9	7.5	**–**	–	–	**0.6**	0.4	0.2	–
Arizona	**118.3**	92.1	26.2	**111.2**	86.6	24.6	**6.6**	5.1	1.5	**0.6**	0.4	0.1	–
Arkansas	**170.0**	135.4	34.6	**167.6**	133.3	34.3	**0.8**	0.7	0.1	**1.6**	1.4	0.2	–
California	**2,216.3**	1,440.6	775.7	**1,995.4**	1,297.0	698.4	**132.2**	86.0	46.3	**88.6**	57.6	31.0	–
Colorado	**239.4**	157.3	82.0	**112.6**	74.0	38.7	**120.9**	79.5	41.4	**5.9**	3.9	2.0	–
Connecticut	**36.6**	34.4	2.2	**–**	–	–	**33.0**	21.4	11.5	**3.7**	2.4	1.3	$10.6
Delaware	**42.2**	28.6	13.6	**16.6**	11.4	5.3	**24.8**	16.7	8.1	**0.8**	0.6	0.3	–
District of Columbia	**23.7**	18.7	5.0	**23.3**	18.4	4.9	**–**	–	–	**0.7**	0.5	0.1	–
Florida	**581.6**	417.9	163.7	**148.2**	106.8	41.4	**375.4**	269.5	105.9	**58.0**	41.7	16.4	–
Georgia	**403.0**	309.6	93.4	**96.9**	74.3	22.6	**274.2**	210.7	63.4	**31.9**	24.6	7.4	–
Hawaii	**49.2**	32.7	16.5	**46.3**	30.8	15.5	**–**	–	–	**2.9**	2.0	1.0	–
Idaho	**61.7**	49.5	12.2	**10.0**	8.0	2.0	**49.0**	39.3	9.7	**2.7**	2.2	0.5	–
Illinois	**437.8**	286.8	151.0	**114.0**	74.4	39.6	**288.2**	189.1	99.1	**35.6**	23.4	12.2	–
Indiana	**157.6**	120.7	37.0	**104.3**	79.9	24.5	**47.3**	36.2	11.1	**6.0**	4.6	1.4	–
Iowa	**153.3**	105.7	47.6	**34.6**	23.8	10.8	**106.9**	73.7	33.2	**11.8**	8.2	3.7	–
Kansas	**116.0**	80.8	35.2	**–**	–	–	**105.9**	73.8	32.1	**10.1**	7.0	3.1	–
Kentucky	**222.0**	174.8	47.2	**130.5**	102.5	27.9	**80.5**	63.5	16.9	**11.0**	8.7	2.3	–
Louisiana	**237.4**	174.3	63.1	**179.4**	131.7	47.7	**45.5**	33.5	12.1	**12.5**	9.2	3.3	–
Maine	**31.8**	23.4	8.5	**18.7**	13.7	5.0	**12.2**	9.0	3.2	**1.0**	0.7	0.3	–
Maryland	**313.2**	203.6	109.6	**289.0**	187.9	101.2	**–**	–	–	**24.2**	15.7	8.5	–
Massachusetts	**581.3**	377.9	203.5	**271.6**	176.6	95.1	**251.5**	163.5	88.0	**58.1**	37.8	20.3	–
Michigan	**327.5**	248.9	78.6	**218.6**	166.3	52.4	**104.5**	79.3	25.2	**4.3**	3.3	1.0	–
Minnesota	**32.5**	46.8	-14.3	**1.1**	0.7	0.4	**30.5**	19.9	10.6	**0.9**	0.6	0.3	25.6
Mississippi	**235.0**	191.5	43.4	**58.1**	47.3	10.7	**173.7**	141.6	32.1	**3.2**	2.6	0.6	–
Missouri	**171.8**	127.7	44.1	**106.3**	79.1	27.2	**48.4**	35.9	12.4	**17.1**	12.7	4.4	–
Montana	**91.7**	69.8	21.9	**24.7**	18.8	5.9	**62.0**	47.2	14.8	**5.1**	3.9	1.2	–
Nebraska	**82.5**	55.5	27.0	**67.1**	45.2	22.0	**13.5**	9.1	4.4	**1.9**	1.3	0.6	–
Nevada	**61.2**	45.9	15.3	**15.2**	11.4	3.8	**43.4**	32.6	10.8	**2.6**	1.9	0.6	–

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	**$29.0**	$24.8	$4.2	**$28.9**	$18.8	$10.1	**$0.0**	$0.0	$0.0	**$0.0**	$0.0	$0.0	$6.0
New Jersey	**441.9**	287.6	154.3	**216.7**	140.8	75.8	**202.5**	131.9	70.5	**22.7**	14.8	7.9	–
New Mexico	**116.1**	91.5	24.7	**113.6**	89.4	24.1	**1.5**	1.2	0.3	**1.1**	0.8	0.2	–
New York	**1,165.4**	757.7	407.8	**617.6**	401.4	216.2	**532.5**	346.3	186.3	**15.3**	10.0	5.4	–
North Carolina	**430.3**	327.6	102.8	**253.6**	193.1	60.6	**168.4**	128.2	40.2	**8.3**	6.3	2.0	–
North Dakota	**22.3**	14.5	7.8	**12.4**	8.0	4.3	**8.9**	5.8	3.1	**1.0**	0.7	0.4	–
Ohio	**349.2**	257.9	91.3	**346.7**	256.1	90.6	**–**	–	–	**2.5**	1.9	0.7	–
Oklahoma	**179.6**	131.8	47.8	**155.2**	113.8	41.4	**18.9**	13.9	5.0	**5.6**	4.1	1.5	–
Oregon	**206.3**	154.4	51.9	**5.3**	4.0	1.3	**186.8**	139.8	47.0	**14.1**	10.6	3.6	–
Pennsylvania	**388.8**	257.7	131.1	**63.6**	42.2	21.5	**308.0**	204.1	103.8	**17.2**	11.4	5.8	–
Rhode Island	**72.8**	47.3	25.5	**68.1**	44.2	23.9	**2.7**	1.8	1.0	**2.0**	1.3	0.7	–
South Carolina	**154.4**	122.4	31.9	**149.2**	118.5	30.7	**–**	–	–	**5.2**	3.9	1.3	–
South Dakota	**24.7**	16.3	8.4	**18.2**	12.0	6.2	**6.0**	4.0	2.0	**0.4**	0.3	0.1	–
Tennessee	**205.5**	155.1	50.4	**52.4**	39.6	12.8	**135.6**	102.3	33.2	**17.5**	13.2	4.3	–
Texas	**1,354.1**	956.4	397.7	**421.8**	297.8	123.9	**866.3**	611.9	254.4	**66.1**	46.7	19.4	–
Utah	**147.5**	117.0	30.4	**114.2**	90.6	23.6	**27.3**	21.7	5.6	**6.0**	4.7	1.2	–
Vermont	**9.5**	13.6	-4.1	**10.0**	6.9	3.1	**–**	–	–	**0.9**	0.7	0.3	7.0
Virginia	**287.7**	187.0	100.7	**119.9**	78.0	42.0	**146.4**	95.2	51.3	**21.3**	13.9	7.5	–
Washington	**117.9**	125.3	-7.4	**28.3**	18.4	9.9	**84.9**	55.3	29.6	**4.6**	3.0	1.6	48.6
West Virginia	**62.1**	49.7	12.5	**18.3**	14.6	3.7	**39.7**	31.8	8.0	**4.1**	3.3	0.8	–
Wisconsin	**200.4**	150.5	49.8	**100.5**	71.0	29.5	**92.1**	65.2	26.9	**7.8**	5.5	2.3	8.8
Wyoming	**12.0**	7.8	4.2	**1.7**	1.1	0.6	**9.5**	6.2	3.3	**0.8**	0.5	0.3	–
Subtotal	**$13,461.4**	**$9,528.0**	**$3,933.4**	**$7,417.6**	**$5,166.6**	**$2,251.0**	**$5,410.1**	**$3,813.8**	**$1,596.3**	**$635.5**	**$442.3**	**$193.2**	**$106.6**
American Samoa	**2.1**	1.7	0.4	**2.1**	1.7	0.4	**–**	–	–	**–**	–	–	–
Guam	**8.1**	5.9	2.2	**8.1**	5.9	2.2	**–**	–	–	**–**	–	–	–
N. Mariana Islands	**1.0**	0.9	0.1	**1.0**	0.9	0.1	**–**	–	–	**–**	–	–	–
Puerto Rico	**184.1**	128.9	55.1	**184.1**	128.9	55.1	**–**	–	–	**–**	–	–	–
Virgin Islands	**5.4**	3.8	1.6	**5.4**	3.8	1.6	**–**	–	–	**–**	–	–	–
Total	**$13,662.2**	**$9,669.3**	**$3,993.0**	**$7,618.4**	**$5,307.9**	**$2,310.5**	**$5,410.1**	**$3,813.8**	**$1,596.3**	**$635.5**	**$442.3**	**$193.2**	**$106.6**

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.

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

[1] Four states (Colorado, New Jersey, Rhode Island, and Virginia) 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 table as having negative state CHIP spending (Minnesota, Vermont, and Washington).

Source: MACPAC, 2015, analysis of Medicaid and CHIP Budget Expenditure System data from Centers for Medicare & Medicaid Services as of December 30, 2015.

EXHIBIT 33. Federal CHIP Allotments, FY 2016 (millions)

State	FY 2014 federal CHIP allotments[1]	FY 2015 federal CHIP allotments	FY 2016 federal CHIP allotments[2]
Alabama	$173.1	$172.9	$267.6
Alaska	21.8	23.9	20.4
Arizona	145.4	80.7	123.7
Arkansas	109.7	94.0	174.5
California	1,377.3	1,744.1	1,995.2
Colorado	140.5	157.5	228.3
Connecticut	43.9	48.1	61.9
Delaware	16.7	20.3	38.5
District of Columbia	16.3	20.7	25.6
Florida	382.3	566.0	595.0
Georgia	300.9	410.6	418.2
Hawaii	27.5	46.3	46.3
Idaho	38.2	66.2	66.4
Illinois	292.8	361.4	406.2
Indiana	153.9	162.9	165.7
Iowa	98.3	126.0	147.6
Kansas	58.9	85.1	112.2
Kentucky	157.2	171.9	232.0
Louisiana	182.9	180.1	238.9
Maine	33.5	27.4	32.3
Maryland	170.5	234.3	290.8
Massachusetts	351.6	413.8	535.8
Michigan[3]	58.2	118.6	323.9
Minnesota	34.1	41.1	98.6
Mississippi	188.0	226.2	246.7
Missouri	130.7	163.2	172.9
Montana	68.2	91.7	95.8
Nebraska	64.4	69.7	78.2
Nevada	33.5	43.1	63.3
New Hampshire	19.3	20.0	39.2
New Jersey	680.3	344.8	406.8
New Mexico	132.0	73.6	122.5
New York	677.3	972.8	1,074.6
North Carolina	323.7	395.0	448.2
North Dakota	18.8	21.0	21.2
Ohio	357.1	342.8	352.6

EXHIBIT 33. (continued)

State	FY 2014 federal CHIP allotments[1]	FY 2015 federal CHIP allotments	FY 2016 federal CHIP allotments[2]
Oklahoma	$121.9	$173.1	$189.2
Oregon	152.9	193.5	211.3
Pennsylvania	324.9	371.1	364.3
Rhode Island	42.0	46.0	65.4
South Carolina	104.7	142.9	162.0
South Dakota	20.8	18.9	23.6
Tennessee	212.9	198.1	213.3
Texas	955.8	1,068.7	1,345.1
Utah	66.8	59.1	148.9
Vermont	13.9	15.6	29.3
Virginia	198.3	247.6	265.2
Washington	103.3	129.0	215.3
West Virginia	51.3	55.2	65.4
Wisconsin	109.5	221.2	225.8
Wyoming	11.5	11.4	10.9
Subtotal	**$9,569.5**	**$11,089.2**	**$13,302.8**
American Samoa	1.4	1.7	2.1
Guam	4.8	5.9	8.0
N. Mariana Islands	1.0	1.2	1.0
Puerto Rico	141.0	183.2	179.8
Virgin Islands	0.0	5.0	5.3
Total	**$9,717.7**	**$11,286.1**	**$13,499.2**

Notes: FY is fiscal year.

[1] These amounts reflect increases provided to Arizona, Montana, Nebraska, and New York for approved program expansions described in Section 2104(m)(7) of the Social Security Act (the Act).

[2] Per statute, FY 2015 and FY 2016 federal CHIP allotments were both based on each state's prior-year federal CHIP spending. In addition because a 23 percentage point increase in the CHIP matching rate went into effect in FY 2016, the FY 2016 allotments were calculated by increasing federal CHIP spending by each state in FY 2015 as if the 23 percentage point increase in the CHIP matching rate had been in effect in FY 2015. The FY 2016 allotment increase factor was then applied, which was approximately 5 percent for most states.

[3] In FY 2015, Michigan was poised to exhaust its federal CHIP allotments. As a result, the state requested and qualified for federal CHIP contingency funds totaling $52.6 million (§2104(n) of the Act). Because the contingency fund payment was insufficient to eliminate the state's shortfall, Michigan also qualified for $61.5 million in redistribution funds (§2104(f) of the Act). The combination of contingency and redistribution funds eliminated the state's shortfall. The only other state to ever qualify for contingency funds was Iowa, in FY 2011, which did not then require redistribution funds.

Source: Centers for Medicare & Medicaid Services, 2016, communication with MACPAC staff, February 24, 2016.

SECTION 4

Medicaid and CHIP Eligibility

Section 4: Medicaid and CHIP Eligibility

Key Points

- More than half of states are now covering non-disabled low-income adults, a new Medicaid eligibility group created under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) (Exhibit 35). Most of these new adults are eligible at incomes up to 138 percent of the federal poverty level (FPL). This amounts to $16,394 for a single individual in 2016 (Exhibit 37).
- Beginning in 2014, Medicaid and State Children's Health Insurance Program (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 prevents states from lowering their existing eligibility levels for children through the end of fiscal year (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 2015 and 2016 (Exhibit 36).
- In 2016, in the lower 48 states and the District of Columbia, 100 percent FPL is $11,880 for an individual plus $4,140–$4,160 for each additional family member, depending on the size of the family (Exhibit 37).

EXHIBIT 34. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State, July 2016

State	Medicaid coverage						CHIP program type[2] (as of July 1, 2016)	Separate CHIP coverage		Medicaid/CHIP coverage
	Infants under age 1		Age 1–5		Age 6–18			Birth through age 18[3]	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	147	–	141	–	133	104–133	Combination	200[5]	–	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[7]	–	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[7]	–	375
Kansas	166	–	149	–	133	113–133	Combination	238	–	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	195–212	160	143–212	160	109–212	Medicaid expansion	–	195	195
Minnesota	275	275–283[8]	275	–	275	–	Combination	–	278	278
Mississippi	194	–	143	–	133	107–133	Combination	209	–	194
Missouri	196	–	148	148–150	148	110–150	Combination	300	300	196/300
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 July 1, 2016)	Separate CHIP coverage		Medicaid/CHIP coverage
	Infants under age 1		Age 1–5		Age 6–18			Birth through age 18[3]	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[7]	301	301
Wyoming	154	–	154	–	133	119–133	Combination	200	–	154

Notes: FPL is federal poverty level. In 2016, 100 percent FPL is $11,880 for an individual plus $4,140–$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 July 2016. 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.

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)

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

[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. Ten states (including the District of Columbia) are Medicaid expansions and 2 states are separate CHIP only (Connecticut and Washington). Thirty-nine 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] Arizona closed its separate CHIP program (KidsCare) to new enrollment in January 2010. The state reinstated the program on September 1, 2016.

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

[7] The separate CHIP programs in Delaware, Florida, Iowa, and Wisconsin cover 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 up to 283 percent FPL.

[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, 2016, analysis of Centers for Medicare & Medicaid Services (CMS), 2016, *State Medicaid and CHIP income eligibility standards (For selected MAGI Groups, based on state decisions as of June 1, 2016)*, https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html; MACPAC, 2016, analysis of state websites; 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; 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, July 2016

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	142	133 (142 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	133
Maine	100	156 only for those age 19–20
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	24	133
Nebraska	58	–
Nevada	32	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[5]	133[5]
North Carolina	44	44 only for those age 19–20
North Dakota	52	133
Ohio	90	133
Oklahoma	41[3]	–[4]
Oregon	40	133
Pennsylvania	33	133
Rhode Island	116	133
South Carolina	62	–
South Dakota	57	–
Tennessee	103	–
Texas	15	–
Utah	44[3]	–[4]
Vermont	53	133
Virginia	49	–
Washington	40	133
West Virginia	19	133
Wisconsin	95	95
Wyoming	55	–

Notes: FPL is federal poverty level. In 2016, 100 percent FPL is $11,880 for an individual plus $4,140–$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 July 2016. 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 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.

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

[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 2016, 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] In Minnesota and New York, individuals with incomes between 133 and 200 percent FPL are covered under the Basic Health Program.

Sources: MACPAC, 2016, analysis of Centers for Medicare & Medicaid Services, 2016, State Medicaid and CHIP income eligibility standards (For selected MAGI Groups, based on state decisions as of June 1, 2016), https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html; and MACPAC, 2016, analysis of state websites.

EXHIBIT 36. Medicaid Income Eligibility Levels as a Percentage of the FPL for Individuals Age 65 and Older and Persons with Disabilities by State, 2016

State	State eligibility type[1]	SSI recipients[2]	209(b) eligibility[1]	Poverty level[3]	Medically needy[4]	Special income level[5]
Alabama	1634	74%	–	–	–	222%
Alaska	SSI criteria	59[6]	–	–	–	178
Arizona	1634	74	–	100%	–	222
Arkansas	1634	74	–	80 (aged only)	11%	222
California	1634	74	–	100	61	–
Colorado	1634	74	–	–	–	222
Connecticut	209(b)	–	64%[7]	–	64	222
Delaware	1634	74	–	–	–	185
District of Columbia	1634	74	–	100	64	222
Florida	1634	74	–	88	18	222
Georgia	1634	74	–	–	32	222
Hawaii	209(b)	–	64	100	41	–
Idaho	SSI criteria	74	–	77	–	222
Illinois	209(b)	–	100	100	100	–
Indiana	1634	74	–	100	–	222
Iowa	1634	74	–	–	49	222
Kansas	SSI criteria	74	–	–	48	222
Kentucky	1634	74	–	–	22	222
Louisiana	1634	74	–	–	10	222
Maine	1634	74	–	100	32	222
Maryland	1634	74	–	–	35	222
Massachusetts[8]	1634	74	–	100 (aged) / 133 (disabled)	53	222
Michigan	1634	74	–	100	41	222
Minnesota	209(b)	–	80	100	80	222
Mississippi	1634	74	–	–	–	222
Missouri	209(b)	–	85	85	85	130
Montana	1634	74	–	–	53	–
Nebraska	SSI criteria	74	–	100	40	–
Nevada	SSI criteria	74	–	–	–	222

EXHIBIT 36. (continued)

State	State eligibility type[1]	SSI recipients[2]	209(b) eligibility[1]	Poverty level[3]	Medically needy[4]	Special income level[5]
New Hampshire	209(b)	–	75%	–	60%	222%
New Jersey	1634	74%	–	100%	37	222
New Mexico	1634	74	–	–	–	222
New York	1634	74	–	83	83	–
North Carolina	1634	74	–	100	24	–
North Dakota	209(b)	–	83	–	83	–
Ohio[9]	1634	74	–	–	–	222
Oklahoma[9]	SSI criteria	74	–	100	–	222
Oregon	SSI criteria	74	–	–	–	222
Pennsylvania	1634	74	–	100	43	222
Rhode Island	1634	74	–	100	88	222
South Carolina	1634	74	–	100	–	222
South Dakota	1634	74	–	–	–	222
Tennessee	1634	74	–	–	–	222
Texas	1634	74	–	–	–	222
Utah	SSI criteria	74	–	100	100	222
Vermont	1634	74	–	–	109	222
Virginia	209(b)	–	74	80	47	222
Washington	1634	74	–	–	74	222
West Virginia	1634	74	–	–	20	222
Wisconsin	1634	74	–	83	60	222
Wyoming	1634	74	–	–	–	222

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. 209(b) refers to Section 209(b) of the Social Security Amendments of 1972; 1634 refers to Section 1634 of the Social Security Act. In 2016, 100 percent FPL is $11,880 for an individual and $4,140–$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 table 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)

[1] SSI criteria are used to determine Medicaid eligibility in both 1634 and SSI-criteria states. In 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. 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 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] The SSI federal benefit rate as a percent of the FPL decreased from last year due the FPL increasing about 1 percent from 2015 to 2016 while the SSI federal benefit rate did not change.

[3] 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.

[4] 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.

[5] 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 222 percent FPL in 2016). The income standard listed in this column may be for institutional services, home and community-based waiver services, or both.

[6] 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.

[7] The income standards in Connecticut vary by geography; the highest income standard for region A is listed. The income standard in regions B and C is 53 percent of FPL.

[8] 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.

[9] Oklahoma was a 209(b) state until October 1, 2015, at which point it became an SSI-criteria state. Ohio was a 209(b) state until August 1, 2016, at which point it became a 1634 state; the state also eliminated its medically needy program during the conversion to 1634 criteria.

Source: MACPAC, 2016, analysis of eligibility information from state websites and Medicaid state plans as of October 2016.

EXHIBIT 37. Income as a Percentage of the FPL for Various Family Sizes, 2016

State	FPL	Annual amount					Monthly amount				
		Family size					Family size				
		1	2	3	4	Each additional person[1]	1	2	3	4	Each additional person[1]
Lower 48 states and the District of Columbia	100%	$11,880	$16,020	$20,160	$24,300	$4,140–$4,160	$990	$1,335	$1,680	$2,025	$345–$347
	133	15,800	21,307	26,813	32,319	5,506–5,533	1,317	1,776	2,234	2,693	459-461
	138	16,394	22,108	27,821	33,534	5,713–5,741	1,366	1,842	2,318	2,795	476-478
	150	17,820	24,030	30,240	36,450	6,210–6,240	1,485	2,003	2,520	3,038	518-520
	185	21,978	29,637	37,296	44,955	7,659–7,696	1,832	2,470	3,108	3,746	638-641
	200	23,760	32,040	40,320	48,600	8,280–8,320	1,980	2,670	3,360	4,050	690-693
	250	29,700	40,050	50,400	60,750	10,350–10,400	2,475	3,338	4,200	5,063	863-867
	300	35,640	48,060	60,480	72,900	12,420–12,480	2,970	4,005	5,040	6,075	1,035-1,040
	400	47,520	64,080	80,640	97,200	16,560–16,640	3,960	5,340	6,720	8,100	1,380-1,387
Alaska	100%	$14,840	$20,020	$25,200	$30,380	$5,180–$5,200	$1,237	$1,668	$2,100	$2,532	$432-$433
	133	19,737	26,627	33,516	40,405	6,889–6,916	1,645	2,219	2,793	3,367	574-576
	138	20,479	27,628	34,776	41,924	7,148–7,176	1,707	2,302	2,898	3,494	596-598
	150	22,260	30,030	37,800	45,570	7,770–7,800	1,855	2,503	3,150	3,798	648-650
	185	27,454	37,037	46,620	56,203	9,583–9,620	2,288	3,086	3,885	4,684	799-802
	200	29,680	40,040	50,400	60,760	10,360–10,400	2,473	3,337	4,200	5,063	863-867
	250	37,100	50,050	63,000	75,950	12,950–13,000	3,092	4,171	5,250	6,329	1,079-1,083
	300	44,520	60,060	75,600	91,140	15,540–15,600	3,710	5,005	6,300	7,595	1,295-1,300
	400	59,360	80,080	100,800	121,520	20,720–20,800	4,947	6,673	8,400	10,127	1,727-1,733

EXHIBIT 37. (continued)

State	FPL	Annual amount					Monthly amount				
		Family size					Family size				
		1	2	3	4	Each additional person[1]	1	2	3	4	Each additional person[1]
Hawaii	100%	$13,670	$18,430	$23,190	$27,950	$4,760–$4,780	$1,139	$1,536	$1,933	$2,329	$397-$398
	133	18,181	24,512	30,843	37,174	6,331–6,357	1,515	2,043	2,570	3,098	528-530
	138	18,865	25,433	32,002	38,571	6,569–6,596	1,572	2,119	2,667	3,214	547-550
	150	20,505	27,645	34,785	41,925	7,140–7,170	1,709	2,304	2,899	3,494	595-598
	185	25,290	34,096	42,902	51,708	8,806–8,843	2,107	2,841	3,575	4,309	734-737
	200	27,340	36,860	46,380	55,900	9,520–9,560	2,278	3,072	3,865	4,658	793-797
	250	34,175	46,075	57,975	69,875	11,900–11,950	2,848	3,840	4,831	5,823	992-996
	300	41,010	55,290	69,570	83,850	14,280–14,340	3,418	4,608	5,798	6,988	1,190-1,195
	400	54,680	73,720	92,760	111,800	19,040–19,120	4,557	6,143	7,730	9,317	1,587-1,593

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services 2016 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.

[1] In rare circumstances, the rounding and standardizing adjustments in the update formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In order to prevent a reduction in the guidelines in these rare circumstances, a minor adjustment was implemented to the formula beginning in 2016. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. For the lower 48 states and DC, the increase per person is $4,140 for a family size of five or six, $4,150 for a family size of seven, and $4,160 for a family size of eight or more. For Alaska, the increase per person is $5,180 for a family size of five, six, or seven and $5,200 for a family size of eight or more. For Hawaii, the increase per person is $4,760 for a family size of five, six, or seven and $4,780 for a family size of eight or more.

Source: U.S. Department of Health and Human Services (HHS), 2016, Annual update of the HHS poverty guidelines, *Federal Register* 81, no. 15 (January 25): 4036–4037.

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 the State Children's Health Insurance Program (CHIP) are less likely to be in excellent or very good health than those who have private coverage or are uninsured (Exhibit 38). However, estimates of their use of services relative to other groups vary depending on the type of care and data source. For example, data from both the National Health Interview Survey (NHIS) and the Medical Expenditures Panel Survey (MEPS) 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 (80.9 percent in 2015) and MEPS (38.0 percent in 2014), with similar differences observed for children who have private coverage or are uninsured (Exhibits 39 and 40).
- Like children, adults age 19–64 whose primary coverage source is Medicaid or CHIP are less likely to be in excellent or very good health than those who have private coverage or are uninsured, and comparisons of their service use relative to other groups vary by data source. Adults age 19–64 whose primary coverage source is Medicare, who must meet federal disability criteria to receive coverage, report the poorest health and highest service use in this age group (Exhibits 42–44).
- Children whose primary coverage source is Medicaid or CHIP are reported as seeing a general doctor or having a well-child checkup at rates similar to those with private coverage (Exhibit 39). However, they are more likely to have trouble finding a doctor or delayed care than those with private coverage (Exhibit 41).
- Adults age 19–64 whose primary coverage is Medicaid report having a usual source of care at a similar rate as those with private coverage but are more likely to report having difficulties with access to care. Adults age 19–64 whose primary coverage source is Medicare report the highest rates of delayed care and unmet need due to cost when adults who are uninsured are excluded (Exhibit 45).
- Measures of use of care for specific types of services, 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, these results are unadjusted for differences in age, health, income, race and 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—individuals who have multiple coverage sources were assigned to a single source based on a hierarchy. For selected characteristics of individuals without the application of this hierarchy, see Exhibit 2.

EXHIBIT 38. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2015

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%**	**54.9%**	**36.5%**	**4.7%**
Coverage				
Length of time with any coverage during the year				
Full year	**92.7***	97.5*	95.5	–
Part year	**4.9**	2.5*	4.5	41.4*
No coverage during year	**2.5***	–	–	58.6*
Demographics				
Age				
0–5	**30.8***	28.9*	34.3	20.7*
6–11	**31.8***	30.7*	34.0	27.3*
12–18	**37.4***	40.3*	31.7	51.9*
Gender				
Male	**51.1**	50.4	51.6	49.7
Female	**48.9**	49.6	48.4	50.3
Race				
Hispanic	**24.6***	14.7*	37.2	43.1
White, non-Hispanic	**53.7***	67.4*	34.9	42.9*
Black, non-Hispanic	**14.6***	9.9*	22.1	8.3*
Other non-white, non-Hispanic	**7.1**	8.0*	5.8	5.7
Parents present in family				
Mother, no father	**23.2***	13.3*	37.8	22.2*
Father, no mother	**3.6**	3.4	3.8	4.8
Both present	**69.9***	82.1*	52.3	69.0*
No parents	**3.2***	1.2*	6.1	4.1
Family income				
Has income less than 138 percent FPL	**31.1***	8.5*	63.9	38.9*
Has income in ranges shown below				
Less than 100 percent FPL	**21.1***	4.2*	46.6	22.9*
100–199 percent FPL	**23.0***	12.6*	35.7	35.2
200–399 percent FPL	**27.6***	35.5*	14.7	33.0*
400 percent FPL or higher	**28.1***	47.6*	2.9	8.5*

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	**97.5%**	98.2%	97.7%	86.9%*
Receives SSI[6]	**1.0***	0.4*	2.1	†
Family receives WIC	**6.9***	1.4*	15.5	4.0*
Health				
Current health status				
Excellent or very good	**84.3***	89.9*	76.1	80.9*
Good	**14.0***	9.2*	20.7	17.7
Fair or poor	**1.8***	0.9*	3.2	†
Body Mass Index (BMI)[7]				
Healthy weight (BMI less than 25)	**75.9***	79.2*	71.4	66.8
Overweight (BMI 25–29)	**16.2**	14.4*	17.8	24.0
Obese (BMI 30 or higher)	**7.9***	6.4*	10.8	9.3
Special needs, impairments, and health conditions				
Has special health care needs[8]	**21.3***	19.0*	24.8	15.4*
Receives special education or early intervention services[9]	**8.2**	7.4*	9.5	3.6*
Has impairment requiring special equipment	**1.0**	0.9	1.1	†
Has impairment limiting ability to crawl, walk, run, or play[9]	**1.3**	1.1	1.6	†
Has impairment limiting ability to crawl, walk, run, or play that is expected to last 12+ months[9]	**1.0**	0.9	1.3	†
Ever been told he or she has selected conditions				
ADHD/ADD[10]	**9.3***	8.4*	10.9	4.4*
Asthma	**13.3***	12.1*	15.2	13.4
Autism[10]	**2.3**	2.1	2.6	†
Cerebral palsy[9]	**0.3**	†	†	–
Congenital heart disease[9]	**0.2**	†	†	–
Diabetes	**0.3**	†	†	†
Down syndrome[9]	**0.1**	†	†	†
Intellectual disability[9]	**1.2**	0.7*	1.7	†
Other developmental delay[9]	**3.4**	3.3	3.6	†

EXHIBIT 38. (continued)

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. WIC is Supplemental Nutrition Program for Women, Infants, and Children. 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. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/coverage-demographic-and-health-characteristics-of-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage/. 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 12 or older.

[8] Due in part to changes in the 2011 NHIS questionnaire as well as other methodological changes, the definition of children with special health care needs differs slightly from the definition MACPAC used in prior versions. 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 the 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 0–17.

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

Source: MACPAC, 2016, analysis of NHIS data.

EXHIBIT 39. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2015, 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%**	**54.9%**	**36.5%**	**4.7%**
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	**8.9**	7.7	8.2	28.6*
At least 1	**91.1**	92.3	91.8	71.4*
1	**23.5**	23.6	22.9	27.5
2–3	**36.9**	37.5	37.4	24.1*
4 or more	**30.7**	31.2	31.5	19.8*
Saw selected health professional				
General doctor	**83.5**	85.5	83.9	57.5*
General doctor, nurse practitioner, physician assistant, midwife, or ob-gyn	**85.1**	87.3*	85.2	59.9*
Medical specialist	**14.4***	16.9*	11.2	8.8
Eye doctor	**25.8**	27.9*	24.3	15.5*
Mental health professional[6]	**8.9***	8.0*	10.5	3.7*
Doctor, for emotional or behavioral problem[7]	**5.1***	3.8*	7.1	†
Dentist[8]	**81.4**	83.9*	80.9	57.7*
Any health professional, excluding dental[9]	**89.1**	91.5*	88.4	67.3*
Any health professional, including dental	**96.5**	98.1*	96.0	81.4*
Had at least 1 overnight hospital stay[10]	**5.0**	5.0	5.0	†
Received care at home	**0.9**	0.9	1.0	†
Receipt of appropriate care (past 12 months)				
Had well-child checkup[7]	**84.0**	86.1	84.5	52.7
Had more than 15 office or clinic visits	**2.2**	2.2	2.1	†
Number of emergency room visits				
None	**83.0***	87.1*	77.4	86.9*
At least 1	**17.0***	12.9*	22.6	13.1*
1	**11.7***	9.9*	13.8	9.5*
2–3	**4.1***	2.5*	6.6	3.1*
4 or more	**1.2***	0.5*	2.1	†
Had at least 1 emergency room visit, and most recent visit was for a serious health problem	**12.1***	9.7*	14.9	9.0*

EXHIBIT 39. (continued)

Notes: Ob-gyn is obstetrician-gynecologist. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-data-from-national-health-interview-survey/. 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] Survey information is limited to children age two or older.

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

[8] Survey information is limited to children age one or older.

[9] Any health professional includes general doctor, nurse practitioner, physician assistant, midwife, ob-gyn, medical specialist, eye doctor, mental health professional, doctor for emotional or behavioral problem, therapist, chiropractor, or podiatrist.

[10] Includes stays for newborns.

Source: MACPAC, 2016, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2014, 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%**	**53.5%**	**37.5%**	**7.3%**
Contact with health care professionals (past 12 months)				
Number of office-based visits (to a doctor or other health professional), excluding dental visits and inpatient hospital stays				
None	**25.3**	20.6*	27.2	46.7*
At least 1	**74.7**	79.4*	72.8	53.3*
1	**23.5**	23.0	24.4	22.0
2–3	**26.4**	28.0	26.6	17.9*
4 or more	**24.8***	28.4*	21.7	13.4*
Had at least 1 overnight hospital stay	**2.9**	1.9*	2.8	†
Received care at home	**1.3**	†	1.4	†
Saw a general dentist	**43.6***	50.7*	38.0	29.0*
Saw an orthodontist	**9.2***	13.5*	4.1	4.4
Receipt of appropriate care (past 12 months)				
Had dental cleaning, prophylaxis, or polishing[6]	**47.8***	46.0*	53.1	48.5
Had more than 15 office-based or hospital outpatient visits	**4.1**	5.0*	3.4	†
Number of emergency room visits				
None	**87.2***	89.7*	84.4	88.8*
At least 1	**12.8***	10.3*	15.6	11.2*
1	**9.8***	8.4*	11.4	8.1*
2–3	**2.7***	1.9*	3.8	†
4 or more	**0.3**	†	†	†

Notes: Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-data-from-medical-expenditures-panel-survey/. 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] Limited to people who reported a dental event in 2014.

Source: MACPAC, 2016, analysis of MEPS data.

EXHIBIT 41. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2015

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%**	**54.9%**	**36.5%**	**4.7%**
Connection to the health care system (past 12 months)				
Has a usual source of care[6]	**95.2**	97.3*	95.1	68.9*
Had the same usual source of medical care 12 months ago	**88.2**	90.7*	87.8	65.8*
Had trouble finding a doctor or was told that coverage or new patients were not accepted[7]	**3.4***	2.4*	4.3	5.9
Timeliness of care (past 12 months)				
Delayed medical care due to any access barrier indicated below	**10.1***	6.6*	13.4	22.6*
Delayed because of costs	**2.6**	1.8	2.1	17.0*
Delayed for provider-related reasons[8]	**7.2***	5.2*	9.7	9.1
Delayed due to lack of transportation	**1.8***	0.3*	3.6	†
Unmet need for selected types of care due to cost				
Medical care	**1.4**	0.7*	1.2	10.4*
Mental health care or counseling[9]	**0.7**	0.5	0.8	†
Dental care[9]	**4.2**	2.6*	4.7	18.6*
Prescription drugs	**1.6**	1.2	1.7	7.1*
Eyeglasses[9]	**1.9***	1.0*	2.6	8.2*
Specialist care	**1.2**	0.7*	1.3	6.1*
Follow-up care	**1.3**	0.6*	1.4	8.8*

Notes: Percentage calculations for each item in the table exclude individuals with missing and unknown values. The individual components listed under the subcategories are not mutually exclusive and may not add to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/measures-of-access-to-care-for-non-institutionalized-children-by-source-of-health-coverage/. 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.

EXHIBIT 41. (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 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] Excludes emergency room.

[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 two or older.

Source: MACPAC, 2016, analysis of NHIS data.

EXHIBIT 42. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2015

Characteristic	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%**	**3.9%**	**69.0%**	**10.8%**	**12.8%**
Coverage					
Length of time with any coverage during year					
Full year	**82.2***	95.7*	94.6*	85.8	–
Part year	**8.8***	4.3*	5.4*	14.2	25.2*
No coverage during year	**9.1**	–	–	–	74.8
Demographics					
Age					
19–25	**15.6***	2.0*	14.7*	21.7	19.2
26–44	**40.9***	16.1*	40.0*	46.6	50.8*
45–54	**22.4***	25.1*	23.6*	18.5	17.9
55–64	**21.1***	56.9*	21.8*	13.2	12.0
Gender					
Male	**49.0***	50.0*	49.4*	36.6	55.7*
Female	**51.0***	50.0*	50.6*	63.4	44.3*
Race					
Hispanic	**17.2***	9.5*	12.4*	27.4	37.7*
White, non-Hispanic	**62.8***	69.1*	69.3*	43.3	42.7
Black, non-Hispanic	**12.6***	17.5*	10.4*	21.9	14.0*
Other non-white, non-Hispanic	**7.3**	3.9*	7.9	7.4	5.5*
Marital status[6]					
Married	**54.0***	36.6	60.7*	33.2	39.5*
Widowed	**1.6***	5.2*	1.3	1.9	1.7
Divorced or separated	**11.3***	26.3*	9.4*	14.7	13.5
Living with partner	**8.6***	7.6*	7.1*	13.1	13.5
Never married	**24.5***	24.3*	21.5*	37.1	31.8*
Family income					
Less than 138 percent FPL	**20.5***	46.4*	8.2*	64.1	39.9*
Has income in ranges below					
Less than 100 percent FPL	**13.3***	29.0*	4.5*	46.4	26.9*
100–199 percent FPL	**17.6***	34.1	11.1*	34.3	31.1
200–399 percent FPL	**28.1***	25.2*	29.6*	15.4	30.8*
400 percent FPL or higher	**40.9***	11.7*	54.7*	3.7	11.1*

EXHIBIT 42. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Education					
Less than high school	**11.0%***	22.8%	5.1%*	25.5%	27.7%
High school diploma/GED	**23.4***	35.3	19.6*	31.9	33.2
Some college	**32.5***	30.0	33.0	34.1	28.1*
College or graduate degree	**33.1***	11.9*	42.4*	8.6	11.0*
Other demographic characteristics					
Citizen of United States	**90.3***	96.7*	93.6*	88.3	71.7*
Parent of a dependent child	**36.6***	12.6*	36.5*	47.6	36.7*
Currently working	**73.1***	10.0*	83.6*	43.7	64.9*
Veteran	**5.7***	9.0*	4.6*	3.3	2.8
Receives SSI or SSDI[7]	**5.6***	74.7*	1.0*	16.6	0.8*
Receives SSI	**2.6***	22.4*	0.4*	13.0	†
Receives SSDI	**3.8***	63.8*	0.7*	6.3	0.6*
Health					
Current health status					
Excellent or very good	**63.4***	11.9*	70.5*	43.8	58.5*
Good	**25.6***	30.4	23.6*	31.7	29.6
Fair or poor	**11.0***	57.8*	5.9*	24.5	11.9*
Body Mass Index (BMI)					
Healthy weight (BMI less than 25)	**36.0***	22.6*	37.4*	33.2	36.0
Overweight (BMI 25–29)	**33.3***	29.0	33.4*	30.4	36.4*
Obese (BMI 30 or higher)	**30.7***	48.4*	29.3*	36.4	27.7*
Smoking status					
Current smoker	**16.9***	29.4	12.0*	30.1	27.8
Former smoker	**17.9***	27.1*	18.4*	14.3	14.8
Never smoked	**65.1***	43.5*	69.6*	55.6	57.4
Limitations and health conditions					
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[8]	**24.9***	86.2*	18.8*	41.8	23.0*
Any complex activity limitation[9]	**12.5***	85.6*	6.1*	29.3	9.1*
Either one	**26.6***	92.4*	19.9*	45.8	24.1*
Has functional limitation[10]	**11.5***	69.5*	6.6*	23.6	8.6*

EXHIBIT 42. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/ CHIP[3]	Uninsured[4]
Has difficulty walking without equipment	**3.4%***	31.2%*	1.3%*	8.3%	1.5%*
Has health condition requiring special equipment	**4.2***	31.8*	2.2*	9.0	1.7*
Needs help with any of the following ADLs					
Personal care	**1.4***	13.1*	0.5*	4.0	†
Bathing	**0.8***	8.4*	0.3*	2.2	†
Eating	**0.3***	2.3	†	1.1	†
Transferring	**0.6***	5.1*	0.2*	2.1	†
Toileting	**0.5***	3.6*	†	1.5	†
Getting around in home	**0.5***	5.4*	0.2*	1.6	†
Number of ADLs needing assistance					
None	**98.9***	88.7*	99.6*	96.7	99.8*
1–2	**0.6***	6.7*	0.2*	1.7	†
3–4	**0.4***	4.1*	†	1.0	†
5–6	**0.1***	†	†	0.6	–
Unable to work now due to health problem	**7.6***	73.0*	2.4*	20.0	4.3*
Limited in amount or kind of work due to health	**10.3***	81.6*	4.5*	25.5	6.2*
Lost all natural teeth	**4.4***	21.3*	2.9*	7.9	4.1*
Has depressed or anxious feelings[11]	**3.9***	14.8*	2.0*	9.3	5.7*
Currently pregnant[12]	**3.9***	†	3.4*	8.0	1.7*
Ever been told he or she has selected conditions					
Hypertension	**24.1***	58.3*	22.7*	26.8	17.5*
Coronary heart disease	**2.2***	12.0*	1.5*	3.6	1.2*
Heart attack	**1.6***	11.6*	1.0*	2.5	0.9*
Stroke	**1.5***	10.9*	0.7*	3.2	1.2*
Cancer	**4.8**	14.3*	4.7	5.3	2.3*
Diabetes	**6.9***	29.5*	5.6*	9.0	4.9*
Arthritis	**16.7***	56.4*	15.0*	19.7	9.7*
Asthma	**13.1***	24.7*	12.4*	16.7	10.3*
Chronic bronchitis (past 12 months)	**3.4***	15.4*	2.5*	5.8	2.6*
Liver condition (past 12 months)	**1.6***	7.2*	1.0*	2.6	1.4*
Weak or failing kidneys (past 12 months)	**1.2***	10.3*	0.6*	2.1	1.0*

EXHIBIT 42. (continued)

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. ADL is activity of daily living. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/coverage-demographic-and-health-characteristics-of-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage/.

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.

[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] These estimates should not be compared to the 2014 estimates published in the December 2015 data book due to errors in last's year publication.

[7] 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.

[8] 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.

[9] 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.

[10] 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. These estimates should not be compared to the 2014 estimates published in the December 2015 data book which also included responses of "only a little" and "somewhat difficult".

[11] These estimates should not be compared to the 2014 estimates published in the December 2015 data book due to a change in the characteristic's definition.

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

Source: MACPAC, 2016, analysis of NHIS data.

EXHIBIT 43. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2015, 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%**	**3.9%**	**69.0%**	**10.8%**	**12.8%**
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	**20.7***	6.0*	16.6*	18.8	51.0*
At least 1	**79.3***	94.0*	83.4*	81.2	49.0*
1	**19.2***	4.8*	21.1*	14.3	17.3*
2–3	**26.8***	19.4*	29.8*	23.3	16.4*
4 or more	**33.3**	69.8*	32.5*	43.6	15.3*
Saw selected health professional					
General doctor	**65.2***	85.1*	68.5	69.0	35.7*
General doctor, nurse practitioner, physician assistant, midwife, or ob-gyn	**73.4***	89.5*	77.2	77.7	42.5*
Medical specialist	**23.4**	52.0*	24.4	22.7	8.4*
Eye doctor	**36.4***	39.5*	41.7*	27.5	14.3*
Mental health professional	**8.7**	22.3*	7.3*	14.3	4.6*
Dentist	**63.7***	42.5*	72.5*	50.7	33.8*
Any health professional, excluding dental[6]	**81.2***	94.0*	85.4*	82.9	51.7*
Any health professional, including dental	**89.3***	95.4*	93.4*	89.1	64.4*
Had at least 1 overnight hospital stay	**7.1**	24.0*	5.5*	13.5	4.8*
Received care at home	**1.4**	10.9*	0.8*	3.2	†
Receipt of appropriate care (past 12 months)					
Had cholesterol checked[7]					
All individuals	**59.7***	80.9*	63.8*	59.7	29.2*
Men age 35–64	**66.6**	79.9*	70.7*	65.0	32.1*
Individuals with elevated risk of cardiac disease[7,8]	**69.1***	84.6*	75.7*	65.1	35.3*
Had flu shot					
All individuals	**36.5***	52.6*	40.4*	31.0	14.7*
Individuals age 50–64	**47.9**	56.5*	50.8*	41.6	19.6*

EXHIBIT 43. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid/CHIP[3]	Uninsured[4]
Had any test for colorectal cancer (age 50–64)	**23.8%**	30.8%*	24.4%*	20.3%	11.3%*
Had Pap smear or test for cervical cancer (women age 21–60)	**56.5***	44.2*	60.9*	56.4	33.3*
Had professional counseling about smoking (current smokers)	**53.9**	77.7*	56.8	60.2	30.9*
Had more than 15 office or clinic visits	**5.2**	18.2*	4.5*	7.8	1.6*
Number of emergency room visits					
None	**82.0***	56.8*	86.4*	66.1	81.6*
At least 1	**18.0***	43.2*	13.6*	33.9	18.4*
1	**11.4**	21.0*	9.9*	16.6	11.3*
2–3	**4.7***	15.3*	2.7*	11.8	5.6*
4 or more	**1.9**	6.9	1.0*	5.5	1.5*
Had at least 1 emergency room visit, and most recent visit was for a serious health problem	**13.8***	36.2*	10.3*	26.1	13.4*

Notes: Ob-gyn is obstetrician-gynecologist. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage-data-from-national-health-interview-survey/. 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.

[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.

EXHIBIT 43. (continued)

[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] Any health professional includes general doctor, nurse practitioner, physician assistant, midwife, ob-gyn, medical specialist, eye doctor, mental health professional, therapist, chiropractor, or podiatrist.

[7] These estimates should not be compared to the 2014 estimates published in the December 2015 data book due to a change in the screening questions for cholesterol, blood pressure, and diabetes. In 2014, the NHIS included additional blood pressure and cholesterol screening questions as part of the supplemental questions pertaining to the Million Hearts® Initiative that were only used in 2014. The 2015 NHIS screening questions reverted back to the original screening questions and should be comparable with years earlier than 2014.

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

Source: MACPAC, 2016, analysis of NHIS data.

EXHIBIT 44. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2014, 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%**	**3.9%**	**65.8%**	**10.0%**	**18.6%**
Contact with health care professionals (past 12 months)					
Number of office-based visits (to a doctor or other health professional), excluding dental visits and inpatient hospital stays					
None	**30.3**	6.1*	25.0*	29.6	54.6*
At least 1	**69.7**	93.9*	75.0*	70.4	45.4*
1	**15.6***	4.6*	16.3*	13.7	16.9*
2–3	**18.3***	12.1*	20.8*	15.8	11.7*
4 or more	**35.8***	77.2*	37.8	41.0	16.8*
Had at least 1 overnight hospital stay	**5.7***	22.3*	4.5*	10.9	3.4*
Received care at home	**1.7***	16.5*	0.8*	3.4	0.9*
Saw a general dentist	**35.6***	25.7	43.8*	25.3	14.2*
Saw an orthodontist	**1.2**	†	1.4	1.0	0.5*
Receipt of appropriate care (past 12 months)					
Had dental cleaning, prophylaxis, or polishing[6]	**55.0***	33.0	58.2*	37.7	46.5*
Had more than 15 office-based or hospital outpatient visits	**9.3***	34.0*	9.0*	12.2	3.4*
Number of emergency room visits					
None	**87.1***	65.3*	90.2*	76.3	87.1*
At least 1	**12.9***	34.7*	9.8*	23.7	12.9*
1	**9.3***	17.9	7.7*	15.6	9.4*
2–3	**3.0***	13.7*	1.9*	6.3	3.2*
4 or more	**0.6***	3.2	0.3*	1.8	†

Notes: Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage-data-from-medical-expenditures-panel-survey/. 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.

EXHIBIT 44. (continued)

– 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] Limited to people who reported a dental event in 2014.

Source: MACPAC, 2016, analysis of MEPS data.

EXHIBIT 45. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2015

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%**	**3.9%**	**69.0%**	**10.8%**	**12.8%**
Connection to the health care system (past 12 months)					
Has a usual source of care[6]	**82.7***	93.3*	88.2*	84.7	46.2*
Had the same usual source of medical care 12 months ago	**75.4**	83.0*	80.7*	75.6	42.6*
Had trouble finding a doctor or was told that coverage or new patients were not accepted[7]	**6.4***	13.2*	5.0*	9.8	9.1
Timeliness of care (past 12 months)					
Delayed medical care due to any access barrier indicated below	**18.1***	31.7*	13.7*	24.0	32.1*
Delayed because of costs	**9.3**	15.0*	6.1*	9.0	25.9*
Delayed for provider-related reasons[8]	**10.1***	17.7	8.8*	14.9	9.0*
Delayed due to lack of transportation	**1.8***	9.6*	0.5*	6.1	2.6*
Unmet need for selected types of care due to cost					
Medical care	**7.0**	12.7*	3.8*	7.9	21.9*
Mental health care or counseling	**2.3***	5.4*	1.3*	3.5	5.7*
Dental care	**12.0***	26.2*	6.9*	19.2	28.4*
Prescription drugs	**7.0***	19.2*	3.9*	10.5	17.6*
Eyeglasses	**7.1***	19.6*	4.0*	12.3	15.8*
Specialist care	**4.7***	10.2*	2.5*	6.5	13.5*
Follow-up care	**4.0**	7.2*	2.0*	5.0	13.7*

Notes: Percentage calculations for each item in the table exclude individuals with missing and unknown values. The individual components listed under the subcategories are not mutually exclusive and may not add to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/measures-of-access-to-care-for-non-institutionalized-individuals-age-19-64-by-source-of-health-coverage/. 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.

EXHIBIT 45. (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 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] Excludes emergency room.

[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, 2016, 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 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 compiled by states and the federal government 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 the timing of the reports and the beneficiaries covered: 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 than estimates 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, and 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 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 and estimates from 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 more likely to be 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 NHIS and MEPS 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 does have some limitations. As in most surveys, respondents in the NHIS do not always accurately report information about participation in programs such as Medicaid, CHIP, Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance. As a result, survey data may not match estimates of program participation computed from the programs' own administrative data. In addition, although the NHIS asks about participation in Medicaid and CHIP in two different questions, program participation estimates from the survey 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 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:[11]

- The child is limited in his or her ability or unable to do things most children the same age can do.[12]
- The child needs or uses medications prescribed by a doctor (other than vitamins).[13]
- The child needs or uses specialized therapies such as physical, occupational, or speech therapy.[14]
- The child has above-routine need or use of medical, mental health, home care, or education services.[15]
- The child needs or receives treatment or counseling for an emotional, behavioral, or developmental problem.[16]

Estimates for the category of CSHCN in this edition of MACStats are not directly comparable to those in prior years, which used a slightly different definition.[17]

Methodology for Adjusting Benefit Spending Data

The FY 2013 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.[18]

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.[19] 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 (DSH) payments and additional types of supplemental payments made to hospitals and other providers, Medicare premium payments, and certain other amounts.[20]
- 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.[21]
- 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).[22]

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 from 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:

- Beginning with the 2014 edition of MACStats, we excluded 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 audit 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.[23] As a result, we now exclude DSH payments from CMS-64 totals when we adjust MSIS spending.
- Also starting with the 2014 edition, 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.
- Beginning with the 2015 edition, we excluded incentive and uncompensated care pool payments made under Section 1115 waiver expenditure authority from CMS-64 totals used to adjust MSIS spending.[24] In earlier editions, these payments were included in CMS-64 totals. Because these payments may be made for purposes other than providing services to Medicaid patients, we now exclude them when we adjust MSIS spending.
- Also starting with 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.

With regard to changes in data, complete MSIS Annual Person Summary (APS) files have not been available in a timely manner for use in MACStats since the 2013 edition. Therefore, beginning with the 2014 edition, 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 2013 (millions)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted MSIS	CMS-64[1]	MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
Total	**$375,433**	**$401,239**	**93.6%**	**$15,457**	**$10,799**
Alabama	4,179	4,568	91.5	471	–
Alaska	1,321	1,335	99.0	22	–
Arizona	8,229	7,586	108.5	173	679
Arkansas	3,497	4,141	84.4	61	5
California	41,003	57,297	71.6	2,120	2,487
Colorado	4,004	4,898	81.7	194	–
Connecticut	6,241	6,453	96.7	273	–
Delaware	1,662	1,552	107.1	11	–
District of Columbia	2,360	2,232	105.7	56	–
Florida	20,301	17,233	117.8	335	994
Georgia	9,310	8,530	109.1	430	–
Hawaii	1,464	1,524	96.1	25	82
Idaho	[2]	[2]	[2]	[2]	[2]
Illinois	13,782	15,211	90.6	447	–
Indiana	6,603	7,630	86.5	338	–
Iowa	3,547	3,649	97.2	55	6
Kansas	2,533	2,441	103.7	77	60
Kentucky	5,575	5,606	99.4	216	–
Louisiana	[2]	[2]	[2]	[2]	[2]
Maine	2,041	2,850	71.6	37	–
Maryland	7,195	7,647	94.1	134	–
Massachusetts	11,144	12,338	90.3	–	828
Michigan	11,529	11,998	96.1	388	–
Minnesota	8,561	8,873	96.5	46	–
Mississippi	3,842	4,518	85.0	218	–
Missouri	7,121	8,248	86.3	703	–
Montana	864	989	87.3	18	–
Nebraska	1,749	1,788	97.8	45	–
Nevada	1,477	1,742	84.8	81	–
New Hampshire	1,045	1,162	89.9	41	–
New Jersey	9,075	9,266	97.9	1,298	42
New Mexico	2,615	3,270	80.0	25	–

EXHIBIT 46. (continued)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted MSIS	CMS-64[1]	MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
New York	$50,560	$50,354	100.4%	$3,423	$644
North Carolina	9,932	11,298	87.9	617	–
North Dakota	805	783	102.8	1	–
Ohio	16,001	16,154	99.0	649	–
Oklahoma	3,925	4,754	82.6	42	–
Oregon	3,996	4,782	83.6	77	253
Pennsylvania	18,749	20,245	92.6	847	–
Rhode Island	[2]	[2]	[2]	[2]	[2]
South Carolina	4,862	4,449	109.3	457	–
South Dakota	757	765	99.0	1	–
Tennessee	13,563	7,617	178.1	80	1,020
Texas	22,084	24,417	90.4	227	3,695
Utah	2,640	2,101	125.6	29	–
Vermont	1,136	1,431	79.4	37	5
Virginia	6,363	7,105	89.6	186	–
Washington	6,684	7,805	85.6	367	–
West Virginia	3,216	2,949	109.1	75	–
Wisconsin	5,689	7,105	80.1	1	–
Wyoming	603	554	108.9	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 $6.8 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 have been 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 have also been 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.

[1] The total amount reported on the CMS-64 may differ slightly from the state and national totals of our adjusted MSIS spending reported in other exhibits due to rounding when applying certain adjustments.

[2] Idaho, Louisiana, and Rhode Island were excluded due to data reliability concerns regarding completeness of monthly claims and enrollment data.

Source: MACPAC, 2016, analysis of MSIS data as of December 2015 and CMS-64 Financial Management Report net expenditure data as of June 2016.

EXHIBIT 47. Service Categories Used to Adjust FY 2013 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 (including primary care physician payment increase) • Physician services supplemental payments • Preventive services with USPSTF Grade A or B and ACIP vaccines • 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 • MCO, PAHP, and PIHP payments associated with the primary care physician payment increase, Community First Choice option, preventive services with USPSTF Grade A or B, and ACIP vaccines • 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) • HCBS–1915(k)
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. USPSTF is U.S. Preventive Services Task Force. ACIP is Advisory Committee on Immunization Practices. EPSDT is early and periodic screening, diagnostic, and treatment services. 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 as 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 identified in the MSIS for each state.

[4] Medicare coinsurance and deductibles are reported under individual service types throughout the MSIS. We distribute CMS-64 amounts 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 2011 Medicare data. See MedPAC and MACPAC, 2016, *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 (page 13), https://www.macpac.gov/wp-content/uploads/2015/01/Dually-Eligible-Beneficiares-DataBook.pdf.

Sources: MACPAC, 2016, analysis of MSIS and CMS-64 Financial Management Report net expenditure data.

Understanding Managed Care Enrollment and Spending Data

There are four main sources of data on Medicaid managed care available from Centers for Medicare & Medicaid Services (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.
- **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 (between 2 and 5 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.[25]
- 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 enrolled 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. Although 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/Downloads/2010SummariesGlossary.zip.

[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, U.S. Department of Health and Human Services, 2016, About the National Health Interview Survey, http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[6] Agency for Health Care Research and Quality, U.S. Department of Health and Human Services, 2016, 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*, Plewes, T.J., ed., 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, http://ww2.amstat.org/sections/srms/Proceedings/y2010/Files/307444_58577.pdf.

[9] McPherson, M., P. Arrango, H. Fox, 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 Supplemental Security Income (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] The following conditions were identified in the most recent NHIS: attention deficit disorder; intellectual disability; other developmental delay or problems that cause difficulty with activity; other mental health condition; Down syndrome; cerebral palsy; muscular dystrophy; cystic fibrosis; sickle cell anemia; autism; diabetes; arthritis; heart disease or condition; cancer; any of the following episodes/attacks in the past 12 months: seizure, asthma, respiratory allergy, eczema or skin allergy, food or digestive allergy, anemia, frequent severe headache or migraines, or frequent diarrhea or colitis; depressed or anxious feelings most or all of the time in the past 30 days, feelings interfered with life a lot in the past 30 days; depression/anxiety/emotional problem causes difficulty with activity, difficulties with emotions/concentration/behavior/getting along; very low birth weight (less than 1500 grams) and under two years old; chronic condition that limits activity; at least one condition that causes functional limitation and is chronic; or reported fair or poor health status.

[12] Limitations in ability to do things other children do include the following: any activity limitation, needs help with activities of daily living, has mobility impairment that has lasted or is expected to last more than 12 months, has any functional limitation, is blind, or has a lot of trouble with hearing ability without a hearing aid.

[13] Need or use of medications includes the following: took a prescription medicine for three or more months or reported unmet need for prescription medications due to cost in the past 12 months.

[14] Need or use of specialized therapies includes the following: saw or talked to a therapist in the past 12 months.

[15] Above-routine need or use or services includes the following: has impairment or health problem that requires use of special equipment, had 10 or more visits to a health professional in the past 12 months, had two or more emergency department visits in the past 12 months, had one or more hospital stays other than for birth in the past 12 months, any homecare visits in the past 12 months, received special education or early intervention services, or reported unmet need for medical care due to cost in the past 12 months.

[16] Need or receives counseling includes the following: family member seen/talked to a mental health professional concerning health of the child in the past 12 months or reported unmet need for mental health counseling due to cost in the past 12 months.

[17] The 2016 estimates may differ from 2015 due to changes in the conditions or criteria used to identify CSHCN. For full details on the definition of CSHCN used in MACStats editions prior to December 2015, 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.

[18] 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.

[19] 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, –.

[20] 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.

[21] 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*, Plewes, T.J., ed., Washington, DC: The National Academies Press, http://www.nap.edu/catalog/13024.html.

[22] 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.

[23] See Medicaid and CHIP Payment and Access Commission (MACPAC), 2016, Improving data as the first step to a more targeted disproportionate share hospital policy, in *Report to Congress on Medicaid and CHIP*, March 2016, Washington, DC: MACPAC, https://www.macpac.gov/wp-content/uploads/2016/03/Improving-Data-as-the-First-Step-to-a-More-Targeted-Disproportionate-Share-Hospital-Policy.pdf; and Centers for Medicare & Medicaid Services (CMS), 2016, Medicaid disproportionate share hospital payments, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html.

[24] 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.

[25] 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 of the Social Security Act). 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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