MACStats: Medicaid and CHIP Data Book

December 2020

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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Medicaid Managed Care

Introduction

This 2020 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 covered more than one-quarter of the U.S. population in 2018 (Exhibit 1). Spending and enrollment in Medicaid typically grow around recessions and slow when the economy improves. From July 2019 to July 2020, enrollment in Medicaid and CHIP increased by about 5.6 percent, driven in large part by the economic downturn created by the COVID-19 pandemic as well as the continuous coverage requirement attached to the federal medical assistance percentage (FMAP) increase under the Families First Coronavirus Response Act (P.L. 116-127) (Exhibit 11). Even so, Medicaid and CHIP combined still account for a smaller share of total health care spending than Medicare or private insurance (Exhibit 3). Children whose primary coverage source is Medicaid or CHIP are reported to have well-child checkups at rates slightly less than those with private coverage, but more than those who are uninsured (Exhibit 40).

This is the first edition of MACStats to use data from the Transformed Medicaid Statistical Information System (T-MSIS), which is designed to capture substantially more data and information than previously available under the Medicaid Statistical Information System (MSIS). We focused on using the most recently available T-MSIS data. Specifically, we used fiscal year (FY) 2018 T-MSIS data for exhibits that provide enrollment and spending data by eligibility group, which are much more recent than the FYs 2013–2014 MSIS data available in prior years.

Regrettably, due to a delay in the release of National Health Interview Survey (NHIS) results after a redesign in 2019, we are unable to update eight exhibits on topics such as beneficiary characteristics, health, service use, and access to care. We plan to publish updated tables on our website in early 2021 as we complete our analyses on the 2019 NHIS data.

The pages that follow are 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 presented 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 for interpreting the exhibits and explains 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 at the University of Minnesota and Acumen, LLC—who provided their insights and assistance. We would also like to thank Paula Gordon and Kevin Kempske and his team at GKV 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 2018, 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: 86.7 million in Medicaid and 9.4 million in CHIP (Exhibit 1). About 36.2 percent of children had Medicaid or CHIP coverage in 2018 (Exhibit 2).
- Over 40 percent of individuals enrolled in Medicaid or CHIP in 2018 had family incomes below 100 percent of the federal poverty level (FPL). Almost 6 out of 10 individuals (59.7 percent) enrolled in Medicaid or CHIP had incomes of less than 138 percent FPL, the threshold used to determine eligibility for Medicaid in states that have expanded Medicaid to low-income adults (Exhibit 2).
- Medicaid and CHIP enrollees of all ages were more likely to be in fair or poor health than individuals who were covered by private insurance or who were uninsured (Exhibit 2).
- Medicaid and CHIP together accounted for 16.9 percent of national health expenditures in calendar year 2018, less than either Medicare (20.6 percent) or private insurance (34.1 percent) (Exhibit 3).
- The share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965. Even so, in fiscal year 2019, Medicaid continued to account for a smaller share (9.2 percent) than Medicare (14.5 percent) (Exhibit 4).
- Medicaid spending as a share of state budgets varies depending on whether federal funds are included. Considering only 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 16.3 percent in state fiscal year (SFY) 2018. When federal funds are included, Medicaid's share was 29.2 percent in SFY 2018 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2018 (millions)^

Population	Ever during FY 2018	Point in time during FY 2018	Point in time during CY 2018
	Estimates based on administrative data (CMS)[1]		Survey data (NHIS)[2]
Medicaid enrollees	86.7[3]	74.6	Not available
CHIP enrollees	9.4[4]	6.7[4]	Not available
Totals for Medicaid and CHIP	**96.1[3]**	**81.3**	**55.4**
	Census Bureau data		Survey data (NHIS)[2]
U.S. population	327.6[5]	327.8[5]	321.3
	Administrative and Census Bureau data		Survey data (NHIS)[2]
Medicaid and CHIP enrollment as a percentage of U.S. population	29.3%[1]	24.8%	17.3%

Notes: FY is fiscal year. CY is calendar year. NHIS is National Health Interview Survey. Excludes the territories. Medicaid and CHIP enrollment numbers can vary for reasons including differences in the sources of data (e.g., administrative records versus survey interviews), categories of 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 facility), and the enrollment period examined (e.g., ever during the year versus at a point in time). For a more detailed discussion of enrollment numbers, see https://www.macpac.gov/macstats/data-sources-and-methods/.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

[1] Estimates based on administrative data are from the President's budget. Point in time estimates are from the FY 2019 President's budget and ever-enrolled estimates are from the FY 2017 President's budget because the CMS Office of the Actuary (OACT) did not produce ever-enrolled estimates for the FY 2018 or FY 2019 President's budget. 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 1.4 million individuals in the territories.

[2] NHIS data exclude individuals in active-duty military and in institutions such as nursing facilities; in addition, surveys such as the NHIS generally do not classify limited benefits as Medicaid or CHIP coverage. The NHIS reports a combined total for the Medicaid and CHIP populations. Respondents are also 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; total reflects the point-in-time estimate from the FY 2018 President's budget for this group instead. As a result, the total is an underestimate of the number of people ever enrolled.

[4] These estimates reflect FY 2017 CHIP enrollment because the FY 2019 President's budget did not include information for FY 2018.

[5] The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of September 2018 (the month with the largest count in FY 2018); 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 2018.

Source: MACPAC, 2019, analysis of the following: U.S. Bureau of the Census, 2019, *Monthly population estimates for the United States: April 1, 2010, to December 1, 2019, National totals: Vintage 2018*, https://www2.census.gov/programs-surveys/popest/tables/2010-2018/national/totals/na-est2018-01.xlsx; CMS, 2018, *Fiscal year 2019 justification of estimates for appropriations committees*, Baltimore, MD: CMS, https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2019-CJ-Final.pdf; OACT, CMS, 2017a, e-mail to MACPAC staff, August 15; OACT, 2017b, e-mail to MACPAC staff, July 24; and NHIS data.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2018^

Characteristic	Selected coverage source at time of interview, all ages[1]					Selected coverage source at time of interview, age 0–18[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**17.6%**	**62.9%**	**17.3%**	**9.2%**	**100.0%**	**55.6%**	**36.2%**	**5.1%**
Coverage									
Length of time with any coverage during year									
Full year	**88.0***	98.8*	96.1*	93.5	–	**92.8***	97.4*	95.5	–
Part year	**6.2**	1.2*	3.9*	6.5	29.3*	**4.8**	2.6*	4.5	43.0*
No coverage during year	**5.8**	–	–	–	70.7	**2.3**	–	–	57.0
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid or CHIP combination[6]	**1.8***	10.0	–	10.2	–	**†**	–	†	–
Yes, any private and Medicaid or CHIP combination	**0.6***	–	0.9*	3.3	–	**1.5***	2.7*	4.1	–
Yes, any other combination	**7.8***	44.0*	12.3*	0.8	–	**–**	–	–	–
No	**89.9***	46.0*	86.8	85.7	100.0*	**98.5***	97.3*	95.7	100.0*
Demographics									
Age									
0–18	**24.0***	0.7*	21.2*	50.3	13.3*	**100.0**	100.0	100.0	100.0
19–64	**60.0***	13.8*	66.3*	42.4	85.8*	**–**	–	–	–
65 or older	**16.0***	85.5*	12.5*	7.3	0.9*	**–**	–	–	–
Gender									
Male	**48.9***	45.6	49.0*	44.3	55.1*	**51.1**	50.8	51.5	50.9
Female	**51.1***	54.4	51.0*	55.7	44.9*	**48.9**	49.2	48.5	49.1
Race									
Hispanic	**18.4***	9.3*	13.1*	32.1	37.1*	**25.5***	16.1*	38.7	37.2
White, non-Hispanic	**61.3***	75.0*	68.7*	38.9	41.9	**52.5***	65.6*	33.7	41.7*
Black, non-Hispanic	**12.6***	10.3*	10.1*	21.2	14.1*	**14.2***	9.5*	21.4	13.3*
Other non-white, non-Hispanic	**7.7**	5.4*	8.1	7.8	7.0	**7.7***	8.8*	6.1	7.8

EXHIBIT 2. (continued)

Characteristic	Selected coverage source at time of interview, age 19–64[1]					Selected coverage source at time of interview, age 65 or older[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid or CHIP[3]
Total (percent distribution across coverage sources)[5]	**100.0%**	**4.0%**	**69.5%**	**12.2%**	**13.1%**	**100.0%**	**94.5%**	**49.1%**	**7.8%**
Coverage									
Length of time with any coverage during year									
Full year	**83.2***	97.1*	95.0*	90.5	–	**98.6**	99.1	99.6*	97.0
Part year	**8.2**	†	5.0*	9.5	27.7*	**1.0**	0.9	0.4	†
No coverage during year	**8.6**	–	–	–	72.3	**0.5**	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid or CHIP combination[6]	**1.2***	30.1*	–	10.0	–	**6.4***	6.8*	–	81.6
Yes, any private and Medicaid or CHIP combination	**0.4***	–	0.5*	2.9	–	**†**	–	†	†
Yes, any other combination	**0.8**	19.2	1.1	†	–	**45.7***	48.3*	93.0*	7.1
No	**97.6***	50.7*	98.4*	86.4	100.0*	**47.9***	44.9*	7.0*	11.2
Demographics									
Age									
0–18	**–**	–	–	–	–	**–**	–	–	–
19–64	**100.0**	100.0	100.0	100.0	100.0	**–**	–	–	–
65 or older	**–**	–	–	–	–	**100.0**	100.0	100.0	100.0
Gender									
Male	**49.1***	51.3*	49.2*	37.9	55.8*	**44.9***	44.6*	45.0*	32.2
Female	**50.9***	48.7*	50.8*	62.1	44.2*	**55.1***	55.4*	55.0*	67.8
Race									
Hispanic	**18.1***	15.3*	13.7*	24.7	36.9*	**8.7***	8.2*	4.9*	29.6
White, non-Hispanic	**60.7***	61.5*	66.8*	44.9	42.1	**76.4***	77.5*	84.4*	38.9
Black, non-Hispanic	**12.9***	18.1	11.0*	21.5	14.2*	**9.1***	8.9*	6.3*	18.4
Other non-white, non-Hispanic	**8.3**	5.1*	8.5	8.9	6.8	**5.7***	5.4*	4.4*	13.2

EXHIBIT 2. (continued)

Characteristic	Selected coverage source at time of interview, all ages[1]					Selected coverage source at time of interview, age 0–18[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Education[7]									
Less than high school	**11.0%***	15.8%*	5.1%*	27.0%	26.1%	–	–	–	–
High school diploma or GED certificate	**24.3***	28.4*	20.5*	34.9	33.2	–	–	–	–
Some college	**30.6**	28.1	31.4*	28.7	26.0	–	–	–	–
College or graduate degree	**34.0***	27.6*	42.9*	9.3	14.6*	–	–	–	–
Marital status[7]									
Married	**53.4***	54.1*	59.7*	28.1	38.4*	–	–	–	–
Widowed	**5.8**	20.0*	4.3*	6.0	1.8*	–	–	–	–
Divorced or separated	**11.0***	14.9*	9.0*	17.6	13.0*	–	–	–	–
Living with partner	**7.6***	3.1*	7.0*	11.4	11.7	–	–	–	–
Never married	**22.1***	8.0*	20.0*	37.0	35.1	–	–	–	–
Family income									
Has income less than 138 percent FPL	**20.2***	20.1*	6.9*	59.7	36.5*	**27.1%***	6.4%*	58.4%	31.4%*
Has income in ranges shown below									
Less than 100 percent FPL	**12.7***	11.2*	3.8*	41.0	23.0*	**17.9***	3.5*	39.9	21.1*
100–199 percent FPL	**18.3***	22.7*	10.3*	36.7	30.8*	**21.7***	10.3*	38.3	25.8*
200–399 percent FPL	**28.8***	30.8*	31.1*	17.2	30.7*	**29.1***	35.4*	17.7	36.3*
400 percent FPL or higher	**40.0***	35.1*	54.7*	4.9	15.2*	**31.2***	50.9*	3.8	16.6*
Other demographic characteristics									
Citizen of United States	**93.4**	97.5*	95.1*	93.7	77.3*	**97.8**	98.3	98.1	92.2*
Parent of a dependent child[7]	**27.2***	1.9*	29.1*	33.5	33.1	**†**	†	†	†
Currently working[7]	**63.7***	16.6*	74.9*	38.7	69.1*	**2.1**	2.6*	1.5	†
Veteran[7]	**8.8***	18.5*	6.8*	3.0	2.2	–	–	–	–
Receives SSI or SSDI	**4.0***	12.9	1.2*	12.9	1.0*	**1.3***	†	3.2	†
Health									
Current health status									
Excellent or very good	**66.4***	41.8*	72.7*	58.8	60.0	**85.5***	91.0*	77.5	78.5
Good	**23.4**	32.3*	20.8*	24.8	29.5*	**12.7***	7.9*	19.2	18.8
Fair or poor	**10.2***	25.8*	6.4*	16.4	10.5*	**1.8***	1.1*	3.3	†

EXHIBIT 2. (continued)

Characteristic	Selected coverage source at time of interview, age 19–64[1]					Selected coverage source at time of interview, age 65 or older[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid or CHIP[3]
Education[7]									
Less than high school	**9.9%***	20.5%	4.4%*	23.8%	26.0%	**15.1%***	15.1%*	9.0%*	46.3%
High school diploma or GED certificate	**23.6***	35.6	19.4*	36.3	33.4	**27.2**	27.2	26.3	26.4
Some college	**31.5**	30.1	32.0	31.3	26.0*	**27.6***	27.8*	28.7*	13.2
College or graduate degree	**35.1***	13.8*	44.2*	8.6	14.6*	**30.1***	29.9*	36.0*	14.1
Marital status[7]									
Married	**52.3***	33.9*	59.1*	27.7	38.3*	**57.5***	57.3*	63.2*	30.5
Widowed	**1.6***	4.5*	1.3*	2.2	1.5	**21.9***	22.4*	20.6*	27.8
Divorced or separated	**10.4***	23.9*	8.6*	15.8	13.1*	**13.6***	13.4*	11.0*	27.6
Living with partner	**9.1***	8.8*	7.9*	12.9	11.8	**2.2**	2.2	1.7	2.8
Never married	**26.7***	28.8*	23.1*	41.4	35.4*	**4.8***	4.6*	3.5*	11.2
Family income									
Has income less than 138 percent FPL	**18.4***	42.3*	7.0*	60.1	37.2*	**16.6***	16.2*	7.4*	66.4
Has income in ranges below									
Less than 100 percent FPL	**11.7***	26.6*	4.1*	41.5	23.1*	**8.9***	8.5*	3.2*	45.6
100–199 percent FPL	**16.4***	34.3	9.5*	35.4	31.8	**20.4***	20.7*	14.9*	32.1
200–399 percent FPL	**28.2***	24.6*	29.5*	17.0	30.0*	**31.5***	32.0*	32.2*	14.6
400 percent FPL or higher	**43.6***	14.2*	56.9*	5.7	15.0*	**39.0***	38.7*	49.6*	7.5
Other demographic characteristics									
Citizen of United States	**90.7**	95.4*	93.5*	89.5	75.2*	**97.0***	97.8*	98.3*	88.2
Parent of a dependent child[7]	**34.2***	10.7*	34.4*	39.2	33.5*	**0.7**	0.5	0.8	†
Currently working[7]	**75.8***	15.4*	84.7*	44.3	69.6*	**18.3***	16.7*	22.8*	6.3
Veteran[7]	**5.7***	7.5*	4.6*	2.4	2.2	**20.5***	20.3*	18.6*	6.5
Receives SSI or SSDI	**5.1***	68.9*	1.5*	21.4	1.0*	**4.1***	4.1*	1.2*	31.0
Health									
Current health status									
Excellent or very good	**64.2***	17.6*	70.9*	43.6	57.3*	**45.5***	45.4*	51.2*	17.4
Good	**25.4***	30.3	22.8*	30.8	31.0	**32.4**	32.8*	32.4	28.5
Fair or poor	**10.4***	52.2*	6.2*	25.6	11.7*	**22.1***	21.8*	16.4*	54.1

EXHIBIT 2. (continued)

Notes: GED is General Equivalence Diploma. FPL is federal poverty level. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available online in the 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 sum 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 Expenditure 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

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

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

– Dash indicates zero.

[1] Total includes all non-institutionalized individuals, regardless of coverage source. In this exhibit, the values across health insurance coverage types may not sum 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 or 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 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, 2019, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2018

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 payer expenditures	**$3,649,386**	**$597,387**	**$18,583**	**$750,182**	**$1,243,050**	**$119,747**	**$544,825**	**$375,610**
Hospital care	**1,191,813**	196,642	4,673	296,989	481,088	67,500	110,093	34,829
Physician and clinical services	**725,553**	77,394	4,395	170,242	311,808	30,195	70,354	61,165
Dental services	**135,636**	12,783	2,137	1,189	62,246	1,870	560	54,852
Other professional services[3]	**103,894**	7,694	399	27,195	35,129	–	7,350	26,128
Home health care	**102,191**	35,893	73	40,262	12,210	758	2,840	10,155
Other non-durable medical products[4]	**66,352**	–	–	2,103	–	–	–	64,250
Prescription drugs	**335,037**	33,363	2,010	107,248	134,259	9,327	1,750	47,079
Durable medical equipment[5]	**54,864**	8,082	188	8,859	11,287	–	956	25,492
Nursing care facilities and continuing care retirement communities[6]	**168,504**	49,893	16	38,135	17,080	5,646	12,898	44,837
Other health, residential, and personal care services[7]	**191,615**	111,089	1,648	4,931	13,623	1,046	52,454	6,825
Administration[8]	**306,039**	64,554	3,043	53,032	164,320	3,405	17,684	–
Public health activity	**93,522**	–	–	–	–	–	93,523	–
Investment	**174,364**	–	–	–	–	–	174,364	–

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 payer share of expenditures	**100.0%**	**16.4%**	**0.5%**	**20.6%**	**34.1%**	**3.3%**	**14.9%**	**10.3%**
Hospital care	**100.0**	16.5	0.4	24.9	40.4	5.7	9.2	2.9
Physician and clinical services	**100.0**	10.7	0.6	23.5	43.0	4.2	9.7	8.4
Dental services	**100.0**	9.4	1.6	0.9	45.9	1.4	0.4	40.4
Other professional services[3]	**100.0**	7.4	0.4	26.2	33.8	–	7.1	25.1
Home health care	**100.0**	35.1	0.1	39.4	11.9	0.7	2.8	9.9
Other non-durable medical products[4]	**100.0**	–	–	3.2	–	–	–	96.8
Prescription drugs	**100.0**	10.0	0.6	32.0	40.1	2.8	0.5	14.1
Durable medical equipment[5]	**100.0**	14.7	0.3	16.1	20.6	–	1.7	46.5
Nursing care facilities and continuing care retirement communities[6]	**100.0**	29.6	0.0	22.6	10.1	3.4	7.7	26.6
Other health, residential, and personal care services[7]	**100.0**	58.0	0.9	2.6	7.1	0.5	27.4	3.6
Administration[8]	**100.0**	21.1	1.0	17.3	53.7	1.1	5.8	–
Public health activity	**100.0**	–	–	–	–	–	100.0	–
Investment	**100.0**	–	–	–	–	–	100.0	–

Notes: Every five years 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. The values shown here reflect the comprehensive revision made in 2014, and thus, 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 implemented 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. That change caused a downward revision for hospitals and home health and an upward revision for other service categories.

EXHIBIT 3. (continued)

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

[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 practioners other than physicians and dentists, including those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational, and speech therapists.

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

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

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

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

[8] The 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), CMS, 2019, *National health expenditures by type of service and source of funds: Calendar years 1960–2018*, Baltimore, MD: OACT, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2018.zip. OACT, 2019, *National health expenditure accounts: Methodology paper*, 2018, Baltimore, MD: OACT, https://www.cms.gov/files/document/definitions-sources-and-methods.pdf. OACT, 2014, *Summary of 2014 comprehensive revision to the national health expenditure accounts*, Baltimore, MD: OACT, 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 Federal Budget as a Share of Federal Outlays, FYs 1965–2019

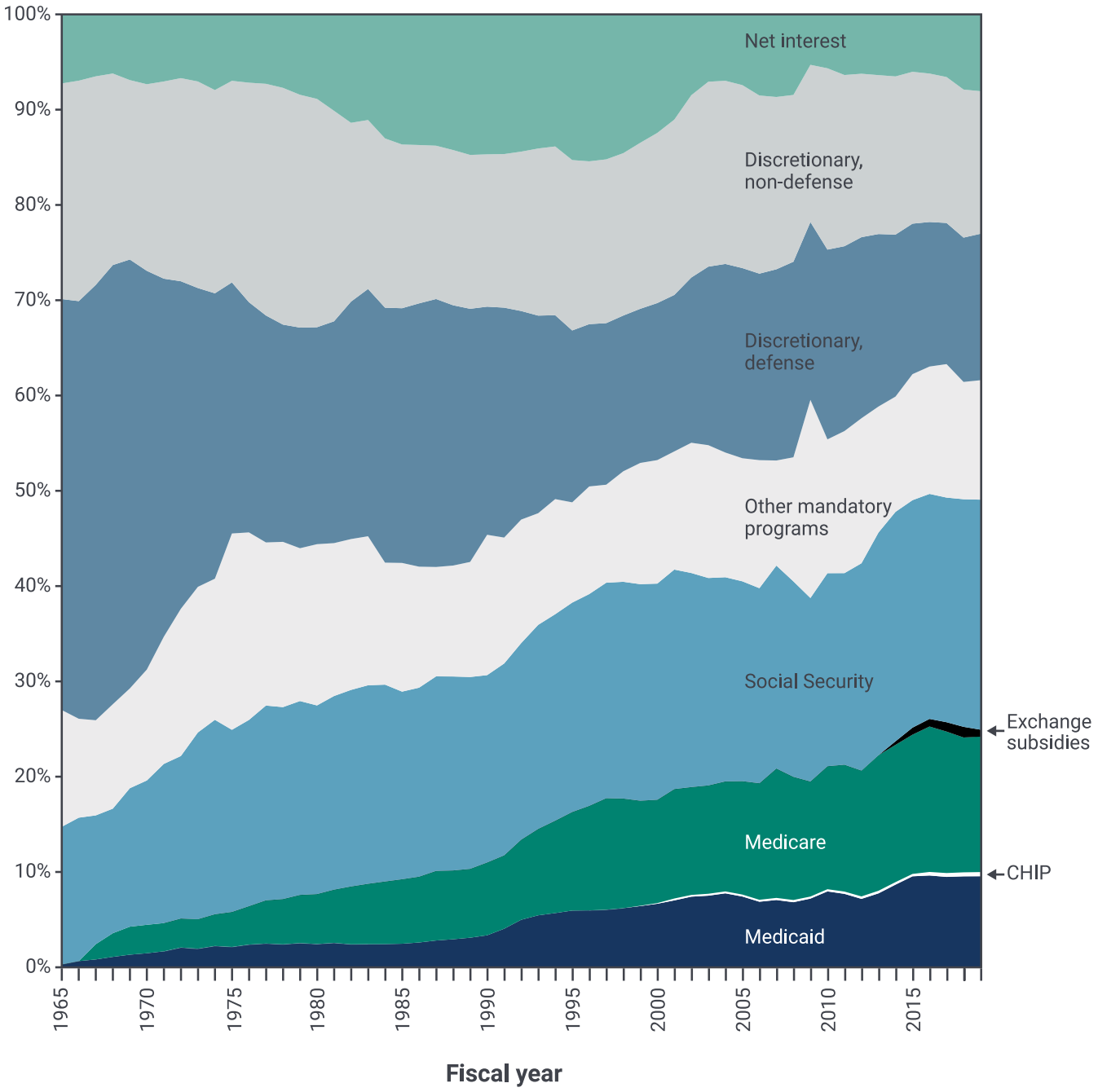


EXHIBIT 4. (continued)

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
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	–	21.8	15.2	19.0	17.2	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	6.0
2016	9.6	0.4	15.3	0.8	23.6	13.4	15.2	15.6	6.2
2017	9.4	0.4	14.9	1.0	23.6	14.0	14.8	15.3	6.6
2018	9.5	0.4	14.2	1.1	23.9	12.3	15.2	15.5	7.9
2019	9.2	0.4	14.5	1.1	23.3	13.0	15.2	14.9	8.4

Notes: FY is fiscal year.

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

Source: MACPAC, 2020, analysis of Office of Management and Budget (OMB), Tables 6.1, 8.5, and 8.7, in *Historical tables, budget of the United States Government, fiscal year 2021*, Washington, DC: OMB, https://www.govinfo.gov/app/details/BUDGET-2021-TAB/context.

EXHIBIT 5. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, SFY 2018

State	Total budget (including state and federal funds)				State-funded budget			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
Total	**$2,017,531**	**29.2%**	**19.7%**	**10.2%**	**$1,392,911**	**16.3%**	**24.7%**	**13.3%**
Alabama	27,262	24.1	21.1	20.9	17,304	11.4	27.1	26.6
Alaska	10,302	20.0	16.2	7.5	6,688	9.7	21.5	9.8
Arizona	37,494	33.1	16.0	17.0	21,495	13.7	22.4	25.4
Arkansas	25,637	27.7	14.2	15.3	17,717	9.2	17.5	22.1
California	269,668	31.6	20.8	7.5	177,316	17.9	27.9	8.5
Colorado	39,814	23.6	23.8	14.8	29,886	13.5	29.7	18.8
Connecticut	33,152	24.4	12.5	9.8	27,011	16.7	13.4	11.2
Delaware	10,847	21.0	23.5	3.8	8,355	9.7	28.1	4.3
District of Columbia	13,312	22.4	20.8	1.3	9,961	8.2	25.0	1.5
Florida	78,523	32.4	18.6	10.2	51,122	21.0	24.9	15.4
Georgia	51,394	21.1	24.4	19.0	36,948	9.1	27.7	26.3
Hawaii	15,199	14.1	13.8	8.8	12,571	5.5	14.9	10.6
Idaho	7,963	27.0	26.3	9.3	5,279	15.2	34.3	13.9
Illinois	72,783	31.1	14.4	2.8	55,843	17.2	14.8	3.4
Indiana	33,621	33.5	28.1	6.2	20,043	15.9	41.9	9.1
Iowa	23,382	23.0	16.3	26.5	17,122	13.1	19.5	33.4
Kansas	15,934	21.2	31.1	17.8	12,161	12.5	36.9	20.5
Kentucky	34,052	30.3	17.1	24.0	21,611	11.0	23.0	34.0
Louisiana	31,253	35.6	16.9	8.9	19,168	16.1	21.6	14.2
Maine	8,411	33.6	17.6	3.7	5,713	18.8	22.1	5.5
Maryland	43,796	26.3	18.3	14.4	31,649	14.6	21.9	18.6
Massachusetts	57,125	29.2	13.7	2.3	42,693	20.2	15.5	3.1
Michigan	56,614	30.5	25.5	4.0	35,881	14.2	35.6	6.0
Minnesota	39,819	31.8	25.2	4.5	28,466	19.1	32.6	6.2
Mississippi	19,653	25.9	16.5	19.8	11,866	10.6	21.4	31.5

EXHIBIT 5. (continued)

State	Total budget (including state and federal funds)				State-funded budget			
	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	$26,038	39.0%	22.5%	4.5%	$17,678	27.1%	27.6%	6.6%
Montana	6,952	26.4	14.6	9.6	4,089	10.1	20.3	15.6
Nebraska	12,141	17.7	13.9	23.6	9,040	11.4	14.5	25.7
Nevada	14,263	26.4	15.1	6.8	9,639	9.2	19.3	10.0
New Hampshire	6,131	35.5	20.2	2.3	3,834	23.8	27.6	3.6
New Jersey	60,775	24.3	23.4	8.7	45,147	12.1	29.5	11.8
New Mexico	20,460	27.4	16.5	15.0	11,964	9.9	24.7	20.5
New York	163,744	35.6	19.1	6.6	106,936	20.1	26.0	9.8
North Carolina	49,832	28.0	22.3	13.2	34,536	13.6	27.9	18.9
North Dakota	5,889	20.7	19.9	19.7	4,417	10.6	23.4	23.5
Ohio	69,683	38.0	17.0	4.2	54,570	32.7	18.4	5.3
Oklahoma	22,669	24.4	15.4	24.5	15,147	16.8	18.7	30.3
Oregon	40,619	21.7	13.1	3.3	30,143	7.6	15.5	4.3
Pennsylvania	84,909	36.1	17.5	2.3	55,764	22.7	22.2	3.6
Rhode Island	9,262	29.3	14.9	13.3	6,266	18.0	19.1	19.5
South Carolina	25,257	26.1	19.7	19.5	16,664	11.6	24.0	28.7
South Dakota	4,457	20.1	16.4	21.0	3,050	12.2	18.5	28.4
Tennessee	34,190	32.9	18.4	14.9	21,572	19.8	23.7	23.3
Texas	115,208	29.4	26.9	15.4	75,832	16.3	34.1	17.8
Utah	14,789	18.9	27.1	13.4	10,865	9.0	32.4	18.2
Vermont	5,675	28.2	32.9	1.8	3,749	18.4	46.4	2.7
Virginia	52,076	18.9	15.1	14.3	41,913	12.0	16.3	15.7
Washington	46,021	26.7	25.2	13.3	33,728	13.3	31.8	18.2
West Virginia	16,857	22.7	13.6	16.1	12,376	6.9	15.7	20.0
Wisconsin	48,199	20.3	16.3	14.3	36,624	12.2	19.3	14.3
Wyoming	4,425	13.8	20.2	10.0	3,499	8.4	25.6	12.7

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. Other state funds are amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds. 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 (includes hospitals, economic development, housing environmental programs, CHIP, parks and recreation, natural resources, and air and water transportation). 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, because federal reimbursements for Medicaid expenditures funded from the General Revenue Fund (GRF) are deposited into the GRF, Ohio's general revenue expenditures look higher and conversely make Ohio's federal expenditures look lower relative to most other states that don't follow this practice. In addition, in many states, some functions—particularly elementary and secondary education—may be partially funded outside of the state budget by local governments.

Source: NASBO, 2019, 2019 *State expenditure report: Fiscal years 2017–2019*, Washington, DC: NASBO, https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives.

EXHIBIT 6. Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages by State, FYs 2018–2021

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2018[1]	FY 2019[1]	FY 2020[1]	FY 2020 (Emergency)[2]	FY 2021[1,3]	FY 2018[4]	FY 2019[4]	FY 2020[5]	FY 2020 (Emergency)[5,6]	FY 2021[3]
Alabama	71.44%	71.88%	71.97%	78.17%	72.58%	100.00%	100.00%	91.88%	96.22%	80.81%
Alaska	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Arizona	69.89	69.81	70.02	76.22	70.01	100.00	100.00	90.51	94.85	79.01
Arkansas	70.87	70.51	71.42	77.62	71.23	100.00	100.00	91.49	95.83	79.86
California	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Colorado	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Connecticut	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Delaware	56.43	57.55	57.86	64.06	57.74	92.50	93.29	82.00	86.34	70.42
District of Columbia	70.00	70.00	70.00	76.20	70.00	100.00	100.00	90.50	94.84	79.00
Florida	61.79	60.87	61.47	67.67	61.96	96.25	95.61	84.53	88.87	73.37
Georgia	68.50	67.62	67.30	73.50	67.03	100.00	100.00	88.61	92.95	76.92
Hawaii	54.78	53.92	53.47	59.67	53.02	91.35	90.74	78.93	83.27	67.11
Idaho	71.17	71.13	70.34	76.54	70.41	100.00	100.00	90.74	95.08	79.29
Illinois	50.74	50.31	50.14	56.34	50.96	88.52	88.22	76.60	80.94	65.67
Indiana	65.59	65.96	65.84	72.04	65.83	98.91	99.17	87.59	91.93	76.08
Iowa	58.48	59.93	61.20	67.40	61.75	93.94	94.95	84.34	88.68	73.23
Kansas	54.74	57.10	59.16	65.36	59.68	91.32	92.97	82.91	87.25	71.78
Kentucky	71.17	71.67	71.82	78.02	72.05	100.00	100.00	91.77	96.11	80.44
Louisiana	63.69	65.00	66.86	73.06	67.42	97.58	98.50	88.30	92.64	77.19
Maine	64.34	64.52	63.80	70.00	63.69	98.04	98.16	86.16	90.50	74.58
Maryland	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Massachusetts	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Michigan	64.78	64.45	64.06	70.26	64.08	98.35	98.12	86.34	90.68	74.86
Minnesota	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Mississippi	75.65	76.39	76.98	83.18	77.76	100.00	100.00	95.39	99.73	84.43
Missouri	64.61	65.40	65.65	71.85	64.96	98.23	98.78	87.46	91.80	75.47
Montana	65.38	65.54	64.78	70.98	65.60	98.77	98.88	86.85	91.19	75.92
Nebraska	52.55	52.58	54.72	60.92	56.47	89.79	89.81	79.80	84.14	69.53
Nevada	65.75	64.87	63.93	70.13	63.30	99.03	98.41	86.25	90.59	74.31
New Hampshire	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
New Jersey	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
New Mexico	72.16	72.26	72.71	78.91	73.46	100.00	100.00	92.40	96.74	81.42
New York	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00

EXHIBIT 6. (continued)

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2018[1]	FY 2019[1]	FY 2020[1]	FY 2020 (Emergency)[2]	FY 2021[1, 3]	FY 2018[4]	FY 2019[4]	FY 2020[5]	FY 2020 (Emergency)[5, 6]	FY 2021[3]
North Carolina	67.61%	67.16%	67.03%	73.23%	67.40%	100.00%	100.00%	88.42%	92.76%	77.18%
North Dakota	50.00	50.00	50.05	56.25	52.40	88.00	88.00	76.54	80.88	66.68
Ohio	62.78	63.09	63.02	69.22	63.63	96.95	97.16	85.61	89.95	74.54
Oklahoma	58.57	62.38	66.02	72.22	67.99	94.00	96.67	87.71	92.05	77.59
Oregon	63.62	62.56	61.23	67.43	60.84	97.53	96.79	84.36	88.70	72.59
Pennsylvania	51.82	52.25	52.25	58.45	52.20	89.27	89.58	78.08	82.42	66.54
Rhode Island	51.45	52.57	52.95	59.15	54.09	89.02	89.80	78.57	82.91	67.86
South Carolina	71.58	71.22	70.70	76.90	70.63	100.00	100.00	90.99	95.33	79.44
South Dakota	55.34	56.71	57.62	63.82	58.28	91.74	92.70	81.83	86.17	70.80
Tennessee	65.82	65.87	65.21	71.41	66.10	99.07	99.11	87.15	91.49	76.27
Texas	56.88	58.19	60.89	67.09	61.81	92.82	93.73	84.12	88.46	73.27
Utah	70.26	69.71	68.19	74.39	67.52	100.00	100.00	89.23	93.57	77.26
Vermont	53.47	53.89	53.86	60.06	54.57	90.43	90.72	79.20	83.54	68.20
Virginia	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
Washington	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
West Virginia	73.24	74.34	74.94	81.14	74.99	100.00	100.00	93.96	98.30	82.49
Wisconsin	58.77	59.37	59.36	65.56	59.37	94.14	94.56	83.05	87.39	71.56
Wyoming	50.00	50.00	50.00	56.20	50.00	88.00	88.00	76.50	80.84	65.00
American Samoa[7]	55.00	55.00	83.00	89.20	83.00	91.50	91.50	99.60	100.00	88.10
Guam[7]	55.00	55.00	83.00	89.20	83.00	91.50	91.50	99.60	100.00	88.10
N. Mariana Islands[7]	55.00	55.00	83.00	89.20	83.00	91.50	91.50	99.60	100.00	88.10
Puerto Rico[7]	55.00	55.00	76.00	82.20	76.00	91.50	91.50	94.70	99.04	83.20
Virgin Islands[7]	55.00	55.00	83.00	89.20	83.00	91.50	91.50	99.60	100.00	88.10

Notes: FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. FY is fiscal year. 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 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). E-FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent. For FYs 2018–2020, the E-FMAPs are then increased by a set number of percentage points determined by statute (see below, notes 4 and 5).

EXHIBIT 6. (continued)

[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 expanded eligibility to low-income parents and non-pregnant adults without children prior to enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

[2] The Families First Coronavirus Response Act of 2020 (P.L. 116-127) provides a temporary 6.2 percentage point FMAP increase during a public health emergency for each calendar quarter occurring during the period beginning on the first day of the public health emergency period, as defined in Section 1135(g)(1)(B) of the Social Security Act (the Act), and ending on the last day of the calendar quarter in which the last day of such emergency period occurs. The Secretary of the U.S. Department of Health and Human Services declared a public health emergency on January 31, 2020, with an effective date of January 27, 2020, meaning the FMAP increase is effective as of January 1, 2020. States, including the District of Columbia and the territories, must meet certain maintenance-of-effort requirements in order to qualify for the FMAP increase. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Services facility that already receive a higher matching rate.

[3] At the time of publication, the public health emergency period has not ended. The FY 2021 FMAPs and E-FMAPs will also receive a temporary increase for any quarters during which the public health emergency is still in effect after September 30, 2020.

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

[5] Under the HEALTHY KIDS Act (P.L. 115-120), beginning on October 1, 2019, and ending on September 30, 2020, the E-FMAP was increased by 11.5 percentage points, not to exceed 100 percent, for all states.

[6] Because the E-FMAP in Section 2105(b) of the Act is calculated based on the FMAP, the E-FMAP is also higher for states, though not in the same amount, for the duration of the public health emergency period.

[7] Under the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), the territories receive a temporary FMAP increase for FYs 2020 and 2021. For the period October 1, 2019–December 20, 2019, the FMAP for all territories is 100 percent. For the period December 21, 2019–September 30, 2021, Puerto Rico receives an FMAP of 76 percent and the other territories receive an FMAP of 83 percent. The E-FMAPs for FYs 2020 and 2021 were calculated from these increased FMAPs. The FMAPs and E-FMAPs for the period December 21, 2019–September 30, 2021 are listed.

Source: MACPAC, 2020, analysis of U.S. Department of Health and Human Services, Federal Register notices for FYs 2017–2021, and Further Consolidated Appropriations Act, 2020 (P.L. 116-94). CMS, 2020, Families First Coronavirus Response Act: Increased FMAP FAQs, accessed April 2, 2020, Baltimore, MD: CMS, https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf. Center for Medicaid and CHIP Services, CMS, 2020, e-mail messages to MACPAC, March 27 and March 30.

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 then slowed as economic conditions improved.
  - The large increases in Medicaid enrollment and spending in fiscal years (FYs) 2014 and 2015 were primarily due to expanded eligibility under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).
  - Most recently, enrollment in Medicaid and the State Children's Health Insurance Program (CHIP) increased by about 5.6 percent from July 2019 to July 2020. Much of this increase is attributable to the economic downturn created by the COVID-19 pandemic as well as the continuous coverage requirement attached to the federal medical assistance percentage (FMAP) increase under the Families First Coronavirus Response Act (P.L. 116-127). Enrollment increased in all states except the District of Columbia and Montana (Exhibit 11).
- Medicaid enrollment trends vary by eligibility group (Exhibit 7).
  - Adults (excluding those eligible on the basis of disability) generally experience larger enrollment increases during periods of economic recession than other eligibility groups. For example, from FY 2008 through FY 2013, enrollment for adults grew on average 5.8 percent annually, compared to 3.0 percent annually for children (excluding those eligible on the basis of disability) and individuals qualifying for Medicaid on the basis of disability.
  - Enrollment for adults has grown substantially due to the expansion of Medicaid under the ACA, increasing at an average annual rate of 11.3 percent from FY 2013 through FY 2018.
  - Individuals age 65 and older generally have the slowest enrollment growth rate regardless of time period.
- Medicaid's share of state-funded budgets (excluding federal funds) and total state budgets (including federal funds) has varied over time. In state fiscal year 2015, Medicaid's share of total state budgets increased, but its share of state-funded budgets decreased slightly. The decrease can be attributed to 100 percent federal funding made available for low-income adults not otherwise eligible on the basis of disability, who became newly eligible for Medicaid under the ACA. Medicaid's share of state-funded budgets has increased slightly since 2015 (Exhibit 13).
- Medicaid and CHIP expenditures as a share of national health expenditures are projected to grow from 16.8 percent in 2019 to about 16.9 percent in 2028. Medicare's share is projected to increase from 21.0 percent to 25.2 percent during the same time period (Exhibit 12).

EXHIBIT 7. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FYs 1975–2018 (thousands)

Fiscal year	Total	Child	Adult[1]	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	Child	Adult[1]	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	**67,516**	30,703	16,889	10,123	4,500	5,301
2018[2]	**82,940**	30,769	28,870	9,062	6,086	8,153

Notes: FY is fiscal year. Excludes Medicaid-expansion CHIP and the territories. 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.

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. For FYs 1975–2013, this exhibit does not recode individuals age 65 and older who are reported as disabled, due to lack of detail in the historical data (unlike the majority of MACStats). Due to the way eligibility is reported in the Transformed Medicaid Statistical Information System (T-MSIS), age must be used to separate beneficiaries eligible on the basis of age from those eligible based on disability. This means that the 2018 beneficiary count for the disabled category no longer includes anyone age 65 and older. 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.

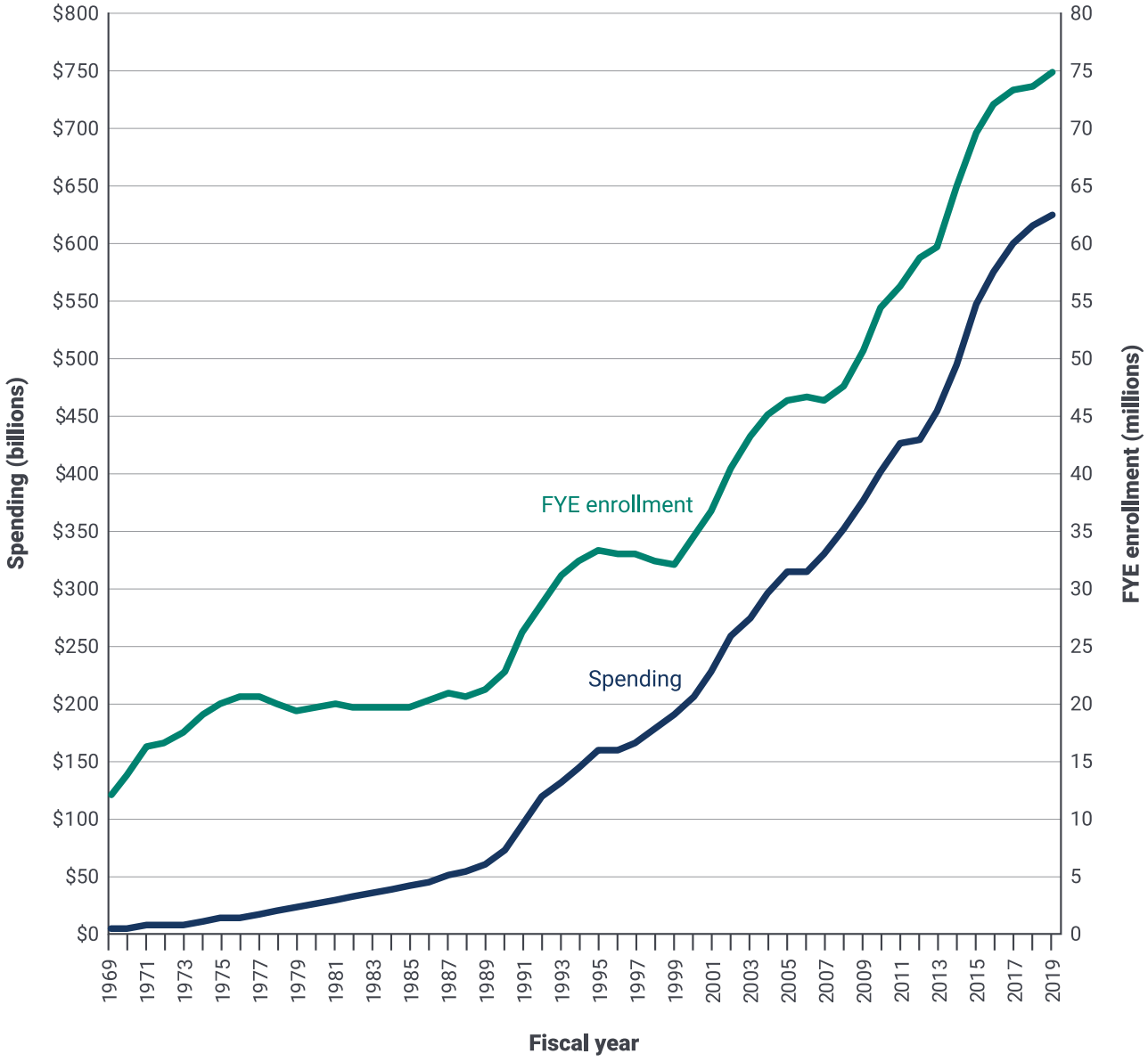
For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The national enrollment counts shown here are unduplicated using this national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

[1] Includes the new adult group made eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

[2] Due to the transition from the Medicaid Statistical Information System (MSIS) to T-MSIS, complete and valid data are not available for all states for several years. We jumped to FY 2018 because this was the most complete year of data available to develop our MACStats exhibits.

Sources: For FY 2018: MACPAC, 2020, analysis of T-MSIS data as of April 2020. For FYs 1999–2013: MACPAC, 2017, analysis of MSIS data. For FYs 1975–1998: CMS, Table 13.4: Number of Medicaid persons served (beneficiaries), by eligibility group: fiscal years 1975–2008, in Medicare & Medicaid statistical supplement, 2010 edition, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2010_Section13.pdf#Table%2013.4.

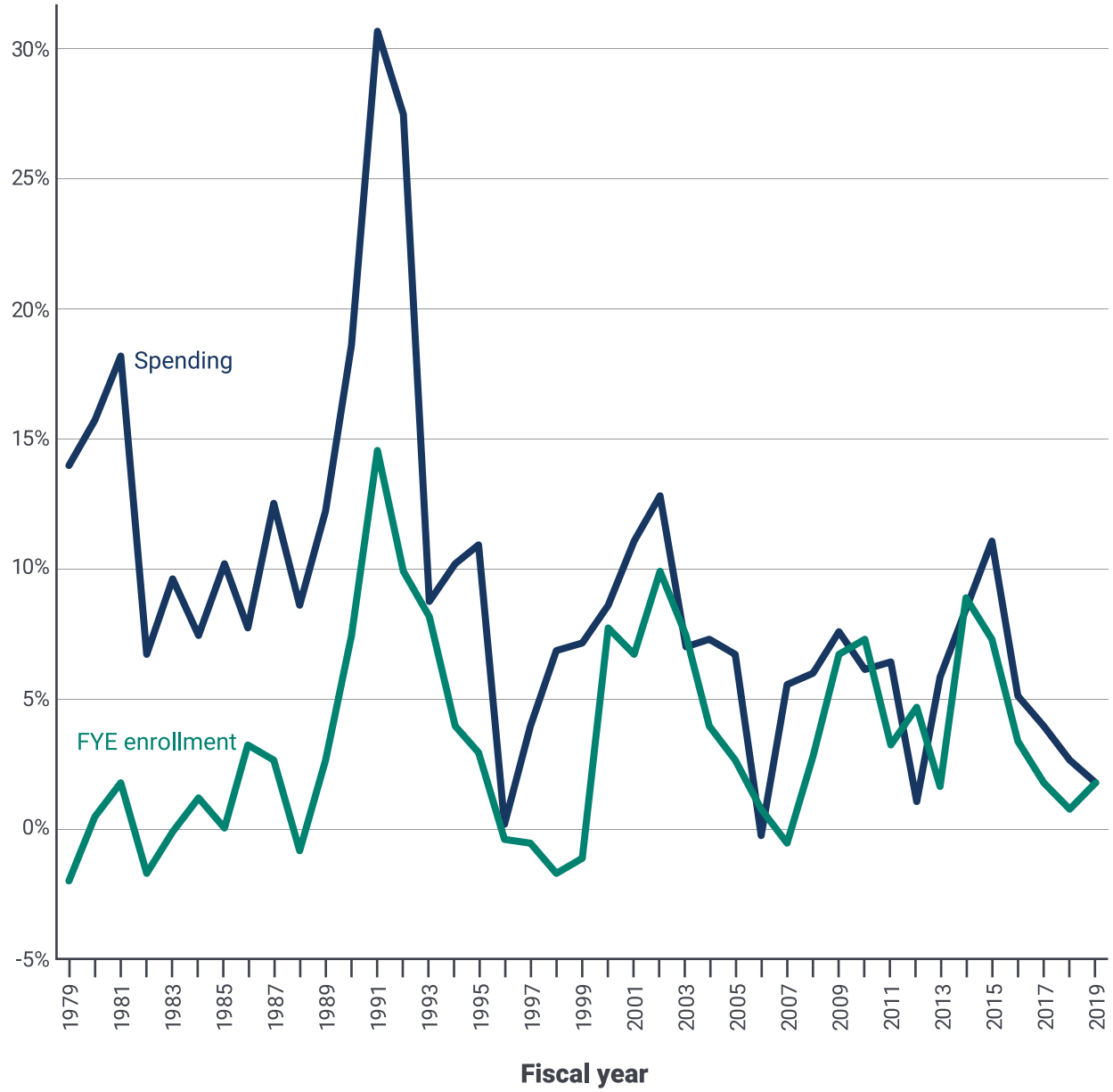
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1969–2019



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 CMS Office of the Actuary (OACT). Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are FYEs 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 2013–2019 are projected. Enrollment for FYs 1999–2019 include estimates for the territories.

Sources: For FY 2019 spending: MACPAC, 2020, analysis of CMS-64 financial management report net expenditure data as of August 5, 2020. OACT, 2020, data compilation provided to MACPAC, October 19, 2020.

EXHIBIT 9. Annual Growth in Medicaid Enrollment and Spending, FYs 1979—2019



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. 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 CMS Office of the Actuary (OACT). Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are FYEs 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 2013–2019 are projected. Enrollment for FYs 1999–2019 include estimates for the territories.

Sources: For FY 2019 spending: MACPAC, 2020, analysis of CMS-64 financial management report net expenditure data as of August 5, 2020. OACT, 2020, data compilation provided to MACPAC, October 19, 2020.

EXHIBIT 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1969–2019

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
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

EXHIBIT 10. (continued)

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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	56.3	7,582	6.3	3.2	3.0
2012	431	58.9	7,313	0.9	4.6	-3.5
2013	456	59.8	7,622	5.8	1.5	4.2
2014	495	65.1	7,599	8.5	8.8	-0.3
2015	549	69.8	7,866	11.0	7.2	3.5
2016	577	72.1	8,003	5.1	3.3	1.7
2017	600	73.4	8,179	3.9	1.7	2.2
2018	616	73.9	8,339	2.7	0.7	2.0
2019[1]	627	75.1	8,343	1.8	1.7	0.1

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 CMS Office of the Actuary (OACT). Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are FYEs 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 2013–2019 are projected. Enrollment for FYs 1999–2019 include estimates for the territories.

[1] Due to the unavailability of more recent data from OACT, we updated spending estimates for FY 2019 using amounts reported on the CMS-64 net financial management report (FMR).

Sources: For FY 2019 spending: MACPAC, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020. OACT, 2020, data compilation provided to MACPAC, October 19, 2020.

EXHIBIT 11. Full-Benefit Medicaid and CHIP Enrollment, Selected Months in 2013–2020

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2017	July 2018	July 2019	July 2020	July 2017 to July 2018	July 2018 to July 2019	July 2019 to July 2020	July–September 2013 average to July 2020
Total	**56,511,799**[1]	**73,403,299**	**72,501,774**	**71,544,194**	**75,521,263**	**-1.2%**	**-1.3%**	**5.6%**	**31.7%**[2]
Alabama	799,176[3]	892,956	904,059	922,278	965,307	1.2	2.0	4.7	20.8
Alaska	122,334	196,121	211,609	223,117	232,578	7.9	5.4	4.2	90.1
Arizona	1,201,770	1,745,097	1,688,791	1,715,655	1,862,408	-3.2	1.6	8.6	55.0
Arkansas	556,851	860,770	839,797	798,044	839,653	-2.4	-5.0	5.2	50.8
California	7,755,381	12,277,389	12,059,138	11,743,500	11,899,370	-1.8	-2.6	1.3	53.4
Colorado	783,420	1,420,173	1,350,594	1,291,058	1,361,828	-4.9	-4.4	5.5	73.8
Connecticut	–	799,837[4]	845,276	857,415	885,365	5.7	1.4	3.3	–
Delaware	223,324	228,628	231,090	231,571	241,814	1.1	0.2	4.4	8.3
District of Columbia	235,786[5, 6]	255,711	254,689	256,139	250,086	-0.4	0.6	-2.4	6.1
Florida	3,695,306	3,882,461	3,729,831	3,657,394	3,930,734	-3.9	-1.9	7.5	6.4
Georgia	1,535,090	1,754,492	1,874,411	1,848,553	1,951,725	6.8	-1.4	5.6	27.1
Hawaii	288,357	346,435	337,722	328,393	357,758	-2.5	-2.8	8.9	24.1
Idaho	238,150	294,571	274,741	265,493	345,793	-6.7	-3.4	30.2	45.2
Illinois	2,626,943	3,073,670	2,974,380	2,843,003	3,018,195	-3.2	-4.4	6.2	14.9
Indiana	1,120,674	1,494,850	1,448,302	1,461,778	1,627,602	-3.1	0.9	11.3	45.2
Iowa	493,515	649,401	662,978	678,370	708,907	2.1	2.3	4.5	43.6
Kansas	378,160	403,231	386,547	370,250	406,698	-4.1	-4.2	9.8	7.5
Kentucky	606,805	1,355,660	1,339,911	1,307,459	1,460,399	-1.2	-2.4	11.7	140.7
Louisiana	1,019,787	1,449,244	1,449,055	1,516,298	1,607,959	-0.0	4.6	6.0	57.7
Maine	–	234,918	228,524	226,429	235,022	-2.7	-0.9	3.8	–
Maryland	856,297	1,306,788	1,312,271	1,326,315	1,387,773	0.4	1.1	4.6	62.1
Massachusetts	1,296,359	1,627,506	1,609,281	1,572,581	1,629,141	-1.1	-2.3	3.6	25.7
Michigan	1,912,009	2,380,232[7]	2,355,527[7]	2,305,227[7]	2,469,188[7]	-1.0	-2.1	7.1	29.1
Minnesota	873,040[8]	1,065,061	1,086,267	1,046,325	1,099,289	2.0	-3.7	5.1	25.9
Mississippi	615,556	656,733	628,519	620,982	639,560	-4.3	-1.2	3.0	3.9
Missouri	846,084	1,006,683	956,346	860,768	941,651	-5.0	-10.0	9.4	11.3
Montana	148,974	262,329	280,638	270,280	250,388	7.0	-3.7	-7.4	68.1

EXHIBIT 11. (continued)

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2017	July 2018	July 2019	July 2020	July 2017 to July 2018	July 2018 to July 2019	July 2019 to July 2020	July–September 2013 average to July 2020
Nebraska	244,600	245,909	248,379	246,175	258,315	1.0%	-0.9%	4.9%	5.6%
Nevada	332,560	633,838	655,533	632,838	695,931	3.4	-3.5	10.0	109.3
New Hampshire	127,082	187,798	185,233	178,761	196,204	-1.4	-3.5	9.8	54.4
New Jersey	1,283,851	1,778,951	1,788,090	1,721,103	1,787,806	0.5	-3.7	3.9	39.3
New Mexico	457,678	781,857[5]	728,449[5]	730,037[5]	780,781[5]	-6.8	0.2	7.0	70.6
New York	5,678,417	6,096,142	6,152,207	6,097,811	6,367,146[9]	0.9	-0.9	4.4	12.1
North Carolina	1,595,952	1,789,708	1,772,526	1,738,840	1,874,977	-1.0	-1.9	7.8	17.5
North Dakota	69,980[10]	93,148	93,970	89,895	98,657	0.9	-4.3	9.7	41.0
Ohio	2,130,322	2,881,568	2,727,615	2,642,614	2,819,633	-5.3	-3.1	6.7	32.4
Oklahoma	790,051	753,610	739,877	735,152	809,286	-1.8	-0.6	10.1	2.4
Oregon	626,356[11]	989,582	972,808	986,744	1,066,371	-1.7	1.4	8.1	70.2
Pennsylvania	2,386,046	2,947,533	2,989,593	2,962,254	3,096,382	1.4	-0.9	4.5	29.8
Rhode Island	190,833	313,103	311,231	301,142	308,847	-0.6	-3.2	2.6	61.8
South Carolina	889,744	1,032,955	1,030,392	1,058,406	1,061,957	-0.2	2.7	0.3	19.4
South Dakota	115,501	112,529	112,018	110,329	115,715	-0.5	-1.5	4.9	0.2
Tennessee	1,244,516	1,484,821	1,443,541	1,440,224	1,506,801	-2.8	-0.2	4.6	21.1
Texas	4,203,449	4,434,104	4,355,227	4,202,466	4,518,167	-1.8	-3.5	7.5	7.5
Utah	294,029[6]	307,267[6]	296,702[6]	309,995[6]	346,009[6]	-3.4	4.5	11.6	17.7
Vermont	161,081	168,455	162,726	154,546	162,600	-3.4	-5.0	5.2	0.9
Virginia	935,434	1,015,609	1,046,260	1,336,892	1,519,888	3.0	27.8	13.7	62.5
Washington	1,117,576	1,789,309	1,745,561	1,710,797	1,803,168	-2.4	-2.0	5.4	61.3
West Virginia	354,544	546,785	531,645	516,288	528,335	-2.8	-2.9	2.3	49.0
Wisconsin	985,531[12]	1,037,696	1,032,239	1,040,306	1,131,380	-0.5	0.8	8.8	14.8
Wyoming	67,518	60,075	59,658	55,904	60,716	-0.7	-6.3	8.6	-10.1

Notes: Enrollment excludes individuals with limited benefits, such as those who receive only 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 baseline from before the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) was implemented, 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. Some data are preliminary or estimated, and all data are subject to change as states may revise their submissions at any time. See data sources for full details.

EXHIBIT 11. (continued)

– Dash indicates that state did not report data; 0.0% or -0.0% indicates an amount between 0.05% and -0.05% that rounds to zero.

[1] Excludes two states not reporting data.

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

[3] Data are for September 2013 only.

[4] May not include all enrollees.

[5] Includes limited-benefit enrollees.

[6] Includes enrollees in other financial assistance programs not enrolled in Medicaid or CHIP.

[7] Does not include all full-benefit Medicaid enrollees.

[8] May include duplicates.

[9] Includes retroactive enrollment.

[10] Data are for July 2013 only.

[11] Includes emergency Medicaid population.

[12] Excludes retroactive enrollment.

Source: MACPAC, 2020, analysis of CMS, 2020, State Medicaid and CHIP applications, eligibility determinations, and enrollment data, accessed on October 30, 2020, https://data.medicaid.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxme.

EXHIBIT 12. Historical and Projected National Health Expenditures by Payer for Selected Years, CYs 1970–2028

Calendar year	Total (billions)	Payer amount (billions) and share of total											
		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	**1,369**	203	14.9	225	16.4	458	33.4	33	2.4	251	18.4	199	14.5
2005	**2,024**	317	15.7	340	16.8	701	34.6	56	2.8	346	17.1	264	13.0
2010	**2,593**	409	15.8	520	20.0	858	33.1	84	3.2	422	16.3	300	11.6
2011	**2,683**	419	15.6	545	20.3	890	33.2	88	3.3	430	16.0	310	11.6
2012	**2,791**	436	15.6	568	20.4	922	33.0	90	3.2	456	16.3	319	11.4
2013	**2,875**	459	16.0	589	20.5	939	32.7	92	3.2	469	16.3	327	11.4
2014	**3,025**	511	16.9	619	20.4	994	32.9	99	3.3	471	15.6	332	11.0
2015	**3,200**	557	17.4	649	20.3	1,061	33.2	106	3.3	484	15.1	342	10.7
2016	**3,347**	582	17.4	677	20.2	1,120	33.5	109	3.2	503	15.0	357	10.7
2017	**3,487**	598	17.2	705	20.2	1,175	33.7	114	3.3	530	15.2	365	10.5
2018	**3,649**	616	16.9	750	20.6	1,243	34.1	120	3.3	545	14.9	376	10.3
Projected													
2019	**$3,815**	$641	16.8%	$801	21.0%	$1,290	33.8%	$127	3.3%	$567	14.9%	$390	10.2%
2020	**4,014**	669	16.7	859	21.4	1,357	33.8	136	3.4	589	14.7	405	10.1
2021	**4,217**	705	16.7	923	21.9	1,411	33.4	144	3.4	614	14.6	421	10.0
2022	**4,456**	746	16.7	997	22.4	1,480	33.2	152	3.4	642	14.4	439	9.9

EXHIBIT 12. (continued)

Calendar year	Total (billions)	Payer amount (billions) and share of total											
		Medicaid and CHIP		Medicare		Private insurance		Other health insurance[1]		Other third-party payers[2]		Out of pocket	
2023	**$4,706**	$788	16.7%	$1,076	22.9%	$1,555	33.0%	$160	3.4%	$670	14.2%	$458	9.7%
2024	**4,966**	828	16.7	1,161	23.4	1,632	32.9	168	3.4	700	14.1	477	9.6
2025	**5,247**	877	16.7	1,251	23.8	1,714	32.7	177	3.4	731	13.9	497	9.5
2026	**5,549**	936	16.9	1,345	24.2	1,799	32.4	186	3.4	765	13.8	519	9.3
2027	**5,863**	990	16.9	1,449	24.7	1,888	32.2	196	3.3	799	13.6	541	9.2
2028	**6,192**	1,046	16.9	1,559	25.2	1,982	32.0	207	3.3	835	13.5	564	9.1

Notes: CY is calendar year. Components may not sum to total due to rounding. The latest projections begin after the latest historical year (2018) and go through 2028.

[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, 2020, analysis of Office of the Actuary (OACT), CMS, 2019, *National health expenditures by type of service and source of funds: Calendar years 1960–2018*, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2018.zip. For projected data: MACP AC, 2020, analysis of OACT, 2020, *National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1960–2028* in projections format, as of April 2020, https://www.cms.gov/files/zip/nhe-historical-and-projections-1960-2028.zip-0; and OACT, 2020, Table 17: *Health insurance enrollment and enrollment growth rates, calendar years, 2012–2028*, https://www.cms.gov/files/zip/nhe-projections-2019-2028-tables.zip-0 .

EXHIBIT 13. Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1992–2018

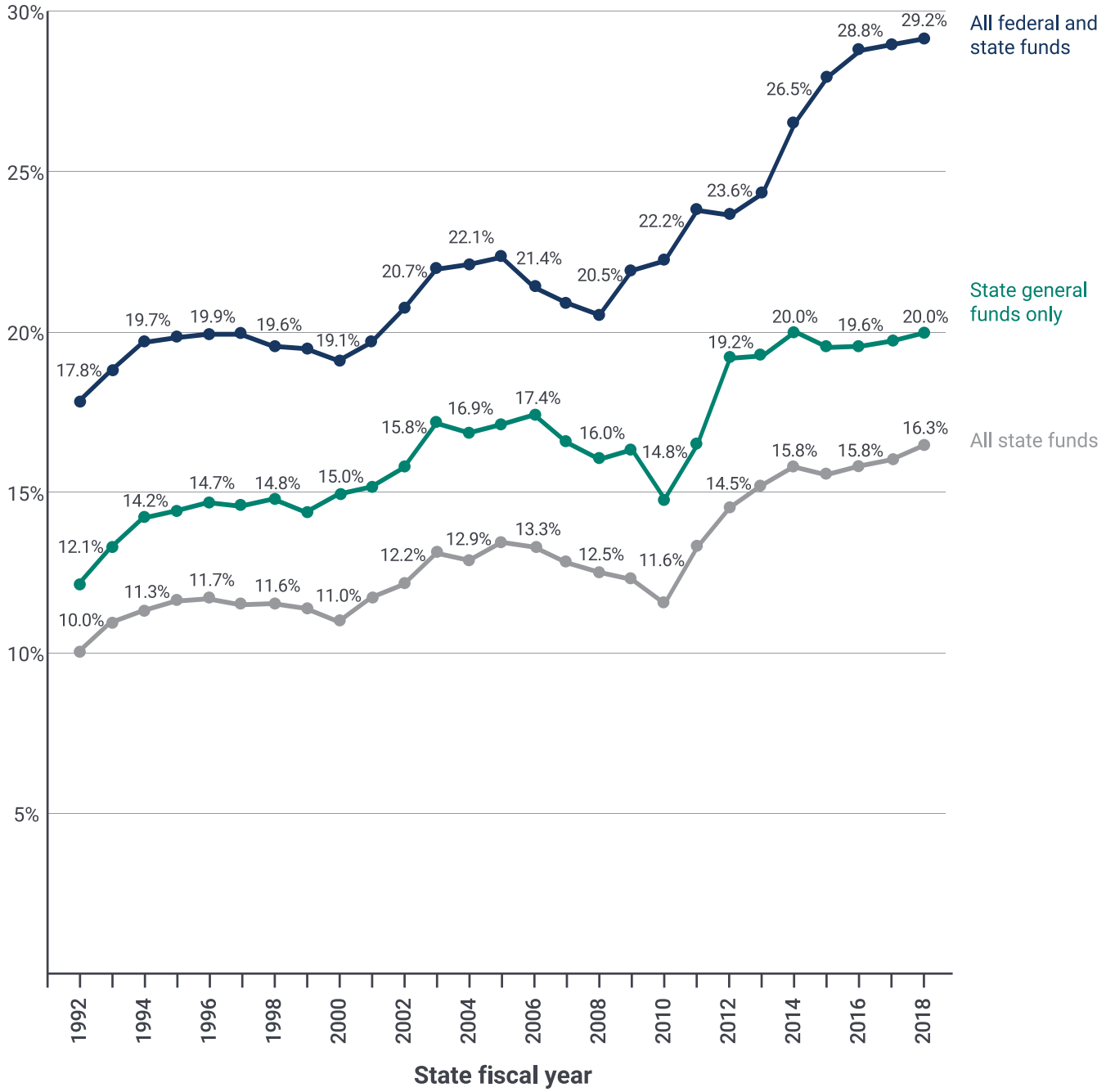


EXHIBIT 13. (continued)

State fiscal year	Medicaid as a share of all federal and state funds	Medicaid as a share of state general funds only	Medicaid as a share of all state funds
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	26.5	20.0	15.8
2015	27.9	19.5	15.6
2016	28.8	19.6	15.8
2017	28.9	19.9	16.0
2018	29.2	20.0	16.3

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 only category reflects amounts from revenues raised through income, sales, and other broad-based state taxes and excludes federal funds. 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) and excludes federal funds.

Source: MACPAC, 2020, analysis of state expenditure reports from the National Association of State Budget Officers, http://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 $631.8 billion in fiscal year (FY) 2019 (Exhibit 16). Spending for the State Children's Health Insurance Program (CHIP) was $18.8 billion (Exhibit 33).
- In FY 2018, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 21 percent of Medicaid enrollees but about 57 percent of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports (LTSS). LTSS users accounted for only 5.5 percent of Medicaid enrollees but almost one-third of all Medicaid spending (Exhibit 20).
- The new adult group, which includes those individuals eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), accounted for over 20 percent of enrollees and 17 percent of spending in FY 2018 (Exhibits 14 and 21). This group is comprised primarily of those newly eligible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), but also includes some adults who were previously eligible in states that expanded Medicaid prior to the ACA.
- About half of Medicaid spending for enrollees was for capitation payments to managed care plans (Exhibits 17 and 18). Spending for enrollees who are eligible on the basis of disability and enrollees age 65 and older has been shifting to managed care. Over half (51.2 percent) of enrollees who are eligible on the basis of disability and over one third (34.6 percent) of enrollees age 65 and older were enrolled in comprehensive managed care in FY 2018, including in plans that provide managed LTSS (Exhibit 30).
- 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 enrollee characteristics, such as health status, that affect their use of services.
- Drug rebates reduced gross drug spending by over half (55.7 percent) in FY 2019 (Exhibit 28). The majority (63.3 percent) of Medicaid gross spending for drugs occurred under managed care in FY 2019 (Exhibit 26).
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for over half (52.1 percent) of fee-for-service payments to hospitals in FY 2019 (Exhibit 24).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2018 (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	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Total	**84,427**	**32,419**	**18,097**	**15,867**	**10,105**	**7,939**	**12,302**	**7,341**	**9,003**	**5,344**	**3,298**	**1,997**
Alabama	**1,146**	562	–	226	228	130	**240**	130	**99**	51	**141**	79
Alaska	**234**	99	54	50	18	13	**22**	12	**21**	11	**1**	1
Arizona	**2,202**	803	570	477	183	168	**275**	160	**219**	123	**55**	37
Arkansas[5]	**1,064**	382	374	75	154	79	**–**	–	**–**	–	**–**	–
California[6]	**15,187**	3,893	4,734	4,128	1,023	1,410	**1,740**	1,274	**1,681**	1,229	**58**	45
Colorado	**1,502**	510	538	249	119	87	**110**	59	**57**	27	**53**	32
Connecticut	**1,071**	357	297	197	74	145	**201**	139	**82**	49	**119**	90
Delaware	**283**	104	81	52	27	19	**35**	19	**16**	9	**19**	10
District of Columbia[7]	**281**	82	78	56	38	27	**40**	25	**27**	16	**13**	9
Florida[8]	**4,791**	2,434	19	978	674	685	**978**	656	**547**	371	**431**	285
Georgia	**2,342**	1,295	–	435	379	232	**377**	226	**172**	101	**206**	125
Hawaii	**382**	133	136	53	25	35	**51**	33	**45**	29	**6**	4
Idaho	**329**	194	–	51	54	29	**54**	28	**32**	16	**22**	12
Illinois[7]	**3,310**	1,351	283	1,064	326	285	**406**	230	**368**	207	**39**	24
Indiana	**1,706**	664	549	169	214	110	**243**	116	**168**	79	**75**	38
Iowa	**744**	285	205	121	84	49	**101**	49	**79**	35	**22**	14
Kansas	**453**	253	–	77	81	42	**79**	39	**47**	24	**31**	15
Kentucky	**1,557**	451	619	147	235	105	**224**	104	**124**	60	**100**	45
Louisiana	**1,710**	629	582	138	226	135	**265**	141	**140**	70	**125**	71
Maine	**312**	116	4	62	74	56	**99**	55	**61**	28	**38**	28
Maryland	**1,443**	524	382	282	154	102	**170**	98	**98**	55	**72**	43
Massachusetts	**1,984**	452	404	535	372	220	**395**	198	**370**	174	**25**	24
Michigan	**3,049**	1,092	965	410	386	196	**386**	192	**313**	155	**73**	37
Minnesota	**1,343**	606	272	250	125	91	**161**	85	**144**	75	**17**	10
Mississippi	**804**	400	–	129	176	100	**191**	99	**98**	50	**92**	49

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	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri	**1,219**	706	–	199	207	107	**214**	101	**167**	78	**47**	22
Montana	**292**	109	118	23	25	17	**32**	17	**22**	11	**10**	6
Nebraska[9]	**256**	143	–	47	41	25	**44**	23	**40**	20	**5**	3
Nevada	**835**	333	298	84	68	53	**60**	37	**30**	18	**30**	19
New Hampshire	**235**	89	80	17	29	19	**39**	17	**24**	11	**15**	6
New Jersey	**1,911**	705	717	143	183	162	**268**	153	**265**	152	**3**	1
New Mexico	**953**	342	297	190	73	51	**116**	69	**78**	46	**38**	24
New York	**6,875**	1,920	2,494	976	675	809	**1,175**	758	**992**	625	**183**	133
North Carolina	**2,315**	1,127	–	611	373	204	**380**	204	**292**	152	**88**	52
North Dakota[6]	**118**	48	31	16	13	10	**18**	10	**15**	9	**3**	2
Ohio	**3,196**	1,129	878	533	422	234	**414**	209	**274**	143	**140**	66
Oklahoma	**910**	519	–	200	119	73	**134**	69	**108**	56	**26**	13
Oregon	**1,080**	338	496	123	58	65	**119**	65	**59**	32	**60**	33
Pennsylvania	**3,271**	1,018	985	340	627	302	**469**	294	**365**	235	**104**	59
Rhode Island[7]	**349**	101	100	73	42	33	**52**	28	**44**	23	**7**	4
South Carolina	**1,351**	622	–	450	182	97	**186**	96	**175**	89	**11**	7
South Dakota	**132**	74	–	23	21	13	**23**	12	**14**	8	**8**	4
Tennessee	**1,769**	889	–	450	277	152	**297**	150	**163**	75	**134**	75
Texas[8]	**5,356**	3,516	0	541	747	553	**805**	523	**428**	283	**377**	240
Utah[6]	**384**	225	–	89	50	21	**35**	18	**33**	16	**3**	1
Vermont[7, 10]	**198**	70	–	36	70	23	**32**	17	**23**	11	**9**	7
Virginia[8]	**1,329**	577	0	424	202	126	**224**	118	**151**	81	**72**	37
Washington	**2,125**	868	862	69	195	131	**227**	124	**154**	86	**73**	38
West Virginia	**647**	218	216	65	99	49	**94**	46	**57**	27	**37**	20
Wisconsin	**1,321**	488	–	494	190	149	**194**	97	**165**	78	**29**	19
Wyoming	**83**	47	–	15	12	9	**12**	5	**8**	3	**4**	2

EXHIBIT 14. (continued)

Notes: FY is fiscal year. Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between the Transformed Medicaid Statistical Information System (T-MSIS) and the Medicaid Statistical Information System (MSIS).

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 the 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.

– Dash indicates zero; 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. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category.

[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] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[4] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

[5] State did not identify dually eligible beneficiaries.

[6] State has a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced California's child enrollment by approximately 243,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 13,500.

[7] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The average monthly enrollment in the District of Columbia was 37 percent less than the benchmark; the average monthly enrollment in Illinois was 66 percent less than the benchmark; and average monthly enrollment in Rhode Island was 31 percent more than the benchmark. Vermont did not report any enrollees in the new adult group but reported approximately 58,000 average monthly enrollees on the CMS-64 enrollment report.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2018.

[9] State reported total enrollment that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. Nebraska's average monthly enrollment was 24 percent less than the benchmark.

[10] State reported about a 60 percent decrease in enrollment for the other adult group and a 65 percent increase in enrollment for the disabled group compared to prior years.

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2018 (thousands)

State	Total		Child		New Adult Group[1]		Other Adult[2]		Disabled		Aged	
	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]
Total	**71,527**	**65,164**	**27,778**	**27,660**	**14,793**	**14,314**	**12,413**	**9,621**	**9,471**	**8,317**	**7,072**	**5,252**
Alabama	**951**	**736**	450	450	–	–	172	86	210	154	119	46
Alaska	**201**	**200**	85	85	46	46	43	43	16	16	11	11
Arizona	**1,842**	**1,672**	680	668	442	412	398	323	170	154	151	114
Arkansas	**908**	**908**	328	328	303	303	63	63	145	145	70	70
California[4]	**12,627**	**10,607**	3,327	3,271	3,900	3,513	3,131	1,631	978	965	1,292	1,227
Colorado	**1,241**	**1,197**	435	435	412	412	211	211	109	92	74	48
Connecticut	**939**	**826**	314	314	254	254	168	167	70	43	132	49
Delaware	**236**	**210**	87	86	63	63	42	35	26	18	17	8
District of Columbia[5]	**253**	**241**	71	71	70	70	51	51	35	32	24	16
Florida[6]	**3,895**	**3,395**	2,047	2,045	7	0	628	515	609	480	604	355
Georgia	**1,944**	**1,707**	1,075	1,075	–	–	316	263	346	274	207	95
Hawaii	**332**	**327**	118	118	115	115	45	44	23	21	32	28
Idaho	**259**	**239**	153	153	–	–	32	32	48	39	25	15
Illinois[5]	**2,875**	**2,844**	1,202	1,202	245	245	884	883	299	288	244	226
Indiana	**1,344**	**1,226**	545	539	381	379	123	84	199	165	96	59
Iowa	**611**	**584**	233	233	165	164	93	87	78	71	42	29
Kansas	**379**	**350**	212	212	–	–	57	57	74	59	36	23
Kentucky	**1,429**	**1,334**	416	416	559	558	134	133	225	173	95	54
Louisiana	**1,513**	**1,395**	567	567	488	488	118	106	217	172	123	62
Maine	**260**	**224**	95	95	1	1	47	46	67	58	49	25
Maryland	**1,255**	**1,173**	464	464	319	319	238	220	144	119	89	52
Massachusetts	**1,670**	**1,467**	386	361	316	314	420	283	350	349	197	160
Michigan	**2,586**	**2,498**	938	930	775	770	344	328	361	333	168	137
Minnesota	**1,117**	**1,088**	516	514	211	210	194	184	117	111	79	70
Mississippi	**687**	**569**	340	340	–	–	94	61	163	123	91	45

EXHIBIT 15. (continued)

State	Total		Child		New Adult Group[1]		Other Adult[2]		Disabled		Aged	
	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]
Missouri	**1,039**	**1,000**	620	620	–	–	149	149	180	159	90	71
Montana	**254**	**243**	97	97	100	100	19	17	23	19	15	10
Nebraska[7]	**187**	**184**	108	108	–	–	29	29	33	31	18	16
Nevada	**654**	**627**	267	267	219	218	62	60	60	51	46	31
New Hampshire	**192**	**179**	77	77	59	59	13	13	26	19	16	10
New Jersey	**1,603**	**1,598**	601	601	576	574	109	107	173	173	145	144
New Mexico	**816**	**713**	292	290	255	241	157	103	66	54	46	25
New York	**5,800**	**5,623**	1,645	1,642	2,044	2,040	749	740	640	598	722	604
North Carolina	**1,925**	**1,563**	913	912	–	–	486	205	345	311	181	136
North Dakota[4]	**90**	**88**	37	37	22	22	12	12	11	10	9	7
Ohio	**2,727**	**2,601**	976	976	693	692	454	453	401	335	203	144
Oklahoma	**696**	**638**	397	397	–	–	129	93	107	97	63	51
Oregon	**869**	**780**	277	276	389	363	95	83	53	33	55	26
Pennsylvania	**2,790**	**2,667**	868	861	783	777	288	270	588	547	265	212
Rhode Island[5]	**315**	**307**	85	85	91	91	68	67	41	38	30	26
South Carolina	**1,176**	**954**	547	544	–	–	375	166	167	162	88	81
South Dakota	**106**	**99**	61	61	–	–	15	15	19	16	11	7
Tennessee	**1,537**	**1,414**	765	765	–	–	378	378	257	203	137	68
Texas[6]	**4,318**	**3,988**	2,858	2,858	0	0	298	297	678	559	484	274
Utah[4]	**281**	**279**	170	170	–	–	51	51	43	42	17	16
Vermont[5, 8]	**173**	**165**	62	62	–	–	31	31	60	58	20	14
Virginia[6]	**1,112**	**885**	477	477	0	0	339	177	185	153	110	77
Washington	**1,788**	**1,707**	755	754	690	688	47	32	182	151	115	82
West Virginia	**543**	**510**	184	184	170	170	54	53	93	78	42	25
Wisconsin	**1,080**	**1,002**	407	404	–	–	366	317	178	169	129	112
Wyoming	**62**	**59**	36	36	–	–	9	9	11	9	6	4

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. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between the Transformed Medicaid Statistical Information System (T-MSIS) and the Medicaid Statistical Information System (MSIS).

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 the 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.

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

[1] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[2] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

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

[4] State has a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced California's child FYE enrollment by approximately 204,000, North Dakota's child FYE enrollment by approximately 2,300, and Utah's child FYE enrollment by approximately 10,300.

[5] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The average monthly enrollment in the District of Columbia was 37 percent less than the benchmark; the average monthly enrollment in Illinois was 66 percent less than the benchmark; and average monthly enrollment in Rhode Island was 31 percent more than the benchmark. Vermont did not report any enrollees in the new adult group but reported approximately 58,000 average monthly enrollees on the CMS-64 enrollment report.

[6] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2018.

[7] State reported total enrollment that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. Nebraska's average monthly enrollment was 24 percent less than the benchmark.

[8] State reported about a 60 percent decrease in enrollment for the other adult group and a 65 percent increase in enrollment for the disabled group compared to prior years.

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2019 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$5,880**	$4,243	$1,637	**$216**	$132	$85	**$6,096**	$4,375	$1,722
Alaska	**2,096**	1,528	568	**147**	100	48	**2,244**	1,628	616
Arizona	**13,168**	10,109	3,059	**314**	210	104	**13,482**	10,319	3,163
Arkansas	**6,843**	5,230	1,613	**401**	273	128	**7,244**	5,503	1,741
California	**87,856**	52,919	34,937	**6,243**	3,798	2,446	**94,099**	56,717	37,382
Colorado	**9,202**	5,311	3,891	**316**	207	109	**9,518**	5,517	4,000
Connecticut	**8,168**	4,820	3,348	**362**	238	124	**8,531**	5,058	3,472
Delaware	**2,246**	1,461	784	**101**	66	35	**2,347**	1,528	819
District of Columbia	**2,892**	2,125	767	**231**	149	82	**3,123**	2,274	849
Florida	**24,384**	14,858	9,526	**745**	436	309	**25,129**	15,294	9,835
Georgia	**10,852**	7,359	3,493	**579**	367	211	**11,430**	7,726	3,704
Hawaii	**2,178**	1,396	782	**102**	70	32	**2,281**	1,467	814
Idaho	**2,143**	1,525	618	**123**	79	45	**2,266**	1,604	662
Illinois	**18,470**	10,932	7,538	**885**	564	321	**19,356**	11,496	7,859
Indiana	**12,439**	8,885	3,554	**555**	355	200	**12,994**	9,240	3,754
Iowa	**5,200**	3,439	1,761	**153**	102	50	**5,352**	3,542	1,811
Kansas	**3,602**	2,061	1,541	**197**	128	69	**3,799**	2,189	1,610
Kentucky	**10,208**	7,964	2,243	**303**	212	91	**10,510**	8,176	2,334
Louisiana	**11,642**	8,433	3,209	**405**	264	141	**12,047**	8,698	3,350
Maine	**2,867**	1,885	982	**152**	104	48	**3,019**	1,989	1,030
Maryland	**11,730**	7,067	4,663	**524**	341	184	**12,254**	7,408	4,847
Massachusetts	**17,413**	9,647	7,766	**1,227**	740	487	**18,640**	10,386	8,253
Michigan	**18,258**	12,974	5,284	**731**	502	229	**18,989**	13,476	5,513
Minnesota	**12,721**	7,227	5,494	**798**	475	323	**13,519**	7,702	5,817
Mississippi	**5,507**	4,210	1,296	**175**	121	54	**5,681**	4,331	1,350
Missouri	**10,535**	6,950	3,585	**376**	239	137	**10,910**	7,189	3,722
Montana	**1,858**	1,442	416	**94**	64	29	**1,952**	1,506	446
Nebraska	**2,142**	1,135	1,007	**124**	82	41	**2,266**	1,217	1,048
Nevada	**3,979**	2,948	1,030	**201**	135	66	**4,179**	3,084	1,096
New Hampshire	**1,985**	1,098	887	**142**	100	42	**2,127**	1,199	928
New Jersey	**15,909**	9,386	6,523	**941**	568	374	**16,850**	9,953	6,897
New Mexico	**5,263**	4,153	1,109	**229**	150	79	**5,492**	4,303	1,188

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
New York	**$58,094**	$41,098	$16,997	**$2,115**	$1,276	$839	**$60,209**	$42,373	$17,836
North Carolina	**13,596**	9,151	4,445	**790**	548	242	**14,386**	9,699	4,687
North Dakota	**1,164**	693	471	**111**	86	25	**1,275**	779	495
Ohio	**23,466**	16,017	7,449	**1,043**	614	430	**24,509**	16,630	7,879
Oklahoma	**4,760**	3,072	1,688	**204**	124	80	**4,965**	3,196	1,769
Oregon	**9,427**	6,927	2,500	**510**	317	193	**9,936**	7,244	2,693
Pennsylvania	**32,080**	18,706	13,374	**881**	561	320	**32,961**	19,267	13,694
Rhode Island	**2,586**	1,562	1,024	**179**	117	62	**2,765**	1,679	1,087
South Carolina	**6,306**	4,495	1,811	**374**	252	122	**6,680**	4,747	1,932
South Dakota	**899**	552	347	**50**	30	21	**949**	582	368
Tennessee	**10,092**	6,680	3,412	**692**	488	204	**10,784**	7,168	3,616
Texas	**40,026**	23,361	16,664	**1,460**	893	567	**41,486**	24,254	17,232
Utah	**2,724**	1,902	822	**174**	118	56	**2,899**	2,020	878
Vermont	**1,638**	971	667	**164**	108	56	**1,802**	1,079	723
Virginia	**11,307**	6,337	4,970	**513**	329	184	**11,820**	6,666	5,154
Washington	**13,128**	8,259	4,869	**1,362**	743	619	**14,490**	9,001	5,489
West Virginia	**3,926**	3,093	834	**183**	132	51	**4,109**	3,225	884
Wisconsin	**9,133**	5,452	3,681	**393**	250	143	**9,525**	5,701	3,824
Wyoming	**584**	307	277	**77**	58	20	**662**	365	297
Subtotal (states)	**$594,570**	**$383,358**	**$211,212**	**$29,369**	**$18,413**	**$10,956**	**$623,939**	**$401,771**	**$222,168**
American Samoa	**53**	46	7	**3**	3	0	**55**	48	7
Guam	**113**	106	7	**3**	3	0	**116**	108	8
Northern Mariana Islands	**59**	49	10	**1**	1	0	**60**	50	10
Puerto Rico[2]	**2,453**	2,489	-36	**156**	156	–	**2,609**	2,646	-36
Virgin Islands	**138**	112	26	**14**	12	2	**151**	124	28
Subtotal (states and territories)	**$597,385**	**$386,159**	**$211,226**	**$29,545**	**$18,587**	**$10,958**	**$626,930**	**$404,746**	**$222,184**
State Medicaid Fraud Control Units	**–**	–	–	**361**	271	90	**361**	271	90
Medicaid survey and certification of nursing and intermediate care facilities	**–**	–	–	**370**	277	92	**370**	277	92
Vaccines for Children program	**–**	–	–	**–**	–	–	**4,161**	4,161	–
Total	**$597,385**	**$386,159**	**$211,226**	**$30,276**	**$19,135**	**$11,141**	**$631,822[3]**	**$409,455[3]**	**$222,367**

EXHIBIT 16. (continued)

Notes: FY is fiscal year. Total federal Medicaid spending shown here ($409,455 million) will differ from total federal outlays shown in FY 2021 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 Medicaid Fraud Control Units (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 Vaccines for Children (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 for state programs only; federal oversight spending is not included.

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

[1] All states had certified their CMS-64 financial management report (FMR) submissions as of August 5, 2020. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] Puerto Rico reports negative territory Medicaid spending due to federal Medicaid spending exceeding total Medicaid spending. Federal spending exceeds total spending due to negative prior period adjustments and the temporary 100 percent federal medical assistance percentage (FMAP) in effect from January 1, 2018, to September 30, 2019. Because these prior period adjustments apply to periods before the 100 percent FMAP, these negative adjustments decrease total spending to a greater extent than federal spending.

[3] 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, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020. For all other spending (MCFUs, survey and certification, VFC program): CMS, 2020, *Fiscal year 2021 justification of estimates for appropriations committees*, Baltimore, MD: CMS, https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2019 (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 services	Drugs	Institutional LTSS	Home- and community-based LTSS			
Alabama	**$5,880**	$2,307	$446	$68	$71	$104	$555	$288	$1,052	$502	$175	$348	-$36
Alaska	**2,096**	621	162	96	37	401	176	47	211	330	1	33	-17
Arizona	**13,168**	1,264	53	5	18	156	564	73	95	3	10,570	378	-11
Arkansas	**6,843**	1,296	351	3	26	71	787	81	927	460	2,566	331	-56
California	**87,856**	12,218	675	867	14	3,484	9,945	722	4,071	13,019	40,703	3,017	-880
Colorado[2]	**9,202**	2,918	-60	643	–	919	469	271	906	2,049	1,001	184	-98
Connecticut	**8,168**	2,327	472	157	237	367	575	485	1,623	1,819	0	537	-430
Delaware[3]	**2,246**	74	12	42	1	3	115	-4	53	160	1,747	53	-9
District of Columbia	**2,892**	400	50	17	5	194	169	125	383	588	909	61	-9
Florida	**24,384**	2,213	654	233	8	216	570	117	1,373	1,399	15,904	1,818	-120
Georgia	**10,852**	2,900	406	22	37	20	794	221	1,609	1,409	2,976	517	-57
Hawaii	**2,178**	53	0	34	0	19	4	1	9	146	1,910	48	-45
Idaho[2]	**2,143**	564	126	-0	32	35	220	73	284	448	310	70	-20
Illinois	**18,470**	3,041	172	10	114	82	625	34	1,596	1,548	10,797	571	-119
Indiana	**12,439**	1,055	124	28	9	527	341	131	2,921	1,546	5,518	299	-59
Iowa	**5,200**	228	30	36	2	49	148	9	75	108	4,430	153	-69
Kansas[3]	**3,602**	179	5	0	0	1	50	-1	97	0	3,181	109	-19
Kentucky	**10,208**	386	28	3	5	235	450	42	1,197	973	6,663	265	-39
Louisiana	**11,642**	2,296	39	0	0	33	353	49	1,531	805	6,342	384	-191
Maine	**2,867**	634	92	21	52	196	523	88	453	652	3	226	-74
Maryland	**11,730**	1,037	136	147	94	269	1,126	363	1,467	1,611	5,181	377	-78
Massachusetts	**17,413**	2,478	188	268	39	290	1,570	336	1,571	3,317	6,981	585	-210
Michigan	**18,258**	1,288	284	40	14	286	596	740	2,257	839	11,437	578	-100
Minnesota[3]	**12,721**	665	199	22	200	130	762	-100	1,283	3,532	5,908	228	-107
Mississippi	**5,507**	655	119	5	12	34	276	23	1,108	488	2,534	273	-20
Missouri	**10,535**	2,593	9	5	12	347	790	570	1,489	2,230	2,188	395	-94
Montana	**1,858**	687	134	58	55	55	284	79	221	218	43	54	-31
Nebraska	**2,142**	62	2	0	0	1	46	0	438	485	1,087	56	-36
Nevada	**3,979**	613	151	86	25	55	397	164	345	303	1,665	197	-23
New Hampshire[3]	**1,985**	261	8	23	1	5	173	-28	450	348	714	42	-14

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 services	Drugs	Institutional LTSS	Home- and community-based LTSS			
New Jersey	**$15,909**	$1,650	$53	$2	$9	$418	$1,038	$18	$1,593	$1,678	$9,224	$437	-$213
New Mexico	**5,263**	419	24	11	51	5	80	3	33	423	4,080	150	-16
New York[3]	**58,094**	6,641	262	30	157	845	2,029	-2,879	7,467	8,551	35,266	1,970	-2,245
North Carolina	**13,596**	4,276	1,005	330	144	267	1,285	604	1,516	834	2,998	520	-184
North Dakota	**1,164**	145	37	13	15	12	45	14	362	257	258	16	-11
Ohio	**23,466**	2,444	204	30	8	65	747	100	2,274	3,995	13,181	601	-185
Oklahoma	**4,760**	1,663	444	96	32	383	450	483	731	596	130	177	-424
Oregon	**9,427**	401	29	3	35	329	351	85	499	2,194	5,322	257	-79
Pennsylvania	**32,080**	1,811	54	14	2	43	493	24	3,677	5,396	20,004	782	-219
Rhode Island	**2,586**	364	9	7	1	54	220	0	324	238	1,313	70	-13
South Carolina	**6,306**	1,126	122	135	13	106	355	32	891	747	2,736	251	-207
South Dakota	**899**	247	62	22	6	54	64	47	183	182	1	37	-7
Tennessee	**10,092**	486	30	169	0	81	394	423	257	710	7,158	453	-68
Texas	**40,026**	6,219	195	41	168	22	5,962	104	1,825	2,532	22,355	1,373	-771
Utah	**2,724**	362	82	15	5	13	164	65	410	390	1,200	53	-34
Vermont[3]	**1,638**	23	–	–	–	–	1,542	-139	132	77	–	4	-2
Virginia[3]	**11,307**	1,446	172	159	11	60	390	-15	327	1,960	6,544	303	-49
Washington	**13,128**	654	129	172	12	855	735	77	1,064	2,716	8,108	437	-1,831
West Virginia	**3,926**	252	40	11	10	28	231	205	852	510	1,653	159	-24
Wisconsin	**9,133**	813	42	86	30	369	806	417	849	1,140	4,331	343	-92
Wyoming	**584**	132	33	11	17	34	22	24	142	160	3	15	-9
Subtotal (states)	**$594,570**	**$78,885**	**$8,093**	**$4,297**	**$1,846**	**$12,629**	**$40,854**	**$4,691**	**$56,505**	**$76,619**	**$299,310**	**$20,594**	**-$9,754**
American Samoa	**53**	34	–	–	–	3	13	1	–	–	–	2	–
Guam[2]	**113**	40	11	3	-0	1	39	18	0	0	–	2	–
N. Mariana Islands	**59**	31	–	1	–	4	18	3	–	2	–	1	–
Puerto Rico	**2,453**	–	–	–	–	–	35	–	–	–	2,418	–	–
Virgin Islands	**138**	87	8	5	3	12	8	14	0	0	–	0	–
Total	**$597,385**	**$79,077**	**$8,113**	**$4,305**	**$1,848**	**$12,648**	**$40,968**	**$4,727**	**$56,505**	**$76,622**	**$301,727**	**$20,599**	**-$9,754**
Percent of total, exclusive of collections	**—**	**13.0%**	**1.3%**	**0.7%**	**0.3%**	**2.1%**	**6.7%**	**0.8%**	**9.3%**	**12.6%**	**49.7%**	**3.4%**	**—**

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 CMS data sources, such as the Transformed Medicaid Statistical Information System (T-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 (FQHC), and freestanding birth center.
- Other acute services include lab or X-ray; sterilizations; abortions; early and periodic screening, diagnostic, and treatment screenings (EPSDT); emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; U.S. Preventive Services Task Force (USPSTF) grade A or B preventive services 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; health home with substance use disorder; 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, personal care, and certified community behavioral health clinic.
- 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, USPSTF grade A or B preventive services, ACIP vaccines, and certified community behavioral health clinic.

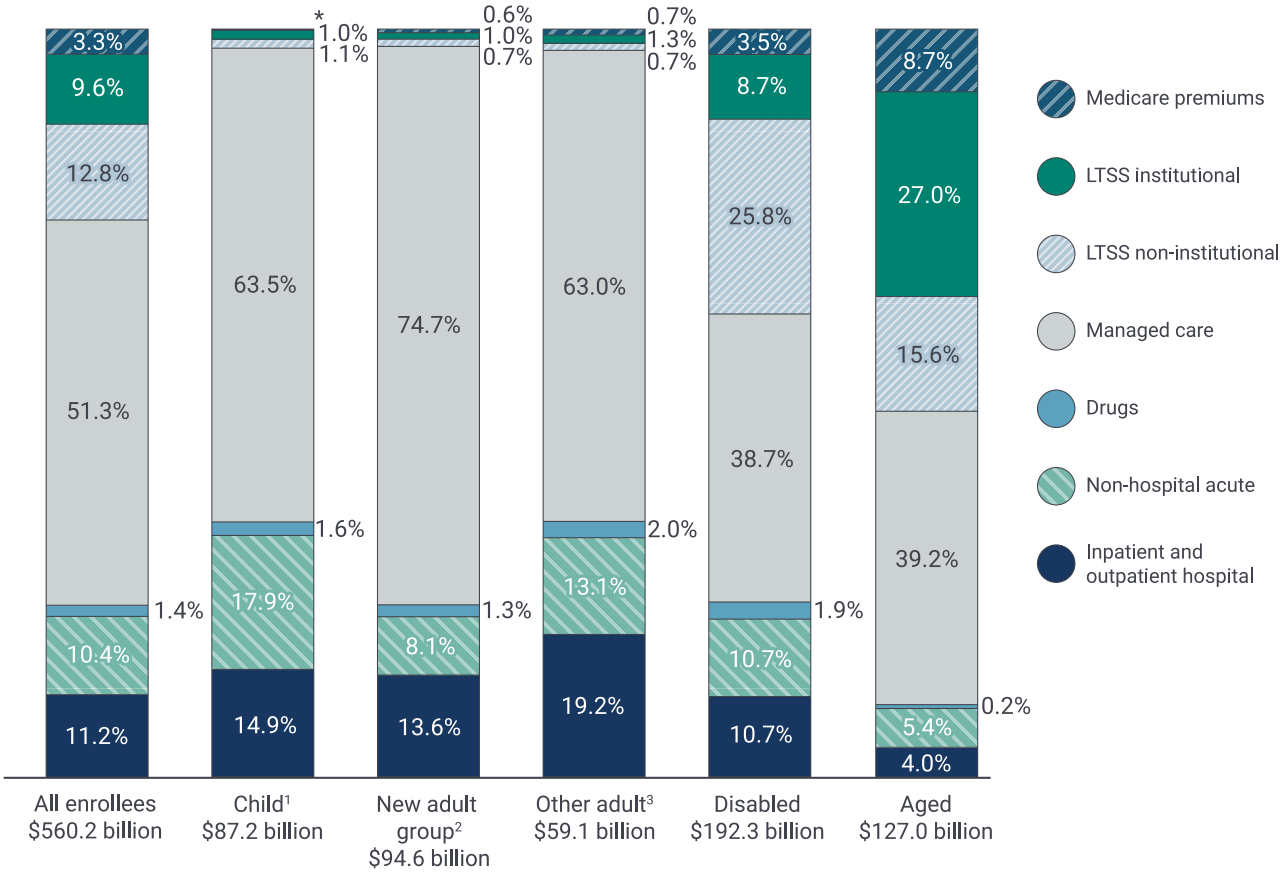
[1] All states had certified their CMS-64 financial management report (FMR) submissions as of August 5, 2020. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] State or territory reports negative spending in a category due to prior period adjustments. Colorado reports negative spending for physician services, Idaho reports negative spending for dental services, and Guam reports negative spending for other practitioner services.

[3] State reports negative fee-for-service (FFS) drug spending after the application of drug rebates. The negative net amount may reflect prior period adjustments, a difference in the timing of payments and rebates after 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, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2018



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. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Amounts are fee for service unless otherwise noted. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between T-MSIS and the Medicaid Statistical Information System (MSIS).

* Values less than 0.1 percent are not shown.

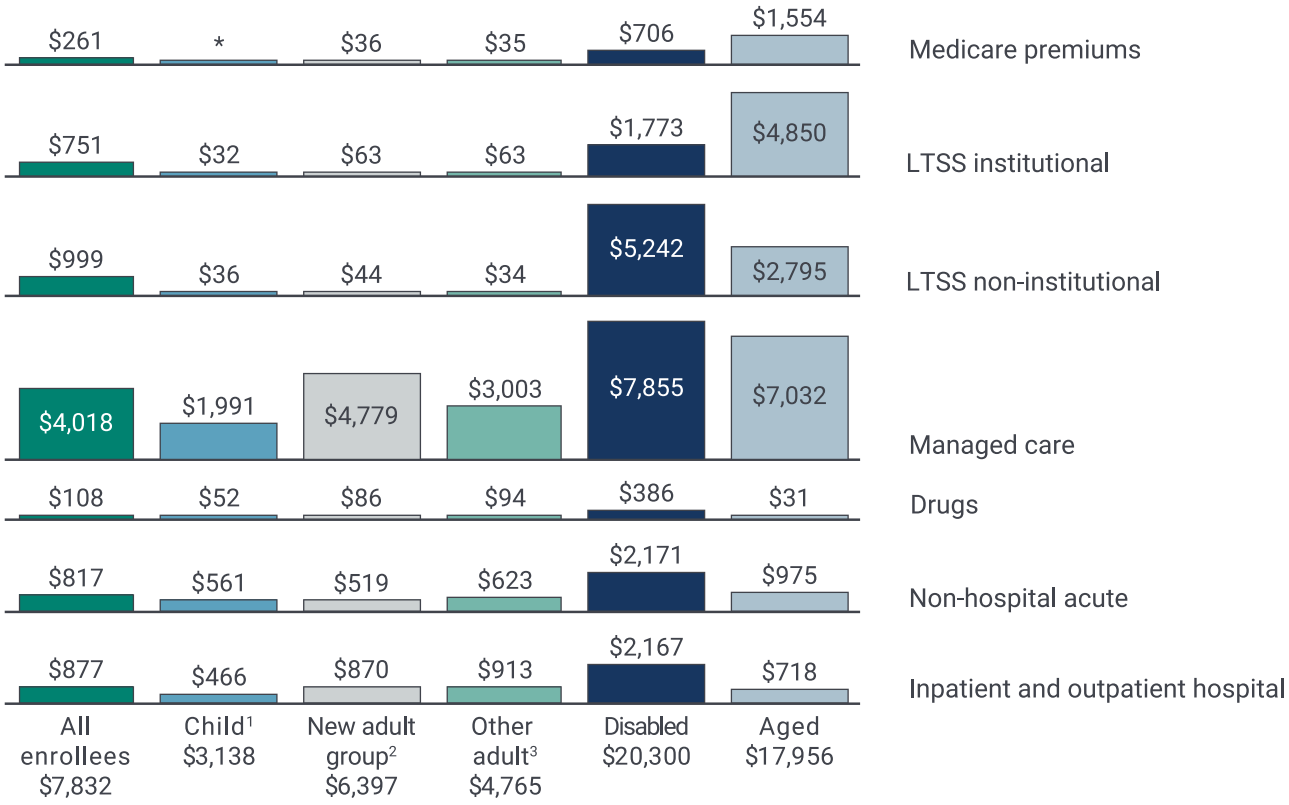
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced child spending by $526.1 million.

[2] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[3] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020 and CMS-64 financial management report net expenditure data as of October 2019.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2018



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. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Amounts are fee for service unless otherwise noted, and they reflect all enrollees, including those with limited benefits. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between T-MSIS and the Medicaid Statistical Information System (MSIS).

* Values less than $1 are not shown.

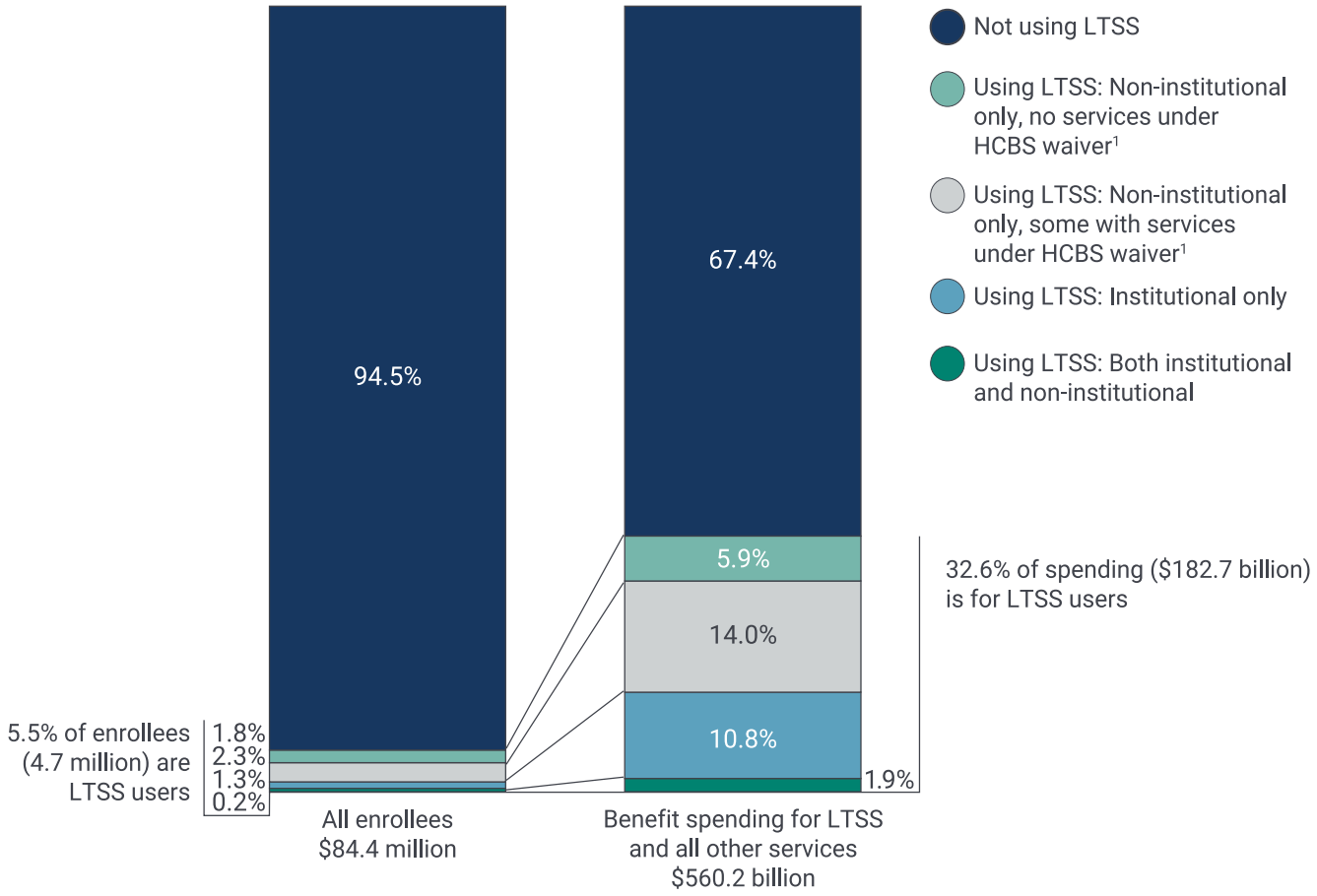
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced child FYE enrollment by 211,000 and child spending by $526.1 million.

[2] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[3] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020 and CMS-64 financial management report net expenditure data as of October 2019.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2018



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 Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals, and enrollment counts are unduplicated using unique national identification numbers. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between T-MSIS and the Medicaid Statistical Information System (MSIS).

LTSS users are defined here as enrollees using at least one LTSS service during the year under a fee-for-service arrangement. (The data do not allow a breakout of LTSS services delivered through managed care.) For example, an enrollee with a short stay in a nursing facility for rehabilitation following a hospital discharge and an enrollee with permanent residence in a nursing facility would both be counted as LTSS users.

California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced child enrollment by 259,000 and spending by $526.1 million.

[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. The number of HCBS waiver enrollees and associated spending may be different from other sources such as the CMS-372 report (a state-reported source containing aggregate spending and enrollment for HCBS waivers).

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020 and CMS-64 financial management report net expenditure data as of October 2019.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2018 (millions)

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	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Total	**$560,188**	**15.6%**	**16.9%**	**10.6%**	**34.3%**	**22.7%**	**$190,440**	**61.5%**	**$181,618**	**61.7%**	**$8,822**	**57.4%**
Alabama	**5,084**	19.5	–	8.8	46.3	25.3	**1,962**	65.2	**1,644**	67.3	**318**	54.3
Alaska	**2,035**	25.6	20.3	15.1	26.0	13.0	**477**	50.0	**474**	50.0	**3**	54.9
Arizona	**11,895**	17.3	26.4	15.9	29.0	11.4	**2,565**	48.3	**2,469**	47.8	**96**	60.9
Arkansas[5]	**6,178**	20.0	30.3	3.8	30.9	15.0	**–**	–	**–**	–	**–**	–
California[6]	**78,554**	10.7	27.8	11.6	27.6	22.3	**22,412**	69.7	**21,946**	69.7	**466**	68.3
Colorado	**8,831**	15.3	27.5	13.9	27.7	15.7	**1,247**	53.9	**1,099**	53.5	**148**	56.3
Connecticut	**8,602**	14.2	22.4	11.7	24.8	26.9	**3,466**	60.9	**3,112**	60.5	**354**	65.1
Delaware	**2,227**	17.2	22.8	16.3	27.7	15.9	**638**	54.6	**596**	54.7	**42**	52.5
District of Columbia[7]	**2,767**	12.0	16.4	11.5	40.0	20.1	**779**	65.5	**739**	65.4	**40**	67.5
Florida[8]	**21,815**	14.8	0.3	8.7	34.0	42.1	**11,834**	74.8	**10,956**	75.7	**878**	63.7
Georgia	**10,455**	21.6	–	11.6	45.2	21.6	**3,265**	66.3	**2,874**	67.3	**391**	58.6
Hawaii[9]	**2,266**	16.1	30.8	10.2	23.6	19.3	**677**	58.8	**664**	58.6	**14**	65.7
Idaho	**1,894**	20.2	–	11.3	48.4	20.0	**675**	51.4	**628**	51.7	**47**	47.5
Illinois[7]	**21,963**	19.3	5.0	27.2	27.2	21.4	**5,391**	58.7	**5,291**	58.7	**100**	56.3
Indiana	**11,235**	14.6	23.2	12.1	31.1	19.1	**4,333**	59.8	**4,161**	60.4	**172**	45.8
Iowa	**4,834**	14.1	20.2	11.2	36.1	18.3	**1,774**	49.8	**1,725**	49.6	**49**	59.4
Kansas	**3,282**	19.8	–	11.6	46.0	22.6	**1,334**	50.1	**1,237**	50.7	**97**	42.0
Kentucky	**9,610**	14.2	31.7	7.6	33.7	12.8	**2,272**	52.7	**2,019**	54.9	**253**	35.1
Louisiana	**9,721**	19.6	31.8	6.9	29.4	12.3	**2,096**	57.2	**1,952**	57.0	**145**	58.9
Maine	**2,731**	15.4	0.3	8.4	48.6	27.3	**1,406**	52.2	**1,319**	51.2	**88**	67.1
Maryland	**11,396**	13.7	24.2	15.1	30.9	16.0	**2,988**	58.1	**2,785**	58.3	**204**	54.5
Massachusetts	**16,413**	9.3	13.3	10.8	40.4	26.1	**7,526**	53.8	**7,481**	53.6	**45**	96.1
Michigan	**15,839**	14.3	22.4	9.3	33.7	20.3	**5,120**	62.5	**4,912**	63.3	**208**	44.2
Minnesota	**12,698**	14.2	13.4	9.5	38.9	24.1	**5,233**	55.0	**5,193**	55.0	**40**	57.1
Mississippi	**5,069**	25.6	–	9.1	42.3	23.0	**2,018**	57.5	**1,795**	58.7	**223**	47.9

EXHIBIT 21. (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	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri	**$9,616**	25.9%	–	8.8%	47.0%	18.4%	**$3,481**	45.5%	**$3,385**	45.6%	**$96**	41.0%
Montana	**1,855**	21.8	32.5%	6.5	21.9	17.3	**492**	63.2	**460**	64.3	**32**	48.0
Nebraska	**2,135**	17.9	–	10.9	33.6	37.6	**1,022**	72.3	**1,014**	72.4	**8**	55.4
Nevada	**3,866**	18.4	34.0	8.3	27.0	12.2	**461**	61.0	**376**	61.1	**86**	60.2
New Hampshire	**1,900**	15.7	26.0	4.2	28.9	25.2	**785**	57.0	**745**	57.9	**39**	39.7
New Jersey	**14,124**	11.6	24.3	5.8	36.0	22.3	**5,499**	53.3	**5,476**	53.4	**22**	25.5
New Mexico	**5,002**	20.9	28.4	11.5	27.5	11.7	**1,131**	53.5	**1,061**	53.0	**70**	60.1
New York	**69,060**	9.2	22.2	8.2	30.3	30.2	**29,512**	67.5	**28,912**	67.4	**600**	74.7
North Carolina	**13,039**	23.6	–	13.4	46.0	17.0	**3,932**	56.2	**3,783**	56.4	**149**	52.0
North Dakota[6]	**1,230**	14.7	1.2	5.5	39.3	39.3	**796**	60.3	**738**	60.2	**58**	61.8
Ohio	**21,841**	12.9	19.9	10.0	36.6	20.6	**7,145**	54.1	**6,852**	54.5	**293**	44.3
Oklahoma	**4,756**	32.3	–	13.4	36.8	17.5	**1,398**	53.7	**1,360**	53.8	**38**	49.3
Oregon	**8,723**	14.3	38.5	9.5	17.1	20.7	**2,788**	63.8	**2,574**	65.9	**214**	38.3
Pennsylvania	**29,103**	13.1	15.6	5.9	41.9	23.6	**10,187**	65.8	**9,929**	66.2	**258**	53.3
Rhode Island[7]	**2,491**	15.6	23.3	11.6	33.5	15.9	**785**	49.0	**771**	48.9	**14**	53.4
South Carolina	**5,699**	23.1	–	16.8	40.3	19.7	**2,006**	55.1	**1,977**	55.0	**30**	62.1
South Dakota	**873**	20.7	–	10.9	45.4	23.0	**361**	53.4	**339**	53.7	**22**	47.8
Tennessee	**8,843**	26.4	–	17.2	36.0	20.4	**3,126**	56.6	**2,881**	56.9	**246**	53.0
Texas[8]	**30,544**	28.7	0.0	6.2	42.8	22.3	**10,047**	64.3	**8,666**	64.6	**1,381**	62.5
Utah[6]	**2,425**	23.6	–	14.3	47.0	15.1	**660**	45.0	**644**	44.7	**15**	58.5
Vermont[7]	**1,409**	10	10	10	10	10	**10**	10	**10**	10	**10**	10
Virginia[8]	**9,415**	15.2	–	12.7	50.3	21.9	**3,970**	46.1	**3,778**	46.1	**192**	46.0
Washington	**11,666**	15.4	33.7	3.0	29.8	18.1	**3,310**	56.9	**3,130**	57.3	**180**	50.0
West Virginia	**3,802**	14.0	24.0	6.9	31.8	23.3	**1,359**	62.7	**1,134**	63.1	**225**	61.0
Wisconsin	**8,777**	12.1	–	14.7	47.1	26.1	**4,124**	53.5	**4,012**	53.8	**113**	45.6
Wyoming	**602**	24.6	–	11.6	39.5	24.2	**198**	44.7	**193**	44.5	**6**	49.2

EXHIBIT 21. (continued)

Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between T-MSIS and the Medicaid Statistical Information System (MSIS).

– Dash indicates zero; 0.0% indicates an amount less than 0.05% 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. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category.

[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] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[4] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

[5] State did not identify dually eligible beneficiaries. Because we could not identify dually eligible enrollees, spending total excludes Medicare premiums and cost sharing.

[6] State has a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced California's child spending by approximately $491.7 million; North Dakota's child spending by approxmiately $10.6 million, and Utah's child spending by approximately $23.8 million.

[7] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The average monthly enrollment in the District of Columbia was 37 percent less than the benchmark; the average monthly enrollment in Illinois was 66 percent less than the benchmark; and average monthly enrollment in Rhode Island was 31 percent more than the benchmark. Vermont did not report any enrollees in the new adult group but reported approximately 58,000 average monthly enrollees on the CMS-64 enrollment report. Similarly, these potential enrollment discrepancies will affect the proportion of spending across eligibility groups.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2018.

[9] Spending total excludes a small amount of fee-for-service (FFS) drug spending reported on the CMS-64 because there were no FFS drug claims reported in T-MSIS.

[10] Due to large differences in the way spending is reported by Vermont in CMS-64 and T-MSIS data, MACPAC's adjustment methodology is applied only to total Medicaid spending.

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020 and CMS-64 financial management report net expenditure data as of October 2019.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent Enrollee by State and Eligibility Group, FY 2018

State	Total		Child		New adult group[1]		Other adult[2]		Disabled		Aged	
	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]
Total	**$7,832**	**$8,346**	**$3,138**	**$3,146**	**$6,397**	**$6,474**	**$4,765**	**$5,684**	**$20,300**	**$22,634**	**$17,956**	**$23,089**
Alabama	**5,345**	**6,352**	2,206	2,206	–	–	2,598	4,155	11,227	14,378	10,831	24,142
Alaska	**10,125**	**10,161**	6,120	6,120	9,081	9,081	7,229	7,229	32,394	32,904	23,059	24,468
Arizona	**6,458**	**6,944**	3,034	3,079	7,103	7,452	4,733	5,558	20,305	22,155	8,936	11,104
Arkansas[4]	**6,801**	**6,801**	3,771	3,771	6,182	6,182	3,663	3,663	13,207	13,207	13,312	13,312
California[5]	**6,221**	**7,037**	2,531	2,566	5,598	5,811	2,899	4,538	22,206	22,311	13,551	13,767
Colorado	**7,116**	**7,254**	3,105	3,105	5,895	5,895	5,822	5,822	22,375	25,998	18,628	26,982
Connecticut	**9,161**	**9,929**	3,888	3,886	7,571	7,524	5,979	5,900	30,392	47,319	17,500	42,374
Delaware	**9,441**	**10,351**	4,377	4,422	8,018	8,025	8,578	10,052	24,145	33,734	20,624	43,949
District of Columbia[6]	**10,959**	**11,303**	4,673	4,673	6,443	6,446	6,218	6,170	31,181	33,894	22,809	32,756
Florida[7]	**5,601**	**6,055**	1,581	1,579	10,114	13,348	3,013	3,232	12,191	14,717	15,215	24,252
Georgia	**5,379**	**5,788**	2,100	2,093	–	–	3,832	4,080	13,643	16,558	10,960	21,238
Hawaii[8]	**6,818**	**6,859**	3,104	3,104	6,061	6,060	5,171	4,918	23,326	24,925	13,721	15,343
Idaho	**7,317**	**7,704**	2,499	2,499	–	–	6,649	6,528	19,066	22,765	14,942	24,329
Illinois[6]	**7,639**	**7,651**	3,521	3,521	4,459	4,460	6,758	6,650	19,942	20,567	19,217	20,549
Indiana	**8,358**	**8,926**	3,002	3,031	6,841	6,852	11,014	15,219	17,570	20,609	22,314	34,337
Iowa	**7,909**	**8,149**	2,928	2,929	5,919	5,905	5,822	6,066	22,310	24,184	21,191	29,302
Kansas	**8,663**	**9,057**	3,064	3,064	–	–	6,696	6,470	20,451	24,757	20,540	31,027
Kentucky	**6,723**	**6,998**	3,287	3,286	5,448	5,438	5,460	5,437	14,358	17,754	12,913	21,026
Louisiana	**6,426**	**6,884**	3,358	3,361	6,326	6,327	5,678	6,239	13,200	16,365	9,752	18,244
Maine	**10,508**	**11,776**	4,426	4,431	6,908	6,908	4,892	4,947	19,717	22,465	15,057	27,793
Maryland	**9,081**	**9,382**	3,374	3,360	8,661	8,664	7,216	7,004	24,439	28,965	20,428	33,026
Massachusetts	**9,830**	**10,921**	3,969	4,200	6,921	6,943	4,211	5,391	18,944	19,003	21,785	26,071
Michigan	**6,125**	**6,243**	2,410	2,423	4,586	4,587	4,269	4,414	14,766	15,716	19,193	22,807
Minnesota	**11,368**	**11,579**	3,492	3,498	8,057	8,021	6,209	6,422	41,995	44,148	38,744	43,475
Mississippi	**7,375**	**8,388**	3,811	3,813	–	–	4,928	6,331	13,166	16,538	12,863	23,449

EXHIBIT 22. (continued)

State	Total		Child		New adult group[1]		Other adult[2]		Disabled		Aged	
	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]
Missouri	**$9,257**	**$9,524**	$4,013	$4,013	–	–	$5,681	$5,681	$25,131	$27,986	$19,573	$24,205
Montana	**7,309**	**7,492**	4,183	4,183	$6,038	$6,041	6,290	6,791	17,560	20,216	21,462	30,609
Nebraska[9]	**11,392**	**11,583**	3,547	3,546	–	–	8,144	8,136	21,998	22,979	43,712	49,521
Nevada	**5,916**	**5,922**	2,670	2,670	5,998	5,875	5,215	4,950	17,416	19,599	10,376	13,561
New Hampshire	**9,913**	**10,420**	3,867	3,867	8,440	8,438	5,989	5,983	20,947	27,034	29,402	46,753
New Jersey	**8,809**	**8,730**	2,730	2,726	5,946	5,855	7,511	6,990	29,398	29,415	21,833	21,777
New Mexico	**6,132**	**6,710**	3,590	3,597	5,574	5,684	3,661	4,843	20,747	24,807	12,660	21,437
New York	**11,908**	**12,169**	3,848	3,851	7,495	7,497	7,536	7,605	32,663	34,735	28,903	33,827
North Carolina	**6,773**	**7,974**	3,366	3,366	–	–	3,591	6,709	17,416	18,936	12,259	15,774
North Dakota[5]	**13,611**	**13,319**	4,895	4,895	684	658	5,734	5,733	43,023	44,779	55,441	61,696
Ohio	**8,009**	**8,270**	2,875	2,875	6,280	6,256	4,806	4,780	19,922	23,348	22,237	30,396
Oklahoma	**6,831**	**7,301**	3,873	3,873	–	–	4,943	6,286	16,341	17,833	13,176	15,765
Oregon	**10,039**	**10,859**	4,513	4,526	8,631	8,993	8,660	9,723	28,233	43,494	32,527	66,248
Pennsylvania	**10,430**	**10,787**	4,391	4,412	5,798	5,819	5,934	6,166	20,748	22,046	25,921	31,680
Rhode Island[6]	**7,914**	**8,053**	4,550	4,550	6,419	6,418	4,275	4,287	20,280	21,505	13,312	15,152
South Carolina	**4,845**	**5,735**	2,411	2,418	–	–	2,558	4,702	13,795	14,012	12,792	13,587
South Dakota	**8,210**	**8,588**	2,948	2,948	–	–	6,400	6,398	20,817	24,691	18,051	26,032
Tennessee	**5,752**	**6,079**	3,054	3,054	–	–	4,012	4,012	12,366	15,096	13,237	24,793
Texas[7]	**7,073**	**7,231**	3,071	3,061	37,453	37,453	6,335	6,150	19,259	22,227	14,093	21,306
Utah[5]	**8,636**	**8,547**	3,368	3,364	–	–	6,785	6,502	26,603	26,784	21,315	21,660
Vermont[6]	**8,128**	**10**	10	10	10	10	10	10	10	10	10	10
Virginia[7]	**8,470**	**10,107**	2,996	2,996	–	–	3,524	5,583	25,519	29,703	18,747	25,569
Washington	**6,524**	**6,613**	2,380	2,383	5,707	5,706	7,383	5,828	19,132	22,386	18,355	24,343
West Virginia	**6,999**	**7,008**	2,900	2,900	5,362	5,360	4,872	4,868	12,956	14,387	20,917	29,882
Wisconsin	**8,125**	**8,548**	2,620	2,628	–	–	3,521	3,806	23,178	24,032	17,774	19,879
Wyoming	**9,726**	**10,136**	4,145	4,144	–	–	7,394	7,316	22,365	25,711	24,253	32,559

EXHIBIT 22. (continued)

Notes: FY is fiscal year. Full-year equivalent (FYE) may also be referred to as average monthly enrollment. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included prior to the December 2015 data book. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information. Additionally, figures shown here may not be directly comparable to prior years due to differences in reporting between T-MSIS and the Medicaid Statistical Information System (MSIS).

– Dash indicates zero.

[1] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[2] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

[3] In this table, full-benefit enrollees excludes those reported by states in T-MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

[4] State did not identify dually eligible beneficiaries. Because we could not identify dually eligible enrollees, spending total excludes Medicare premiums and cost sharing.

[5] State has a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced California's child FYE enrollment by approximately 204,000 and spending by $491.7 million; North Dakota's child FYE enrollment by approxmiately 2,300 and spending by $10.6 million, and Utah's child FYE enrollment by approximately 10,300 and spending by $23.8 million.

[6] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The average monthly enrollment in the District of Columbia was 37 percent less than the benchmark; the average monthly enrollment in Illinois was 66 percent less than the benchmark; and average monthly enrollment in Rhode Island was 31 percent more than the benchmark. Vermont did not report any enrollees in the new adult group but reported approximately 58,000 average monthly enrollees on the CMS-64 enrollment report.

[7] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2018.

[8] Spending total excludes a small amount of fee-for-service (FFS) drug spending reported on the CMS-64 because there were no FFS drug claims reported in T-MSIS.

[9] State reported total enrollment that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. Nebraska's average monthly enrollment was 24 percent less than the benchmark.

[10] Due to large differences in the way spending is reported by Vermont in CMS-64 and T-MSIS data, MACPAC's adjustment methodology is applied only to total Medicaid spending.

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020 and CMS-64 financial management report net expenditure data as of October 2019.

EXHIBIT 23. Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2019

State[1]	All Medicaid enrollees			Newly eligible adults[2]		
	FYE enrollees	Medicaid benefit spending	Spending per FYE enrollee	FYE enrollees	Medicaid benefit spending	Spending per FYE enrollee
Alabama	1,034,559	$5,880,233,770	$5,684	–	–	–
Alaska	209,848	2,096,340,139	9,990	51,403	$447,673,889	$8,709
Arizona	1,878,992	13,167,873,159	7,008	106,928	445,165,327	4,163
Arkansas	837,300	6,842,930,884	8,173	253,594	1,765,319,361	6,961
California	12,660,291	87,855,979,661	6,939	3,744,874	19,941,368,256	5,325
Colorado	1,249,083	9,201,828,436	7,367	379,944	1,652,512,335	4,349
Connecticut	949,714	8,168,318,604	8,601	241,482	1,726,575,684	7,150
Delaware	214,198	2,245,537,767	10,483	9,667	51,421,499	5,319
District of Columbia	261,184	2,892,033,951	11,073	66,937	424,614,643	6,343
Florida	3,789,899	24,384,268,451	6,434	–	–	–
Georgia	1,970,558	10,851,623,393	5,507	–	–	–
Hawaii	311,390	2,178,370,796	6,996	20,276	435,625,248	21,485
Idaho	296,048	2,143,001,207	7,239	–	–	–
Illinois	2,694,520	18,470,094,556	6,855	580,910	3,711,420,273	6,389
Indiana	1,319,627	12,439,243,969	9,426	308,155	2,510,979,314	8,148
Iowa	604,559	5,199,821,191	8,601	156,219	971,033,268	6,216
Kansas	364,353	3,601,873,235	9,886	–	–	–
Kentucky	1,291,626	10,207,733,005	7,903	450,768	2,989,349,321	6,632
Louisiana	1,638,357	11,642,038,286	7,106	485,304	3,138,426,661	6,467
Maine	262,685	2,867,136,972	10,915	13,619	–	–
Maryland	1,223,843	11,730,186,550	9,585	310,446	2,718,959,167	8,758
Massachusetts	1,724,416	17,412,670,180	10,098	–	–	–
Michigan	2,408,370	18,257,869,906	7,581	624,502	4,154,748,566	6,653
Minnesota	1,065,194	12,720,672,282	11,942	191,310	1,844,500,817	9,641
Mississippi	673,577	5,506,770,865	8,175	–	–	–

EXHIBIT 23. (continued)

State[1]	All Medicaid enrollees			Newly eligible adults[2]		
	FYE enrollees	Medicaid benefit spending	Spending per FYE enrollee	FYE enrollees	Medicaid benefit spending	Spending per FYE enrollee
Missouri	873,180	$10,534,803,881	$12,065	–	–	–
Montana	255,736	1,857,962,976	7,265	97,489	$699,758,384	$7,178
Nebraska	243,705	2,141,794,131	8,788	–	–	–
Nevada	589,953	3,978,540,873	6,744	210,840	1,281,940,877	6,080
New Hampshire	183,341	1,985,132,112	10,828	53,298	250,608,167	4,702
New Jersey	1,636,822	15,908,523,928	9,719	541,561	3,293,097,437	6,081
New Mexico	832,221	5,262,891,223	6,324	255,803	1,469,615,813	5,745
New York	6,123,431	58,094,211,692	9,487	302,669	5,153,601,771	17,027
North Carolina	2,178,652	13,595,881,059	6,241	–	–	–
North Dakota	89,784	1,163,970,291	12,964	18,873	239,935,509	12,713
Ohio	2,775,438	23,465,691,647	8,455	573,223	4,009,414,624	6,995
Oklahoma	643,919	4,760,177,632	7,393	–	–	–
Oregon	960,996	9,426,870,932	9,809	382,294	2,933,015,934	7,672
Pennsylvania	2,855,768	32,079,703,325	11,233	732,597	4,529,109,439	6,182
Rhode Island	303,093	2,586,208,738	8,533	67,329	442,233,068	6,568
South Carolina	1,281,672	6,305,731,666	4,920	–	–	–
South Dakota	104,154	899,072,690	8,632	–	–	–
Tennessee	1,556,045	10,091,876,637	6,486	–	–	–
Texas	4,187,451	40,025,676,488	9,558	–	–	–
Utah	292,652	2,724,326,505	9,309	–	–	–
Vermont	169,539	1,637,796,926	9,660	–	–	–
Virginia	1,188,417	11,307,295,979	9,515	198,069	1,594,147,098	8,048
Washington	1,770,916	13,128,258,799	7,413	501,902	4,254,444,320	8,477
West Virginia	523,739	3,926,176,801	7,496	161,513	918,476,164	5,687
Wisconsin	1,181,293	9,132,546,898	7,731	–	–	–
Wyoming	55,306	584,259,094	10,564	–	–	–

EXHIBIT 23. (continued)

State[1]	All Medicaid enrollees			Newly eligible adults[2]		
	FYE enrollees	Medicaid benefit spending	Spending per FYE enrollee	FYE enrollees	Medicaid benefit spending	Spending per FYE enrollee
Subtotal (states)	**73,791,410**	**$594,569,834,138**	**$8,057**	**12,093,799**	**$79,999,092,234**	**$6,615**
American Samoa	33,006	52,551,662	1,592	–	–	–
Guam	35,919	113,109,284	3,149	–	–	–
Northern Mariana Islands	16,253	59,151,342	3,639	–	–	–
Puerto Rico	1,207,841	2,452,962,312	2,031	–	–	–
Virgin Islands	28,334	137,693,285	4,860	–	–	–
Total (states and territories)	**75,112,762**	**$597,385,302,023**	**$7,953**	**12,093,799**	**$79,999,092,234**	**$6,615**

Notes: FY is fiscal year. FYE is full-year equivalent. FYE may also be referred to as average monthly enrollment. Includes federal and state funds. Excludes spending for administration and Medicaid-expansion CHIP enrollees. Enrollment counts come from CMS-64 enrollment data and may differ from other data sources. Quarterly enrollment was tabulated from the most recent non-zero CMS-64 submission to account for any lag in reporting; this typically is the report submitted three quarters later (e.g., January–March 2019 enrollment was taken from the submission quarter ending December 31, 2019). Unlike other MACStats exhibits that show spending per FYE, this exhibit includes spending for disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act).

– Dash indicates zero.

[1] All states had certified their CMS-64 financial management report (FMR) submissions as of August 5, 2020. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] Newly eligible adults include those enrollees who are newly eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act and receive a federal matching rate of 94 percent for quarters in calendar year 2018 and 93 percent for quarters in calendar year 2019.

Source: MACPAC, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020, and CMS-64 enrollment reports as of October 27, 2020.

EXHIBIT 24. Medicaid Supplemental Payments to Hospital Providers by State, FY 2019 (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	**$87,703.7**	**$14,946.5**	**$16,494.7**	**$14,227.4**	**52.1%**
Alabama	**2,306.7**	486.3	823.7	–	56.8
Alaska	**621.3**	9.6	–	–	1.5
Arizona[3]	**1,264.1**	135.4	293.6	16.5	35.2
Arkansas	**1,296.2**	81.3	398.3	–	37.0
California[4, 5]	**16,101.1**	636.5	5,852.1	3,905.1	64.6
Colorado	**2,917.6**	248.2	1,170.7	–	48.6
Connecticut	**2,326.9**	3.2	508.4	–	22.0
Delaware	**74.3**	9.1	–	–	12.3
District of Columbia	**399.9**	82.2	17.9	–	25.0
Florida[4]	**2,212.8**	236.8	232.9	756.3	55.4
Georgia	**2,899.6**	455.8	7.9	–	16.0
Hawaii	**53.2**	36.2	0.5	–	69.0
Idaho	**564.5**	26.0	11.5	–	6.6
Illinois	**3,040.8**	205.2	883.2	–	35.8
Indiana	**1,054.5**	267.4	36.6	–	28.8
Iowa	**228.4**	70.9	39.2	–	48.2
Kansas[4, 5]	**178.7**	68.1	1.5	72.9	79.7
Kentucky	**385.9**	212.9	7.8	–	57.2
Louisiana	**2,296.2**	1,080.3	102.2	–	51.5
Maine	**634.2**	1.8	89.3	–	14.4
Maryland[6]	**1,036.7**	-0.2	53.1	–	5.1
Massachusetts[3, 4, 5]	**2,861.8**	–	82.5	831.2	31.9
Michigan	**1,287.9**	160.9	627.1	–	61.2
Minnesota[3]	**665.4**	61.6	63.1	70.1	29.3
Mississippi	**654.6**	230.1	–	–	35.1
Missouri[3, 7]	**2,593.2**	539.6	141.3	-0.4	26.2
Montana	**687.0**	1.8	236.5	–	34.7
Nebraska	**62.2**	58.5	–	–	94.0
Nevada	**613.4**	101.8	229.0	–	53.9
New Hampshire[5]	**279.5**	225.9	0.3	18.4	87.5
New Jersey[3]	**1,650.1**	765.5	–	238.8	60.9
New Mexico[4, 5]	**419.0**	32.3	118.2	80.9	55.2
New York[5]	**8,554.9**	3,096.0	420.7	1,914.2	63.5
North Carolina	**4,276.2**	307.7	1,146.8	–	34.0

EXHIBIT 24. (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
North Dakota	**$145.1**	$1.0	$2.2	–	2.2%
Ohio	**2,444.0**	1,315.2	426.5	–	71.3
Oklahoma[5]	**1,770.3**	40.8	638.1	$107.7	44.4
Oregon	**401.0**	29.4	102.8	–	33.0
Pennsylvania	**1,810.6**	811.3	429.2	–	68.5
Rhode Island	**363.9**	142.3	0.2	–	39.2
South Carolina	**1,125.6**	498.1	121.4	–	55.0
South Dakota	**246.8**	0.8	2.9	–	1.5
Tennessee[3, 4]	**485.9**	79.1	–	380.3	94.6
Texas[4, 5]	**8,965.7**	1,658.2	122.5	6,071.2	87.6
Utah	**361.6**	31.1	42.8	–	20.4
Vermont[5]	**25.8**	22.7	–	3.1	100.0
Virginia	**1,446.3**	93.0	913.9	–	69.6
Washington[5, 7]	**415.1**	163.8	–	-238.8	-18.1
West Virginia	**252.2**	53.0	11.7	–	25.6
Wisconsin	**813.2**	71.5	50.0	–	14.9
Wyoming	**132.0**	0.5	34.6	–	26.6

Notes: FY is fiscal year. DSH is disproportionate share hospital. Includes federal and state funds. Section 1115 refers to Section 1115 of the Social Security Act (the Act). 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. Some fluctuation in supplemental payments may reflect the fact that states may not consistently classify payments in the same way over time.

– Dash indicates zero.

[1] All states had certified their CMS-64 financial management report (FMR) submissions as of August 5, 2020. 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 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 other supplemental payments, including graduate medical education, under Section 1115 waiver expenditure authority.

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

[5] State made supplemental payments through a DSRIP or DSRIP-like program under Section 1115 waiver expenditure authority.

[6] State reported negative DSH payments due to prior period adjustments.

[7] State reported negative Section 1115 waiver authority payments due to prior period adjustments.

Source: MACPAC, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020, and CMS-64 Schedule C waiver report data as of September 24, 2020.

EXHIBIT 25. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2019 (millions)

State[1]	Mental health facilities[2]			Nursing facilities and ICF/IDs[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	**$6,092.1**	**$2,867.2**	**47.1%**	**$50,412.9**	**$3,368.2**	**6.7%**	**$9,583.9**	**$1,446.4**	**15.1%**
Alabama	**84.8**	3.2	3.8	**967.0**	–	–	**472.1**	–	–
Alaska	**27.9**	15.4	55.1	**182.9**	–	–	**198.7**	–	–
Arizona	**35.2**	28.5	80.9	**60.2**	9.2	15.3	**67.3**	–	–
Arkansas	**60.8**	0.0	0.0	**865.9**	–	–	**373.7**	41.1	11.0
California	**735.9**	0.0	0.0	**3,335.2**	208.3	6.2	**684.4**	83.7	12.2
Colorado[5]	**2.4**	–	–	**903.5**	113.6	12.6	**-59.7**	144.4	-241.9
Connecticut	**195.9**	105.6	53.9	**1,426.8**	–	–	**709.0**	13.0	1.8
Delaware	**24.3**	6.0	24.6	**28.3**	–	–	**12.4**	–	–
District of Columbia	**10.9**	6.1	56.1	**372.3**	–	–	**52.2**	4.5	8.6
Florida[6]	**717.7**	121.5	16.9	**655.2**	–	–	**660.9**	427.1	64.6
Georgia	**7.8**	–	–	**1,600.8**	127.9	8.0	**442.9**	59.4	13.4
Hawaii	**–**	–	–	**9.0**	–	–	**0.2**	–	–
Idaho	**2.6**	–	–	**281.9**	59.2	21.0	**157.5**	–	–
Illinois	**153.0**	89.4	58.4	**1,443.0**	–	–	**274.5**	–	–
Indiana	**55.7**	–	–	**2,865.7**	1,039.4	36.3	**132.5**	–	–
Iowa	**3.3**	–	–	**72.0**	–	–	**31.1**	9.6	31.0
Kansas	**14.4**	14.4	99.9	**82.3**	–	–	**5.3**	0.2	4.4
Kentucky	**41.2**	39.9	97.0	**1,156.3**	0.6	0.0	**29.8**	3.5	11.9
Louisiana	**104.1**	96.5	92.7	**1,426.7**	3.8	0.3	**38.7**	7.7	20.0
Maine[7]	**24.6**	-40.3	-163.4	**428.3**	–	–	**125.7**	2.6	2.1
Maryland	**230.3**	57.9	25.2	**1,236.8**	–	–	**209.3**	–	–
Massachusetts[6,8]	**112.4**	79.7	70.9	**1,458.7**	–	–	**204.0**	8.3	4.1
Michigan	**196.4**	160.3	81.6	**2,060.1**	444.1	21.6	**291.2**	156.3	53.7
Minnesota	**121.7**	0.5	0.4	**1,161.0**	–	–	**374.6**	52.4	14.0
Mississippi	**26.3**	–	–	**1,081.5**	28.2	2.6	**121.2**	10.1	8.3
Missouri	**226.9**	205.3	90.5	**1,262.2**	–	–	**21.3**	–	–

EXHIBIT 25. (continued)

State[1]	Mental health facilities[2]			Nursing facilities and ICF/IDs[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
Montana	**$23.7**	–	–	**$197.7**	$17.1	8.7%	**$186.5**	–	–
Nebraska	**1.8**	$1.8	100.0%	**436.0**	16.4	3.8	**2.6**	–	–
Nevada	**39.0**	–	–	**305.5**	104.9	34.3	**164.4**	$3.1	1.9%
New Hampshire	**45.2**	44.0	97.3	**405.3**	131.1	32.3	**8.5**	–	–
New Jersey	**492.0**	357.4	72.6	**1,101.5**	–	–	**56.6**	–	–
New Mexico	**1.8**	–	–	**31.1**	–	–	**74.1**	5.0	6.8
New York	**908.5**	444.8	49.0	**6,558.7**	367.6	5.6	**419.2**	38.9	9.3
North Carolina	**166.4**	166.3	99.9	**1,350.0**	–	–	**1,029.2**	118.1	11.5
North Dakota	**21.9**	1.2	5.6	**340.0**	–	–	**49.1**	–	–
Ohio	**95.6**	93.4	97.7	**2,178.8**	–	–	**212.5**	29.1	13.7
Oklahoma	**69.5**	3.3	4.7	**661.5**	–	–	**474.6**	–	–
Oregon	**30.2**	20.0	66.1	**469.2**	–	–	**60.6**	–	–
Pennsylvania	**368.0**	292.3	79.4	**3,308.6**	437.2	13.2	**54.6**	–	–
Rhode Island	**3.6**	–	–	**320.4**	–	–	**9.1**	–	–
South Carolina	**69.2**	60.8	88.0	**822.3**	18.5	2.2	**130.8**	20.9	16.0
South Dakota	**3.1**	0.8	24.6	**179.9**	4.3	2.4	**68.3**	–	–
Tennessee	**45.9**	–	–	**211.3**	–	–	**30.1**	–	–
Texas[6, 9]	**296.1**	292.6	98.8	**1,529.2**	5.9	0.4	**350.1**	82.8	23.6
Utah	**20.5**	1.9	9.1	**389.3**	101.9	26.2	**87.1**	16.8	19.3
Vermont	**–**	–	–	**132.5**	–	–	**–**	–	–
Virginia[10]	**-24.3**	-4.8	19.8	**351.6**	17.3	4.9	**183.0**	99.8	54.5
Washington	**109.5**	82.5	75.4	**954.9**	5.7	0.6	**141.6**	7.8	5.5
West Virginia	**58.5**	18.9	32.3	**793.3**	–	–	**45.5**	–	–
Wisconsin	**20.3**	–	–	**828.5**	69.7	8.4	**70.4**	–	–
Wyoming	**9.7**	–	–	**132.3**	36.3	27.4	**45.0**	–	–

EXHIBIT 25. (continued)

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. Some fluctuation in supplemental payments may reflect the fact that states may not consistently classify payments in the same way over time.

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

[1] All states had certified their CMS-64 financial management report (FMR) submissions as of August 5, 2020. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[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 (the Act) as well as uncompensated care pool and other non-DSH supplemental payments made under waiver expenditure authority of Section 1115 of the Act. States are not instructed to break out non-DSH supplemental payments for mental health facilities.

[3] Supplemental payments to nursing facilities and ICF/IDs include those 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 made in addition to the standard fee schedule payment as well as uncompensated care pool payments made under Section 1115 waiver expenditure authority. There is no regulatory upper payment limit for physicians and other practitioners (as there is for institutional providers).

[5] State reports negative base payments for physicians due to prior period adjustments; this leads to negative total payments overall for physicians. Because the state reports positive supplemental payments, this results in a negative percentage greater than 100 percent.

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

[7] State reports negative DSH payments for mental health facilities due to prior period adjustments. This results in a negative percentage greater than 100 percent.

[8] 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.

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

[10] State reports negative base and DSH payments to mental health facilities due to prior period adjustments; this leads to negative total payments overall for mental health facilities.

Source: MACPAC, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020, and CMS-64 Schedule C waiver report data as of September 24, 2020.

EXHIBIT 26. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2019 (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]	**$66,734.9**	**83.0%**	**16.8%**	**0.2%**	**$24,475.5**	**85.5%**	**14.3%**	**0.2%**	**$42,259.4**	**81.6%**	**18.2%**	**0.2%**
Alabama	**754.5**	**85.1**	**14.9**	**0.0**	**754.5**	85.1	14.9	0.0	**–**	–	–	–
Alaska	**144.5**	**78.6**	**21.1**	**0.3**	**144.5**	78.6	21.1	0.3	**–**	–	–	–
Arizona	**1,326.8**	**81.5**	**18.3**	**0.2**	**20.5**	90.7	9.3	0.0	**1,306.3**	81.4	18.4	0.2
Arkansas	**359.5**	**79.2**	**20.7**	**0.1**	**337.9**	79.2	20.7	0.1	**21.6**	79.3	20.7	0.0
California	**8,047.7**	**83.3**	**16.6**	**0.0**	**4,380.7**	88.3	11.7	0.0	**3,667.0**	77.4	22.6	0.0
Colorado	**985.3**	**86.5**	**13.3**	**0.2**	**953.8**	86.6	13.2	0.2	**31.5**	83.0	17.0	0.0
Connecticut[5]	**964.2**	**86.9**	**13.1**	**0.1**	**964.2**	86.9	13.1	0.1	**–**	–	–	–
Delaware[6]	**2.7**	**84.9**	**15.1**	**0.0**	**2.7**	84.9	15.1	0.0	**–**	–	–	–
District of Columbia	**264.9**	**90.2**	**9.8**	**0.0**	**195.0**	94.4	5.5	0.0	**69.8**	78.2	21.7	0.1
Florida	**2,796.4**	**88.6**	**11.4**	**0.0**	**363.4**	92.1	7.8	0.1	**2,432.9**	88.0	11.9	0.0
Georgia	**1,150.2**	**79.6**	**20.2**	**0.2**	**726.0**	87.5	12.5	0.0	**424.2**	66.1	33.4	0.4
Hawaii	**180.4**	**81.1**	**18.8**	**0.1**	**0.1**	82.9	17.1	–	**180.3**	81.1	18.8	0.1
Idaho	**216.5**	**84.1**	**15.9**	**0.1**	**216.5**	84.1	15.9	0.1	**–**	–	–	–
Illinois	**1,847.9**	**84.0**	**15.9**	**0.0**	**211.1**	87.4	12.6	0.0	**1,636.8**	83.6	16.4	0.0
Indiana	**1,736.5**	**81.2**	**18.7**	**0.1**	**406.4**	90.1	9.9	0.0	**1,330.1**	78.6	21.4	0.1
Iowa	**319.6**	**89.0**	**11.0**	**0.0**	**7.5**	76.8	23.2	–	**312.1**	89.3	10.7	0.0
Kansas	**299.3**	**79.3**	**20.7**	**0.1**	**1.2**	82.9	17.1	–	**298.0**	79.3	20.7	0.1
Kentucky	**1,395.6**	**75.7**	**24.1**	**0.3**	**63.8**	77.2	22.6	0.2	**1,331.7**	75.6	24.2	0.3
Louisiana	**1,307.0**	**78.8**	**21.0**	**0.1**	**49.4**	76.4	23.6	0.0	**1,257.5**	78.9	20.9	0.1
Maine	**244.2**	**88.5**	**11.4**	**0.0**	**244.2**	88.5	11.4	0.0	**–**	–	–	–
Maryland	**1,158.4**	**85.7**	**14.3**	**0.0**	**603.2**	87.3	12.7	0.0	**555.2**	84.0	16.0	0.0
Massachusetts	**1,513.2**	**84.8**	**14.9**	**0.3**	**720.1**	84.3	15.4	0.4	**793.1**	85.3	14.6	0.2
Michigan	**1,992.1**	**82.5**	**17.1**	**0.3**	**1,126.3**	85.9	13.9	0.2	**865.9**	78.2	21.3	0.4
Minnesota	**927.5**	**79.9**	**19.5**	**0.5**	**159.8**	71.3	27.9	0.7	**767.7**	81.7	17.8	0.5
Mississippi	**462.5**	**79.7**	**20.2**	**0.1**	**86.8**	82.5	17.5	0.0	**375.7**	79.1	20.9	0.1
Missouri	**1,214.5**	**76.1**	**23.8**	**0.1**	**1,214.5**	76.1	23.8	0.1	**–**	–	–	–
Montana	**261.4**	**83.1**	**16.8**	**0.0**	**261.4**	83.1	16.8	0.0	**–**	–	–	–
Nebraska	**182.3**	**81.1**	**18.8**	**0.1**	**0.1**	56.2	43.8	–	**182.2**	81.1	18.8	0.1

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]
Nevada	$507.2	80.7%	18.2%	1.1%	$202.7	82.9%	14.4%	2.7%	$304.5	79.3%	20.6%	0.0%
New Hampshire	154.1	79.9	20.0	0.2	16.0	98.1	1.9	0.0	138.1	77.7	22.0	0.2
New Jersey	1,424.3	83.4	16.6	0.0	25.8	83.4	16.6	0.0	1,398.5	83.4	16.6	0.0
New Mexico	362.9	75.8	24.1	0.1	25.2	84.8	15.2	0.0	337.6	75.1	24.8	0.1
New York	6,198.7	83.2	16.6	0.2	777.0	76.4	23.2	0.4	5,421.7	84.2	15.6	0.2
North Carolina	1,867.5	86.3	13.6	0.1	1,867.5	86.3	13.6	0.1	–	–	–	–
North Dakota	54.4	79.0	20.8	0.1	30.3	78.6	21.3	0.1	24.1	79.6	20.3	0.1
Ohio	3,308.5	84.2	15.7	0.0	288.0	81.7	18.3	0.0	3,020.5	84.5	15.5	0.0
Oklahoma	521.8	80.2	19.8	0.1	521.8	80.2	19.8	0.1	–	–	–	–
Oregon	664.4	81.0	19.0	0.0	106.8	70.0	30.0	0.0	557.7	83.1	16.9	0.0
Pennsylvania	3,128.8	84.2	15.8	0.0	57.3	77.8	22.2	–	3,071.5	84.3	15.7	0.0
Rhode Island	235.8	79.1	20.9	0.0	6.0	83.8	16.2	–	229.8	79.0	21.0	0.0
South Carolina	546.9	82.0	17.8	0.2	119.5	88.2	11.7	0.1	427.4	80.3	19.5	0.3
South Dakota[7]	72.2	79.2	20.4	0.4	72.2	79.2	20.4	0.4	–	–	–	–
Tennessee	1,076.4	85.2	14.7	0.1	992.5	84.3	15.6	0.1	84.0	96.2	3.5	0.3
Texas	3,285.8	82.9	17.1	0.0	65.9	81.2	18.7	0.1	3,219.9	82.9	17.1	0.0
Utah	242.6	85.0	15.0	0.0	133.5	84.3	15.7	0.0	109.1	85.8	14.2	0.0
Vermont	160.4	87.7	12.3	0.0	160.4	87.7	12.3	0.0	0.0	95.3	4.7	–
Virginia	2,162.5	64.0	34.6	1.3	38.8	79.4	19.8	0.8	2,123.7	63.8	34.9	1.3
Washington	1,139.1	85.9	14.0	0.1	111.3	91.0	8.9	0.1	1,027.9	85.4	14.6	0.1
West Virginia	651.2	82.3	17.6	0.0	629.8	81.8	18.1	0.0	21.4	96.4	3.4	0.1
Wisconsin[8]	1,279.1	85.4	14.6	0.0	1,279.1	85.4	14.6	0.0	–	–	–	–
Wyoming	31.6	83.4	16.6	–	31.6	83.4	16.6	–	–	–	–	–

EXHIBIT 26. (continued)

Notes: FY is fiscal year. Amounts include federal and state funds. Gross spending reflects expenditures prior to the application of manufacturer rebates. Drug expenditures in this exhibit use information from the state drug utilization data that states submit to CMS for rebate purposes and are different from the CMS-64 financial management report (FMR) and Transformed Medicaid Statistical Information System (T-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 (FFS) 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.

Since October 2016, CMS has suppressed all records in the state drug utilization data that are less than 11 counts, as obligated by the Privacy Act of 1974 (5 USC § 552a) and the HIPAA Privacy Rule (45 CFR Parts 160 and 164). The different brand and generic proportions under FFS 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. 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 file. Although the amount of suppressed spending in the FY 2019 national file is not known, comparison of totals from previous years may be instructive. A comparison of the updated FY 2014 files with data suppression to prior versions without suppression indicates that about $370 million dollars, or 0.9 percent of gross spending, was suppressed in the FY 2014 data.

[5] Connecticut's spending is underreported because it did not report data for April–June 2019.

[6] Delaware's managed care and total spending are substantially lower than prior years due to the apparent underreporting of MCO spending in all quarters of FY 2019.

[7] South Dakota's spending is underreported because it did not report data for October–December 2018.

[8] Wisconsin reports prescriptions for managed care but does not report any Medicaid spending.

Source: MACPAC, 2020, analysis of Medicaid drug product data and state drug rebate utilization data as of September 2020.

EXHIBIT 27. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2019 (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]	**726,087**	**15.8%**	**83.6%**	**0.7%**	**204,238**	**18.3%**	**81.1%**	**0.7%**	**521,849**	**14.8%**	**84.6%**	**0.6%**
Alabama	**7,321**	**19.8**	**79.9**	**0.3**	**7,321**	19.8	79.9	0.3	**–**	–	–	–
Alaska	**1,333**	**20.0**	**79.6**	**0.4**	**1,333**	20.0	79.6	0.4	**–**	–	–	–
Arizona	**15,714**	**14.1**	**85.1**	**0.8**	**91**	24.7	75.1	0.2	**15,623**	14.0	85.2	0.8
Arkansas	**4,839**	**16.6**	**83.1**	**0.3**	**4,569**	16.5	83.2	0.3	**270**	18.2	81.8	0.1
California	**94,707**	**14.9**	**84.9**	**0.1**	**25,275**	19.6	80.3	0.1	**69,432**	13.2	86.6	0.1
Colorado	**7,699**	**19.2**	**80.5**	**0.4**	**7,296**	19.4	80.2	0.4	**404**	14.9	84.9	0.1
Connecticut[5]	**7,030**	**23.0**	**76.6**	**0.5**	**7,030**	23.0	76.6	0.5	**–**	–	–	–
Delaware	**2,677**	**18.9**	**80.9**	**0.2**	**32**	24.0	75.8	0.2	**2,644**	18.8	81.0	0.2
District of Columbia	**2,131**	**18.2**	**81.3**	**0.5**	**867**	22.3	77.2	0.4	**1,264**	15.4	84.2	0.5
Florida	**27,096**	**17.8**	**82.1**	**0.2**	**1,688**	22.0	77.8	0.2	**25,409**	17.5	82.4	0.2
Georgia	**15,898**	**15.1**	**84.6**	**0.3**	**7,114**	18.2	81.7	0.1	**8,784**	12.5	87.0	0.5
Hawaii	**2,359**	**13.4**	**86.5**	**0.2**	**2**	1.9	98.1	–	**2,357**	13.4	86.5	0.2
Idaho	**2,299**	**18.7**	**80.9**	**0.4**	**2,299**	18.7	80.9	0.4	**–**	–	–	–
Illinois	**24,650**	**14.0**	**85.8**	**0.2**	**2,409**	18.4	81.5	0.1	**22,241**	13.5	86.2	0.2
Indiana	**16,045**	**16.7**	**83.1**	**0.2**	**2,711**	16.2	83.8	0.0	**13,335**	16.8	83.0	0.3
Iowa	**4,579**	**17.1**	**82.8**	**0.0**	**154**	16.6	83.4	–	**4,425**	17.1	82.8	0.0
Kansas	**3,315**	**17.3**	**82.4**	**0.2**	**15**	10.8	89.2	–	**3,300**	17.4	82.4	0.2
Kentucky	**23,776**	**11.6**	**87.6**	**0.8**	**1,047**	10.4	88.7	1.0	**22,729**	11.7	87.6	0.8
Louisiana	**19,506**	**12.4**	**87.0**	**0.6**	**734**	14.3	85.5	0.2	**18,772**	12.4	87.1	0.6
Maine	**2,056**	**27.3**	**72.6**	**0.2**	**2,056**	27.3	72.6	0.2	**–**	–	–	–
Maryland	**14,154**	**17.2**	**82.6**	**0.2**	**4,426**	22.8	77.1	0.1	**9,728**	14.6	85.1	0.3
Massachusetts	**17,350**	**16.4**	**80.7**	**2.9**	**8,654**	15.9	80.4	3.7	**8,696**	16.9	81.1	2.1
Michigan	**28,261**	**14.1**	**85.0**	**0.9**	**8,919**	16.8	82.9	0.4	**19,342**	12.9	86.0	1.1
Minnesota	**12,211**	**13.2**	**81.0**	**5.8**	**2,054**	13.0	80.0	7.0	**10,157**	13.2	81.2	5.5
Mississippi	**5,436**	**15.6**	**84.2**	**0.3**	**954**	15.7	84.1	0.2	**4,482**	15.5	84.2	0.3

EXHIBIT 27. (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]
Missouri	11,721	17.0%	82.6%	0.4%	11,721	17.0%	82.6%	0.4%	–	–	–	–
Montana	3,033	18.6	81.3	0.1	3,033	18.6	81.3	0.1	–	–	–	–
Nebraska	2,813	15.7	84.0	0.3	2	16.8	83.2	–	2,811	15.7%	84.0%	0.3%
Nevada	6,408	14.6	85.0	0.4	1,815	16.7	83.0	0.4	4,593	13.8	85.9	0.4
New Hampshire	1,755	17.3	82.2	0.6	34	27.3	72.0	0.7	1,721	17.1	82.4	0.6
New Jersey	20,011	13.7	86.2	0.1	351	15.8	84.1	0.1	19,661	13.6	86.2	0.1
New Mexico	5,060	15.2	84.7	0.1	269	19.5	80.4	0.1	4,790	15.0	84.9	0.1
New York	76,638	14.2	84.3	1.5	12,833	12.6	85.7	1.7	63,805	14.6	84.0	1.4
North Carolina	15,513	23.4	76.3	0.3	15,513	23.4	76.3	0.3	–	–	–	–
North Dakota	776	16.9	82.5	0.6	436	16.8	82.5	0.6	339	17.0	82.4	0.6
Ohio	45,653	16.2	83.7	0.1	3,731	14.9	85.1	0.0	41,922	16.3	83.6	0.1
Oklahoma	5,435	16.9	82.9	0.2	5,435	16.9	82.9	0.2	–	–	–	–
Oregon	9,480	13.7	86.3	0.0	2,129	6.6	93.4	0.0	7,351	15.7	84.2	0.0
Pennsylvania	34,880	15.3	84.6	0.1	1,175	11.6	88.4	–	33,705	15.5	84.5	0.1
Rhode Island	3,440	13.2	86.8	0.0	122	14.4	85.6	–	3,319	13.2	86.8	0.0
South Carolina	6,352	16.6	82.7	0.6	1,041	17.6	81.6	0.8	5,311	16.5	82.9	0.6
South Dakota[6]	583	18.6	80.8	0.6	583	18.6	80.8	0.6	–	–	–	–
Tennessee	12,970	16.1	83.1	0.8	12,539	15.7	83.5	0.8	431	27.1	71.8	1.0
Texas	33,164	17.4	82.6	0.0	895	22.2	77.7	0.2	32,269	17.2	82.7	0.0
Utah	2,492	17.9	82.1	0.0	1,186	17.4	82.6	0.0	1,306	18.4	81.6	0.1
Vermont	1,514	29.1	70.9	0.0	1,507	29.1	70.9	0.0	7	21.5	78.5	–
Virginia	15,135	15.7	83.4	0.9	699	17.7	81.6	0.7	14,436	15.6	83.5	0.9
Washington	15,019	14.9	84.8	0.3	1,281	13.8	85.8	0.3	13,737	15.0	84.7	0.3
West Virginia	9,414	17.1	82.7	0.2	9,118	16.6	83.2	0.2	297	32.0	66.9	1.0
Wisconsin[7]	11,399	19.9	79.9	0.2	11,332	19.9	79.8	0.2	67	9.6	89.1	1.3
Wyoming	382	20.2	79.8	–	382	20.2	79.8	–	–	–	–	–

EXHIBIT 27. (continued)

Notes: FY is fiscal year. Drug utilization in this exhibit reflects the number of prescriptions reported in the state drug utilization data that states submit to CMS for rebate purposes and are different from Transformed Medicaid Statistical Information System (T-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 (FFS) 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.

Since October 2016, CMS has suppressed all records in the state drug utilization data that are less than 11 counts, as obligated by the Privacy Act of 1974 (5 USC § 552a) and the HIPAA Privacy Rule (45 CFR Parts 160 and 164). The different brand and generic proportions under FFS 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. 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 file. Although the number of suppressed prescriptions in the FY 2019 national file is not known, a comparison of totals from previous years may be instructive. A comparison of the updated FY 2014 files with data suppression to prior versions without suppression indicates that about 4 million prescriptions, or 0.7 percent of prescriptions, were suppressed in the FY 2014 data.

[5] Connecticut's utilization is underreported because it did not report data for April–June 2019.

[6] South Dakota's utilization is underreported because it did not report data for October–December 2018.

[7] Wisconsin reports prescriptions for managed care but does not report any Medicaid spending.

Source: MACPAC, 2020, analysis of Medicaid drug product data and state drug rebate utilization data as of September 2020.

EXHIBIT 28. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2019 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total[1]	**$66,734.9**	**$24,475.5**	**$42,259.4**	**-$37,143.2**	**-$17,804.3**	**-$19,338.9**
Alabama	**754.5**	754.5	–	**-466.9**	-466.9	–
Alaska	**144.5**	144.5	–	**-103.6**	-103.6	–
Arizona	**1,326.8**	20.5	1,306.3	**-774.6**	-19.5	-755.1
Arkansas[2]	**359.5**	337.9	21.6	**-277.4**	-277.4	–
California	**8,047.7**	4,380.7	3,667.0	**-4,801.4**	-2,427.9	-2,373.4
Colorado	**985.3**	953.8	31.5	**-751.6**	-717.1	-34.5
Connecticut[3]	**964.2**	964.2	–	**-919.9**	-920.2	0.2
Delaware[4]	**2.7**	2.7	–	**-171.8**	-8.6	-163.2
District of Columbia	**264.9**	195.0	69.8	**-142.5**	-89.9	-52.6
Florida	**2,796.4**	363.4	2,432.9	**-1,854.0**	-292.0	-1,561.9
Georgia	**1,150.2**	726.0	424.2	**-817.8**	-576.0	-241.8
Hawaii	**180.4**	0.1	180.3	**-152.7**	-0.3	-152.5
Idaho	**216.5**	216.5	–	**-151.0**	-151.0	–
Illinois	**1,847.9**	211.1	1,636.8	**-1,108.0**	-187.0	-921.1
Indiana	**1,736.5**	406.4	1,330.1	**-974.4**	-226.3	-748.1
Iowa	**319.6**	7.5	312.1	**-401.6**	-14.2	-387.4
Kansas	**299.3**	1.2	298.0	**-228.3**	-2.7	-225.6
Kentucky	**1,395.6**	63.8	1,331.7	**-687.0**	-52.0	-635.0
Louisiana	**1,307.0**	49.4	1,257.5	**-623.2**	-43.6	-579.6
Maine	**244.2**	244.2	–	**-182.0**	-182.0	–
Maryland	**1,158.4**	603.2	555.2	**-621.0**	-302.6	-318.5
Massachusetts	**1,513.2**	720.1	793.1	**-939.2**	-485.7	-453.5
Michigan	**1,992.1**	1,126.3	865.9	**-1,108.1**	-507.3	-600.7
Minnesota	**927.5**	159.8	767.7	**-515.8**	-296.1	-219.7
Mississippi	**462.5**	86.8	375.7	**-353.3**	-103.9	-249.4
Missouri	**1,214.5**	1,214.5	–	**-722.5**	-722.5	–
Montana	**261.4**	261.4	–	**-192.2**	-192.2	–

EXHIBIT 28. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Nebraska	**$182.3**	$0.1	$182.2	**-$139.5**	-$0.7	-$138.8
Nevada	**507.2**	202.7	304.5	**-294.1**	-139.0	-155.1
New Hampshire	**154.1**	16.0	138.1	**-123.5**	-52.7	-70.8
New Jersey	**1,424.3**	25.8	1,398.5	**-815.2**	-18.5	-796.7
New Mexico	**362.9**	25.2	337.6	**-195.0**	-15.3	-179.7
New York[5]	**6,198.7**	777.0	5,421.7	**-3,107.0**	-3,417.9	310.8
North Carolina	**1,867.5**	1,867.5	–	**-1,239.3**	-1,239.3	–
North Dakota	**54.4**	30.3	24.1	**-57.2**	-31.8	-25.4
Ohio	**3,308.5**	288.0	3,020.5	**-1,930.2**	-204.7	-1,725.5
Oklahoma	**521.8**	521.8	–	**-328.4**	-328.4	–
Oregon	**664.4**	106.8	557.7	**-429.6**	-71.9	-357.7
Pennsylvania	**3,128.8**	57.3	3,071.5	**-1,849.1**	-73.0	-1,776.2
Rhode Island	**235.8**	6.0	229.8	**-137.1**	-8.4	-128.7
South Carolina	**546.9**	119.5	427.4	**-373.0**	-128.8	-244.2
South Dakota[6]	**72.2**	72.2	–	**-50.8**	-50.8	–
Tennessee[2]	**1,076.4**	992.5	84.0	**-783.1**	-783.1	–
Texas	**3,285.8**	65.9	3,219.9	**-2,011.0**	-48.7	-1,962.3
Utah	**242.6**	133.5	109.1	**-179.3**	-97.7	-81.6
Vermont	**160.4**	160.4	0.0	**-138.7**	-138.7	–
Virginia	**2,162.5**	38.8	2,123.7	**-641.8**	-53.0	-588.8
Washington	**1,139.1**	111.3	1,027.9	**-860.5**	-133.1	-727.4
West Virginia	**651.2**	629.8	21.4	**-487.4**	-474.8	-12.6
Wisconsin[7]	**1,279.1**	1,279.1	–	**-896.5**	-891.6	-5.0
Wyoming	**31.6**	31.6	–	**-34.0**	-34.0	–

EXHIBIT 28. (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 CMS for rebate purposes and are different from the CMS-64 financial management report (FMR) and Transformed Medicaid Statistical Information System (T-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 (FFS) and managed care drug utilization and spending information at the national drug code (NDC) level, which is not available in CMS-64 data. The state drug utilization data are available at https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html.

Since October 2016, CMS has suppressed all records in the state drug utilization data that are less than 11 counts, as obligated by the Privacy Act of 1974 (5 USC § 552a) and the HIPAA Privacy Rule (45 CFR Parts 160 and 164). The drug rebate information comes from the CMS-64 and does allow states to separately identify FFS and managed care drug rebates. The rebate totals shown here include federal rebates, state supplemental rebates, and the rebate increases attributable to the Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

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 does not equal the sum of the states due to the suppression of records. 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 file. Although the amount of suppressed spending in the FY 2019 national file is not known, comparison of totals from previous years may be instructive. A comparison of the updated FY 2014 files with data suppression to prior versions without suppression indicates that about $370 million dollars, or 0.9 percent of gross spending, was suppressed in the FY 2014 data.

[2] 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 FFS rebates.

[3] Connecticut's spending is underreported because it did not report data for April–June 2019. Additionally, Connecticut reported prior period adjustments for managed care that ultimately results in a positive managed care rebate amount.

[4] Delaware's managed care and total spending are substantially lower than prior years due to the apparent underreporting of MCO spending in all quarters of FY 2019.

[5] New York reported large prior period adjustments for managed care that ultimately result in a positive managed care rebate amount.

[6] South Dakota's gross spending is underreported because it did not report data for October–December 2018.

[7] Wisconsin reports prescriptions for managed care but does not report any Medicaid spending.

Source: MACPAC, 2020, analysis of Medicaid state drug rebate utilization data as of September 2020 and CMS-64 FMR net expenditure data as of August 5, 2020.

EXHIBIT 29. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2018

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	**78,393,091**	**69.0%**	**0.5%**	**9.9%**	**11.7%**	**19.4%**	**1.7%**	**7.0%**
Alabama	**1,019,417**	0.0	–	–	–	–	2.2	60.0
Alaska[2]	**198,417**	–	–	–	–	–	–	–
Arizona	**1,849,465**	84.4	–	–	–	–	–	–
Arkansas	**979,619**	0.0	–	–	58.9	59.2	–	48.4
California	**13,140,347**	81.1	–	0.0	6.4	–	0.0	–
Colorado[3]	**1,302,808**	9.4	–	–	–	–	–	80.5
Connecticut[4]	**928,800**	–	–	–	–	–	–	–
Delaware	**236,760**	84.4	–	–	–	88.2	–	–
District of Columbia	**264,984**	71.5	–	–	–	20.6	–	–
Florida	**3,885,169**	77.9	2.6	–	–	–	–	–
Georgia[5]	**2,074,310**	69.7	–	–	–	78.3	1.9	–
Hawaii[6]	**355,873**	98.8	–	1.3	–	–	–	–
Idaho	**300,252**	1.3	–	89.7	90.9	90.9	–	84.9
Illinois	**3,110,093**	69.0	1.0	–	–	–	–	–
Indiana	**1,457,544**	77.3	–	–	–	–	–	–
Iowa	**626,011**	90.2	–	–	48.4	2.5	–	–
Kansas	**417,140**	85.9	–	–	–	–	–	–
Kentucky	**1,385,239**	90.9	–	–	–	89.0	–	–
Louisiana	**1,640,075**	84.5	–	7.2	91.7	–	–	–
Maine	**270,243**	–	–	–	–	86.7	–	52.5
Maryland	**1,401,781**	83.4	–	–	–	–	–	–
Massachusetts	**1,865,755**	40.2	–	28.3	–	–	–	24.6
Michigan[7]	**4,623,834**	51.5	0.2	49.2	21.0	–	–	–
Minnesota	**1,122,672**	79.5	–	–	–	–	–	–
Mississippi	**683,577**	64.6	–	–	–	–	–	–

EXHIBIT 29. (continued)

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
Missouri	**971,143**	73.4%	–	–	–	24.9%	–	–
Montana	**291,890**	–	–	–	–	–	–	73.8%
Nebraska	**250,056**	99.6	–	–	99.0%	–	–	–
Nevada	**666,561**	68.7	–	–	68.7	88.2	–	–
New Hampshire	**200,850**	66.6	–	–	–	–	–	–
New Jersey	**1,668,451**	94.1	–	–	–	93.6	–	–
New Mexico	**842,138**	79.1	–	–	–	–	–	–
New York	**6,153,799**	74.0	3.4%	–	–	–	–	–
North Carolina	**2,178,225**	0.1	–	72.5%	–	–	–	68.6
North Dakota	**93,042**	21.2	–	–	–	–	–	52.6
Ohio	**2,915,546**	84.0	–	–	–	–	–	–
Oklahoma	**880,954**	0.1	–	–	–	73.6	–	73.6
Oregon[8]	**1,062,787**	79.9	–	0.3	4.1	–	–	–
Pennsylvania	**2,897,085**	81.4	–	30.9	–	21.5	0.0%	–
Rhode Island	**313,095**	79.3	–	–	35.6	85.4	–	–
South Carolina	**1,195,703**	62.4	–	–	–	100.0	–	0.0
South Dakota	**123,890**	–	–	–	–	–	–	74.4
Tennessee[9]	**1,510,045**	91.8	–	–	53.2	–	82.2	–
Texas	**3,981,912**	92.8	–	–	72.3	96.6	–	–
Utah	**275,511**	82.4	–	97.4	45.4	84.0	–	–
Vermont[10]	**174,682**	70.6	–	–	–	–	–	–
Virginia	**1,063,122**	82.3	–	–	–	–	–	–
Washington	**1,781,048**	88.4	–	100.0	–	100.0	–	0.3
West Virginia	**505,528**	80.5	–	–	–	–	–	–
Wisconsin	**1,197,453**	63.4	4.1	0.1	–	–	0.3	–
Wyoming	**58,390**	0.2	–	–	–	–	0.4	–

EXHIBIT 29. (continued)

Notes: 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. PCCM is primary care case management. 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 across program types as a percentage of total Medicaid enrollment may be greater than 100 percent.

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

[1] Includes comprehensive managed care and Programs of All-Inclusive Care for the Elderly (PACE). 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] Alaska was not able to provide total Medicaid enrollment as of July 1, 2018. This figure is from the July–September 2018 enrollment data collected through the Medicaid Budget and Expenditure System (MBES), updated December 2019 and accessed January 14, 2020. See https://data.medicaid.gov/Enrollment/2018-4Q- Medicaid-MBES-Enrollment/qjmt-6zzy.

[3] Colorado reported plan-level enrollment as 0 for plans that had less than 30 beneficiaries. As a result, reported PACE program-level enrollment may be lower than actual enrollment.

[4] Connecticut was not able to provide total Medicaid enrollment as of July 1, 2018. This figure is from the July–September 2018 enrollment data collected through the MBES, updated December 2019 and accessed January 14, 2020. See https://data.medicaid.gov/Enrollment/2018-4Q-Medicaid-MBES-Enrollment/qjmt-6zzy.

[5] Georgia is unable to provide separate counts of managed care and fee-for-service (FFS) beneficiaries for their non-emergency medical transportation program (which uses both payment models). As a result, enrollment counts presented in this table include enrollees in both managed care and FFS.

[6] Some plans that appear to be limited-benefit plans (dental, BHO, or other managed care) were classified as comprehensive managed care in the CMS report. The values shown here use plan-level information in the CMS report to recategorize enrollment in Ohana Community Care Service as enrollment in a BHO.

[7] Michigan has two programs that provide home- and community-based service waiver services under capitation: MI Choice and the Specialty Prepaid Inpatient Health Plan (SPIHP). MI Choice is reported as an MLTSS program and SPIHP is reported as a BHO.

[8] Some plans that appear to be limited-benefit plans (dental, BHO, or other managed care) were classified as comprehensive managed care in the CMS report. The values shown here use plan-level information in the CMS report to recategorize enrollment in Access Dental Plan, Advantage Dental Services, Capitol Dental Care, CareOregon Dental, Family Dental Care, Managed Dental Care of Oregon, and ODS Community Health as dental and enrollment in Greater Oregon Behavioral Health as enrollment in a BHO.

[9] Some plans that appear to be limited-benefit plans (dental, BHO, or other managed care) were classified as comprehensive managed care in the CMS report. The values shown here use plan-level information in the CMS report to recategorize enrollment in DentaQuest as dental and enrollment in Magellan Health Services as other.

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

Source: MACPAC, 2020, analysis of data from CMS, 2020, *Medicaid managed care enrollment and program characteristics, 2018*, Baltimore, MD: CMS, https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf.

EXHIBIT 30. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2018

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care											
		Comprehensive managed care[1]						Limited-benefit plans[2]					
		Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged	Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged
Total	**84,427**	**69.5%**	**81.3%**	**81.4%**	**61.0%**	**51.2%**	**34.6%**	**38.3%**	**45.2%**	**36.4%**	**28.2%**	**43.5%**	**28.4%**
Alabama	**1,146**	**0.0**	–	–	–	0.0	0.1	**4.9**	–	–	0.0	12.2	22.1
Alaska	**234**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Arizona	**2,202**	**84.3**	92.0	85.8	75.7	84.5	66.9	**–**	–	–	–	–	–
Arkansas	**1,064**	**0.0**	–	–	–	0.0	0.4	**91.1**	97.6	96.9	95.8	75.9	56.5
California[6]	**15,187**	**71.6**	86.0	82.3	42.4	84.1	72.6	**5.8**	6.4	7.6	3.8	6.9	3.5
Colorado	**1,502**	**1.5**	3.2	0.1	0.1	0.8	4.8	**95.0**	99.3	97.7	96.3	85.6	63.0
Connecticut	**1,071**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Delaware	**283**	**86.0**	95.9	93.7	79.5	65.9	46.2	**89.5**	98.3	98.9	82.4	71.6	46.7
District of Columbia[7]	**281**	**73.7**	93.0	90.0	93.8	18.2	3.4	**30.3**	16.5	18.3	16.7	79.5	66.9
Florida[8]	**4,791**	**79.2**	97.6	0.4	75.4	62.6	37.8	**11.7**	10.6	29.0	24.5	6.5	1.7
Georgia	**2,342**	**71.3**	97.0	–	91.8	3.8	0.0	**83.8**	96.0	–	81.0	68.2	46.0
Hawaii	**382**	**97.9**	99.9	99.3	98.0	93.2	87.9	**1.5**	0.0	0.9	0.4	14.0	2.0
Idaho	**329**	**–**	–	–	–	–	–	**86.2**	91.7	–	89.1	79.9	57.0
Illinois[7]	**3,310**	**79.0**	86.1	84.8	84.7	56.1	44.3	**–**	–	–	–	–	–
Indiana	**1,706**	**76.9**	90.6	97.6	46.5	41.3	6.8	**15.2**	9.6	0.1	20.4	48.2	52.7
Iowa	**744**	**90.3**	95.6	93.2	84.0	88.2	67.0	**60.3**	19.0	94.9	81.7	79.0	70.8
Kansas	**453**	**93.1**	99.6	–	97.1	83.0	65.8	**–**	–	–	–	–	–
Kentucky	**1,557**	**87.4**	97.7	93.8	93.4	70.4	35.4	**90.2**	97.2	93.8	94.0	79.7	57.5
Louisiana	**1,710**	**91.9**	99.9	98.6	88.0	78.7	51.1	**92.1**	99.9	98.6	88.5	79.6	52.3
Maine	**312**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Maryland	**1,443**	**84.3**	98.3	96.1	87.5	56.3	2.7	**–**	–	–	–	–	–
Massachusetts	**1,984**	**55.9**	64.1	81.3	49.3	41.9	32.2	**40.2**	60.0	41.1	36.8	42.9	1.7
Michigan	**3,049**	**63.7**	72.0	63.9	66.5	58.6	21.0	**91.3**	94.2	89.3	89.3	93.1	85.3
Minnesota	**1,343**	**84.1**	89.0	93.4	82.9	49.7	74.0	**–**	–	–	–	–	–
Mississippi	**804**	**68.8**	96.4	–	72.1	41.7	1.2	**–**	–	–	–	–	–

EXHIBIT 30. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care											
		Comprehensive managed care[1]						Limited-benefit plans[2]					
		Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged	Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged
Missouri	1,219	68.6%	96.1%	–	78.6%	0.7%	0.0%	94.8%	100.0%	–	89.1%	89.5%	81.5%
Montana	292	–	–	–	–	–	–	–	–	–	–	–	–
Nebraska[9]	256	97.5	99.8	–	97.9	94.5	88.7	97.3	99.6	–	97.7	94.4	88.2
Nevada	835	74.2	85.5	87.4%	82.3	5.7	2.6	92.4	99.1	98.0%	92.7	72.5	43.5
New Hampshire	235	63.0	95.5	21.8	85.4	68.0	55.4	54.0	32.4	92.8	56.9	30.7	26.6
New Jersey	1,911	94.1	95.8	94.3	88.2	95.9	89.4	100.0	100.0	100.0	100.0	100.0	100.0
New Mexico	953	80.0	90.5	90.3	54.2	75.3	53.6	–	–	–	–	–	–
New York	6,875	75.5	93.0	92.1	65.8	50.4	15.6	3.7	0.0	0.2	0.4	5.7	25.7
North Carolina	2,315	0.1	0.0	–	0.0	0.1	1.1	85.9	99.8	–	61.1	91.0	73.9
North Dakota[6]	118	28.8	0.0	99.3	14.6	4.4	2.8	–	–	–	–	–	–
Ohio	3,196	82.6	96.5	93.3	93.7	49.4	8.8	4.3	0.0	0.0	1.6	13.1	31.3
Oklahoma	910	0.1	–	–	–	0.1	0.7	90.2	96.9	–	81.0	83.8	78.4
Oregon	1,080	80.9	92.4	86.1	79.3	38.7	22.2	8.3	7.3	5.4	7.8	22.8	23.1
Pennsylvania	3,271	83.1	96.4	94.3	92.5	67.5	23.8	91.5	97.3	95.9	94.1	89.5	58.6
Rhode Island[7]	349	86.4	91.3	90.1	78.9	91.9	69.2	25.7	84.4	0.0	0.0	10.1	–
South Carolina	1,351	64.1	89.1	–	49.4	40.1	16.8	–	–	–	–	–	–
South Dakota	132	–	–	–	–	–	–	–	–	–	–	–	–
Tennessee	1,769	92.9	100.0	–	100.0	80.8	51.9	–	–	–	–	–	–
Texas[8]	5,356	87.5	97.2	44.7	90.9	70.7	45.2	90.8	99.5	68.4	94.4	77.2	50.0
Utah[6]	384	85.1	88.2	–	81.0	83.8	73.6	99.3	99.6	–	98.4	99.7	99.1
Vermont[7]	198	–	–	–	–	–	–	–	–	–	–	–	–
Virginia[8]	1,329	65.0	94.7	–	54.0	39.6	6.9	18.0	0.3	–	0.9	76.3	63.0
Washington	2,125	85.6	96.2	96.1	69.6	51.8	5.6	86.5	89.1	89.7	65.1	78.2	71.2
West Virginia	647	81.8	92.7	98.1	95.9	51.6	3.7	93.0	99.0	98.8	98.7	80.1	59.5
Wisconsin	1,321	70.3	91.9	–	82.5	32.9	7.1	93.0	99.6	–	99.0	95.4	47.9
Wyoming	83	0.2	–	–	–	0.2	1.5	0.0	0.0	–	–	–	–

EXHIBIT 30. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care					
		Primary care case management[3]					
		Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged
Total	**84,427**	**8.0%**	**11.1%**	**4.8%**	**7.9%**	**8.2%**	**2.3%**
Alabama	**1,146**	**63.4**	91.4	–	44.8	48.3	1.4
Alaska	**234**	**–**	–	–	–	–	–
Arizona	**2,202**	**–**	–	–	–	–	–
Arkansas	**1,064**	**47.9**	86.8	13.7	56.9	52.8	3.8
California[6]	**15,187**	**0.0**	0.0	0.0	0.0	0.1	0.0
Colorado	**1,502**	**79.3**	88.9	75.4	80.8	73.3	50.7
Connecticut	**1,071**	**–**	–	–	–	–	–
Delaware	**283**	**–**	–	–	–	–	–
District of Columbia[7]	**281**	**–**	–	–	–	–	–
Florida[8]	**4,791**	**–**	–	–	–	–	–
Georgia	**2,342**	**–**	–	–	–	–	–
Hawaii	**382**	**–**	–	–	–	–	–
Idaho	**329**	**86.3**	96.2	–	85.4	75.0	43.4
Illinois[7]	**3,310**	**8.7**	9.5	12.8	9.8	5.6	0.8
Indiana	**1,706**	**–**	–	–	–	–	–
Iowa	**744**	**0.3**	0.2	0.2	0.2	1.2	0.1
Kansas	**453**	**–**	–	–	–	–	–
Kentucky	**1,557**	**–**	–	–	–	–	–
Louisiana	**1,710**	**–**	–	–	–	–	–
Maine	**312**	**53.8**	84.8	8.4	76.1	28.9	0.9
Maryland	**1,443**	**–**	–	–	–	–	–
Massachusetts	**1,984**	**34.0**	47.5	38.7	33.4	33.0	1.1
Michigan	**3,049**	**–**	–	–	–	–	–
Minnesota	**1,343**	**–**	–	–	–	–	–
Mississippi	**804**	**–**	–	–	–	–	–

EXHIBIT 30. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care					
		Primary care case management[3]					
		Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged
Missouri	1,219	–	–	–	–	–	–
Montana	292	83.6%	94.7%	93.6%	81.8%	43.7%	3.7%
Nebraska[9]	256	–	–	–	–	–	–
Nevada	835	–	–	–	–	–	–
New Hampshire	235	–	–	–	–	–	–
New Jersey	1,911	–	–	–	–	–	–
New Mexico	953	–	–	–	–	–	–
New York	6,875	0.0	0.0	0.0	–	0.0	0.0
North Carolina	2,315	79.6	96.9	–	60.5	77.3	45.0
North Dakota[6]	118	52.3	89.1	10.3	96.7	1.7	0.1
Ohio	3,196	–	–	–	–	–	–
Oklahoma	910	64.9	83.8	–	57.7	33.4	1.5
Oregon	1,080	24.5	24.5	26.0	25.4	23.0	13.5
Pennsylvania	3,271	0.0	–	–	–	0.0	–
Rhode Island[7]	349	–	–	–	–	–	–
South Carolina	1,351	0.1	0.0	–	–	0.3	–
South Dakota	132	73.8	91.0	–	88.6	37.3	10.3
Tennessee	1,769	–	–	–	–	–	–
Texas[8]	5,356	–	–	–	–	–	–
Utah[6]	384	–	–	–	–	–	–
Vermont[7]	198	–	–	–	–	–	–
Virginia[8]	1,329	–	–	–	–	–	–
Washington	2,125	1.8	0.3	0.4	0.4	7.2	13.8
West Virginia	647	0.0	–	0.0	–	–	–
Wisconsin	1,321	–	–	–	–	–	–
Wyoming	83	–	–	–	–	–	–

EXHIBIT 30. (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. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Data are from the Transformed Medicaid Statistical Information System (T-MSIS) and may not be comparable to prior years due to differences in data reporting.

Individuals are counted as participating in managed care if they had at least one month indicating plan enrollment. 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. 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 across program types as a percentage of total Medicaid enrollment may be greater than 100 percent.

Figures shown here, which are based on T-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, health insuring organizations, and Programs of All-Inclusive Care for the Elderly (PACE).

[2] Includes prepaid inpatient health plan (PIHP), prepaid ambulatory health plans (PAHP), accountable care organizations, and other plan types. PIHPs and PAHPs include plans covering services for long-term services and supports, behavioral health, substance use disorder, dental, transportation, and pharmacy.

[3] Primary care case management (PCCM) includes traditional PCCM, enhanced PCCM, and medical and health homes.

[4] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[5] Includes adults age 19–64 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

[6] State has a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced California's child enrollment by approximately 243,000, North Dakota's child enrollment by approxmiately 3,000, and Utah's child enrollment by approximately 13,500.

[7] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The average monthly enrollment in the District of Columbia was 37 percent less than the benchmark; the average monthly enrollment in Illinois was 66 percent less than the benchmark; and average monthly enrollment in Rhode Island was 31 percent more than the benchmark. Vermont did not report any enrollees in the new adult group but reported approximately 58,000 average monthly enrollees on the CMS-64 enrollment report.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2018.

[9] State reported total enrollment that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. Nebraska's average monthly enrollment was 24 percent less than the benchmark.

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020.

EXHIBIT 31. Total Medicaid Administrative Spending by State and Category, FY 2019 (millions)

State[1]	Total spending on administration	Spending by category					Collections
		MMIS[2]	Eligibility systems[2]	EHR incentive program[3]	Other functions, federal match above 50%[4]	Other functions, federal match of 50%[5]	
Alabama	**$216**	$34	$25	$10	$12	$135	-$0
Alaska	**147**	34	5	6	5	97	–
Arizona	**314**	36	147	22	13	96	–
Arkansas	**401**	127	98	5	40	131	–
California	**6,243**	398	2,268	67	294	3,217	–
Colorado	**316**	46	140	25	8	97	-0
Connecticut	**362**	38	120	12	24	169	–
Delaware	**101**	29	8	3	2	60	–
District of Columbia	**231**	41	50	5	14	121	–
Florida	**745**	89	103	13	33	507	–
Georgia	**579**	103	143	19	22	292	-0
Hawaii	**102**	19	41	4	4	35	-0
Idaho	**123**	32	15	7	5	64	–
Illinois	**885**	68	279	23	68	448	–
Indiana	**555**	61	187	11	16	281	–
Iowa	**153**	35	68	4	11	35	–
Kansas	**197**	46	72	3	4	72	-0
Kentucky	**303**	49	108	18	23	104	–
Louisiana	**405**	46	137	11	2	209	–
Maine	**152**	52	33	2	11	54	-0
Maryland	**524**	73	152	23	19	258	–
Massachusetts	**1,227**	117	229	24	54	804	–
Michigan	**731**	150	246	27	16	295	-2
Minnesota	**798**	75	192	11	16	504	–
Mississippi	**175**	63	30	10	9	62	–
Missouri	**376**	56	111	9	12	188	–
Montana	**94**	34	21	1	3	35	-0
Nebraska	**124**	20	34	9	3	57	–
Nevada	**201**	39	74	5	10	72	–

EXHIBIT 31. (continued)

State[1]	Total spending on administration	Spending by category					Collections
		MMIS[2]	Eligibility systems[2]	EHR incentive program[3]	Other functions, federal match above 50%[4]	Other functions, federal match of 50%[5]	
New Hampshire	**$142**	$35	$66	$1	$5	$36	–
New Jersey	**941**	74	270	11	25	561	-$0
New Mexico	**229**	51	64	2	10	102	–
New York	**2,115**	234	282	130	66	1,403	–
North Carolina	**790**	86	402	17	37	249	–
North Dakota	**111**	26	44	8	2	31	-0
Ohio	**1,043**	127	118	17	25	757	–
Oklahoma	**204**	40	13	9	15	127	–
Oregon	**510**	32	123	23	14	317	-0
Pennsylvania	**881**	89	303	24	22	443	-0
Rhode Island	**179**	26	48	9	2	95	-0
South Carolina	**374**	81	111	7	17	159	–
South Dakota	**50**	8	1	3	2	36	–
Tennessee	**692**	159	259	13	16	246	-1
Texas	**1,460**	269	438	13	38	709	-7
Utah	**174**	43	45	6	10	70	–
Vermont	**164**	30	41	6	9	78	–
Virginia	**513**	78	175	8	14	237	–
Washington	**1,362**	98	65	37	18	1,144	-0
West Virginia	**183**	33	53	7	30	59	-0
Wisconsin	**393**	90	120	10	5	169	-2
Wyoming	**77**	33	15	11	4	15	-0
Subtotal (states)	**$29,369**	**$3,753**	**$8,191**	**$760**	**$1,135**	**$15,543**	**-$13**
American Samoa	**3**	–	–	1	–	2	–
Guam	**3**	–	–	0	0	3	–
N. Mariana Islands	**1**	0	–	0	–	1	–
Puerto Rico	**156**	31	25	11	–	89	–
Virgin Islands	**14**	2	1	0	–	11	–
Subtotal (states and territories)	**$29,545**	**$3,786**	**$8,217**	**$772**	**$1,135**	**$15,648**	**-$13**

EXHIBIT 31. (continued)

State[1]	Total spending on administration	Spending by category					Collections
		MMIS[2]	Eligibility systems[2]	EHR incentive program[3]	Other functions, federal match above 50%[4]	Other functions, federal match of 50%[5]	
Medicaid Fraud Control Units (MFCUs)[6]	**$361**	–	–	–	$361	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	**370**	–	–	–	370	–	–
Total	**$30,276**	**$3,786**	**$8,217**	**$772**	**$1,866**	**$15,648**	**-$13**
Percent of total, exclusive of collections	–	12.5%	27.1%	2.5%	6.2%	51.7%	–

Notes: FY is fiscal year. MMIS is Medicaid Management Information Systems. EHR is electronic health record. Includes federal and state funds. Excludes administrative activities performed by Medicaid managed care plans (which are included in the capitation payments that states make to these plans) and activities that are exclusively federal, such as program oversight by CMS staff. Collections may include, for example, donations made by hospitals to compensate for the cost of on-site stationing of state or local Medicaid agency personnel to determine eligibility or provide outreach. For more information on specific items from the Medicaid and CHIP Budget Expenditure System (MBES CBES) 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/downloads/cms-6410-admin-category-of-services-definition-2-14.pdf.

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

[1] All states had certified their CMS-64 financial management report (FMR) submissions as of August 5, 2020. 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 (TANF) 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, 2020, analysis of CMS-64 FMR net expenditure data as of August 5, 2020. For MCFUs and survey and certification: CMS, 2020, *Fiscal year 2021 justification of estimates for appropriations committees*, CMS: Baltimore, MD, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf.

EXHIBIT 32. Child Enrollment in CHIP and Medicaid by State, FY 2019 (thousands)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
Total[1]	**45,154**	**5,573**	**4,100**	**9,676**	**35,478**
Alabama	**755**	104	116	**220**	**535**
Alaska	**126**	23	–	**23**	**104**
Arizona	**988**	75	52	**127**	**861**
Arkansas	**514**	38	66	**104**	**410**
California	**6,473**	1,873	74	**1,947**	**4,527**
Colorado	**656**	74	100	**174**	**482**
Connecticut	**385**	–	24	**24**	**361**
Delaware	**122**	2	12	**14**	**108**
District of Columbia	**99**	18	–	**18**	**81**
Florida	**2,737**	172	299	**472**	**2,265**
Georgia	**1,551**	80	171	**251**	**1,300**
Hawaii	**173**	31	–	**31**	**142**
Idaho	**237**	40	24	**64**	**173**
Illinois	**1,687**	106	223	**329**	**1,358**
Indiana	**805**	90	47	**138**	**668**
Iowa	**443**	22	83	**105**	**338**
Kansas	**316**	15	55	**70**	**246**
Kentucky	**640**	64	44	**108**	**531**
Louisiana	**882**	172	13	**185**	**697**
Maine	**175**	18	11	**29**	**146**
Maryland[2]	**699**	148	–	**148**	**551**
Massachusetts	**772**	89	145	**233**	**538**
Michigan	**1,263**	84	4	**88**	**1,175**
Minnesota	**656**	1	3	**4**	**653**
Mississippi	**488**	34	52	**86**	**402**
Missouri	**708**	54	61	**115**	**593**
Montana[3]	**185**	10	33	**43**	**142**
Nebraska	**228**	59	2	**61**	**167**
Nevada	**459**	24	49	**73**	**386**
New Hampshire	**107**	18	–	**18**	**89**
New Jersey	**971**	112	157	**269**	**702**
New Mexico	**409**	13	–	**13**	**396**

EXHIBIT 32. (continued)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
New York	**2,868**	324	467	**791**	**2,077**
North Carolina	**1,437**	181	136	**317**	**1,120**
North Dakota	**64**	[4]	[4]	**4**	**60**
Ohio	**1,531**	243	–	**243**	**1,288**
Oklahoma	**718**	200	11	**211**	**508**
Oregon	**588**	63	134	**197**	**391**
Pennsylvania	**1,596**	109	264	**373**	**1,223**
Rhode Island	**146**	35	2	**37**	**109**
South Carolina	**759**	114	–	**114**	**646**
South Dakota	**95**	15	5	**20**	**75**
Tennessee	**986**	12	66	**78**	**908**
Texas	**4,460**	346	734	**1,080**	**3,380**
Utah	**282**	26	30	**56**	**226**
Vermont	**76**	5	–	**5**	**71**
Virginia	**924**	123	120	**243**	**681**
Washington	**910**	–	90	**90**	**820**
West Virginia	**269**	12	27	**40**	**229**
Wisconsin	**692**	99	90	**189**	**504**
Wyoming	**46**	1	6	**7**	**39**

Notes: FY is fiscal year. The CHIP and Medicaid 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 eligiblity 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 November 6, 2020, and may be revised at a later date.

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

[1] Total exceeds the sum of Medicaid expansion and separate CHIP columns due to North Dakota reporting total CHIP enrollment only.

[2] CMS has indicated that Maryland is in the process of revising their enrollment counts, but these changes had not been made at the time the data were pulled.

[3] CMS has indicated that Montana's FY 2019 enrollment totals contain duplicates and are artificially high.

[4] CMS has indicated that there are inconsistencies between what the state has reported in the Statistical Enrollment Data System (SEDS) and the counts the state has provided to CMS. The figures reported here reflect the numbers reported to CMS. Because North Dakota did not provide subtotals for Medicaid expansion and separate CHIP, we do not display those counts here.

Sources: MACPAC, 2020, analysis of CHIP SEDS data as of November 6, 2020. Center for Medicaid and CHIP Services, CMS, 2020, e-mail to MACPAC, September 30.

EXHIBIT 33. CHIP Spending by State, FY 2019 (millions)

State	Total CHIP			Benefits						State program administration			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	**$391.4**	$391.4	–	**$148.5**	$148.5	–	**$231.3**	$231.3	–	**$11.6**	$11.6	–	–
Alaska	**37.0**	32.5	$4.4	**33.3**	29.3	$4.0	**–**	–	–	**3.7**	3.3	$0.4	–
Arizona[3]	**234.4**	234.4	-0.0	**158.5**	158.5	-0.0	**64.5**	64.5	-$0.0	**11.3**	11.3	-0.0	–
Arkansas[3]	**189.5**	189.5	-0.0	**63.8**	63.8	-0.0	**121.6**	121.6	-0.0	**4.0**	4.0	-0.0	–
California	**3,650.6**	3,212.4	438.2	**3,474.4**	3,057.3	417.1	**126.0**	110.9	15.1	**50.2**	44.2	6.0	–
Colorado	**360.1**	316.9	43.3	**135.4**	119.1	16.3	**212.7**	187.2	25.5	**12.0**	10.6	1.4	–
Connecticut	**47.9**	99.6	-51.7	**–**	–	–	**43.2**	38.0	5.2	**4.8**	4.2	0.6	$57.4
Delaware	**42.2**	39.4	2.8	**5.8**	5.4	0.4	**35.2**	32.9	2.3	**1.2**	1.1	0.1	–
District of Columbia	**55.3**	55.3	–	**53.5**	53.5	–	**–**	–	–	**1.8**	1.8	–	–
Florida	**841.5**	804.6	36.9	**284.8**	272.3	12.6	**517.6**	495.0	22.6	**39.0**	37.3	1.7	–
Georgia[3]	**434.6**	434.6	-0.0	**135.1**	135.1	-0.0	**279.0**	279.1	-0.0	**20.5**	20.5	-0.0	–
Hawaii	**58.6**	53.3	5.4	**55.2**	50.1	5.0	**-0.0**	-0.0	-0.0	**3.4**	3.1	0.3	–
Idaho	**87.1**	87.1	–	**7.0**	7.0	–	**76.6**	76.6	–	**3.5**	3.5	–	–
Illinois	**430.5**	379.9	50.7	**140.6**	124.0	16.7	**258.8**	228.5	30.4	**31.1**	27.4	3.6	–
Indiana	**235.7**	233.8	1.9	**163.8**	162.5	1.3	**58.8**	58.3	0.5	**13.1**	13.0	0.1	–
Iowa	**144.6**	137.4	7.3	**38.2**	36.2	1.9	**95.0**	90.2	4.8	**11.5**	10.9	0.6	–
Kansas	**150.8**	140.2	10.6	**31.0**	28.8	2.2	**108.9**	101.2	7.7	**10.9**	10.1	0.8	–
Kentucky	**228.1**	228.0	0.1	**134.9**	134.9	0.1	**89.4**	89.4	-0.0	**3.8**	3.8	-0.0	–
Louisiana	**401.4**	395.4	6.0	**314.7**	310.0	4.7	**71.2**	70.1	1.1	**15.5**	15.3	0.2	–
Maine	**36.8**	36.1	0.7	**17.7**	17.4	0.3	**17.2**	16.9	0.3	**1.9**	1.9	0.0	–
Maryland	**384.6**	338.4	46.2	**387.3**	340.8	46.5	**-29.2**	-25.6	-3.5	**26.4**	23.3	3.2	–
Massachusetts	**780.8**	687.2	93.6	**269.2**	236.9	32.3	**433.5**	381.6	52.0	**78.1**	68.7	9.4	–
Michigan	**303.5**	297.8	5.6	**268.6**	263.6	5.0	**11.6**	11.4	0.2	**23.2**	22.9	0.4	–
Minnesota	**16.2**	129.4	-113.2	**1.3**	1.2	0.2	**13.3**	11.7	1.6	**1.6**	1.4	0.2	115.1
Mississippi	**264.5**	264.5	–	**97.5**	97.5	–	**163.5**	163.5	–	**3.5**	3.5	–	–
Missouri	**287.0**	283.5	3.5	**145.4**	143.6	1.8	**128.8**	127.2	1.6	**12.9**	12.7	0.2	–
Montana	**114.7**	113.5	1.3	**30.2**	29.8	0.3	**79.5**	78.6	0.9	**5.1**	5.0	0.1	–
Nebraska	**94.1**	84.5	9.5	**80.8**	72.6	8.2	**8.5**	7.6	0.8	**4.9**	4.4	0.5	–
Nevada	**81.2**	79.9	1.3	**23.4**	23.0	0.4	**50.9**	50.1	0.8	**6.9**	6.8	0.1	–
New Hampshire	**33.9**	45.5	-11.5	**33.9**	29.9	4.1	**0.0**	0.0	0.0	**0.0**	0.0	0.0	15.6
New Jersey	**621.4**	546.5	74.9	**263.9**	232.3	31.7	**295.3**	259.6	35.7	**62.2**	54.7	7.5	–

EXHIBIT 33. (continued)

State	Total CHIP			Benefits						State program administration			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 Mexico	**$102.4**	$102.4	$0.1	**$100.2**	$100.2	$0.1	**–**	–	–	**$2.2**	$2.2	–	–
New York	**1,655.6**	1,456.9	198.7	**814.6**	716.9	97.8	**$787.9**	$693.3	$94.5	**53.1**	46.7	$6.4	–
North Carolina	**558.9**	558.9	0.0	**306.6**	306.6	-0.0	**236.7**	236.7	0.0	**15.6**	15.6	0.0	–
North Dakota	**29.2**	25.7	3.5	**19.1**	16.8	2.3	**8.1**	7.1	1.0	**2.1**	1.9	0.3	–
Ohio	**539.9**	523.8	16.1	**497.8**	482.9	14.9	**–**	–	–	**42.1**	40.9	1.2	–
Oklahoma	**258.0**	249.5	8.6	**265.2**	256.4	8.8	**-17.6**	-16.9	-0.7	**10.4**	10.0	0.4	–
Oregon	**446.6**	432.5	14.2	**119.0**	115.2	3.8	**312.5**	302.6	9.9	**15.1**	14.7	0.5	–
Pennsylvania	**767.8**	687.8	80.0	**317.6**	284.5	33.1	**431.7**	386.8	45.0	**18.5**	16.6	1.9	–
Rhode Island	**113.7**	102.0	11.7	**108.7**	97.5	11.2	**–**	–	–	**5.0**	4.5	0.5	–
South Carolina	**203.2**	203.2	–	**189.3**	189.3	–	**-0.4**	-0.4	–	**14.3**	14.3	–	–
South Dakota	**32.9**	30.5	2.4	**23.0**	21.4	1.7	**9.4**	8.7	0.7	**0.5**	0.4	0.0	–
Tennessee	**210.6**	208.7	1.9	**78.9**	78.2	0.7	**118.7**	117.6	1.1	**13.0**	12.9	0.1	–
Texas	**1,549.9**	1,452.6	97.3	**562.9**	527.5	35.4	**929.3**	871.0	58.3	**57.8**	54.1	3.6	–
Utah[3]	**128.1**	128.2	-0.0	**83.4**	83.4	-0.0	**37.8**	37.8	-0.0	**7.0**	7.0	-0.0	–
Vermont	**13.8**	27.9	-14.1	**14.1**	12.7	1.3	**-1.6**	-1.4	-0.1	**1.4**	1.3	0.1	$15.4
Virginia	**429.0**	377.5	51.5	**199.3**	175.4	23.9	**207.3**	182.4	24.9	**22.4**	19.7	2.7	–
Washington	**218.9**	273.0	-54.1	**26.1**	23.0	3.1	**186.4**	164.1	22.3	**6.4**	5.7	0.8	80.3
West Virginia	**75.4**	75.4	–	**23.3**	23.3	–	**48.3**	48.3	–	**3.8**	3.8	–	–
Wisconsin	**211.4**	230.6	-19.3	**96.9**	91.7	5.2	**100.8**	95.4	5.4	**13.7**	12.9	0.7	30.6
Wyoming	**14.7**	13.0	1.8	**2.4**	2.1	0.3	**11.5**	10.1	1.4	**0.8**	0.7	0.1	–
Subtotal (states)	**$18,600.4**	**$17,532.5**	**$1,067.8**	**$10,846.1**	**$9,989.6**	**$856.5**	**$6,969.3**	**$6,500.3**	**$469.0**	**$785.0**	**$728.3**	**$56.7**	**$314.3**
American Samoa	**2.5**	2.5	0.0	**2.5**	2.5	0.0	**–**	–	–	**–**	–	–	–
Guam	**34.6**	31.9	2.7	**34.6**	31.9	2.7	**–**	–	–	**–**	–	–	–
Northern Mariana Islands	**5.9**	5.6	0.3	**5.9**	5.6	0.3	**–**	–	–	**–**	–	–	–
Puerto Rico	**101.7**	94.3	7.4	**101.7**	94.3	7.4	**–**	–	–	**–**	–	–	–
Virgin Islands	**15.3**	14.0	1.3	**15.3**	14.0	1.3	**–**	–	–	**–**	–	–	–
Total (states and territories)	**$18,760.4**	**$17,680.7**	**$1,079.6**	**$11,006.0**	**$10,137.8**	**$868.3**	**$6,969.3**	**$6,500.3**	**$469.0**	**$785.0**	**$728.3**	**$56.7**	**$314.3**

EXHIBIT 33. (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 Medicaid-expansion CHIP 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 or -$0.0 indicates an amount between $0.05 million and -$0.05 million that rounds to zero.

[1] Six states (Colorado, Missouri, New Jersey, Rhode Island, Virginia, and West 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 (Connecticut, Minnesota, New Hampshire, Vermont, Washington, and Wisconsin).

[3] State reports negative state CHIP spending for benefits or state program administration due to federal CHIP spending exceeding total CHIP spending. Federal CHIP spending exceeds total CHIP spending due to negative prior period adjustments and the 23 percentage point increase in the enhanced federal medical assistance percentage (E-FMAP) that went into effect in FY 2016. Because these prior period adjustments apply to periods before the 23 percentage point increase to the E-FMAP, these negative adjustments decrease total spending to a greater extent than federal spending.

Source: MACPAC, 2020, analysis of Medicaid and CHIP Budget Expenditure System data as of July 15, 2020.

EXHIBIT 34. Federal CHIP Allotments, FYs 2018–2020 (millions)

State	FY 2018 federal CHIP allotments	FY 2019 federal CHIP allotments	FY 2020 federal CHIP allotments
Alabama	$338.5	$396.3	$418.5
Alaska	34.6	30.4	32.1
Arizona[1]	388.6	251.7	266.4
Arkansas	205.8	167.8	177.2
California	2,825.9	3,038.4	3,209.0
Colorado	270.4	298.4	315.4
Connecticut	82.0	101.4	107.1
Delaware	37.3	37.9	40.0
District of Columbia	45.8	49.2	52.8
Florida	734.1	793.2	842.5
Georgia	429.7	444.3	469.3
Hawaii	55.4	63.1	66.7
Idaho	88.4	78.4	83.3
Illinois	579.7	392.7	414.8
Indiana	202.3	261.5	276.2
Iowa[1]	163.4	130.0	137.3
Kansas	132.0	119.1	125.8
Kentucky	284.0	218.0	230.2
Louisiana	380.0	373.3	394.2
Maine	37.8	37.0	39.1
Maryland	313.4	316.6	334.4
Massachusetts	710.9	724.6	765.2
Michigan	280.4	273.7	289.1
Minnesota	122.3	129.4	137.0
Mississippi	335.5	257.2	271.6
Missouri[1]	233.7	279.0	294.6
Montana	110.3	91.4	96.6
Nebraska	77.1	87.1	92.2
Nevada	74.9	78.2	83.4
New Hampshire	40.5	44.9	47.4
New Jersey	490.2	519.7	548.8
New Mexico	144.1	101.4	107.0
New York	1,306.3	1,473.1	1,555.8
North Carolina	508.7	500.7	528.8
North Dakota	23.4	26.7	28.5
Ohio[1]	458.7	520.8	550.1

EXHIBIT 34. (continued)

State	FY 2018 federal CHIP allotments	FY 2019 federal CHIP allotments	FY 2020 federal CHIP allotments
Oklahoma	$264.0	$233.6	$246.7
Oregon[1]	395.9	370.1	511.6
Pennsylvania	558.4	668.2	705.7
Rhode Island	77.1	93.0	98.2
South Carolina	164.0	184.6	195.6
South Dakota	28.8	31.2	33.2
Tennessee	493.2	234.6	247.9
Texas	1,476.3	1,510.2	1,601.5
Utah	140.5	135.1	143.3
Vermont	32.0	28.3	29.8
Virginia	308.3	378.4	399.6
Washington	259.3	236.3	251.2
West Virginia	64.6	77.4	81.7
Wisconsin	237.7	272.8	288.1
Wyoming	13.4	13.4	14.1
Subtotal (states)	**$17,059.8**	**$17,173.8**	**$18,277.2**
American Samoa	3.1	4.8	5.1
Guam	28.1	32.2	34.0
Northern Mariana Islands	7.1	11.2	11.8
Puerto Rico	203.8	182.6	192.8
Virgin Islands	7.3	10.9	11.6
Total (states and territories)	**$17,309.2**	**$17,415.6**	**$18,532.6**

Notes: FY is fiscal year.

[1] States with approved CHIP state plans to expand eligibility for children or benefits may request an increased CHIP allotment for even numbered years beginning in FY 2010 and ending in FY 2026 (§ 2104(m)(7) of the Social Security Act). The FY 2018 allotment for this state differs from previously published allotments for the fiscal year because the state received such an allotment increase.

Sources: MACPAC, 2020, analysis of Medicaid and CHIP Budget Expenditure System data as of July 10, 2020.

SECTION 4

Medicaid and CHIP Eligibility

Section 4: Medicaid and CHIP Eligibility

Key Points

- Thirty-five states and the District of Columbia now cover low-income adults not otherwise eligible on the basis of disability, a new Medicaid eligibility group created under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Adult eligibility levels in Exhibit 36 do not include three additional states (Nebraska, Oklahoma, and Missouri) that have approved a Medicaid expansion through voter referendum, but had not implemented it as of April 2020.
- Since 2014, eligibility levels under Medicaid and the State Children's Health Insurance Program (CHIP) for most children and adults eligible on a basis other than disability are determined using uniform modified adjusted gross income (MAGI) rules (Exhibits 35 and 36).
- 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 2019 and 2020 (Exhibit 37).
- In 2020, in the lower 48 states and the District of Columbia, 100 percent FPL is $12,760 for an individual plus $4,480 for each additional family member (Exhibit 38).

EXHIBIT 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State, April 2020

State	CHIP program type[1] (as of April 2020)	Medicaid coverage[2]						Separate CHIP coverage		Medicaid or CHIP coverage
		Infants under age 1		Age 1–5		Age 6–18				
		Medicaid funded	CHIP funded	Medicaid funded	CHIP funded	Medicaid funded	CHIP funded	Birth through age 18[3]	Unborn children[4]	Pregnant women and deemed newborns[5]
Alabama	Combination	141%	–	141%	–	141%	107–141%	312%	–	141%
Alaska	Medicaid expansion	177	159–203%	177	159–203%	177	124–203	–	–	200
Arizona	Combination	147	–	141	–	133	104–133	200	–	156
Arkansas	Combination	142	–	142	–	142	107–142	211	209%	209
California	Combination	208	208–261	142	142–261	133	108–261	317[6]	317	208
Colorado	Combination	142	–	142	–	142	108–142	260	–	195; 260
Connecticut	Separate	196	–	196	–	196	–	318	–	258
Delaware	Combination	212	194–212	142	–	133	110–133	212[7]	–	212
District of Columbia	Medicaid expansion	319	206–319	319	146–319	319	112–319	–	–	319
Florida	Combination	206	192–206	140	–	133	112–133	210[7]	–	191
Georgia	Combination	205	–	149	–	133	113–133	247	–	220
Hawaii	Medicaid expansion	191	191–308	139	139–308	133	105–308	–	–	191
Idaho	Combination	142	–	142	–	133	107–133	185	–	133
Illinois	Combination	142	–	142	–	142	108–142	313	208	208
Indiana	Combination	208	157–208	158	141–158	158	106–158	250	–	208
Iowa	Combination	375	240–375	167	–	167	122–167	302[7]	–	375
Kansas	Combination	166	–	149	–	133	113–133	227	–	166
Kentucky	Combination	195	–	142	142–159	133	109–159	213	–	195
Louisiana	Combination	142	142–212	142	142–212	142	108–212	250	209	133
Maine	Combination	191	–	157	140–157	157	132–157	208	–	209
Maryland	Medicaid expansion	194	194–317	138	138–317	133	109–317	–	–	259
Massachusetts	Combination	200	185–200	150	133–150	150	114–150	300	200	200
Michigan	Combination	195	195–212	160	143–212	160	109–212	–	195	195
Minnesota	Combination	275	275–283[8]	275	–	275	–	–	278	278
Mississippi	Combination	194	–	143	–	133	107–133	209	–	194
Missouri	Combination	196	–	148	148–150	148	110–150	300	300	196; 300
Montana	Combination	143	–	143	–	133	109–143	261	–	157

EXHIBIT 35. (continued)

State	CHIP program type[1] (as of April 2020)	Medicaid coverage[2]						Separate CHIP coverage		Medicaid or CHIP coverage
		Infants under age 1		Age 1–5		Age 6–18		Birth through age 18[3]	Unborn children[4]	Pregnant women and deemed newborns[5]
		Medicaid funded	CHIP funded	Medicaid funded	CHIP funded	Medicaid funded	CHIP funded			
Nebraska	Combination	162%	162–213%	145%	145–213%	133%	109–213%	–	197%	194%
Nevada	Combination	160	–	160	–	133	122–133	200%	–	160
New Hampshire	Medicaid expansion	196	196–318	196	196–318	196	196–318	–	–	196
New Jersey	Combination	194	–	142	–	142	107–142	350	–	194; 200
New Mexico	Medicaid expansion	240	200–300	240	200–300	190	138–240	–	–	250
New York	Combination	218	–	149	–	149	110–149	400	–	218
North Carolina	Combination	210	194–210	210	141–210	133	107–133	211[9]	–	196
North Dakota	Medicaid expansion	147	147–170	147	147–170	133	111–170	–	–	157
Ohio	Medicaid expansion	156	141–206	156	141–206	156	107–206	–	–	200
Oklahoma	Combination	205	169–205	205	151–205	205	115–205	–	205	133
Oregon	Combination	185	133–185	133	–	133	100–133	300	185	185
Pennsylvania	Combination	215	–	157	–	133	119–133	314	–	215
Rhode Island	Combination	190	190–261	142	142–261	133	109–261	–	253	190; 253
South Carolina	Medicaid expansion	194	194–208	143	143–208	133	107–208	–	–	194
South Dakota	Combination	182	147–182	182	147–182	182	111–182	204	133	133
Tennessee[10]	Combination	195	–	142	–	133	109–133	250	250	195
Texas	Combination	198	–	144	–	133	109–133	201	202	198
Utah	Combination	139	–	139	–	133	105–133	200	–	139
Vermont	Medicaid expansion	312	237–312	312	237–312	312	237–312	–	–	208
Virginia	Combination	143	–	143	–	143	109–143	200	–	143; 200
Washington	Separate	210	–	210	–	210	–	312	193	193
West Virginia	Combination	158	–	141	–	133	108–133	300	–	185; 300
Wisconsin	Combination	301	–	186	–	133	101–151	301[7]	301	301
Wyoming	Combination	154	–	154	–	133	119–133	200	–	154

Notes: As of January 2020, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $12,760 for an individual plus $4,480 for each additional family member. Prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing when determining Medicaid and CHIP eligibility. In 2014, uniform modified adjusted gross income (MAGI) rules became mandatory for determining Medicaid and CHIP eligibility for most children and adults under age 65 eligible for Medicaid on a basis other than disability, 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 April 2020. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income

EXHIBIT 35. (continued)

disregard that applies to an individual's eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

Medicaid (Title XIX of the Social Security Act (the Act)) funding continues to finance Medicaid coverage of children under age 19 in families with incomes below state eligibility levels in effect as of March 31, 1997. 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 of the Act) 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 waivers under Section 1115 of the Act; in addition, the unborn children of pregnant women may receive CHIP-funded coverage under a state plan option.

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

[1] Under CHIP, states can implement Medicaid expansion, separate CHIP, or a combination program. Nine states (Alaska, Hawaii, Maryland, New Hampshire, New Mexico, North Dakota, Ohio, South Carolina, Vermont) and the District of Columbia use Medicaid expansion and two states (Connecticut and Washington) use separate CHIP. Thirty-nine states use combination programs, although some of these are combination programs solely as a result of the transition of children in families with income less than or equal to 133 percent FPL from separate CHIP to Medicaid. In five states with combination programs (Michigan, Minnesota, Nebraska, Oklahoma, and Rhode Island), separate CHIP coverage is only through the unborn child option.

[2] Under Medicaid-funded coverage, there is no lower threshold for income eligibility. The eligibility levels listed are the highest income levels under which each age group of children is covered under the Medicaid state plan. The eligibility levels listed under CHIP-funded Medicaid coverage are the income levels to which Medicaid has expanded using CHIP funds (which became available when CHIP was created in 1997). For states that set different CHIP-funded eligibility levels for children age 6–13 and age 14–18, this table shows only the levels for children age 6–13. In addition, Section 2105(g) of the 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).

[3] Separate CHIP eligibility for children from birth through age 18 generally begins where Medicaid coverage ends (as shown in the previous columns).

[4] For unborn children, there is no lower threshold for income eligibility if the mother is not eligible for Medicaid.

[5] Deemed newborns are infants up to age one 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. 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.

[6] In California, certain children up to age two with incomes up to 317 percent FPL are covered statewide, and children in three counties are covered up to 317 percent FPL through a separate CHIP program.

[7] In Delaware, Florida, Iowa, and Wisconsin, separate CHIP covers children age 1–18.

[8] In Minnesota, infants (defined by the state as being under age two) are eligible for Medicaid-expansion CHIP up to 283 percent FPL.

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

[10] Although Tennessee covers children with CHIP-funded Medicaid, coverage is available only for children under age 19 who are enrolled in Medicaid, but no longer qualify and lack access to health insurance through a parent's employer.

Sources: MACPAC, 2020, analysis of CMS, 2020, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html; CMS, 2020, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2020, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2020, *Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2020: Findings from a 50-state survey*, San Francisco, CA: KFF, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/; and eligibility information from state websites.

EXHIBIT 36. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-Aged, Non-Disabled, Non-Pregnant Adults by State, April 2020

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	132	133% (age 19–20 only: 132%)
Arizona	106	133
Arkansas	15	133
California	109	133
Colorado	68	133
Connecticut	155	133
Delaware	87	133
District of Columbia	216	210 (age 19–20 only: 216)
Florida	27	Age 19–20 only: 27
Georgia	32	–
Hawaii	105	133
Idaho	22	133
Illinois	133	133
Indiana	17	133
Iowa	50	133
Kansas	33	–
Kentucky	22	133
Louisiana	19	133
Maine	100	133 (age 19–20 only: 156)
Maryland	123	133
Massachusetts	133	133 (age 19–20 only: 150)
Michigan	54	133
Minnesota	133[3]	133[3]
Mississippi	21	–
Missouri[4]	17[5]	–[6]
Montana	24	133
Nebraska[4]	58	–
Nevada	31	133

EXHIBIT 36. (continued)

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
New Hampshire	63%	133%
New Jersey	29	133
New Mexico	42	133
New York	133[3]	133[3]
North Carolina	41	Age 19–20 only: 41
North Dakota	49	133
Ohio	90	133
Oklahoma[4]	38[5]	–[6]
Oregon	38	133
Pennsylvania	33	133
Rhode Island	116	133
South Carolina	95	–[6]
South Dakota	53	–
Tennessee	96	–
Texas	14	–
Utah	41	133[6]
Vermont	49	133
Virginia	49	133
Washington	37	133
West Virginia	18	133
Wisconsin	95	95
Wyoming	51	–

Notes: As of January 2020, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $12,760 for an individual plus $4,480 for each additional family member. Prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing when determining Medicaid and CHIP eligibility. In 2014, uniform modified adjusted gross income (MAGI) rules became mandatory for determining Medicaid and CHIP eligibility for most children and adults under age 65 eligible for Medicaid on a basis other than disability, 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 April 2020. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income disregard that applies to an individual's determination of eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

EXHIBIT 36. (continued)

States are required to provide Medicaid coverage for parents and other caretaker relatives (and their dependent children), at or above the state's 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 19–20, and other individuals age 19–64 who have incomes less than or equal to 133 percent FPL and are not pregnant or eligible for Medicare. Certain states provide coverage through Section 1115 waivers, which allow them to operate their Medicaid programs with fewer 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 might 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 percentage of FPL to determine eligibility for parents, dollar amounts were converted to percentage of FPL, and the highest percentage was selected to reflect eligibility level for the group. Parents and caretaker relatives with income above the reported threshold for this group may be eligible for coverage under the new adult group (under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)) in states that have adopted the expansion.

[2] Reflects state plan coverage under Section 1902(a)(10)(A)(i)(VIII) of the Act for individuals who are age 19–64, have incomes less than or equal to 133 percent FPL, and are not pregnant or eligible for Medicare; state plan coverage for children age 19–20 where indicated; and Section 1115 waiver coverage that is not subject to the limitations indicated in note 6.

[3] In Minnesota and New York, individuals with incomes that are greater than 133 percent FPL but do not exceed 200 percent FPL are covered under the Basic Health Program (BHP).

[4] Three additional states have opted to expand Medicaid through voter referendum, but had not yet implemented as of April 2020: Nebraska (which voted in November 2018), Oklahoma (June 2020), and Missouri (August 2020).

[5] 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.

[6] The state has a Section 1115 demonstration 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.

Sources: MACPAC, 2020, analysis of CMS, 2020, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html; CMS, 2020, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2020, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2020, *Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2020: Findings from a 50-state survey*, San Francisco, CA: KFF, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/; and eligibility information from state websites.

EXHIBIT 37. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Individuals Age 65 and Older and Persons with Disabilities by State, 2020

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
Alabama	§ 1634	74%	–	–	–	221%
Alaska	SSI criteria	59[6]	–	–	–	177
Arizona	§ 1634	74	–	–	–	221
Arkansas	§ 1634	74	–	80% (aged only)	10%	221
California	§ 1634	74	–	100	49	–
Colorado	§ 1634	74	–	–	–	221
Connecticut	§ 209(b)	–	60%[7]	–	60	221
Delaware	§ 1634	74	–	–	–	184
District of Columbia	§ 1634	74	–	100	64	221
Florida	§ 1634	74	–	88	17	221
Georgia	§ 1634	74	–	–	30	221
Hawaii	§ 209(b)	–	64	100	38	–
Idaho	SSI criteria	74	–	77	–	221
Illinois	§ 209(b)	–	100	100	100	–
Indiana	§ 1634	74	–	100	–	221
Iowa	§ 1634	74	–	–	45	221
Kansas	SSI criteria	74	–	–	45	221
Kentucky	§ 1634	74	–	–	20	221
Louisiana	§ 1634	74	–	–	9	221
Maine	§ 1634	74	–	100	30	221
Maryland	§ 1634	74	–	–	33	221
Massachusetts[8]	§ 1634	74	–	100 (aged); 133 (disabled)	49	221
Michigan	§ 1634	74	–	100	38	221
Minnesota	§ 209(b)	–	79	100	45	221
Mississippi	§ 1634	74	–	–	–	221
Missouri	§ 209(b)	–	85	85	85	129
Montana	§ 1634	74	–	–	49	–
Nebraska	SSI criteria	74	–	100	37	–
Nevada	SSI criteria	74	–	–	–	221

EXHIBIT 37. (continued)

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
New Hampshire	§ 209(b)	–	75%	–	56%	221%
New Jersey	§ 1634	74%	–	100%	35	221
New Mexico	§ 1634	74	–	–	–	221
New York	§ 1634	74	–	82	82	–
North Carolina	§ 1634	74	–	100	23	–
North Dakota	§ 209(b)	–	83	–	47	–
Ohio	§ 1634	74	–	–	–	221
Oklahoma	SSI criteria	74	–	100	–	221
Oregon	SSI criteria	74	–	–	–	221
Pennsylvania	§ 1634	74	–	100	40	221
Rhode Island	§ 1634	74	–	100	88	221
South Carolina	§ 1634	74	–	100	–	221
South Dakota	§ 1634	74	–	–	–	221
Tennessee	§ 1634	74	–	–	–	221
Texas	§ 1634	74	–	–	–	221
Utah	SSI criteria	74	–	100	100	221
Vermont	§ 1634	74	–	–	111	221
Virginia	§ 209(b)	–	74	80	47	221
Washington	§ 1634	74	–	–	74	221
West Virginia	§ 1634	74	–	–	19	221
Wisconsin	§ 1634	74	–	82	100	221
Wyoming	§ 1634	74	–	–	–	221

Notes: SSI is Supplemental Security Income. Section 209(b) refers to Section 209(b) of the Social Security Act Amendments of 1972. Section 1634 refers to Section 1634 of the Social Security Act. In 2020, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $12,760 for an individual and $4,480 for each additional family member. Eligibility levels shown here apply to countable income; as a result, states that use optional income disregards to reduce countable income effectively allow more people to qualify at a given eligibility level (e.g., 100 percent FPL) than states that do not use income disregards. 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 age 65 and older or those who qualify on the basis of other disabilities.

In most states, enrollment in the SSI program for individuals age 65 and older and persons eligible on the basis of disability automatically qualifies them for Medicaid. However, Section 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 37. (continued)

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

[1] SSI criteria are used to determine Medicaid eligibility in both Section 1634 and SSI-criteria states. In Section 1634 states, the federal eligibility determination process for SSI automatically qualifies an individual for Medicaid; in SSI-criteria states, individuals must submit information to the state for a separate eligibility determination. Section 209(b) states may use eligibility criteria (related to income and assets, disability, or both) that are more restrictive than SSI program criteria, but they may not use more restrictive criteria than those in effect in the state on January 1, 1972. If a Section 209(b) state does not have a separate medically needy standard, it must allow individuals with higher incomes to spend down to the Section 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 slightly from last year (but rounds up to 74 percent) because the FPL increased by 2.2 percent but the SSI federal benefit rate increased by 1.6 percent.

[3] Under the poverty level option (§ 1902(a)(10)(A)(ii)(X)), states may choose to provide Medicaid coverage to individuals who are age 65 and older or have disabilities and whose income is above the SSI or Section 209(b) level but is less than or equal to the FPL. Some states, such as Arizona, provide coverage to other low-income individuals falling within their aged, blind, and disabled categories through an income disregard. Such coverage is not included here.

[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 facility or other institutional care and have incomes up to 300 percent of the SSI benefit rate (which was about 221 percent FPL in 2020). The income thresholds 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 49 percent of FPL.

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

Source: MACPAC, 2020, analysis of eligibility information from state websites and Medicaid state plans as of October 2020.

EXHIBIT 38. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2020

State	FPL	Annual amount					Monthly amount				
		Family size					Family size				
		1	2	3	4	Each additional person	1	2	3	4	Each additional person
Lower 48 states and District of Columbia	100%	$12,760	$17,240	$21,720	$26,200	$4,480	$1,063	$1,437	$1,810	$2,183	$373
	133	16,971	22,929	28,888	34,846	5,958	1,414	1,911	2,407	2,904	497
	138	17,609	23,791	29,974	36,156	6,182	1,467	1,983	2,498	3,013	515
	150	19,140	25,860	32,580	39,300	6,720	1,595	2,155	2,715	3,275	560
	185	23,606	31,894	40,182	48,470	8,288	1,967	2,658	3,349	4,039	691
	200	25,520	34,480	43,440	52,400	8,960	2,127	2,873	3,620	4,367	747
	250	31,900	43,100	54,300	65,500	11,200	2,658	3,592	4,525	5,458	933
	300	38,280	51,720	65,160	78,600	13,440	3,190	4,310	5,430	6,550	1,120
	400	51,040	68,960	86,880	104,800	17,920	4,253	5,747	7,240	8,733	1,493
Alaska	100	15,950	21,550	27,150	32,750	5,600	1,329	1,796	2,263	2,729	467
	133	21,214	28,662	36,110	43,558	7,448	1,768	2,388	3,009	3,630	621
	138	22,011	29,739	37,467	45,195	7,728	1,834	2,478	3,122	3,766	644
	150	23,925	32,325	40,725	49,125	8,400	1,994	2,694	3,394	4,094	700
	185	29,508	39,868	50,228	60,588	10,360	2,459	3,322	4,186	5,049	863
	200	31,900	43,100	54,300	65,500	11,200	2,658	3,592	4,525	5,458	933
	250	39,875	53,875	67,875	81,875	14,000	3,323	4,490	5,656	6,823	1,167
	300	47,850	64,650	81,450	98,250	16,800	3,988	5,388	6,788	8,188	1,400
	400	63,800	86,200	108,600	131,000	22,400	5,317	7,183	9,050	10,917	1,867

EXHIBIT 38. (continued)

State	FPL	Annual amount					Monthly amount				
		Family size					Family size				
		1	2	3	4	Each additional person	1	2	3	4	Each additional person
Hawaii	100%	$14,680	$19,830	$24,980	$30,130	$5,150	$1,223	$1,653	$2,082	$2,511	$429
	133	19,524	26,374	33,223	40,073	6,850	1,627	2,198	2,769	3,339	571
	138	20,258	27,365	34,472	41,579	7,107	1,688	2,280	2,873	3,465	592
	150	22,020	29,745	37,470	45,195	7,725	1,835	2,479	3,123	3,766	644
	185	27,158	36,686	46,213	55,741	9,528	2,263	3,057	3,851	4,645	794
	200	29,360	39,660	49,960	60,260	10,300	2,447	3,305	4,163	5,022	858
	250	36,700	49,575	62,450	75,325	12,875	3,058	4,131	5,204	6,277	1,073
	300	44,040	59,490	74,940	90,390	15,450	3,670	4,958	6,245	7,533	1,288
	400	58,720	79,320	99,920	120,520	20,600	4,893	6,610	8,327	10,043	1,717

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services (HHS) 2020 federal poverty guidelines. These differ slightly from the U.S. Census Bureau's federal poverty thresholds, which are used mainly for statistical purposes. The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period.

Source: HHS, 2020, Annual update of the HHS poverty guidelines, *Federal Register* 85, no. 12 (January 17): 3060–3061.

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 (Exhibit 39).
- Data from the National Health Interview Survey (NHIS) and the Medical Expenditure 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 or have had a dental visit in the past 12 months. However, the rates of service use differ between the two data sources. Approximately 81.2 percent of children with Medicaid or CHIP reported seeing a dentist in 2018 in the NHIS compared to 44.6 percent of children reported having a dental visit in 2018 in the MEPS. Similar differences between the data sources were observed for children who have private coverage or are uninsured (Exhibits 40 and 41).
- 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. 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 43–45).
- Children whose primary coverage source is Medicaid or CHIP are less likely to report seeing a general doctor or having a well-child checkup than those with private coverage, but more likely than those who are uninsured (Exhibit 40). Children whose primary coverage source is Medicaid or CHIP are more likely to experience delayed care than children with private coverage (Exhibit 42).
- Adults age 19–64 whose primary coverage is Medicaid are slightly less likely to report having a usual source of care than those with private coverage and are more likely to report having difficulties with access to care. Among adults age 19–64 with health coverage (i.e., excluding the uninsured), adults whose primary coverage source is Medicare report the highest rates of delayed care and unmet need due to cost (Exhibit 46).
- Measures of use of care for specific types of services should be interpreted with caution due to the limitations of survey data and the characteristics of the populations examined. For example, the results shown are unadjusted for differences in age, health, income, race and ethnicity, and family and household characteristics, which are known factors in explaining some of the differences in access and use observed between individuals with different coverage sources. In addition, this section presents data based on primary source of coverage, with multiple coverage sources narrowed down to a single source based on a hierarchy. (For selected characteristics of individuals without the application of this hierarchy, see Exhibit 2.)

EXHIBIT 39. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2018^

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.6%**	**34.6%**	**5.1%**
Coverage				
Length of time with any coverage during the year				
Full year	**91.8***	97.4*	95.4	–
Part year	**4.8**	2.6*	4.5	43.0*
No coverage during year	**2.3***	–	–	57.0*
Demographics				
Age				
0–5	**30.6***	28.9*	34.5	21.8*
6–11	**32.6**	31.8	33.4	33.5
12–18	**36.8***	39.3*	32.0	44.8*
Gender				
Male	**51.1**	50.8	51.6	50.9
Female	**48.9**	49.2	48.4	49.1
Race				
Hispanic	**25.5***	16.1*	39.2	37.2
White, non-Hispanic	**52.5***	65.6*	33.1	41.7*
Black, non-Hispanic	**14.2***	9.5*	21.6	13.3*
Other non-white, non-Hispanic	**7.7***	8.8*	6.1	7.8
Parents present in family				
Mother, no father	**21.8***	11.4*	38.5	20.3*
Father, no mother	**4.0**	3.8	4.6	5.7
Both present	**71.3***	84.0*	51.0	71.4*
No parents	**2.9***	0.8*	5.9	†
Family income				
Has income less than 138 percent FPL	**27.1***	6.4*	59.0	31.4*
Has income in ranges shown below				
Less than 100 percent FPL	**18.0***	3.5*	40.5	21.1*
100–199 percent FPL	**21.6***	10.3*	38.4	25.8*
200–399 percent FPL	**29.0***	35.4*	17.3	36.3*
400 percent FPL or higher	**31.3***	50.9*	3.5	16.6*

EXHIBIT 39. (continued)

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Other demographic characteristics				
Citizen of United States	**97.8%**	98.3%	98.0%	92.2%*
Receives SSI[6]	**1.2***	†	2.8	†
Family receives WIC	**5.6***	1.5*	12.5	†
Health				
Current health status				
Excellent or very good	**85.5***	91.0*	77.7	78.5
Good	**12.7***	7.9*	19.3	18.8
Fair or poor	**1.8***	1.1*	3.0	†
Body mass index (BMI)[7]				
Healthy weight (BMI less than 25)	**76.9***	81.9*	67.1	74.6
Overweight (BMI 25–29)	**14.6***	12.5*	18.6	17.5
Obese (BMI 30 or higher)	**8.6***	5.6*	14.3	7.9*
Special needs, impairments, and health conditions				
Has special health care needs[8]	**23.4***	20.3*	25.9	21.4
Receives special education or early intervention services[9]	**8.4***	6.9*	10.9	6.9*
Has impairment requiring special equipment	**1.3**	1.2	1.8	†
Has impairment limiting ability to crawl, walk, run, or play[9]	**1.6***	1.3*	2.3	†
Has impairment limiting ability to crawl, walk, run, or play that is expected to last 12 or more months[9]	**1.3***	†	†	–
Ever been told he or she has selected conditions				
ADHD or ADD[10]	**9.3***	7.8*	12.4	6.8*
Asthma	**12.0***	11.1*	14.0	11.4
Autism[10]	**2.4***	1.7*	3.4	†
Cerebral palsy[9]	**0.3**	†	†	–
Congenital heart disease[9]	**0.3**	†	†	–
Diabetes	**0.2**	†	†	–
Down syndrome[9]	**0.2**	†	†	–
Intellectual disability[9]	**1.2***	0.6*	2.2	†
Other developmental delay[9]	**4.0***	1.2*	2.8	†

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.

EXHIBIT 39. (continued)

The individual components listed under the subcategories are not always mutually exclusive and may not sum to 100 percent. Standard errors are available online in the 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

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

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

– Dash indicates 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 and 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 federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because 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 or 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 or 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 versions prior to 2016. 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, 2019, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2018, NHIS Data^

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.6%**	**34.6%**	**5.1%**
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	**8.5**	7.1	8.0	26.2*
At least 1	**91.5**	92.9	92.0	73.8*
1	**24.2**	22.9	25.3	31.3
2–3	**37.7**	38.8	37.2	27.5*
4 or more	**29.6**	31.2	29.5	15.0*
Saw selected health professional				
General doctor	**84.2**	87.5*	82.1	64.5*
General doctor, nurse practitioner, physician assistant, midwife, or obstetrician-gynecologist	**86.3**	89.7*	84.1	67.5*
Medical specialist	**16.0***	18.3*	13.5	6.2*
Eye doctor	**27.7**	30.0*	25.6	20.5*
Mental health professional[6]	**9.8**	9.4	10.5	†
Doctor, for emotional or behavioral problem[7]	**5.6***	4.6*	7.2	5.0
Dentist[8]	**82.6**	85.6*	81.2	60.1*
Any health professional, excluding dental[9]	**89.9**	92.6*	88.3	74.4*
Any health professional, including dental[9]	**96.7**	98.3*	95.9	85.1*
Had at least 1 overnight hospital stay[10]	**4.8**	5.0	4.8	†
Received care at home	**1.1**	0.9	1.4	†
Receipt of appropriate care (past 12 months)				
Had well-child checkup[7]	**86.5**	88.7*	86.6	61.1*
Had more than 15 office or clinic visits	**2.2**	2.5	1.9	†
Number of emergency room visits				
None	**80.7***	84.8*	73.9	81.6*
At least 1	**19.3***	15.2*	26.1	18.4*
1	**11.9***	10.1*	14.7	10.3*
2–3	**6.0***	4.2*	8.9	7.5
4 or more	**1.5***	0.9*	2.5	†

EXHIBIT 40. (continued)

Notes: NHIS is National Health Interview Survey. 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 sum to 100 percent. Standard errors are available in the 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 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

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

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

[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 or 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 federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because 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 or 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 and 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 0–17.

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

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

[10] Includes stays for newborns.

Source: MACPAC, 2019, analysis of NHIS data.

EXHIBIT 41. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2018, MEPS Data

Characteristics	Primary coverage source at time of most recent interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**57.6%**	**35.0%**	**5.8%**
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	**22.3***	18.2*	26.7	36.9*
At least 1	**77.7***	81.8*	73.3	63.1*
1	**22.8**	21.4*	24.4	26.7
2–3	**27.0**	28.6*	25.1	22.7
4 or more	**27.8***	31.8*	23.8	13.7*
Had at least 1 overnight hospital stay	**2.1**	1.7	2.5	3.6
Received care at home	**1.8***	1.4*	3.0	†
Had at least 1 dental care visit[6]	**52.7***	59.4*	44.6	34.6*
Receipt of appropriate care (past 12 months)				
Had more than 15 office-based or hospital outpatient visits	**4.3**	4.0	5.1	†
Number of emergency room visits				
None	**88.9***	90.8*	85.6	90.6*
At least 1	**11.1***	9.2*	14.4	9.4*
1	**8.8***	7.1*	11.7	8.0*
2–3	**2.2**	2.1	2.5	†
4 or more	**0.1***	†	0.3	†

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the 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 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 or CHIP is statistically significant at the 0.05 level.

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

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 or 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 federal government-sponsored programs. Coverage source is defined as of the time of the most recent survey interview. Because 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 or 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 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 or 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] This is a new measure that should not be compared to other dental measures included in data books prior to 2019. Dental visit is defined as a visit to any person for dental care including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. Additional dental variables included in previous years (general dentist, orthodontist, dental check-up) are no longer available.

Source: MACPAC, 2020, analysis of MEPS data.

EXHIBIT 42. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2018^

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.6%**	**34.6%**	**5.1%**
Connection to the health care system (past 12 months)				
Has a usual source of care[6]	**95.0**	97.1*	95.0	73.3*
Had the same usual source of medical care 12 months ago	**88.4**	90.8*	88.0	67.7*
Timeliness of care (past 12 months)				
Delayed medical care due to any access barrier indicated below	**10.7***	7.6*	14.7	22.0*
Delayed because of costs	**2.5**	1.8	1.9	16.0*
Delayed for provider-related reasons[7]	**7.8***	5.9*	11.1	8.7
Delayed due to lack of transportation	**1.6***	0.5*	3.6	†
Unmet need for selected types of care due to cost				
Medical care	**1.3**	0.9	1.2	8.0*
Mental health care or counseling[8]	**1.1**	0.7	1.3	†
Dental care[8]	**4.7**	3.3*	5.1	18.6*
Prescription drugs	**1.8***	0.8*	2.8	7.3*
Eyeglasses[8]	**1.7**	1.1*	2.2	5.1

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 sum to 100 percent. Standard errors are available in the 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 Expenditure 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

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

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

EXHIBIT 42. (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 or 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 federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because 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 or 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 or 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] 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.

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

Source: MACPAC, 2019, analysis of NHIS data.

EXHIBIT 43. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2018^

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**4.0%**	**68.8%**	**10.5%**	**13.1%**
Coverage					
Length of time with any coverage during year					
Full year	**83.2***	97.1*	94.9*	89.7	–
Part year	**8.2***	†	5.1*	10.3	27.7*
No coverage during year	**8.6***	–	–	–	72.3*
Demographics					
Age					
19–25	**15.0***	†	14.7*	19.7	18.0
26–44	**42.1***	20.6*	41.3*	48.5	48.2
45–54	**21.3***	21.1*	22.3*	15.9	20.2*
55–64	**21.6***	56.3*	21.7*	15.9	13.6
Gender					
Male	**49.1***	51.3*	49.1*	37.4	55.8*
Female	**50.9***	48.7*	50.9*	62.6	44.2*
Race					
Hispanic	**18.1***	15.3*	13.8*	25.8	36.9*
White, non-Hispanic	**60.7***	61.5*	66.7*	43.3	42.1
Black, non-Hispanic	**12.9***	18.1	11.0*	21.4	14.2*
Other non-white, non-Hispanic	**8.3**	5.1*	8.6	9.5	6.8
Marital status					
Married	**52.3***	33.9	59.1*	29.2	38.3*
Widowed	**1.6**	4.5*	1.3*	2.0	1.5
Divorced or separated	**10.4***	23.9*	8.4*	14.1	13.1
Living with partner	**9.1***	8.8*	8.0*	13.5	11.8
Never married	**26.7***	28.8*	23.2*	41.2	35.4*
Family income					
Less than 138 percent FPL	**18.4***	42.3*	6.9*	59.7	20.9*
Has income in ranges below					
Less than 100 percent FPL	**11.7***	26.6*	4.0*	41.3	12.6*
100–199 percent FPL	**16.4***	34.3	9.3*	35.2	19.9*
200–399 percent FPL	**28.1***	24.6*	29.5*	17.3	30.2*

EXHIBIT 43. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
400 percent FPL or higher	**43.8%***	14.2%*	57.2%*	5.9%	37.2%*
Education					
Less than high school	**9.9***	20.5	4.4*	24.1	26.0
High school diploma or GED certificate	**23.6***	35.6	19.3*	35.6	33.4
Some college	**31.5**	30.1	32.0	31.8	26.0*
College or graduate degree	**35.1***	13.8*	44.4*	8.5	14.6*
Other demographic characteristics					
Citizen of United States	**90.7**	95.4*	93.4*	88.7	75.2*
Parent of a dependent child	**34.2***	12.0*	36.3*	43.7	34.6*
Currently working	**75.8***	15.4*	85.5*	48.3	69.6*
Veteran	**5.7***	7.5*	4.5*	2.3	2.2
Receives SSI or SSDI[6]	**5.1***	68.9*	0.8*	14.2	1.0*
Receives SSI	**2.3***	20.8*	0.3*	11.3	†
Receives SSDI	**3.5***	57.0*	0.6*	5.5	†
Health					
Current health status					
Excellent or very good	**64.2***	17.6*	71.6*	47.2	57.3*
Good	**25.4***	30.3	22.7*	30.5	31.0
Fair or poor	**10.4***	52.2*	5.7*	22.2	11.7*
Body mass index (BMI)					
Healthy weight (BMI less than 25)	**32.8***	23.2*	34.3*	29.3	32.0
Overweight (BMI 25–29)	**32.9**	26.5*	33.5	31.5	32.0
Obese (BMI 30 or higher)	**34.3***	50.3*	32.2*	39.2	36.0
Smoking status					
Current smoker	**15.4***	28.8	11.2*	25.7	24.1
Former smoker	**18.1***	23.0*	18.7*	13.8	14.7
Never smoked	**66.5***	48.2*	70.0*	60.4	61.2
Limitations and health conditions					
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[7]	**27.6***	82.3*	21.4*	44.9	26.7*
Any complex activity limitation[8]	**12.2***	77.7*	6.0*	27.5	11.0*

EXHIBIT 43. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Either one	**29.2%***	87.7%*	22.6%*	47.3%	28.8%*
Has functional limitation[9]	**11.1***	61.5*	6.3*	22.6	9.5*
Has difficulty walking without equipment	**3.4***	29.3*	1.4*	7.1	2.0*
Has health condition requiring special equipment	**4.3***	30.5*	2.3*	8.1	2.6*
Needs help with any of the following ADLs					
Personal care	**1.5***	15.2*	0.5*	4.3	0.6*
Bathing	**0.9***	9.7*	0.2*	3.1	†
Eating	**0.3***	†	†	0.9	†
Transferring	**0.7***	5.8*	0.3*	2.2	†
Toileting	**0.5***	4.3*	†	1.7	†
Getting around in home	**0.6***	4.8*	0.2*	1.9	†
Number of ADLs needing assistance					
None	**98.7***	87.2*	99.6*	96.0	99.7*
1–2	**0.6***	6.1*	0.2*	1.6	†
3–4	**0.4***	4.6*	†	1.3	†
5–6	**0.3**	2.1	†	†	†
Other limitations					
Unable to work now due to health problem	**6.8***	61.9*	2.1*	17.7	4.3*
Limited in amount or kind of work due to health	**10.0***	72.6*	4.2*	24.1	8.0*
Lost all natural teeth	**4.5***	14.3*	3.3*	8.0	4.7*
Has depressed or anxious feelings[10]	**5.4***	19.6*	3.0*	12.5	7.2*
Currently pregnant[11]	**3.0***	–	2.7*	5.7	†
Ever been told he or she has selected conditions					
Hypertension	**23.7***	54.4*	22.2*	26.4	17.9*
Coronary heart disease	**2.0***	10.2*	1.4*	3.0	0.9*
Heart attack	**1.6***	8.8*	0.9*	3.0	1.1*
Stroke	**1.7***	12.6*	0.8*	3.1	1.5*
Cancer	**5.2**	11.3*	5.4	5.0	2.1*
Diabetes	**7.4***	27.1*	5.8*	11.4	5.8*
Arthritis	**17.2***	49.1*	15.4*	21.4	10.8*
Asthma	**13.8***	19.9	13.5*	17.3	10.3*

EXHIBIT 43. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Chronic bronchitis (past 12 months)	**3.2%***	11.2%*	2.6%*	5.1%	2.7%*
Liver condition (past 12 months)	**1.7***	7.4*	1.2*	2.8	1.2*
Weak or failing kidneys (past 12 months)	**1.4**	10.5*	0.8*	2.1	0.9*

Notes: ADL is activity of daily living. FPL is federal poverty level. GED is General Equivalence Diploma. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

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

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

– Dash indicates 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 or CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because 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 or 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 or CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

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

EXHIBIT 43. (continued)

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

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

[9] Functional limitation is defined as "very difficult" or "cannot do" for the following activities: grasp small objects; reach above one's head; sit more than 2 hours; lift or carry 10 pounds; climb a flight of stairs; push a heavy object; walk one-quarter of a 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".

[10] 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.

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

Source: MACPAC, 2019, analysis of NHIS data.

EXHIBIT 44. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2018, NHIS Data^

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**4.0%**	**68.8%**	**10.5%**	**13.1%**
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	**20.1**	8.7*	16.3	18.3	46.8*
At least 1	**79.9**	91.3*	83.7	81.7	53.2*
1	**20.0***	7.3*	21.8*	17.0	17.9
2–3	**27.0***	20.2	29.3*	23.5	19.6*
4 or more	**32.9***	63.8*	32.7*	41.2	15.7*
Saw selected health professional					
General doctor	**65.6**	83.0*	69.5	67.4	36.4*
General doctor, nurse practitioner, physician assistant, midwife, or obstetrician-gynecologist	**74.5**	87.2*	78.6	76.6	45.7*
Medical specialist	**24.8**	49.8*	26.1	24.7	9.7*
Eye doctor	**39.0***	42.5*	43.9*	29.2	19.2*
Mental health professional	**11.1***	26.7*	9.4*	18.9	6.1*
Dentist	**65.7***	50.6	73.7*	54.5	37.2*
Any health professional, excluding dental[6]	**82.5**	92.5*	86.5*	83.4	56.8*
Any health professional, including dental[6]	**90.5**	94.8*	94.5*	89.7	68.6*
Had at least 1 overnight hospital stay	**6.8***	18.9*	5.5*	12.9	4.9*
Received care at home	**1.5***	10.8*	0.8*	3.5	†
Receipt of appropriate care (past 12 months)					
Had cholesterol checked[7]					
All individuals	**61.7**	83.4*	65.7*	59.8	32.6*
Men age 35–64	**68.3**	84.4*	73.1*	63.2	34.2*
Individuals with elevated risk of cardiac disease[7, 8]	**71.6**	87.7*	77.4*	69.2	38.6*

EXHIBIT 44. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Had flu shot					
All individuals	**38.4%***	53.0%*	41.9%*	33.1%	16.4%*
Individuals age 50–64	**47.0**	56.4*	49.0	46.2	20.8*
Had any test for colorectal cancer (age 50–64)[9]	**20.2***	24.8	20.3*	25.5	8.5*
Had Pap smear or test for cervical cancer (women age 21–60)[9]	**48.5**	30.5*	51.6	51.4	31.3*
Had more than 15 office or clinic visits	**5.7***	19.9*	5.0*	8.7	2.0*
Number of emergency room visits					
None	**79.9***	62.3	84.0*	62.6	79.3*
At least 1	**20.1***	37.7	16.0*	37.4	20.7*
1	**12.4***	13.7*	11.1*	19.0	13.0*
2–3	**5.5***	15.0	3.7*	12.4	5.6*
4 or more	**2.2***	9.0*	1.2*	6.0	2.1*

Notes: NHIS is the National Health Interview Survey. 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 sum to 100 percent. Standard errors are available on the second sheet of the 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 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

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

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

[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 or CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because 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.

EXHIBIT 44. (continued)

[3] Medicaid or 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 or 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, obstetrician-gynecologist, 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, as part of the supplemental questions pertaining to the Million Hearts® Initiative, the NHIS included additional blood pressure and cholesterol screening questions. After 2014, the NHIS reverted back to the originial screening questions, so estimates should be comparable with years earlier than 2014.

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

[9] These estimates should not be compared to the 2017 estimates published in the December 2018 data book due to a change in the characteristic's definition.

Source: MACPAC, 2019, analysis of NHIS data.

EXHIBIT 45. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2018, MEPS Data

Characteristics	Primary coverage source at time of most recent interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**4.1%**	**69.1%**	**10.5%**	**14.1%**
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	**29.1***	7.3*	24.6*	31.7	56.7*
At least 1	**70.9***	92.7*	75.4*	68.3	43.3*
1	**14.9**	6.8*	15.5	14.5	14.8
2–3	**18.4***	11.7	20.3*	14.8	13.8
4 or more	**37.5**	74.2*	39.7	39.0	14.8*
Had at least 1 overnight hospital stay	**6.2***	20.1*	5.2*	11.3	3.1*
Received care at home	**1.7***	14.7*	0.8*	3.7	†
Had at least 1 dental care visit[6]	**42.0***	33.0*	49.5*	26.6	20.0*
Receipt of appropriate care (past 12 months)					
Had more than 15 office-based or hospital outpatient visits	**10.1***	30.9*	9.8*	12.8	2.8*
Number of emergency room visits					
None	**86.4***	65.7*	88.9*	74.4	89.7*
At least 1	**13.6***	34.3*	11.1*	25.6	10.3*
1	**10.0***	22.0*	8.8*	16.1	7.6*
2–3	**3.1***	9.1	2.2*	7.6	2.5*
4 or more	**0.5***	3.2	0.2*	1.9	†

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the 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 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 or CHIP is statistically significant at the 0.05 level.

EXHIBIT 45. (continued)

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

[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 or CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the most recent survey interview. Because 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 or 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 or 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] This is a new measure that should not be compared to other dental measures included in data books prior to 2019. Dental visit is defined as a visit to any person for dental care including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. Additional dental variables included in previous years (general dentist, orthodontist, dental check-up) are no longer available.

Source: MACPAC, 2020, analysis of MEPS data.

EXHIBIT 46. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2018^

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**4.0%**	**68.8%**	**10.5%**	**13.1%**
Connection to the health care system (past 12 months)					
Has a usual source of care[6]	**82.4***	92.5*	87.8*	85.3	47.5*
Had the same usual source of medical care 12 months ago	**74.1**	85.1*	78.7	76.5	43.5*
Timeliness of care (past 12 months)					
Delayed medical care due to any access barrier indicated below	**22.2***	33.9*	18.4*	25.7	35.8*
Delayed because of costs	**11.1***	16.5*	8.1	7.9	29.5*
Delayed for provider-related reasons[7]	**13.1***	20.5	12.4*	17.1	10.5*
Delayed due to lack of transportation	**2.3***	9.5	0.9*	7.4	3.0*
Unmet need for selected types of care due to cost					
Medical care	**7.4**	12.1*	4.4*	6.2	23.7*
Mental health care or counseling	**3.2***	6.5	2.1*	4.8	6.9*
Dental care	**12.4***	27.8*	7.8*	17.7	28.0*
Prescription drugs	**6.8***	18.7*	4.0*	8.6	17.4*
Eyeglasses	**6.9***	17.2*	4.0*	12.1	15.7*

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 sum to 100 percent. Standard errors are available in the 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 Expenditure 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.

^ Values have not been updated from those published in the December 2019 data book due to a delay in the release of the NHIS after a redesign in 2019.

EXHIBIT 46. (continued)

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

[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 or CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because 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 or 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 or 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] 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.

Source: MACPAC, 2019, analysis of NHIS data.

SECTION 6

Technical Guide to MACStats

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 and enrollment;
- Transformed Medicaid Statistical Information System (T-MSIS) data for person-level detail;
- CMS performance indicator enrollment data;
- Medicaid managed care enrollment reports; and
- Statistical Enrollment Data System (SEDS) data for CHIP enrollment.

CMS began reporting two new administrative data sources on enrollment in 2014, referred to here as performance indicator enrollment data and CMS-64 enrollment data.[2] These sources differ in the timing of the reports and the enrollees covered. Performance indicator enrollment data are published monthly by CMS and include only full-benefit Medicaid and CHIP enrollees. CMS-64 enrollment data are published quarterly and include Medicaid enrollees with limited benefits but exclude CHIP enrollees.

Additionally, CMS-64 enrollment data include detailed information about the new adult group made eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act) by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). MACPAC uses the spending and enrollment data submitted on the CMS-64 to produce an exhibit on spending and enrollment from the most recent year for all Medicaid enrollees and those adults newly eligible for Medicaid under the ACA (Exhibit 23).

Transition to T-MSIS. This is the first edition of MACStats to use data from T-MSIS. Over the past several years, CMS has been working with states to implement this updated version of the Medicaid Statistical Information System (MSIS). T-MSIS builds on the person-level and claims-level data previously available under MSIS to improve timeliness, reliability, and completeness of national Medicaid and CHIP data. Additionally, T-MSIS is designed to capture significantly more data and information. It includes additional variables and expands reporting options for many existing variables. All states are now submitting T-MSIS data.

CMS takes each state's raw T-MSIS data and standardizes them into a research ready data set known as the T-MSIS Analytic Files (TAF). CMS publicly released the TAF for each calendar year (CY) 2014–2016 in November 2019 and released the TAF for CYs 2017 and 2018 in August 2020.

CMS is developing resources to help users understand how to use the TAF data and identify potential concerns in validity and reliability. In conjunction with the TAF data releases, CMS

published data quality briefs on CY 2016 data and, more recently, an interactive, web-based Data Quality Atlas that contains information for CYs 2016–2018.[3] These resources are designed to help users explore the quality and usability of the TAF and include summary statistics on a number of priority fields (e.g., eligibility group, dually eligible status, type of service). These statistics include information on file usability, the percentage of values missing, benchmark comparisons to other data sources (e.g., performance indicator enrollment), and data anomalies that may require special consideration.

One consequence of the extended transition from MSIS to T-MSIS is that not all states transitioned at the same time and data for 2014 and 2015 are split between MSIS and T-MSIS data.[4] Additionally, CMS has been working closely with states to improve the quality and completeness of the data.[5] These quality improvement efforts have focused on more recent data, and not all states have gone back to prior periods to make these improvements and resubmit the data. The CMS data quality resources have shown the quality and completeness of data are better for more recent periods.

Because of the mix of data sources for 2014 and 2015 and the improvements in data quality over time, in this data book, we used the most recently available T-MSIS data that had more than 12 months of claims run-out. Specifically, we used fiscal year (FY) 2018 T-MSIS data for exhibits that provide enrollment and spending data by eligibility group.

Survey data. MACStats also uses nationally representative surveys based on interviews of individuals, including the National Health Interview Survey (NHIS) and the Medical Expenditure Panel Survey (MEPS). The NHIS was redesigned in 2019, causing a delay in the data release. We were not able to review the survey changes and analyze the data in time for this year's publication. As a result, we are reprinting eight exhibits from last year's edition.[6] We plan to publish updated tables on our website in early 2021 as we complete our analyses on the 2019 NHIS data.

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 specific definitions in administrative data sources provided by CMS:[7]

- Enrollees (less commonly referred to as eligibles) are individuals who are eligible for and enrolled in Medicaid or CHIP. Prior to FY 1990, CMS did not track the number of Medicaid enrollees, but 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 reported 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.[8] (In common usage outside of CMS statistical publications, the term beneficiaries is typically synonymous with enrollees.)

Institutionalized and limited-benefit enrollees

Administrative Medicaid data include enrollees who are in institutions, such as nursing facilities, as well as individuals who receive only limited benefits (for example, coverage for emergency services only). 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).

CHIP enrollees

Medicaid-expansion CHIP enrollees are children who are entitled to the covered services of a state's Medicaid program, but whose Medicaid coverage is generally funded with CHIP dollars. Depending on the data source, Medicaid enrollment and spending figures may include both Medicaid enrollees funded with Medicaid dollars and Medicaid-expansion CHIP enrollees funded with CHIP dollars. 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 the 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.

NHIS and MEPS 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.[9] 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.[10]

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.[11]

However, the NHIS is known to produce higher estimates of service use than the MEPS.[12] 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 has 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."[13] This definition 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.[14]

To identify children in the CSHCN category in the NHIS, MACPAC uses responses to several questions, based on an approach developed by the Child and Adolescent Health Measurement Initiative.[15] Children identified as meeting CSHCN criteria include those with at least one diagnosed or parent-reported ongoing health condition and elevated service use. The selected ongoing health conditions include, for example, attention deficit disorder, developmental delays, cerebral palsy, and heart disease. Examples of parent-reported conditions include suffering from seizures, frequent migraines, and allergies within the past 12 months.[16] In addition to having one of the identified conditions, a child must also meet one of the following criteria related to elevated service use:

- The child is limited in his or her ability or unable to do things most children the same age can do.[17]
- The child needs or uses medications prescribed by a doctor (other than vitamins).[18]
- The child needs or uses specialized therapies such as physical, occupational, or speech therapy.[19]
- The child has above-routine need or use of medical, mental health, home care, or education services.[20]
- The child needs or receives treatment or counseling for an emotional, behavioral, or developmental problem.[21]

The NHIS varies from year to year in the diagnoses and health conditions it asks parents to report, so estimates for number of children in the CSHCN category may not be comparable from year to year.

Methodology for T-MSIS Analysis

As noted above, this is the first year MACStats uses T-MSIS data to create exhibits on Medicaid enrollment and spending by eligibility group. Although we used the raw T-MSIS data instead of the TAF, our process of identifying final action records is similar and should produce similar results as the TAF. We relied on the final action indicator CMS appends to claims as part of their TAF development process. Additionally, claims are organized by service date (ending date of service) to assign a claim to a particular time period, which is similar to the TAF.[22] Our tabulations of the raw T-MSIS data produced similar totals to the TAF; however, there were some differences due to a difference in how many months of claims run-out were included.

Our process of assigning enrollee characteristics is similar to prior years, relying on the most recent valid value for a particular characteristic. T-MSIS includes a new eligibility group variable that expands the number of groups reported and is more specific than the basis-of-eligibility variable reported in MSIS. As such, we developed a new algorithm to aggregate these more granular eligibility codes into our larger groupings of child, adult, disabled, and aged. In addition, we further split adults into the new adult group and other adults.[23] Furthermore, the new T-MSIS eligibility groups do not specifically separate individuals who qualify on the basis of a disability from the aged, and do not separate children from adults in many categories. We included age as another identifier to assign enrollees to our larger groupings. The assignment of beneficiaries is shown in Exhibit 47.

EXHIBIT 47. MACPAC Assignment of T-MSIS Eligibility Groups

MACPAC group	T-MSIS eligibility code	Age
Child	06, 07, 08, 28, 29, 30, 31, 54, 55	Any age
	01, 02, 03, 04, 14, 27, 32, 33, 35, 36, 56, 69, 70, 71	Age under 19 years
New adult group[1, 2]	72, 73, 74, 75	Any age
Other adult[3]	05, 09	Any age
	01, 02, 03, 04, 27, 33, 35, 36, 56, 70	Age 19 and older
	32, 69, 71	Age 19–64
Disabled	11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 59, 60	Age under 65 years (age 19–64 for code 14)
Aged	11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 32, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 59, 60, 69, 71	Age 65 and older

Notes: T-MSIS is Transformed Medicaid Statistical Information System. Excludes individuals enrolled in CHIP-financed Medicaid coverage (e.g., Medicaid-expansion CHIP) when the CHIP code indicates separate or Medicaid-expansion CHIP (values of 2 or 3) or the T-MSIS eligibility code is 61–68.

[1] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). Newly eligible adults include those who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Not newly eligible adults include those who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate.

[2] Because Pennsylvania classifies their new adult group under eligibility code 71, we assign eligibility code 71 to the new adult group for Pennsylvania.

[3] Includes adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

Source: MACPAC, 2020, analysis of T-MSIS data.

We also assigned Medicaid enrollees 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 national enrollment counts are then unduplicated using this national ID, which results in slightly lower enrollment counts than the sum of state-level enrollment.

T-MSIS includes spending amounts on a claim at both the header and line levels. To calculate spending, we used the Medicaid paid amounts reported on the header.[24] We included payment amounts from FFS, capitation, service tracking, and supplemental payment claim types that were linked to an individual enrollee. We did not include any lump sum payments, such as supplemental payments, that could not be linked to a specific enrollee. Additionally, we did not include paid amounts from encounter records because that spending is already represented in the amount the state made in capitation payments.

To classify claims into our broad service categories, we primarily relied on the type-of-service variable (Exhibit 49). Because type of service is reported at the line level, it is possible for a single claim to include multiple types of service. To assign a single type of service to a claim, we applied the type of service associated with the greatest proportion of line-level spending. We did additional checks to assess the reasonableness of the type of service assignment. For facility-based services (e.g., hospital, nursing facility), we checked to see if the claim had a bill type that corresponded to a facility service or a valid revenue code. For professional services, we checked for place of service. In cases where a final type of service was still undetermined, we defaulted to the claim file in which the claim was reported. Claims in the inpatient file were assigned to the hospital category, claims in the long-term care file were assigned to the institutional long-term services and supports (LTSS) category, claims in the prescription drug file were assigned to the drug category, and claims in the other services file were assigned to the non-hospital acute care category.

We used additional variables to categorize managed care and non-institutional LTSS claims. We assigned any claim classified as a capitation payment (claim type 2) as managed care regardless of the type of service assigned to the claim. We classified a claim as non-institutional LTSS if any of the following variables so indicated: type of service, program type, or Title XIX service category (i.e., CMS-64 service category) (Exhibit 49).

Readers should note that due to changes in both methods and data, T-MSIS figures shown in this year's data book may not be directly comparable to figures from earlier editions that were based on MSIS data. Key differences between the current and previous methodologies include the following:

- We assigned a time period to T-MSIS claims using the service date. This corresponds to how CMS classifies the time period in the TAF. In our previous work with MSIS, we used the file submission date (which generally corresponds to a paid date) when assigning a claim to a particular time period.
- The new eligibility groups in T-MSIS means that some enrollees may be classified differently than under MSIS, depending on how states map individuals between the two systems. In particular, the new T-MSIS eligibility categories do not separate individuals who qualify on the basis of a disability from the aged, and do not separate children from adults in many categories. We included age as another identifier to categorize beneficiaries into our larger groupings. Although we had previously taken those age 65 and older in the disabled category and classified them as aged, this is the first time we specifically incorporate age into the classification of children and adults. Furthermore, the separate identification of the new adult group may make it difficult to compare adults to prior years. The other adult category generally corresponds to the adult category used in previous MACStats publications based on MSIS data, but in states that expanded coverage to adults prior to the

ACA, the expansion adults that would have appeared in the adult category in prior years are now included in the new adult group category.

- The expanded type-of-service categories in T-MSIS means that some spending may be classified differently than under MSIS, depending on how states map services between the two systems. This is particularly true for non-institutional LTSS. Previously in MSIS, we relied on program type, because home- and community-based services (HCBS) was not a separate type of service. We still use program type, but we can now also capture claims with an HCBS type of service or a Title XIX service category. This expansion of the algorithm may result in our capturing more claims as non-institutional LTSS.
- State practices for classifying enrollees and services in T-MSIS may change over time as states become more familiar with the T-MSIS reporting structure and requirements. Future changes in enrollment and spending, particularly across eligibility groups or service categories, may reflect changes in reporting in addition to changes in policy. Finally, enrollment and spending amounts for a particular year could change over time if states correct reporting errors and anomalies for past years.

Methodology for Adjusting Benefit Spending Data

The FY 2018 Medicaid benefit spending amounts presented in this data book were calculated based on T-MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[25] Although the CMS-64 provides a more complete accounting of spending than T-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. Thus, we adjust T-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, T-MSIS data are used primarily for statistical purposes.
- T-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.[26] Although states may report DSH and other supplemental payments through T-MSIS, most states are not reporting these data at this time.
- T-MSIS generally overstates net spending on prescribed drugs because it excludes rebates from drug manufacturers. Although T-MSIS does allow states to report drug rebate collections, most states are not reporting these data at this time.
- The extent to which spending in T-MSIS differs from that reported on the CMS-64 varies by state, meaning that a cross-state comparison of unadjusted T-MSIS amounts may not reflect true differences in benefit spending. (See Exhibit 48 for unadjusted benefit spending amounts in T-MSIS as a percentage of benefit spending in the CMS-64.)

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

- We aggregate the service types into broad categories that are comparable between the two sources. (See Exhibit 49 for additional detail on these categories.) This is necessary because there is not a one-to-one correspondence of service types in T-MSIS and CMS-64 data. Even service types with identical names may be reported differently in the two sources due to differences in the instructions given to states. Although T-MSIS includes a new variable that corresponds to the service categories reported on the CMS-64, many states are not currently

submitting complete information under this variable. The submission of complete and accurate information for this variable would allow us to make more direct comparisons between T-MSIS and the CMS-64 in the future.

- We calculate state-specific adjustment factors for each of the service categories by dividing CMS-64 benefit spending by T-MSIS benefit spending.
- We then multiply T-MSIS dollar amounts in each service category by the state-specific factors to obtain adjusted T-MSIS spending. For example, in a state with an FFS hospital factor of 1.2, each Medicaid enrollee with hospital spending in T-MSIS would have that spending multiplied by 1.2; doing so makes the sum of adjusted hospital spending amounts among individual Medicaid enrollees in T-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).[27]

These adjustments to T-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 Family Foundation, and the Urban Institute, use similar methodologies, although these may differ in some ways—for example, by using the proportion of spending across eligibility groups in T-MSIS to allocate CMS-64 spending to these groups. Even so, data anomalies in T-MSIS may create large discrepancies between the results obtained by our methodology and results obtained by methodologies used by other organizations. We expect to see these discrepancies wane as states get used to T-MSIS reporting and the accuracy and consistency of their T-MSIS data improves.

EXHIBIT 48. Medicaid Benefit Spending in T-MSIS and CMS-64 Data by State, FY 2018 (millions)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted T-MSIS	CMS-64[1]	T-MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
Total	**$528,682**	**$560,188**	**94.4%**	**$16,539**	**$15,579**
Alabama	4,392	5,084	86.4	484	–
Alaska	2,122	2,035	104.3	18	–
Arizona	11,900	11,895	100.0	145	98
Arkansas[2]	5,629	6,178	91.1	45	–
California[3]	82,351	78,554	104.8	591	4,025
Colorado	7,501	8,831	84.9	173	–
Connecticut	8,254	8,602	96.0	66	–
Delaware	2,322	2,227	104.3	14	–
District of Columbia	2,831	2,767	102.3	46	–
Florida	14,611	21,815	67.0	354	879
Georgia	10,475	10,455	100.2	441	–
Hawaii[4]	2,317	2,266	102.3	–	-8
Idaho	1,988	1,894	105.0	25	–
Illinois	15,812	21,963	72.0	335	–
Indiana	19,778	11,235	176.0	71	–
Iowa	4,772	4,834	98.7	83	–
Kansas	3,418	3,282	104.1	106	78
Kentucky	12,854	9,610	133.7	220	–
Louisiana	10,080	9,721	103.7	1,249	–
Maine	2,473	2,731	90.6	43	–
Maryland	11,839	11,396	103.9	101	–
Massachusetts	16,330	16,413	99.5	–	1,424
Michigan	14,136	15,839	89.3	603	–
Minnesota	10,494	12,698	82.6	67	–
Mississippi	5,243	5,069	103.4	227	–
Missouri	9,033	9,616	93.9	782	7
Montana	1,539	1,855	83.0	1	–
Nebraska	1,673	2,135	78.4	40	–
Nevada	3,703	3,866	95.8	79	–
New Hampshire	1,852	1,900	97.5	228	35
New Jersey	13,313	14,124	94.3	781	167
New Mexico	5,051	5,002	101.0	52	78
New York	64,026	69,060	92.7	4,062	1,676
North Carolina	10,882	13,039	83.5	537	–

EXHIBIT 48. (continued)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted T-MSIS	CMS-64[1]	T-MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
North Dakota[3]	$996	$1,230	81.0%	$1	–
Ohio	22,105	21,841	101.2	93	–
Oklahoma	4,021	4,756	84.5	44	–
Oregon	5,804	8,723	66.5	61	$146
Pennsylvania	17,453	29,103	60.0	943	–
Rhode Island	1,946	2,491	78.1	139	–
South Carolina	5,852	5,699	102.7	526	–
South Dakota	911	873	104.3	2	–
Tennessee	8,967	8,843	101.4	32	860
Texas	31,397	30,544	102.8	1,886	5,770
Utah[3]	2,575	2,425	106.2	25	–
Vermont	1,477	1,409	104.8	27	161
Virginia	8,150	9,415	86.6	208	–
Washington	9,989	11,666	85.6	342	185
West Virginia	4,158	3,802	109.4	72	–
Wisconsin	7,321	8,777	83.4	71	–
Wyoming	564	602	93.7	0	–

Notes: T-MSIS is Transformed Medicaid Statistical Information System. FY is fiscal year. DSH is disproportionate share hospital. Includes federal and state funds. T-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 $7.6 billion in offsetting collections from third-party liability, estate, and other recoveries. For greater detail on the difference between T-MSIS and CMS-64, please see the Methodology for Adjusting Benefit Spending Data section. DSH payments and incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act have also been excluded from CMS-64 totals. 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 T-MSIS spending reported in other exhibits due to rounding when applying certain adjustments.

[2] The CMS-64 total for Arkansas excludes $214.0 million in Medicare premiums because we could not identify dually eligible beneficiaries to allocate these expenditures.

[3] State has a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children that would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced California's T-MSIS spending by $491.7 million, North Dakota's T-MSIS spending by $10.6 million, and Utah's T-MSIS spending by $23.8 million.

[4] The CMS-64 total for Hawaii excludes $1.9 million in fee-for-service (FFS) drug spending because the state did not report any FFS drug spending in T-MSIS.

Source: MACPAC, 2020, analysis of T-MSIS data as of April 2020, and CMS-64 financial management report net expenditure data as of October 2019.

EXHIBIT 49. Service Categories Used to Adjust FY 2018 Medicaid Benefit Spending in T-MSIS to Match CMS-64 Totals

Service category	T-MSIS service types[1]	CMS-64 service types
Hospital	• Inpatient hospital • Outpatient hospital, including mental health other than outpatient substance abuse treatment • Emergency hospital • Critical access hospital • Skilled care, exceptional care, and non-acute care – hospital residing	• 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	• Rural health clinic • Laboratory • Radiology • EPSDT • Family planning • Physician • Dental • Outpatient substance abuse treatment • Other practitioner • Home health – supplies, equipment, and appliances • Private duty nursing • Nursing, including advanced practice, pediatric, nurse-midwife, and nurse practitioner • Respiratory care for ventilator-dependent individuals • Clinic • Physical, occupational, speech, and hearing therapy • Over-the-counter medications (not on pharmacy claim) • Dentures • Medical equipment and prosthetics (not on pharmacy claim) • Eyeglasses • Hearing aids • Diagnostic and screening services • Preventive services • Well-baby and well-child services • Rehabilitative services • Targeted case management • Other case management • Care coordination	• 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 • Laboratory and radiology • 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

EXHIBIT 49. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
Non-hospital acute care (continued)	• Transportation • Enabling services • Sterilizations • Prenatal care and prepregnancy family planning • Other pregnancy-related procedures • Hospice • Disposable medical supplies • Indian Health Service – family plan • Religious non-medical health care institutions • Other care	
Drugs	• Prescribed drugs • Over-the-counter medications (on a pharmacy claim) • Medical equipment and prosthetic (on a pharmacy claim)	• Prescribed drugs • Drug rebates (national, state sidebar, ACA offset – fee for service)
Managed care and premium assistance	Claim type 2 (capitated payment) or type of service: • Capitated payments to comprehensive risk based managed care plans (HMO, HIO, PACE) • Capitated payments to PHP • Capitated payments for PCCM • Premium payments for private insurance	• MCO (i.e., comprehensive risk-based managed care) • MCO drug rebates (national, state sidebar, ACA offset – fee for service) • PACE • PAHP • PIHP • PCCM • MCO, PAHP, and PIHP payments associated with the primary care physician payment increase, Community First Choice option, certified community behavioral health clinic, preventive services with USPSTF Grade A or B, and ACIP vaccines • Premium assistance for private coverage
LTSS non-institutional	Type of service: • Home health, including nursing, home health aide, and physical, occupational, speech, and hearing therapy • Personal care • HCBS waiver or program type: • HCBS waiver • Balancing incentive payment • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) or Title XIX service code is one of the LTSS non-institutional CM-64 service types	• Home health • Personal care • Personal care—1915(j) • HCBS waiver • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) • Certified community behavioral health clinic

EXHIBIT 49. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
LTSS institutional	• Nursing facility • Inpatient hospital and nursing facility services for individuals age 65 and older in institution for mental disease • Intermediate care facility • Inpatient psychiatric or skilled nursing facility for individuals under age 21 • Inpatient and residential substance abuse treatment	• 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. T-MSIS is Transformed Medicaid Statistical Information System. DSH is disproportionate share hospital. GME is graduate medical education. EPSDT is early and periodic screening, diagnostic, and treatment. USPSTF is U.S. Preventive Services Task Force. ACIP is Advisory Committee on Immunization Practices. ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). HMO is health maintenance organization. HIO is health insuring 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). HCBS is home- and community-based services. 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 T-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 T-MSIS spending in the relevant service categories (e.g., drugs).

[1] Claims in T-MSIS include variables for claim type (e.g., fee for service, capitated payment), type of service (such as inpatient hospital, physician, personal care), program type (including HCBS waiver), and Title XIX service category code (corresponds to CMS-64 category). When classifying T-MSIS claims into service categories, we generally relied on type of service, with a few exceptions. We classified all claims with a claim type indicating a capitated payment as managed care regardless of the type of service associated with the claim. For non-institutional LTSS, we also included any claim with a program type indicating HCBS or a Title XIX service category code that matched the CMS-64 service types we select for this category.

[2] Emergency services for non-qualified aliens are reported under individual service types throughout T-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 T-MSIS. We distribute CMS-64 amounts proportionately across dually eligible enrollees identified in T-MSIS for each state.

[4] Medicare coinsurance and deductibles are reported under individual service types throughout T-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 using 2013 Medicare data. See MedPAC and MACPAC, 2018, Table 5: Fee-for-service Medicare Part A and Part B cost sharing incurred by dual-eligible and non-dual Medicare beneficiaries, CY 2013, in *Data book: Beneficiaries dually eligible for Medicare and Medicaid*, Washington, DC: MedPAC and MACPAC, https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf.

Source: MACPAC, 2020, analysis of T-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 CMS.

Medicaid Managed Care Enrollment and Program Characteristics Report

The Medicaid Managed Care Enrollment and Program Characteristics Report provides state-reported aggregate enrollment statistics and other basic information for each managed care plan within

a state. This report is the source of information on Medicaid managed care most commonly cited by CMS as well as by outside analysts and researchers.

T-MSIS

T-MSIS provides person-level and claims-level information for all Medicaid enrollees. For managed care, T-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 may be referred to as encounter or so-called dummy claims). All states collect encounter data from their Medicaid managed care plans, and CMS is working with states so these data are reported into T-MSIS. Managed care enrollees may also have FFS claims in T-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 provides aggregate spending information for Medicaid grouped into 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 of individuals covered under FFS and managed care systems. The SEDS is currently the primary source of information on managed care participation among separate CHIP enrollees across states. However, states can submit information on separate CHIP into T-MSIS, so T-MSIS may become another source of information on separate CHIP in the future.

Historically, the annual Medicaid managed care enrollment report generally contains the most recent information available from CMS on Medicaid managed care for all states; however, 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. Due to improved timeliness, T-MSIS provides data that is as recent as the Medicaid managed care report, and these data can be analyzed at the beneficiary level. As a result, MACStats also includes statistics based on T-MSIS and CMS-64 data, such as the percentage of individuals enrolled in managed care by eligibility group and the percentage of Medicaid benefit spending attributable to managed care.

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

- Figures in the annual Medicaid managed care enrollment report published by CMS include Medicaid-expansion CHIP enrollees. Although we generally exclude these children (about 5 to 6 million) from Medicaid analyses in MACStats, it is not possible to do so with the CMS annual Medicaid managed care enrollment report data.[28]
- The types of managed care reported by states may differ somewhat between the Medicaid managed care enrollment report and T-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.
- The Medicaid managed care enrollment report provides point-in-time figures. In contrast, T-MSIS data allow the calculation of 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 the MACStats archive page of the MACPAC website, https://www.macpac.gov/publication/macstats-archive/. For MACStats prior to December 2015, the technical guide is included in each year's June report.

[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] The 2016 data quality briefs can be found through the ResDAC website at https://www.resdac.org/taf-data-quality-resources. The Data Quality Atlas can be found at https://www.medicaid.gov/dq-atlas/welcome.

[4] The timing of each state's transition from MSIS to T-MSIS can be found at https://www.resdac.org/sites/resdac.umn.edu/files/MAX%20TAF%20Availability%20Matrix.xlsx.

[5] Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Tim Hill to state health officials regarding "Transformed-Medicaid Statistical Information System (T-MSIS)." August 10, 2018, https://www.medicaid.gov/federal-policy-guidance/downloads/sho18008.pdf.

[6] These exhibits are: Exhibit 1, Medicaid and CHIP enrollment as a percentage of the U.S. population; Exhibit 2, Characteristics of non-institutionalized individuals by age and source of health coverage; Exhibit 39, Coverage, demographic, and health characteristics of non-institutionalized individuals age 0–18 by primary source of health coverage; Exhibit 40, Use of care among non-institutionalized individuals age 0–18 by primary source of health coverage; Exhibit 42, Measures of access to care among non-institutionalized individuals age 0–18 by primary source of health coverage; Exhibit 43, Coverage, demographic, and health characteristics of non-institutionalized individuals age 19–64 by primary source of health coverage; Exhibit 44, Use of care among non-institutionalized individuals age 19–64 by primary source of health coverage; and Exhibit 46, Measures of access to care among non-institutionalized individuals age 19–64 by primary source of health coverage.

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

[8] 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 they have used any health services.

[9] Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, 2019, About the National Health Interview Survey, http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[10] Agency for Health Care Research and Quality (AHRQ), 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.

[11] 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: National Academies Press, http://www.nap.edu/catalog/13024.html.

[12] 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 (pp. 2828–2837, health policy statistics section), in *JSM Proceedings*, Alexandria, VA: American Statistical Association, http://www.asasrms.org/Proceedings/y2010/Files/307444_58577.pdf.

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

[14] For children under age 18 to be determined disabled under SSI rules, the child must have at least one medically determinable physical or mental impairment that causes marked and severe functional limitations and that can be expected to cause death or last at least 12 months (§ 1614(a)(3)(C)(i) of the Act).

[15] To operationalize the Maternal and Child Health Bureau definition of CSHCN, researchers developed a set of survey questions referred to as the CSHCN Screener. It incorporates four components of the definition of CSHCN considered by researchers as essential: functional limitations, need for health-related services, presence of a health condition, and minimum expected duration of health condition (e.g., 12 months). The CSHCN Screener is currently used in several national surveys, but not the NHIS. An alternative approach was developed by the Child and Adolescent Health Measurement Initiative (CAHMI) specifically for use in the NHIS and uses the term children with chronic conditions and elevated service use or need, or CCCESUN. CAHMI's work builds on earlier work conducted by Davidoff using the NHIS. (Child and Adolescent Health Measurement Initiative, 2012, *Identifying children with chronic conditions and elevated service use or need (CCCESUN) in the National Health Interview Survey (NHIS)*, Portland, OR: Oregon Health and Science University; and Davidoff, A., 2004, Children with special health care needs in the NHIS, *Health Services Research* 39, no. 1: 53–72).

[16] 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 2 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.

[17] 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.

[18] 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.

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

[20] Above-routine need or use of 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 2 or more emergency department visits in the past 12 months, had 1 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.

[21] Needs 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.

[22] In Kansas, several claims were missing service dates. We used paid dates to assign these claims to a time period.

[23] The new adult group includes those enrollees who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. We include both newly eligible adults and not newly eligible adults eligible under this pathway. Newly eligible adults include those enrollees who were not eligible for Medicaid under the rules that a state had in place on December 1, 2009, and received a federal matching rate of 100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and subsequent years. Adults not considered not newly eligible include those enrollees who would have previously been eligible for Medicaid under the rules that a state had in place on December 1, 2009; this includes states that had already expanded to adults with incomes greater than 100 percent of the federal poverty level as of March 23, 2010, and receive the expansion state transitional matching rate. Other adults include adults under age 65 who qualify through a pathway other than disability or Section 1902(a)(10)(A)(i)(VIII) of the Act (e.g., parents and caretakers, pregnant women).

[24] Until December 2017, Georgia did not report header-level spending for capitation payments. If the header amount was zero or missing, we used the aggregate line-level spending for capitated payments in Georgia.

[25] 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.

[26] 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 T-MSIS spending in the relevant service categories.

[27] The sum of adjusted T-MSIS benefit spending for all service categories is equal to 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 T-MSIS.

[28] We generally exclude children enrolled in Medicaid-expansion CHIP from Medicaid analyses because their funding stream (Title XXI of the Act) differs from that of other Medicaid enrollees (Title XIX of the 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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