MACStats: Medicaid and CHIP Data Book

December 2021

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

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

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

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

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

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Table of Contents

Introduction

This 2021 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. Medicaid and CHIP covered more than one-quarter of the U.S. population in 2019 (Exhibit 1). Spending and enrollment in Medicaid typically grow around recessions and slow when the economy improves. As of May 2021, more than 82 million people were enrolled in Medicaid and CHIP. From July 2020 to May 2021, enrollment in Medicaid and CHIP increased by 8.9 percent. This follows a 6.1 percent increase in Medicaid and CHIP enrollment from July 2019 to July 2020. Much of this increase from July 2019 is attributable to the economic downturn created by the COVID-19 pandemic and 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).

Although the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965, Medicaid and CHIP spending combined continue to account for a small share of the federal budget. In fiscal year (FY) 2020, the share of federal spending on Medicaid, CHIP, and Medicare fell from the previous fiscal year as spending in other areas of the federal budget increased, due to the availability of COVID-19 pandemic-related relief such as unemployment compensation, coronavirus tax relief and economic impact payments, and other housing credits (Exhibit 4).

Total Medicaid spending was $688.0 billion in FY 2020 (Exhibit 16). Spending for CHIP was $19.8 billion (Exhibit 33). The annual growth in Medicaid spending increased from 1.8 percent in FY 2019 to 8.9 percent in FY 2020. The spending growth reflects increased enrollment and federal requirements that states not disenroll individuals during the COVID-19 public health emergency (Exhibit 10). In FY 2019, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 22 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.

As in prior years, 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). Children 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 (Exhibit 39) but are as likely to report seeing a doctor or having a well-child checkup as those with private coverage and more likely than those who are uninsured (Exhibit 40).

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 regarding data sources, methods, and guidance for interpreting exhibits.

We would like to thank staff 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 insights and assistance. We would also like to thank Lori Michelle Ryan and the team at GKV for providing copyediting and formatting services.

SECTION 1

Overview—
Key Statistics

Section 1: Overview—Key Statistics

Key Points

- In 2019, 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: 83.0 million in Medicaid and 9.7 million in CHIP (Exhibit 1). About 36.3 percent of children had Medicaid or CHIP coverage in 2019 (Exhibit 2).
- Over 40 percent of individuals enrolled in Medicaid or CHIP in 2019 had family incomes below 100 percent of the federal poverty level (FPL). Almost 6 out of 10 individuals (58.4 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 16.7 percent of national health expenditures in calendar year 2019, less than either Medicare (21.1 percent) or private insurance (31.5 percent) (Exhibit 3).
- In general, the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965. Both Medicaid's and Medicare's share of the federal budget are lower than in prior years because of a large increase in other mandatory program spending in 2020 for pandemic-related relief such as unemployment compensation, coronavirus tax relief and economic impact payments, and other housing credits (Exhibit 4).
- In fiscal year 2020, Medicaid continued to account for a smaller share (7.0 percent) than Medicare (11.7 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 (i.e., the portion states must finance on their own through taxes and other means), Medicaid's share was 15.8 percent in state fiscal year (SFY) 2019. When federal funds are included, Medicaid's share was 28.7 percent in SFY 2019 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2019 (millions)

Population	Ever during FY 2019	Point in time during FY 2019	Point in time during CY 2019
	Estimates based on administrative data (CMS)[1]		Survey data (NHIS)[2]
Medicaid enrollees	83.0[3]	70.2[3]	Not available
CHIP enrollees	9.7[4]	7.1[4]	Not available
Totals for Medicaid and CHIP	**92.7**	**77.3**	**57.8**
	Census Bureau data		Survey data (NHIS)[2]
U.S. population	328.6[5]	327.8[5]	322.9
	Administrative and Census Bureau data		Survey data (NHIS)[2]
Medicaid and CHIP enrollment as a percentage of U.S. population	28.2%[1]	23.6%	17.9%

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/.

[1] Estimates based on administrative data are from the Transformed Medicaid Statistical Information System (T-MSIS) and the 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, and respondents are known to underreport Medicaid and CHIP coverage.

[3] Medicaid enrollment estimates are from MACPAC analysis of FY 2019 T-MSIS data (see Exhibits 14 and 15). Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification 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.

[4] CHIP enrollment estimates from administrative data are from the FY 2021 president's budget.

[5] The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of September 2019 (the month with the largest count in FY 2019); 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 2019.

Source: MACPAC, 2021, analysis of the following: T-MSIS data as of December 2020; HHS, 2020, *Putting America's health first, FY 2021 president's budget for HHS*, Baltimore, MD, https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf; NHIS data; and U.S. Bureau of the Census, 2021, *Monthly population estimates for the United States: April 1, 2010 to December 1, 2020, National totals: vintage 2019* https://www2.census.gov/programs-surveys/popest/tables/2010-2019/national/totals/na-est2019-01.xlsx.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2019

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%**	**23.0%**	**62.0%**	**17.9%**	**10.2%**	**100.0%**	**56.0%**	**36.3%**	**5.2%**
Coverage									
Length of time with any coverage during year									
Full year	**87.3***	98.8*	96.8*	93.1	–	**92.7***	98.0*	95.0	–
Part year	**6.5**	1.2*	3.2*	6.9	32.1*	**5.1**	2.0*	5.0	47.7*
No coverage during year	**6.3***	–	–	–	67.9*	**2.2***	–	–	52.3*
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/CHIP combination[6]	**1.9***	10.4	–	10.4	–	**–**	–	–	–
Yes, any private and Medicaid/CHIP combination	**0.6***	–	0.9*	3.2	–	**1.4***	2.5*	3.9	–
Yes, any other combination	**8.1***	45.6*	13.1*	1.0	–	**–**	–	–	–
No	**89.5***	44.0*	86.0	85.4	100.0*	**98.6***	97.5*	96.1	100.0*
Demographics									
Age									
0–18	**23.9***	†	21.6*	48.6	12.2*	**100.0**	100.0	100.0	100.0
19–64	**59.6***	13.5*	65.1*	43.5	86.2*	**–**	–	–	–
65 or older	**16.5***	86.4*	13.3*	7.9	1.6*	**–**	–	–	–
Gender									
Male	**48.9***	45.2	49.2*	44.5	53.7*	**51.0**	50.5	51.7	50.5
Female	**51.1***	54.8	50.8*	55.5	46.3*	**48.9**	49.5	48.2	49.5
Race									
Hispanic	**18.6***	8.4*	13.0*	30.4	38.9*	**25.6***	16.4*	37.5	38.2
White, non-Hispanic	**60.7***	74.9*	68.6*	38.3	42.0	**51.8***	64.5*	33.1	44.4*
Black, non-Hispanic	**11.9***	10.6*	9.3*	21.3	11.6*	**12.7***	8.4*	20.8	8.1*
American Indian or Alaska Native, non-Hispanic	**†**	0.7	0.5	†	†	**†**	0.4	†	†
Asian, non-Hispanic	**5.6**	4.1	6.4*	4.9	3.1*	**4.3***	5.6*	2.6	†
Other single and multiple races, non-Hispanic	**3.3***	2.0*	2.7*	5.0	4.4	**5.5**	5.1	5.9	6.9

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%**	**67.6%**	**13.1%**	**14.7%**	**100.0%**	**93.6%**	**50.1%**	**8.6%**
Coverage									
Length of time with any coverage during year									
Full year	**82.0***	96.3*	95.8*	90.2	–	**98.2**	99.1*	99.4*	96.8
Part year	**8.5**	3.7*	4.2*	9.8	30.3*	**1.2**	0.9	0.6	†
No coverage during year	**9.5***	–	–	–	69.7*	**0.6***	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/CHIP combination[6]	**1.2***	30.6*	–	9.4	–	**6.8***	7.3*	–	79.5
Yes, any private and Medicaid/CHIP combination	**0.4***	–	0.5*	2.8	–	**†**	–	†	†
Yes, any other combination	**0.9**	22.0*	1.3*	0.7	–	**46.2***	49.3*	92.3*	9.5
No	**97.5***	47.5*	98.2*	87.1	100.0*	**47.0***	43.4*	7.6	10.5
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***	49.5*	49.7*	38.4	54.3*	**44.9***	44.5*	44.7*	33.4
Female	**50.9***	50.5*	50.3*	61.6	45.7*	**55.1***	55.5*	55.3*	66.6
Race									
Hispanic	**18.5***	11.6*	13.5*	23.1	38.5*	**8.8***	7.8*	4.6*	26.8
White, non-Hispanic	**60.0***	60.9*	66.8*	44.5	42.2	**75.7***	77.1*	84.1*	36.6
Black, non-Hispanic	**12.4***	20.7	10.1*	22.5	12.2*	**9.1***	9.1*	7.0*	18.4
American Indian or Alaska Native, non-Hispanic	**†**	†	0.5	†	†	**0.6**	0.5	0.4	†
Asian, non-Hispanic	**6.3**	†	7.3*	5.7	3.0*	**4.7***	4.3*	3.1*	14.4
Other single and multiple races, non-Hispanic	**2.8**	4.0	2.3*	4.3	4.1	**1.7**	1.7	1.3	†

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	**12.0%***	16.9%*	5.6%*	27.2%	26.7%	–	–	–	–
High school diploma/GED	**27.3***	30.1*	24.0*	35.7	35.2	–	–	–	–
Some college	**31.2***	28.3	32.6*	27.4	26.7	–	–	–	–
College or graduate degree	**29.5***	24.7*	37.7*	9.7	11.4	–	–	–	–
Marital status[7]									
Married	**53.4***	54.0*	59.9*	29.2	38.8*	–	–	–	–
Widowed	**6.1***	21.0*	4.4*	7.4	2.1*	–	–	–	–
Divorced or separated	**10.4***	14.4	8.5*	15.7	11.3*	–	–	–	–
Living with partner	**9.0***	3.0*	7.4*	12.6	18.9*	–	–	–	–
Never married	**21.1***	7.6*	19.8*	35.1	28.9*	–	–	–	–
Family income									
Has income less than 138 percent FPL	**20.4***	20.2*	7.1*	58.4	36.0*	**27.1%***	6.3%*	59.0%	34.2%*
Has income in ranges shown below									
Less than 100 percent FPL	**12.6***	11.7*	3.8*	40.3	21.1*	**17.5***	3.3*	39.6	18.8*
100–199 percent FPL	**19.7***	23.1*	11.4*	37.1	33.9*	**22.9***	11.1*	39.9	33.5*
200–399 percent FPL	**30.8***	32.2*	33.4*	18.2	32.8*	**30.3***	37.6*	17.2	37.3*
400 percent FPL or higher	**36.9***	33.1*	51.5*	4.4	12.3*	**29.3***	48.0*	3.3	10.4*
Other demographic characteristics									
Citizen of United States	**92.9**	98.0*	95.1*	93.3	73.6*	**97.4**	98.4*	97.3	86.5*
Parent of a dependent child[7]	**27.2***	2.1*	28.2*	33.5	35.3	–	–	–	–
Currently working[7]	**63.2***	17.0*	73.5*	39.8	70.7*	–	–	–	–
Veteran[7]	**8.4***	17.4*	7.1*	2.7	2.4	–	–	–	–
Family receives SSI or SSDI	**9.0***	18.4*	4.4*	23.6	6.7*	**7.0***	2.7*	14.1	3.7*
Health									
Current health status									
Excellent or very good	**64.2***	39.2*	70.2*	57.4	57.7	**87.1***	91.8*	79.1	87.0*
Good	**23.3**	31.0*	21.8	22.7	28.3*	**10.0***	6.6*	15.4	10.5*
Fair or poor	**12.4***	29.8*	8.0*	19.9	14.0*	**3.0***	1.5*	5.5	†

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	**10.5%***	19.9%	4.7%*	23.2%	26.1%	**17.1%***	16.5%*	10.3%*	49.6%
High school diploma/GED	**27.0***	38.0	23.0*	37.8	35.6	**28.5***	28.9*	29.3*	23.7
Some college	**32.3***	32.4	33.4*	29.3	27.0	**27.3***	27.6*	29.0*	17.0
College or graduate degree	**30.2***	9.8	38.9*	9.7	11.2	**27.2***	27.0*	31.5*	9.7
Marital status[7]									
Married	**52.4***	37.4*	59.6*	28.9	38.7*	**56.7***	56.6*	61.6*	30.6
Widowed	**1.6***	7.0*	1.1*	3.1	1.7*	**22.6***	23.2*	20.7*	31.6
Divorced or separated	**9.6***	22.4*	7.9*	14.1	11.3*	**13.2***	13.1*	11.2*	25.2
Living with partner	**10.8***	5.7*	8.4*	14.5	19.1*	**2.7**	2.5	2.5	†
Never married	**25.6***	27.5*	23.0*	39.4	29.2*	**4.7***	4.5*	4.0*	10.7
Family income									
Has income less than 138 percent FPL	**18.7***	44.8*	7.2*	57.4	35.9*	**16.6***	16.3*	8.4*	60.0
Has income in ranges shown below									
Less than 100 percent FPL	**11.6***	27.8*	3.9*	40.6	21.3*	**9.3***	9.1*	3.8*	43.1
100–199 percent FPL	**18.0***	36.4	10.7*	34.7	33.8	**21.0***	21.0*	15.4*	33.0
200–399 percent FPL	**30.6***	27.1*	32.0*	19.6	32.3*	**32.6***	33.0*	33.1*	17.1
400 percent FPL or higher	**39.8***	8.7*	53.4*	5.1	12.6*	**37.1***	36.9*	47.6*	6.7
Other demographic characteristics									
Citizen of United States	**89.9**	97.7*	93.2*	89.9	72.3*	**96.8***	98.0*	98.5*	86.7
Parent of a dependent child[7]	**34.4***	11.5*	33.8*	39.2	35.8*	**0.9**	0.6	0.9	†
Currently working[7]	**75.4***	15.5*	83.7*	46.1	71.5*	**19.0***	17.2*	23.5*	5.2
Veteran[7]	**5.6***	8.4*	4.8*	2.1	2.4	**18.8***	18.9*	18.4*	6.0
Family receives SSI or SSDI	**9.6***	74.5*	4.8*	31.0	7.1*	**9.6***	9.8*	5.3*	44.1
Health									
Current health status									
Excellent or very good	**60.9***	16.8*	67.4*	40.3	54.2*	**43.1***	42.7*	49.1*	17.9
Good	**26.3***	24.0*	24.9*	29.8	30.4	**32.0**	32.1	31.1	28.8
Fair or poor	**12.8***	59.2*	7.8*	29.9	15.4*	**25.0***	25.2*	19.9*	53.3

EXHIBIT 2. (continued)

Notes: GED is general equivalency 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 downloadable Excel version of this exhibit at https://www.macpac.gov/publication/characteristics-of-non-institutionalized-individuals-by-source-of-health-insurance/. The individual components listed under the subcategories are not always mutually exclusive and may not 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.

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

* 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, 2021, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2019

Type of expenditure	Payer amount (millions) and share of total							
	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third-party payers[2]	Out of pocket
Total payer expenditures	**$3,795,384**	**$613,487**	**$19,927**	**$799,356**	**$1,195,146**	**$124,921**	**$636,040**	**$406,507**
Hospital care	**1,191,978**	206,610	5,103	315,837	438,124	69,265	121,108	35,931
Physician and clinical services	**772,115**	83,278	4,642	192,968	305,001	33,458	92,145	60,623
Dental services	**143,191**	13,719	2,276	1,930	61,805	1,713	1,746	60,003
Other professional services[3]	**110,630**	7,680	432	28,431	34,151	–	13,231	26,705
Home health care	**113,510**	36,338	79	43,969	16,561	808	3,252	12,503
Other non-durable medical products[4]	**82,059**	–	–	2,194	–	–	–	79,865
Prescription drugs	**369,687**	31,425	2,046	104,616	164,649	8,922	4,289	53,740
Durable medical equipment[5]	**57,572**	8,465	204	9,756	12,418	–	1,173	25,557
Nursing care facilities and continuing care retirement communities[6]	**172,655**	50,778	24	38,161	18,000	6,013	14,119	45,560
Other health, residential, and personal care services[7]	**193,633**	111,339	1,844	4,789	13,404	1,100	55,138	6,019
Administration[8]	**288,888**	63,855	3,278	56,706	131,034	3,642	30,373	–
Public health activity	**97,805**	–	–	–	–	–	97,805	–
Investment	**201,662**	–	–	–	–	–	201,662	–

EXHIBIT 3. (continued)

Type of expenditure	Payer amount (millions) and 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%**	**16.2%**	**0.5%**	**21.1%**	**31.5%**	**3.3%**	**16.8%**	**10.7%**
Hospital care	**100.0**	17.3	0.4	26.5	36.8	5.8	10.2	3.0
Physician and clinical services	**100.0**	10.8	0.6	25.0	39.5	4.3	11.9	7.9
Dental services	**100.0**	9.6	1.6	1.3	43.2	1.2	1.2	41.9
Other professional services[3]	**100.0**	6.9	0.4	25.7	30.9	–	12.0	24.1
Home health care	**100.0**	32.0	0.1	38.7	14.6	0.7	2.9	11.0
Other non-durable medical products[4]	**100.0**	–	–	2.7	–	–	–	97.3
Prescription drugs	**100.0**	8.5	0.6	28.3	44.5	2.4	1.2	14.5
Durable medical equipment[5]	**100.0**	14.7	0.4	16.9	21.6	–	2.0	44.4
Nursing care facilities and continuing care retirement communities[6]	**100.0**	29.4	0.0	22.1	10.4	3.5	8.2	26.4
Other health, residential, and personal care services[7]	**100.0**	57.5	1.0	2.5	6.9	0.6	28.5	3.1
Administration[8]	**100.0**	22.1	1.1	19.6	45.4	1.3	10.5	–
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 2019, 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 2019 methodology improved the allocation of Medicaid managed care premiums to the goods and services categories for some states by the additional use of Medicaid Drug Rebate System data. This change caused a downward revision to retail prescription drug spending and an upward revision for most of the 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 practitioners 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, 2020, *National health expenditures by type of service and source of funds: Calendar years 1960–2019*, Baltimore, MD: OACT, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2019.zip. OACT, 2020, *National health expenditure accounts: Methodology paper, 2019*, Baltimore, MD: OACT, https://www.cms.gov/files/document/definitions-sources-and-methods.pdf. OACT, 2020, *Summary of the 2019 comprehensive revision to the national health expenditure accounts*, Baltimore, MD: OACT, https://www.cms.gov/files/document/summary-benchmark-changes-2019.pdf.

EXHIBIT 4. Major Health Programs and Other Components of Federal Budget as a Share of Federal Outlays, FYs 1965–2020

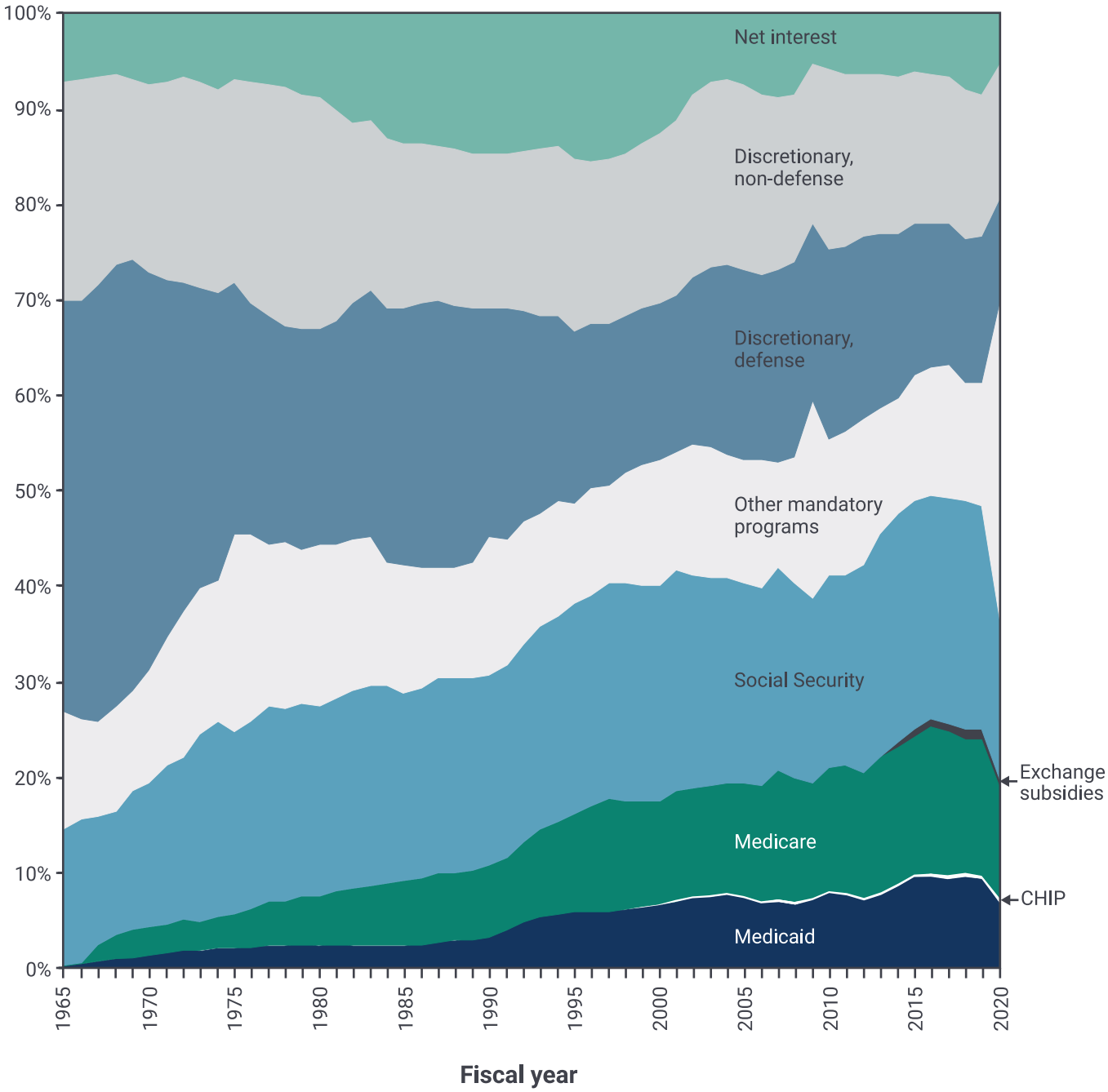


EXHIBIT 4. (continued)

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
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	23.4	13.0	15.2	14.9	8.4
2020	7.0	0.3	11.7	0.8	16.6	33.5	10.9	13.9	5.3

Notes: FY is fiscal year.

– Dash indicates zero.

Source: MACPAC, 2021, 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 2022*, Washington, DC: OMB, https://www.govinfo.gov/app/details/BUDGET-2022-TAB/context.

EXHIBIT 5. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, SFY 2019

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	**$2,115,249**	**28.7%**	**19.7%**	**10.1%**	**$1,469,203**	**15.8%**	**24.5%**	**13.0%**
Alabama	28,834	24.2	21.0	20.6	18,198	11.0	27.4	26.4
Alaska	11,148	20.5	14.9	7.1	7,395	9.1	19.4	9.0
Arizona	38,691	31.4	16.8	16.2	22,963	15.6	23.4	22.9
Arkansas	25,639	28.9	13.8	15.1	17,798	10.0	16.9	21.7
California	300,445	29.6	20.4	7.2	203,243	16.4	26.5	7.9
Colorado	42,793	23.2	23.9	13.7	32,533	13.4	29.6	16.6
Connecticut	34,420	23.8	11.8	9.7	27,963	15.6	12.4	11.1
Delaware	11,325	19.3	24.1	3.7	8,922	8.5	28.3	4.1
District of Columbia	13,748	22.6	20.5	1.4	10,292	8.5	25.0	1.6
Florida	82,575	31.4	18.3	9.9	53,977	20.1	24.6	15.0
Georgia	53,921	21.1	24.7	19.3	38,812	9.5	27.9	26.2
Hawaii	15,619	14.9	14.0	7.7	13,091	6.1	14.7	9.1
Idaho	8,422	27.5	26.1	8.8	5,485	15.0	34.8	13.5
Illinois	71,840	26.0	14.9	2.9	55,857	12.9	15.2	3.4
Indiana	34,087	36.0	28.2	5.8	20,502	18.4	41.7	9.7
Iowa	23,441	24.7	16.5	26.9	16,915	13.7	20.0	34.6
Kansas	16,928	20.9	30.0	17.6	12,839	11.9	35.8	20.4
Kentucky	34,837	29.2	17.2	23.6	22,170	10.5	22.9	33.2
Louisiana	32,257	36.1	16.5	8.8	19,599	16.5	21.0	14.2
Maine	8,813	33.8	17.7	3.6	6,016	18.5	22.4	5.3
Maryland	45,121	25.8	18.4	15.6	32,723	14.1	21.9	18.4
Massachusetts	59,818	29.8	13.7	2.4	44,970	20.7	15.4	3.1
Michigan	59,624	31.1	24.5	4.0	37,838	14.7	34.1	6.1
Minnesota	40,845	30.7	25.5	4.5	29,648	18.5	32.5	6.1
Mississippi	19,161	26.7	16.9	20.5	11,320	11.0	22.3	33.2

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	$26,403	38.4%	22.6%	4.2%	$17,913	26.3%	27.9%	6.2%
Montana	7,174	25.2	14.6	9.2	4,190	9.8	20.5	15.5
Nebraska	12,109	18.3	13.7	24.4	9,318	11.5	14.0	25.7
Nevada	16,073	25.1	13.5	6.4	10,858	9.0	17.0	9.5
New Hampshire	6,224	35.2	20.2	2.2	3,911	23.9	27.4	3.5
New Jersey	64,166	24.4	23.7	8.9	48,056	12.2	29.8	11.9
New Mexico	19,642	28.9	17.3	15.4	11,623	10.7	25.3	20.9
New York	170,875	35.3	19.2	6.4	110,459	19.3	26.0	9.6
North Carolina	49,162	29.1	23.9	13.8	34,812	13.8	29.3	19.2
North Dakota	6,393	18.8	18.8	20.1	4,696	10.2	22.2	25.0
Ohio	71,003	38.0	16.7	4.1	55,586	33.0	17.9	5.2
Oklahoma	23,833	24.3	16.9	23.0	15,680	15.8	20.8	29.0
Oregon	42,642	22.0	12.8	3.2	31,806	7.8	15.1	4.2
Pennsylvania	88,931	36.4	17.3	2.2	58,442	23.6	21.9	3.4
Rhode Island	9,736	28.6	14.9	13.1	6,617	17.3	18.7	19.1
South Carolina	26,074	26.0	19.3	20.6	17,633	11.5	23.2	29.7
South Dakota	4,488	20.4	16.3	18.4	3,037	12.1	18.5	24.8
Tennessee	33,826	33.9	18.9	14.6	21,347	20.6	24.6	22.8
Texas	121,036	29.3	25.7	14.9	78,466	15.4	32.4	17.5
Utah	16,601	18.1	24.6	13.2	12,688	8.4	29.3	17.1
Vermont	5,836	28.7	32.8	1.7	3,949	17.9	45.7	2.5
Virginia	55,263	20.4	14.7	14.4	43,816	12.5	16.1	16.1
Washington	50,512	25.1	28.1	13.0	37,655	12.5	34.9	17.5
West Virginia	17,946	22.5	13.3	15.3	13,254	6.6	15.2	18.8
Wisconsin	50,243	21.0	16.4	14.3	38,456	12.7	19.4	14.4
Wyoming	4,708	13.3	18.7	9.3	3,864	7.6	22.7	11.3

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 do not 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, 2020, *2020 State expenditure report: Fiscal years 2018–2020*, Washington, DC: NASBO, https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives.

EXHIBIT 6. Federal Medical Assistance Percentages and Enhanced FMAPs by State, FYs 2019–2022

State	FMAPs for Medicaid						E-FMAPs for CHIP					
	FY 2019[1]	FY 2020[1]	FY 2020 (Emergency)[2]	FY 2021[1]	FY 2021 (Emergency)[2]	FY 2022[1, 3]	FY 2019[4]	FY 2020[5]	FY 2020 (Emergency)[5, 6]	FY 2021[3]	FY 2021 (Emergency)[6]	FY 2022[3]
Alabama	71.88%	71.97%	78.17%	72.58%	78.78%	72.37%	100.00%	91.88%	96.22%	80.81%	85.15%	80.66%
Alaska	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Arizona	69.81	70.02	76.22	70.01	76.21	70.01	100.00	90.51	94.85	79.01	83.35	79.01
Arkansas	70.51	71.42	77.62	71.23	77.43	71.62	100.00	91.49	95.83	79.86	84.20	80.13
California	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Colorado	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Connecticut	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Delaware	57.55	57.86	64.06	57.74	63.94	57.72	93.29	82.00	86.34	70.42	74.76	70.40
District of Columbia	70.00	70.00	76.20	70.00	76.20	70.00	100.00	90.50	94.84	79.00	83.34	79.00
Florida	60.87	61.47	67.67	61.96	68.16	61.03	95.61	84.53	88.87	73.37	77.71	72.72
Georgia	67.62	67.30	73.50	67.03	73.23	66.85	100.00	88.61	92.95	76.92	81.26	76.80
Hawaii	53.92	53.47	59.67	53.02	59.22	53.64	90.74	78.93	83.27	67.11	71.45	67.55
Idaho	71.13	70.34	76.54	70.41	76.61	70.21	100.00	90.74	95.08	79.29	83.63	79.15
Illinois	50.31	50.14	56.34	50.96	57.16	51.09	88.22	76.60	80.94	65.67	70.01	65.76
Indiana	65.96	65.84	72.04	65.83	72.03	66.30	99.17	87.59	91.93	76.08	80.42	76.41
Iowa	59.93	61.20	67.40	61.75	67.95	62.14	94.95	84.34	88.68	73.23	77.57	73.50
Kansas	57.10	59.16	65.36	59.68	65.88	60.16	92.97	82.91	87.25	71.78	76.12	72.11
Kentucky	71.67	71.82	78.02	72.05	78.25	72.75	100.00	91.77	96.11	80.44	84.78	80.93
Louisiana	65.00	66.86	73.06	67.42	73.62	68.02	98.50	88.30	92.64	77.19	81.53	77.61
Maine	64.52	63.80	70.00	63.69	69.89	64.00	98.16	86.16	90.50	74.58	78.92	74.80
Maryland	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Massachusetts	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Michigan	64.45	64.06	70.26	64.08	70.28	65.48	98.12	86.34	90.68	74.86	79.20	75.84
Minnesota	50.00	50.00	56.20	50.00	56.20	50.51	88.00	76.50	80.84	65.00	69.34	65.36
Mississippi	76.39	76.98	83.18	77.76	83.96	78.31	100.00	95.39	99.73	84.43	88.77	84.82
Missouri	65.40	65.65	71.85	64.96	71.16	66.36	98.78	87.46	91.80	75.47	79.81	76.45
Montana	65.54	64.78	70.98	65.60	71.80	64.90	98.88	86.85	91.19	75.92	80.26	75.43
Nebraska	52.58	54.72	60.92	56.47	62.67	57.80	89.81	79.80	84.14	69.53	73.87	70.46
Nevada	64.87	63.93	70.13	63.30	69.50	62.59	98.41	86.25	90.59	74.31	78.65	73.81

EXHIBIT 6. (continued)

State	FMAPs for Medicaid						E-FMAPs for CHIP					
	FY 2019[1]	FY 2020[1]	FY 2020 (Emergency)[2]	FY 2021[1]	FY 2021 (Emergency)[2]	FY 2022[1, 3]	FY 2019[4]	FY 2020[5]	FY 2020 (Emergency)[5, 6]	FY 2021[3]	FY 2021 (Emergency)[6]	FY 2022[3]
New Hampshire	50.00%	50.00%	56.20%	50.00%	56.20%	50.00%	88.00%	76.50%	80.84%	65.00%	69.34%	65.00%
New Jersey	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
New Mexico	72.26	72.71	78.91	73.46	79.66	73.71	100.00	92.40	96.74	81.42	85.76	81.60
New York	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
North Carolina	67.16	67.03	73.23	67.40	73.60	67.65	100.00	88.42	92.76	77.18	81.52	77.36
North Dakota	50.00	50.05	56.25	52.40	58.60	53.59	88.00	76.54	80.88	66.68	71.02	67.51
Ohio	63.09	63.02	69.22	63.63	69.83	64.10	97.16	85.61	89.95	74.54	78.88	74.87
Oklahoma	62.38	66.02	72.22	67.99	74.19	68.31	96.67	87.71	92.05	77.59	81.93	77.82
Oregon	62.56	61.23	67.43	60.84	67.04	60.22	96.79	84.36	88.70	72.59	76.93	72.15
Pennsylvania	52.25	52.25	58.45	52.20	58.40	52.68	89.58	78.08	82.42	66.54	70.88	66.88
Rhode Island	52.57	52.95	59.15	54.09	60.29	54.88	89.80	78.57	82.91	67.86	72.20	68.42
South Carolina	71.22	70.70	76.90	70.63	76.83	70.75	100.00	90.99	95.33	79.44	83.78	79.53
South Dakota	56.71	57.62	63.82	58.28	64.48	58.69	92.70	81.83	86.17	70.80	75.14	71.08
Tennessee	65.87	65.21	71.41	66.10	72.30	66.36	99.11	87.15	91.49	76.27	80.61	76.45
Texas	58.19	60.89	67.09	61.81	68.01	60.80	93.73	84.12	88.46	73.27	77.61	72.56
Utah	69.71	68.19	74.39	67.52	73.72	66.83	100.00	89.23	93.57	77.26	81.60	76.78
Vermont	53.89	53.86	60.06	54.57	60.77	56.47	90.72	79.20	83.54	68.20	72.54	69.53
Virginia	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
Washington	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
West Virginia	74.34	74.94	81.14	74.99	81.19	74.68	100.00	93.96	98.30	82.49	86.83	82.28
Wisconsin	59.37	59.36	65.56	59.37	65.57	59.88	94.56	83.05	87.39	71.56	75.90	71.92
Wyoming	50.00	50.00	56.20	50.00	56.20	50.00	88.00	76.50	80.84	65.00	69.34	65.00
American Samoa[7]	55.00	83.00	89.20	83.00	89.20	55.00	91.50	99.60	100.00	88.10	92.44	68.50
Guam[7]	55.00	83.00	89.20	83.00	89.20	55.00	91.50	99.60	100.00	88.10	92.44	68.50
N. Mariana Islands[7]	55.00	83.00	89.20	83.00	89.20	55.00	91.50	99.60	100.00	88.10	92.44	68.50
Puerto Rico[7]	55.00	76.00	82.20	76.00	82.20	55.00	91.50	94.70	99.04	83.20	87.54	68.50
Virgin Islands[7]	55.00	83.00	89.20	83.00	89.20	55.00	91.50	99.60	100.00	88.10	92.44	68.50

EXHIBIT 6. (continued)

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 2019–2020, the E-FMAPs are then increased by a set number of percentage points determined by statute.[4, 5]

[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 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 2022 FMAPs and E-FMAPs will also receive the temporary increase for any quarters during which the public health emergency is still in effect after September 30, 2021.

[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 of 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 off of these increased FMAPs. The FMAPs and E-FMAPs for the period December 21, 2019–September 30, 2021 are listed.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for FYs 2019–2022; Further Consolidated Appropriations Act, 2020 (P.L. 116-94); Centers for Medicare & Medicaid Services, *COVID-19 frequently asked questions (FAQs) for state Medicaid and Children's Health Insurance Program (CHIP) agencies*, updated January 6, 2021, Baltimore, MD: CMS, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf; Center for Medicaid and CHIP Services, CMS. 2020. E-mail 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 8.9 percent from July 2020 to May 2021. This follows a 6.1 percent increase in Medicaid and CHIP enrollment from July 2019 to July 2020. Much of this increase from July 2019 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 (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 with 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 9.9 percent from FY 2013 through FY 2019.
  - Individuals age 65 and older generally have the slowest growth rate regardless of time period (Exhibit 7).
- 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 since 2015, but most recently, decreased slightly from 2018 to 2019 (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 1975–2019 (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
2003	**50,716**	23,742	11,530	7,664	4,041	3,739

EXHIBIT 7. (continued)

Fiscal year	Total	Child	Adult[1]	Disabled	Aged	Unknown
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
2019	**81,655**	29,998	29,792	8,811	6,265	6,789

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 beneficiary count for the disabled category in 2018 and subsequent years 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.

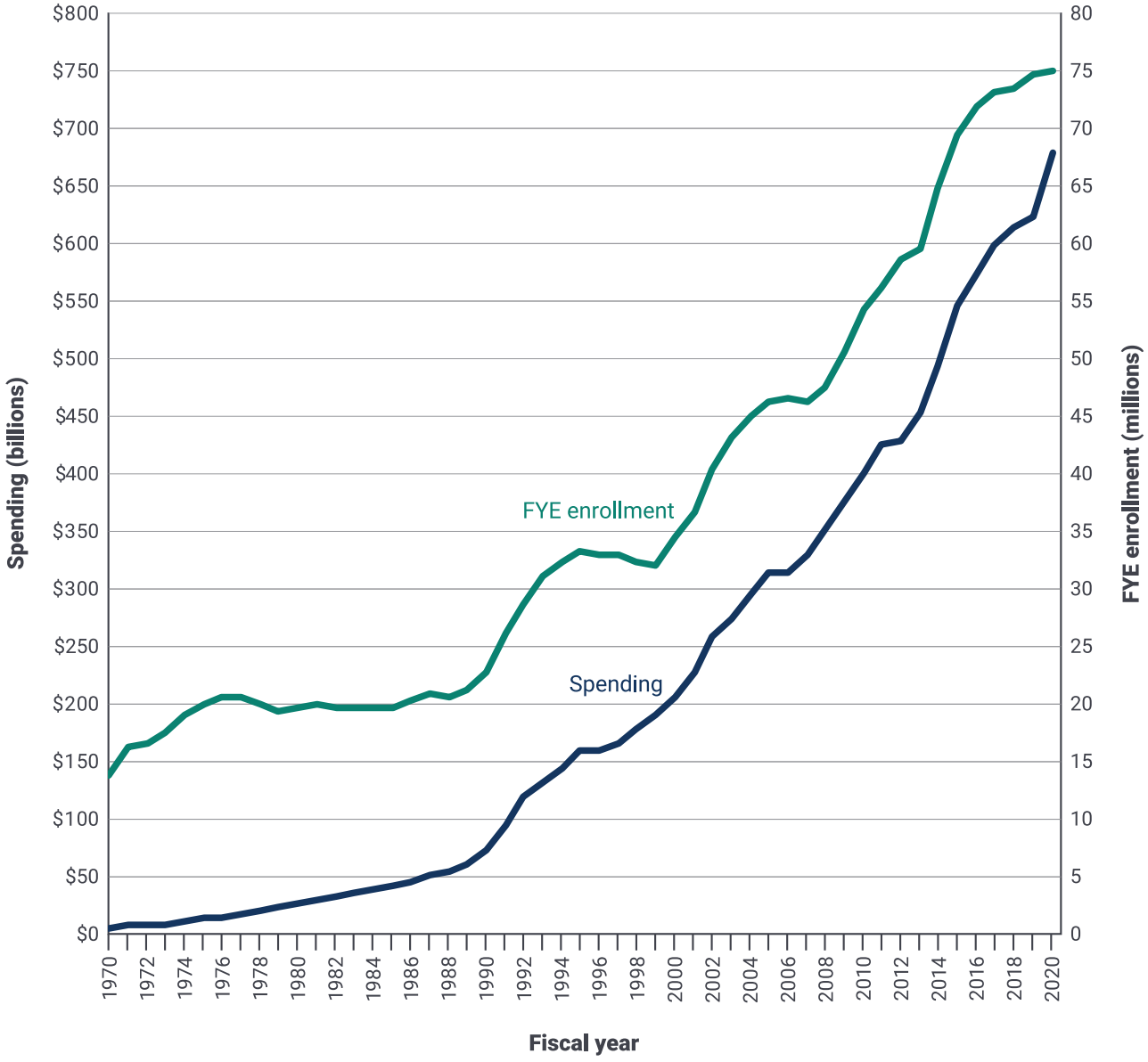
For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The national enrollment counts shown here are unduplicated using this national 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 2019: MACPAC, 2021, analysis of T-MSIS data as of December 2020. 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: Centers for Medicare & Medicaid Services, *Medicare & Medicaid statistical supplement,* 2010 edition, Table 13.4, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2010_Section13.pdf#Table%2013.4.

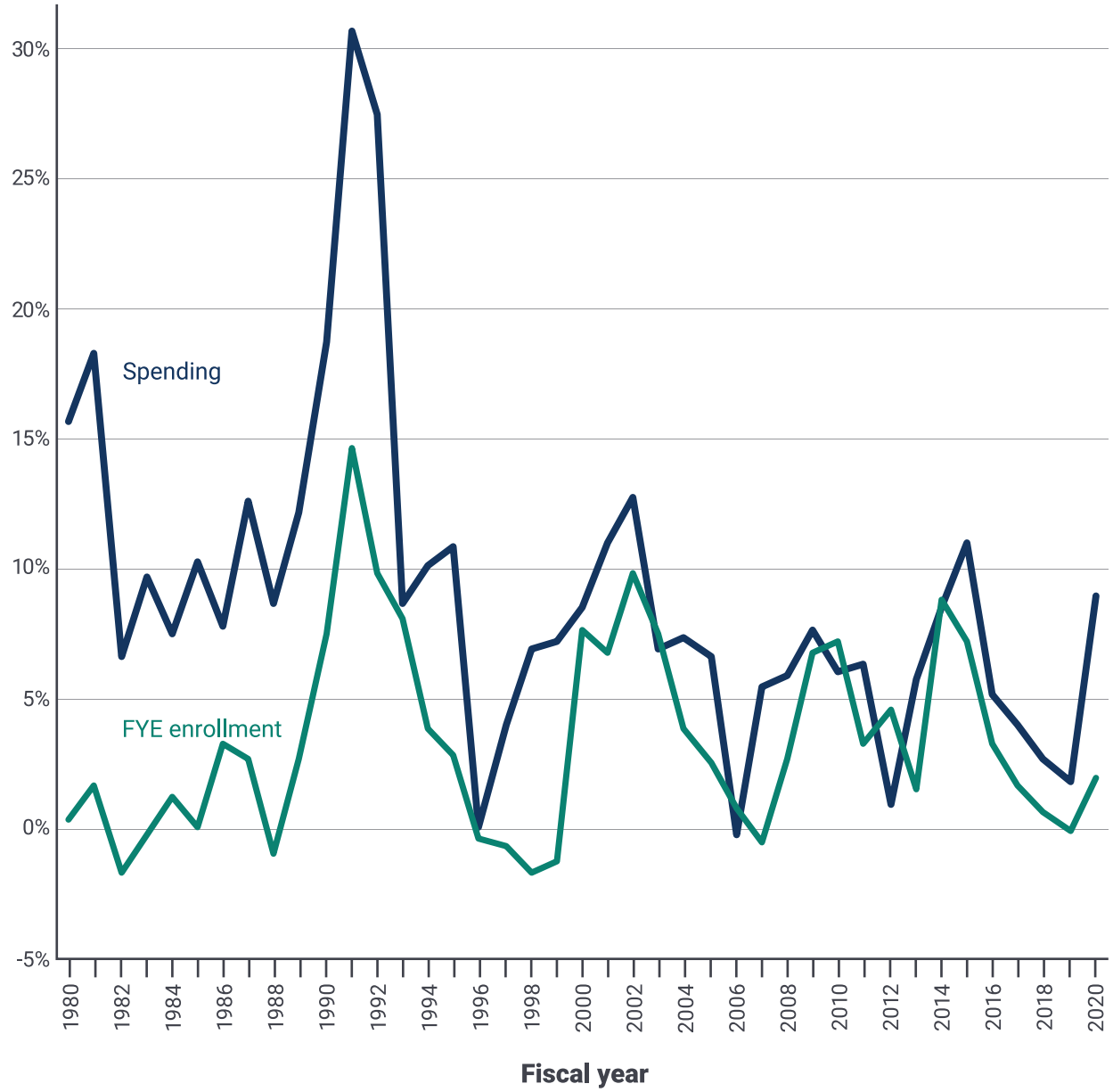
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1970–2020



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 2013–2020 are projected. Enrollment for FYs 1999–2020 include estimates for the territories.

Sources: For FYs 2019 and 2020: OACT, CMS, 2021, data compilation provided to MACPAC, September 21. OACT, CMS, 2020, data compilation provided to MACPAC, October 19.

EXHIBIT 9. Annual Growth in Medicaid Enrollment and Spending, FYs 1980–2020



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 2013–2020 are projected. Enrollment for FYs 1999–2020 include estimates for the territories.

Sources: For FYs 2019 and 2020: OACT, CMS, 2021, data compilation provided to MACPAC, September 21. OACT, CMS, 2020, data compilation provided to MACPAC, October 19.

EXHIBIT 10. Medicaid Enrollment and Total Spending Levels and Annual Growth, FYs 1970–2020

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
2000	206	34.5	5,972	8.6	7.7	0.8

EXHIBIT 10. (continued)

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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	627	73.9	8,487	1.8	0.0	1.8
2020	683	75.3	9,070	8.9	1.9	6.9

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 2013–2020 are projected. Enrollment for FYs 1999–2020 include estimates for the territories.

Sources: For FYs 2019 and 2020: OACT, CMS, 2021, data compilation provided to MACPAC, September 21. OACT, CMS, 2020, data compilation provided to MACPAC, October 19.

EXHIBIT 11. Full-Benefit Medicaid and CHIP Enrollment, Selected Months in 2013–2021

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2018	July 2019	July 2020	May 2021	July 2018 to July 2019	July 2019 to July 2020	July 2020 to May 2021	July–September 2013 average to May 2021
Total	**56,511,799**[1]	**72,519,324**	**71,586,539**	**75,965,109**	**82,761,078**	**-1.3%**	**6.1%**	**8.9%**	**44.2%**[2]
Alabama	799,176[3]	898,978	915,545	959,675	1,034,994	1.8	4.8	7.8	20.1
Alaska	122,334	211,609	223,117	233,334	247,581	5.4	4.6	6.1	90.7
Arizona	1,201,770	1,688,791	1,715,655	1,862,408	2,044,604	1.6	8.6	9.8	55.0
Arkansas	556,851	839,797	798,044	843,515	917,474	-5.0	5.7	8.8	51.5
California	7,755,381	12,059,138	11,743,500	12,016,056	12,810,442	-2.6	2.3	6.6	54.9
Colorado	783,420	1,350,594	1,291,058	1,368,198	1,563,445	-4.4	6.0	14.3	74.6
Connecticut	–	845,276	857,415	885,365	951,563	1.4	3.3	7.5	–
Delaware	223,324	231,090	231,571	241,814	267,045	0.2	4.4	10.4	8.3
District of Columbia	235,786[4, 5]	254,646	256,101	253,009	267,598	0.6	-1.2	5.8	7.3
Florida	3,695,306	3,729,831	3,657,394	3,930,734	4,281,662	-1.9	7.5	8.9	6.4
Georgia	1,535,090	1,874,411	1,848,553	1,970,507	2,159,944	-1.4	6.6	9.6	28.4
Hawaii	288,357	337,722	328,393	357,858	406,876	-2.8	9.0	13.7	24.1
Idaho	238,150	274,741	265,493	347,777	394,436	-3.4	31.0	13.4	46.0
Illinois	2,626,943	2,974,380	2,843,003	3,032,490	3,331,614	-4.4	6.7	9.9	15.4
Indiana	1,120,674	1,448,302	1,461,778	1,649,380	1,850,103	0.9	12.8	12.2	47.2
Iowa	493,515	662,978	678,370	711,187	775,710	2.3	4.8	9.1	44.1
Kansas	378,160	386,547	370,250	406,698	443,921	-4.2	9.8	9.2	7.5
Kentucky	606,805	1,339,911	1,307,459	1,465,221	1,582,081	-2.4	12.1	8.0	141.5
Louisiana	1,019,787	1,449,055	1,516,298	1,623,090	1,745,824	4.6	7.0	7.6	59.2
Maine	–	230,826	257,603	291,569	320,251	11.6	13.2	9.8	–
Maryland	856,297	1,312,271	1,326,315	1,392,038	1,510,290	1.1	5.0	8.5	62.6
Massachusetts	1,296,359	1,609,281	1,572,581	1,640,354	1,779,418	-2.3	4.3	8.5	26.5
Michigan	1,912,009	2,355,527[6]	2,305,227[6]	2,487,485[6]	2,733,485[6]	-2.1	7.9	9.9	30.1
Minnesota	873,040[7]	1,086,267	1,046,325	1,108,531	1,214,107	-3.7	5.9	9.5	27.0
Mississippi	615,556	628,519	620,982	645,270	701,409	-1.2	3.9	8.7	4.8

EXHIBIT 11. (continued)

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2018	July 2019	July 2020	May 2021	July 2018 to July 2019	July 2019 to July 2020	July 2020 to May 2021	July–September 2013 average to May 2021
Missouri	846,084	956,346	860,768	951,731	1,064,287	-10.0%	10.6%	11.8%	12.5%
Montana	148,974	280,638	270,280	259,433	288,786	-3.7	-4.0	11.3	74.1
Nebraska	244,600	248,379	246,175	261,168	324,200	-0.9	6.1	24.1	6.8
Nevada	332,560	655,533	632,838	695,931	790,368	-3.5	10.0	13.6	109.3
New Hampshire	127,082	185,233	178,761	197,601	220,849	-3.5	10.5	11.8	55.5
New Jersey	1,283,851	1,788,090	1,721,103	1,806,736	1,973,335	-3.7	5.0	9.2	40.7
New Mexico	457,678	736,359	735,977	782,159	838,590	-0.1	6.3	7.2	70.9
New York	5,678,417	6,152,207	6,097,811	6,349,834	6,832,700[8]	-0.9	4.1	7.6	11.8
North Carolina	1,595,952	1,772,526	1,738,840	1,900,966	2,072,202	-1.9	9.3	9.0	19.1
North Dakota	69,980[9]	93,970	89,895	98,657	111,357	-4.3	9.7	12.9	41.0
Ohio	2,130,322	2,727,615	2,642,614	2,819,633	3,051,328	-3.1	6.7	8.2	32.4
Oklahoma	790,051	739,877	735,152	809,286	887,980	-0.6	10.1	9.7	2.4
Oregon	626,356[10]	972,808	986,744	1,069,272	1,198,138	1.4	8.4	12.1	70.7
Pennsylvania	2,386,046	2,989,593	2,962,254	3,112,613	3,344,155	-0.9	5.1	7.4	30.5
Rhode Island	190,833	311,231	301,142	309,281	334,556	-3.2	2.7	8.2	62.1
South Carolina	889,744	1,030,392	1,058,406	1,077,781	1,159,844	2.7	1.8	7.6	21.1
South Dakota	115,501	112,018	110,329	115,715	127,829	-1.5	4.9	10.5	0.2
Tennessee	1,244,516	1,443,541	1,440,224	1,511,991	1,619,678	-0.2	5.0	7.1	21.5
Texas	4,203,449	4,355,227	4,202,466	4,531,429	5,000,327	-3.5	7.8	10.3	7.8
Utah	294,029[5]	296,702[5]	309,995[5]	349,201[5]	415,131[5]	4.5	12.6	18.9	18.8
Vermont	161,081	162,726	154,546	163,055	177,688	-5.0	5.5	9.0	1.2
Virginia	935,434	1,046,260	1,336,892	1,529,228	1,708,166	27.8	14.4	11.7	63.5
Washington	1,117,576	1,758,023	1,722,799	1,811,777	1,965,401	-2.0	5.2	8.5	62.1
West Virginia	354,544	531,645	516,288	528,335	581,329	-2.9	2.3	10.0	49.0
Wisconsin	985,531[11]	1,032,239	1,040,306	1,137,130	1,269,139	0.8	9.3	11.6	15.4
Wyoming	67,518	59,658	55,904	61,603	67,838	-6.3	10.2	10.1	-8.8

EXHIBIT 11. (continued)

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. May 2021 data are shown here as it was the most recent month at the time of publication.

– Dash indicates that state did not report data.

[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] Includes limited-benefit enrollees.

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

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

[7] May include duplicates.

[8] Includes retroactive enrollment.

[9] Data are for July 2013 only.

[10] Includes emergency Medicaid population.

[11] Excludes retroactive enrollment.

Source: MACPAC, 2021, analysis of CMS, 2021, State Medicaid and CHIP applications, eligibility determinations, and enrollment data, accessed on October 27, 2021, https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360.

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.

^ Values have not been updated from those published in the December 2020 data book due to a delay in the release of health care spending projections for categories within the National Health Expenditure Accounts.

[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: MACPAC, 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; 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.

EXHIBIT 13. Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1993–2019

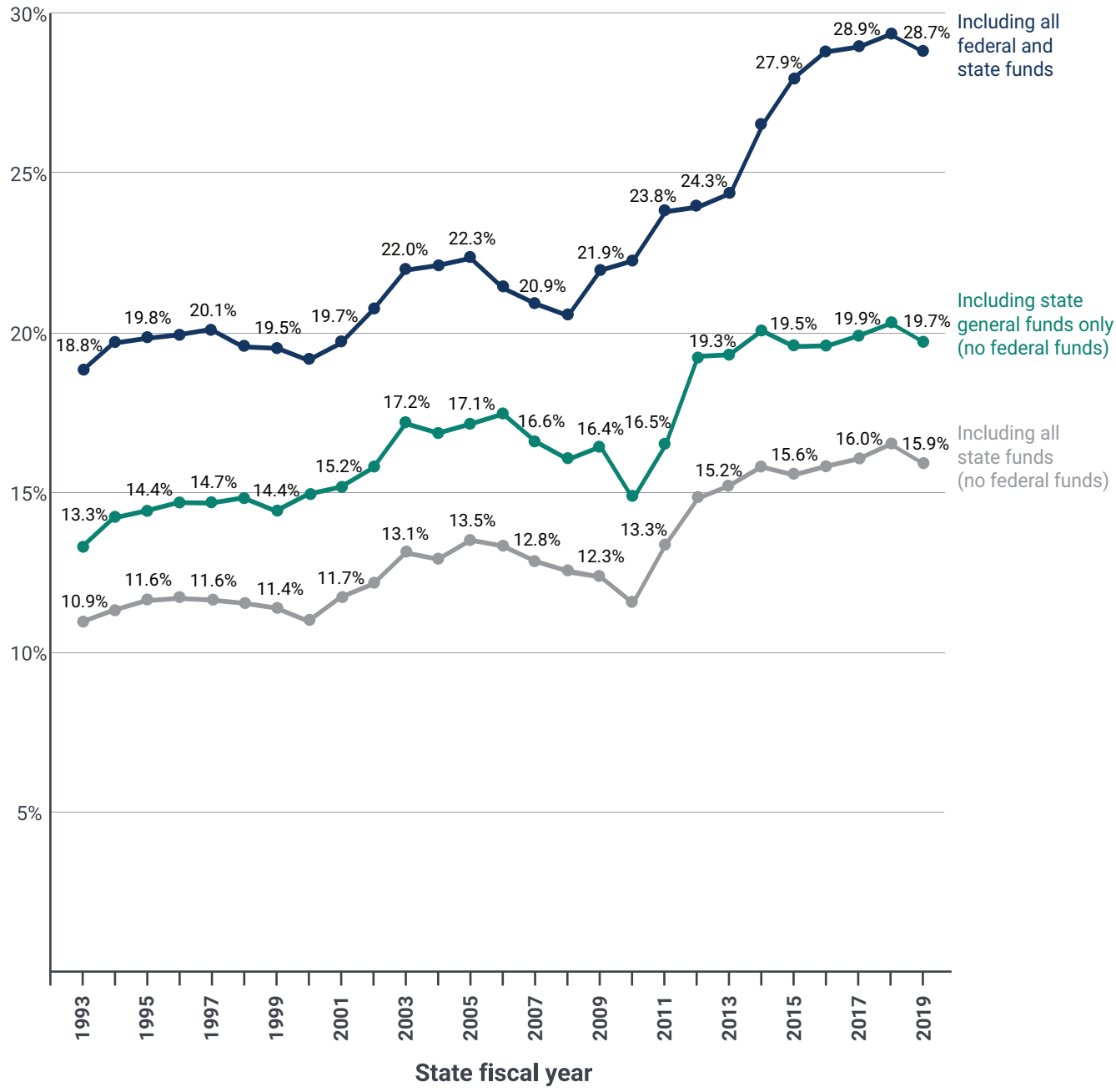


EXHIBIT 13. (continued)

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
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	20.1	14.7	11.6
1998	19.6	14.8	11.5
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	16.4	12.3
2010	22.2	14.8	11.6
2011	23.8	16.5	13.3
2012	23.9	19.2	14.8
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	29.3	20.3	16.5
2019	28.7	19.7	15.9

Notes: SFY is state fiscal year. Amounts shown here reflect the most recent information available in cases in which 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, 2021, 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 $688.0 billion in fiscal year (FY) 2020 (Exhibit 16). Spending for the State Children's Health Insurance Program (CHIP) was $19.8 billion (Exhibit 33).
- The federal share was 67.6 percent of total Medicaid benefit spending in FY 2020, compared with an average federal share of approximately 63 percent since 2015. This increase in federal spending is due to the 6.2 percentage point increase in the federal medical assistance percentage (FMAP) under the Families First Coronavirus Response Act (P.L. 116-127) that was retroactively applied back to January 1, 2020 (Exhibit 16).
- In FY 2019, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 22 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 5.4 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 24 percent of enrollees and 18 percent of spending in FY 2019 (Exhibits 14 and 21). This group is composed primarily of those newly eligible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) but includes some adults who were previously eligible in states that expanded Medicaid prior to the ACA.
- Over 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 (50.8 percent) of enrollees who are eligible on the basis of disability and over one-third (35.8 percent) of enrollees age 65 and older were enrolled in comprehensive managed care in FY 2019, 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 (54.6 percent) in FY 2020 (Exhibit 28). The majority (64.9 percent) of Medicaid gross spending for drugs occurred under managed care in FY 2020 (Exhibit 26).
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for over half (54.0 percent) of fee-for-service payments to hospitals in FY 2020 (Exhibit 24).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2019 (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	**82,955**	**31,113**	**19,504**	**14,489**	**9,765**	**8,083**	**12,513**	**7,639**	**9,031**	**5,495**	**3,482**	**2,145**
Alabama	**1,126**	547	–	222	224	133	**241**	133	**98**	52	**143**	81
Alaska	**244**	103	60	51	17	14	**23**	13	**21**	12	**1**	1
Arizona	**2,162**	783	561	456	184	178	**280**	169	**222**	130	**57**	39
Arkansas	**1,030**	369	351	72	158	80	**152**	79	**81**	46	**72**	32
California[5]	**14,731**	3,789	4,663	3,851	988	1,440	**1,747**	1,300	**1,686**	1,253	**62**	48
Colorado	**1,460**	497	515	243	118	87	**149**	87	**99**	56	**49**	31
Connecticut	**1,094**	359	316	196	73	149	**206**	143	**79**	48	**127**	95
Delaware	**284**	103	81	52	27	20	**36**	20	**17**	9	**19**	11
District of Columbia[6]	**274**	81	73	56	36	28	**40**	26	**27**	16	**13**	10
Florida	**4,621**	2,339	–	925	660	698	**981**	670	**544**	376	**437**	294
Georgia	**2,333**	1,257	–	452	378	247	**393**	241	**170**	102	**223**	138
Hawaii	**374**	130	135	49	24	36	**51**	35	**44**	30	**7**	5
Idaho	**326**	191	–	49	54	31	**56**	29	**33**	16	**23**	13
Illinois[6, 7]	**3,236**	776	1,820	134	214	293	**418**	244	**366**	212	**52**	32
Indiana	**1,716**	675	530	196	202	113	**252**	125	**172**	83	**80**	42
Iowa	**754**	288	217	114	85	49	**101**	49	**79**	35	**22**	14
Kansas	**446**	247	–	74	81	43	**79**	40	**47**	24	**32**	16
Kentucky[6]	**1,568**	468	619	150	224	106	**223**	107	**127**	62	**95**	45
Louisiana[7]	**1,727**	619	585	214	211	97	**270**	147	**161**	84	**109**	63
Maine[6]	**333**	109	45	53	70	56	**99**	55	**60**	28	**38**	28
Maryland	**1,439**	527	378	276	153	105	**174**	101	**99**	56	**74**	45
Massachusetts	**1,941**	442	391	510	371	226	**386**	200	**362**	177	**24**	23
Michigan	**2,842**	1,018	880	387	367	191	**372**	187	**299**	151	**72**	35
Minnesota	**1,342**	617	265	244	123	92	**160**	86	**144**	76	**17**	10
Mississippi	**776**	379	–	123	172	102	**189**	101	**96**	50	**93**	51
Missouri	**1,177**	677	–	188	203	108	**212**	102	**166**	79	**46**	23

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+
Montana	**300**	110	123	24	25	18	**34**	18	**24**	12	**10**	6
Nebraska	**264**	149	–	47	41	26	**46**	24	**40**	21	**5**	3
Nevada	**826**	324	297	82	67	56	**91**	55	**39**	22	**52**	32
New Hampshire	**228**	86	78	17	28	19	**39**	17	**24**	11	**15**	6
New Jersey	**1,872**	680	708	138	180	166	**262**	156	**260**	155	**2**	1
New Mexico	**925**	330	298	168	70	59	**114**	69	**60**	34	**54**	34
New York	**6,990**	1,952	2,505	1,033	664	835	**1,132**	777	**918**	620	**214**	158
North Carolina	**2,345**	1,096	–	666	372	211	**377**	208	**283**	152	**94**	56
North Dakota[5]	**116**	48	31	15	12	10	**18**	10	**15**	9	**3**	2
Ohio	**3,114**	1,141	811	507	418	237	**416**	212	**280**	144	**136**	68
Oklahoma	**894**	510	–	191	119	74	**135**	71	**108**	57	**26**	14
Oregon	**1,074**	332	486	130	59	68	**120**	69	**59**	33	**60**	36
Pennsylvania	**3,237**	994	972	335	627	309	**482**	307	**377**	247	**105**	60
Rhode Island	**332**	95	92	68	42	34	**52**	29	**44**	24	**9**	5
South Carolina	**1,344**	623	–	442	179	100	**186**	99	**177**	92	**10**	6
South Dakota	**129**	73	–	22	21	13	**24**	13	**15**	9	**9**	5
Tennessee	**1,691**	854	–	408	273	156	**304**	155	**168**	76	**137**	79
Texas[8]	**4,990**	3,173	0	523	731	563	**808**	532	**424**	284	**383**	248
Utah[5, 6, 9]	**274**	180	49	35	5	5	**6**	4	**5**	3	**2**	1
Vermont	**194**	69	70	10	22	22	**32**	18	**23**	11	**9**	7
Virginia[6]	**1,555**	601	0	628	194	132	**224**	122	**149**	83	**75**	39
Washington[6]	**2,081**	850	837	69	191	135	**229**	129	**155**	89	**73**	39
West Virginia	**623**	205	211	61	97	50	**85**	42	**50**	23	**34**	18
Wisconsin	**1,304**	479	–	486	190	149	**196**	99	**169**	81	**27**	18
Wyoming	**76**	42	–	13	12	9	**12**	6	**7**	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 are 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 has a state plan amendment (SPA) that allows the state to receive the enhanced federal medical assistance percentage (FMAP) for Medicaid children who 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 the 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 242,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 11,000.

[6] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 39 percent less than the benchmark; Illinois's average monthly enrollment was 117 percent more than the benchmark; Kentucky's average monthly enrollment was 26 percent more than the benchmark; Maine's average monthly enrollment was 65 percent more than the benchmark; and Washington's average monthly enrollment was 29 percent more than the benchmark. Utah reported an average monthly enrollment in the new adult group of approximately 30,000 in T-MSIS but did not report any enrollment on the CMS-64 enrollment report. Virginia did not report any enrollees in the new adult group compared with approximately 198,000 average monthly enrollees on the CMS-64 enrollment report; Virginia expanded coverage to the new adult group beginning January 1, 2019, and may not be reporting enrollment under the correct eligibility code in T-MSIS.

[7] State reported a large shift of enrollees between eligibility groups. Illinois reported about a 43 percent decrease for the child group, a 35 percent decrease for the disabled group, an 87 percent decrease for the other adult group, and a 543 percent increase in the new adult group compared with 2018; the state appears to have corrected its reporting of the new adult group but appears to have also reclassified some children, other adult, and disabled beneficiaries into the new adult group. Louisiana reported a 27 percent decrease in the aged group and a 50 percent increase in the other adult group compared with 2018.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2019.

[9] State reported total enrollment that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. Utah's average monthly enrollment was 24 percent less than the benchmark, and the ever enrolled total was 29 percent less than what was reported in T-MSIS in 2018.

Source: MACPAC, 2021, analysis of T-MSIS data as of December 2020.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2019 (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	**70,179**	**63,837**	**26,609**	**26,486**	**15,852**	**15,382**	**11,353**	**8,676**	**9,152**	**7,992**	**7,213**	**5,301**
Alabama	**960**	**745**	457	457	–	–	175	91	206	150	122	47
Alaska	**210**	**209**	87	87	52	52	43	43	16	16	12	11
Arizona	**1,846**	**1,678**	675	665	450	420	389	316	171	155	161	122
Arkansas	**859**	**795**	312	312	269	269	59	59	148	113	71	42
California[4]	**12,299**	**10,432**	3,245	3,194	3,847	3,463	2,950	1,598	938	925	1,320	1,252
Colorado	**1,188**	**1,146**	420	420	387	386	200	200	107	91	75	49
Connecticut	**965**	**846**	319	319	273	273	168	167	69	40	136	48
Delaware	**236**	**210**	87	86	64	64	42	35	25	18	18	8
District of Columbia[5]	**248**	**237**	71	71	66	66	52	52	34	31	25	17
Florida	**3,784**	**3,272**	1,975	1,973	–	–	588	468	598	471	623	360
Georgia	**1,955**	**1,681**	1,058	1,058	–	–	333	257	345	269	219	97
Hawaii	**319**	**313**	114	114	109	109	40	40	22	21	33	29
Idaho	**261**	**240**	153	153	–	–	32	32	49	40	27	15
Illinois[5, 6]	**2,713**	**2,671**	670	670	1,496	1,496	103	102	192	177	252	226
Indiana	**1,354**	**1,227**	553	545	370	368	142	100	189	154	99	58
Iowa	**625**	**601**	237	236	176	176	90	86	80	73	42	30
Kansas	**364**	**335**	201	201	–	–	53	53	73	58	37	23
Kentucky[5]	**1,452**	**1,361**	434	434	567	567	139	138	215	168	97	55
Louisiana[6]	**1,537**	**1,431**	562	562	493	492	192	112	202	191	87	74
Maine[5]	**272**	**237**	88	88	29	29	41	40	65	55	50	25
Maryland	**1,258**	**1,172**	470	470	316	316	235	216	144	118	92	53
Massachusetts	**1,607**	**1,406**	365	342	300	298	392	255	348	347	202	165
Michigan	**2,377**	**2,296**	862	855	689	686	321	306	342	315	163	134
Minnesota	**1,061**	**1,035**	500	498	191	190	177	169	114	108	79	70
Mississippi	**664**	**545**	321	321	–	–	91	59	159	120	93	46

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	**956**	**917**	557	557	–	–	131	131	177	157	92	73
Montana	**252**	**242**	94	94	100	100	19	18	23	20	15	10
Nebraska	**216**	**212**	125	125	–	–	32	32	37	36	22	20
Nevada	**642**	**596**	258	258	216	216	60	58	60	43	48	21
New Hampshire	**185**	**172**	75	75	56	56	13	13	25	19	16	10
New Jersey	**1,545**	**1,511**	572	559	553	541	102	94	171	170	147	146
New Mexico	**797**	**689**	283	282	258	244	139	84	64	53	53	26
New York	**5,868**	**5,671**	1,665	1,663	2,031	2,029	797	789	629	580	745	610
North Carolina	**1,954**	**1,512**	889	888	–	–	535	180	343	307	187	138
North Dakota[4]	**87**	**85**	36	36	21	21	11	11	11	10	9	7
Ohio	**2,636**	**2,513**	976	976	623	622	432	431	397	336	208	147
Oklahoma	**685**	**628**	391	391	–	–	125	90	105	95	64	53
Oregon	**878**	**788**	273	272	387	367	105	90	54	33	59	27
Pennsylvania	**2,749**	**2,619**	848	838	765	758	280	259	585	545	271	218
Rhode Island	**280**	**270**	78	78	73	73	59	57	40	36	30	25
South Carolina	**1,185**	**969**	556	553	–	–	375	172	165	160	90	84
South Dakota	**105**	**98**	60	60	–	–	15	15	19	15	11	7
Tennessee	**1,532**	**1,406**	771	771	–	–	364	364	256	202	141	69
Texas[7]	**3,992**	**3,656**	2,549	2,549	0	0	286	285	664	546	494	276
Utah[4, 5, 8]	**185**	**184**	134	134	30	30	16	15	3	2	2	2
Vermont	**166**	**158**	61	61	57	57	8	8	21	19	20	14
Virginia[5]	**1,262**	**1,024**	496	496	0	0	472	301	180	148	114	79
Washington[5]	**1,747**	**1,666**	738	737	667	666	47	31	177	148	118	84
West Virginia	**520**	**490**	172	172	165	165	48	48	91	78	43	27
Wisconsin	**1,070**	**995**	400	397	–	–	363	314	178	170	129	113
Wyoming	**56**	**53**	31	31	–	–	8	8	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 are 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 enhanced federal medical assistance percentage (FMAP) for Medicaid children who 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 the 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 203,000, North Dakota's child FYE enrollment by approximately 2,200, and Utah's child FYE enrollment by approximately 8,600.

[5] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 39 percent less than the benchmark; Illinois's average monthly enrollment was 117 percent more than the benchmark; Kentucky's average monthly enrollment was 26 percent more than the benchmark; Maine's average monthly enrollment was 65 percent more than the benchmark; and Washington's average monthly enrollment was 29 percent more than the benchmark. Utah reported an average monthly enrollment in the new adult group of approximately 30,000 in T-MSIS but did not report any enrollment on the CMS-64 enrollment report. Virginia did not report any enrollees in the new adult group compared with approximately 198,000 average monthly enrollees on the CMS-64 enrollment report; Virginia expanded coverage to the new adult group beginning January 1, 2019, and may not be reporting enrollment under the correct eligibility code in T-MSIS.

[6] State reported a large shift of enrollees between eligibility groups. Illinois reported about a 44 percent decrease for the child group, a 36 percent decrease for the disabled group, an 88 percent decrease for the other adult group, and a 511 percent increase in the new adult group compared with 2018; the state appears to have corrected its reporting of the new adult group but appears to have also reclassified some children, other adult, and disabled beneficiaries into the new adult group. Louisiana reported a 29 percent decrease in the aged group and a 63 percent increase in the other adult group compared with 2018.

[7] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2019.

[8] State reported total enrollment that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. Utah's average monthly enrollment was 24 percent less than the benchmark and 34 percent less than what was reported in T-MSIS in 2018.

Source: MACPAC, 2021, analysis of T-MSIS data as of December 2020.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2020 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$6,096**	$4,678	$1,418	**$215**	$132	$83	**$6,311**	$4,810	$1,501
Alaska	**2,019**	1,529	490	**169**	105	65	**2,189**	1,634	555
Arizona	**14,380**	11,442	2,938	**292**	189	103	**14,672**	11,632	3,040
Arkansas	**6,620**	5,311	1,309	**461**	322	139	**7,080**	5,632	1,448
California	**97,210**	61,466	35,743	**6,677**	4,066	2,611	**103,887**	65,533	38,354
Colorado	**9,571**	5,821	3,750	**547**	354	193	**10,118**	6,175	3,943
Connecticut	**8,488**	5,297	3,191	**340**	215	126	**8,828**	5,512	3,316
Delaware	**2,376**	1,643	733	**82**	49	32	**2,458**	1,693	765
District of Columbia	**3,116**	2,403	714	**253**	172	82	**3,370**	2,574	796
Florida	**25,287**	16,823	8,465	**647**	384	263	**25,934**	17,207	8,727
Georgia	**11,299**	8,147	3,152	**525**	333	192	**11,824**	8,480	3,344
Hawaii	**2,331**	1,574	757	**101**	69	32	**2,432**	1,643	789
Idaho	**2,486**	1,915	571	**129**	83	46	**2,615**	1,998	617
Illinois	**22,388**	14,076	8,312	**935**	591	344	**23,323**	14,667	8,656
Indiana	**14,269**	10,699	3,570	**513**	326	188	**14,782**	11,025	3,758
Iowa	**5,823**	4,098	1,725	**141**	94	47	**5,963**	4,191	1,772
Kansas	**3,830**	2,450	1,380	**227**	161	66	**4,057**	2,612	1,446
Kentucky	**11,906**	9,606	2,299	**285**	201	84	**12,191**	9,807	2,384
Louisiana	**12,559**	9,603	2,956	**346**	235	111	**12,906**	9,838	3,067
Maine	**3,209**	2,277	932	**147**	98	49	**3,355**	2,374	981
Maryland	**11,902**	7,511	4,390	**524**	333	192	**12,426**	7,844	4,582
Massachusetts	**17,967**	10,681	7,286	**960**	581	380	**18,928**	11,262	7,666
Michigan	**19,111**	14,067	5,044	**669**	424	244	**19,780**	14,491	5,289
Minnesota	**13,612**	8,307	5,305	**753**	433	320	**14,365**	8,740	5,625
Mississippi	**5,596**	4,571	1,026	**173**	118	55	**5,769**	4,688	1,081
Missouri	**10,905**	7,729	3,177	**430**	265	165	**11,335**	7,994	3,341

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Montana	**$1,993**	$1,584	$409	**$101**	$70	$31	**$2,094**	$1,654	$440
Nebraska	**2,291**	1,365	926	**168**	122	46	**2,459**	1,486	972
Nevada	**4,120**	3,202	918	**196**	119	77	**4,315**	3,321	995
New Hampshire	**2,253**	1,366	887	**118**	77	41	**2,371**	1,443	928
New Jersey	**16,412**	10,224	6,188	**1,064**	633	430	**17,476**	10,857	6,618
New Mexico	**6,287**	5,185	1,103	**297**	200	97	**6,584**	5,385	1,199
New York	**70,674**	45,262	25,413	**2,142**	1,250	892	**72,816**	46,512	26,305
North Carolina	**14,778**	10,608	4,171	**829**	563	266	**15,608**	11,171	4,437
North Dakota	**1,274**	811	464	**100**	80	20	**1,374**	891	484
Ohio	**25,194**	18,231	6,963	**993**	585	408	**26,187**	18,816	7,371
Oklahoma	**4,971**	3,602	1,370	**203**	120	82	**5,174**	3,722	1,452
Oregon	**10,661**	7,980	2,681	**536**	330	206	**11,196**	8,310	2,886
Pennsylvania	**34,965**	21,953	13,012	**1,037**	633	405	**36,002**	22,586	13,417
Rhode Island	**2,810**	1,796	1,014	**151**	96	56	**2,961**	1,892	1,069
South Carolina	**6,652**	5,013	1,638	**380**	248	132	**7,032**	5,262	1,770
South Dakota	**926**	617	309	**56**	33	23	**982**	651	332
Tennessee	**11,538**	8,060	3,478	**720**	500	220	**12,258**	8,560	3,698
Texas	**41,799**	27,533	14,266	**1,499**	911	588	**43,298**	28,444	14,853
Utah	**3,085**	2,313	772	**177**	115	62	**3,262**	2,429	833
Vermont	**1,617**	1,021	596	**178**	124	54	**1,795**	1,145	650
Virginia	**13,512**	8,561	4,952	**481**	315	166	**13,993**	8,876	5,117
Washington	**13,616**	8,835	4,781	**962**	532	430	**14,578**	9,366	5,211
West Virginia	**4,146**	3,397	749	**149**	104	45	**4,295**	3,501	794
Wisconsin	**9,345**	6,114	3,231	**501**	316	185	**9,846**	6,430	3,416
Wyoming	**611**	347	263	**81**	58	23	**692**	406	286
Subtotal (states)	**$649,887**	**$438,702**	**$211,185**	**$29,660**	**$18,467**	**$11,193**	**$679,546**	**$457,168**	**$222,378**

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
American Samoa	**$48**	$44	$4	**$3**	$2	$1	**$51**	$46	$5
Guam	**131**	121	10	**4**	2	2	**135**	123	12
Northern Mariana Islands	**42**	39	3	**1**	1	0	**43**	39	4
Puerto Rico	**2,745**	2,444	301	**99**	73	27	**2,845**	2,517	328
Virgin Islands	**78**	72	6	**9**	6	3	**86**	78	9
Subtotal (states and territories)	**$652,931**	**$441,422**	**$211,509**	**$29,775**	**$18,549**	**$11,225**	**$682,706**	**$459,971**	**$222,735**
State Medicaid Fraud Control Units	**–**	–	–	**387**	290	97	**387**	290	97
Medicaid survey and certification of nursing and intermediate care facilities	**–**	–	–	**333**	250	83	**333**	250	83
Vaccines for Children program	**–**	–	–	**–**	–	–	**4,578**	4,578	–
Total	**$652,931**	**$441,422**	**$211,509**	**$30,495**	**$19,090**	**$11,405**	**$688,004[2]**	**$465,089[2]**	**$222,915**

Notes: FY is fiscal year. Total federal spending shown here ($465,089 million) will differ from total federal outlays shown in FY 2022 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 only for state programs; federal oversight spending is not included.

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

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 28, 2021. Figures presented in this exhibit may change if states revise their expenditure data after this date.

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

Sources: For state and territory spending: MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of June 28, 2021. For all other spending (MFCUs, survey and certification, VFC program): CMS, 2021, *Fiscal year 2022 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/files/document/fy2022-cms-congressional-justification-estimates-appropriations-committees.pdf.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2020 (millions)

State[1]	Total spending on benefits	Fee for service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home- and community-based LTSS			
Alabama	**$6,096**	$2,437	$455	$56	$76	$100	$597	$267	$1,102	$535	$134	$368	-$31
Alaska	**2,019**	619	154	76	33	381	140	62	219	323	1	35	-23
Arizona	**14,380**	1,329	55	5	16	225	623	228	99	4	11,394	408	-5
Arkansas	**6,620**	1,196	323	1	24	69	600	97	878	349	2,762	361	-40
California	**97,210**	12,749	639	1,197	12	3,044	9,567	438	4,288	18,901	43,781	3,186	-591
Colorado[2]	**9,571**	2,781	478	265	-0	983	708	235	924	1,625	1,471	194	-94
Connecticut	**8,488**	2,592	449	118	232	351	589	512	1,490	1,831	0	557	-232
Delaware	**2,376**	60	10	36	0	2	109	200	46	180	1,706	45	-18
District of Columbia	**3,116**	435	53	13	5	252	189	133	408	657	913	65	-6
Florida	**25,287**	2,420	580	342	2	203	799	122	1,501	1,439	16,000	1,968	-90
Georgia	**11,299**	2,287	309	16	35	19	728	332	1,648	1,540	3,900	547	-63
Hawaii	**2,331**	22	0	27	0	22	7	1	12	131	2,105	49	-45
Idaho	**2,486**	692	138	–	37	48	263	147	179	396	532	77	-22
Illinois[3]	**22,388**	2,984	146	35	97	56	625	-10	1,620	1,346	14,998	606	-114
Indiana	**14,269**	1,538	170	22	9	522	404	129	3,010	1,677	6,520	327	-58
Iowa	**5,823**	164	17	27	1	49	95	11	48	49	5,256	165	-59
Kansas[3]	**3,830**	177	6	0	0	1	48	-1	84	0	3,421	117	-23
Kentucky	**11,906**	826	39	4	8	253	495	61	1,264	1,006	7,695	283	-28
Louisiana	**12,559**	1,437	31	0	1	33	268	41	1,632	818	8,007	415	-124
Maine	**3,209**	732	110	16	85	190	556	116	537	679	4	230	-46
Maryland	**11,902**	890	111	115	74	228	943	308	1,405	1,760	5,725	396	-54
Massachusetts	**17,967**	2,781	350	206	41	315	1,624	259	1,549	2,991	7,364	636	-148
Michigan	**19,111**	1,635	295	27	15	271	656	526	2,355	1,195	11,918	639	-420
Minnesota[3]	**13,612**	615	179	18	194	146	788	-215	1,166	4,086	6,493	246	-103
Mississippi	**5,596**	639	114	4	10	34	238	15	1,098	469	2,698	292	-15
Missouri	**10,905**	2,895	9	4	11	374	759	488	1,468	2,360	2,218	397	-79
Montana	**1,993**	785	131	54	55	75	234	94	229	259	48	56	-27
Nebraska[3]	**2,291**	64	3	0	2	0	53	-0	449	541	1,138	60	-20
Nevada[2]	**4,120**	443	181	-76	14	84	548	143	397	307	1,882	215	-18
New Hampshire[3]	**2,253**	268	6	18	1	2	151	-42	464	378	978	38	-10

EXHIBIT 17. (continued)

State[1]	Total spending on benefits	Fee for service									Managed care and premium assistance	Medicare premiums and coinsurance	Collections
		Hospital	Physician	Dental	Other practitioner	Clinic and health center	Other acute	Drugs	Institutional LTSS	Home- and community-based LTSS			
New Jersey	**$16,412**	$1,581	$77	$2	$11	$436	$1,014	$4	$1,469	$1,863	$9,703	$461	-$209
New Mexico[3]	**6,287**	445	23	8	50	6	87	-30	38	452	5,059	168	-18
New York[3]	**70,674**	8,168	274	21	138	930	4,846	-3,037	6,987	9,537	43,019	1,994	-2,203
North Carolina	**14,778**	4,462	991	276	155	293	1,282	693	1,874	940	3,422	557	-168
North Dakota	**1,274**	144	35	12	16	13	52	41	403	269	281	17	-8
Ohio	**25,194**	1,350	203	23	10	74	705	99	2,356	4,188	15,704	664	-181
Oklahoma	**4,971**	1,761	473	90	36	382	367	523	832	636	131	190	-449
Oregon	**10,661**	419	25	3	42	246	405	104	524	2,361	6,279	300	-48
Pennsylvania[3]	**34,965**	1,747	42	7	1	95	481	-0	2,128	3,786	26,065	818	-206
Rhode Island	**2,810**	229	8	5	0	45	202	2	366	327	1,564	75	-12
South Carolina[3]	**6,652**	1,124	135	110	14	92	327	-11	946	706	3,162	264	-218
South Dakota	**926**	242	60	18	5	53	65	45	205	199	1	40	-9
Tennessee	**11,538**	755	28	128	0	87	347	436	255	705	8,370	483	-56
Texas	**41,799**	6,423	183	28	146	23	5,391	61	1,612	2,644	24,562	1,466	-740
Utah	**3,085**	436	92	8	7	14	186	82	434	431	1,373	57	-34
Vermont[3]	**1,617**	23	–	–	–	–	1,513	-138	138	79	–	4	-1
Virginia[3]	**13,512**	1,697	281	137	8	61	347	-178	441	2,162	8,278	332	-53
Washington	**13,616**	856	54	140	11	903	984	23	1,105	3,222	10,820	468	-4,970
West Virginia	**4,146**	233	35	8	9	21	214	241	887	541	1,811	169	-23
Wisconsin	**9,345**	831	34	71	30	283	827	451	763	1,084	4,691	358	-78
Wyoming	**611**	126	31	11	16	37	21	28	156	166	6	21	-8
Subtotal	**$649,887**	**$81,542**	**$8,626**	**$3,731**	**$1,796**	**$12,431**	**$43,068**	**$4,135**	**$55,485**	**$84,126**	**$345,361**	**$21,884**	**-$12,299**
American Samoa	**48**	28	–	–	–	2	16	0	–	–	–	2	–
Guam	**131**	57	12	2	0	1	39	18	1	1	–	2	–
N. Mariana Islands	**42**	25	–	1	–	4	8	3	–	2	–	1	–
Puerto Rico	**2,745**	256	–	–	–	59	–	36	–	–	2,395	–	-0
Virgin Islands	**78**	33	8	6	2	2	7	18	–	0	–	1	–
Total	**$652,931**	**$81,939**	**$8,645**	**$3,739**	**$1,799**	**$12,499**	**$43,138**	**$4,210**	**$55,486**	**$84,129**	**$347,756**	**$21,890**	**-$12,299**
Percent of total, exclusive of collections	**—**	**12.3%**	**1.3%**	**0.6%**	**0.3%**	**1.9%**	**6.5%**	**0.6%**	**8.3%**	**12.6%**	**52.3%**	**3.3%**	**—**

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 payments.

• Physician includes physician and surgical services.

• Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center (FQHC), and freestanding birth center.

• Other acute includes 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 Community First Choice option, USPSTF grade A or B preventive services, ACIP vaccines, and certified community behavioral health clinic.

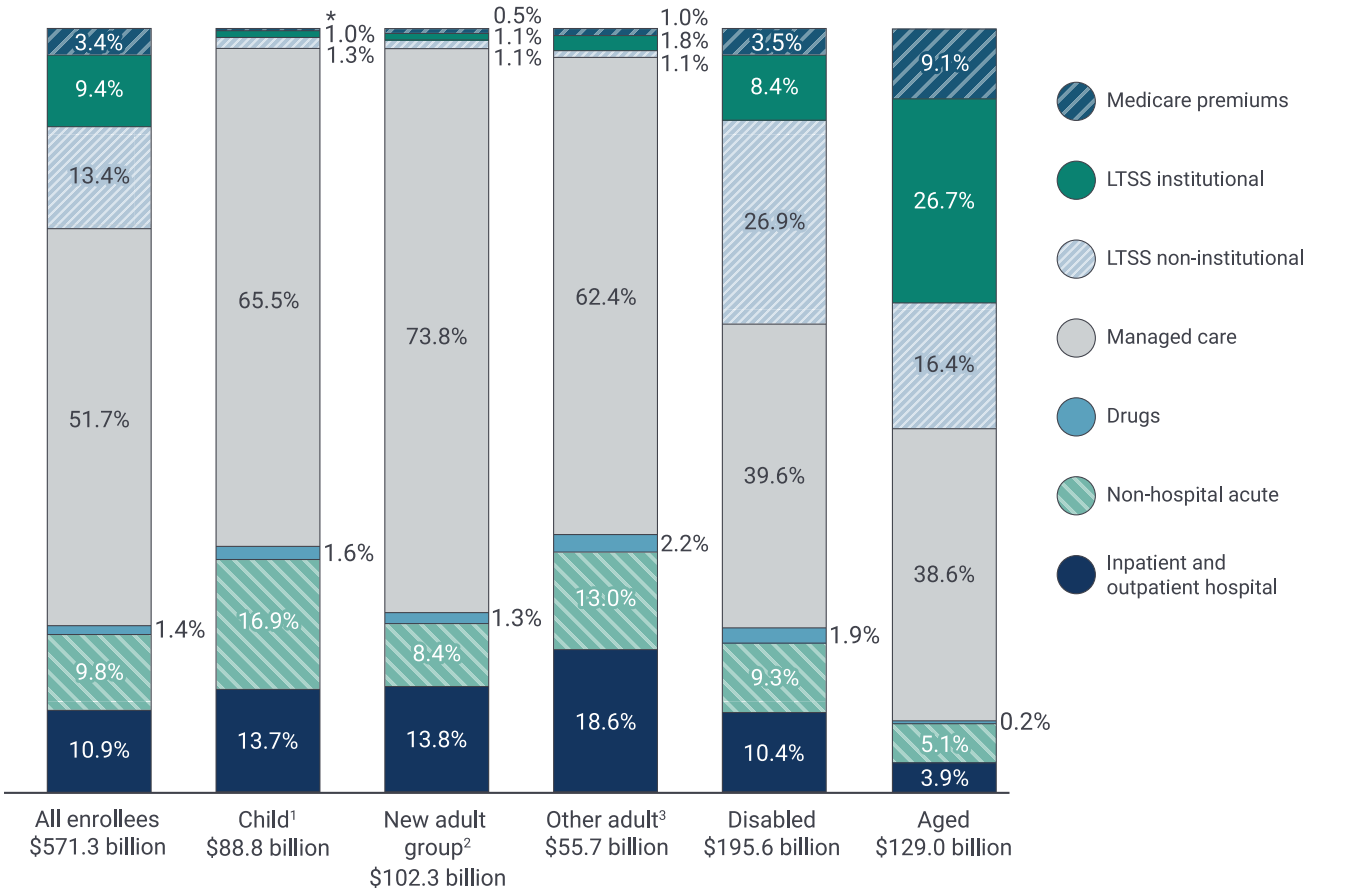
[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 28, 2021. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] State or territory reports negative spending in a category due to prior period adjustments. Colorado reports negative spending for other practitioner, and Nevada reports negative spending for dental 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, 2021, analysis of CMS-64 FMR net expenditure data as of June 28, 2021.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2019



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.

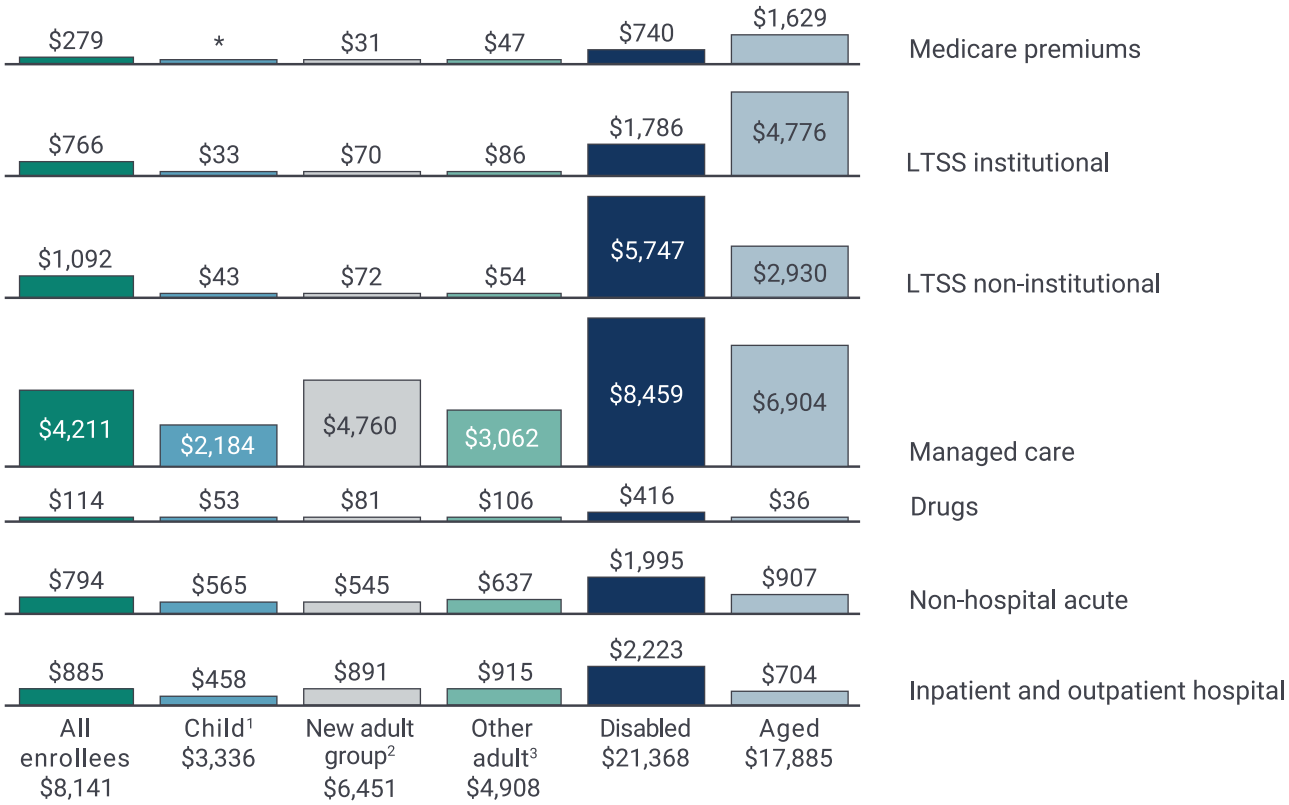
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in the 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 $538.0 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 are 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).

Sources: MACPAC, 2021, analysis of T-MSIS data as of December 2020 and analysis of CMS-64 financial management report net expenditure data as of August 2020.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2019



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.

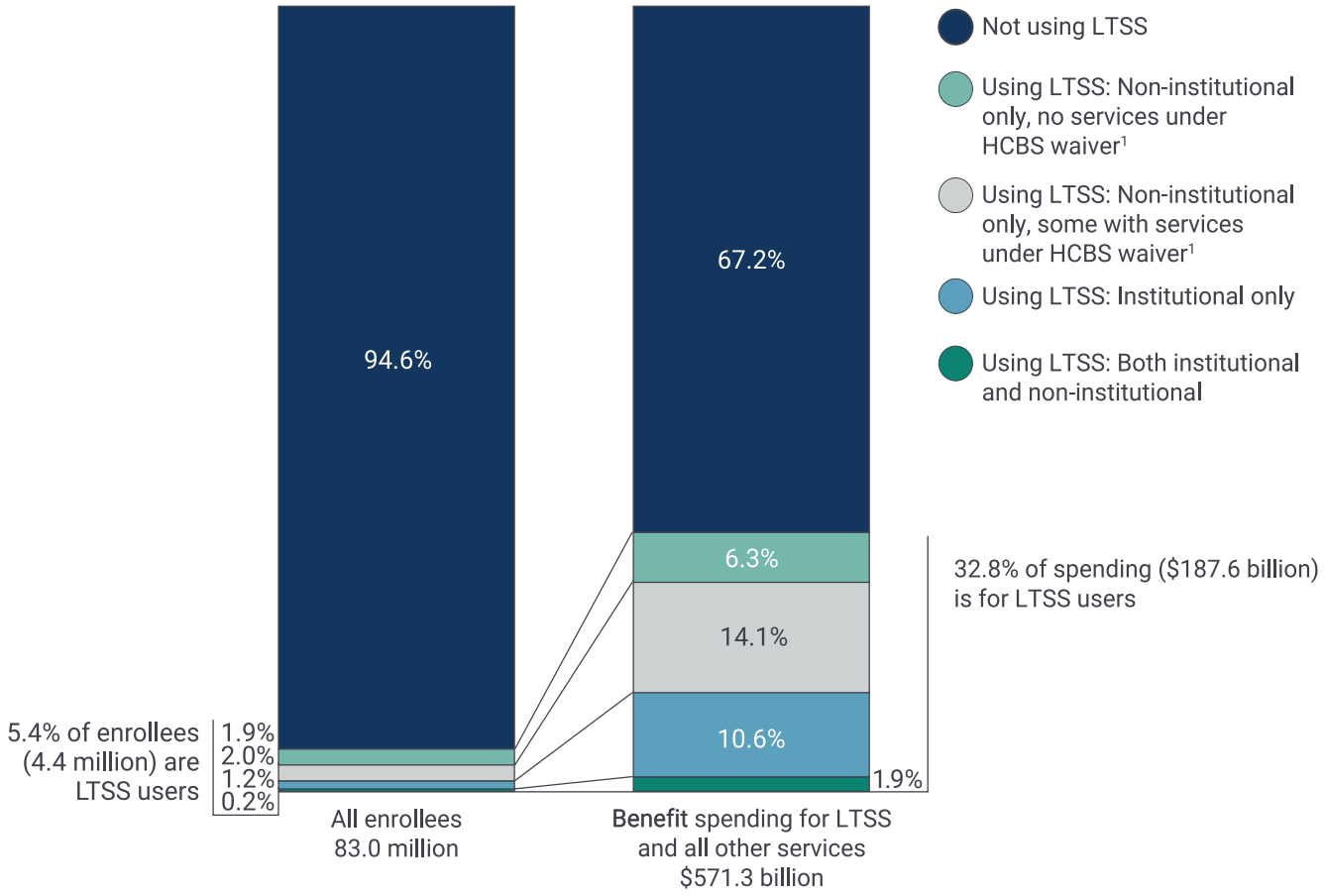
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, prior to January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in the 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 213,800 and child spending by $538.0 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 are 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).

Sources: MACPAC, 2021, analysis of T-MSIS data as of December 2020 and analysis of CMS-64 financial management report net expenditure data as of August 2020.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2019



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 who 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 the 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 256,000 and spending by $538.0 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).

Sources: MACPAC, 2021, analysis of T-MSIS data as of December 2020 and analysis of CMS-64 financial management report net expenditure data as of August 2020.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2019 (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	**$571,303**	**15.5%**	**17.9%**	**9.8%**	**34.2%**	**22.6%**	**$195,780**	**61.7%**	**$186,402**	**61.9%**	**$9,378**	**58.3%**
Alabama	**5,427**	19.2	–	5.4	50.1	25.4	**2,072**	65.9	**1,766**	67.7	**305**	55.3
Alaska	**2,089**	25.0	21.6	14.6	25.5	13.3	**488**	51.4	**485**	51.3	**3**	65.6
Arizona	**12,881**	16.4	26.9	15.0	30.1	11.6	**2,677**	50.5	**2,579**	50.0	**98**	62.5
Arkansas	**6,818**	18.8	15.7	4.0	45.2	16.4	**2,288**	47.9	**2,153**	48.3	**136**	41.8
California[5]	**84,207**	11.1	27.2	12.0	27.3	22.4	**23,607**	70.9	**23,086**	70.9	**521**	70.0
Colorado	**9,051**	13.9	24.0	12.0	32.4	17.6	**2,527**	60.5	**2,403**	60.9	**123**	53.7
Connecticut	**8,489**	14.2	22.9	11.5	24.1	27.3	**3,404**	61.8	**3,032**	61.2	**372**	67.1
Delaware	**2,239**	17.7	22.5	15.2	28.1	16.4	**657**	54.9	**614**	54.9	**43**	54.9
District of Columbia[6]	**2,813**	11.6	15.3	11.6	40.2	21.3	**830**	66.4	**794**	66.3	**37**	68.1
Florida	**23,288**	22.3	–	11.0	37.0	29.6	**9,282**	69.6	**8,356**	70.2	**926**	64.7
Georgia	**10,453**	20.9	–	11.5	44.4	23.3	**3,457**	67.3	**3,056**	68.3	**401**	59.8
Hawaii[7]	**2,187**	16.4	29.1	9.1	24.2	21.1	**691**	60.6	**677**	60.6	**13**	64.1
Idaho	**2,137**	21.1	–	10.9	48.7	19.4	**763**	49.8	**712**	49.8	**51**	49.1
Illinois[6,8]	**18,295**	10.4	49.2	2.8	15.5	22.2	**4,829**	57.3	**4,702**	57.3	**127**	60.4
Indiana	**12,231**	13.6	24.7	16.1	28.3	17.3	**4,569**	61.2	**4,380**	61.8	**190**	47.8
Iowa	**5,198**	14.0	20.9	10.7	37.3	17.1	**1,839**	48.1	**1,786**	47.7	**53**	58.7
Kansas	**3,465**	20.3	–	11.7	45.3	22.7	**1,377**	51.1	**1,306**	51.6	**71**	42.8
Kentucky[6]	**9,993**	14.8	31.3	8.0	33.1	12.8	**2,302**	53.8	**2,090**	55.1	**212**	40.8
Louisiana[8]	**10,656**	15.2	26.8	7.9	34.7	15.3	**3,017**	55.8	**2,698**	56.4	**319**	50.6
Maine[6]	**2,980**	13.5	6.6	6.9	46.2	26.9	**1,484**	53.2	**1,395**	52.3	**89**	66.3
Maryland	**11,750**	14.1	22.8	15.0	31.3	16.8	**3,252**	57.7	**3,032**	57.8	**219**	55.5
Massachusetts	**16,353**	8.5	13.0	10.3	41.2	27.2	**7,609**	54.9	**7,565**	54.7	**44**	96.1
Michigan	**18,037**	14.2	21.6	9.9	34.6	19.8	**5,712**	61.7	**5,501**	62.4	**211**	43.6
Minnesota	**12,766**	15.2	14.9	9.4	38.2	22.3	**5,014**	53.4	**4,976**	53.3	**38**	56.6
Mississippi	**5,297**	24.2	–	9.0	42.9	23.9	**2,129**	59.1	**1,892**	60.4	**237**	48.9
Missouri	**9,885**	24.5	–	7.9	48.8	18.8	**3,632**	45.4	**3,549**	45.5	**82**	43.1
Montana	**1,887**	20.5	32.8	6.2	22.8	17.6	**533**	62.8	**508**	63.3	**25**	51.5

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+
Nebraska	**$2,118**	18.6%	–	10.3%	32.6%	38.6%	**$1,023**	73.5%	**$1,015**	73.6%	**$8**	58.0%
Nevada	**3,899**	17.2	34.0%	7.9	27.6	13.3	**818**	59.7	**700**	59.7	**118**	59.4
New Hampshire	**1,703**	16.9	18.8	4.3	31.6	28.4	**796**	57.1	**762**	57.9	**35**	40.7
New Jersey	**14,998**	11.2	24.2	5.5	35.1	24.0	**5,944**	55.7	**5,927**	55.7	**18**	31.7
New Mexico	**5,165**	21.0	28.7	10.8	27.2	12.2	**1,171**	54.1	**1,062**	53.6	**109**	59.7
New York[9]	**54,735**	7.8	20.3	7.3	31.2	33.4	**25,498**	69.1	**25,012**	69.0	**487**	73.7
North Carolina	**13,306**	23.3	–	12.9	46.2	17.6	**3,992**	57.8	**3,803**	58.0	**189**	55.2
North Dakota[5]	**1,172**	15.0	1.2	5.3	37.3	41.4	**754**	64.2	**746**	64.3	**8**	60.7
Ohio	**22,242**	13.1	18.3	9.9	37.8	20.9	**7,447**	53.0	**7,167**	53.2	**280**	46.7
Oklahoma	**5,033**	32.4	–	13.1	37.1	17.5	**1,474**	54.0	**1,434**	54.1	**39**	49.4
Oregon	**9,457**	13.9	39.5	10.0	15.6	21.0	**2,917**	67.3	**2,717**	68.4	**201**	51.5
Pennsylvania	**31,196**	11.7	16.7	5.2	39.4	27.0	**12,198**	68.6	**11,940**	68.9	**259**	53.8
Rhode Island	**2,405**	11.1	21.3	15.6	32.6	19.4	**759**	58.1	**741**	58.3	**18**	50.8
South Carolina	**5,954**	23.6	–	16.5	40.1	19.7	**2,061**	56.0	**2,036**	55.9	**25**	62.0
South Dakota	**905**	20.9	–	10.8	45.8	22.6	**378**	53.7	**355**	54.0	**23**	48.5
Tennessee	**9,636**	28.4	–	15.1	36.1	20.4	**3,361**	57.2	**3,113**	57.4	**248**	53.6
Texas[10]	**32,696**	27.3	0.0	6.5	43.6	22.6	**10,705**	65.0	**9,203**	65.3	**1,503**	63.2
Utah[5, 6, 11]	**2,725**	40.0	15.7	11.3	11.8	21.2	**765**	74.0	**693**	75.4	**72**	60.3
Vermont	**1,477**	[12]	[12]	[12]	[12]	[12]	**[12]**	[12]	**[12]**	[12]	**[12]**	[12]
Virginia[6]	**11,268**	18.2	–	13.2	47.6	21.0	**4,430**	46.1	**4,209**	46.2	**221**	45.7
Washington[6, 9]	**14,719**	17.5	35.2	3.0	27.9	16.4	**3,795**	57.6	**3,610**	57.9	**184**	51.9
West Virginia	**3,878**	12.6	23.5	6.7	31.9	25.3	**1,336**	62.1	**1,075**	61.8	**261**	63.5
Wisconsin	**9,153**	13.8	–	21.7	43.3	21.2	**3,552**	52.1	**3,446**	52.4	**106**	44.3
Wyoming	**593**	22.2	–	11.6	41.8	24.4	**211**	47.6	**204**	47.5	**7**	52.2

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 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).

EXHIBIT 21. (continued)

– 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 are 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 has a state plan amendment (SPA) that allows the state to receive the enhanced federal medical assistance percentage (FMAP) for Medicaid children who 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 the 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 $503.4 million, North Dakota's child spending by approximately $10.2 million, and Utah's child spending by approximately $24.4 million.

[6] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 39 percent less than the benchmark; Illinois's average monthly enrollment was 117 percent more than the benchmark; Kentucky's average monthly enrollment was 26 percent more than the benchmark; Maine's average monthly enrollment was 65 percent more than the benchmark; and Washington's average monthly enrollment was 29 percent more than the benchmark. Utah reported an average monthly enrollment in the new adult group of approximately 30,000 in T-MSIS but did not report any enrollment on the CMS-64 enrollment report. Virginia did not report any enrollees in the new adult group compared with approximately 198,000 average monthly enrollees on the CMS-64 enrollment report; Virginia expanded coverage to the new adult group beginning January 1, 2019, and may not be reporting enrollment under the correct eligibility code in T-MSIS.

[7] 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.

[8] State reported a large shift of enrollees between eligibility groups. Illinois reported about a 43 percent decrease for the child group, a 35 percent decrease for the disabled group, an 87 percent decrease for the other adult group, and a 543 percent increase in the new adult group compared with 2018; the state appears to have corrected its reporting of the new adult group but appears to have also reclassified some children, other adult, and disabled beneficiaries into the new adult group. Louisiana reported a 27 percent decrease in the aged group and a 50 percent increase in the other adult group compared with 2018.

[9] State reported CMS-64 spending that shows a difference greater than 20 percent when compared with the prior year. New York's spending on the CMS-64 was 20.7 percent lower compared with 2018. Washington's spending on the CMS-64 was 26.2 percent higher compared with 2018.

[10] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2019.

[11] State reported total enrollment that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. Utah's average monthly enrollment was 24 percent less than the benchmark, and the ever enrolled total was 29 percent less than what was reported in T-MSIS in 2018. The decrease is not uniform across eligibility groups and affects the distribution of spending across groups.

[12] 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.

Sources: MACPAC, 2021, analysis of T-MSIS data as of December 2020 and analysis of CMS-64 financial management report net expenditure data as of August 2020.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2019

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	**$8,141**	**$8,690**	**$3,336**	**$3,344**	**$6,451**	**$6,546**	**$4,908**	**$5,886**	**$21,368**	**$23,951**	**$17,885**	**$23,205**
Alabama	**5,653**	**6,806**	2,276	2,276	–	–	1,663	2,681	13,175	17,149	11,326	25,820
Alaska	**9,940**	**9,979**	6,000	6,000	8,683	8,683	7,087	7,087	32,920	33,451	23,137	24,704
Arizona	**6,976**	**7,499**	3,129	3,168	7,704	8,070	4,971	5,839	22,646	24,734	9,273	11,520
Arkansas	**7,934**	**8,407**	4,112	4,112	3,971	3,971	4,625	4,625	20,754	26,499	15,629	25,154
California[4]	**6,847**	**7,760**	2,885	2,924	5,946	6,296	3,424	5,444	24,498	24,645	14,315	14,625
Colorado	**7,621**	**7,791**	3,004	3,004	5,631	5,631	5,464	5,465	27,366	31,487	21,270	31,093
Connecticut	**8,800**	**9,536**	3,778	3,775	7,128	7,056	5,805	5,730	29,810	48,732	17,042	42,862
Delaware	**9,472**	**10,398**	4,574	4,619	7,909	7,916	8,051	9,515	24,658	33,761	20,457	43,543
District of Columbia[5]	**11,321**	**11,703**	4,598	4,597	6,512	6,513	6,206	6,151	33,563	36,411	23,828	34,572
Florida	**6,155**	**6,671**	2,635	2,631	–	–	4,377	4,541	14,401	17,519	11,070	17,393
Georgia	**5,348**	**5,862**	2,066	2,060	–	–	3,599	4,056	13,454	16,539	11,117	22,506
Hawaii[6]	**6,852**	**6,883**	3,141	3,141	5,845	5,713	4,933	4,887	23,704	25,403	14,016	15,802
Idaho	**8,195**	**8,662**	2,950	2,947	–	–	7,196	7,031	21,217	25,348	15,461	25,589
Illinois[5,7]	**6,742**	**6,782**	2,830	2,829	6,014	6,014	4,896	4,423	14,764	15,757	16,120	17,638
Indiana	**9,034**	**9,700**	3,004	3,038	8,159	8,176	13,883	18,731	18,301	21,743	21,267	34,161
Iowa	**8,319**	**8,519**	3,072	3,072	6,171	6,141	6,166	6,248	24,359	26,380	20,994	28,794
Kansas	**9,530**	**10,094**	3,491	3,491	–	–	7,651	7,502	21,586	26,181	21,343	32,813
Kentucky[5]	**6,885**	**7,171**	3,410	3,408	5,519	5,505	5,750	5,718	15,376	18,993	13,212	21,620
Louisiana[7]	**6,935**	**7,189**	2,888	2,879	5,796	5,797	4,402	5,307	18,309	19,044	18,705	21,421
Maine[5]	**10,944**	**12,195**	4,533	4,539	6,827	6,827	4,989	5,072	21,306	24,404	16,196	29,748
Maryland	**9,340**	**9,639**	3,516	3,497	8,487	8,487	7,484	7,154	25,587	30,357	21,392	35,128
Massachusetts	**10,176**	**11,380**	3,786	4,012	7,065	7,085	4,281	5,735	19,326	19,389	22,007	26,264
Michigan	**7,588**	**7,748**	2,971	2,987	5,641	5,647	5,555	5,739	18,246	19,473	21,869	25,892
Minnesota	**12,037**	**12,249**	3,882	3,888	9,932	9,896	6,801	7,010	42,881	44,937	36,051	40,367
Mississippi	**7,982**	**9,136**	3,994	3,996	–	–	5,243	6,750	14,275	17,951	13,663	25,166
Missouri	**10,338**	**10,688**	4,356	4,356	–	–	5,959	5,958	27,304	30,456	20,225	25,071
Montana	**7,486**	**7,694**	4,111	4,111	6,205	6,208	6,095	6,562	18,427	21,003	21,577	31,052

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]
Nebraska	**$9,790**	**$9,946**	$ 3,147	$3,146	–	–	$6,824	$6,821	$18,529	$19,319	$36,742	$41,257
Nevada	**6,075**	**6,299**	2,596	2,595	$6,137	$6,134	5,159	4,963	18,043	23,671	10,711	21,527
New Hampshire	**9,199**	**9,688**	3,847	3,847	5,757	5,757	5,637	5,637	21,233	27,627	29,443	46,624
New Jersey	**9,708**	**9,699**	2,924	2,929	6,579	6,481	8,148	7,446	30,826	30,857	24,447	24,374
New Mexico	**6,478**	**7,139**	3,844	3,847	5,731	5,840	4,018	5,580	21,859	25,766	11,995	22,319
New York[8]	**9,328**	**9,563**	2,559	2,562	5,466	5,469	4,989	5,028	27,169	29,245	24,541	29,404
North Carolina	**6,808**	**8,344**	3,485	3,485	–	–	3,203	7,212	17,922	19,530	12,499	16,210
North Dakota[4]	**13,428**	**13,728**	4,879	4,879	647	625	5,848	5,848	39,582	43,406	55,323	65,767
Ohio	**8,438**	**8,726**	2,995	2,993	6,527	6,507	5,101	5,070	21,146	24,594	22,382	30,688
Oklahoma	**7,344**	**7,852**	4,171	4,171	–	–	5,274	6,666	17,702	19,427	13,663	16,370
Oregon	**10,772**	**11,672**	4,807	4,824	9,651	10,057	9,017	10,108	27,453	42,119	33,642	70,616
Pennsylvania	**11,350**	**11,780**	4,311	4,339	6,813	6,847	5,764	6,042	21,030	22,352	31,032	37,926
Rhode Island	**8,591**	**8,743**	3,425	3,425	7,004	6,988	6,378	6,426	19,808	21,017	15,436	17,951
South Carolina	**5,022**	**5,933**	2,534	2,543	–	–	2,620	4,809	14,508	14,724	13,016	13,725
South Dakota	**8,603**	**9,034**	3,146	3,146	–	–	6,575	6,570	21,878	26,109	17,988	26,356
Tennessee	**6,288**	**6,676**	3,548	3,548	–	–	3,985	3,985	13,589	16,672	13,984	26,601
Texas[9]	**8,189**	**8,427**	3,507	3,493	38,481	38,481	7,448	7,249	21,474	24,821	14,930	22,756
Utah[4, 5, 10]	**14,748**	**14,272**	8,114	8,108	14,321	14,309	19,419	18,523	125,820	134,007	256,730	292,218
Vermont	**8,877**	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]
Virginia[5]	**8,930**	**10,661**	4,138	4,138	–	–	3,150	4,569	29,710	35,222	20,864	28,626
Washington[5, 8]	**8,425**	**8,588**	3,488	3,491	7,772	7,771	9,361	8,207	23,145	27,044	20,505	27,257
West Virginia	**7,459**	**7,386**	2,843	2,843	5,521	5,517	5,361	5,356	13,570	14,733	22,580	30,156
Wisconsin	**8,554**	**8,973**	3,169	3,178	–	–	5,468	5,978	22,267	22,944	15,049	16,636
Wyoming	**10,510**	**11,088**	4,228	4,228	–	–	8,094	8,014	23,377	27,397	23,508	33,748

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

EXHIBIT 22. (continued)

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 are 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 has a state plan amendment (SPA) that allows the state to receive the enhanced FMAP for Medicaid children who 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 the 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 203,000 and spending by $503.4 million; North Dakota's child FYE enrollment by approximately 2,200 and spending by $10.2 million, and Utah's child FYE enrollment by approximately 8,600 and spending by $24.4 million.

[5] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 39 percent less than the benchmark; Illinois's average monthly enrollment was 117 percent more than the benchmark; Kentucky's average monthly enrollment was 26 percent more than the benchmark; Maine's average monthly enrollment was 65 percent more than the benchmark; and Washington's average monthly enrollment was 29 percent more than the benchmark. Utah reported an average monthly enrollment in the new adult group of approximately 30,000 in T-MSIS but did not report any enrollment on the CMS-64 enrollment report. Virginia did not report any enrollees in the new adult group compared with approximately 198,000 average monthly enrollees on the CMS-64 enrollment report; Virginia expanded coverage to the new adult group beginning January 1, 2019, and may not be reporting enrollment under the correct eligibility code in T-MSIS.

[6] 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.

[7] State reported a large shift of enrollees between eligibility groups. Illinois reported about a 43 percent decrease for the child group, a 35 percent decrease for the disabled group, an 87 percent decrease for the other adult group, and a 543 percent increase in the new adult group compared with 2018; the state appears to have corrected its reporting of the new adult group but appears to have also reclassified some children, other adult, and disabled beneficiaries into the new adult group. Louisiana reported a 27 percent decrease in the aged group and a 50 percent increase in the other adult group compared with 2018.

[8] State reported CMS-64 spending that shows a difference greater than 20 percent when compared with the prior year. New York's spending on the CMS-64 was 20.7 percent lower compared with 2018. Washington's spending on the CMS-64 was 26.2 percent higher compared with 2018.

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

[10] State reported total enrollment that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. Utah's average monthly enrollment was 24 percent less than the benchmark, and the ever enrolled total was 29 percent less than what was reported in T-MSIS in 2018. The decrease is not uniform across eligibility groups and affects the distribution of spending across groups.

[11] 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.

Sources: MACPAC, 2021, analysis of T-MSIS data as of December 2020 and analysis of CMS-64 financial management report net expenditure data as of August 2020.

EXHIBIT 23. Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2020

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	1,069,624	$6,096,166,669	$5,699	–	–	–
Alaska	219,664	2,019,250,659	9,192	57,148	$475,258,686	$8,316
Arizona	1,933,142	14,380,097,500	7,439	116,308	517,240,431	4,447
Arkansas	851,633	6,619,665,977	7,773	267,454	1,810,008,144	6,768
California	12,476,801	97,209,600,476	7,791	3,713,537	22,223,011,929	5,984
Colorado	1,249,232	9,571,142,660	7,662	392,343	1,686,045,030	4,297
Connecticut	970,730	8,488,113,264	8,744	251,175	1,865,313,974	7,426
Delaware	218,772	2,376,240,280	10,862	9,753	55,499,226	5,691
District of Columbia	261,719	3,116,473,398	11,908	66,766	443,211,662	6,638
Florida	3,948,382	25,287,463,190	6,405	–	–	–
Georgia	2,049,484	11,298,595,472	5,513	–	–	–
Hawaii	328,058	2,330,861,339	7,105	20,510	521,653,806	25,435
Idaho	343,725	2,486,061,085	7,233	53,026	324,795,776	6,125
Illinois	2,724,336	22,387,970,467	8,218	611,948	4,938,605,321	8,070
Indiana	1,421,721	14,269,009,974	10,036	352,727	3,110,422,073	8,818
Iowa	618,759	5,822,570,106	9,410	163,299	1,099,645,666	6,734
Kansas	364,983	3,829,902,734	10,493	–	–	–
Kentucky	1,351,121	11,905,613,440	8,812	497,384	3,532,362,890	7,102
Louisiana	1,663,649	12,559,462,713	7,549	506,540	3,340,509,657	6,595
Maine	296,080	3,208,972,015	10,838	41,566	–	–
Maryland	1,277,961	11,901,582,041	9,313	324,020	2,724,908,793	8,410
Massachusetts	1,717,218	17,967,352,114	10,463	–	–	–
Michigan	2,473,754	19,110,820,883	7,725	667,122	4,288,840,516	6,429
Minnesota	1,083,580	13,611,654,951	12,562	196,652	2,045,345,604	10,401
Mississippi	685,243	5,596,349,573	8,167	–	–	–
Missouri	883,356	10,905,114,581	12,345	–	–	–

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
Montana	245,941	$1,992,926,465	$8,103	91,601	$812,532,345	$8,870
Nebraska	244,044	2,290,915,253	9,387	–	–	–
Nevada	615,954	4,119,506,708	6,688	224,112	1,586,766,109	7,080
New Hampshire	188,142	2,252,876,680	11,974	56,613	373,540,711	6,598
New Jersey	1,631,840	16,411,726,557	10,057	553,193	3,498,408,129	6,324
New Mexico	849,958	6,287,136,348	7,397	269,500	1,752,595,257	6,503
New York	6,236,806	70,674,153,157	11,332	329,000	2,157,475,296	6,558
North Carolina	2,211,781	14,778,330,531	6,682	–	–	–
North Dakota	93,796	1,274,342,537	13,586	20,017	284,520,032	14,214
Ohio	2,909,265	25,194,454,160	8,660	599,131	5,052,402,883	8,433
Oklahoma	682,088	4,971,314,398	7,288	–	–	–
Oregon	1,007,562	10,660,624,000	10,581	411,659	3,265,077,465	7,932
Pennsylvania	2,906,422	34,964,896,749	12,030	767,112	5,448,768,495	7,103
Rhode Island	296,580	2,810,004,409	9,475	68,686	537,135,963	7,820
South Carolina	1,294,747	6,651,671,712	5,137	–	–	–
South Dakota	105,582	926,188,243	8,772	–	–	–
Tennessee	1,597,700	11,538,272,557	7,222	–	–	–
Texas	4,314,582	41,798,895,649	9,688	–	–	–
Utah	319,509	3,084,967,869	9,655	42,762	383,603,976	8,971
Vermont	168,934	1,616,960,203	9,572	–	–	–
Virginia[3]	1,392,251	13,512,390,024	9,705	393,012	3,270,438,119	8,321
Washington	1,774,691	13,616,067,808	7,672	566,147	5,535,500,182	9,777
West Virginia	529,108	4,145,950,758	7,836	167,345	877,273,408	5,242
Wisconsin	1,228,727	9,345,285,225	7,606	–	–	–
Wyoming	57,168	610,632,960	10,681	–	–	–
Subtotal (states)	**75,385,901**	**$649,886,598,521**	**$8,621**	**12,869,168**	**$89,838,717,554**	**$6,981**

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
American Samoa	35,002	$48,358,967	$1,382	–	–	–
Guam	34,072	131,306,973	3,854	–	–	–
Northern Mariana Islands	16,240	41,937,624	2,582	–	–	–
Puerto Rico	1,168,182	2,745,413,942	2,350	–	–	–
Virgin Islands	31,171	77,596,122	2,489	–	–	–
Total (states and territories)	**76,670,568**	**$652,931,212,149**	**$8,516**	**12,869,168**	**$89,838,717,554**	**$6,981**

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 2020 enrollment was taken from the submission quarter ending December 31, 2020). 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 the Social Security Act (the Act).

– Dash indicates zero.

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 28, 2021. 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 93 percent for quarters in calendar year 2019 and 90 percent for quarters in calendar year 2020.

[3] Virginia did not report enrollment for October 2019–March 2020 on its enrollment reports ending September 30, 2020, or December 31, 2020. We used October–December 2019 enrollment as reported in the CMS-64 enrollment report for the period ending December 31, 2019, and January–March 2020 enrollment as reported in the CMS-64 enrollment report for the period ending March 31, 2020.

Source: MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of June 28, 2021, and CMS-64 enrollment reports as of October 22, 2021.

EXHIBIT 24. Medicaid Supplemental Payments to Hospital Providers by State, FY 2020 (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	**$90,373.3**	**$14,539.5**	**$19,675.9**	**$14,551.6**	**54.0%**
Alabama	**2,437.4**	466.7	980.2	–	59.4
Alaska	**619.2**	9.3	–	–	1.5
Arizona[3]	**1,328.8**	109.2	538.7	21.8	50.4
Arkansas	**1,196.0**	3.5	450.6	–	38.0
California[4, 5]	**16,354.8**	589.6	6,006.8	3,606.3	62.4
Colorado	**2,781.3**	197.9	1,239.9	–	51.7
Connecticut	**2,591.7**	17.2	714.1	–	28.2
Delaware	**59.8**	–	–	–	–
District of Columbia	**435.3**	76.2	48.4	–	28.6
Florida[4]	**2,420.4**	228.1	375.5	902.5	62.2
Georgia	**2,287.2**	436.9	271.0	–	30.9
Hawaii	**21.8**	10.4	0.4	–	49.6
Idaho	**691.5**	24.6	13.0	–	5.4
Illinois	**2,983.9**	400.8	796.2	–	40.1
Indiana	**1,537.9**	668.9	50.7	–	46.8
Iowa	**163.8**	71.8	43.5	–	70.4
Kansas[4, 5]	**176.6**	58.7	2.9	76.5	78.2
Kentucky	**825.8**	171.0	19.9	–	23.1
Louisiana	**1,437.0**	1,116.5	104.2	–	84.9
Maine	**732.4**	–	110.9	–	15.1
Maryland	**889.9**	94.9	55.2	–	16.9
Massachusetts[3, 4, 5]	**3,109.4**	–	238.4	763.1	32.2
Michigan	**1,634.8**	551.1	551.2	–	67.4
Minnesota	**614.6**	59.6	111.0	–	27.8
Mississippi	**639.3**	220.4	36.8	–	40.2
Missouri	**2,894.9**	728.0	164.9	–	30.8
Montana	**785.2**	0.1	342.0	–	43.6
Nebraska	**64.0**	41.6	–	–	64.9
Nevada	**443.1**	1.1	153.4	–	34.9
New Hampshire[5]	**284.0**	217.7	24.2	15.9	90.8
New Jersey	**1,580.9**	502.7	462.7	–	61.1
New Mexico[4, 5]	**445.4**	31.8	165.8	46.4	54.8
New York[5]	**9,950.9**	2,775.0	1,157.3	1,783.1	57.4
North Carolina	**4,462.3**	335.3	1,265.8	–	35.9
North Dakota	**144.0**	0.8	0.9	–	1.2

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
Ohio	**$1,349.8**	$574.1	$102.9	–	50.2%
Oklahoma	**1,760.9**	59.1	661.7	–	40.9
Oregon	**419.1**	55.5	123.0	–	42.6
Pennsylvania	**1,747.0**	754.7	549.7	–	74.7
Rhode Island[5]	**233.0**	128.1	3.7	$4.4	58.4
South Carolina	**1,123.5**	434.0	112.3	–	48.6
South Dakota	**241.6**	0.8	3.0	–	1.5
Tennessee[4]	**754.7**	74.3	50.0	607.1	96.9
Texas[4, 5]	**9,513.2**	1,719.9	118.1	6,721.2	90.0
Utah	**435.6**	27.0	47.6	–	17.1
Vermont[5]	**25.9**	22.7	–	3.2	100.0
Virginia	**1,696.7**	24.1	1,262.4	–	75.8
Washington	**856.3**	263.2	–	–	30.7
West Virginia	**233.0**	53.6	12.3	–	28.3
Wisconsin	**831.3**	130.9	98.5	–	27.6
Wyoming	**126.1**	0.5	34.2	–	27.5

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 June 28, 2021. 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 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.

Source: MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of June 28, 2021, and CMS-64 Schedule C waiver report data as of October 19, 2021.

EXHIBIT 25. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2020 (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	**$6,747.6**	**$3,357.9**	**49.8%**	**$48,737.9**	**$3,127.9**	**6.4%**	**$10,041.0**	**$1,638.3**	**16.3%**
Alabama	**82.2**	3.2	3.9	**1,019.4**	–	–	**478.8**	–	–
Alaska	**27.6**	14.0	50.6	**191.4**	–	–	**187.2**	–	–
Arizona	**35.6**	27.9	78.4	**63.1**	10.8	17.2	**66.7**	–	–
Arkansas	**19.1**	–	–	**858.7**	–	–	**343.6**	39.4	11.5
California	**856.9**	0.1	0.0	**3,430.7**	280.3	8.2	**652.3**	192.3	29.5
Colorado	**19.4**	–	–	**904.8**	148.0	16.4	**478.3**	172.5	36.1
Connecticut	**184.5**	105.6	57.2	**1,305.0**	–	–	**680.5**	14.7	2.2
Delaware[5]	**10.5**	-3.6	-34.4	**35.6**	–	–	**10.2**	–	–
District of Columbia	**19.4**	6.5	33.8	**388.5**	–	–	**54.4**	4.5	8.3
Florida[6]	**968.7**	112.3	11.6	**532.3**	–	–	**581.5**	386.9	66.5
Georgia	**6.5**	–	–	**1,641.1**	152.0	9.3	**344.4**	–	–
Hawaii	**–**	–	–	**12.4**	–	–	**0.2**	–	–
Idaho	**3.7**	–	–	**175.0**	49.2	28.1	**175.7**	–	–
Illinois	**153.7**	89.4	58.2	**1,466.6**	–	–	**232.8**	–	–
Indiana	**64.2**	–	–	**2,945.5**	996.1	33.8	**177.7**	–	–
Iowa	**1.2**	–	–	**46.4**	–	–	**17.8**	8.4	46.9
Kansas	**16.5**	15.3	92.4	**67.8**	–	–	**6.2**	1.6	25.5
Kentucky	**39.8**	37.1	93.1	**1,224.0**	0.6	0.0	**42.0**	–	–
Louisiana	**118.3**	111.5	94.3	**1,513.4**	4.4	0.3	**31.7**	1.2	3.8
Maine	**119.4**	54.0	45.2	**417.2**	–	–	**173.8**	2.6	1.5
Maryland	**166.7**	58.8	35.3	**1,238.0**	–	–	**165.7**	–	–
Massachusetts[7]	**245.4**	206.3	84.1	**1,303.5**	–	–	**364.2**	29.3	8.0
Michigan	**327.9**	267.6	81.6	**2,027.0**	438.6	21.6	**302.5**	182.5	60.3
Minnesota[8]	**-11.4**	0.3	-2.4	**1,177.8**	–	–	**350.4**	38.7	11.0
Mississippi	**21.5**	–	–	**1,076.7**	17.5	1.6	**115.2**	8.4	7.3

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
Missouri	**$212.7**	$190.8	89.7%	**$1,255.5**	–	–	**$19.9**	–	–
Montana	**24.6**	–	–	**204.0**	$24.3	11.9%	**183.8**	–	–
Nebraska	**1.8**	1.8	99.2	**447.2**	14.8	3.3	**2.9**	$0.3	11.4%
Nevada	**40.2**	–	–	**357.2**	131.7	36.9	**179.7**	7.4	4.1
New Hampshire	**53.1**	52.5	98.8	**410.6**	85.2	20.7	**5.9**	–	–
New Jersey	**504.0**	360.5	71.5	**964.9**	–	–	**81.2**	–	–
New Mexico	**1.8**	–	–	**36.0**	–	–	**71.8**	4.4	6.1
New York	**1,003.7**	666.3	66.4	**5,983.2**	269.0	4.5	**412.1**	44.2	10.7
North Carolina	**155.6**	155.5	99.9	**1,718.7**	–	–	**1,013.5**	92.9	9.2
North Dakota	**20.5**	1.0	4.7	**382.7**	1.8	0.5	**46.6**	–	–
Ohio	**99.9**	93.4	93.5	**2,256.5**	–	–	**213.1**	30.4	14.3
Oklahoma	**60.7**	3.3	5.4	**771.1**	–	–	**506.8**	5.4	1.1
Oregon	**23.1**	20.0	86.5	**500.8**	–	–	**65.0**	–	–
Pennsylvania	**373.3**	292.5	78.3	**1,755.1**	233.0	13.3	**42.8**	–	–
Rhode Island	**3.0**	–	–	**363.0**	–	–	**8.5**	–	–
South Carolina	**64.0**	60.9	95.1	**882.3**	13.1	1.5	**143.6**	39.5	27.5
South Dakota	**3.6**	0.7	20.1	**201.5**	3.9	2.0	**65.7**	–	–
Tennessee	**46.4**	–	–	**208.7**	–	–	**28.5**	–	–
Texas[6]	**248.9**	246.0	98.9	**1,363.3**	6.4	0.5	**316.8**	90.2	28.5
Utah	**19.8**	0.9	4.6	**413.9**	117.2	28.3	**99.2**	16.1	16.2
Vermont	**–**	–	–	**137.5**	–	–	**–**	–	–
Virginia	**107.3**	–	–	**333.6**	34.7	10.4	**289.1**	217.2	75.1
Washington	**112.9**	88.6	78.5	**992.4**	3.1	0.3	**64.9**	7.2	11.1
West Virginia	**43.2**	17.0	39.5	**843.4**	–	–	**40.8**	–	–
Wisconsin	**18.2**	–	–	**744.8**	53.8	7.2	**62.6**	–	–
Wyoming	**7.8**	–	–	**148.4**	38.4	25.9	**42.2**	–	–

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% that rounds to zero.

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 28, 2021. 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 DSH payments for mental health facilities due to prior period adjustments.

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

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

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

Source: MACPAC, 2021, analysis of CMS-64 FMR net expenditure data as of June 28, 2021, and CMS-64 Schedule C waiver report data as of October 19, 2021.

EXHIBIT 26. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2020 (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]	**$71,817.1**	**83.1%**	**16.7%**	**0.3%**	**$25,192.1**	**85.6%**	**14.2%**	**0.2%**	**$46,625.0**	**81.7%**	**18.0%**	**0.3%**
Alabama	**771.5**	**84.8**	**15.2**	**0.0**	**771.5**	84.8	15.2	0.0	**–**	–	–	–
Alaska	**144.7**	**79.2**	**20.6**	**0.2**	**144.7**	79.2	20.6	0.2	**–**	–	–	–
Arizona	**1,481.2**	**84.0**	**15.8**	**0.2**	**24.2**	78.1	21.8	0.1	**1,456.9**	84.1	15.7	0.2
Arkansas	**373.5**	**79.6**	**20.3**	**0.1**	**303.8**	79.7	20.2	0.1	**69.7**	79.4	20.5	0.1
California	**7,819.0**	**83.8**	**16.2**	**0.1**	**4,009.1**	87.9	12.0	0.1	**3,810.0**	79.4	20.6	0.0
Colorado	**1,023.3**	**86.8**	**12.5**	**0.6**	**988.2**	87.1	12.2	0.7	**35.0**	79.7	20.3	0.0
Connecticut	**1,357.3**	**87.2**	**12.7**	**0.1**	**1,357.3**	87.2	12.7	0.1	**–**	–	–	–
Delaware	**204.8**	**91.4**	**8.6**	**0.0**	**1.7**	91.2	8.8	–	**203.1**	91.4	8.6	0.0
District of Columbia	**260.1**	**91.1**	**8.9**	**0.0**	**195.2**	94.1	5.9	0.0	**64.9**	82.0	18.0	0.0
Florida	**2,961.4**	**88.5**	**11.5**	**0.0**	**291.4**	92.6	7.3	0.1	**2,670.0**	88.0	11.9	0.0
Georgia	**1,164.6**	**82.7**	**17.2**	**0.2**	**774.2**	87.6	12.4	0.1	**390.4**	72.9	26.7	0.4
Hawaii	**178.4**	**81.1**	**18.8**	**0.1**	**0.0**	–	100.0	–	**178.3**	81.1	18.7	0.1
Idaho	**290.3**	**84.4**	**15.6**	**0.1**	**290.3**	84.4	15.6	0.1	**–**	–	–	–
Illinois	**2,256.6**	**82.2**	**17.8**	**0.0**	**153.2**	82.8	17.2	0.0	**2,103.4**	82.2	17.8	0.0
Indiana	**1,801.5**	**87.5**	**12.5**	**0.0**	**489.4**	91.0	9.0	0.0	**1,312.1**	86.1	13.9	0.0
Iowa	**400.6**	**89.2**	**10.8**	**0.0**	**3.9**	79.0	21.0	–	**396.8**	89.3	10.7	0.0
Kansas	**299.8**	**78.9**	**21.1**	**0.0**	**0.5**	74.3	25.7	0.0	**299.3**	78.9	21.1	0.0
Kentucky	**1,370.3**	**78.4**	**21.4**	**0.3**	**90.9**	74.6	24.9	0.6	**1,279.4**	78.6	21.1	0.2
Louisiana	**1,673.6**	**81.2**	**18.5**	**0.3**	**49.7**	74.9	24.7	0.4	**1,624.0**	81.3	18.3	0.3
Maine	**327.3**	**89.4**	**10.6**	**0.0**	**327.3**	89.4	10.6	0.0	**–**	–	–	–
Maryland	**1,239.0**	**86.5**	**13.5**	**0.0**	**490.4**	84.1	15.9	0.0	**748.5**	88.1	11.9	0.0
Massachusetts	**1,621.3**	**85.0**	**14.8**	**0.2**	**788.6**	84.4	15.3	0.3	**832.6**	85.6	14.3	0.1
Michigan	**2,182.0**	**83.1**	**16.5**	**0.3**	**1,225.9**	87.0	12.7	0.3	**956.1**	78.1	21.4	0.4
Minnesota	**1,063.3**	**80.7**	**18.9**	**0.5**	**180.1**	68.4	30.8	0.8	**883.3**	83.2	16.4	0.4
Mississippi	**452.4**	**79.5**	**20.5**	**0.0**	**74.1**	80.2	19.8	0.0	**378.3**	79.4	20.6	0.0

EXHIBIT 26. (continued)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Missouri	$1,190.4	78.5%	21.5%	0.0%	$1,190.4	78.5%	21.5%	0.0%	–	–	–	–
Montana	276.4	84.4	15.6	0.0	276.4	84.4	15.6	0.0	–	–	–	–
Nebraska	194.1	81.6	18.3	0.2	0.1	61.7	38.3	–	$194.0	81.6%	18.3%	0.2%
Nevada	519.2	82.3	14.9	2.8	235.6	80.2	13.6	6.2	283.6	84.0	16.0	0.1
New Hampshire	181.5	82.1	17.8	0.1	0.4	78.7	21.2	0.1	181.1	82.1	17.8	0.1
New Jersey	1,440.9	84.6	15.4	0.0	20.8	81.8	18.2	0.0	1,420.1	84.6	15.4	0.0
New Mexico	339.8	81.1	18.8	0.1	25.6	88.0	12.0	0.0	314.1	80.6	19.3	0.1
New York	5,964.0	85.2	14.5	0.3	642.7	76.0	23.2	0.8	5,321.3	86.3	13.5	0.2
North Carolina	1,974.5	86.1	13.7	0.3	1,974.5	86.1	13.7	0.3	–	–	–	–
North Dakota	66.2	81.3	18.6	0.1	55.4	80.8	19.1	0.1	10.8	83.8	16.2	0.0
Ohio	3,414.9	82.6	17.4	0.0	284.8	81.1	18.9	0.0	3,130.1	82.7	17.2	0.0
Oklahoma	532.0	82.0	17.9	0.0	532.0	82.0	17.9	0.0	–	–	–	–
Oregon	720.9	81.6	18.4	0.0	117.2	72.2	27.7	0.0	603.7	83.4	16.6	0.0
Pennsylvania	3,197.1	84.0	16.0	0.0	34.0	73.8	26.2	0.0	3,163.1	84.1	15.9	0.0
Rhode Island	231.8	79.3	20.7	–	6.3	81.3	18.7	–	225.5	79.3	20.7	–
South Carolina	593.4	84.1	15.7	0.3	116.5	87.5	12.3	0.2	476.9	83.2	16.5	0.3
South Dakota	110.9	79.5	19.8	0.8	110.9	79.5	19.8	0.8	–	–	–	–
Tennessee	1,199.0	85.1	14.7	0.1	1,030.9	83.5	16.4	0.1	168.1	95.1	4.7	0.2
Texas	3,187.7	84.2	15.8	0.0	65.1	80.8	19.1	0.1	3,122.6	84.3	15.7	0.0
Utah	317.7	87.1	12.8	0.0	153.5	86.4	13.6	0.0	164.2	87.9	12.1	0.1
Vermont	148.2	86.9	13.1	0.0	148.1	86.9	13.1	0.0	0.1	99.7	0.3	–
Virginia	3,757.7	57.7	40.6	1.7	19.8	81.1	18.8	0.1	3,738.0	57.6	40.7	1.7
Washington	1,236.3	87.3	12.7	0.0	84.5	89.6	10.3	0.0	1,151.7	87.1	12.9	0.0
West Virginia	717.1	84.3	15.7	0.0	693.2	83.9	16.1	0.0	23.9	97.1	2.7	0.2
Wisconsin[5]	1,406.2	85.7	14.2	0.0	1,406.2	85.7	14.2	0.0	–	–	–	–
Wyoming	31.7	84.9	15.1	0.0	31.7	84.9	15.1	0.0	–	–	–	–

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 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 U.S.C. § 552a) and the HIPAA Privacy Rule (45 C.F.R 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 between zero and $0.05 million that rounds to 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 2020 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] Wisconsin reports prescriptions for managed care but does not report any Medicaid spending.

Source: MACPAC, 2021, analysis of Medicaid drug product data and state drug rebate utilization data as of August 2021.

EXHIBIT 27. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2020 (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]	**712,859**	**15.1%**	**84.3%**	**0.6%**	**197,403**	**17.2%**	**82.3%**	**0.5%**	**515,456**	**14.3%**	**85.1%**	**0.6%**
Alabama	**6,941**	**18.6**	**81.3**	**0.1**	**6,941**	18.6	81.3	0.1	**–**	–	–	–
Alaska	**1,283**	**17.7**	**81.8**	**0.6**	**1,283**	17.7	81.8	0.6	**–**	–	–	–
Arizona	**15,525**	**14.1**	**85.1**	**0.7**	**135**	19.3	80.4	0.2	**15,390**	14.1	85.2	0.7
Arkansas	**4,787**	**15.8**	**84.0**	**0.1**	**3,947**	15.6	84.2	0.2	**840**	16.6	83.3	0.1
California	**90,973**	**14.5**	**85.4**	**0.1**	**23,233**	17.3	82.5	0.1	**67,740**	13.5	86.4	0.1
Colorado	**7,382**	**17.3**	**82.5**	**0.2**	**6,931**	17.6	82.2	0.2	**452**	13.2	86.8	0.1
Connecticut	**9,055**	**21.6**	**78.2**	**0.2**	**9,055**	21.6	78.2	0.2	**–**	–	–	–
Delaware	**2,723**	**16.7**	**83.2**	**0.1**	**14**	33.8	66.2	–	**2,710**	16.6	83.3	0.1
District of Columbia	**1,960**	**17.5**	**82.3**	**0.2**	**814**	21.8	77.9	0.3	**1,146**	14.4	85.4	0.1
Florida	**26,307**	**16.4**	**83.5**	**0.1**	**1,271**	19.3	80.5	0.1	**25,036**	16.3	83.6	0.1
Georgia	**15,436**	**14.1**	**85.5**	**0.4**	**7,088**	17.1	82.7	0.2	**8,347**	11.5	87.9	0.6
Hawaii	**2,206**	**12.8**	**86.8**	**0.4**	**2**	–	100.0	–	**2,205**	12.8	86.8	0.4
Idaho	**2,984**	**16.3**	**83.4**	**0.3**	**2,984**	16.3	83.4	0.3	**–**	–	–	–
Illinois	**25,385**	**13.6**	**86.4**	**0.0**	**2,009**	15.9	84.1	0.0	**23,376**	13.4	86.6	0.0
Indiana	**16,406**	**15.7**	**84.3**	**0.1**	**2,807**	15.0	84.9	0.2	**13,599**	15.8	84.1	0.1
Iowa	**5,597**	**16.4**	**83.5**	**0.0**	**75**	17.9	82.1	–	**5,522**	16.4	83.5	0.0
Kansas	**3,208**	**15.7**	**84.3**	**0.1**	**10**	12.7	87.1	0.1	**3,199**	15.7	84.2	0.1
Kentucky	**22,876**	**10.9**	**88.3**	**0.7**	**1,415**	9.6	89.0	1.4	**21,461**	11.0	88.3	0.7
Louisiana	**19,316**	**13.0**	**86.4**	**0.6**	**698**	13.0	86.3	0.7	**18,618**	13.0	86.4	0.6
Maine	**2,438**	**28.4**	**71.6**	**0.1**	**2,438**	28.4	71.6	0.1	**–**	–	–	–
Maryland	**13,687**	**16.4**	**83.5**	**0.1**	**4,531**	19.3	80.7	0.0	**9,156**	15.0	84.9	0.1
Massachusetts	**17,164**	**16.2**	**81.4**	**2.4**	**8,627**	15.6	81.1	3.3	**8,537**	16.8	81.6	1.5
Michigan	**28,866**	**13.6**	**85.6**	**0.8**	**8,674**	16.3	83.5	0.2	**20,192**	12.5	86.5	1.0
Minnesota	**12,600**	**12.6**	**81.4**	**6.0**	**2,072**	11.5	79.9	8.6	**10,528**	12.8	81.7	5.5
Mississippi	**5,103**	**14.4**	**85.5**	**0.1**	**828**	13.4	86.5	0.0	**4,275**	14.6	85.3	0.1

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	11,151	16.3%	83.5%	0.2%	11,151	16.3%	83.5%	0.2%	–	–	–	–
Montana	2,917	16.4	83.6	0.0	2,917	16.4	83.6	0.0	–	–	–	–
Nebraska	2,630	14.9	84.8	0.2	1	33.0	67.0	–	2,629	14.9%	84.8%	0.2%
Nevada	6,478	13.2	86.6	0.2	1,815	15.1	84.5	0.3	4,663	12.4	87.4	0.2
New Hampshire	2,039	15.8	83.7	0.5	12	18.1	81.2	0.7	2,028	15.8	83.7	0.5
New Jersey	19,266	13.2	86.7	0.1	302	15.3	84.7	0.0	18,964	13.2	86.8	0.1
New Mexico	4,535	15.9	83.9	0.2	254	21.5	78.3	0.2	4,282	15.6	84.2	0.2
New York	70,831	13.7	85.0	1.3	9,958	12.6	86.4	0.9	60,873	13.9	84.7	1.4
North Carolina	15,007	21.9	77.9	0.2	15,007	21.9	77.9	0.2	–	–	–	–
North Dakota	835	16.0	83.4	0.6	701	14.7	84.8	0.5	134	22.7	76.2	1.1
Ohio	43,195	15.5	84.4	0.0	3,551	13.9	86.1	0.0	39,644	15.7	84.3	0.0
Oklahoma	5,216	16.2	83.7	0.1	5,216	16.2	83.7	0.1	–	–	–	–
Oregon	9,815	13.2	86.8	0.0	2,143	5.8	94.2	0.0	7,673	15.2	84.7	0.0
Pennsylvania	32,782	14.6	85.4	0.0	712	11.9	88.1	0.0	32,071	14.6	85.4	0.0
Rhode Island	3,161	12.4	87.6	–	121	11.7	88.3	–	3,040	12.4	87.6	–
South Carolina	6,848	15.4	83.9	0.8	1,008	17.2	81.9	0.9	5,841	15.1	84.2	0.8
South Dakota	768	16.9	82.4	0.6	768	16.9	82.4	0.6	–	–	–	–
Tennessee	13,779	15.0	84.2	0.8	12,345	13.9	85.5	0.6	1,433	24.6	73.6	1.8
Texas	29,905	15.9	84.1	0.0	798	22.4	77.5	0.0	29,106	15.7	84.3	0.0
Utah	2,767	17.3	82.6	0.1	1,229	17.9	82.1	0.0	1,538	16.8	83.1	0.1
Vermont	1,438	26.1	73.8	0.0	1,426	26.2	73.8	0.0	12	23.2	75.7	1.0
Virginia	18,730	15.7	83.5	0.9	362	16.5	82.5	1.0	18,368	15.6	83.5	0.9
Washington	14,688	14.4	85.5	0.1	1,096	14.0	85.7	0.3	13,592	14.4	85.5	0.1
West Virginia	9,104	17.2	82.7	0.1	8,890	17.0	83.0	0.1	214	28.2	70.8	1.0
Wisconsin[5]	11,378	19.1	80.8	0.1	11,363	19.1	80.8	0.1	16	10.8	87.8	1.4
Wyoming	349	18.3	81.7	0.0	349	18.3	81.7	0.0	–	–	–	–

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 U.S.C. § 552a) and the HIPAA Privacy Rule (45 C.F.R 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 2020 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] Wisconsin reports prescriptions for managed care but does not report any Medicaid spending.

Source: MACPAC, 2021, analysis of Medicaid drug product data and state drug rebate utilization data as of August 2021.

EXHIBIT 28. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2020 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total[1]	**$71,817.1**	**$25,192.1**	**$46,625.0**	**-$39,242.0**	**-$18,989.6**	**-$20,252.5**
Alabama	**771.5**	771.5	–	**-514.3**	-514.3	–
Alaska	**144.7**	144.7	–	**-105.3**	-105.3	–
Arizona	**1,481.2**	24.2	1,456.9	**-961.3**	-25.5	-935.7
Arkansas[2]	**373.5**	303.8	69.7	**-237.5**	-237.5	–
California	**7,819.0**	4,009.1	3,810.0	**-4,658.3**	-2,386.2	-2,272.0
Colorado	**1,023.3**	988.2	35.0	**-745.5**	-718.1	-27.4
Connecticut	**1,357.3**	1,357.3	–	**-953.0**	-953.0	–
Delaware[3]	**204.8**	1.7	203.1	**-207.8**	197.3	-405.0
District of Columbia	**260.1**	195.2	64.9	**-148.6**	-96.4	-52.2
Florida	**2,961.4**	291.4	2,670.0	**-2,004.3**	-210.8	-1,793.5
Georgia	**1,164.6**	774.2	390.4	**-675.8**	-507.1	-168.7
Hawaii	**178.4**	0.0	178.3	**-114.4**	-0.8	-113.7
Idaho	**290.3**	290.3	–	**-161.7**	-161.7	–
Illinois	**2,256.6**	153.2	2,103.4	**-943.7**	-163.0	-780.7
Indiana	**1,801.5**	489.4	1,312.1	**-1,049.5**	-314.8	-734.7
Iowa	**400.6**	3.9	396.8	**-417.2**	-12.7	-404.5
Kansas	**299.8**	0.5	299.3	**-199.5**	-2.9	-196.6
Kentucky	**1,370.3**	90.9	1,279.4	**-705.8**	-70.5	-635.2
Louisiana	**1,673.6**	49.7	1,624.0	**-954.3**	-53.3	-901.0
Maine	**327.3**	327.3	–	**-226.8**	-226.8	–
Maryland	**1,239.0**	490.4	748.5	**-555.6**	-231.9	-323.6
Massachusetts	**1,621.3**	788.6	832.6	**-1,270.7**	-633.4	-637.3
Michigan	**2,182.0**	1,225.9	956.1	**-1,444.7**	-780.6	-664.1
Minnesota	**1,063.3**	180.1	883.3	**-766.2**	-406.9	-359.3
Mississippi	**452.4**	74.1	378.3	**-333.8**	-104.8	-229.0

EXHIBIT 28. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Missouri	**$1,190.4**	$1,190.4	–	**-$788.4**	-$788.4	–
Montana	**276.4**	276.4	–	**-209.0**	-209.0	–
Nebraska	**194.1**	0.1	$194.0	**-140.9**	-0.5	-$140.4
Nevada	**519.2**	235.6	283.6	**-333.6**	-193.1	-140.5
New Hampshire	**181.5**	0.4	181.1	**-104.7**	-50.8	-53.9
New Jersey	**1,440.9**	20.8	1,420.1	**-822.6**	-30.2	-792.5
New Mexico	**339.8**	25.6	314.1	**-256.4**	-47.1	-209.3
New York[4]	**5,964.0**	642.7	5,321.3	**-3,491.6**	-3,676.2	184.5
North Carolina	**1,974.5**	1,974.5	–	**-1,304.8**	-1,304.8	–
North Dakota	**66.2**	55.4	10.8	**-56.1**	-35.6	-20.6
Ohio	**3,414.9**	284.8	3,130.1	**-1,830.6**	-194.8	-1,635.8
Oklahoma	**532.0**	532.0	–	**-360.7**	-360.7	–
Oregon	**720.9**	117.2	603.7	**-322.3**	-60.3	-261.9
Pennsylvania	**3,197.1**	34.0	3,163.1	**-1,821.4**	-55.0	-1,766.5
Rhode Island	**231.8**	6.3	225.5	**-136.6**	-7.4	-129.2
South Carolina	**593.4**	116.5	476.9	**-335.5**	-173.2	-162.3
South Dakota	**110.9**	110.9	–	**-55.7**	-55.7	–
Tennessee[2]	**1,199.0**	1,030.9	168.1	**-821.7**	-821.7	–
Texas	**3,187.7**	65.1	3,122.6	**-2,096.7**	-105.0	-1,991.7
Utah	**317.7**	153.5	164.2	**-192.8**	-106.6	-86.2
Vermont	**148.2**	148.1	0.1	**-138.4**	-138.4	–
Virginia	**3,757.7**	19.8	3,738.0	**-854.4**	-199.0	-655.3
Washington	**1,236.3**	84.5	1,151.7	**-884.1**	-146.7	-737.4
West Virginia	**717.1**	693.2	23.9	**-523.7**	-508.2	-15.5
Wisconsin[5]	**1,406.2**	1,406.2	–	**-972.1**	-968.3	-3.7
Wyoming	**31.7**	31.7	–	**-32.0**	-32.0	–

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 http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-programs-data-and-resources.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 U.S.C. § 552a) and the HIPAA Privacy Rule (45 C.F.R 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 $0.05 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 2020 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 fee-for-service rebates.

[3] Delaware reported large prior period adjustments for FFS that ultimately result in a positive FFS rebate amount.

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

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

Source: MACPAC, 2021, analysis of Medicaid state drug rebate utilization data as of August 2021 and CMS-64 FMR net expenditure data as of June 28, 2021.

EXHIBIT 29. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2019

State	Total Medicaid enrollees	Percentage in managed care						
		Comprehensive managed care[1]	Limited-benefit plans					PCCM
			MLTSS	BHO (PIHP and/or PAHP)	Dental	Transportation	Other	
Total	**77,406,242**	**69.5%**	**0.6%**	**12.0%**	**14.6%**	**17.5%**	**1.8%**	**7.2%**
Alabama	**1,039,621**	0.0	–	–	–	–	3.1	80.5
Alaska[2]	**207,174**	–	–	–	–	–	–	–
Arizona	**1,874,857**	84.3	–	–	–	–	–	–
Arkansas	**951,645**	4.8	–	–	61.1	69.7	–	43.8
California	**12,780,305**	81.3	–	0.0	6.3	–	0.0	–
Colorado[3]	**1,231,952**	9.5	–	–	–	–	–	82.8
Connecticut[4]	**837,367**	–	–	–	–	–	–	–
Delaware	**237,244**	84.3	–	–	–	87.9	–	–
District of Columbia	**267,329**	72.6	–	–	–	20.6	–	–
Florida	**3,813,067**	77.9	2.9	–	81.2	–	–	–
Georgia[5]	**1,917,560**	74.0	–	–	–	–	2.5	–
Hawaii[6]	**327,893**	100.0	–	1.4	–	–	–	–
Idaho	**291,466**	4.2	–	90.8	99.2	99.2	–	84.9
Illinois	**3,001,288**	70.7	1.7	–	–	–	–	–
Indiana	**1,462,152**	73.5	–	–	–	–	–	–
Iowa	**642,329**	93.9	–	–	60.7	1.5	–	–
Kansas	**398,034**	85.9	–	–	–	–	–	–
Kentucky	**1,353,368**	90.5	–	–	–	88.8	–	–
Louisiana	**1,622,025**	83.7	–	8.2	92.4	–	–	–
Maine	**258,581**	–	–	–	–	93.8	–	60.0
Maryland	**1,457,966**	81.7	–	–	–	–	–	–
Massachusetts	**1,829,245**	40.0	–	29.0	–	–	–	25.3
Michigan[7]	**4,713,103**	51.9	0.2	46.8	20.7	–	–	–
Minnesota	**1,085,204**	78.3	–	–	–	–	–	–
Mississippi	**673,247**	64.8	–	–	–	–	–	–

EXHIBIT 29. (continued)

State	Total Medicaid enrollees	Percentage in managed care						
		Comprehensive managed care[1]	Limited-benefit plans					PCCM
			MLTSS	BHO (PIHP and/or PAHP)	Dental	Transportation	Other	
Missouri	**858,077**	69.5%	–	–	–	28.5%	–	–
Montana	**254,273**	–	–	–	–	–	–	81.5%
Nebraska	**248,377**	99.6	–	–	99.1%	–	–	–
Nevada	**654,497**	76.2	–	–	76.2	87.9	–	–
New Hampshire	**193,363**	89.5	–	–	–	–	–	–
New Jersey	**1,612,863**	93.0	–	–	–	92.1	–	–
New Mexico	**832,295**	80.3	–	–	–	–	–	–
New York	**6,140,117**	72.7	3.9%	–	–	–	–	–
North Carolina	**2,173,625**	0.1	–	71.0%	–	–	–	73.2
North Dakota	**88,829**	22.4	–	–	–	–	–	51.7
Ohio	**2,823,271**	84.0	–	–	–	–	–	–
Oklahoma	**790,443**	0.1	–	–	–	81.6	–	66.9
Oregon[8]	**1,080,170**	80.5	–	0.1	4.2	–	–	–
Pennsylvania	**2,827,289**	86.4	–	91.5	–	22.0	0.0%	–
Rhode Island	**312,141**	83.1	–	–	36.3	93.0	–	–
South Carolina	**1,253,433**	63.9	–	–	–	100.0	–	0.1
South Dakota	**122,209**	–	–	–	–	–	–	73.9
Tennessee[9]	**1,565,485**	91.8	–	–	54.0	–	82.5	–
Texas	**3,878,840**	92.3	–	–	44.1	96.4	–	–
Utah	**290,203**	74.3	–	88.1	68.6	82.6	–	–
Vermont[10]	**166,114**	65.5	–	–	–	–	–	–
Virginia	**1,460,075**	87.4	–	–	–	–	–	–
Washington	**1,742,684**	86.8	–	100.0	–	100.0	0.8	0.2
West Virginia	**508,092**	76.2	–	–	–	–	–	–
Wisconsin	**1,194,983**	63.5	4.2	0.1	–	–	0.3	–
Wyoming	**60,472**	0.2	–	–	–	–	–	–

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 in each program type as a percentage of total Medicaid enrollment may be greater than 100 percent.

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

[1] Includes comprehensive managed care and Programs of All-Inclusive Care for the Elderly (PACE). 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's total Medicaid enrollment as of July 1, 2019, was taken from the Medicaid Budget and Expenditure System, accessed June 16, 2021. See https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360.

[3] Colorado reported plan level enrollment as 0 for plans that had fewer than 30 beneficiaries. As a result, reported Medicaid enrollment in comprehensive managed care may be lower than actual enrollment.

[4] Connecticut's total Medicaid enrollment as of July 1, 2019, was taken from the Medicaid Budget and Expenditure System, accessed June 16, 2021. See https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360.

[5] Georgia did not monitor non-emergency medical transportation program enrollment in 2019, so total enrollment in transportation programs is reported here as zero.

[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 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 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, 2021, analysis of data from CMS, *Medicaid managed care enrollment and program characteristics*, 2019, Baltimore, MD: CMS, https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html.

EXHIBIT 30. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2019

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	**82,955**	**69.6%**	**81.1%**	**81.3%**	**60.9%**	**50.8%**	**35.8%**	**44.4%**	**54.4%**	**34.8%**	**36.7%**	**51.2%**	**34.1%**
Alabama	**1,126**	**0.0**	–	–	–	0.0	0.1	**5.8**	–	–	0.1	14.4	25.2
Alaska	**244**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Arizona	**2,162**	**90.7**	98.3	93.3	82.1	90.7	71.2	**–**	–	–	–	–	–
Arkansas	**1,030**	**0.0**	–	–	–	0.0	0.4	**90.0**	97.5	95.7	96.1	74.9	55.2
California[6]	**14,731**	**72.1**	86.0	81.7	43.5	84.4	72.9	**5.7**	6.1	7.3	3.8	6.7	3.5
Colorado	**1,460**	**12.7**	10.8	14.5	12.7	11.7	14.7	**94.8**	99.0	97.5	96.6	86.1	61.9
Connecticut	**1,094**	**0.0**	–	0.0	–	–	–	**89.4**	100.0	100.0	100.0	64.3	39.9
Delaware	**284**	**86.0**	95.7	93.6	78.5	70.2	46.8	**89.1**	98.1	98.6	81.4	72.8	46.4
District of Columbia[7]	**274**	**73.4**	93.2	89.3	94.0	19.3	3.3	**31.0**	15.9	20.9	17.0	80.3	65.7
Florida	**4,621**	**78.2**	97.4	–	72.7	62.3	36.2	**78.6**	95.8	–	78.8	65.7	32.6
Georgia	**2,333**	**70.5**	96.7	–	92.1	3.6	0.0	**82.1**	95.8	–	78.3	67.3	42.0
Hawaii	**374**	**98.0**	99.9	99.3	99.7	93.5	87.6	**1.4**	0.0	0.9	0.4	13.5	2.1
Idaho	**326**	**–**	–	–	–	–	–	**93.1**	99.9	–	98.4	83.0	59.8
Illinois[7, 8]	**3,236**	**79.1**	86.0	86.5	82.6	38.5	43.3	**–**	–	–	–	–	–
Indiana	**1,716**	**74.0**	89.6	94.2	40.3	39.0	6.9	**26.9**	30.8	1.5	34.5	55.2	58.5
Iowa	**754**	**93.4**	98.0	96.4	89.2	89.5	70.2	**60.0**	14.2	98.0	84.7	78.1	71.3
Kansas	**446**	**92.9**	99.7	–	97.3	82.8	66.1	**–**	–	–	–	–	–
Kentucky[7]	**1,568**	**86.2**	97.5	90.6	93.6	69.5	35.2	**88.9**	96.7	90.6	94.2	79.3	57.6
Louisiana[8]	**1,727**	**92.2**	99.8	97.6	60.0	92.7	81.4	**92.8**	99.8	98.6	61.1	92.9	82.5
Maine[7]	**333**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Maryland	**1,439**	**84.6**	98.5	96.9	87.7	56.5	2.8	**–**	–	–	–	–	–
Massachusetts	**1,941**	**43.6**	50.2	59.5	36.9	33.9	33.9	**33.4**	46.9	40.6	29.0	34.9	1.8
Michigan	**2,842**	**58.9**	65.4	57.8	60.9	59.5	23.6	**97.6**	99.6	98.1	96.8	96.0	88.9
Minnesota	**1,342**	**84.3**	88.8	93.3	83.2	51.3	74.7	**–**	–	–	–	–	–
Mississippi	**776**	**67.8**	95.8	–	72.1	42.2	1.3	**16.6**	3.9	–	6.5	32.8	48.7

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	1,177	67.6%	95.7%	–	77.9%	0.8%	0.0%	94.7%	100.0%	–	89.4%	89.3%	81.4%
Montana	300	–	–	–	–	–	–	–	–	–	–	–	–
Nebraska	264	97.4	99.8	–	98.0	93.9	87.8	97.1	99.6	–	97.8	93.7	87.2
Nevada	826	73.9	85.5	87.6%	82.7	5.4	2.8	92.2	99.2	98.0%	93.1	72.7	43.1
New Hampshire	228	88.3	98.7	89.7	95.6	69.2	58.2	32.8	11.8	67.1	28.3	17.9	14.2
New Jersey	1,872	93.9	95.4	93.8	87.5	96.4	91.2	100.0	100.0	100.0	100.0	100.0	100.0
New Mexico	925	81.1	91.2	90.6	57.1	77.0	49.9	–	–	–	–	–	–
New York	6,990	74.5	92.9	91.6	62.7	49.8	14.9	4.1	0.0	0.3	0.5	6.5	27.6
North Carolina	2,345	0.1	0.0	–	0.0	0.1	1.1	82.8	99.8	–	53.3	90.9	73.3
North Dakota[6]	116	28.9	0.0	99.5	15.1	4.2	2.8	–	–	–	–	–	–
Ohio	3,114	82.8	97.1	93.9	94.1	50.2	9.6	4.7	0.0	0.0	1.8	14.4	33.0
Oklahoma	894	0.1	–	–	–	0.1	0.7	90.2	96.9	–	81.1	83.6	78.1
Oregon	1,074	83.0	92.9	87.7	80.0	49.6	35.6	8.6	7.4	5.9	8.5	22.5	21.7
Pennsylvania	3,237	86.7	96.3	94.5	91.6	75.8	48.4	93.2	98.1	97.8	93.8	91.9	64.7
Rhode Island	332	80.7	89.2	96.1	80.4	70.8	27.6	88.8	91.9	97.1	80.8	92.2	69.8
South Carolina	1,344	64.8	89.5	–	49.6	40.1	22.3	82.8	99.3	–	54.5	94.5	84.1
South Dakota	129	–	–	–	–	–	–	–	–	–	–	–	–
Tennessee	1,691	92.3	100.0	–	100.0	80.5	50.8	–	–	–	–	–	–
Texas[9]	4,990	86.7	97.1	25.0	91.0	70.9	44.7	90.0	99.4	62.5	94.6	77.2	49.3
Utah[6, 7, 10]	274	70.2	86.5	20.4	62.3	55.0	36.6	92.3	98.6	83.8	77.1	76.3	69.3
Vermont	194	–	–	–	–	–	–	–	–	–	–	–	–
Virginia[7]	1,555	69.8	96.7	–	78.7	3.0	2.6	18.2	0.3	–	7.0	79.0	63.8
Washington[7]	2,081	85.4	96.4	96.0	68.3	52.3	5.6	76.6	78.4	78.1	51.7	75.8	69.8
West Virginia	623	82.9	98.4	98.2	94.8	50.8	3.6	79.7	84.8	80.7	83.3	77.7	54.0
Wisconsin	1,304	70.0	91.6	–	82.2	33.1	7.8	93.2	99.6	–	98.9	95.9	50.5
Wyoming	76	0.2	–	–	–	0.2	1.5	0.0	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	**82,955**	**7.8%**	**10.9%**	**4.8%**	**7.8%**	**8.0%**	**2.4%**
Alabama	**1,126**	**66.0**	91.7	–	47.4	50.8	17.1
Alaska	**244**	**–**	–	–	–	–	–
Arizona	**2,162**	**–**	–	–	–	–	–
Arkansas	**1,030**	**47.8**	87.3	11.4	60.8	53.7	2.7
California[6]	**14,731**	**0.0**	0.0	0.0	0.0	0.1	0.0
Colorado	**1,460**	**93.8**	98.1	96.4	95.4	85.2	61.3
Connecticut	**1,094**	**–**	–	–	–	–	–
Delaware	**284**	**–**	–	–	–	–	–
District of Columbia[7]	**274**	**–**	–	–	–	–	–
Florida	**4,621**	**–**	–	–	–	–	–
Georgia	**2,333**	**–**	–	–	–	–	–
Hawaii	**374**	**–**	–	–	–	–	–
Idaho	**326**	**85.6**	96.4	–	85.7	73.7	40.5
Illinois[7, 8]	**3,236**	**–**	–	–	–	–	–
Indiana	**1,716**	**–**	–	–	–	–	–
Iowa	**754**	**0.1**	0.1	0.1	0.1	0.3	0.0
Kansas	**446**	**–**	–	–	–	–	–
Kentucky[7]	**1,568**	**–**	–	–	–	–	–
Louisiana[8]	**1,727**	**–**	–	–	–	–	–
Maine[7]	**333**	**55.8**	84.3	71.7	76.0	29.9	1.1
Maryland	**1,439**	**–**	–	–	–	–	–
Massachusetts	**1,941**	**27.3**	34.9	38.5	25.9	24.6	1.1
Michigan	**2,842**	**–**	–	–	–	–	–
Minnesota	**1,342**	**–**	–	–	–	–	–
Mississippi	**776**	**–**	–	–	–	–	–

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	1,177	–	–	–	–	–	–
Montana	300	84.0%	94.8%	94.4%	82.4%	43.4%	4.4%
Nebraska	264	–	–	–	–	–	–
Nevada	826	–	–	–	–	–	–
New Hampshire	228	–	–	–	–	–	–
New Jersey	1,872	–	–	–	–	–	–
New Mexico	925	–	–	–	–	–	–
New York	6,990	0.0	0.0	–	0.0	0.0	0.0
North Carolina	2,345	76.6	96.3	–	55.3	75.4	43.8
North Dakota[6]	116	51.5	88.1	10.9	96.3	1.5	0.0
Ohio	3,114	–	–	–	–	–	–
Oklahoma	894	64.7	83.8	–	58.2	32.7	1.4
Oregon	1,074	24.6	23.9	26.2	25.9	23.7	14.5
Pennsylvania	3,237	–	–	–	–	–	–
Rhode Island	332	–	–	–	–	–	–
South Carolina	1,344	0.1	0.0	–	–	0.3	–
South Dakota	129	73.1	90.5	–	88.6	36.9	10.2
Tennessee	1,691	–	–	–	–	–	–
Texas[9]	4,990	–	–	–	–	–	–
Utah[6, 7, 10]	274	–	–	–	–	–	–
Vermont	194	–	–	–	–	–	–
Virginia[7]	1,555	–	–	–	–	–	–
Washington[7]	2,081	0.2	0.2	0.3	0.2	0.4	0.0
West Virginia	623	–	–	–	–	–	–
Wisconsin	1,304	–	–	–	–	–	–
Wyoming	76	–	–	–	–	–	–

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 organization, and Programs of All-Inclusive Care for the Elderly (PACE).

[2] Includes prepaid inpatient health plan (PIHP), prepaid ambulatory health plans (PAHP), accountable care organization, 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 are 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 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 the 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 242,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 11,000.

[7] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 39 percent less than the benchmark; Illinois's average monthly enrollment was 117 percent more than the benchmark; Kentucky's average monthly enrollment was 26 percent more than the benchmark; Maine's average monthly enrollment was 65 percent more than the benchmark; and Washington's average monthly enrollment was 29 percent more than the benchmark. Utah reported an average monthly enrollment in the new adult group of approximately 30,000 in T-MSIS but did not report any enrollment on the CMS-64 enrollment report. Virginia did not report any enrollees in the new adult group compared with approximately 198,000 average monthly enrollees on the CMS-64 enrollment report; Virginia expanded coverage to the new adult group beginning January 1, 2019, and may not be reporting enrollment under the correct eligibility code in T-MSIS.

[8] State reported a large shift of enrollees between eligibility groups. Illinois reported about a 43 percent decrease for the child group, a 35 percent decrease for the disabled group, an 87 percent decrease for the other adult group, and a 543 percent increase in the new adult group compared with 2018; the state appears to have corrected their reporting of the new adult group but appears to have also reclassified some children, other adult, and disabled beneficiaries into the new adult group. Louisiana reported a 27 percent decrease in the aged group and a 50 percent increase in the other adult group compared with 2018.

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2019.

[10] State reported total enrollment that shows a difference of greater than 20 percent when compared with the CMS-64 enrollment report. Utah's average monthly enrollment was 24 percent less than the benchmark, and the ever enrolled total was 29 percent less than what was reported in T-MSIS in 2018.

Source: MACPAC, 2021, analysis of T-MSIS data as of December 2020.

EXHIBIT 31. Total Medicaid Administrative Spending by State and Category, FY 2020 (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	**$215**	$33	$26	$11	$12	$132	-$0
Alaska	**169**	50	4	9	6	101	–
Arizona	**292**	34	124	18	12	104	–
Arkansas	**461**	125	127	4	39	164	–
California	**6,677**	452	2,339	34	284	3,568	–
Colorado	**547**	64	119	16	15	333	-0
Connecticut	**340**	37	93	8	27	174	–
Delaware	**82**	20	8	1	2	50	–
District of Columbia	**253**	39	86	8	8	113	–
Florida	**647**	84	105	6	29	423	–
Georgia	**525**	124	116	7	17	262	-0
Hawaii	**101**	20	39	1	4	36	-0
Idaho	**129**	32	19	3	13	64	–
Illinois	**935**	90	274	11	69	491	–
Indiana	**513**	82	152	7	22	250	–
Iowa	**141**	33	65	2	13	28	-0
Kansas	**227**	61	80	1	5	80	–
Kentucky	**285**	55	94	24	18	94	–
Louisiana	**346**	55	141	10	5	135	-0
Maine	**147**	44	35	2	13	53	-0
Maryland	**524**	71	131	19	24	279	–
Massachusetts	**960**	130	140	17	51	624	-1
Michigan	**669**	126	165	18	16	348	-3
Minnesota	**753**	76	153	6	17	501	–
Mississippi	**173**	67	29	10	9	58	–
Missouri	**430**	62	93	11	12	253	–
Montana	**101**	34	21	6	5	35	-0
Nebraska	**168**	29	35	10	33	61	–
Nevada	**196**	41	62	2	10	81	–
New Hampshire	**118**	36	39	1	4	38	–
New Jersey	**1,064**	79	267	14	23	681	-0

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 Mexico	**$297**	$83	$72	$11	$9	$122	–
New York	**2,142**	195	166	143	57	1,580	–
North Carolina	**829**	96	398	11	33	291	–
North Dakota	**100**	28	35	8	2	28	-$0
Ohio	**993**	121	195	4	16	657	-0
Oklahoma	**203**	33	17	2	17	133	–
Oregon	**536**	40	143	14	13	327	-0
Pennsylvania	**1,037**	96	295	10	22	614	-0
Rhode Island	**151**	25	32	9	3	82	-0
South Carolina	**380**	71	109	4	19	178	–
South Dakota	**56**	10	4	1	2	39	–
Tennessee	**720**	213	226	8	16	259	-1
Texas	**1,499**	279	424	9	25	770	-9
Utah	**177**	33	48	6	11	80	–
Vermont	**178**	44	49	13	8	65	–
Virginia	**481**	72	211	4	20	173	–
Washington	**962**	93	70	15	16	767	-0
West Virginia	**149**	45	26	3	21	54	-0
Wisconsin	**501**	128	122	8	7	240	-4
Wyoming	**81**	36	18	5	4	19	-0
Subtotal (states)	**$29,660**	**$4,029**	**$7,839**	**$586**	**$1,136**	**$16,088**	**-$19**
American Samoa	**3**	–	–	1	–	2	–
Guam	**4**	–	–	0	0	3	–
N. Mariana Islands	**1**	0	–	0	–	0	–
Puerto Rico	**99**	34	14	3	–	48	–
Virgin Islands	**9**	0	6	–	–	3	–
Subtotal (states and territories)	**$29,775**	**$4,064**	**$7,859**	**$591**	**$1,136**	**$16,145**	**-$19**

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[6]	**$387**	–	–	–	$387	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	**333**	–	–	–	333	–	–
Total	**$30,495**	**$4,064**	**$7,859**	**$591**	**$1,857**	**$16,145**	**-$19**
Percent of total, exclusive of collections	**–**	**13.3%**	**25.8%**	**1.9%**	**6.1%**	**52.9%**	**–**

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 June 28, 2021. 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 Medicaid Fraud Control Units (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 (FMAP)); eligibility changes associated with the Temporary Assistance for Needy Families program (75 or 90 percent); administration of family planning services (90 percent); and immigration status verification systems and design development and implementation of Prescription Drug Monitoring Program 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, 2021, analysis of CMS-64 FMR net expenditure data as of June 28, 2021. For MFCUs and survey and certification: CMS, 2021, *Fiscal year 2022 justification of estimates for appropriations committees,* Baltimore, MD, https://www.cms.gov/files/document/fy2022-cms-congressional-justification-estimates-appropriations-committees.pdf.

EXHIBIT 32. Child Enrollment in CHIP and Medicaid by State, FY 2020 (thousands)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
Total	**44,260**	**5,256**	**3,806**	**9,063**	**35,197**
Alabama	**751**	101	109	**210**	**541**
Alaska	**130**	21	–	**21**	**109**
Arizona	**990**	72	49	**120**	**870**
Arkansas	**506**	38	67	**105**	**401**
California	**6,157**	1,750	62	**1,812**	**4,345**
Colorado	**633**	85	79	**165**	**468**
Connecticut	**391**	–	22	**22**	**370**
Delaware	**121**	1	12	**14**	**108**
District of Columbia	**100**	18	–	**18**	**81**
Florida	**2,770**	143	318	**462**	**2,309**
Georgia	**1,589**	79	173	**252**	**1,337**
Hawaii	**172**	28	–	**28**	**144**
Idaho	**230**	9	35	**44**	**186**
Illinois	**1,665**	106	224	**330**	**1,335**
Indiana	**822**	82	42	**123**	**699**
Iowa	**438**	19	82	**102**	**336**
Kansas	**310**	16	53	**69**	**241**
Kentucky	**654**	60	41	**101**	**553**
Louisiana	**872**	164	12	**177**	**696**
Maine	**178**	21	11	**32**	**146**
Maryland	**697**	132	–	**132**	**565**
Massachusetts	**749**	98	121	**219**	**530**
Michigan	**1,222**	69	3	**72**	**1,150**
Minnesota	**631**	1	3	**3**	**627**
Mississippi	**480**	35	49	**84**	**395**
Missouri	**684**	50	67	**117**	**567**
Montana[1]	**177**	10	30	**41**	**136**
Nebraska	**231**	60	2	**62**	**169**
Nevada	**443**	23	43	**66**	**377**
New Hampshire	**107**	17	–	**17**	**90**
New Jersey	**951**	111	151	**262**	**689**

EXHIBIT 32. (continued)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
New Mexico	**407**	10	–	**10**	**397**
New York	**2,796**	315	436	**751**	**2,045**
North Carolina	**1,428**	185	124	**309**	**1,119**
North Dakota[2]	**40**	4	3	**6**	**34**
Ohio	**1,452**	211	–	**211**	**1,241**
Oklahoma	**724**	209	10	**220**	**504**
Oregon[3]	**566**	59	128	**187**	**378**
Pennsylvania	**1,595**	105	253	**358**	**1,238**
Rhode Island	**142**	31	2	**33**	**109**
South Carolina	**745**	112	–	**112**	**634**
South Dakota	**86**	13	4	**17**	**70**
Tennessee	**1,022**	12	61	**74**	**948**
Texas	**4,254**	314	592	**905**	**3,349**
Utah	**264**	26	24	**50**	**215**
Vermont	**74**	5	–	**5**	**70**
Virginia	**928**	126	114	**239**	**689**
Washington	**896**	–	80	**80**	**816**
West Virginia	**261**	13	24	**37**	**224**
Wisconsin	**683**	87	86	**173**	**510**
Wyoming	**44**	1	5	**6**	**38**

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 (e.g., in Medicaid-funded coverage for the first half of the year but in CHIP-funded coverage for the second half) in the most recent category (state-specific exceptions to this rule are noted below). Medicaid-funded child enrollment shown here includes all children, regardless of disability status; in other MACStats exhibits that break enrollment out by eligibility group, children qualifying on the basis of disability may be counted in the disabled category rather than the child category. Data were reported by individual states as of June 23, 2021, and may be revised at a later date.

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

[1] CMS has indicated that Montana's FY 2020 enrollment totals are artificially high, as children who transitioned between CHIP and Medicaid are reported in both programs.

[2] CMS has indicated that North Dakota's FY 2020 data are not available, so the state's FY 2019 data are included in this exhibit.

[3] CMS has indicated that Oregon's FY 2020 enrollment totals are artificially low due to missing data.

Sources: CMS, 2021, *Table: Unduplicated number of children ever enrolled (as of June 23)*, http://www.medicaid.gov/chip/downloads/fy-2020-childrens-enrollment-report.pdf. CMS, 2021, data compilation provided to MACPAC, September 27.

EXHIBIT 33. CHIP Spending by State, FY 2020 (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	**$366.7**	$348.5	$18.3	**$129.4**	$122.9	$6.5	**$227.1**	$215.8	$11.3	**$10.3**	$9.8	$0.5	–
Alaska	**30.7**	24.4	6.4	**27.7**	21.9	5.7	**–**	–	–	**3.1**	2.4	0.6	–
Arizona	**251.2**	235.7	15.5	**154.0**	144.5	9.5	**85.3**	80.0	5.3	**11.9**	11.1	0.7	–
Arkansas	**211.2**	198.2	13.1	**76.1**	71.4	4.8	**131.2**	123.2	8.0	**3.9**	3.6	0.2	–
California	**3,865.9**	3,167.8	698.1	**3,540.2**	2,898.0	642.2	**268.9**	222.8	46.1	**56.7**	47.0	9.7	–
Colorado	**336.0**	265.4	70.6	**115.8**	89.7	26.1	**210.8**	168.2	42.6	**9.4**	7.5	1.9	–
Connecticut	**46.4**	69.7	-23.3	**–**	–	–	**41.8**	33.3	8.5	**4.6**	3.7	0.9	$32.8
Delaware	**44.7**	35.5	9.2	**5.7**	4.5	1.2	**37.7**	29.9	7.8	**1.3**	1.1	0.3	–
District of Columbia	**61.1**	57.3	3.8	**59.7**	56.0	3.7	**-0.1**	-0.0	-0.0	**1.4**	1.3	0.1	–
Florida	**840.6**	737.1	103.5	**289.6**	253.7	36.0	**515.1**	452.0	63.1	**35.8**	31.4	4.4	–
Georgia	**431.8**	397.3	34.5	**138.6**	127.4	11.2	**274.7**	252.8	21.8	**18.5**	17.1	1.5	–
Hawaii	**63.8**	52.5	11.3	**60.4**	49.7	10.7	**–**	–	–	**3.4**	2.8	0.6	–
Idaho	**85.8**	80.7	5.1	**6.6**	6.2	0.4	**75.5**	71.1	4.5	**3.7**	3.4	0.2	–
Illinois	**635.3**	508.7	126.5	**218.4**	174.8	43.7	**381.2**	305.4	75.8	**35.7**	28.6	7.1	–
Indiana	**284.5**	258.3	26.2	**186.2**	169.1	17.1	**82.9**	75.2	7.7	**15.3**	13.9	1.4	–
Iowa	**180.2**	158.1	22.2	**40.0**	35.0	5.0	**134.0**	117.6	16.4	**6.3**	5.5	0.8	–
Kansas	**161.7**	139.0	22.7	**30.3**	25.9	4.4	**119.4**	102.8	16.6	**12.0**	10.3	1.7	–
Kentucky	**253.5**	240.5	13.0	**146.5**	138.7	7.8	**102.9**	97.9	5.0	**4.1**	3.9	0.2	–
Louisiana	**408.2**	373.7	34.5	**322.3**	295.1	27.2	**69.9**	63.9	6.0	**16.1**	14.7	1.4	–
Maine	**38.0**	33.9	4.1	**21.0**	18.8	2.3	**15.2**	13.6	1.6	**1.7**	1.5	0.2	–
Maryland	**340.2**	270.8	69.4	**334.7**	266.4	68.3	**-17.7**	-14.3	-3.3	**23.1**	18.8	4.4	–
Massachusetts	**805.3**	645.3	160.0	**244.8**	196.0	48.8	**477.8**	383.1	94.7	**82.6**	66.3	16.4	–
Michigan	**284.5**	254.5	30.0	**256.5**	229.3	27.2	**9.3**	8.3	0.9	**18.8**	16.9	1.9	–
Minnesota	**18.5**	108.8	-90.3	**1.7**	1.4	0.3	**16.1**	12.9	3.1	**0.8**	0.6	0.1	93.9
Mississippi	**260.7**	257.0	3.6	**95.5**	94.2	1.3	**161.0**	158.8	2.3	**4.2**	4.1	0.1	–
Missouri	**341.4**	310.0	31.3	**163.6**	148.4	15.2	**163.6**	148.8	14.9	**14.1**	12.9	1.3	–
Montana	**91.6**	82.2	9.4	**10.0**	8.6	1.4	**75.4**	68.0	7.4	**6.2**	5.6	0.6	–
Nebraska	**93.3**	77.5	15.8	**80.7**	67.0	13.8	**8.7**	7.3	1.4	**3.9**	3.3	0.6	–
Nevada	**85.4**	77.9	7.5	**34.2**	32.1	2.1	**47.8**	42.8	5.0	**3.4**	3.0	0.4	–
New Hampshire	**42.4**	45.4	-3.0	**42.4**	33.8	8.5	**–**	–	–	**0.0**	0.0	0.0	11.5

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 Jersey	**$728.7**	$582.7	$146.0	**$289.5**	$231.1	$58.4	**$366.5**	$293.4	$73.1	**$72.7**	$58.2	$14.5	–
New Mexico	**114.5**	109.5	5.0	**111.8**	106.9	4.9	**–**	–	–	**2.8**	2.6	0.1	–
New York	**1,895.7**	1,522.3	373.4	**784.7**	625.3	159.4	**926.9**	748.4	178.5	**184.1**	148.7	35.5	–
North Carolina	**576.5**	527.0	49.5	**320.5**	292.6	27.9	**237.3**	217.3	20.0	**18.7**	17.1	1.6	–
North Dakota	**21.8**	17.3	4.5	**18.2**	14.5	3.7	**1.7**	1.3	0.4	**1.9**	1.5	0.4	–
Ohio	**556.7**	494.6	62.1	**522.2**	464.1	58.2	**–**	–	–	**34.5**	30.6	3.9	–
Oklahoma	**273.3**	249.2	24.2	**285.3**	259.7	25.6	**-23.3**	-20.6	-2.8	**11.4**	10.0	1.4	–
Oregon	**461.5**	407.8	53.7	**122.5**	107.7	14.8	**321.9**	285.0	36.9	**17.1**	15.1	2.0	–
Pennsylvania	**812.5**	659.9	152.6	**354.2**	287.0	67.2	**443.9**	361.1	82.7	**14.5**	11.8	2.7	–
Rhode Island	**89.2**	71.8	17.4	**86.7**	69.8	16.9	**-1.9**	-1.5	-0.3	**4.3**	3.5	0.8	–
South Carolina	**208.4**	196.4	12.0	**200.4**	188.8	11.5	**-0.9**	-0.8	-0.1	**9.0**	8.4	0.5	–
South Dakota	**33.0**	27.9	5.1	**24.4**	20.6	3.8	**8.0**	6.8	1.2	**0.5**	0.5	0.1	–
Tennessee	**317.7**	287.6	30.1	**189.0**	171.2	17.8	**119.0**	107.6	11.4	**9.7**	8.8	0.9	–
Texas	**1,467.9**	1,281.8	186.1	**591.9**	517.2	74.7	**821.3**	716.9	104.4	**54.7**	47.7	7.0	–
Utah	**130.2**	120.7	9.5	**86.8**	80.5	6.3	**36.8**	34.1	2.7	**6.6**	6.1	0.5	–
Vermont	**13.6**	19.7	-6.1	**13.2**	10.9	2.3	**-0.9**	-0.8	-0.2	**1.3**	1.1	0.2	$8.5
Virginia	**449.1**	358.8	90.2	**201.8**	160.3	41.5	**216.9**	174.1	42.8	**30.3**	24.4	6.0	–
Washington	**208.9**	234.1	-25.2	**16.1**	13.9	2.3	**187.8**	144.6	43.2	**5.0**	3.8	1.1	71.9
West Virginia	**77.0**	74.8	2.2	**23.8**	23.2	0.6	**47.3**	45.9	1.4	**5.9**	5.7	0.2	–
Wisconsin	**253.8**	237.4	16.4	**113.2**	97.2	16.0	**125.0**	107.5	17.5	**15.6**	13.4	2.2	19.3
Wyoming	**14.5**	11.6	2.9	**2.6**	2.1	0.5	**11.1**	8.9	2.2	**0.8**	0.6	0.2	–
Subtotal (states)	**$19,664.8**	**$17,004.6**	**$2,660.2**	**$11,191.4**	**$9,524.8**	**$1,666.6**	**$7,559.8**	**$6,470.1**	**$1,089.6**	**$913.6**	**$771.9**	**$141.8**	**$237.8**
American Samoa	**5.8**	5.8	–	**5.8**	5.8	–	**–**	–	–	**–**	–	–	–
Guam	**29.2**	29.1	0.0	**29.2**	29.1	0.0	**–**	–	–	**–**	–	–	–
Northern Mariana Islands	**16.3**	16.3	–	**16.3**	16.3	–	**–**	–	–	**–**	–	–	–
Puerto Rico	**112.3**	111.4	0.8	**112.3**	111.4	0.8	**–**	–	–	**–**	–	–	–
Virgin Islands	**11.6**	11.6	0.0	**11.6**	11.6	0.0	**–**	–	–	**–**	–	–	–
Total (states and territories)	**$19,839.9**	**$17,178.8**	**$2,661.1**	**$11,366.5**	**$9,699.0**	**$1,667.5**	**$7,559.8**	**$6,470.1**	**$1,089.6**	**$913.6**	**$771.9**	**$141.8**	**$237.8**

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, and Washington).

Source: MACPAC, 2021, analysis of Medicaid and CHIP Budget Expenditure System data from CMS as of July 15, 2021.

EXHIBIT 34. Federal CHIP Allotments, FYs 2019–2021 (millions)

State	FY 2019 federal CHIP allotments	FY 2020 federal CHIP allotments	FY 2021 federal CHIP allotments
Alabama[1]	$396.3	$426.6	$367.1
Alaska	30.4	32.1	25.7
Arizona	251.7	266.4	248.9
Arkansas	167.8	177.2	208.8
California	3,038.4	3,209.0	3,337.6
Colorado	298.4	315.4	279.6
Connecticut	101.4	107.1	73.5
Delaware	37.9	40.0	37.4
District of Columbia	49.2	52.8	61.1
Florida	793.2	842.5	780.8
Georgia	444.3	469.3	418.6
Hawaii	63.1	66.7	55.3
Idaho	78.4	83.3	85.7
Illinois	392.7	414.8	536.0
Indiana	261.5	276.2	272.1
Iowa[1]	130.0	145.5	166.5
Kansas	119.1	125.8	146.4
Kentucky	218.0	230.2	253.4
Louisiana	373.3	394.2	393.7
Maine	37.0	39.1	35.7
Maryland	316.6	334.4	285.4
Massachusetts	724.6	765.2	679.9
Michigan	273.7	289.1	268.2
Minnesota	129.4	137.0	114.8
Mississippi	257.2	271.6	270.8
Missouri	279.0	294.6	326.7
Montana	91.4	96.6	86.6
Nebraska	87.1	92.2	81.6
Nevada	78.2	83.4	82.6
New Hampshire	44.9	47.4	47.8
New Jersey	519.7	548.8	613.9
New Mexico	101.4	107.0	115.4

EXHIBIT 34. (continued)

State	FY 2019 federal CHIP allotments	FY 2020 federal CHIP allotments	FY 2021 federal CHIP allotments
New York	$1,473.1	$1,555.8	$1,607.9
North Carolina	500.7	528.8	555.8
North Dakota	26.7	28.5	18.4
Ohio	520.8	550.1	521.2
Oklahoma	233.6	246.7	262.5
Oregon	370.1	511.6	429.7
Pennsylvania	668.2	705.7	695.2
Rhode Island	93.0	98.2	75.6
South Carolina	184.6	195.6	207.9
South Dakota	31.2	33.2	29.5
Tennessee	234.6	247.9	303.7
Texas	1,510.2	1,601.5	1,355.6
Utah	135.1	143.3	127.3
Vermont	28.3	29.8	20.8
Virginia	378.4	399.6	378.1
Washington	236.3	251.2	247.6
West Virginia	77.4	81.7	78.8
Wisconsin	272.8	288.1	250.1
Wyoming	13.4	14.1	12.2
Subtotal (states)	**$17,173.8**	**$18,293.5**	**$17,935.4**
American Samoa	4.8	5.1	6.1
Guam	32.2	34.0	30.7
Northern Mariana Islands	11.2	11.8	17.2
Puerto Rico	182.6	192.8	87.3
Virgin Islands	10.9	11.6	9.7
Total (states and territories)	**$17,415.6**	**$18,548.9**	**$18,086.3**

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 2020 allotment for this state differs from previously published allotments for the fiscal year because the state received such an allotment increase.

Sources: MACPAC, 2021, analysis of Medicaid and CHIP Budget Expenditure System data as of June 25, 2021.

SECTION 4

Medicaid and CHIP Eligibility

Section 4: Medicaid and CHIP Eligibility

Key Points

- Thirty-seven 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). Missouri approved a Medicaid expansion through voter referendum but had not implemented it as of July 2021 (Exhibit 36). Missouri has since begun processing applications for this eligibility group.
- 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 2020 and 2021 (Exhibit 37).
- In 2021, in the lower 48 states and the District of Columbia, 100 percent of the federal poverty level is $12,880 for an individual plus $4,540 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, July 2021

State	CHIP program type[1] (as of July 2021)	Medicaid coverage[2]						Separate CHIP coverage		Medicaid and 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			
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	–[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	225	–	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
Nebraska	Combination	162	162–213	145	145–213	133	109–213	–	197	194
Nevada	Combination	160	–	160	–	133	122–133	200	–	160

EXHIBIT 35. (continued)

State	CHIP program type[1] (as of July 2021)	Medicaid coverage[2]						Separate CHIP coverage		Medicaid and 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			
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	Medicaid expansion	154	154–200	154	154–200	133	119–200	–	–	154

Notes: As of January 2021, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $12,880 for an individual plus $4,540 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 July 2021. 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 eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

EXHIBIT 35. (continued)

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. Ten states (Alaska, Hawaii, Maryland, New Hampshire, New Mexico, North Dakota, Ohio, South Carolina, Vermont, and Wyoming) and the District of Columbia use Medicaid expansion, and two states (Connecticut and Washington) use separate CHIP. Thirty-eight 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.

Source: MACPAC, 2021, analysis of CMS, 2021, 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, 2021, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2021, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2021, *Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2021: Findings from a 50-state survey*, San Francisco, CA: KFF, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-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, July 2021

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	131	133%
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	31	–
Hawaii	105	133
Idaho	22	133
Illinois	133	133
Indiana	17	133
Iowa	49	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	58	133
Nevada	30	133
New Hampshire	62	133
New Jersey	29	133

EXHIBIT 36. (continued)

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
New Mexico	42%	133%
New York	133[3]	133[3]
North Carolina	40	Age 19–20 only: 40
North Dakota	48	133
Ohio	90	133
Oklahoma	38[5]	133[6]
Oregon	37	133
Pennsylvania	33	133
Rhode Island	116	133
South Carolina	95	–[6]
South Dakota	52	–
Tennessee	95	–
Texas	14	–
Utah	41[5]	133[6]
Vermont	49	133
Virginia	49	133
Washington	37	133
West Virginia	18	133
Wisconsin	95	95
Wyoming	51	–

Notes: As of January 2021, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $12,880 for an individual plus $4,540 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 July 2021. 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 eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

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.

EXHIBIT 36. (continued)

– 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.

[4] Missouri opted to expand Medicaid through voter referendum in August 2020 but had not implemented as of July 2021.

[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.

Source: MACPAC, 2021, analysis of CMS, 2021, 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, 2021, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2021, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2021, *Medicaid and CHIP eligibility, enrollment, and cost sharing policies as of January 2021: Findings from a 50-state survey*, San Francisco, CA: KFF, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2021-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, 2021

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
Alabama	§ 1634	74%	–	–	–	222%
Alaska	SSI criteria	59[6]	–	–	–	178
Arizona	§ 1634	74	–	–	–	222
Arkansas	§ 1634	74	–	80% (aged only)	10%	222
California	§ 1634	74	–	100	48	–
Colorado	§ 1634	74	–	–	–	222
Connecticut	§ 209(b)	–	60%[7]	–	60	222
Delaware	§ 1634	74	–	–	–	185
District of Columbia	§ 1634	74	–	100	64	222
Florida	§ 1634	74	–	88	17	222
Georgia	§ 1634	74	–	–	30	222
Hawaii	§ 209(b)	–	64	100	38	–
Idaho	SSI criteria	74	–	77	–	222
Illinois	§ 209(b)	–	100	100	100	–
Indiana	§ 1634	74	–	100	–	222
Iowa	§ 1634	74	–	–	45	222
Kansas	SSI criteria	74	–	–	44	222
Kentucky	§ 1634	74	–	–	20	222
Louisiana	§ 1634	74	–	–	9	222
Maine	§ 1634	74	–	100	29	222
Maryland	§ 1634	74	–	–	33	222
Massachusetts[8]	§ 1634	74	–	100 (aged); 133 (disabled)	49	222
Michigan	§ 1634	74	–	100	38	222
Minnesota	§ 209(b)	–	81	100	45	222
Mississippi	§ 1634	74	–	–	–	222
Missouri	§ 209(b)	–	85	85	85	129
Montana	§ 1634	74	–	–	49	–
Nebraska	SSI criteria	74	–	100	37	–
Nevada	SSI criteria	74	–	–	–	222
New Hampshire	§ 209(b)	–	75	–	55	222

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 Jersey	§ 1634	74%	–	100%	34%	222%
New Mexico	§ 1634	74	–	–	–	222
New York	§ 1634	74	–	82	82	–
North Carolina	§ 1634	74	–	100	23	–
North Dakota	§ 209(b)	–	83%	–	83[9]	–
Ohio	§ 1634	74	–	–	–	222
Oklahoma	SSI criteria	74	–	100	–	222
Oregon	SSI criteria	74	–	–	–	222
Pennsylvania	§ 1634	74	–	100	40	222
Rhode Island	§ 1634	74	–	100	87	222
South Carolina	§ 1634	74	–	100	–	222
South Dakota	§ 1634	74	–	–	–	222
Tennessee	§ 1634	74	–	–	–	222
Texas	§ 1634	74	–	–	–	222
Utah	SSI criteria	74	–	100	100	222
Vermont	§ 1634	74	–	–	111	222
Virginia	§ 209(b)	–	74	80	47	222
Washington	§ 1634	74	–	–	74	222
West Virginia	§ 1634	74	–	–	19	222
Wisconsin	§ 1634	74	–	82	100	222
Wyoming	§ 1634	74	–	–	–	222

Notes: SSI is Supplemental Security Income. § 209(b) refers to Section 209(b) of the Social Security Act Amendments of 1972. § 1634 refers to Section 1634 of the Social Security Act. In 2021, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $12,880 for an individual and $4,540 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 or older or 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)

The categories displayed in this exhibit do not include all Medicaid eligibility pathways for individuals 65 years old or those qualifying on the basis of disability. Other eligibility groups include but are not limited to individuals who meet the income and resource requirements of the cash assistance programs; individuals receiving only optional state supplements; individuals receiving state plan home and community-based services; individuals who have disabilities and are earning income; individuals who are either receiving hospice services or are in the Program for All Inclusive Care for the Elderly (PACE); and other discrete eligibility groups.

– 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 increased slightly from last year (but still rounds to 74 percent) because the FPL increased by 3.1 percent but the SSI federal benefit rate increased by 3.0 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 aged, blind, and disabled individuals 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 222 percent FPL in 2021). 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.

[9] North Dakota disregards income between the medically needy income limit ($500 per month or approximately 47 percent FPL) and 83 percent FPL for its aged, blind, and disabled medically needy group. This effectively raises the medically needy income limit to 83 percent FPL.

Source: MACPAC, 2021, analysis of eligibility information from state websites and Medicaid state plans as of September 2021.

EXHIBIT 38. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2021

States	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%	$12,880	$17,420	$21,960	$26,500	$4,540	$1,073	$1,452	$1,830	$2,208	$378
	133	17,130	23,169	29,207	35,245	6,038	1,428	1,931	2,434	2,937	503
	138	17,774	24,040	30,305	36,570	6,265	1,481	2,003	2,525	3,048	522
	150	19,320	26,130	32,940	39,750	6,810	1,610	2,178	2,745	3,313	568
	185	23,828	32,227	40,626	49,025	8,399	1,986	2,686	3,386	4,085	700
	200	25,760	34,840	43,920	53,000	9,080	2,147	2,903	3,660	4,417	757
	250	32,200	43,550	54,900	66,250	11,350	2,683	3,629	4,575	5,521	946
	300	38,640	52,260	65,880	79,500	13,620	3,220	4,355	5,490	6,625	1,135
	400	51,520	69,680	87,840	106,000	18,160	4,293	5,807	7,320	8,833	1,513
Alaska	100	16,090	21,770	27,450	33,130	5,680	1,341	1,814	2,288	2,761	473
	133	21,400	28,954	36,509	44,063	7,554	1,783	2,413	3,042	3,672	630
	138	22,204	30,043	37,881	45,719	7,838	1,850	2,504	3,157	3,810	653
	150	24,135	32,655	41,175	49,695	8,520	2,011	2,721	3,431	4,141	710
	185	29,767	40,275	50,783	61,291	10,508	2,481	3,356	4,232	5,108	876
	200	32,180	43,540	54,900	66,260	11,360	2,682	3,628	4,575	5,522	947
	250	40,225	54,425	68,625	82,825	14,200	3,352	4,535	5,719	6,902	1,183
	300	48,270	65,310	82,350	99,390	17,040	4,023	5,443	6,863	8,283	1,420
	400	64,360	87,080	109,800	132,520	22,720	5,363	7,257	9,150	11,043	1,893

EXHIBIT 38. (continued)

States	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%	$14,820	$20,040	$25,260	$30,480	$5,220	$1,235	$1,670	$2,105	$2,540	$435
	133	19,711	26,653	33,596	40,538	6,943	1,643	2,221	2,800	3,378	579
	138	20,452	27,655	34,859	42,062	7,204	1,704	2,305	2,905	3,505	600
	150	22,230	30,060	37,890	45,720	7,830	1,853	2,505	3,158	3,810	653
	185	27,417	37,074	46,731	56,388	9,657	2,285	3,090	3,894	4,699	805
	200	29,640	40,080	50,520	60,960	10,440	2,470	3,340	4,210	5,080	870
	250	37,050	50,100	63,150	76,200	13,050	3,088	4,175	5,263	6,350	1,088
	300	44,460	60,120	75,780	91,440	15,660	3,705	5,010	6,315	7,620	1,305
	400	59,280	80,160	101,040	121,920	20,880	4,940	6,680	8,420	10,160	1,740

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services (HHS) 2021 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, 2021, Annual update of the HHS poverty guidelines, *Federal Register* 86, no. 19 (February 1): 7732–7734.

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).
- Children whose primary coverage source is Medicaid or CHIP are as likely to report seeing a doctor or having a well-child checkup as those with private coverage and more likely than those who are uninsured (Exhibit 40). Children whose primary coverage source is Medicaid or CHIP are as likely to experience delayed care because of cost as children with private coverage. However, while most children whose primary coverage source is Medicaid or CHIP had a usual source of care, they were less likely to have one compared with children with private coverage (Exhibit 42).
- Data from the National Health Interview Survey (NHIS) indicate that children with Medicaid or CHIP are as likely as those with private coverage to have had a dental exam or cleaning in the past 12 months (Exhibit 40). Data from both the NHIS and Medical Expenditure Panel Survey indicate that children with Medicaid or CHIP are more likely than those who are uninsured to have had a dental visit or have had a dental exam or cleaning in the past 12 months (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).
- Adults age 19–64 whose primary coverage is Medicaid are 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, 2019

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%**	**56.0%**	**34.9%**	**5.2%**
Coverage				
Length of time with any coverage during the year				
Full year	**91.7***	97.9*	94.7	–
Part year	**5.1**	2.0*	5.2	47.7*
No coverage during year	**2.2***	–	–	52.3*
Demographics				
Age				
0–5	**30.4***	28.4*	34.1	27.2*
6–11	**31.3**	31.0	31.8	29.5
12–18	**38.3***	40.6*	34.1	43.3*
Gender				
Male	**51.1**	50.5	51.8	50.5
Female	**48.9**	49.5	48.2	49.5
Race				
Hispanic	**25.6***	16.4*	38.4	38.2
White, non-Hispanic	**51.8***	64.5*	32.3	44.4*
Black, non-Hispanic	**12.7***	8.4*	20.6	8.1*
American Indian or Alaska Native, non-Hispanic	**†**	0.4	†	†
Asian, non-Hispanic	**4.3***	5.6*	2.7	†
Other single and multiple races, non-Hispanic	**5.5**	5.1	6.0	6.9
Parents present in family				
0 parents	**1.8***	0.6*	3.8	†
1 parent	**30.3***	20.1*	47.4	26.2*
2 or more parents	**67.9***	79.4*	48.8	72.1*
Family income				
Has income less than 138 percent FPL	**27.1***	6.3*	60.0	34.2*
Has income in ranges shown below				
Less than 100 percent FPL	**17.5***	3.3*	40.4	18.8*
100–199 percent FPL	**22.9***	11.1*	40.2	33.5*
200–399 percent FPL	**30.3***	37.6*	16.4	37.3*
400 percent FPL or higher	**29.3***	48.0*	2.9	10.4*

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	**97.4%**	98.4%*	97.3%	86.5%*
Lives in a family that receives				
SSI or SSDI	**7.0***	2.7*	14.1	3.7*
SSI	**4.0***	1.2*	8.9	†
SSDI	**3.8***	1.7*	7.0	†
WIC	**12.6***	3.3*	28.0	9.6*
SNAP	**19.3***	3.5*	46.4	12.0*
Public assistance	**6.0***	1.3*	13.9	†
Health				
Current health status				
Excellent or very good	**87.1***	91.8*	79.2	87.0*
Good	**10.0***	6.6*	15.4	10.5*
Fair or poor	**3.0***	1.5*	5.4	†
Special needs, impairments, and health conditions				
Receives special education or early intervention services[6]	**7.9***	6.1*	11.1	4.4*
Uses a hearing aid	**0.8**	0.8	0.9	†
Uses special equipment for walking	**1.2**	1.1	1.5	†
Uses glasses	**26.5**	26.5	26.0	24.0
Ever been told he or she has selected conditions				
ADHD/ADD[7]	**8.2***	7.0*	10.2	5.6*
Asthma	**10.7***	8.9*	14.3	6.3*
Autism[7]	**2.7**	2.3*	3.4	†
Diabetes	**0.4**	0.4	†	†
Intellectual disability[6]	**1.5***	0.9*	2.6	†
Other developmental delay[7]	**4.7***	3.8*	6.3	†

Notes: FPL is federal poverty level. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. WIC is Supplemental Nutrition Program for Women, Infants, and Children. SNAP is Supplemental Nutrition Assistance Program, formerly referred to as food stamps. ADHD is attention deficit hyperactivity disorder. ADD is attention deficit disorder. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not sum to 100 percent. Standard errors are available online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/coverage-demographic-and-health-characteristics-of-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates

EXHIBIT 39. (continued)

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.

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

* 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 or CHIP, other, and 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] Because 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] Survey information is limited to children age 0–17.

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

Source: MACPAC, 2021, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2019, 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%**	**56.0%**	**34.9%**	**5.2%**
Contact with health care professionals (past 12 months)				
Saw doctor or other health care professional	**95.2**	96.2	96.0	80.1*
Had eye exam	**44.3**	46.3*	42.4	31.1*
Received counseling/therapy from mental health professional[6]	**8.7**	8.2*	10.1	5.2*
Dental exam/cleaning[7]	**83.8**	85.7	84.3	60.0*
Had at least one overnight hospital stay[7]	**2.7***	1.9*	4.2	†
Received care at home	**1.3**	1.1	1.7	†
Receipt of appropriate care (past 12 months)				
Had well-child checkup	**80.5***	81.3	86.1	39.3*
Number of emergency room visits				
None	**81.9***	86.4*	74.9	84.6*
At least 1	**18.1***	13.6*	25.1	15.4*
1	**11.4***	9.3*	14.5	10.7
2–3	**5.8***	3.9*	8.8	4.1*
4 or more	**1.0***	0.5*	2.0	†

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 downloadable Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-data-from-national-health-interview-survey/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the 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.

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

EXHIBIT 40. (continued)

* 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, and 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] Because 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] Survey information is limited to children age two or older.

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

Source: MACPAC, 2021, analysis of NHIS data.

EXHIBIT 41. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2019, 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%**	**56.3%**	**35.4%**	**6.5%**
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	**24.9***	20.6*	27.7	44.6*
At least 1	**75.1***	79.4*	72.3	55.4*
1	**22.5***	20.7*	25.4	22.2
2–3	**26.5***	29.0*	23.8	20.9
4 or more	**26.1***	29.7*	23.1	12.3*
Had at least 1 overnight hospital stay	**2.1***	1.6*	2.8	†
Received care at home	**1.3***	1.1*	1.9	†
Had at least 1 dental care visit[6]	**53.2***	58.7*	47.5	35.4*
Receipt of appropriate care (past 12 months)				
Had more than 15 office-based or hospital outpatient visits	**4.2**	4.2	4.5	†
Number of emergency room visits				
None	**88.8***	91.6*	84.0	91.1*
At least 1	**11.2***	8.4*	16.0	8.9*
1	**8.7***	7.1*	11.4	7.7*
2–3	**2.2***	1.3*	4.1	†
4 or more	**0.2***	†	†	†

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.

EXHIBIT 41. (continued)

* 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 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] Because 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 measure should not be compared with other dental measures included in databooks 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, 2021, analysis of MEPS data.

EXHIBIT 42. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2019

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%**	**56.0%**	**34.9%**	**5.2%**
Connection to the health care system (past 12 months)				
Has a usual source of care[6]	**97.0**	98.4*	96.9	81.7*
Timeliness of care (past 12 months)				
Delayed medical care because of costs	**1.4***	0.6	0.9	14.7*
Unmet need for selected types of care due to cost				
Medical care	**1.2**	0.6	0.9	11.4*
Mental health care or counseling[7]	**1.2**	0.9	1.2	3.6*
Dental care[8]	**4.0**	2.7	3.7	19.4*
Prescription drugs	**1.1**	0.8	1.1	4.5*

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 downloadable Excel version of this exhibit at https://www.macpac.gov/publication/measures-of-access-to-care-for-non-institutionalized-children-by-source-of-health-coverage/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical 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.

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

* 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, and 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.

EXHIBIT 42. (continued)

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

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

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

Source: MACPAC, 2021, analysis of NHIS data.

EXHIBIT 43. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2019

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%**	**66.7%**	**11.4%**	**14.7%**
Coverage					
Length of time with any coverage during year					
Full year	**82.0***	96.3*	95.8*	89.2	–
Part year	**8.5***	3.7*	4.2*	10.8	30.3*
No coverage during year	**9.5***	–	–	–	69.7*
Demographics					
Age					
19–25	**15.1***	†	14.8*	18.3	18.0
26–44	**42.1***	18.8*	41.2*	47.5	49.8
45–54	**21.0***	24.6*	22.2*	16.9	17.5
55–64	**21.8***	54.1*	21.8*	17.3	14.8*
Gender					
Male	**49.1***	49.5*	49.8*	38.1	54.3*
Female	**50.9***	50.5*	50.2*	61.9	45.7*
Race					
Hispanic	**18.5***	11.6*	13.6*	24.5	38.5*
White, non-Hispanic	**60.0***	60.9*	66.8*	42.7	42.2
Black, non-Hispanic	**12.4***	20.7	10.0*	22.7	12.2*
American Indian or Alaska Native, non-Hispanic	**†**	†	0.5	†	†
Asian, non-Hispanic	**6.3**	†	7.4	6.1	3.0*
Other single and multiple races, non-Hispanic	**2.8**	4.0	2.3	4.0	4.1

EXHIBIT 43. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Marital status					
Married	**52.4%***	37.4%*	59.6%*	30.6%	38.7%*
Widowed	**1.6**	7.0*	1.1*	2.3	1.7
Divorced or separated	**9.6***	22.4*	7.8*	13.0	11.3
Living with partner	**10.8***	5.7*	8.5*	15.3	19.1*
Never married	**25.6***	27.5*	23.1*	38.8	29.2*
Family income					
Less than 138 percent FPL	**18.7***	44.8*	6.9*	57.0	35.9*
Has income in ranges below					
Less than 100 percent FPL	**11.6***	27.8*	3.7*	40.2	21.3*
100–199 percent FPL	**18.0***	36.4	10.5*	34.9	33.8
200–399 percent FPL	**30.6***	27.1*	32.0*	19.9	32.3*
400 percent FPL or higher	**39.8***	8.7*	53.8*	5.0	12.6*
Education					
Less than high school	**10.5***	19.9	4.6*	22.8	26.1*
High school diploma/GED	**27.0***	38.0	22.7*	37.8	35.6
Some college	**32.3***	32.4	33.4*	29.5	27.0
College or graduate degree	**30.2***	9.8	39.2*	9.9	11.2
Other demographic characteristics					
Citizen of United States	**89.9**	97.7*	93.2*	88.7	72.3*
Parent of a dependent child	**34.4***	11.5*	34.0*	42.7	35.8*
Currently working	**75.4***	15.5*	84.7*	50.0	71.5*
Veteran	**5.6***	8.4*	4.8*	1.9	2.4

EXHIBIT 43. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Lives in a family that receives					
SSI or SSDI	**9.6%***	74.5%*	3.9%*	24.2%	7.1%*
SSI	**4.3***	22.7*	1.6*	16.0	3.3*
SSDI	**6.4***	62.3*	2.7*	11.3	4.3*
WIC	**6.4***	7.1*	2.9*	18.8	12.3*
SNAP	**11.9***	35.3*	3.2*	48.4	18.2*
Public assistance	**3.4***	8.9*	1.2*	14.4	3.9*
Health					
Current health status					
Excellent or very good	**60.9***	16.8*	68.1*	43.3	54.2*
Good	**26.3***	24.0*	24.9*	30.7	30.4
Fair or poor	**12.8***	59.2*	7.0*	25.9	15.4*
BMI					
Healthy weight (BMI less than 25)	**33.4**	22.5*	34.6	33.6	31.7
Overweight (BMI 25–29)	**33.2***	30.1	33.6*	29.2	34.6*
Obese (BMI 30 or higher)	**33.4***	47.4*	31.8*	37.2	33.8*
Smoking status					
Current smoker	**15.8***	31.3*	11.5*	26.6	23.0*
Former smoker	**18.6***	22.3*	19.3*	15.1	15.2
Never smoked	**65.6***	46.4*	69.2*	58.3	61.8
Health conditions and limitations					
Has depressed or anxious feelings in past two weeks	**7.5***	21.7*	5.2*	14.1	8.5*
Currently pregnant[6]	**3.3***	†	3.1*	5.2	2.1*
Unable to work now due to health problem	**7.1***	68.8*	1.5*	21.9	4.1*
Limited in amount or kind of work due to mental, physical, or emotional problem	**18.6***	82.0*	12.4*	32.6	17.0*

EXHIBIT 43. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Needs help with dressing and bathing	**0.5%***	4.6%*	0.1%*	1.7%	†
Has difficulty walking 100 yards without equipment	**3.4***	32.5*	1.5*	7.5	3.4%*
Has mobility or hearing problem that requires special equipment	**4.7***	33.4*	2.9*	8.1	2.2*
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[7]	**13.7***	50.4*	9.3*	25.2	13.9*
Any complex activity limitation[8]	**20.0***	88.7*	13.0*	36.8	18.3*
Either one	**26.6***	90.7*	19.3*	44.9	26.8*
Ever been told he or she has selected conditions					
Hypertension	**23.9***	57.0*	22.0*	28.4	19.2*
Coronary heart disease	**2.2***	14.7*	1.5*	3.4	1.1*
Heart attack	**1.6***	10.2*	1.1*	2.5	0.7*
Stroke	**1.8***	13.7*	0.8*	3.5	1.2*
Cancer	**5.4**	14.7*	5.3	5.4	3.2*
Diabetes	**6.6***	26.3*	5.3*	9.7	5.0*
Arthritis	**14.7***	51.6*	12.5*	19.8	9.7*
Asthma	**14.0***	23.0	13.3*	19.5	11.0*
Chronic bronchitis, COPD, or emphysema	**3.1***	19.0*	1.7*	6.1	2.7*

Notes: FPL is federal poverty level. GED is general equivalency diploma. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. WIC is Supplemental Nutrition Program for Women, Infants, and Children. SNAP is Supplemental Nutrition Assistance Program, formerly referred to as food stamps. BMI is body mass index. COPD is chronic obstructive pulmonary disease. 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 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 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.

EXHIBIT 43. (continued)

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

* 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, and 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] Because 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] Information is limited to women age 19–44.

[7] Captures limitations or difficulties in movement (walking, 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 problem. Due to availability of fields in 2019 following the redesign, this measure no longer captures difficulty related to standing, bending, kneeling, hearing, or climbing stairs.

[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. Due to availability of fields in 2019 following redesign, this definition no longer includes "difficulty relaxing at home without special equipment" or "help with routine needs."

Source: MACPAC, 2021, analysis of NHIS data.

EXHIBIT 44. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2019, 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%**	**66.7%**	**11.4%**	**14.7%**
Contact with health care professionals (past 12 months)					
Saw selected health professional					
Saw doctor or other health care professional	**81.9***	95.1*	85.2	85.6	58.3*
Had eye exam	**49.4***	54.7*	54.4*	44.7	27.1*
Received counseling/therapy from mental health professional	**10.5***	23.8*	9.7*	15.5	5.5*
Had dental exam/cleaning	**65.0***	48.5*	73.5*	55.3	38.3*
Had at least one overnight hospital stay	**7.6***	23.1*	6.0*	12.9	5.8*
Received care at home	**1.8***	14.1*	1.0*	4.0	0.6*
Receipt of appropriate care (past 12 months)					
Had cholesterol checked					
All individuals	**68.4**	87.8*	71.9	69.8	43.8*
Men age 35–64	**71.7**	87.6*	75.5	71.0	42.4*
Individuals with elevated risk of cardiac disease[6]	**77.3**	89.3*	82.8*	75.0	50.3*
Had flu shot					
All individuals	**40.5***	51.8*	44.3*	36.9	21.0*
Individuals age 50–64	**48.0**	53.2*	51.0*	46.4	23.1*
Had any test for colorectal cancer in past year (age 50–64)	**18.9**	26.5*	19.6	20.9	7.1*
Had Pap smear or test for cervical cancer in past year (women age 21–60)	**53.3**	36.7*	56.1	55.6	39.0*

EXHIBIT 44. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Number of emergency room visits					
None	**79.2***	58.7	83.8*	62.4	77.8*
At least 1	**20.8***	41.3	16.2*	37.6	22.2*
1	**12.6***	17.3	10.9*	19.7	12.9*
2–3	**6.4***	15.6	4.6*	12.9	7.5*
4 or more	**1.8***	9.8*	0.8*	5.8	1.9*

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 online in the downloadable Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage-data-from-national-health-interview-survey/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the 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.

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

* 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, and 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. 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- 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] Because 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] Includes individuals of any age or sex who report hypertension or diabetes or who currently smoke.

Source: MACPAC, 2021, analysis of NHIS data.

EXHIBIT 45. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2019, 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%**	**4.0%**	**68.3%**	**11.0%**	**14.4%**
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	**29.7**	8.4*	24.7*	30.6	58.4*
At least 1	**70.3**	91.6*	75.3*	69.4	41.6*
1	**15.0**	6.2*	15.3	14.8	16.1
2–3	**18.3***	15.6	20.1*	16.4	11.5*
4 or more	**37.1**	69.8*	39.8	38.2	14.1*
Had at least 1 overnight hospital stay	**5.9***	19.2*	4.9*	10.7	3.3*
Received care at home	**1.7***	15.8*	0.7*	4.5	†
Had at least 1 dental care visit[6]	**41.5***	31.7*	49.7*	24.7	19.2*
Receipt of appropriate care (past 12 months)					
Had more than 15 office-based or hospital outpatient visits	**10.5**	33.0*	10.5	11.8	2.8*
Number of emergency room visits					
None	**86.7***	66.5*	89.8*	73.2	88.5*
At least 1	**13.3***	33.5*	10.2*	26.8	11.5*
1	**9.9***	20.9	8.1*	17.4	9.0*
2–3	**2.8***	10.3*	1.9*	7.2	2.1*
4 or more	**0.6***	2.2	0.3*	2.2	†

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)

EXHIBIT 45. (continued)

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.

[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] Because 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 measure should not be compared with other dental measures included in databooks 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, 2021, analysis of MEPS data.

EXHIBIT 46. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2019

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%**	**66.7%**	**11.4%**	**14.7%**
Connection to the health care system (past 12 months)					
Has a usual source of care[6]	**85.3**	94.3*	90.2*	85.6	59.1*
Timeliness of care (past 12 months)					
Delayed medical care because of costs	**10.7**	14.3*	6.3*	9.4	32.2*
Unmet need for selected types of care due to cost					
Medical care	**9.8**	14.5*	5.4*	8.7	30.3*
Mental health care or counseling	**5.2***	6.7	3.9*	6.5	10.0*
Dental care	**18.9***	33.9*	12.4*	26.2	38.4*
Prescription drugs	**7.8***	17.9*	4.8*	9.7	18.4*

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 downloadable Excel version of this exhibit at https://www.macpac.gov/publication/measures-of-access-to-care-for-non-institutionalized-individuals-age-19-64-by-source-of-health-coverage/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical 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.

The NHIS underwent significant redesign in 2019, and users should be cautious about making any comparisons to prior years. More information about the redesign is available at https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm/.

* 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, and 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 46. (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] Because 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.

Source: MACPAC, 2021, 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).

T-MSIS. Over the past several years, CMS has worked with states to implement the 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). The TAF is further refined to remove certain personally identifiable information and proprietary information on managed care payment amounts to providers before the data are publicly released as the TAF research identifiable file (RIF). In addition, CMS has released updated versions of earlier TAF RIF files as states have addressed certain data quality issues.

CMS has developed 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 publishes an interactive, web-based Data Quality Atlas that contains information for calendar years (CY) 2016–2019.[3] These resources provide insight on 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, fiscal year (FY) 2018 was the first year of T-MSIS data that was used for MACStats. In this data book, we used the most recently available T-MSIS data that had more than 12 months of claims run-out.

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, so users should be cautious about making comparisons to prior years. Additionally, certain measures in previous editions of MACStats are no longer available.

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 (e.g., 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:[6]

- 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.[7] (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 (e.g., 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.

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.[8] 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.[9]

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 estimates by coverage source 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.[10]

However, the NHIS is known to produce higher estimates of service use than the MEPS.[11] 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, 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.

In previous editions of MACStats, NHIS data allowed MACPAC to use responses to several questions to identify children and youth with special health care needs (CYSHCN). Based on an approach developed by the Child and Adolescent Health Measurement Initiative, children were identified as meeting CYSHCN criteria if they had at least one diagnosed or parent-reported ongoing health condition and elevated service use. Following the 2019 redesign, a number of variables used to identify specific health conditions, as well as some of the variables related to elevated service use, are no longer available. As such, we are no longer able to identify CYSHCN using the NHIS.

Methodology for T-MSIS Analysis

As noted above, 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 its 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.[12] 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.[13] 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

Note: 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 its 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, 2021, 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.[14] 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 in which 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 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.[15] 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.[16] 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).[17]

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 2019 (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	**$567,485**	**$571,303**	**99.3%**	**$17,734**	**$15,286**
Alabama	4,247	5,427	78.3	490	–
Alaska	2,210	2,089	105.8	25	–
Arizona	12,926	12,881	100.4	164	134
Arkansas	6,073	6,818	89.1	81	–
California[2]	81,021	84,207	96.2	636	3,893
Colorado	7,921	9,051	87.5	248	–
Connecticut	8,556	8,489	100.8	109	–
Delaware	2,423	2,239	108.2	15	–
District of Columbia	2,874	2,813	102.2	88	–
Florida	18,386	23,288	79.0	358	858
Georgia	10,797	10,453	103.3	456	–
Hawaii[3]	2,217	2,187	101.4	36	–
Idaho	2,248	2,137	105.2	26	–
Illinois	15,896	18,295	86.9	295	–
Indiana	20,521	12,231	167.8	267	–
Iowa	5,343	5,198	102.8	71	–
Kansas	3,691	3,465	106.5	82	73
Kentucky	13,557	9,993	135.7	253	–
Louisiana	10,879	10,656	102.1	1,177	–
Maine	2,728	2,980	91.6	-38	–
Maryland	12,231	11,750	104.1	58	–
Massachusetts	16,479	16,353	100.8	–	1,270
Michigan	14,229	18,037	78.9	321	–
Minnesota	12,366	12,766	96.9	62	–
Mississippi	5,210	5,297	98.4	230	–
Missouri	9,186	9,885	92.9	745	-0
Montana	1,677	1,887	88.9	2	–
Nebraska	1,732	2,118	81.8	60	–
Nevada	3,820	3,899	98.0	102	–
New Hampshire	1,763	1,703	103.5	270	26
New Jersey	14,819	14,998	98.8	1,123	–

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
New Mexico	$5,148	$5,165	99.7%	$32	$81
New York	89,464	54,735	163.4	3,541	2,063
North Carolina	11,229	13,306	84.4	474	–
North Dakota[2]	1,019	1,172	86.9	2	–
Ohio	22,806	22,242	102.5	1,409	–
Oklahoma	4,146	5,033	82.4	44	108
Oregon	6,097	9,457	64.5	49	–
Pennsylvania	15,321	31,196	49.1	1,104	–
Rhode Island	2,130	2,405	88.6	142	52
South Carolina	6,134	5,954	103.0	559	–
South Dakota	944	905	104.4	2	–
Tennessee	8,500	9,636	88.2	79	445
Texas	32,016	32,696	97.9	1,951	6,150
Utah[2]	1,165	2,725	42.8	33	–
Vermont	1,431	1,477	96.8	23	140
Virginia	8,681	11,268	77.0	88	–
Washington	10,572	14,719	71.8	246	-5
West Virginia	4,449	3,878	114.7	72	–
Wisconsin	7,653	9,153	83.6	72	–
Wyoming	553	593	93.3	1	–

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 $9.8 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 or -$0 indicates an amount between $0.5 and -$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] State has a state plan amendment (SPA) that allows the state to receive the enhanced federal medical assistance percentage (FMAP) for Medicaid-covered children who 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 the 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 SPAs. Correspondingly, we reduced California's T-MSIS spending by approximately $503.4 million, North Dakota's T-MSIS spending by approximately $10.2 million, and Utah's T-MSIS spending by approximately $24.4 million.

[3] The CMS-64 total for Hawaii excludes $0.8 million in fee-for-service (FFS) drug spending because the state did not report any FFS drug spending in T-MSIS.

Source: MACPAC, 2021, analysis of T-MSIS data as of December 2020, and CMS-64 financial management report net expenditure data as of August 2020.

EXHIBIT 49. Service Categories Used to Adjust FY 2019 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 • Transportation	• 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 • Health home for enrollees with substance use disorder • 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)	• 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 CMS-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 the 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, 2021, 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 the 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 are 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.[18]
- 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 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.medicaid.gov/medicaid/data-and-systems/downloads/macbis/taf-rif-availability-chart.pdf.

[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] 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.

[7] 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.

[8] Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, 2020, About the National Health Interview Survey, http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[9] Agency for Health Care Research and Quality (AHRQ), U.S. Department of Health and Human Services, 2019, Medical Expenditure Panel Survey: Survey background, http://meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp.

[10] 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.

[11] 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.

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

[13] 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 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).

[14] 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.

[15] 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.

[16] 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.

[17] 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 the T-MSIS.

[18] 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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