MACStats: Medicaid and CHIP Data Book

DECEMBER 2023

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, Section 1900 of the Social Security Act, 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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MACPAC
Medicaid and CHIP Payment and Access Commission

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Philadelphia, PA

Robert Duncan, MBA, *Vice Chair*
Prospect, CT

Term Expires April 2024

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Columbia University School of Social Work
New York, NY

Melanie Bella, MBA
Cressey & Company
Philadelphia, PA

Robert Duncan, MBA
Connecticut Children's–Hartford
Prospect, CT

Verlon Johnson, MPA
Acentra Health
Olympia Fields, IL

John B. McCarthy, MPA
Speire Healthcare Strategies
Nashville, TN

Katherine Weno, DDS, JD
Independent Public Health Consultant
Iowa City, IA

Term Expires April 2025

Sonja L. Bjork, JD
Partnership HealthPlan of California
Fairfield, CA

Tricia Brooks, MBA
Georgetown University Center for Children and Families
Bow, NH

Jennifer L. Gerstorff, FSA, MAAA
Milliman
Seattle, WA

Angelo P. Giardino, MD, PhD, MPH
The University of Utah
Salt Lake City, UT

Dennis Heaphy, MPH, MEd, MDiv
Massachusetts Disability Policy Consortium
Boston, MA

Rhonda M. Medows, MD
Renton, WA

Term Expires April 2026

Timothy Hill, MPA
American Institutes for Research
Columbia, MD

Carolyn Ingram, MBA
Molina Healthcare, Inc.
Santa Fe, NM

Patti Killingsworth
CareBridge
Nashville, TN

Adrienne McFadden, MD, JD
Buoy Health, Inc.
Tampa, FL

Jami Snyder, MA
JSN Strategies, LLC
Phoenix, AZ

Commission Staff

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Kiswana Williams, *Executive Assistant*

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Melanie Raible-Tocci, *Communications Specialist*

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Policy Director

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Policy Director and Congressional Liaison

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Policy Director and Data Analytics Advisor

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Principal Analyst and Research Advisor

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Aaron Pervin, MPH
Principal Analyst and Contracting Officer

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Melissa Schober, MPM

Amy Zettle, MPP

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Lesley Baseman, MPH

Tamara Huson, MSPH

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Audrey Nuamah, MPH

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Drew Gerber, MPH

Jerry Mi

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Gabby Ballweg

Ava Williams

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Ken Pezzella, CGFM, *Chief Financial Officer*

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Introduction

This 2023 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 30 percent of the U.S. population in 2022 (Exhibit 1). Spending and enrollment in Medicaid typically grow around recessions and slow when the economy improves. As of July 2023, 91.5 million people were enrolled in Medicaid and CHIP. While enrollment is higher than July 2022, it has been decreasing from its peak as states begin to disenroll beneficiaries following the end of the continuous coverage requirement that was attached to the federal medical assistance percentage (FMAP) increase under the Families First Coronavirus Response Act (FFCRA, 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) 2022, the share of federal spending on Medicaid and CHIP increased from the prior fiscal year. This increase reflects both an increase in federal Medicaid spending as enrollment and the federal share of Medicaid increased under the provisions of the FFCRA, as well as a large decrease in other federal spending related to pandemic-related relief (Exhibit 4).

Total Medicaid spending was $830.6 billion in FY 2022 (Exhibit 16). Spending for CHIP was $22.3 billion (Exhibit 33). Medicaid spending increased 10.2 percent in FY 2022. This increase was largely driven by increased enrollment under the continuous coverage requirement during the public health emergency as spending per full-year equivalent enrollee only increased 1.0 percent (Exhibit 10). In FY 2021, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 21 percent of Medicaid enrollees but about 52 percent of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports.

MACStats continues to include tables on access to and experience of care among non-institutionalized individuals. These data show that Medicaid enrollees were as likely to report not having difficulty reaching their usual medical provider by phone during business hours as those covered by private insurance but were more likely to report having a difficult time reaching their usual medical provider after hours for urgent medical needs compared to those with private insurance (Exhibits 43 and 48). As in prior years, Medicaid and CHIP enrollees of all ages were more likely to be persons of color and to report fair or poor health than individuals who were covered by private insurance (Exhibit 2). Children whose primary coverage source is Medicaid or CHIP are as likely to report seeing a doctor or having a wellness visit within the past year 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 for providing copyediting services.

SECTION 1:

Overview—Key Statistics

Section 1: Overview—Key Statistics

Key Points

- In 2022, more than 30 percent of the U.S. population was enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) at some point during the year: 93.8 million in Medicaid and 8.3 million in CHIP (Exhibit 1). About 39 percent of children had Medicaid or CHIP coverage in 2022 (Exhibit 2).
- About 34 percent of individuals enrolled in Medicaid or CHIP in 2022 had family incomes below 100 percent of the federal poverty level (FPL). Over half of all individuals (53.5 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 17.8 percent of national health expenditures in calendar year 2021, less than either Medicare (21.2 percent) or private insurance (28.5 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. In fiscal year (FY) 2022, the share of federal spending on Medicaid and CHIP (9.7 percent) increased from the prior fiscal year (7.8 percent) due to the increase in the federal medical assistance percentage (FMAP) and enrollment growth under the continuous coverage requirement under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) as well as a large decrease in other federal spending related to pandemic-related relief (Exhibit 4).
- In FY 2022, Medicaid continued to account for a smaller share of the federal budget (9.4 percent) than Medicare (11.9 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 14.4 percent in state fiscal year (SFY) 2021. When federal funds are included, Medicaid's share was 26.8 percent in SFY 2021 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2022 (millions)

Population	Ever during FY 2022	Point in time during FY 2022	Point in time during CY 2022
	Estimates based on administrative data (CMS)[1]		**Survey data (NHIS)[2]**
Medicaid enrollees	93.8[3]	87.1[3]	Not available
CHIP enrollees	8.3[4]	7.2[5]	Not available
Totals for Medicaid and CHIP	**102.0**	**94.3**	**63.8**
	U.S. Census Bureau data		**Survey data (NHIS)[2]**
U.S. population	333.6[6]	332.9[6]	326.8
	Administrative and Census Bureau data		**Survey data (NHIS)[2]**
Medicaid and CHIP enrollment as a percentage of U.S. population	30.6%[1]	28.3%	19.5%

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 Transformed Medicaid Statistical Information System (T-MSIS), CHIP Statistical Enrollment Data System (SEDS), 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 1.6 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 based on administrative data are from MACPAC analysis of FY 2022 T-MSIS data as of February 2023.

[4] CHIP enrollment estimates from administrative data in the ever-enrolled column are from MACPAC analysis of CHIP SEDS data (see Exhibit 32).

[5] CHIP enrollment estimates from administrative data in the point-in-time column are from the FY 2024 president's budget.

[6] The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of September 2022 (the month with the largest count in FY 2022); 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 2022.

Sources: MACPAC, 2023, analysis of the following: T-MSIS data as of February 2023; CHIP SEDS data as of August 14, 2023; HHS, 2023, FY 2024 president's budget for HHS, Baltimore, MD, https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf; NHIS data; and U.S. Census Bureau, 2023, Monthly population estimates for the United States: April 1, 2020 to December 1, 2023 (NA-EST2022-POP) https://www2.census.gov/programs-surveys/popest/tables/2020-2022/national/totals/NA-EST2022-POP.xlsx.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2022

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%**	**24.0%**	**60.8%**	**19.5%**	**8.6%**	**100.0%**	**54.7%**	**38.7%**	**4.2%**
Coverage									
Length of time with any coverage during year									
Full year	**89.2***	99.1*	96.7	96.3	–	**94.6***	98.2	98.0	–
Part year	**5.0***	0.9*	3.3	3.7	26.6*	**3.1***	1.8	2.0	35.3*
No coverage during year	**5.8***	–	–	–	73.4*	**2.3***	–	–	64.7*
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/ CHIP combination[6]	**1.9***	10.2	–	9.7	–	**–**	–	–	–
Yes, any private and Medicaid/CHIP combination	**0.8***	–	1.3*	4.2	–	**1.9***	3.4*	4.8	–
Yes, any other combination	**7.6***	40.6*	12.5*	1.2	–	**–**	–	–	–
No	**89.7***	49.2*	86.2*	84.9	100.0*	**98.1***	96.6*	95.2	100.0*
Demographics									
Age									
0–18	**23.6***	†	21.2*	46.7	11.7*	**100.0**	100.0	100.0	100.0
19–64	**59.1***	13.2*	65.7*	45.9	86.9*	**–**	–	–	–
65 or older	**17.4***	86.7*	13.1*	7.4	1.4*	**–**	–	–	–
Gender									
Male	**49.2***	45.6	50.0*	44.1	56.3*	**51.1**	51.8	50.8	52.0
Female	**50.8***	54.4	50.0*	55.9	43.7*	**48.9**	48.2	49.2	48.0
Race									
Hispanic	**19.1***	8.7*	13.8*	29.3	44.4*	**25.6***	16.8*	36.3	43.0
White, non-Hispanic	**59.6***	74.8*	67.3*	39.6	35.7*	**51.0***	64.2*	34.0	41.2
Black, non-Hispanic	**12.0***	10.4*	9.4*	20.0	12.7*	**12.4***	7.5*	20.0	7.0*
Native Indian, non-Hispanic	**0.8**	†	0.5	†	1.4	**†**	†	†	†
Asian, non-Hispanic	**5.7**	4.4	6.3	5.3	3.7*	**4.6***	5.5*	3.3	5.0
Other single and multiple races, non-Hispanic	**2.8***	1.0*	2.7*	3.8	2.0*	**5.4**	5.6	4.9	†

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%**	**4.2%**	**67.6%**	**15.2%**	**12.6%**	**100.0%**	**93.2%**	**45.7%**	**8.3%**
Coverage									
Length of time with any coverage during year									
Full year	**84.2***	97.9*	95.6*	94.2	–	**98.6**	99.2	99.5	98.5
Part year	**7.1***	2.1*	4.4*	5.8	25.8*	**0.8**	0.8	†	†
No coverage during year	**8.7***	–	–	–	74.2*	**0.6***	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/ CHIP combination[6]	**1.3***	31.2*	–	8.6	–	**6.5***	7.0*	–	78.4
Yes, any private and Medicaid/ CHIP combination	**0.6***	–	0.9*	4.1	–	**†**	–	†	†
Yes, any other combination	**0.8**	19.7*	1.2*	0.7	–	**40.9***	43.8*	89.6*	11.6
No	**97.2***	49.1*	97.9	86.6	100.0*	**52.6***	49.2*	10.3	9.4
Demographics									
Age									
0–18	**–**	–	–	–	–	**–**	–	–	–
19–64	**100.0**	100.0	100.0	100.0	100.0	**–**	–	–	–
65 or older	**–**	–	–	–	–	**100.0**	100.0	100.0	100.0
Gender									
Male	**49.5***	50.0*	50.1*	38.1	57.3*	**45.6***	44.9*	46.2*	38.8
Female	**50.5***	50.0*	49.9*	61.9	42.7*	**54.4***	55.1*	53.8*	61.2
Race									
Hispanic	**19.4***	12.1*	14.3*	22.9	44.0*	**9.4***	8.2*	6.4*	25.9
White, non-Hispanic	**58.6***	64.2*	65.5*	45.1	35.4*	**74.6***	76.5*	81.7*	41.0
Black, non-Hispanic	**12.6***	16.7	10.5*	20.2	13.6*	**9.6***	9.5*	6.9*	18.5
American Indian or Alaska Native, non-Hispanic	**0.8**	†	0.4	†	1.4	**†**	†	0.4	†
Asian, non-Hispanic	**6.4**	3.9*	7.1	6.2	3.5*	**5.0***	4.5*	3.6*	12.4
Other single and multiple races, non-Hispanic	**2.3***	2.3	2.2*	3.3	2.0*	**0.8**	0.8	1.0	†

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	**10.3%***	13.4%*	4.9%*	22.6%	25.7%	–	–	–	–
High school diploma/GED	**27.0***	30.7*	22.5*	37.8	37.9	–	–	–	–
Some college	**29.6**	28.6	29.9	30.0	24.5*	–	–	–	–
College or graduate degree	**33.2***	27.3*	42.8*	9.5	11.9*	–	–	–	–
Marital status[7]									
Married	**52.7***	55.1*	59.5*	28.6	37.4*	–	–	–	–
Widowed	**5.9**	19.0*	3.9*	5.8	2.0*	–	–	–	–
Divorced or separated	**10.1***	14.6	8.2*	14.8	9.2*	–	–	–	–
Living with partner	**9.0***	3.3*	8.1*	12.5	18.2*	–	–	–	–
Never married	**22.3***	8.0*	20.3*	38.3	33.1*	–	–	–	–
Family income									
Has income less than 138 percent FPL	**18.8***	19.2*	6.1*	53.5	33.2*	**25.3%***	5.4%*	53.8%	32.5%*
Has income in ranges shown below									
Less than 100 percent FPL	**11.0***	10.3*	3.1*	33.9	19.8*	**15.4***	2.9*	33.2	21.6*
100–199 percent FPL	**18.7***	22.1*	9.9*	38.2	30.6*	**22.1***	9.2*	40.2	25.1*
200–399 percent FPL	**29.1***	31.3*	29.7*	21.7	34.1*	**29.0***	32.9*	21.7	37.6*
400 percent FPL or higher	**41.2***	36.2*	57.2*	6.2	15.5*	**33.5***	55.0*	4.9	15.7*
Other demographic characteristics									
Citizen of United States	**93.1**	97.5*	95.6*	93.5	68.7*	**97.1**	98.5*	97.2	80.2*
Parent of a dependent child[7]	**26.4***	2.1*	27.7*	34.8	35.5	–	–	–	–
Currently working[7]	**63.7***	16.6*	75.5*	44.3	71.5*	–	–	–	–
Veteran[7]	**7.7***	15.2*	5.8*	2.3	2.9	–	–	–	–
Family receives SSI or SSDI	**8.3***	17.6*	4.2*	20.1	5.0*	**6.1***	2.5*	11.8	†
Health									
Current health status									
Excellent or very good	**62.8***	39.8*	68.5*	56.8	58.7	**86.0***	90.6*	79.1	81.1
Good	**25.3**	32.8*	23.7	25.1	28.7*	**11.2***	7.9*	15.7	16.0
Fair or poor	**11.9***	27.4*	7.9*	18.1	12.6*	**2.8***	1.4*	5.1	†

EXHIBIT 2. (continued)

Characteristic	Selected coverage source at time of interview, age 19–64[1]					Selected coverage source at time of interview, age 65 or older[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid or CHIP[3]
Education[7]									
Less than high school	**9.5%***	19.4%	4.2%*	20.0%	25.1%*	**13.1%***	12.5%*	8.2%*	39.5%
High school diploma/GED	**26.4***	39.6	21.4*	38.7	38.3	**28.9**	29.3	27.6*	32.2
Some college	**29.9**	28.1	30.2	31.3	24.7*	**28.4***	28.7*	28.5*	21.5
College or graduate degree	**34.2***	12.9*	44.2*	10.0	11.9	**29.6***	29.5*	35.7*	6.7
Marital status[7]									
Married	**51.2***	41.4*	58.5*	28.3	37.7*	**57.5***	57.1*	64.8*	30.8
Widowed	**1.7***	6.1*	1.2*	2.7	1.7*	**20.3***	21.0	17.6*	24.9
Divorced or separated	**9.0***	19.0*	7.6*	13.1	9.1*	**13.9***	14.0*	11.0*	25.5
Living with partner	**10.9***	7.0*	9.2*	13.8	18.3*	**2.9**	2.8	2.4*	4.7
Never married	**27.3***	26.6*	23.5*	42.2	33.2*	**5.4***	5.1*	4.2*	14.1
Family income									
Has income less than 138 percent FPL	**17.0***	40.5*	6.1*	51.8	33.3*	**16.0***	16.0*	7.6*	62.4
Has income in ranges shown below									
Less than 100 percent FPL	**10.1***	24.4*	3.2*	33.3	19.5*	**8.3***	8.2*	3.3*	42.3
100–199 percent FPL	**16.9***	33.5	9.3*	36.6	31.2*	**20.3***	20.4*	14.3*	34.6
200–399 percent FPL	**28.3***	25.3	28.4*	22.3	33.6*	**31.9***	32.2*	31.2*	17.7
400 percent FPL or higher	**44.7***	16.8*	59.1*	7.8	15.7*	**39.5***	39.2*	51.1*	5.4
Other demographic characteristics									
Citizen of United States	**90.4**	95.9*	94.1*	90.6	67.7*	**96.6***	97.7*	98.3*	86.4
Parent of a dependent child[7]	**34.0***	12.4*	33.1*	40.2	36.1*	**0.7**	0.5	0.9	†
Currently working[7]	**76.9***	16.4*	85.6*	50.2	72.3*	**19.4***	16.6*	24.9*	7.9
Veteran[7]	**5.2***	6.9*	4.1*	2.0	2.9	**16.3***	16.4*	14.6*	4.4
Family receives SSI or SSDI	**8.8***	70.9*	4.3*	26.5	5.2*	**9.4***	9.6*	6.3*	36.0
Health									
Current health status									
Excellent or very good	**59.3***	17.8*	65.4*	40.0	56.2*	**43.3***	43.1*	48.3*	20.1
Good	**28.6***	29.6	27.0*	33.5	30.5	**33.4**	33.3	32.5	32.4
Fair or poor	**12.1***	52.7*	7.7*	26.5	13.3*	**23.3***	23.6*	19.2*	47.4

EXHIBIT 2. (continued)

Notes: GED is general educational development test. 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 in the Excel version of this exhibit at https://www.macpac.gov/publication/characteristics-of-non-institutionalized-individuals-by-source-of-health-insurance/. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

The NHIS underwent a substantial 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, 2023, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2021

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	**$4,255,127**	**$734,011**	**$22,254**	**$900,787**	**$1,211,431**	**$149,883**	**$803,608**	**$433,153**
Hospital care	**1,323,912**	245,307	5,591	350,726	448,778	86,091	153,335	34,083
Physician and clinical services	**864,563**	99,332	4,874	222,082	328,077	38,768	105,860	65,570
Dental services	**161,777**	15,263	2,586	4,729	64,934	2,109	8,720	63,436
Other professional services[3]	**130,647**	9,494	480	36,240	37,490	–	17,453	29,490
Home health care	**125,195**	42,788	64	46,583	15,926	698	6,242	12,895
Other non-durable medical products[4]	**97,387**	–	–	2,332	–	–	–	95,055
Prescription drugs	**377,987**	39,624	2,281	119,923	151,680	10,146	4,495	49,839
Durable medical equipment[5]	**67,126**	9,102	222	12,357	13,087	–	984	31,374
Nursing care facilities and continuing care retirement communities[6]	**181,314**	54,267	18	40,589	16,281	6,796	18,972	44,391
Other health, residential, and personal care services[7]	**223,479**	129,641	1,966	4,302	14,773	924	64,852	7,020
Administration[8]	**307,106**	89,191	4,172	60,925	120,405	4,350	28,062	–
Public health activity	**187,604**	–	–	–	–	–	187,604	–
Investment	**207,031**	–	–	–	–	–	207,029	–

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%**	**17.3%**	**0.5%**	**21.2%**	**28.5%**	**3.5%**	**18.9%**	**10.2%**
Hospital care	**100.0**	18.5	0.4	26.5	33.9	6.5	11.6	2.6
Physician and clinical services	**100.0**	11.5	0.6	25.7	37.9	4.5	12.2	7.6
Dental services	**100.0**	9.4	1.6	2.9	40.1	1.3	5.4	39.2
Other professional services[3]	**100.0**	7.3	0.4	27.7	28.7	–	13.4	22.6
Home health care	**100.0**	34.2	0.1	37.2	12.7	0.6	5.0	10.3
Other non-durable medical products[4]	**100.0**	–	–	2.4	–	–	–	97.6
Prescription drugs	**100.0**	10.5	0.6	31.7	40.1	2.7	1.2	13.2
Durable medical equipment[5]	**100.0**	13.6	0.3	18.4	19.5	–	1.5	46.7
Nursing care facilities and continuing care retirement communities[6]	**100.0**	29.9	0.0	22.4	9.0	3.7	10.5	24.5
Other health, residential, and personal care services[7]	**100.0**	58.0	0.9	1.9	6.6	0.4	29.0	3.1
Administration[8]	**100.0**	29.0	1.4	19.8	39.2	1.4	9.1	–
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, 2022, *National health expenditures by type of service and source of funds: Calendar years 1960–2021*, Baltimore, MD: OACT, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2021.zip. OACT, 2022, *National health expenditure accounts: Methodology paper, 2021*, Baltimore, MD: OACT, https://www.cms.gov/files/document/definitions-sources-and-methods.pdf. OACT, 2020, *Summary of 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 1965–2022

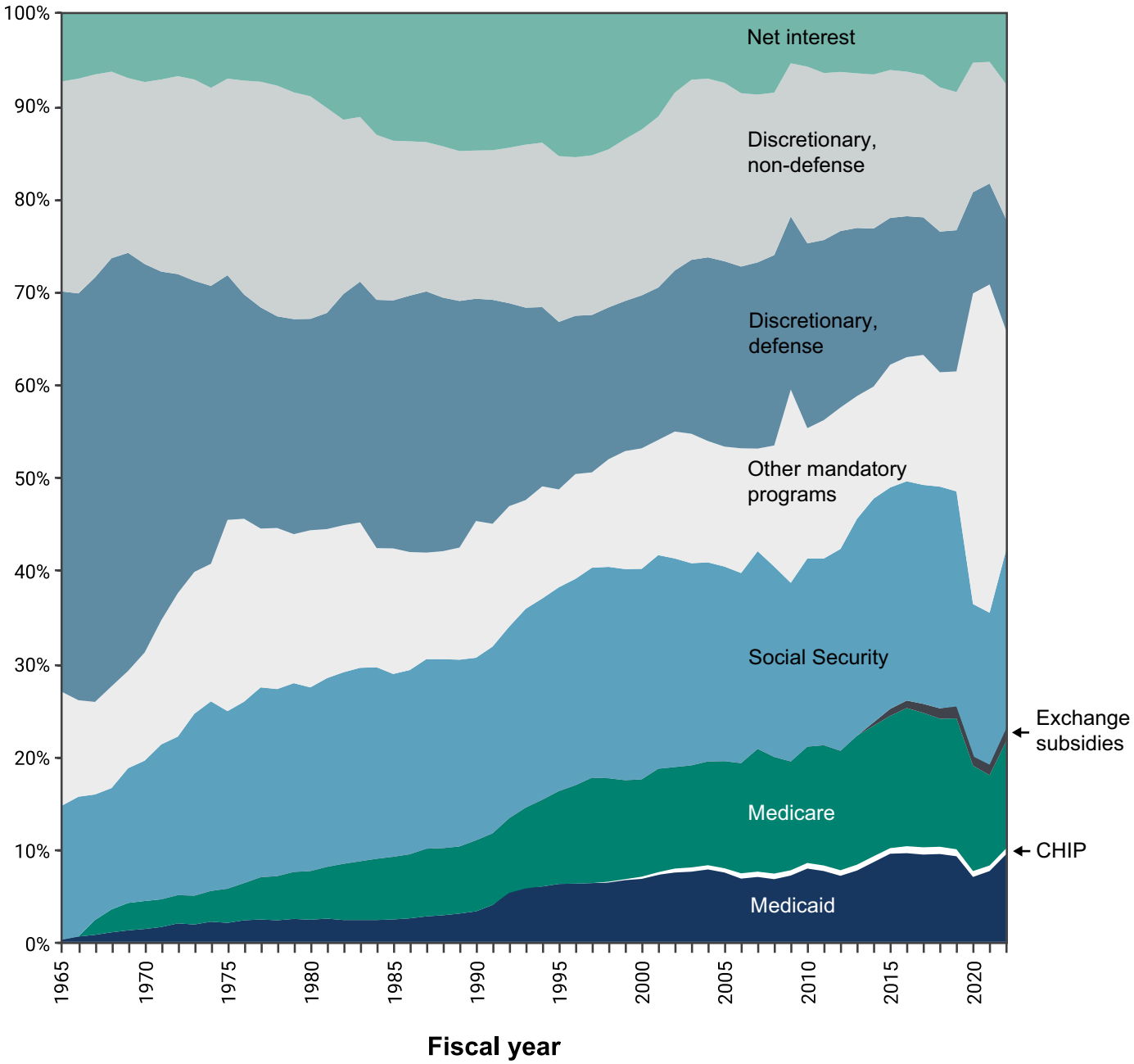


EXHIBIT 4. (continued)

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
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
2021	7.6	0.2	10.1	0.9	16.5	35.4	10.9	13.1	5.2
2022	9.4	0.3	11.9	1.3	19.3	23.7	12.0	14.5	7.6

Notes: FY is fiscal year.

– Dash indicates zero.

Source: MACPAC, 2023, 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 2024*, Washington, DC: OMB, https://www.govinfo.gov/app/details/BUDGET-2024-TAB/context.

EXHIBIT 5. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, SFY 2021

State	Total budget (including state and federal funds)				State-funded budget			
		Total spending as a share of total budget[1]				State-funded spending as a share of state-funded budget[1]		
	Dollars (millions)	Medicaid	Elementary and secondary education	Higher education	Dollars (millions)	Medicaid	Elementary and secondary education	Higher education
Total	**$2,678,389**	**26.8%**	**18.7%**	**8.5%**	**$1,585,532**	**14.4%**	**24.3%**	**12.2%**
Alabama	31,918	24.0	19.9	19.8	19,303	8.9	27.8	26.1
Alaska	11,700	17.8	11.2	4.9	6,817	7.8	19.0	6.1
Arizona	66,826	24.0	10.9	11.1	50,556	6.1	11.4	12.5
Arkansas	31,052	26.1	12.8	12.2	18,727	8.4	16.6	20.2
California	498,883	22.7	18.0	4.9	226,589	16.8	28.2	7.9
Colorado	31,776	37.9	18.5	9.7	21,247	21.0	24.0	12.4
Connecticut	37,305	23.7	12.6	10.4	27,988	16.3	13.4	13.1
Delaware	13,257	19.5	22.1	3.6	9,301	8.1	27.9	4.4
District of Columbia	16,180	21.9	18.9	3.3	10,637	7.2	25.8	2.7
Florida	93,718	31.3	18.3	8.8	58,112	18.2	23.7	14.1
Georgia	64,286	21.0	28.5	16.7	39,581	9.1	28.0	25.7
Hawaii	24,401	11.5	9.6	5.4	19,150	4.6	9.9	6.8
Idaho	10,206	24.1	23.7	8.7	5,504	13.5	36.8	13.5
Illinois	115,535	22.5	11.3	1.9	88,855	10.3	11.0	2.3
Indiana	44,682	34.9	23.9	4.5	24,363	15.5	38.4	8.3
Iowa	28,522	23.2	15.6	23.1	18,102	12.8	19.8	33.0
Kansas	21,808	18.6	26.1	14.2	14,883	9.6	33.8	17.1
Kentucky	42,377	33.3	14.4	18.0	20,899	12.6	23.0	31.1
Louisiana	34,717	44.4	16.8	8.6	18,123	17.3	23.3	16.3
Maine	12,103	28.9	16.5	2.9	6,485	16.1	23.1	5.3
Maryland	55,058	21.5	18.0	13.0	33,313	12.0	23.5	17.5
Massachusetts	67,221	28.8	14.1	2.2	47,739	19.7	16.1	3.2
Michigan	68,420	31.1	23.4	3.7	38,325	14.5	35.5	6.3
Minnesota	48,019	28.8	24.0	3.9	30,011	17.9	33.4	6.3
Mississippi	22,231	24.4	15.8	18.1	11,948	8.7	21.5	31.1

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	$29,779	37.5%	21.3%	4.3%	$18,305	29.1%	27.4%	5.4%
Montana	11,133	20.5	10.1	6.2	5,187	8.9	17.8	13.0
Nebraska	15,067	19.1	12.3	20.5	9,986	10.5	13.6	25.0
Nevada	15,671	29.3	15.6	6.0	10,193	9.9	20.4	9.2
New Hampshire	7,535	32.1	18.1	2.0	3,953	22.8	29.3	3.8
New Jersey	78,706	22.9	25.1	8.5	54,250	10.4	28.8	11.9
New Mexico	24,727	29.0	16.0	12.5	12,185	10.2	27.5	20.4
New York	186,588	35.2	17.2	6.1	114,903	18.7	25.1	9.5
North Carolina	59,445	28.9	22.6	18.0	36,999	14.8	29.5	18.8
North Dakota	8,590	15.2	16.3	17.0	5,590	7.9	19.8	23.6
Ohio	81,216	39.3	15.9	4.0	46,865	18.2	22.0	6.2
Oklahoma	27,768	20.7	15.9	20.1	16,984	10.7	19.4	27.3
Oregon	66,771	16.7	10.0	3.5	44,586	5.9	13.1	5.1
Pennsylvania	103,258	36.6	18.3	2.0	60,200	23.7	22.5	3.4
Rhode Island	13,352	22.0	12.2	8.9	6,787	14.9	19.9	17.2
South Carolina	29,958	24.3	19.2	17.9	17,910	10.0	24.5	28.9
South Dakota	6,779	13.7	15.9	13.5	3,231	10.0	18.4	24.9
Tennessee	39,984	32.3	17.7	12.5	21,554	19.9	25.4	22.6
Texas	135,187	30.8	37.4	14.8	64,314	16.8	43.9	19.8
Utah	19,777	19.8	24.2	12.3	13,461	8.5	31.2	18.1
Vermont	7,290	22.6	29.8	2.4	4,028	14.6	48.1	3.2
Virginia	74,658	21.5	12.5	11.2	47,179	12.0	16.6	14.8
Washington	60,536	25.8	26.3	12.6	41,922	12.3	35.1	17.9
West Virginia	17,438	26.0	15.0	10.6	11,965	6.5	17.8	14.8
Wisconsin	59,355	21.3	15.2	11.7	41,782	12.9	19.2	12.3
Wyoming	5,620	11.2	16.2	6.5	4,654	6.2	19.6	7.9

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, in Ohio, federal reimbursements for Medicaid expenditures funded from the General Revenue Fund (GRF) are deposited into the GRF. In prior reports, this practice made Ohio's general revenue expenditures look higher and conversely made its federal expenditures look lower relative to most other states that do not follow this practice. In the 2019–2022 reports, NASBO removed the federal funds from the GRF number to be consistent with budget presentations in other NASBO surveys, and thus, Ohio's state-funded Medicaid spending is less than what was reported in prior years. 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, 2022, *2022 State expenditure report: fiscal years 2020–2022*, 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 2021–2024

State	FMAPs for Medicaid[1]						E-FMAPs for CHIP					
	FY 2021 (Emergency)[2, 3]	FY 2022 (Emergency)[2, 3]	FY 2023 Q1-2 (Emergency)[2, 4]	FY 2023 Q3 (Emergency)[2, 4]	FY 2023 Q4 (Emergency)[2, 4]	FY 2024[5]	FY 2021 (Emergency)[3, 6]	FY 2022 (Emergency)[3, 6]	FY 2023 Q1-2 (Emergency)[4, 6]	FY 2023 Q3 (Emergency)[4, 6]	FY 2023 Q4 (Emergency)[4, 6]	FY 2024[5, 6]
Alabama	78.78%	78.57%	78.63%	77.43%	74.93%	73.12%	85.15%	85.00%	85.04%	84.20%	82.45%	81.18%
Alaska	56.20	56.20	56.20	55.00	52.50	50.01	69.34	69.34	69.34	68.50	66.75	65.01
Arizona	76.21	76.21	75.76	74.56	72.06	66.29	83.35	83.35	83.03	82.19	80.44	76.40
Arkansas	77.43	77.82	77.51	76.31	73.81	72.00	84.20	84.47	84.26	83.42	81.67	80.40
California	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
Colorado	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
Connecticut	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
Delaware	63.94	63.92	64.69	63.49	60.99	59.71	74.76	74.74	75.28	74.44	72.69	71.80
District of Columbia	76.20	76.20	76.20	75.00	72.50	70.00	83.34	83.34	83.34	82.50	80.75	79.00
Florida	68.16	67.23	66.25	65.05	62.55	57.96	77.71	77.06	76.38	75.54	73.79	70.57
Georgia	73.23	73.05	72.22	71.02	68.52	65.89	81.26	81.14	80.55	79.71	77.96	76.12
Hawaii	59.22	59.84	62.26	61.06	58.56	58.56	71.45	71.89	73.58	72.74	70.99	70.99
Idaho	76.61	76.41	76.31	75.11	72.61	69.72	83.63	83.49	83.42	82.58	80.83	78.80
Illinois	57.16	57.29	56.20	55.00	52.50	51.09	70.01	70.10	69.34	68.50	66.75	65.76
Indiana	72.03	72.50	71.86	70.66	68.16	65.62	80.42	80.75	80.30	79.46	77.71	75.93
Iowa	67.95	68.34	69.33	68.13	65.63	64.13	77.57	77.84	78.53	77.69	75.94	74.89
Kansas	65.88	66.36	65.96	64.76	62.26	60.97	76.12	76.45	76.17	75.33	73.58	72.68
Kentucky	78.25	78.95	78.37	77.17	74.67	71.78	84.78	85.27	84.86	84.02	82.27	80.25
Louisiana	73.62	74.22	73.48	72.28	69.78	67.67	81.53	81.95	81.44	80.60	78.85	77.37
Maine	69.89	70.20	69.49	68.29	65.79	62.65	78.92	79.14	78.64	77.80	76.05	73.86
Maryland	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
Massachusetts	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
Michigan	70.28	71.68	70.91	69.71	67.21	64.94	79.20	80.18	79.64	78.80	77.05	75.46
Minnesota	56.20	56.71	56.99	55.79	53.29	51.49	69.34	69.70	69.89	69.05	67.30	66.04
Mississippi	83.96	84.51	84.06	82.86	80.36	77.27	88.77	89.16	88.84	88.00	86.25	84.09
Missouri	71.16	72.56	72.01	70.81	68.31	66.07	79.81	80.79	80.41	79.57	77.82	76.25
Montana	71.80	71.10	70.32	69.12	66.62	63.91	80.26	79.77	79.22	78.38	76.63	74.74
Nebraska	62.67	64.00	64.07	62.87	60.37	58.60	73.87	74.80	74.85	74.01	72.26	71.02

EXHIBIT 6. (continued)

State	FMAPs for Medicaid[1]						E-FMAPs for CHIP					
	FY 2021 (Emergency)[2, 3]	FY 2022 (Emergency)[2, 3]	FY 2023 Q1-2 (Emergency)[2, 4]	FY 2023 Q3 (Emergency)[2, 4]	FY 2023 Q4 (Emergency)[2, 4]	FY 2024[5]	FY 2021 (Emergency)[3, 6]	FY 2022 (Emergency)[3, 6]	FY 2023 Q1-2 (Emergency)[4, 6]	FY 2023 Q3 (Emergency)[4, 6]	FY 2023 Q4 (Emergency)[4, 6]	FY 2024[5, 6]
Nevada	69.50%	68.79%	68.85%	67.65%	65.15%	60.77%	78.65%	78.15%	78.20%	77.36%	75.61%	72.54%
New Hampshire	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
New Jersey	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
New Mexico	79.66	79.91	79.46	78.26	75.76	72.59	85.76	85.94	85.62	84.78	83.03	80.81
New York	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
North Carolina	73.60	73.85	73.91	72.71	70.21	65.91	81.52	81.70	81.74	80.90	79.15	76.14
North Dakota	58.60	59.79	57.75	56.55	54.05	53.82	71.02	71.85	70.43	69.59	67.84	67.67
Ohio	69.83	70.30	69.78	68.58	66.08	64.30	78.88	79.21	78.85	78.01	76.26	75.01
Oklahoma	74.19	74.51	73.56	72.36	69.86	67.53	81.93	82.16	81.49	80.65	78.90	77.27
Oregon	67.04	66.42	66.52	65.32	62.82	59.31	76.93	76.49	76.56	75.72	73.97	71.52
Pennsylvania	58.40	58.88	58.20	57.00	54.50	54.12	70.88	71.22	70.74	69.90	68.15	67.88
Rhode Island	60.29	61.08	60.16	58.96	56.46	55.01	72.20	72.76	72.11	71.27	69.52	68.51
South Carolina	76.83	76.95	76.78	75.58	73.08	69.53	83.78	83.87	83.75	82.91	81.16	78.67
South Dakota	64.48	64.89	62.94	61.74	59.24	54.98	75.14	75.42	74.06	73.22	71.47	68.49
Tennessee	72.30	72.56	72.30	71.10	68.60	65.28	80.61	80.79	80.61	79.77	78.02	75.70
Texas	68.01	67.00	66.07	64.87	62.37	60.15	77.61	76.90	76.25	75.41	73.66	72.11
Utah	73.72	73.03	72.10	70.90	68.40	65.90	81.60	81.12	80.47	79.63	77.88	76.13
Vermont	60.77	62.67	62.02	60.82	58.32	56.75	72.54	73.87	73.41	72.57	70.82	69.73
Virginia	56.20	56.20	56.85	55.65	53.15	51.22	69.34	69.34	69.80	68.96	67.21	65.85
Washington	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
West Virginia	81.19	80.88	80.22	79.02	76.52	74.10	86.83	86.62	86.15	85.31	83.56	81.87
Wisconsin	65.57	66.08	66.30	65.10	62.60	60.66	75.90	76.26	76.41	75.57	73.82	72.46
Wyoming	56.20	56.20	56.20	55.00	52.50	50.00	69.34	69.34	69.34	68.50	66.75	65.00
American Samoa[7]	89.20	89.20	89.20	88.00	85.50	83.00	92.44	92.44	92.44	91.60	89.85	88.10
Guam[7]	89.20	89.20	89.20	88.00	85.50	83.00	92.44	92.44	92.44	91.60	89.85	88.10
N. Mariana Islands[7]	89.20	89.20	89.20	88.00	85.50	83.00	92.44	92.44	92.44	91.60	89.85	88.10
Puerto Rico[7]	82.20	82.20	82.20	81.00	78.50	76.00	87.54	87.54	87.54	86.70	84.95	83.20
Virgin Islands[7]	89.20	89.20	89.20	88.00	85.50	83.00	92.44	92.44	92.44	91.60	89.85	88.10

EXHIBIT 6. (continued)

Notes: FY is fiscal year. FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. Q is quarter. 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.

[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 before 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 (FFCRA, 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 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 Service facility that already receive a higher matching rate.

[3] Because the public health emergency period was in effect for all of FYs 2021 and 2022, this exhibit displays only the FY 2021 and 2022 FMAPs and E-FMAPs with the 6.2 percentage point increase under the FFCRA.

[4] Section 5131(a) of the Consolidated Appropriations Act, 2023 (P.L. 117-328) subsequently amended the FFCRA to phase down the FMAP increase during calendar year 2023. For the quarter beginning April 1, 2023, and ending June 30, 2023 (Q3 of FY 2023), the FMAP increase is 5 percentage points. For the quarter beginning July 1, 2023, and ending September 30, 2023, the FMAP increase is 2.5 percentage points (Q4 of FY 2023). For the quarter beginning October 1, 2023, and ending December 31, 2023 (Q1 for FY 2024), the FMAP increase is 1.5 percentage points. Section 5131(b) of the Consolidated Appropriations Act, 2023 added a new §1902(tt) of the Act that requires states submit to CMS certain monthly data about activities related to eligibility redeterminations conducted during the period from April 1, 2023, to June 30, 2024. If a state does not satisfy the reporting requirements in §1902(tt) during the period from July 1, 2023, to June 30, 2024, CMS shall reduce the FMAP for the state by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the state has failed to satisfy the reporting requirements.

[5] The FMAPs displayed for FY 2024 are the percentages that are in effect for January 1, 2024, to September 30, 2024. The FMAPs for the first quarter of FY 2024 would receive a 1.5 percentage point increase under the Consolidated Appropriations Act, 2023 (see footnote 4).

[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 numerous legislation that was subsequently consolidated under the Consolidated Appropriations Act, 2023 (P.L. 117-328), American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands receive an FMAP of 83 percent beginning December 21, 2019, and Puerto Rico receives an FMAP of 76 percent from December 21, 2019, through December 3, 2021, and January 1, 2022, through September 30, 2027, but would receive its normal FMAP of 55 percent between December 4, 2021, and December 31, 2021. The E-FMAPs for FYs 2021–2024 were calculated off these increased FMAPs.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for FYs 2021–2024; Consolidated Appropriations Act, 2023 (P.L. 117-328); Centers for Medicare & Medicaid Services, *Families First Coronavirus Response Act – Increased FMAP FAQs*, March 24, 2020, https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-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 through 2009 and then slowed as economic conditions improved.
  - 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).
  - Enrollment continues to increase since 2020 due to the continuous coverage requirement attached to the federal medical assistance percentage (FMAP) increase under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127). From July 2022 to July 2023, enrollment in Medicaid and the State Children's Health Insurance Program (CHIP) increased by 1.6 percent. While enrollment is higher than in 2022, it has been decreasing from its peak as states begin to disenroll beneficiaries following the end of the continuous coverage requirement. Enrollment decreased in 20 states in 2022 (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 9.2 percent from FY 2013 through FY 2021.
  - Individuals age 65 and older generally have the slowest growth rate regardless of time period.
- Medicaid's share of state-funded budgets (excluding federal funds) and total state budgets (including federal funds) has varied over time. In state fiscal year 2015, Medicaid's share of total state budgets increased, but its share of state-funded budgets decreased slightly—the decrease can be attributed to 100 percent federal funding made available for low-income adults not otherwise eligible on the basis of disability, who became newly eligible for Medicaid under the ACA. Most recently, Medicaid's share of state-funded budgets has decreased from 2018 to 2021 due to additional states expanding Medicaid and the FMAP increase under the FFCRA (Exhibit 13).
- Medicaid and CHIP expenditures as a share of national health expenditures are projected to decrease from 17.8 percent in 2021 to about 17.3 percent in 2031. Medicare's share is projected to increase from 21.2 percent to 25.8 percent during the same time period (Exhibit 12).

EXHIBIT 7. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FYs 1975–2021 (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
2020	**81,316**	30,126	30,830	8,703	6,574	5,083
2021	**85,007**	31,458	34,225	8,728	6,846	3,749

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 before 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 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.

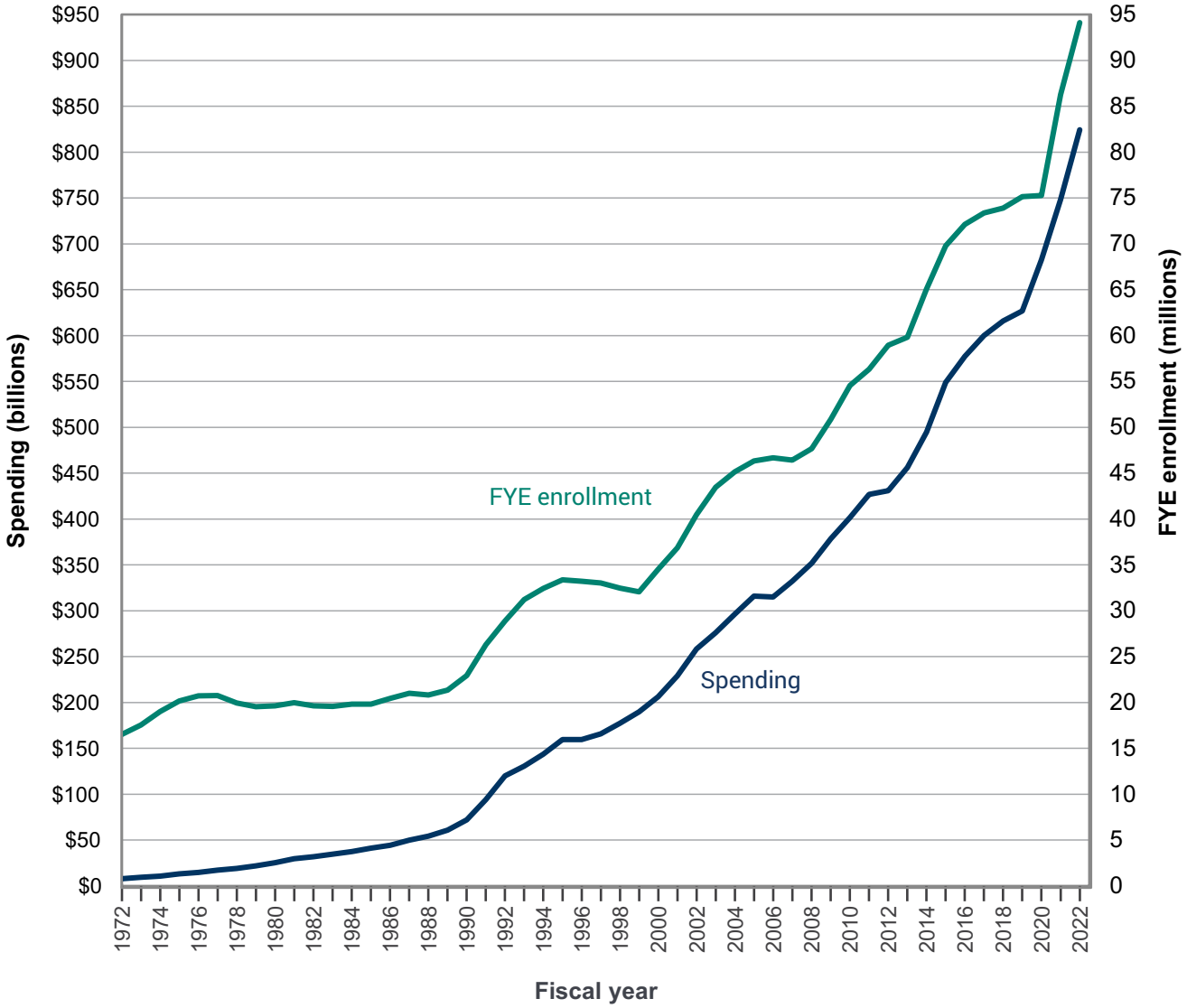
For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The national enrollment counts shown here are unduplicated using this national 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 2021: MACPAC, 2023, analysis of T-MSIS data as of February 2023. For FY 2020: MACPAC, 2022, analysis of T-MSIS data as of February 2022. 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.

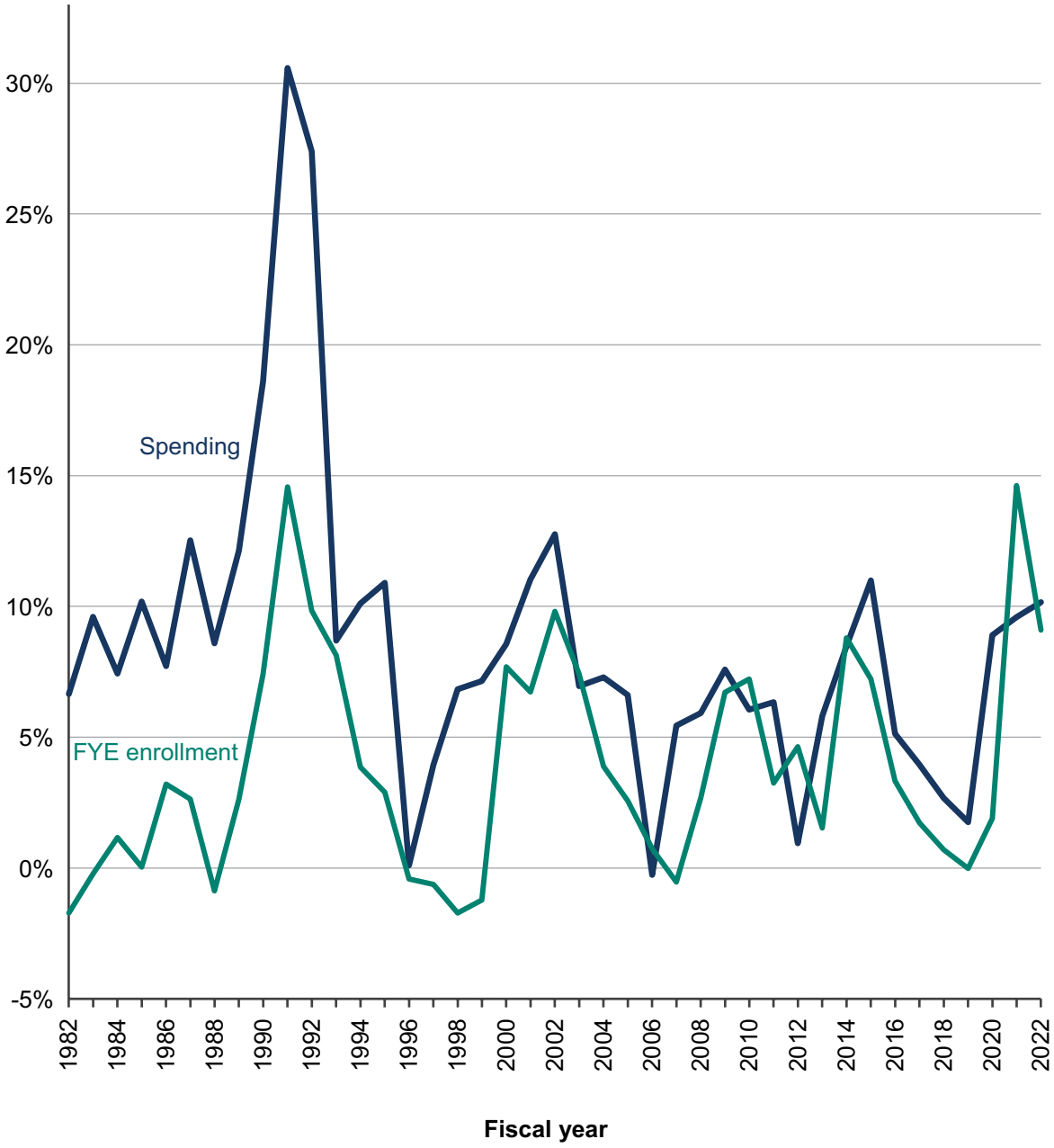
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1972–2022



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 before 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 before 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 1999–2022 include estimates for the territories.

Sources: For FY 2022: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023, and CMS-64 enrollment reports as of October 25, 2023. For FY 2021: MACPAC, 2022, analysis of CMS-64 FMR net expenditure data as of June 8, 2022, and CMS-64 enrollment reports as of October 24, 2022. 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 1982–2022



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 full-year equivalents and, for fiscal years before 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 1999–2022 include estimates for the territories.

Sources: For FY 2022: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023, and CMS-64 enrollment reports as of October 25, 2023. For FY 2021: MACPAC, 2022, analysis of CMS-64 FMR net expenditure data as of June 8, 2022, and CMS-64 enrollment reports as of October 24, 2022. 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 1972–2022

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

EXHIBIT 10. (continued)

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
2021	748	86.3	8,672	9.6	14.6	-4.4
2022	824	94.1	8,757	10.2	9.1	1.0

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 before 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 full-year equivalents and, for fiscal years before 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 data for FYs 1999–2022 include estimates for the territories.

Sources: For FY 2022: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023, and CMS-64 enrollment reports as of October 25, 2023. For FY 2021: MACPAC, 2022, analysis of CMS-64 FMR net expenditure data as of June 8, 2022, and CMS-64 enrollment reports as of October 24, 2022. 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 2013–2023

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2020	July 2021	July 2022	July 2023	July 2020–July 2021	July 2021–July 2022	July 2022–July 2023	July–September 2013 average to July 2023
Total	**56,511,799**[1]	**76,003,528**	**83,999,081**	**90,069,484**	**91,521,722**	**10.5%**	**7.2%**	**1.6%**	**59.5%**[2]
Alabama	799,176[3]	959,675	1,055,463	1,138,406	1,186,358	10.0	7.9	4.2	42.4
Alaska	122,334	233,334	251,024	261,816	261,521	7.6	4.3	-0.1	114.0
Arizona	1,201,770	1,862,408	2,072,102	2,227,971	2,134,921	11.3	7.5	-4.2	85.4
Arkansas	556,851	843,515	934,944	1,012,769	906,259	10.8	8.3	-10.5	81.9
California	7,755,381	12,016,056	12,983,442	13,744,043	14,325,437	8.1	5.9	4.2	77.2
Colorado	783,420	1,357,050	1,532,326	1,646,836	1,640,664	12.9	7.5	-0.4	110.2
Connecticut	–	885,365	960,844	979,293	995,155	8.5	1.9	1.6	–
Delaware	223,324	243,349	271,159	290,979	310,479	11.4	7.3	6.7	30.3
District of Columbia	235,786[4, 5]	253,009	270,938	286,672	289,252	7.1	5.8	0.9	21.6
Florida	3,695,306	3,930,734	4,350,511	4,734,996	4,521,012	10.7	8.8	-4.5	28.1
Georgia	1,535,090	1,970,507	2,214,237	2,405,477	2,511,096	12.4	8.6	4.4	56.7
Hawaii	288,357	363,958	424,531	452,696	438,044	16.6	6.6	-3.2	57.0
Idaho	238,150	347,777	399,433	430,307	359,738	14.9	7.7	-16.4	80.7
Illinois	2,626,943	3,139,748	3,440,508	3,675,203	3,863,904	9.6	6.8	5.1	39.9
Indiana	1,120,674	1,543,368	1,786,580	1,954,908	1,960,430	15.8	9.4	0.3	74.4
Iowa	493,515	711,187	786,223	828,281	793,857	10.6	5.3	-4.2	67.8
Kansas	378,160	406,698	450,537	491,794	474,225	10.8	9.2	-3.6	30.0
Kentucky	606,805	1,465,221	1,489,474	1,576,193	1,578,173	1.7	5.8	0.1	159.8
Louisiana	1,019,787	1,608,573	1,766,777	1,858,130	1,885,983	9.8	5.2	1.5	82.2
Maine	–	291,569	325,876	355,437	377,328	11.8	9.1	6.2	–
Maryland	856,297	1,392,038	1,534,076	1,645,951	1,691,568	10.2	7.3	2.8	92.2
Massachusetts	1,296,359	1,647,914	1,797,825	1,923,683	1,998,111	9.1	7.0	3.9	48.4
Michigan	1,912,009	2,487,485	2,777,203	2,965,223	3,113,849	11.6	6.8	5.0	55.1
Minnesota	873,040[6]	1,108,531	1,239,326	1,332,742	1,401,089	11.8	7.5	5.1	52.7
Mississippi	615,556	645,270	712,012	747,701	766,340	10.3	5.0	2.5	21.5

EXHIBIT 11. (continued)

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2020	July 2021	July 2022	July 2023	July 2020–July 2021	July 2021–July 2022	July 2022–July 2023	July–September 2013 average to July 2023
Missouri	846,084	951,731	1,093,102	1,349,254	1,481,081	14.9%	23.4%	9.8%	59.5%
Montana	148,974	259,433	291,578	313,837	294,114	12.4	7.6	-6.3	110.7
Nebraska	244,600	261,168	335,065	374,026	393,843	28.3	11.6	5.3	52.9
Nevada	332,560	695,931	800,436	868,971	835,888	15.0	8.6	-3.8	161.3
New Hampshire	127,082	197,601	225,025	242,720	191,087	13.9	7.9	-21.3	91.0
New Jersey	1,283,851	1,806,736	2,007,346	2,148,004	2,281,227	11.1	7.0	6.2	67.3
New Mexico	457,678	782,159	847,066	876,177	823,720	8.3	3.4	-6.0	91.4
New York	5,678,417	6,349,834	6,910,492	7,249,900	7,535,276	8.8	4.9	3.9	27.7
North Carolina	1,595,952	1,900,966	2,125,427	2,283,904	2,279,059	11.8	7.5	-0.2	43.1
North Dakota	69,980[7]	98,657	113,589	123,776	124,926	15.1	9.0	0.9	76.9
Ohio	2,130,322	2,819,633	3,086,656	3,270,899	3,295,451	9.5	6.0	0.8	53.5
Oklahoma	790,051	809,286	1,020,015	1,231,239	1,267,103	26.0	20.7	2.9	55.8
Oregon	626,356[8]	1,069,272	1,219,271	1,334,459	1,456,893	14.0	9.4	9.2	113.1
Pennsylvania	2,386,046	3,149,552	3,422,966	3,621,759	3,635,220	8.7	5.8	0.4	51.8
Rhode Island	190,833	309,281	338,291	353,502	372,618	9.4	4.5	5.4	85.2
South Carolina	889,744	1,077,781	1,185,531[9]	1,269,341	1,243,371	10.0	7.1	-2.0	42.7
South Dakota	115,501	115,715	129,870	140,676	116,043	12.2	8.3	-17.5	21.8
Tennessee	1,244,516	1,512,194	1,642,482	1,736,570	1,814,919	8.6	5.7	4.5	39.5
Texas	4,203,449	4,531,429	5,077,158	5,512,172	5,526,633	12.0	8.6	0.3	31.1
Utah	294,029[5]	349,201	420,000[5]	465,497[5]	431,137	20.3	10.8	-7.4	58.3
Vermont	161,081	163,055	180,359	189,194	182,446	10.6	4.9	-3.6	17.5
Virginia	935,434	1,529,228	1,750,410	1,934,368	2,008,101	14.5	10.5	3.8	106.8
Washington	1,117,576	1,811,777	1,993,221	2,120,740	2,038,345	10.0	6.4	-3.9	89.8
West Virginia	354,544	538,836	593,834	631,256	596,525	10.2	6.3	-5.5	78.0
Wisconsin	985,531[10]	1,137,130	1,292,431	1,380,418	1,427,922	13.7	6.8	3.4	40.1
Wyoming	67,518	61,603	70,089	79,318	83,981	13.8	13.2	5.9	17.5

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 before 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.

– 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] May include duplicates.

[7] Data are for July 2013 only.

[8] Includes emergency Medicaid population.

[9] Includes retroactive enrollment.

[10] Excludes retroactive enrollment.

Source: MACPAC, 2023, analysis of CMS, 2023, State Medicaid and CHIP applications, eligibility determinations, and enrollment data, accessed on October 31, 2023, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

EXHIBIT 12. Historical and Projected National Health Expenditures by Payer for Selected Years, CYs 1970–2031

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	**$74**	$5	7.1%	$8	10.4%	$15	20.4%	$3	4.5%	$19	25.0%	$24	32.7%
1975	**133**	13	10.1	16	12.3	30	22.4	6	4.5	31	23.5	36	27.2
1980	**253**	26	10.3	37	14.8	67	26.5	10	3.8	58	22.8	55	21.8
1985	**440**	41	9.3	72	16.3	127	28.8	15	3.5	94	21.3	92	20.8
1990	**719**	74	10.2	110	15.3	226	31.4	21	3.0	154	21.4	134	18.6
1995	**1,020**	145	14.2	184	18.1	315	30.9	27	2.6	208	20.4	141	13.8
2000	**1,366**	203	14.9	225	16.5	441	32.3	33	2.4	270	19.8	194	14.2
2005	**2,027**	317	15.6	340	16.8	671	33.1	56	2.8	378	18.7	264	13.1
2010	**2,590**	409	15.8	520	20.1	820	31.7	84	3.2	456	17.6	301	11.6
2011	**2,677**	419	15.6	545	20.3	851	31.8	88	3.3	464	17.3	310	11.6
2012	**2,783**	435	15.6	568	20.4	878	31.5	90	3.2	489	17.6	323	11.6
2013	**2,857**	458	16.0	589	20.6	880	30.8	92	3.2	506	17.7	331	11.6
2014	**3,003**	511	17.0	617	20.6	923	30.7	99	3.3	511	17.0	341	11.4
2015	**3,165**	558	17.6	648	20.5	977	30.9	106	3.4	523	16.5	354	11.2
2016	**3,307**	582	17.6	676	20.4	1,031	31.2	109	3.3	544	16.5	366	11.1
2017	**3,446**	597	17.3	705	20.5	1,080	31.3	114	3.3	578	16.8	373	10.8
2018	**3,604**	615	17.1	750	20.8	1,130	31.3	118	3.3	605	16.8	387	10.7
2019	**3,757**	635	16.9	802	21.3	1,158	30.8	125	3.3	635	16.9	403	10.7
2020	**4,144**	693	16.7	831	20.1	1,145	27.6	136	3.3	946	22.8	392	9.5
2021	**4,255**	756	17.8	901	21.2	1211	28.5	150	3.5	804	18.9	433	10.2
Projected													
2022	**$4,440**	$828	18.7%	$944	21.3%	$1,248	28.1%	$160	3.6%	$808	18.2%	$452	10.2%
2023	**4,666**	860	18.4	1,020	21.8	1,345	28.8	179	3.8	788	16.9	475	10.2

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	
2024	**$4,898**	$844	17.2%	$1,093	22.3%	$1,447	29.5%	$191	3.9%	$825	16.8%	$498	10.2%
2025	**5,185**	883	17.0	1,190	23.0	1,532	29.5	201	3.9	859	16.6	520	10.0
2026	**5,462**	933	17.1	1,290	23.6	1,597	29.2	211	3.9	893	16.3	539	9.9
2027	**5,774**	989	17.1	1,394	24.1	1,682	29.1	220	3.8	930	16.1	560	9.7
2028	**6,106**	1,051	17.2	1,504	24.6	1,769	29.0	229	3.7	971	15.9	583	9.6
2029	**6,449**	1,110	17.2	1,621	25.1	1,858	28.8	238	3.7	1,016	15.8	607	9.4
2030	**6,804**	1,173	17.2	1,731	25.4	1,957	28.8	247	3.6	1,063	15.6	633	9.3
2031	**7,175**	1,239	17.3	1,849	25.8	2,059	28.7	256	3.6	1,112	15.5	659	9.2

Notes: CY is calendar year. Components may not sum to total due to rounding. The latest projections begin after the latest historical year (2021) and go through 2031.

[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, 2023, analysis of Office of the Actuary (OACT), CMS, 2022, *National health expenditures by type of service and source of funds: Calendar years 1960–2021*, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2021.zip. For projected data: MACPAC, 2023, analysis of OACT, 2023, *National health expenditures by type of expenditure and source of funds: Calendar years 1960 to 2031*, https://www.cms.gov/files/zip/nhe-historical-and-projections-data.zip; and OACT, 2023, *Table 17: Health insurance enrollment and enrollment growth rates, calendar years, 2013–2031*, https://www.cms.gov/files/zip/nhe-projections-tables.zip.

EXHIBIT 13. Medicaid as a Share of State Budgets Including and Excluding Federal Funds, SFYs 1995–2021

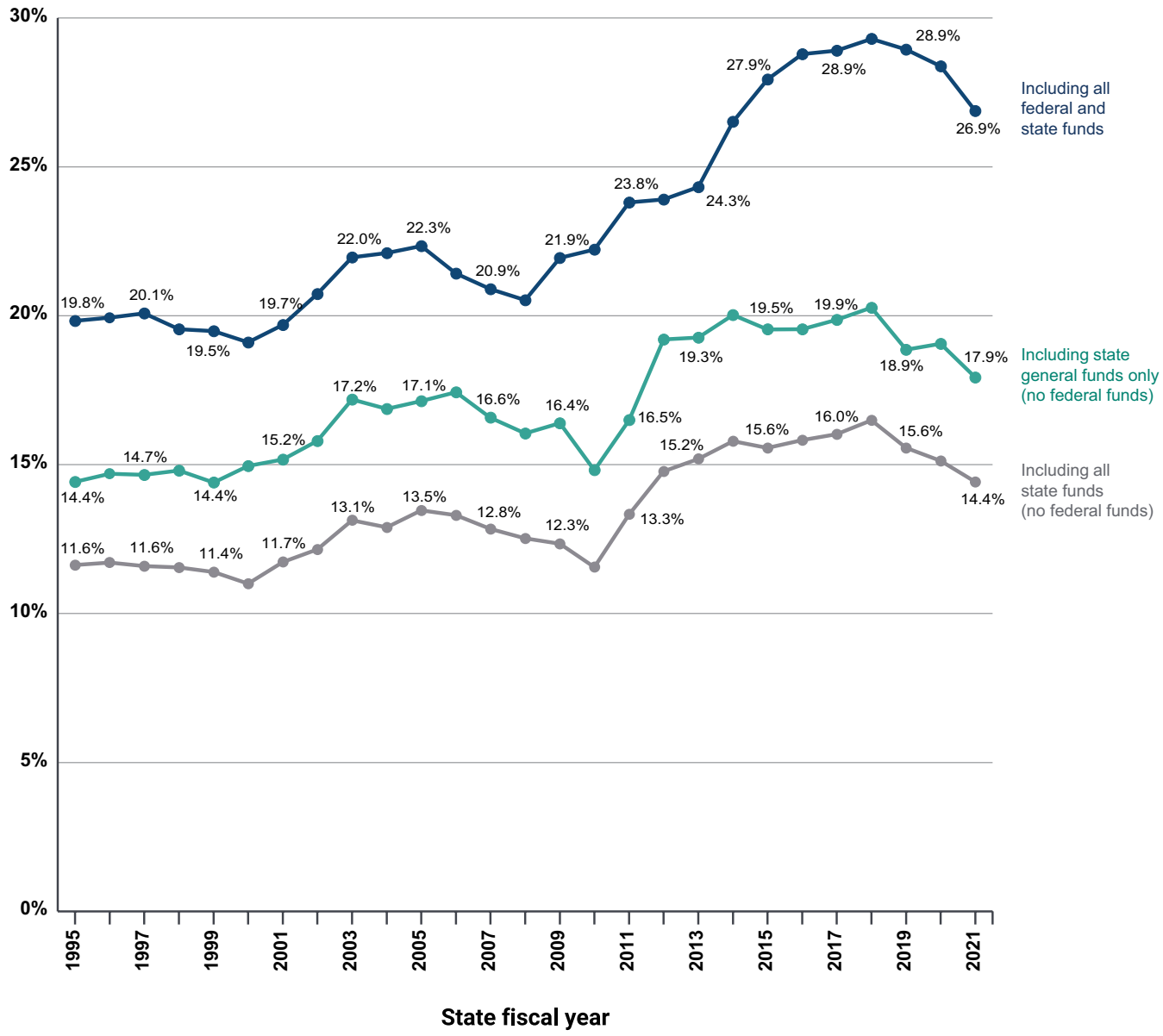


EXHIBIT 13. (continued)

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
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	28.9	18.9	15.6
2020	28.4	19.1	15.1
2021	26.9	17.9	14.4

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, 2023, 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 $830.6 billion in fiscal year (FY) 2022 (Exhibit 16). Spending for the State Children's Health Insurance Program (CHIP) was $22.3 billion (Exhibit 33).
- The federal share was 71.4 percent of total Medicaid benefit spending in FY 2022, compared with an average federal share of approximately 63 percent to 64 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 2021, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 21 percent of Medicaid enrollees but about 52 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 4.9 percent of Medicaid enrollees but more than one-quarter 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 25 percent of enrollees and 22 percent of spending in FY 2021 (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 before the ACA.
- More than 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. More than half (52.9 percent) of enrollees who are eligible on the basis of disability and more than one-third (36.8 percent) of enrollees age 65 and older were enrolled in comprehensive managed care in FY 2021, 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 more than half (52.9 percent) in FY 2022 (Exhibit 28). About two-thirds (64.1 percent) of Medicaid gross spending for drugs occurred under managed care in FY 2022 (Exhibit 26).
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for more than half (52.3 percent) of fee-for-service payments to hospitals in FY 2022 (Exhibit 24).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2021 (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	**87,979**	**32,132**	**22,377**	**15,296**	**9,568**	**8,606**	**13,167**	**8,195**	**9,770**	**5,969**	**3,397**	**2,226**
Alabama	**1,162**	571	–	233	219	138	**242**	138	**98**	53	**144**	85
Alaska	**255**	102	71	52	16	14	**24**	14	**23**	13	**1**	1
Arizona	**2,266**	780	664	447	182	194	**298**	185	**240**	144	**57**	41
Arkansas	**1,045**	459	352	2	151	82	**157**	85	**88**	51	**70**	34
California[5]	**13,918**	3,651	4,727	3,149	900	1,491	**1,774**	1,356	**1,737**	1,325	**37**	31
Colorado[6]	**1,551**	533	689	127	110	91	**158**	98	**113**	65	**46**	33
Connecticut	**1,177**	366	354	236	65	157	**213**	152	**79**	46	**134**	106
Delaware	**292**	107	84	54	26	20	**33**	20	**16**	9	**18**	11
District of Columbia[7]	**278**	78	82	57	32	29	**41**	28	**29**	19	**12**	10
Florida	**5,054**	2,517	–	1,111	679	747	**1,058**	737	**625**	428	**433**	309
Georgia	**2,448**	1,324	–	486	367	271	**414**	265	**178**	110	**236**	156
Hawaii	**429**	140	168	56	22	43	**58**	39	**51**	34	**7**	5
Idaho	**436**	178	129	42	53	34	**58**	32	**35**	17	**23**	14
Illinois[7]	**3,371**	693	2,026	128	206	317	**450**	277	**400**	244	**50**	34
Indiana[6]	**1,932**	726	477	406	186	136	**253**	134	**183**	93	**70**	41
Iowa	**791**	289	246	122	85	50	**107**	52	**84**	37	**22**	15
Kansas	**452**	248	–	77	81	46	**87**	45	**58**	29	**28**	16
Kentucky	**1,734**	477	761	165	218	112	**247**	128	**152**	80	**95**	48
Louisiana[6]	**1,823**	608	710	104	241	159	**284**	160	**162**	86	**122**	74
Maine	**422**	115	95	86	64	63	**103**	59	**63**	29	**40**	30
Maryland	**1,548**	570	425	301	146	106	**185**	108	**114**	62	**71**	46
Massachusetts	**1,980**	450	429	512	350	239	**395**	217	**360**	184	**35**	33
Michigan	**3,001**	1,038	986	420	352	205	**384**	201	**336**	173	**48**	27
Minnesota	**1,338**	604	277	242	120	96	**161**	89	**146**	79	**15**	10
Mississippi	**827**	425	–	132	165	104	**182**	103	**89**	49	**93**	54

EXHIBIT 14. (continued)

State	Total	Basis of eligibility[1]					Dually eligible status[2]					
							All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri	**1,240**	673	60	190	201	116	**224**	109	**186**	87	**39**	22
Montana	**289**	105	114	28	23	18	**35**	20	**25**	14	**9**	6
Nebraska	**331**	158	59	47	41	27	**47**	25	**41**	21	**6**	4
Nevada	**880**	330	340	85	64	61	**100**	61	**46**	25	**54**	36
New Hampshire	**249**	86	88	28	27	19	**42**	18	**28**	12	**13**	6
New Jersey	**1,923**	672	739	176	174	163	**262**	157	**262**	157	**–**	–
New Mexico	**962**	348	311	162	76	66	**115**	71	**62**	34	**54**	37
New York	**7,253**	1,968	2,670	1,139	625	850	**1,200**	824	**1,017**	684	**182**	140
North Carolina	**2,535**	1,076	–	878	361	220	**372**	212	**287**	157	**85**	55
North Dakota[5]	**125**	52	34	16	13	11	**19**	11	**16**	9	**3**	2
Ohio	**3,146**	1,108	860	525	403	249	**420**	221	**282**	147	**138**	74
Oklahoma	**1,109**	563	184	166	118	78	**139**	74	**110**	59	**29**	15
Oregon[6]	**1,275**	332	680	40	115	108	**163**	103	**103**	63	**60**	39
Pennsylvania	**3,390**	1,032	1,093	342	600	322	**582**	324	**484**	264	**98**	60
Rhode Island	**335**	97	101	67	40	29	**57**	32	**48**	27	**8**	6
South Carolina	**1,377**	631	–	461	175	109	**191**	104	**180**	97	**11**	7
South Dakota	**132**	75	–	23	21	14	**23**	13	**15**	8	**9**	5
Tennessee	**1,787**	912	–	443	269	162	**314**	162	**185**	82	**129**	80
Texas[8]	**5,628**	3,354	0	992	707	575	**821**	547	**430**	280	**391**	267
Utah[5]	**446**	200	109	65	47	24	**43**	22	**39**	20	**4**	2
Vermont	**198**	69	74	13	20	22	**31**	18	**23**	12	**8**	6
Virginia	**1,845**	629	608	277	185	146	**220**	127	**151**	88	**69**	39
Washington	**2,153**	844	803	176	183	147	**240**	138	**173**	98	**68**	40
West Virginia	**632**	202	223	62	93	53	**110**	54	**64**	31	**45**	23
Wisconsin	**1,414**	510	–	556	193	155	**204**	106	**189**	95	**15**	11
Wyoming	**81**	45	–	15	12	9	**14**	8	**9**	5	**5**	3

EXHIBIT 14. (continued)

Notes: FY is fiscal year. Enrollment numbers generally include individuals ever enrolled in Medicaid-financed coverage during the year, even if for a single month. However, in the event individuals were also enrolled in CHIP-financed Medicaid coverage (i.e., Medicaid-expansion CHIP) during the year, they are excluded if their most recent enrollment month was in Medicaid-expansion CHIP. Numbers exclude individuals enrolled only in Medicaid-expansion CHIP during the year and enrollees in the territories. 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 (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. Categories may not sum to 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, pregnancy).

[5] 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, before 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 250,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 12,000.

[6] State reported a large shift of enrollees between eligibility groups from the prior year. Colorado reported a 35 percent increase in the new adult group and a 46 percent decrease for the other adult group. Indiana reported a 16 percent decrease for the new adult group and a 60 percent increase for the other adult group. Louisiana reported a 15 percent increase in the new adult group and a 10 percent decrease in the other adult group. Oregon reported a 33 percent increase in the new adult group, a 69 percent decrease in the other adult group, a 102 percent increase in the disabled group, and a 53 percent increase in the aged group.

[7] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 36 percent less than the benchmark, and Illinois's average monthly enrollment was 113 percent more than the benchmark.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2021.

Source: MACPAC, 2023, analysis of T-MSIS data as of February 2023.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2021 (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	**80,838**	**74,023**	**29,688**	**29,567**	**20,360**	**19,786**	**13,744**	**10,868**	**9,192**	**8,079**	**7,855**	**5,723**
Alabama	**1,072**	**865**	524	524	–	–	214	140	209	154	126	48
Alaska	**237**	**236**	94	94	66	66	48	48	16	15	13	12
Arizona	**2,096**	**1,917**	718	708	608	570	418	345	173	158	178	135
Arkansas	**956**	**890**	418	418	319	319	1	1	145	111	74	42
California[4]	**12,702**	**11,171**	3,371	3,337	4,321	3,918	2,740	1,717	875	869	1,396	1,330
Colorado[5]	**1,417**	**1,374**	490	490	625	625	116	115	105	93	82	53
Connecticut	**1,087**	**942**	341	340	330	329	209	192	63	35	145	46
Delaware	**268**	**241**	99	97	76	76	50	40	25	19	19	8
District of Columbia[6]	**262**	**250**	72	72	76	76	55	55	32	29	27	18
Florida	**4,648**	**4,153**	2,355	2,353	–	–	978	893	628	510	686	397
Georgia	**2,229**	**1,924**	1,211	1,211	–	–	433	343	342	268	244	103
Hawaii	**393**	**386**	130	130	151	151	51	51	21	20	40	35
Idaho	**382**	**360**	155	155	111	111	37	37	50	41	30	17
Illinois[6]	**3,059**	**2,988**	655	654	1,818	1,818	108	83	196	182	282	251
Indiana[5]	**1,752**	**1,601**	664	653	426	415	359	300	180	152	122	81
Iowa	**714**	**689**	257	257	223	222	108	105	82	75	44	30
Kansas	**408**	**379**	227	227	–	–	67	65	74	62	40	26
Kentucky	**1,591**	**1,497**	442	442	677	676	156	155	213	167	103	58
Louisiana[4]	**1,707**	**1,589**	572	572	659	659	96	94	233	187	147	77
Maine	**380**	**305**	100	97	84	83	77	48	61	51	57	26
Maryland	**1,440**	**1,354**	537	536	391	391	275	256	141	117	96	54
Massachusetts	**1,819**	**1,566**	409	380	387	366	467	314	334	332	222	175
Michigan	**2,783**	**2,708**	957	954	908	894	391	380	341	322	185	159
Minnesota	**1,227**	**1,199**	563	562	249	247	214	204	116	111	85	76
Mississippi	**770**	**653**	398	398	–	–	120	92	157	119	96	45

EXHIBIT 15. (continued)

State	Total		Child		New adult group[1]		Other adult[2]		Disabled		Aged	
	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]
Missouri	**1,101**	**1,066**	626	626	15	15	168	168	189	174	102	82
Montana	**266**	**256**	98	98	104	104	25	24	22	19	17	11
Nebraska	**289**	**284**	143	143	44	44	40	40	38	36	24	20
Nevada	**785**	**733**	295	295	302	302	73	71	60	43	55	21
New Hampshire	**225**	**204**	80	79	78	78	25	17	26	20	17	11
New Jersey	**1,750**	**1,749**	615	615	670	669	150	148	168	168	148	148
New Mexico	**887**	**799**	314	314	289	283	151	122	72	54	61	26
New York	**6,677**	**6,506**	1,821	1,820	2,466	2,465	1,007	1,003	605	566	778	651
North Carolina	**2,275**	**1,791**	953	948	–	–	780	384	343	311	199	148
North Dakota[4]	**107**	**104**	44	44	28	28	14	14	12	11	9	7
Ohio	**2,929**	**2,798**	1,037	1,036	785	785	493	493	391	330	224	154
Oklahoma	**883**	**808**	453	453	114	84	136	116	111	100	69	55
Oregon[5]	**1,100**	**999**	281	280	609	579	35	12	93	77	82	51
Pennsylvania	**3,103**	**2,989**	935	930	989	985	315	301	576	539	288	234
Rhode Island	**310**	**301**	87	87	93	93	63	62	39	37	27	22
South Carolina	**1,296**	**1,068**	597	593	–	–	432	222	167	162	100	91
South Dakota	**119**	**111**	68	68	–	–	20	20	19	16	12	7
Tennessee	**1,625**	**1,505**	802	802	–	–	418	418	258	212	147	73
Texas[7]	**5,173**	**4,413**	3,110	3,109	0	0	872	477	672	555	519	272
Utah[4]	**392**	**379**	179	178	93	93	54	47	45	43	21	19
Vermont	**184**	**177**	65	65	68	68	12	12	20	18	20	14
Virginia	**1,667**	**1,548**	562	562	547	539	249	203	178	149	131	95
Washington	**1,957**	**1,888**	776	775	722	722	150	145	176	150	133	96
West Virginia	**583**	**540**	186	186	203	201	56	55	89	70	48	27
Wisconsin	**1,303**	**1,242**	470	468	–	–	507	463	186	183	139	129
Wyoming	**70**	**65**	40	40	–	–	12	12	11	9	7	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 (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. Categories may not sum to 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, pregnancy).

[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, COVID-19 diagnostic products or testing-related 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 that would have, before 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 229,000, North Dakota's child FYE enrollment by approximately 2,600, and Utah's child FYE enrollment by approximately 10,900.

[5] State reported a large shift of enrollees between eligibility groups from the prior year. Colorado reported a 54 percent increase in the new adult group and a 41 percent decrease for the other adult group. Indiana reported a 1.2 percent increase for the new adult group and an 80 percent increase for the other adult group. Louisiana reported a 28 percent increase in the new adult group and a 0.5 percent increase in the other adult group. Oregon reported a 45 percent increase in the new adult group, a 67 percent decrease in the other adult group, a 76 percent increase in the disabled group, and a 32 percent increase in the aged group.

[6] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 36 percent less than the benchmark, and Illinois's average monthly enrollment was 113 percent more than the benchmark.

[7] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2021.

Source: MACPAC, 2023, analysis of T-MSIS data as of February 2023.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2022 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$7,166**	$5,685	$1,481	**$241**	$144	$96	**$7,407**	$5,829	$1,578
Alaska	**2,436**	1,911	525	**157**	95	62	**2,592**	2,006	587
Arizona	**20,258**	16,932	3,325	**331**	205	126	**20,589**	17,137	3,452
Arkansas	**8,533**	7,022	1,511	**442**	289	153	**8,975**	7,311	1,664
California	**117,885**	80,358	37,527	**7,190**	4,323	2,867	**125,075**	84,681	40,393
Colorado	**11,874**	7,966	3,908	**551**	334	217	**12,425**	8,300	4,125
Connecticut	**9,672**	6,285	3,387	**353**	226	127	**10,025**	6,511	3,514
Delaware	**3,137**	2,255	882	**103**	64	39	**3,240**	2,319	921
District of Columbia	**3,648**	2,902	745	**281**	183	98	**3,929**	3,086	843
Florida	**32,667**	22,212	10,455	**606**	365	241	**33,274**	22,577	10,697
Georgia	**14,340**	10,664	3,676	**536**	338	198	**14,876**	11,002	3,874
Hawaii	**2,990**	2,130	860	**113**	74	39	**3,103**	2,204	898
Idaho	**3,195**	2,551	644	**135**	87	48	**3,330**	2,638	692
Illinois	**25,956**	17,225	8,731	**1,017**	626	390	**26,973**	17,851	9,122
Indiana	**16,851**	13,042	3,809	**471**	280	191	**17,322**	13,322	4,000
Iowa	**6,614**	4,906	1,708	**163**	110	53	**6,777**	5,016	1,761
Kansas	**4,301**	2,957	1,344	**250**	166	85	**4,551**	3,122	1,429
Kentucky	**14,590**	12,164	2,426	**286**	193	93	**14,877**	12,357	2,520
Louisiana	**14,674**	11,790	2,884	**365**	240	125	**15,039**	12,030	3,009
Maine	**3,786**	2,879	906	**167**	111	55	**3,952**	2,991	962
Maryland	**14,344**	9,609	4,735	**501**	322	178	**14,844**	9,931	4,913
Massachusetts	**20,865**	13,428	7,437	**1,159**	678	480	**22,023**	14,106	7,918
Michigan	**21,023**	16,123	4,900	**673**	424	248	**21,696**	16,547	5,149
Minnesota	**16,159**	10,708	5,451	**738**	427	311	**16,897**	11,135	5,762
Mississippi	**5,944**	5,062	881	**198**	131	67	**6,142**	5,193	949
Missouri	**13,013**	10,303	2,710	**427**	260	167	**13,440**	10,563	2,877

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Montana	**$2,344**	$1,929	$414	**$105**	$73	$31	**$2,448**	$2,003	$446
Nebraska	**3,296**	2,354	942	**185**	125	61	**3,481**	2,479	1,003
Nevada	**5,053**	3,976	1,076	**218**	134	85	**5,271**	4,110	1,161
New Hampshire	**2,461**	1,601	860	**151**	102	49	**2,612**	1,703	909
New Jersey	**20,873**	14,229	6,643	**1,013**	616	397	**21,886**	14,845	7,041
New Mexico	**8,258**	7,074	1,184	**287**	192	95	**8,545**	7,266	1,279
New York	**80,518**	52,155	28,363	**2,046**	1,180	866	**82,565**	53,336	29,229
North Carolina	**18,404**	13,967	4,437	**1,063**	679	384	**19,467**	14,646	4,822
North Dakota	**1,524**	1,076	448	**97**	66	30	**1,621**	1,143	478
Ohio	**30,025**	23,179	6,846	**1,035**	622	413	**31,060**	23,802	7,258
Oklahoma	**7,523**	6,353	1,170	**218**	128	90	**7,741**	6,482	1,260
Oregon	**13,083**	10,174	2,909	**613**	352	261	**13,696**	10,526	3,170
Pennsylvania	**41,178**	28,126	13,052	**1,117**	708	408	**42,295**	28,835	13,460
Rhode Island	**3,393**	2,394	999	**191**	123	69	**3,584**	2,517	1,067
South Carolina	**7,544**	5,887	1,657	**382**	240	142	**7,926**	6,127	1,800
South Dakota	**1,246**	886	360	**74**	47	27	**1,320**	933	387
Tennessee	**11,265**	8,323	2,942	**819**	573	245	**12,083**	8,896	3,187
Texas	**54,942**	37,497	17,444	**1,627**	982	645	**56,569**	38,479	18,090
Utah	**4,211**	3,304	907	**186**	123	63	**4,398**	3,428	970
Vermont	**1,884**	1,304	581	**165**	109	56	**2,049**	1,412	637
Virginia	**17,824**	12,252	5,572	**439**	275	164	**18,263**	12,527	5,736
Washington	**17,141**	12,133	5,007	**1,073**	582	490	**18,213**	12,716	5,498
West Virginia	**5,184**	4,389	795	**209**	152	56	**5,393**	4,542	851
Wisconsin	**11,429**	7,982	3,447	**524**	343	181	**11,953**	8,325	3,628
Wyoming	**668**	410	259	**75**	53	22	**744**	463	281
Subtotal (states)	**$787,191**	**$562,025**	**$225,165**	**$31,365**	**$19,278**	**$12,087**	**$818,555**	**$581,303**	**$237,252**

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
American Samoa	**$68**	$59	$10	**$2**	$2	$1	**$71**	$60	$11
Guam	**167**	150	17	**4**	2	2	**171**	152	19
Northern Mariana Islands	**73**	66	8	**5**	4	1	**78**	70	8
Puerto Rico	**5,098**	3,368	1,730	**102**	75	27	**5,200**	3,443	1,757
Virgin Islands	**137**	121	16	**24**	16	8	**161**	137	24
Subtotal (states and territories)	**$792,734**	**$565,788**	**$226,946**	**$31,502**	**$19,377**	**$12,125**	**$824,236**	**$585,165**	**$239,071**
State Medicaid Fraud Control Units	**–**	–	–	**409**	307	102	**409**	307	102
Medicaid survey and certification of nursing and intermediate care facilities	**–**	–	–	**400**	300	100	**400**	300	100
Vaccines for Children program	**–**	–	–	**–**	–	–	**5,540**	5,540	–
Total	**$792,734**	**$565,788**	**$226,946**	**$32,311**	**$19,983**	**$12,327**	**$830,585[2]**	**$591,312[2]**	**$239,273**

Notes: FY is fiscal year. Total federal spending shown here ($591,312 million) will differ from total federal outlays shown in FY 2024 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 May 30, 2023. 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, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023. For all other spending (MFCUs, survey and certification, VFC program): CMS, 2023, *Fiscal year 2024 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/files/document/cms-fy-2024-congressional-justification-estimates-appropriations-committees.pdf-0.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2022 (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	**$7,166**	$2,835	$483	$89	$108	$126	$712	$432	$1,172	$656	$140	$450	-$37
Alaska	**2,436**	755	173	94	41	499	184	106	235	329	1	43	-24
Arizona	**20,258**	1,377	62	5	18	375	1,242	230	105	8	16,327	509	-0
Arkansas	**8,533**	1,371	359	1	31	88	765	103	934	400	4,111	408	-38
California[2]	**117,885**	10,370	1,074	1,614	-45	4,058	12,640	6,786	3,893	23,408	51,517	3,572	-1,002
Colorado[2]	**11,874**	3,611	380	342	-0	874	351	471	854	2,396	2,464	244	-115
Connecticut	**9,672**	2,860	541	149	298	391	604	462	1,615	2,085	136	629	-96
Delaware[3]	**3,137**	87	9	53	1	3	116	-10	74	246	2,518	44	-4
District of Columbia	**3,648**	287	23	5	5	164	328	96	442	646	1,575	81	-5
Florida	**32,667**	2,921	289	406	69	271	656	140	1,863	1,856	22,218	2,398	-421
Georgia	**14,340**	2,877	379	17	73	20	843	350	1,807	1,829	5,525	703	-84
Hawaii	**2,990**	37	0	33	0	27	34	0	10	156	2,688	52	-48
Idaho	**3,195**	824	186	–	54	54	267	189	200	527	829	95	-31
Illinois	**25,956**	2,590	184	16	29	74	1,090	1	1,106	1,170	19,017	765	-86
Indiana	**16,851**	1,438	220	23	11	197	794	161	3,039	2,250	8,369	409	-61
Iowa[3]	**6,614**	101	15	0	2	71	128	-2	38	56	6,092	196	-84
Kansas[3]	**4,301**	98	4	0	0	1	68	-1	81	0	3,927	145	-22
Kentucky	**14,590**	477	46	2	10	345	418	25	1,457	1,228	10,268	341	-27
Louisiana	**14,674**	1,349	39	–	1	32	334	51	1,602	914	9,918	518	-83
Maine	**3,786**	944	126	21	92	198	564	153	554	945	11	266	-86
Maryland	**14,344**	1,245	140	150	151	209	1,510	264	1,576	2,120	6,614	468	-102
Massachusetts	**20,865**	2,716	366	373	38	277	1,414	407	1,624	4,236	8,829	774	-189
Michigan	**21,023**	1,368	258	27	18	246	751	609	2,129	1,059	14,068	786	-297
Minnesota[3]	**16,159**	612	170	21	125	174	1,016	-314	1,172	4,920	8,122	279	-138
Mississippi	**5,944**	781	150	5	31	65	306	72	1,092	556	2,574	337	-26
Missouri	**13,013**	2,847	12	4	14	458	872	585	1,455	2,788	3,595	463	-79
Montana	**2,344**	938	158	61	84	85	299	135	188	303	53	63	-23
Nebraska[3]	**3,296**	39	2	0	0	0	56	-0	534	642	2,014	59	-50
Nevada	**5,053**	637	161	76	39	76	412	137	387	396	2,512	254	-35
New Hampshire[3]	**2,461**	248	4	22	1	4	164	-90	433	494	1,135	55	-9

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	**$20,873**	$1,285	$54	$0	$18	$518	$1,178	$7	$1,372	$2,376	$13,759	$587	$-281
New Mexico	**8,258**	503	22	8	51	6	120	2	40	706	6,606	209	-15
New York[3]	**80,518**	8,752	277	14	155	1,189	4,262	-3,578	8,605	9,947	51,134	2,487	-2,727
North Carolina	**18,404**	2,388	325	350	55	160	1,076	212	2,111	1,131	10,104	670	-179
North Dakota	**1,524**	164	40	15	22	17	64	49	423	283	433	23	-9
Ohio	**30,025**	924	155	29	15	166	824	135	2,656	4,676	19,843	834	-232
Oklahoma	**7,523**	2,817	730	175	46	703	601	1,107	970	763	108	236	-731
Oregon	**13,083**	414	23	5	19	407	486	90	585	2,981	7,797	341	-65
Pennsylvania	**41,178**	1,884	33	6	1	62	509	12	1,362	3,924	32,617	976	-209
Rhode Island	**3,393**	366	10	4	0	18	245	2	295	417	1,963	88	-15
South Carolina	**7,544**	1,234	129	139	16	85	422	143	971	928	3,440	332	-294
South Dakota	**1,246**	309	68	24	7	65	100	87	231	317	1	47	-11
Tennessee	**11,265**	612	30	152	0	99	348	542	268	754	7,984	567	-90
Texas	**54,942**	8,384	122	12	2,305	24	2,474	448	1,693	2,933	37,585	1,725	-2,762
Utah	**4,211**	477	129	24	14	22	363	113	478	506	2,051	71	-36
Vermont[3]	**1,884**	100	15	7	13	9	1,360	-91	149	303	–	19	-1
Virginia[3]	**17,824**	3,044	241	279	6	90	366	-18	383	2,892	10,946	432	-838
Washington	**17,141**	877	92	191	10	1,068	914	620	1,097	4,279	12,369	565	-4,941
West Virginia	**5,184**	216	27	5	30	14	354	293	929	713	2,439	203	-40
Wisconsin	**11,429**	804	31	101	34	368	1,050	616	777	1,348	5,958	431	-89
Wyoming	**668**	142	70	12	2	49	30	42	139	166	2	23	-9
Subtotal	**$787,191**	**$84,336**	**$8,639**	**$5,160**	**$4,115**	**$14,602**	**$46,085**	**$12,382**	**$57,205**	**$100,961**	**$444,305**	**$26,275**	**-$16,876**
American Samoa	**68**	38	1	–	–	7	21	0	–	0	–	2	–
Guam	**167**	83	18	3	0	2	37	22	1	1	–	2	–
N. Mariana Islands	**73**	46	–	5	–	10	7	4	–	1	–	1	–
Puerto Rico	**5,098**	–	–	–	–	60	31	323	–	–	4,678	–	6
Virgin Islands	**137**	41	10	15	4	14	12	33	0	2	–	1	6
Total	**$792,734**	**$84,544**	**$8,668**	**$5,183**	**$4,119**	**$14,694**	**$46,193**	**$12,764**	**$57,206**	**$100,964**	**$448,983**	**$26,281**	**-$16,865**
Percent of total, exclusive of collections	**–**	**10.4%**	**1.1%**	**0.6%**	**0.5%**	**1.8%**	**5.7%**	**1.6%**	**7.1%**	**12.5%**	**55.5%**	**3.2%**	**–**

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 (EPSDT) screenings; 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; opioid use disorder (OUD) medication assisted treatment (MAT) services; COVID-19 vaccine and administration; and other care not otherwise categorized.
- Drugs (including OUD MAT 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 more than 90 percent of spending in the managed care category. Managed care also includes rebates for drugs (including OUD MAT 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, certified community behavioral health clinic, and services subject to electronic visit verification requirements.

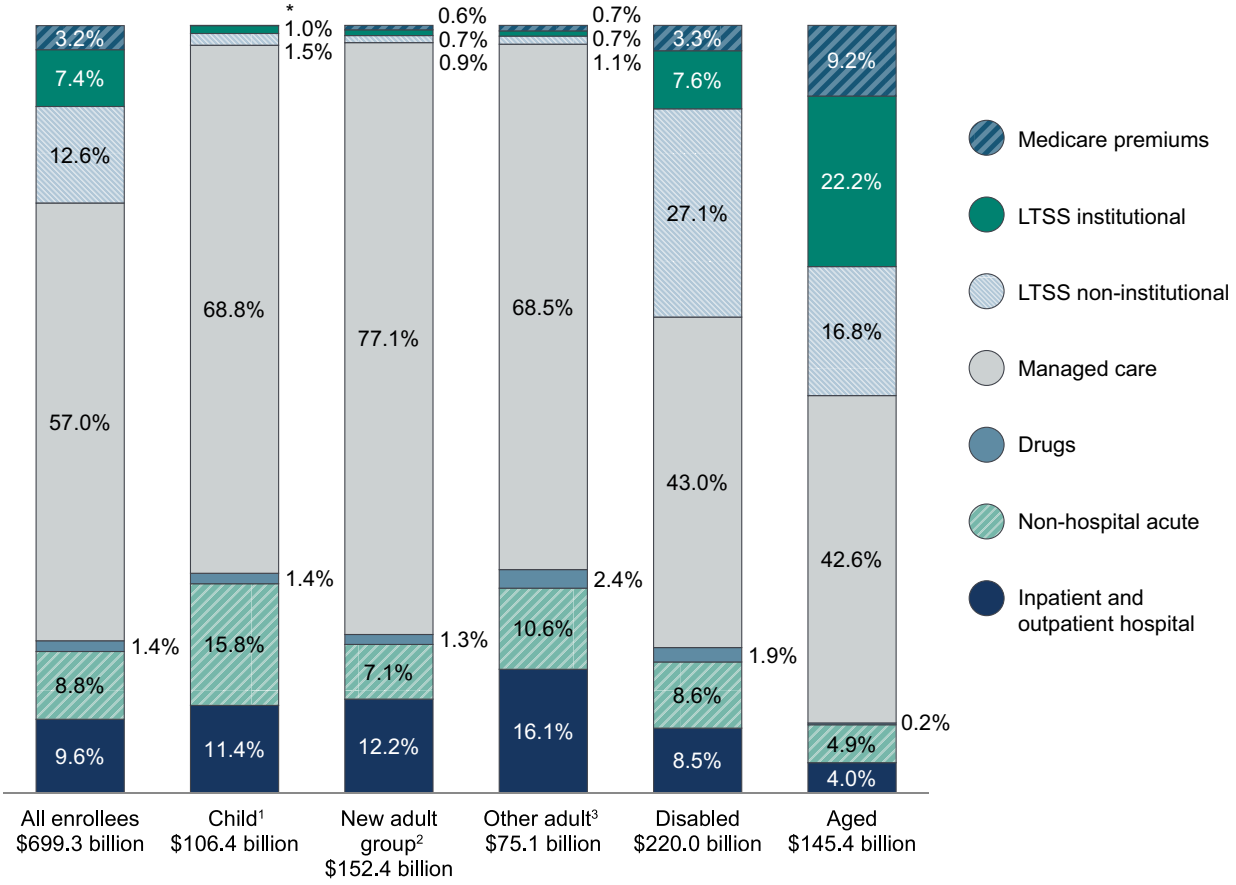
[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of May 30, 2023. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] State or territory reports negative spending in a category due to prior period adjustments. California and Colorado report negative spending for other practitioners.

[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, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2021



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 before 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.

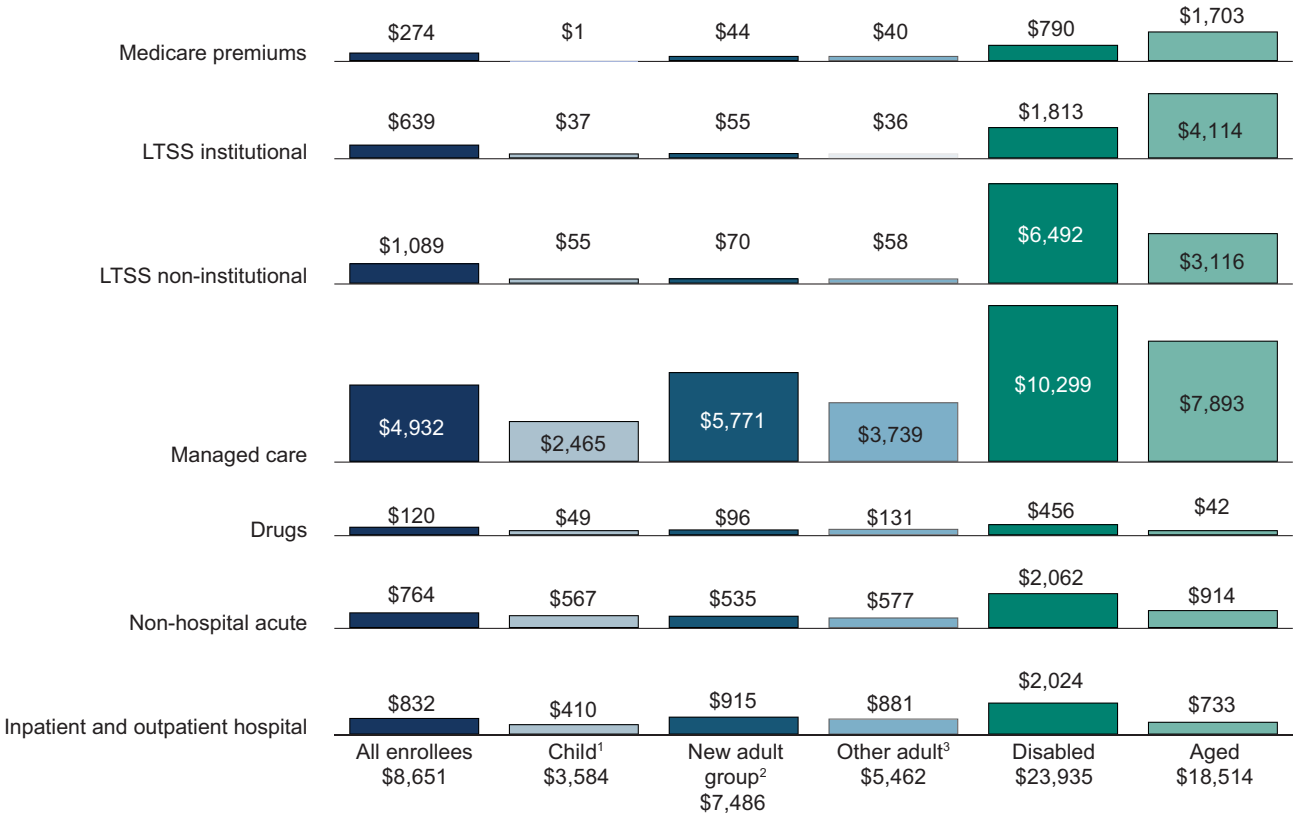
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset 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 $724.7 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, pregnancy).

Sources: MACPAC, 2023, analysis of T-MSIS data as of February 2023 and analysis of CMS-64 financial management report net expenditure data as of June 2022.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent Enrollee (FYE) by Eligibility Group and Service Category, FY 2021



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 before 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).

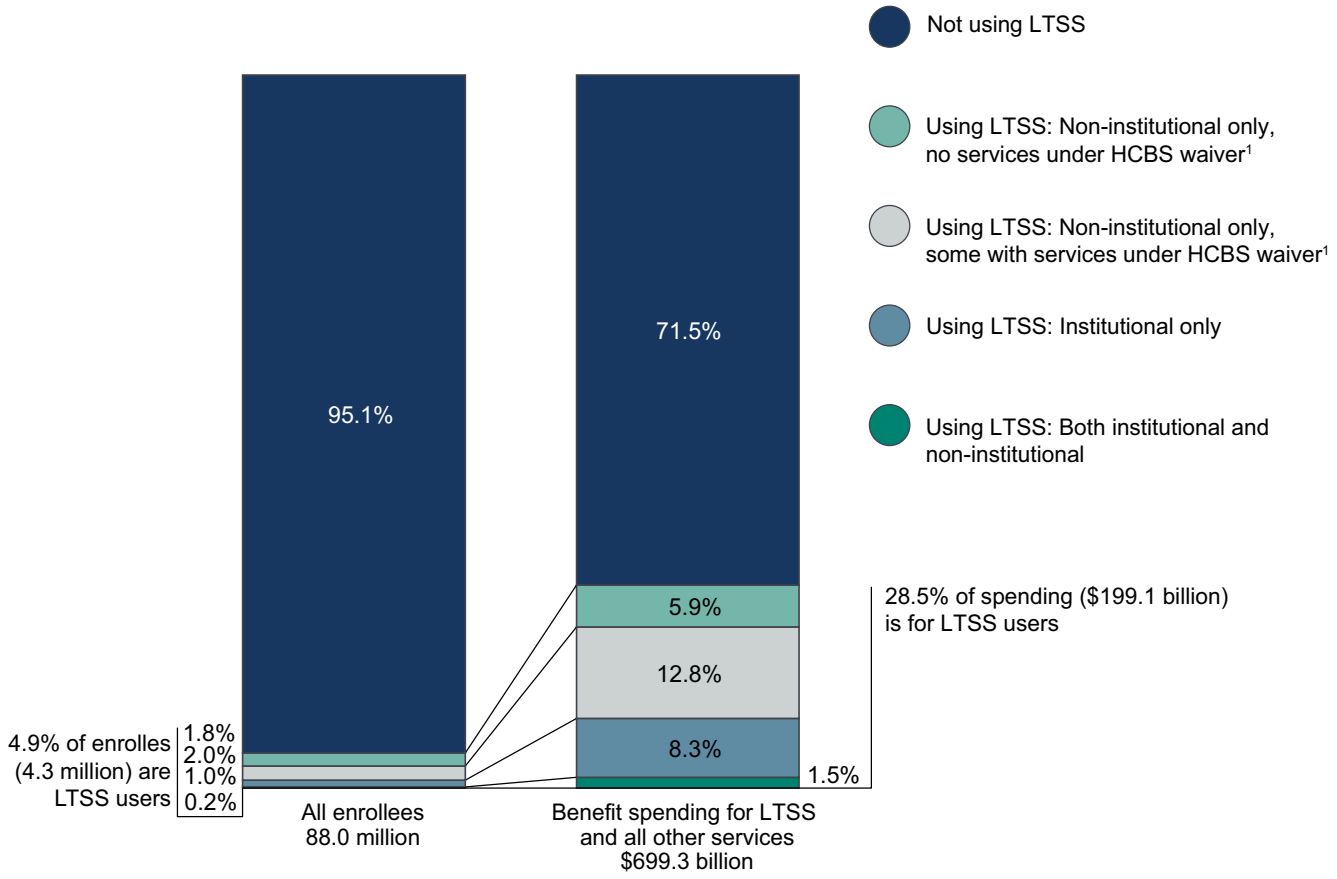
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset 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 by 242,500 and child spending by $724.7 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, pregnancy).

Sources: MACPAC, 2023, analysis of T-MSIS data as of February 2023 and analysis of CMS-64 financial management report net expenditure data as of June 2022.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2021



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 before 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. 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 enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before 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 242,500 and spending by $724.7 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, 2023, analysis of T-MSIS data as of February 2023 and analysis of CMS-64 financial management report net expenditure data as of June 2022.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2021 (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	**$699,301**	**15.2%**	**21.8%**	**10.7%**	**31.5%**	**20.8%**	**$222,573**	**60.8%**	**$213,571**	**60.7%**	**$9,002**	**62.5%**
Alabama	**6,257**	22.1	–	11.9	44.9	21.1	**2,017**	64.7	**1,725**	65.9	**292**	57.7
Alaska	**2,146**	22.5	25.3	15.9	23.4	13.0	**496**	52.5	**494**	52.4	**2**	76.1
Arizona[5]	**17,403**	14.6	32.0	14.2	28.9	10.2	**3,322**	48.6	**3,223**	48.0	**99**	67.8
Arkansas	**7,162**	23.7	32.0	0.1	30.4	13.8	**1,782**	56.4	**1,609**	57.5	**173**	45.6
California[6]	**105,889**	11.7	26.0	13.7	26.1	22.6	**29,695**	70.6	**29,301**	70.6	**394**	74.8
Colorado[7]	**10,568**	14.3	33.9	6.2	29.7	15.8	**2,667**	61.4	**2,585**	61.2	**82**	67.4
Connecticut	**9,180**	13.2	26.7	12.4	22.8	24.9	**3,416**	60.1	**3,019**	58.6	**397**	71.4
Delaware	**2,422**	18.4	25.3	16.1	26.6	13.6	**581**	55.0	**552**	54.7	**29**	60.0
District of Columbia[8]	**3,254**	10.4	16.9	11.9	38.6	22.2	**1,002**	66.5	**969**	66.2	**33**	75.2
Florida	**26,723**	22.1	–	13.1	36.1	28.7	**11,026**	66.7	**9,889**	67.0	**1,138**	63.9
Georgia	**11,850**	25.3	–	15.4	38.7	20.6	**3,467**	67.2	**3,034**	67.6	**433**	64.5
Hawaii[9]	**2,823**	16.8	33.4	9.8	19.5	20.5	**802**	62.2	**795**	62.1	**7**	77.6
Idaho	**2,876**	16.9	23.6	8.1	38.0	13.4	**808**	42.4	**753**	41.6	**55**	53.5
Illinois[8]	**26,392**	10.2	53.9	2.5	12.1	21.2	**6,192**	65.8	**6,087**	65.8	**105**	66.3
Indiana[7]	**15,506**	12.4	24.8	21.8	22.7	18.3	**4,793**	62.1	**4,622**	62.5	**171**	53.3
Iowa	**5,934**	13.4	24.7	11.3	34.4	16.1	**2,038**	47.4	**1,982**	46.8	**56**	66.8
Kansas	**3,934**	20.9	–	11.6	45.3	22.2	**1,630**	49.2	**1,560**	49.2	**71**	48.5
Kentucky[5]	**14,238**	14.2	38.2	8.9	28.4	10.3	**2,649**	54.7	**2,432**	55.6	**216**	43.9
Louisiana[7]	**12,489**	14.7	37.6	5.1	29.8	12.8	**2,706**	56.2	**2,408**	56.3	**298**	55.3
Maine	**3,398**	14.0	16.1	8.1	40.7	21.1	**1,457**	48.6	**1,354**	47.0	**103**	69.3
Maryland	**13,278**	14.5	25.7	13.4	30.9	15.6	**3,676**	54.1	**3,467**	53.6	**209**	60.8
Massachusetts	**19,038**	9.0	15.6	11.3	38.0	26.1	**8,513**	55.2	**8,443**	54.9	**69**	95.6
Michigan	**20,635**	12.8	28.3	9.8	30.9	18.2	**6,459**	58.0	**6,366**	58.1	**94**	55.0
Minnesota	**14,912**	14.9	17.7	10.0	37.5	20.0	**5,417**	50.6	**5,387**	50.5	**30**	68.1
Mississippi	**5,523**	24.1	–	11.3	42.9	21.7	**1,977**	60.0	**1,735**	60.9	**242**	53.6

EXHIBIT 21. (continued)

State	Total	Basis of eligibility[1]					Dually eligible status[2]					
							All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri	**$10,607**	25.4%	0.9%	9.8%	46.1%	17.8%	**$3,894**	42.9%	**$3,827**	42.7%	**$67**	54.7%
Montana	**2,183**	19.0	38.1	8.5	21.1	13.4	**541**	55.7	**515**	55.5	**25**	60.7
Nebraska[5]	**3,035**	17.2	14.3	10.5	36.6	21.5	**1,044**	53.8	**1,031**	53.7	**13**	58.6
Nevada	**4,666**	15.9	41.8	8.2	22.5	11.6	**873**	58.8	**744**	58.1	**129**	63.0
New Hampshire	**2,152**	16.7	26.0	5.3	29.5	22.6	**893**	51.8	**861**	52.1	**32**	42.6
New Jersey	**17,990**	12.3	27.0	6.4	33.3	21.0	**6,523**	53.6	**6,523**	53.6	**–**	–
New Mexico	**6,844**	19.7	30.8	13.2	24.6	11.7	**1,438**	56.3	**1,324**	55.6	**114**	64.6
New York	**71,252**	8.5	24.1	8.4	28.5	30.5	**30,300**	68.9	**29,865**	68.8	**436**	76.7
North Carolina	**16,436**	19.9	–	16.8	43.9	19.4	**5,147**	60.0	**5,001**	59.9	**146**	64.2
North Dakota[6]	**1,378**	13.4	2.9	5.5	40.6	37.6	**890**	58.0	**817**	56.6	**72**	74.3
Ohio	**26,956**	13.7	23.2	11.3	33.8	18.0	**7,827**	51.3	**7,503**	51.3	**324**	51.6
Oklahoma	**5,788**	30.3	9.1	11.1	32.9	16.7	**1,607**	54.3	**1,560**	54.5	**47**	49.3
Oregon[7]	**11,165**	10.6	42.2	1.4	21.5	24.4	**3,506**	74.0	**3,373**	74.5	**133**	62.0
Pennsylvania	**36,392**	11.1	20.5	5.7	40.3	22.4	**14,238**	57.1	**14,039**	57.1	**198**	60.6
Rhode Island	**2,809**	21.3	24.7	11.7	31.5	10.8	**944**	58.4	**929**	58.4	**15**	64.1
South Carolina	**6,726**	22.7	–	16.7	41.4	19.1	**2,261**	55.4	**2,226**	55.3	**35**	64.9
South Dakota	**1,004**	19.7	–	12.2	46.6	21.5	**406**	51.9	**382**	51.9	**24**	52.8
Tennessee	**10,671**	27.6	–	20.2	34.2	18.0	**3,423**	54.8	**3,190**	54.4	**233**	60.6
Texas[10]	**39,271**	29.4	–	11.2	39.0	20.4	**11,598**	65.4	**10,010**	65.2	**1,589**	66.1
Utah[6]	**3,528**	18.5	22.0	10.6	36.0	13.0	**980**	44.6	**924**	44.9	**57**	39.8
Vermont	**1,533**	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]
Virginia	**16,008**	13.3	28.7	7.3	34.2	16.5	**4,540**	48.1	**4,360**	47.9	**181**	52.7
Washington	**21,652**	15.1	36.3	7.6	26.2	14.7	**4,941**	55.1	**4,772**	55.0	**169**	58.0
West Virginia	**4,575**	14.3	29.0	8.3	27.4	21.0	**1,555**	61.7	**1,433**	63.3	**122**	42.9
Wisconsin	**10,253**	14.1	–	24.4	40.6	21.0	**3,933**	52.3	**3,910**	52.1	**23**	74.8
Wyoming	**598**	21.8	–	12.7	41.7	23.8	**259**	54.1	**249**	54.1	**10**	52.5

EXHIBIT 21. (continued)

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

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

[1] Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category.

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

[3] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who 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, pregnancy).

[5] State reported CMS-64 spending that shows a difference greater than 20 percent when compared to the prior year. Arizona's spending on the CMS-64 was 23.0 percent higher compared with 2020. Kentucky's spending on the CMS-64 was 21.4 percent higher compared with 2020. Nebraska's spending on the CMS-64 was 33.9 percent higher compared with 2020.

[6] 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, before 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 $681.9 million, North Dakota's child spending by approximately $9.3 million, and Utah's child spending by approximately $33.5 million.

[7] State reported a large shift of enrollees between eligibility groups. Colorado reported a 35 percent increase in the new adult group and a 46 percent decrease for the other adult group. Indiana reported a 16 percent decrease for the new adult group and a 60 percent increase for the other adult group. Louisiana reported a 15 percent increase in the new adult group and a 10 percent decrease in the other adult group. Oregon reported a 33 percent increase in the new adult group, a 69 percent decrease in the other adult group, a 102 percent increase in the disabled group, and a 53 percent increase in the aged group.

[8] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 36 percent less than the benchmark, and Illinois's average monthly enrollment was 113 percent more than the benchmark.

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

[10] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2021.

[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, 2023, analysis of T-MSIS data as of February 2023 and analysis of CMS-64 financial management report net expenditure data as of June 2022.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent Enrollee (FYE) by State and Eligibility Group, FY 2021

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	**$8,651**	**$9,175**	**$3,584**	**$3,591**	**$7,486**	**$7,508**	**$5,462**	**$6,388**	**$23,935**	**$26,762**	**$18,514**	**$24,247**
Alabama	**5,835**	**6,848**	2,641	2,641	–	–	3,474	5,032	13,451	17,454	10,497	24,247
Alaska	**9,050**	**9,083**	5,110	5,110	8,205	8,205	7,093	7,093	32,182	32,698	21,447	22,789
Arizona[4]	**8,305**	**8,921**	3,543	3,584	9,163	9,613	5,916	6,930	29,098	31,658	9,955	12,484
Arkansas	**7,490**	**7,850**	4,062	4,061	7,191	7,190	5,957	5,957	15,013	18,711	13,456	21,862
California[5]	**8,336**	**8,811**	3,667	3,674	6,367	6,222	5,283	6,562	31,553	31,649	17,137	17,311
Colorado[6]	**7,460**	**7,629**	3,095	3,095	5,743	5,743	5,689	5,732	29,966	33,521	20,403	30,725
Connecticut	**8,444**	**9,249**	3,565	3,567	7,421	7,325	5,431	5,790	33,499	55,991	15,772	43,581
Delaware	**9,031**	**9,877**	4,506	4,546	8,029	8,031	7,840	9,313	25,866	34,100	17,814	38,115
District of Columbia[7]	**12,434**	**12,871**	4,698	4,698	7,205	7,205	7,070	7,049	39,815	42,989	26,788	38,954
Florida	**5,750**	**6,124**	2,507	2,508	–	–	3,587	3,814	15,344	18,059	11,182	17,444
Georgia	**5,315**	**5,830**	2,474	2,470	–	–	4,204	4,894	13,416	16,442	10,029	20,822
Hawaii[8]	**7,185**	**7,247**	3,644	3,644	6,252	6,178	5,485	5,461	25,720	27,420	14,502	16,311
Idaho	**7,529**	**7,827**	3,142	3,142	6,113	6,113	6,364	6,365	22,037	26,007	12,858	20,993
Illinois[7]	**8,629**	**8,731**	4,130	4,133	7,831	7,822	6,217	6,051	16,289	17,332	19,816	21,946
Indiana[6]	**8,852**	**9,390**	2,883	2,921	9,020	9,112	9,424	10,642	19,590	22,634	23,217	33,463
Iowa	**8,307**	**8,490**	3,094	3,094	6,572	6,548	6,238	6,296	25,040	27,011	21,614	30,537
Kansas	**9,653**	**10,096**	3,634	3,634	–	–	6,813	6,488	23,988	28,112	21,861	32,651
Kentucky[4]	**8,949**	**9,342**	4,578	4,574	8,034	8,016	8,172	8,175	19,000	23,496	14,132	23,608
Louisiana[6]	**7,315**	**7,657**	3,212	3,210	7,121	7,123	6,617	6,711	15,969	19,166	10,885	18,475
Maine	**8,938**	**10,772**	4,723	4,894	6,477	6,573	3,596	5,670	22,640	26,318	12,500	24,564
Maryland	**9,220**	**9,555**	3,574	3,560	8,721	8,724	6,444	6,449	29,182	34,388	21,509	36,207
Massachusetts	**10,466**	**11,879**	4,203	4,494	7,656	8,019	4,624	6,082	21,626	21,747	22,355	27,633
Michigan	**7,416**	**7,558**	2,756	2,764	6,439	6,488	5,167	5,272	18,696	19,657	20,283	23,295
Minnesota	**12,150**	**12,367**	3,956	3,961	10,584	10,572	6,933	7,210	48,296	50,230	34,844	38,879
Mississippi	**7,171**	**8,044**	3,339	3,340	–	–	5,217	6,557	15,134	18,947	12,497	23,750
Missouri	**9,634**	**9,889**	4,309	4,309	6,043	6,034	6,202	6,202	25,841	27,939	18,457	22,470
Montana	**8,219**	**8,432**	4,241	4,241	8,015	8,013	7,279	7,664	20,520	23,228	17,686	24,912
Nebraska[4]	**10,509**	**10,654**	3,651	3,649	9,765	9,749	8,028	8,019	28,948	30,430	27,701	31,744

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]
Nevada	**$5,943**	**$6,141**	$2,522	$2,522	$6,451	$6,446	$5,222	$5,045	$17,430	$23,038	$9,865	$21,031
New Hampshire	**9,563**	**10,383**	4,494	4,522	7,182	7,185	4,659	6,704	24,151	31,498	29,170	44,119
New Jersey	**10,278**	**10,201**	3,594	3,585	7,263	7,166	7,672	7,374	35,749	35,725	25,462	25,340
New Mexico	**7,716**	**8,332**	4,284	4,287	7,301	7,360	5,968	7,231	23,305	29,934	13,246	27,521
New York	**10,670**	**10,884**	3,325	3,326	6,968	6,969	5,950	5,972	33,555	35,689	27,920	32,830
North Carolina	**7,223**	**8,881**	3,437	3,450	–	–	3,542	6,541	21,011	22,626	15,996	20,859
North Dakota[5]	**12,921**	**12,535**	4,221	4,221	1,417	1,389	5,591	5,590	46,190	47,806	56,783	62,878
Ohio	**9,202**	**9,508**	3,560	3,557	7,980	7,964	6,163	6,142	23,281	27,105	21,753	30,555
Oklahoma	**6,553**	**6,986**	3,865	3,865	4,588	5,445	4,706	5,260	17,174	18,886	14,010	17,039
Oregon[6]	**10,154**	**10,969**	4,222	4,236	7,737	8,046	4,327	10,692	25,846	30,570	33,065	51,801
Pennsylvania	**11,726**	**12,102**	4,312	4,334	7,544	7,556	6,611	6,902	25,483	27,066	28,234	34,349
Rhode Island	**9,062**	**9,264**	6,899	6,900	7,431	7,430	5,176	5,250	22,542	23,984	11,162	13,303
South Carolina	**5,191**	**6,150**	2,562	2,572	–	–	2,609	4,668	16,681	16,947	12,829	13,834
South Dakota	**8,439**	**8,824**	2,896	2,896	–	–	6,179	6,179	24,254	28,979	18,523	28,012
Tennessee	**6,567**	**6,933**	3,669	3,669	–	–	5,152	5,152	14,165	16,802	13,099	24,356
Texas[9]	**7,592**	**8,379**	3,709	3,700	2,817	2,817	5,052	8,381	22,814	26,417	15,404	25,052
Utah[5]	**8,989**	**9,063**	3,634	3,663	8,335	8,343	6,837	7,578	28,481	28,703	21,669	22,326
Vermont	**8,313**	**10**	10	10	10	10	10	10	10	10	10	10
Virginia	**9,603**	**10,164**	3,789	3,789	8,410	8,388	4,689	5,667	30,747	36,146	20,085	26,790
Washington	**11,064**	**11,272**	4,227	4,229	10,887	10,885	11,014	10,278	32,223	37,329	23,961	31,820
West Virginia	**7,845**	**8,247**	3,501	3,501	6,529	6,465	6,790	6,870	14,011	17,199	20,019	33,795
Wisconsin	**7,868**	**8,179**	3,066	3,072	–	–	4,934	5,286	22,343	22,740	15,407	16,508
Wyoming	**8,544**	**8,996**	3,257	3,258	–	–	6,207	6,201	22,285	26,549	21,787	34,656

Notes: FY is fiscal year. Full-year equivalent (FYE) may also be referred to as average monthly enrollment. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included before 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 22. (continued)

– 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, pregnancy).

[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, emergency services, or COVID-19 diagnostic products or testing-related services.

[4] State reported CMS-64 spending that shows a difference greater than 20 percent when compared to the prior year. Arizona's spending on the CMS-64 was 23.0 percent higher compared with 2020. Kentucky's spending on the CMS-64 was 21.4 percent higher compared with 2020. Nebraska's spending on the CMS-64 was 33.9 percent higher compared with 2020.

[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, before 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 229,000 and spending by $681.9 million, North Dakota's child FYE enrollment by approximately 2,600 and spending by $9.3 million, and Utah's child FYE enrollment by approximately 10,900 and spending by $33.5 million.

[6] State reported a large shift of enrollees between eligibility groups. Colorado reported a 54 percent increase in the new adult group and a 41 percent decrease for the other adult group. Indiana reported a 1.2 percent increase for the new adult group and an 80 percent increase for the other adult group. Louisiana reported a 28 percent increase in the new adult group and a 0.5 percent increase in the other adult group. Oregon reported a 45 percent increase in the new adult group, a 67 percent decrease in the other adult group, a 76 percent increase in the disabled group, and a 32 percent increase in the aged group.

[7] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 36 percent less than the benchmark, and Illinois's average monthly enrollment was 113 percent more than the benchmark.

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

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2021.

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

Sources: MACPAC, 2023, analysis of T-MSIS data as of February 2023 and analysis of CMS-64 financial management report net expenditure data as of June 2022.

EXHIBIT 23. Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2022

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	1,263,175	$7,166,453,694	$5,673	–	–	–
Alaska	251,282	2,435,528,905	9,692	70,665	$642,524,948	$9,093
Arizona	2,325,631	20,257,896,179	8,711	190,602	1,074,112,696	5,635
Arkansas	1,017,974	8,533,079,808	8,382	326,938	2,852,307,635	8,724
California	14,339,675	117,884,562,290	8,221	4,713,543	31,626,470,705	6,710
Colorado	1,599,514	11,873,695,582	7,423	574,326	2,969,913,633	5,171
Connecticut	1,126,626	9,671,697,756	8,585	334,448	2,191,679,409	6,553
Delaware	273,247	3,136,940,055	11,480	13,861	116,549,173	8,409
District of Columbia	291,798	3,647,665,830	12,501	85,249	598,847,121	7,025
Florida	5,186,843	32,667,454,330	6,298	–	–	–
Georgia	2,464,300	14,339,599,611	5,819	–	–	–
Hawaii	446,691	2,990,024,469	6,694	30,443	916,051,591	30,091
Idaho	440,396	3,195,270,944	7,255	119,719	722,183,050	6,032
Illinois	3,276,552	25,956,045,305	7,922	849,801	7,004,360,250	8,242
Indiana	1,937,898	16,850,885,790	8,695	550,604	4,028,880,849	7,317
Iowa	754,159	6,614,098,328	8,770	192,808	1,320,326,430	6,848
Kansas	444,559	4,301,338,042	9,676	–	–	–
Kentucky	1,514,661	14,590,469,639	9,633	604,721	5,017,487,034	8,297
Louisiana	2,511,066	14,673,978,206	5,844	1,278,115	5,329,608,850	4,170
Maine	371,823	3,785,788,570	10,182	78,104	–	–
Maryland	1,851,480	14,343,522,494	7,747	764,001	3,659,001,179	4,789
Massachusetts	2,079,423	20,864,779,727	10,034	–	–	–
Michigan	2,945,520	21,023,267,979	7,137	929,409	5,616,414,579	6,043
Minnesota	1,316,731	16,158,756,247	12,272	285,383	3,024,984,462	10,600
Mississippi	806,859	5,943,740,111	7,367	–	–	–
Missouri	1,234,226	13,013,125,297	10,544	130,329	1,010,444,979	7,753

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	294,335	$2,343,639,013	$7,962	114,925	$1,025,685,648	$8,925
Nebraska	366,346	3,295,908,995	8,997	66,223	671,513,915	10,140
Nevada	799,602	5,052,662,737	6,319	343,249	2,038,489,951	5,939
New Hampshire	229,868	2,460,870,676	10,706	87,629	475,895,902	5,431
New Jersey	1,997,102	20,872,611,334	10,451	730,318	6,091,175,975	8,340
New Mexico	967,813	8,257,965,730	8,533	293,868	2,361,892,528	8,037
New York	7,436,108	80,518,406,335	10,828	431,234	2,572,447,961	5,965
North Carolina	2,737,528	18,403,697,744	6,723	–	–	–
North Dakota	122,969	1,524,148,076	12,395	30,645	441,551,499	14,409
Ohio	3,432,005	30,024,849,008	8,748	820,796	7,315,239,420	8,912
Oklahoma	1,121,392	7,523,240,743	6,709	275,791	2,012,618,979	7,298
Oregon	1,240,155	13,083,208,627	10,550	582,360	4,450,926,990	7,643
Pennsylvania	3,484,071	41,178,251,107	11,819	1,046,001	7,744,544,458	7,404
Rhode Island	343,092	3,392,593,755	9,888	94,233	826,871,497	8,775
South Carolina	1,514,365	7,544,266,509	4,982	–	–	–
South Dakota	129,088	1,246,309,725	9,655	–	–	–
Tennessee	1,793,620	11,264,609,657	6,280	–	–	–
Texas	5,675,484	54,941,921,302	9,681	–	–	–
Utah	479,778	4,211,452,614	8,778	119,798	1,069,685,545	8,929
Vermont	197,893	1,884,369,967	9,522	–	–	–
Virginia	1,819,324	17,823,746,172	9,797	641,093	5,713,323,393	8,912
Washington	2,082,453	17,140,713,645	8,231	776,271	7,232,054,375	9,316
West Virginia	634,581	5,183,933,490	8,169	228,404	1,351,794,647	5,918
Wisconsin	1,495,312	11,429,134,969	7,643	–	–	–
Wyoming	79,222	668,371,415	8,437	–	–	–
Subtotal (states)	**92,545,614**	**$787,190,548,533**	**$8,506**	**18,805,907**	**$133,117,861,256**	**$7,079**

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	31,434	$68,475,260	$2,178	–	–	–
Guam	38,927	167,053,407	4,291	–	–	–
Northern Mariana Islands	17,971	73,254,850	4,076	–	–	–
Puerto Rico	1,454,462	5,097,773,472	3,505	–	–	–
Virgin Islands	36,311	137,287,976	3,781	–	–	–
Total (states and territories)	**94,124,719**	**$792,734,393,498**	**$8,422**	**18,805,907**	**$133,117,861,256**	**$7,079**

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 2022 enrollment was taken from the submission quarter ending December 31, 2022). 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 May 30, 2023. 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 90 percent in FY 2022.

Source: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023, and CMS-64 enrollment reports as of October 25, 2023.

EXHIBIT 24. Medicaid Supplemental Payments to Hospital Providers by State, FY 2022 (millions)

State[1]	Inpatient and outpatient hospitals[2]				
	Total Medicaid payments	DSH payments	Non-DSH supplemental payments	Section 1115 waiver authority payments	Supplemental payments as % of total
Total	**$87,955.0**	**$14,971.3**	**$20,773.6**	**$10,223.6**	**52.3%**
Alabama	**2,835.4**	308.8	1,437.5	–	61.6
Alaska[3]	**754.5**	-0.5	–	–	-0.1
Arizona[4]	**1,377.4**	127.2	391.2	23.9	39.4
Arkansas	**1,371.3**	26.6	493.2	–	37.9
California[5, 6]	**13,698.8**	595.7	4,804.9	3,329.0	63.7
Colorado	**3,611.0**	210.1	1,457.8	–	46.2
Connecticut	**2,859.5**	79.1	600.0	–	23.8
Delaware	**87.5**	25.3	–	–	29.0
District of Columbia	**287.3**	121.4	–	–	42.3
Florida[6]	**2,920.8**	239.8	780.7	1,147.5	74.2
Georgia	**2,876.8**	564.2	666.0	–	42.8
Hawaii	**37.0**	–	0.7	–	1.8
Idaho	**824.4**	27.8	24.3	–	6.3
Illinois	**2,589.9**	507.9	560.6	–	41.3
Indiana	**1,438.1**	619.4	39.4	–	45.8
Iowa	**100.8**	10.0	52.6	–	62.1
Kansas[5, 6]	**98.0**	65.5	0.2	13.8	81.2
Kentucky	**477.1**	13.6	258.5	–	57.0
Louisiana	**1,349.2**	1,074.4	87.5	–	86.1
Maine	**943.5**	–	124.7	–	13.2
Maryland	**1,244.9**	136.2	26.5	–	13.1
Massachusetts[4, 5, 6]	**3,000.7**	–	177.5	576.8	25.1
Michigan	**1,368.0**	445.2	471.5	–	67.0
Minnesota	**611.7**	49.9	191.4	–	39.4
Mississippi	**780.5**	245.7	40.3	–	36.6
Missouri	**2,846.7**	628.0	211.7	–	29.5
Montana	**937.7**	–	393.2	–	41.9
Nebraska	**39.3**	39.9	–	–	101.6
Nevada	**636.8**	144.9	159.5	–	47.8
New Hampshire[5]	**248.1**	197.1	29.5	0.3	91.5
New Jersey	**1,284.7**	570.8	242.0	–	63.3
New Mexico[5]	**503.0**	33.6	228.2	12.0	54.4
New York	**8,752.2**	3,321.2	121.4	–	39.3
North Carolina	**2,388.0**	434.4	345.8	–	32.7
North Dakota	**164.0**	0.5	1.9	–	1.5
Ohio	**923.8**	117.6	–	–	12.7
Oklahoma	**2,816.8**	61.7	1,111.3	–	41.6

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
Oregon	**$414.0**	$68.2	$129.3	–	47.7%
Pennsylvania	**1,884.0**	919.6	571.1	–	79.1
Rhode Island[4]	**366.6**	160.0	36.8	$17.3	58.4
South Carolina	**1,234.2**	529.7	150.8	–	55.1
South Dakota	**309.2**	0.9	3.1	–	1.3
Tennessee	**611.7**	71.9	502.5	–	93.9
Texas[5, 6]	**8,385.4**	1,565.9	838.4	5,100.1	89.5
Utah	**477.4**	33.7	63.6	–	20.4
Vermont[5]	**103.2**	46.4	–	2.9	47.7
Virginia	**3,044.1**	42.3	2,690.8	–	89.8
Washington	**877.2**	277.0	153.7	–	49.1
West Virginia	**216.1**	69.0	14.6	–	38.7
Wisconsin	**804.5**	143.1	52.8	–	24.3
Wyoming	**142.2**	0.5	34.4	–	24.6

Notes: FY is fiscal year. DSH is disproportionate share hospital. Includes federal and state funds. Section 1115 refers to Section 1115 of the Social Security Act (the Act). Excludes payments made under managed care arrangements. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; amounts include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported by states for any given category (e.g., inpatient hospital) sometimes show substantial annual fluctuations. Some fluctuation in supplemental payments may reflect the fact that states may not consistently classify payments in the same way over time.

– Dash indicates zero. $0.0 or -$0.0 indicates a value between $0.05 million and -$0.05 million that rounds to zero. 0.0% or -0.0% indicates a value between 0.05% and -0.05% that rounds to zero.

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of May 30, 2023. 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 reports negative DSH payments due to prior period adjustments.

[4] State made other supplemental payments under Section 1115 waiver expenditure authority.

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

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

Source: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023, and CMS-64 Schedule C waiver report data as of September 29, 2023.

EXHIBIT 25. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2022 (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	**$6,758.8**	**$3,095.5**	**45.8%**	**$50,446.7**	**$3,058.9**	**6.1%**	**$12,315.2**	**$4,087.0**	**33.2%**
Alabama	**67.6**	3.2	4.8	**1,103.9**	–	–	**514.3**	–	–
Alaska	**30.6**	11.5	37.7	**204.7**	–	–	**214.2**	–	–
Arizona	**36.4**	28.5	78.3	**68.4**	12.9	18.9	**69.6**	–	–
Arkansas	**14.1**	–	–	**919.9**	–	–	**385.6**	41.0	10.6
California	**599.6**	0.1	0.0	**3,293.7**	205.2	6.2	**1,025.4**	609.3	59.4
Colorado	**9.6**	–	–	**844.9**	165.8	19.6	**380.2**	173.8	45.7
Connecticut	**263.7**	105.6	40.0	**1,351.2**	–	–	**838.7**	29.4	3.5
Delaware	**31.2**	17.3	55.5	**42.3**	–	–	**9.7**	–	–
District of Columbia	**29.1**	3.8	13.0	**412.8**	2.5	0.6	**24.8**	4.5	18.1
Florida[5]	**1,302.8**	128.2	9.8	**560.3**	–	–	**357.1**	207.3	58.0
Georgia	**7.1**	–	–	**1,800.2**	259.9	14.4	**452.0**	97.4	21.5
Hawaii	**–**	–	–	**10.4**	–	–	**0.1**	–	–
Idaho	**5.0**	–	–	**195.1**	92.1	47.2	**240.0**	–	–
Illinois	**118.4**	89.4	75.5	**987.8**	–	–	**199.6**	–	–
Indiana[6]	**39.6**	-41.2	-104.1	**2,999.3**	1,013.0	33.8	**229.6**	28.9	12.6
Iowa	**1.2**	–	–	**37.2**	–	–	**16.3**	5.8	35.7
Kansas	**18.1**	18.1	99.8	**63.2**	–	–	**4.0**	0.2	6.1
Kentucky	**39.4**	35.6	90.2	**1,417.5**	0.6	0.0	**51.1**	20.0	39.2
Louisiana	**104.0**	97.8	94.0	**1,497.6**	2.7	0.2	**39.7**	9.2	23.1
Maine	**129.2**	58.5	45.3	**424.8**	–	–	**191.5**	1.3	0.7
Maryland	**287.5**	61.6	21.4	**1,288.2**	–	–	**234.3**	–	–
Massachusetts[7]	**207.4**	169.4	81.7	**1,416.4**	58.4	4.1	**368.8**	2.2	0.6
Michigan	**211.7**	163.4	77.2	**1,917.7**	369.6	19.3	**266.6**	142.3	53.4
Minnesota	**82.8**	0.4	0.5	**1,089.4**	–	–	**270.0**	55.9	20.7
Mississippi	**26.6**	–	–	**1,065.1**	14.7	1.4	**153.0**	13.0	8.5

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	**$232.1**	$207.2	89.3%	**$1,222.6**	$5.4	0.4%	**$25.6**	–	–
Montana	**22.3**	–	–	**165.8**	10.9	6.6	**239.4**	–	–
Nebraska	**–**	–	–	**533.8**	24.8	4.6	**2.5**	$1.3	52.6%
Nevada	**40.1**	–	–	**346.7**	126.0	36.3	**174.1**	3.5	2.0
New Hampshire	**49.1**	48.4	98.6	**384.2**	80.5	21.0	**4.6**	–	–
New Jersey	**505.3**	357.4	70.7	**867.1**	10.7	1.2	**59.3**	–	–
New Mexico	**5.0**	–	–	**34.6**	–	–	**73.1**	3.8	5.2
New York	**884.1**	605.0	68.4	**7,721.1**	125.0	1.6	**431.5**	–	–
North Carolina	**28.3**	27.5	97.2	**2,082.9**	–	–	**333.0**	41.4	12.4
North Dakota	**18.0**	1.2	6.9	**404.9**	–	–	**54.9**	–	–
Ohio	**101.2**	93.4	92.3	**2,555.1**	–	–	**169.9**	51.9	30.5
Oklahoma	**84.1**	3.3	3.9	**886.3**	151.2	17.1	**773.9**	9.7	1.3
Oregon	**24.1**	21.1	87.6	**560.7**	–	–	**36.1**	2.0	5.7
Pennsylvania	**389.4**	304.6	78.2	**972.7**	34.8	3.6	**33.4**	–	–
Rhode Island[5, 7, 8]	**0.6**	0.4	68.9	**294.0**	4.1	1.4	**10.2**	0.7	6.7
South Carolina	**64.7**	62.5	96.7	**906.0**	13.9	1.5	**138.9**	33.8	24.4
South Dakota	**2.5**	0.8	30.1	**228.0**	–	–	**74.8**	–	–
Tennessee	**53.8**	–	–	**214.1**	–	–	**30.5**	–	–
Texas[5]	**291.4**	289.2	99.2	**1,401.3**	7.0	0.5	**2,415.2**	2,229.1	92.3
Utah	**18.9**	0.9	5.0	**458.9**	143.5	31.3	**132.6**	44.7	33.7
Vermont	**1.3**	–	–	**147.7**	–	–	**28.5**	–	–
Virginia	**91.2**	–	–	**291.9**	15.5	5.3	**246.9**	195.1	79.0
Washington	**130.6**	100.1	76.6	**966.6**	5.3	0.5	**101.4**	5.4	5.3
West Virginia	**30.3**	21.2	69.8	**899.0**	–	–	**53.4**	–	–
Wisconsin	**21.6**	–	–	**755.6**	58.8	7.8	**64.5**	–	–
Wyoming	**6.2**	–	–	**133.0**	44.1	33.1	**70.6**	23.2	32.9

EXHIBIT 25. (continued)

Notes: FY is fiscal year. ICF/ID is intermediate care facility for persons with intellectual disabilities. Includes federal and state funds. Excludes payments made under managed care arrangements. All amounts in this table are as reported by states in CMS-64 data during the fiscal year to obtain federal matching funds; amounts include expenditures for the current fiscal year and adjustments to expenditures for prior fiscal years that may be positive or negative. Amounts reported by states for any given category (e.g., nursing facility) sometimes show substantial annual fluctuations. Some fluctuation in supplemental payments may reflect the fact that states may not consistently classify payments in the same way over time.

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

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of May 30, 2023. 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 as well as other non-DSH supplemental payments made under waiver expenditure authority of Section 1115 of the Act.

[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, delivery system reform incentive payments (DSRIP), and other non-DSH supplemental 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 made payments to physicians and other practitioners through an uncompensated care pool, DSRIP, or other non-DSH supplemental payments under Section 1115 waiver expenditure authority.

[6] State reports negative supplemental payments to mental health facilities due to prior period adjustments.

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

[8] State made non-DSH payments to nursing facilities through other non-DSH supplemental payments under Section 1115 waiver expenditure authority.

Source: MACPAC, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023, and CMS-64 Schedule C waiver report data as of September 29, 2023.

EXHIBIT 26. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2022 (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]	**$91,708.2**	**84.6%**	**15.2%**	**0.2%**	**$32,918.3**	**86.4%**	**13.5%**	**0.1%**	**$58,789.9**	**83.5%**	**16.2%**	**0.3%**
Alabama	**1,007.0**	**87.0**	**12.9**	**0.0**	**1,007.0**	87.0	12.9	0.0	**–**	–	–	–
Alaska	**196.7**	**85.1**	**14.8**	**0.1**	**196.7**	85.1	14.8	0.1	**–**	–	–	–
Arizona	**1,814.0**	**85.4**	**14.5**	**0.1**	**28.8**	79.0	20.8	0.2	**1,785.2**	85.5	14.4	0.1
Arkansas	**473.2**	**83.5**	**16.4**	**0.1**	**381.4**	82.8	17.1	0.1	**91.8**	86.6	13.3	0.1
California	**10,756.3**	**84.3**	**15.7**	**0.1**	**9,324.0**	84.4	15.5	0.1	**1,432.3**	83.4	16.4	0.2
Colorado	**1,378.2**	**89.9**	**9.9**	**0.1**	**1,327.4**	90.2	9.7	0.1	**50.7**	84.2	15.8	0.0
Connecticut	**1,650.2**	**90.1**	**9.8**	**0.1**	**1,650.2**	90.1	9.8	0.1	**–**	–	–	–
Delaware	**296.2**	**88.9**	**10.9**	**0.2**	**1.6**	94.6	5.4	–	**294.7**	88.9	11.0	0.2
District of Columbia	**244.0**	**91.5**	**8.5**	**0.0**	**148.1**	98.0	2.0	0.0	**95.9**	81.4	18.5	0.1
Florida	**3,645.6**	**89.5**	**10.5**	**0.0**	**265.5**	94.2	5.7	0.0	**3,380.0**	89.1	10.9	0.0
Georgia	**1,380.3**	**84.6**	**15.3**	**0.1**	**868.5**	89.5	10.5	0.0	**511.8**	76.4	23.5	0.1
Hawaii	**222.8**	**83.4**	**16.5**	**0.0**	**0.1**	–	100.0	–	**222.8**	83.5	16.5	0.0
Idaho	**528.1**	**89.1**	**10.9**	**0.0**	**528.1**	89.1	10.9	0.0	**–**	–	–	–
Illinois	**3,252.9**	**88.7**	**11.3**	**0.0**	**128.0**	85.9	14.1	0.0	**3,124.9**	88.8	11.2	0.0
Indiana	**2,485.5**	**86.2**	**13.8**	**0.0**	**479.2**	91.2	8.7	0.1	**2,006.3**	85.0	15.0	0.0
Iowa	**757.7**	**91.8**	**8.2**	**0.0**	**5.2**	86.6	13.3	0.0	**752.5**	91.9	8.1	0.0
Kansas	**287.5**	**83.4**	**16.6**	**0.0**	**0.4**	78.5	21.5	–	**287.1**	83.4	16.6	0.0
Kentucky	**1,960.8**	**89.7**	**10.0**	**0.3**	**76.5**	80.1	19.7	0.3	**1,884.3**	90.1	9.6	0.3
Louisiana	**2,358.4**	**85.9**	**14.0**	**0.1**	**49.3**	81.4	18.4	0.2	**2,309.1**	86.0	13.9	0.1
Maine	**439.5**	**90.2**	**9.8**	**0.0**	**439.5**	90.2	9.8	0.0	**–**	–	–	–
Maryland	**1,598.9**	**88.4**	**11.5**	**0.0**	**544.3**	86.5	13.5	0.0	**1,054.6**	89.5	10.5	0.0
Massachusetts	**2,122.9**	**87.7**	**12.1**	**0.2**	**990.0**	88.4	11.4	0.2	**1,132.8**	87.1	12.8	0.2
Michigan	**3,289.6**	**88.7**	**11.2**	**0.1**	**1,418.9**	88.3	11.6	0.0	**1,870.7**	89.0	10.9	0.1
Minnesota	**1,318.6**	**84.9**	**14.9**	**0.3**	**168.2**	72.5	26.7	0.8	**1,150.4**	86.7	13.2	0.2
Mississippi	**509.9**	**82.5**	**17.5**	**0.0**	**150.0**	80.3	19.7	0.0	**359.8**	83.5	16.5	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	$1,437.4	86.1%	13.9%	0.1%	$1,437.4	86.1%	13.9%	0.1%	–	–	–	–
Montana	388.2	87.7	12.3	0.0	388.2	87.7	12.3	0.0	–	–	–	–
Nebraska	411.9	86.2	13.7	0.1	0.0	–	100.0	–	$411.9	86.2%	13.7%	0.1%
Nevada	549.5	83.1	16.2	0.7	295.0	82.1	16.9	1.0	254.5	84.2	15.4	0.4
New Hampshire	261.6	84.2	15.7	0.1	2.8	95.9	3.2	1.0	258.8	84.1	15.8	0.1
New Jersey	1,803.5	86.3	13.7	0.0	12.1	85.0	15.0	0.0	1,791.4	86.3	13.7	0.0
New Mexico	488.6	71.8	28.1	0.1	99.9	33.1	66.9	0.1	388.7	81.8	18.1	0.1
New York	7,109.8	86.2	13.7	0.2	721.4	79.6	20.3	0.1	6,388.4	86.9	12.9	0.2
North Carolina	2,319.6	89.1	10.9	0.0	846.8	89.0	11.0	0.0	1,472.8	89.2	10.8	0.0
North Dakota	97.6	85.9	14.1	0.0	93.2	86.0	14.0	0.0	4.4	84.2	15.7	0.1
Ohio	4,301.9	84.6	15.4	0.0	316.1	82.8	17.2	0.0	3,985.8	84.7	15.3	0.0
Oklahoma	811.9	84.5	15.5	0.0	811.9	84.5	15.5	0.0	–	–	–	–
Oregon	817.9	82.1	17.9	0.0	139.3	77.8	22.2	0.0	678.6	83.0	17.0	0.1
Pennsylvania	4,253.0	85.0	15.0	0.0	27.6	78.1	21.9	0.0	4,225.4	85.1	14.9	0.0
Rhode Island	327.8	82.1	17.9	0.0	6.5	86.0	14.0	–	321.3	82.0	18.0	0.0
South Carolina	740.9	87.1	12.8	0.1	117.7	87.7	12.0	0.3	623.3	87.0	13.0	0.1
South Dakota	166.6	68.7	30.6	0.7	166.6	68.7	30.6	0.7	–	–	–	–
Tennessee	1,467.3	87.7	12.1	0.2	1,331.9	86.8	13.0	0.2	135.4	95.8	4.0	0.2
Texas	3,882.2	85.6	14.4	0.0	43.9	82.4	17.5	0.0	3,838.4	85.6	14.4	0.0
Utah	491.9	89.4	10.5	0.0	209.7	88.7	11.2	0.0	282.2	90.0	10.0	0.0
Vermont	194.9	88.6	11.4	0.0	194.8	88.6	11.4	0.0	0.0	99.2	0.8	–
Virginia[5]	5,312.1	52.0	45.6	2.4	12.5	81.9	17.8	0.3	5,299.6	51.9	45.7	2.4
Washington	1,533.9	90.0	9.9	0.1	99.5	92.5	7.5	0.0	1,434.5	89.8	10.0	0.1
West Virginia	845.8	87.0	13.0	0.0	822.0	86.7	13.3	0.0	23.8	97.2	2.7	0.0
Wisconsin	1,932.9	87.5	12.4	0.1	1,932.9	87.5	12.4	0.1	–	–	–	–
Wyoming	43.6	86.5	13.5	0.0	43.6	86.5	13.5	0.0	–	–	–	–

EXHIBIT 26. (continued)

Notes: FY is fiscal year. Amounts include federal and state funds. Gross spending reflects expenditures before 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 less than $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 2022 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, or 0.9 percent of gross spending, was suppressed in the FY 2014 data.

[5] Virginia reports an atypical proportion of spending on generic drugs; this may indicate data anomalies in the payment amount for these drugs.

Source: MACPAC, 2023, analysis of Medicaid drug product data and state drug rebate utilization data as of September 2023.

EXHIBIT 27. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2022 (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]	**758,504**	**14.4%**	**85.2%**	**0.4%**	**237,498**	**15.4%**	**84.1%**	**0.4%**	**521,006**	**13.9%**	**85.7%**	**0.4%**
Alabama	**7,870**	**16.7**	**83.1**	**0.2**	**7,870**	16.7	83.1	0.2	**–**	–	–	–
Alaska	**1,406**	**15.9**	**83.7**	**0.4**	**1,406**	15.9	83.7	0.4	**–**	–	–	–
Arizona	**15,871**	**13.8**	**85.7**	**0.5**	**206**	15.6	83.8	0.6	**15,664**	13.8	85.7	0.5
Arkansas	**5,442**	**15.4**	**84.3**	**0.3**	**4,396**	15.4	84.4	0.3	**1,046**	15.7	84.1	0.2
California	**85,576**	**14.3**	**85.4**	**0.2**	**64,447**	13.3	86.5	0.2	**21,129**	17.4	82.2	0.4
Colorado	**8,436**	**17.5**	**82.3**	**0.3**	**7,971**	17.7	82.0	0.3	**464**	14.1	85.8	0.1
Connecticut	**9,299**	**21.4**	**78.3**	**0.3**	**9,299**	21.4	78.3	0.3	**–**	–	–	–
Delaware	**2,686**	**14.9**	**84.8**	**0.3**	**7**	49.4	50.6	–	**2,679**	14.8	84.9	0.3
District of Columbia	**1,434**	**15.4**	**84.4**	**0.2**	**251**	30.4	69.5	0.1	**1,183**	12.2	87.6	0.2
Florida	**29,323**	**16.1**	**83.6**	**0.3**	**991**	18.9	80.7	0.4	**28,332**	16.0	83.7	0.3
Georgia	**16,995**	**12.3**	**87.4**	**0.3**	**7,213**	16.2	83.6	0.1	**9,782**	9.3	90.2	0.5
Hawaii	**2,013**	**11.9**	**87.7**	**0.5**	**5**	–	100.0	–	**2,008**	11.9	87.6	0.5
Idaho	**4,276**	**16.4**	**83.2**	**0.4**	**4,276**	16.4	83.2	0.4	**–**	–	–	–
Illinois	**27,602**	**13.8**	**86.2**	**0.1**	**1,523**	15.4	84.5	0.0	**26,079**	13.7	86.3	0.1
Indiana	**20,171**	**14.2**	**85.5**	**0.3**	**2,796**	14.8	84.8	0.4	**17,375**	14.2	85.6	0.2
Iowa	**8,156**	**14.4**	**85.5**	**0.1**	**67**	18.0	82.0	0.0	**8,089**	14.4	85.5	0.1
Kansas	**3,542**	**14.7**	**85.1**	**0.1**	**8**	10.9	89.1	–	**3,534**	14.8	85.1	0.1
Kentucky	**23,851**	**12.3**	**87.1**	**0.6**	**1,089**	9.0	89.4	1.6	**22,763**	12.4	87.0	0.6
Louisiana	**21,158**	**12.7**	**86.9**	**0.4**	**599**	12.6	86.9	0.5	**20,559**	12.7	86.9	0.4
Maine	**2,845**	**25.7**	**74.2**	**0.2**	**2,845**	25.7	74.2	0.2	**–**	–	–	–
Maryland	**14,893**	**15.5**	**84.4**	**0.1**	**5,008**	18.7	81.2	0.0	**9,885**	13.9	86.0	0.1
Massachusetts	**16,419**	**17.5**	**80.9**	**1.6**	**7,873**	16.7	81.6	1.7	**8,546**	18.2	80.3	1.5
Michigan	**30,775**	**13.8**	**85.7**	**0.5**	**9,598**	14.5	85.3	0.2	**21,176**	13.5	85.9	0.6
Minnesota	**12,135**	**14.7**	**81.6**	**3.7**	**1,638**	12.9	78.8	8.3	**10,497**	15.0	82.0	3.0
Mississippi	**5,256**	**12.4**	**87.4**	**0.2**	**1,715**	11.2	88.7	0.1	**3,541**	13.0	86.8	0.2
Missouri	**13,239**	**15.8**	**84.0**	**0.3**	**13,239**	15.8	84.0	0.3	**–**	–	–	–

EXHIBIT 27. (continued)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Montana	**3,115**	**15.6%**	**84.3%**	**0.2%**	**3,115**	15.6%	84.3%	0.2%	**–**	–	–	–
Nebraska	**4,151**	**15.5**	**84.2**	**0.3**	**0**	–	100.0	–	**4,151**	15.5%	84.2%	0.3%
Nevada	**5,293**	**11.8**	**87.2**	**0.9**	**2,025**	14.8	84.4	0.7	**3,267**	10.0	89.0	1.1
New Hampshire	**2,403**	**13.2**	**86.5**	**0.3**	**8**	20.9	70.0	9.1	**2,395**	13.1	86.6	0.3
New Jersey	**21,635**	**11.2**	**88.7**	**0.0**	**168**	17.4	82.5	0.1	**21,467**	11.2	88.8	0.0
New Mexico	**5,291**	**12.1**	**87.7**	**0.2**	**278**	21.2	78.6	0.2	**5,012**	11.6	88.2	0.2
New York	**78,804**	**12.3**	**86.8**	**0.9**	**9,933**	12.3	86.7	1.0	**68,871**	12.3	86.8	0.9
North Carolina	**15,638**	**19.7**	**80.0**	**0.2**	**5,275**	22.0	77.7	0.3	**10,364**	18.6	81.2	0.2
North Dakota	**998**	**16.6**	**83.0**	**0.3**	**920**	15.8	84.0	0.2	**78**	26.4	71.2	2.3
Ohio	**43,117**	**14.5**	**85.4**	**0.1**	**3,442**	11.8	88.1	0.1	**39,674**	14.7	85.2	0.1
Oklahoma	**7,612**	**11.7**	**88.2**	**0.1**	**7,612**	11.7	88.2	0.1	**–**	–	–	–
Oregon	**10,340**	**12.1**	**87.7**	**0.2**	**2,376**	5.9	94.0	0.0	**7,964**	14.0	85.8	0.2
Pennsylvania	**36,233**	**13.5**	**86.5**	**0.0**	**490**	10.7	89.2	0.0	**35,743**	13.5	86.4	0.0
Rhode Island	**3,840**	**10.7**	**89.3**	**0.0**	**105**	11.0	89.0	–	**3,735**	10.7	89.3	0.0
South Carolina	**6,999**	**14.0**	**85.5**	**0.5**	**983**	15.8	82.9	1.3	**6,016**	13.7	86.0	0.3
South Dakota	**928**	**14.9**	**84.3**	**0.8**	**928**	14.9	84.3	0.8	**–**	–	–	–
Tennessee	**14,511**	**17.2**	**81.9**	**0.9**	**12,855**	14.3	84.8	0.9	**1,656**	40.0	58.7	1.3
Texas	**34,239**	**14.1**	**85.9**	**0.0**	**502**	20.2	79.7	0.1	**33,737**	14.0	86.0	0.0
Utah	**3,508**	**16.6**	**83.3**	**0.1**	**1,512**	17.9	82.0	0.1	**1,996**	15.5	84.3	0.1
Vermont	**1,650**	**23.1**	**76.9**	**0.0**	**1,635**	23.1	76.9	0.0	**15**	23.0	76.7	0.4
Virginia	**22,581**	**14.0**	**85.2**	**0.8**	**216**	15.5	82.0	2.4	**22,365**	14.0	85.2	0.7
Washington	**14,682**	**12.6**	**87.1**	**0.2**	**996**	13.4	86.4	0.2	**13,686**	12.6	87.2	0.2
West Virginia	**8,928**	**16.9**	**82.9**	**0.2**	**8,639**	16.6	83.2	0.2	**288**	25.5	74.3	0.2
Wisconsin	**12,342**	**18.7**	**81.0**	**0.4**	**12,342**	18.7	81.0	0.4	**–**	–	–	–
Wyoming	**419**	**15.1**	**84.8**	**0.1**	**419**	15.1	84.8	0.1	**–**	–	–	–

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 2022 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.

Source: MACPAC, 2023, analysis of Medicaid drug product data and state drug rebate utilization data as of September 2023.

EXHIBIT 28. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2022 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total[1]	**$91,708.2**	**$32,918.3**	**$58,789.9**	**-$48,495.2**	**-$21,317.5**	**-$27,177.7**
Alabama	**1,007.0**	1,007.0	–	**-547.7**	-547.7	–
Alaska	**196.7**	196.7	–	**-120.1**	-120.1	–
Arizona	**1,814.0**	28.8	1,785.2	**-1,171.4**	-65.6	-1,105.8
Arkansas[2]	**473.2**	381.4	91.8	**-320.4**	-320.4	–
California[3]	**10,756.3**	9,324.0	1,432.3	**-4,223.7**	-2,442.2	-1,781.5
Colorado	**1,378.2**	1,327.4	50.7	**-932.5**	-902.3	-30.2
Connecticut[4]	**1,650.2**	1,650.2	–	**-1,142.1**	-1,277.7	135.6
Delaware	**296.2**	1.6	294.7	**-226.9**	-11.1	-215.8
District of Columbia	**244.0**	148.1	95.9	**-144.1**	-74.7	-69.4
Florida	**3,645.6**	265.5	3,380.0	**-2,369.3**	-151.3	-2,218.0
Georgia	**1,380.3**	868.5	511.8	**-749.3**	-540.3	-209.0
Hawaii	**222.8**	0.1	222.8	**-119.0**	-0.8	-118.2
Idaho	**528.1**	528.1	–	**-339.5**	-339.5	–
Illinois	**3,252.9**	128.0	3,124.9	**-2,047.2**	-114.7	-1,932.6
Indiana	**2,485.5**	479.2	2,006.3	**-1,360.9**	-315.6	-1,045.3
Iowa	**757.7**	5.2	752.5	**-494.1**	-15.7	-478.4
Kansas	**287.5**	0.4	287.1	**-207.1**	-2.7	-204.4
Kentucky	**1,960.8**	76.5	1,884.3	**-1,302.0**	-96.5	-1,205.5
Louisiana	**2,358.4**	49.3	2,309.1	**-1,214.4**	-46.3	-1,168.1
Maine	**439.5**	439.5	–	**-312.7**	-312.7	–
Maryland	**1,598.9**	544.3	1,054.6	**-810.7**	-315.8	-494.9
Massachusetts	**2,122.9**	990.0	1,132.8	**-1,457.5**	-749.4	-708.1
Michigan	**3,289.6**	1,418.9	1,870.7	**-2,263.4**	-903.8	-1,359.6
Minnesota	**1,318.6**	168.2	1,150.4	**-899.7**	-513.1	-386.7
Mississippi	**509.9**	150.0	359.8	**-363.2**	-125.9	-237.3

EXHIBIT 28. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Missouri	**$1,437.4**	$1,437.4	–	**-$926.3**	-$926.3	–
Montana	**388.2**	388.2	–	**-259.5**	-259.5	–
Nebraska	**411.9**	0.0	$411.9	**-207.7**	-0.2	-$207.5
Nevada	**549.5**	295.0	254.5	**-503.8**	-243.3	-260.4
New Hampshire	**261.6**	2.8	258.8	**-166.3**	-91.3	-74.9
New Jersey	**1,803.5**	12.1	1,791.4	**-787.2**	-11.4	-775.8
New Mexico	**488.6**	99.9	388.7	**-218.0**	-30.1	-187.9
New York[4]	**7,109.8**	721.4	6,388.4	**-4,307.6**	-4,307.6	0.0
North Carolina	**2,319.6**	846.8	1,472.8	**-1,461.9**	-673.3	-788.6
North Dakota	**97.6**	93.2	4.4	**-79.5**	-76.2	-3.4
Ohio	**4,301.9**	316.1	3,985.8	**-2,535.0**	-204.2	-2,330.8
Oklahoma	**811.9**	811.9	–	**-500.6**	-500.6	–
Oregon	**817.9**	139.3	678.6	**-448.3**	-100.0	-348.2
Pennsylvania	**4,253.0**	27.6	4,225.4	**-2,638.6**	-41.3	-2,597.3
Rhode Island	**327.8**	6.5	321.3	**-149.2**	-6.7	-142.5
South Carolina	**740.9**	117.7	623.3	**-372.1**	-18.6	-353.5
South Dakota	**166.6**	166.6	–	**-54.9**	-54.9	-0.0
Tennessee[2]	**1,467.3**	1,331.9	135.4	**-990.5**	-990.5	–
Texas	**3,882.2**	43.9	3,838.4	**-2,108.5**	-51.0	-2,057.4
Utah	**491.9**	209.7	282.2	**-269.9**	-141.8	-128.1
Vermont	**194.9**	194.8	0.0	**-155.6**	-155.6	–
Virginia[5]	**5,312.1**	12.5	5,299.6	**-1,261.5**	-33.9	-1,227.5
Washington	**1,533.9**	99.5	1,434.5	**-1,046.0**	-198.8	-847.3
West Virginia	**845.8**	822.0	23.8	**-613.5**	-600.1	-13.4
Wisconsin[4]	**1,932.9**	1,932.9	–	**-1,254.3**	-1,254.3	0.0
Wyoming	**43.6**	43.6	–	**-40.2**	-40.2	–

EXHIBIT 28. (continued)

Notes: FY is fiscal year. Amounts include federal and state funds. Gross spending reflects expenditures before the application of manufacturer rebates. The gross drug expenditures in this exhibit use information from the state drug utilization data that states submit to CMS for rebate purposes and are different from the CMS-64 Financial Management Report (FMR) and Transformed Medicaid Statistical Information System (T-MSIS) data that serve as our usual sources of expenditure data. Spending shown in the drug utilization data may differ from these other sources due to differences in timing and run-out of data used. In addition, the drug rebate data may include physician-administered drugs for which rebates are available; the spending for these drugs are typically reported under the physician services category instead of the outpatient prescription drug category in other data. The state drug utilization data provide both fee-for-service (FFS) and managed care drug utilization and spending information at the national drug code (NDC) level, which is not available in CMS-64 data. The state drug utilization data are available at https://www.medicaid.gov/medicaid/prescription-drugs/state-drug-utilization-data/index.html.

Since October 2016, CMS has suppressed all records in the state drug utilization data that are less than 11 counts, as obligated by the Privacy Act of 1974 (5 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), including rebates for opioid use disorder medication assisted treatment.

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 or -$0.0 indicates an amount between -$0.05 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 2022 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, 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, minimal or no rebates for these managed care expenditures have been reported in the CMS-64 data and are likely to have been reported with the FFS rebates.

[3] California carved prescription drugs out of managed care beginning January 1, 2022, resulting in anomalous distributions in spending and rebates between FFS and managed care.

[4] Connecticut, New York, and Wisconsin reported prior period adjustments for managed care that ultimately resulted in a positive managed care rebate amount.

[5] Virginia reports an atypical proportion of spending on generic drugs; this may indicate data anomalies in the payment amount for these drugs.

Source: MACPAC, 2023, analysis of Medicaid state drug rebate utilization data as of September 2023 and CMS-64 FMR net expenditure data as of May 30, 2023.

EXHIBIT 29. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2021

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	**89,018,035**	**74.3%**	**0.6%**	**9.0%**	**16.9%**	**16.0%**	**2.0%**	**6.0%**
Alabama	**1,198,510**	0.0	–	–	–	–	–	79.3
Alaska[2]	**242,176**	–	–	–	–	–	–	–
Arizona	**2,244,273**	80.0	2.8	2.8	–	–	–	–
Arkansas	**1,069,577**	4.7	–	–	67.6	85.1	26.9	42.4
California	**14,150,266**	82.4	–	–	6.3	–	–	–
Colorado[3]	**1,499,303**	10.6	–	–	–	–	–	84.3
Connecticut[4]	**1,106,169**	–	–	–	–	–	–	–
Delaware	**276,475**	87.1	–	–	–	88.6	–	–
District of Columbia	**285,297**	81.1	–	–	–	12.9	–	–
Florida	**4,871,362**	78.3	2.5	–	83.1	–	–	–
Georgia	**2,539,039**	72.1	–	–	–	78.4	2.5	–
Hawaii	**420,033**	100.0	–	–	–	–	–	–
Idaho	**421,589**	5.6	–	87.2	92.8	92.8	–	80.8
Illinois	**3,467,588**	75.4	1.9	–	–	–	–	–
Indiana	**1,870,171**	78.8	–	–	–	–	–	–
Iowa	**749,862**	93.9	–	–	94.8	–	–	–
Kansas	**461,405**	88.1	–	–	–	–	–	–
Kentucky	**1,584,976**	89.4	–	–	–	99.8	–	–
Louisiana	**1,894,676**	85.3	–	7.3	92.8	–	–	–
Maine	**331,396**	–	–	–	–	98.6	–	68.9
Maryland	**1,780,886**	85.4	–	–	–	–	–	–
Massachusetts	**2,091,955**	40.5	–	29.9	–	–	–	26.9
Michigan[5]	**2,900,801**	100.5	0.4	93.1	28.1	–	–	–
Minnesota	**1,253,815**	86.7	–	–	–	–	–	–
Mississippi	**776,482**	61.2	–	–	–	–	–	–
Missouri	**1,048,083**	74.2	–	–	–	25.5	–	–

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	
Montana	**309,776**	–	–	–	–	–	–	79.2%
Nebraska	**336,290**	99.6%	–	–	88.1%	–	–	–
Nevada	**847,650**	75.6	–	–	77.1	90.9%	–	–
New Hampshire	**239,439**	91.3	–	–	–	–	–	–
New Jersey	**1,892,091**	96.2	–	–	–	96.2	–	–
New Mexico	**941,830**	83.0	–	–	–	–	–	–
New York	**7,145,884**	75.2	3.4%	–	–	–	–	–
North Carolina	**2,557,593**	60.6	–	19.6%	–	–	–	20.3
North Dakota	**125,354**	27.0	–	–	–	–	–	41.8
Ohio	**3,238,849**	85.9	–	–	–	–	–	–
Oklahoma	**1,065,121**	0.1	–	–	–	97.6	–	58.4
Oregon[6]	**1,286,095**	85.8	–	–	4.7	–	–	–
Pennsylvania[7]	**3,292,313**	93.9	–	94.5	–	21.4	0.0%	–
Rhode Island	**339,276**	84.6	–	–	37.7	98.8	–	–
South Carolina	**1,446,070**	66.6	–	–	–	100.0	–	0.1
South Dakota	**137,268**	–	–	–	–	–	–	61.1
Tennessee[8]	**1,717,984**	92.9	–	–	54.1	–	83.7	–
Texas	**4,928,655**	81.7	–	–	69.6	–	–	–
Utah	**424,565**	82.9	–	79.0	51.1	80.6	–	–
Vermont[9]	**191,240**	68.5	–	–	–	–	–	–
Virginia	**1,852,563**	91.3	–	–	–	–	–	–
Washington	**2,008,655**	88.3	–	8.3	–	100.0	0.6	0.2
West Virginia	**599,336**	81.4	–	–	–	–	–	–
Wisconsin	**1,484,746**	69.1	3.5	0.1	–	–	0.2	–
Wyoming[10]	**73,227**	–	–	–	–	–	–	–

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, 2021, was taken from the July–September 2021 enrollment data collected through the Medicaid Budget and Expenditure System, updated January 2023 and accessed April 2, 2023.

[3] Colorado did not provide plan level enrollment 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, 2021, was taken from the July–September 2021 enrollment data collected through the Medicaid Budget and Expenditure System, updated January 2023 and accessed April 2, 2023.

[5] 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.

[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 Advantage Dental Services, Capitol Dental Care, Family Dental Care, Managed Dental Care of Oregon, and ODS Community Health as dental.

[7] Pennsylvania did not provide enrollment counts for plans with fewer than 11 beneficiaries. As a result, reported Medicaid enrollment in comprehensive managed care may be lower than actual enrollment.

[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 DentaQuest as dental and enrollment in OptumRx as other.

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

[10] Wyoming's total Medicaid enrollment as of July 1, 2021, was taken from the July–September 2021 enrollment data collected through the Medicaid Budget and Expenditure System, updated January 2023 and accessed April 2, 2023.

Source: MACPAC, 2023, analysis of data from CMS, *Medicaid managed care enrollment and program characteristics, 2021*, 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 2021

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	**87,979**	**72.4%**	**85.0%**	**81.5%**	**64.9%**	**52.9%**	**36.8%**	**42.1%**	**51.3%**	**32.4%**	**36.0%**	**49.7%**	**35.6%**
Alabama	**1,162**	**0.0**	–	–	–	0.0	0.1	**7.5**	0.0	–	0.1	18.8	33.4
Alaska	**255**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Arizona	**2,266**	**91.1**	98.6	93.6	83.2	91.1	71.1	**0.0**	–	0.0	0.0	–	–
Arkansas	**1,045**	**0.1**	–	0.0	–	0.0	0.6	**88.9**	96.9	96.2	77.3	73.4	41.4
California[6]	**13,918**	**78.6**	90.2	84.5	56.9	85.1	73.0	**6.1**	6.2	7.6	4.7	6.5	3.6
Colorado[7]	**1,551**	**12.1**	8.7	14.6	12.4	10.7	13.7	**95.2**	99.3	98.7	92.8	87.5	57.9
Connecticut	**1,177**	**0.0**	–	0.0	–	–	–	**86.1**	99.3	100.0	85.6	59.1	35.8
Delaware	**292**	**86.8**	96.1	94.7	78.7	72.8	44.8	**88.6**	96.9	98.5	80.3	74.1	44.1
District of Columbia[8]	**278**	**81.5**	94.6	94.8	96.9	54.9	7.6	**22.2**	11.4	17.7	11.3	43.4	62.0
Florida	**5,054**	**78.9**	97.5	–	76.6	62.8	34.3	**92.2**	99.5	–	92.8	85.8	72.6
Georgia	**2,448**	**72.3**	98.3	–	93.6	3.4	0.0	**83.3**	97.8	–	79.5	67.8	40.0
Hawaii	**429**	**98.3**	99.9	99.8	99.8	93.4	87.7	**1.3**	0.0	0.9	0.4	13.1	2.2
Idaho	**436**	**–**	–	–	–	–	–	**94.5**	99.9	99.7	98.3	83.6	58.8
Illinois[8]	**3,371**	**81.1**	92.1	87.4	59.7	49.8	45.9	**–**	–	–	–	–	–
Indiana[7]	**1,932**	**78.4**	91.5	100.0	76.4	29.4	6.5	**19.9**	17.2	0.2	13.5	61.6	65.1
Iowa	**791**	**94.0**	98.2	96.4	92.2	89.5	70.3	**94.1**	95.3	98.1	94.9	91.2	70.5
Kansas	**452**	**93.5**	100.0	–	96.7	85.4	67.7	**–**	–	–	–	–	–
Kentucky	**1,734**	**87.8**	97.8	93.0	95.2	69.2	36.2	**92.5**	98.3	96.5	96.8	80.2	58.5
Louisiana[7]	**1,823**	**93.0**	99.9	98.9	93.8	81.9	56.7	**93.3**	99.9	98.9	94.1	83.6	57.2
Maine	**422**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Maryland	**1,548**	**84.9**	98.6	95.4	86.8	57.0	2.0	**–**	–	–	–	–	–
Massachusetts	**1,980**	**41.8**	49.7	52.0	36.5	31.8	34.2	**33.3**	44.7	42.3	28.8	35.8	2.0
Michigan	**3,001**	**78.1**	86.1	84.4	81.0	62.1	28.7	**96.1**	99.0	96.9	95.0	93.9	84.2
Minnesota	**1,338**	**85.6**	89.7	94.3	85.2	53.6	75.1	**–**	–	–	–	–	–
Mississippi	**827**	**66.3**	92.7	–	62.1	42.6	1.4	**–**	–	–	–	–	–

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	1,240	65.6%	97.0%	0.5%	84.2%	0.4%	0.0%	95.2%	100.0%	98.9%	91.6%	89.8%	80.7%
Montana	289	–	–	–	–	–	–	–	–	–	–	–	–
Nebraska	331	97.9	99.8	99.1	99.3	94.8	86.5	87.1	99.6	39.1	98.9	94.6	85.6
Nevada	880	74.8	86.1	88.0	83.9	4.1	2.0	92.3	99.5	98.2	94.3	72.5	37.4
New Hampshire	249	87.6	98.4	97.2	63.6	66.9	59.6	0.7	0.1	0.8	0.7	1.7	1.9
New Jersey	1,923	94.5	95.8	94.8	85.9	97.0	94.1	100.0	100.0	100.0	100.0	100.0	100.0
New Mexico	962	83.3	92.3	91.2	70.5	71.4	43.3	–	–	–	–	–	–
New York	7,253	75.2	94.6	92.1	61.5	50.2	13.8	3.9	0.0	0.5	0.5	7.0	26.2
North Carolina	2,535	55.2	86.0	–	41.8	28.3	2.7	78.0	95.8	–	52.6	90.7	71.6
North Dakota[6]	125	29.5	0.1	99.5	14.8	5.0	4.4	–	–	–	–	–	–
Ohio	3,146	83.5	98.3	94.9	94.7	49.6	10.1	5.1	0.0	0.0	2.0	15.8	34.6
Oklahoma	1,109	0.1	–	–	–	0.2	0.8	–	–	–	–	–	–
Oregon[7]	1,275	84.0	92.7	88.7	32.5	75.0	56.6	7.2	7.2	7.7	6.4	6.9	4.0
Pennsylvania	3,390	88.2	94.4	87.3	89.7	83.7	78.4	93.7	97.6	96.5	93.3	91.0	77.6
Rhode Island	335	82.4	83.8	97.1	88.9	69.2	28.8	92.1	91.4	99.0	91.6	92.9	69.7
South Carolina	1,377	67.0	94.6	–	49.8	41.3	20.6	81.6	99.2	–	52.9	93.9	80.9
South Dakota	132	–	–	–	–	–	–	–	–	–	–	–	–
Tennessee	1,787	92.2	99.3	–	99.4	81.4	50.3	–	–	–	–	–	–
Texas[9]	5,628	81.2	97.1	–	56.1	72.1	42.5	80.2	96.2	–	50.6	74.2	45.1
Utah[6]	446	80.4	87.2	75.9	71.4	81.4	67.1	90.5	98.0	80.0	81.6	96.3	89.2
Vermont	198	–	–	–	–	–	–	–	–	–	–	–	–
Virginia	1,845	73.8	97.4	86.7	75.7	1.9	5.1	16.4	0.2	9.1	1.6	80.7	62.9
Washington	2,153	86.2	96.7	96.6	90.0	52.4	6.5	8.8	1.0	2.4	2.3	32.5	67.3
West Virginia	632	82.6	98.9	97.4	94.7	49.2	3.4	44.3	46.2	60.0	57.8	8.9	17.8
Wisconsin	1,414	72.3	91.9	–	86.0	31.5	9.7	94.4	99.5	–	99.1	96.9	57.1
Wyoming	81	0.2	–	–	–	0.1	1.4	0.5	0.6	–	0.0	1.0	–

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	**87,979**	**8.3%**	**11.2%**	**6.6%**	**7.1%**	**8.7%**	**3.1%**
Alabama	**1,162**	**78.4**	97.4	–	92.9	53.1	16.0
Alaska	**255**	**–**	–	–	–	–	–
Arizona	**2,266**	**–**	–	–	–	–	–
Arkansas	**1,045**	**47.2**	82.5	8.5	38.6	54.4	2.8
California[6]	**13,918**	**–**	–	–	–	–	–
Colorado[7]	**1,551**	**94.3**	98.4	97.5	91.9	86.8	57.5
Connecticut	**1,177**	**–**	–	–	–	–	–
Delaware	**292**	**–**	–	–	–	–	–
District of Columbia[8]	**278**	**–**	–	–	–	–	–
Florida	**5,054**	**–**	–	–	–	–	–
Georgia	**2,448**	**–**	–	–	–	–	–
Hawaii	**429**	**–**	–	–	–	–	–
Idaho	**436**	**85.6**	96.1	92.4	91.7	66.6	26.3
Illinois[8]	**3,371**	**–**	–	–	–	–	–
Indiana[7]	**1,932**	**–**	–	–	–	–	–
Iowa	**791**	**0.1**	0.0	0.0	0.1	0.2	0.0
Kansas	**452**	**–**	–	–	–	–	–
Kentucky	**1,734**	**–**	–	–	–	–	–
Louisiana[7]	**1,823**	**–**	–	–	–	–	–
Maine	**422**	**56.0**	82.2	83.6	48.9	31.6	1.7
Maryland	**1,548**	**–**	–	–	–	–	–
Massachusetts	**1,980**	**28.0**	34.1	41.4	27.3	23.6	1.0
Michigan	**3,001**	**–**	–	–	–	–	–
Minnesota	**1,338**	**–**	–	–	–	–	–
Mississippi	**827**	**–**	–	–	–	–	–

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	1,240	–	–	–	–	–	–
Montana	289	83.7%	95.4%	94.7%	83.0%	41.7%	3.1%
Nebraska	331	–	–	–	–	–	–
Nevada	880	–	–	–	–	–	–
New Hampshire	249	–	–	–	–	–	–
New Jersey	1,923	–	–	–	–	–	–
New Mexico	962	–	–	–	–	–	–
New York	7,253	–	–	–	–	–	–
North Carolina	2,535	67.6	91.6	–	40.1	75.9	45.9
North Dakota[6]	125	52.3	89.3	10.4	96.1	2.4	0.1
Ohio	3,146	–	–	–	–	–	–
Oklahoma	1,109	92.6	98.9	88.0	89.7	84.0	76.9
Oregon[7]	1,275	23.3	22.0	24.7	18.1	26.2	17.9
Pennsylvania	3,390	–	–	–	–	–	–
Rhode Island	335	–	–	–	–	–	–
South Carolina	1,377	0.1	0.0	–	–	0.5	–
South Dakota	132	73.7	89.7	–	91.8	37.2	10.8
Tennessee	1,787	–	–	–	–	–	–
Texas[9]	5,628	–	–	–	–	–	–
Utah[6]	446	–	–	–	–	–	–
Vermont	198	–	–	–	–	–	–
Virginia	1,845	–	–	–	–	–	–
Washington	2,153	0.2	0.2	0.1	0.2	0.3	0.0
West Virginia	632	–	–	–	–	–	–
Wisconsin	1,414	–	–	–	–	–	–
Wyoming	81	–	–	–	–	–	–

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. 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).

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 (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID. The sum of the state totals exceeds the national total because individuals may be enrolled in more than one state during the year. 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 plan (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 to 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, pregnancy).

[6] 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, before 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 250,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 12,000.

[7] State reported a large shift of enrollees between eligibility groups. Colorado reported a 35 percent increase in the new adult group and a 46 percent decrease for the other adult group. Indiana reported a 16 percent decrease for the new adult group and a 60 percent increase for the other adult group. Louisiana reported a 15 percent increase in the new adult group and a 10 percent decrease in the other adult group. Oregon reported a 33 percent increase in the new adult group, a 69 percent decrease in the other adult group, a 102 percent increase in the disabled group, and a 53 percent increase in the aged group.

[8] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 36 percent less than the benchmark, and Illinois's average monthly enrollment was 113 percent more than the benchmark.

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2021.

Source: MACPAC, 2023, analysis of T-MSIS data as of February 2023.

EXHIBIT 31. Total Medicaid Administrative Spending by State and Category, FY 2022 (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	**$241**	$43	$27	$2	$11	$157	–
Alaska	**157**	46	5	1	6	99	–
Arizona	**331**	45	130	7	11	137	–
Arkansas	**442**	129	93	0	24	196	-$0
California	**7,190**	488	2,489	23	295	3,896	-1
Colorado	**551**	77	140	9	19	306	-1
Connecticut	**353**	47	101	3	31	171	–
Delaware	**103**	35	9	1	2	56	–
District of Columbia	**281**	42	81	4	9	145	–
Florida	**606**	113	73	2	34	384	–
Georgia	**536**	132	105	2	14	284	–
Hawaii	**113**	22	41	1	2	47	–
Idaho	**135**	37	22	-2	20	58	–
Illinois	**1,017**	73	292	5	73	574	–
Indiana	**471**	66	87	3	22	293	–
Iowa	**163**	34	80	1	13	35	–
Kansas	**250**	75	67	1	4	103	–
Kentucky	**286**	84	80	1	18	104	–
Louisiana	**365**	68	130	2	6	159	-0
Maine	**167**	52	38	3	11	63	-0
Maryland	**501**	106	136	6	22	230	–
Massachusetts	**1,159**	141	150	5	51	812	-0
Michigan	**673**	165	135	4	21	348	-0
Minnesota	**738**	72	157	5	15	489	–
Mississippi	**198**	72	37	1	7	81	–
Missouri	**427**	70	94	3	12	248	–
Montana	**105**	43	17	6	7	33	-1
Nebraska	**185**	33	39	26	7	80	–
Nevada	**218**	49	71	1	11	86	–
New Hampshire	**151**	59	44	0	5	42	–

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 Jersey	**$1,013**	$104	$281	$7	$32	$589	-$0
New Mexico	**287**	79	88	1	8	111	–
New York	**2,046**	244	193	52	55	1,502	–
North Carolina	**1,063**	103	405	1	69	485	–
North Dakota	**97**	34	31	1	2	29	-0
Ohio	**1,035**	165	188	2	22	659	-0
Oklahoma	**218**	47	11	1	21	138	–
Oregon	**613**	47	102	2	23	439	-0
Pennsylvania	**1,117**	103	413	2	25	573	–
Rhode Island	**191**	43	47	1	1	99	-0
South Carolina	**382**	75	73	2	30	202	–
South Dakota	**74**	13	14	1	3	44	–
Tennessee	**819**	280	244	1	16	279	-2
Texas	**1,627**	302	435	4	20	870	-5
Utah	**186**	49	42	2	14	79	–
Vermont	**165**	40	35	6	9	74	–
Virginia	**439**	83	111	1	25	219	–
Washington	**1,073**	107	99	-3	17	853	-0
West Virginia	**209**	69	41	0	38	60	–
Wisconsin	**524**	148	125	3	7	242	-1
Wyoming	**75**	36	17	–	4	19	-0
Subtotal (states)	**$31,365**	**$4,687**	**$7,964**	**$214**	**$1,229**	**$17,282**	**-$12**
American Samoa	**2**	–	–	0	–	2	–
Guam	**4**	0	–	–	0	4	–
Northern Mariana Islands	**5**	4	–	0	–	1	–
Puerto Rico	**102**	27	34	8	–	33	–
Virgin Islands	**24**	7	9	0	–	8	–
Subtotal (states and territories)	**$31,502**	**$4,724**	**$8,007**	**$224**	**$1,229**	**$17,330**	**-$12**

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]	**$409**	–	–	–	$409	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	**400**	–	–	–	400	–	–
Total	**$32,311**	**$4,724**	**$8,007**	**$224**	**$2,038**	**$17,330**	**-$12**
Percent of total, exclusive of collections	**–**	**14.6%**	**24.8%**	**0.7%**	**6.3%**	**53.6%**	**–**

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 May 30, 2023. 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, 2023, analysis of CMS-64 FMR net expenditure data as of May 30, 2023. For all other spending (MFCUs, survey and certification, VFC program): CMS, 2023, *Fiscal year 2024 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/files/document/cms-fy-2024-congressional-justification-estimates-appropriations-committees.pdf-0.

EXHIBIT 32. Child Enrollment in CHIP and Medicaid by State, FY 2022 (thousands)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
Total	**46,465**	**5,528**	**2,746**	**8,274**	**38,190**
Alabama	**806**	106	95	**202**	**604**
Alaska	**126**	13	–	**13**	**113**
Arizona	**1,058**	73	68	**141**	**916**
Arkansas	**528**	37	46	**83**	**445**
California	**6,034**	1,478	79	**1,556**	**4,478**
Colorado	**537**	111	32	**143**	**393**
Connecticut	**412**	–	18	**18**	**394**
Delaware	**131**	2	9	**11**	**120**
District of Columbia	**102**	16	–	**16**	**85**
Florida	**2,914**	182	151	**333**	**2,581**
Georgia	**1,779**	86	219	**305**	**1,474**
Hawaii	**184**	24	–	**24**	**160**
Idaho	**230**	2	41	**43**	**187**
Illinois	**1,756**	306	39	**344**	**1,412**
Indiana	**923**	87	35	**121**	**802**
Iowa	**449**	17	66	**83**	**366**
Kansas	**349**	15	47	**62**	**287**
Kentucky	**674**	115	13	**128**	**545**
Louisiana	**884**	189	11	**200**	**684**
Maine	**232**	25	9	**34**	**198**
Maryland	**730**	127	–	**127**	**603**
Massachusetts	**804**	124	97	**221**	**583**
Michigan	**1,298**	128	3	**131**	**1,167**
Minnesota	**676**	1	3	**4**	**672**
Mississippi	**517**	34	49	**83**	**434**
Missouri	**743**	54	54	**107**	**636**
Montana	**151**	7	23	**29**	**121**
Nebraska	**239**	56	2	**58**	**180**
Nevada	**435**	46	30	**76**	**358**
New Hampshire	**112**	23	–	**23**	**89**
New Jersey	**1,014**	116	152	**268**	**746**
New Mexico	**794**	11	–	**11**	**783**

EXHIBIT 32. (continued)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
New York	**2,820**	295	329	**624**	**2,196**
North Carolina	**1,558**	234	68	**302**	**1,255**
North Dakota[1]	**75**	3	4	**7**	**68**
Ohio	**1,540**	238	–	**238**	**1,302**
Oklahoma	**759**	231	10	**241**	**518**
Oregon	**664**	74	177	**251**	**413**
Pennsylvania	**1,630**	111	159	**270**	**1,359**
Rhode Island	**145**	31	3	**34**	**111**
South Carolina	**767**	105	–	**105**	**662**
South Dakota	**100**	15	4	**19**	**81**
Tennessee	**1,092**	11	57	**69**	**1,023**
Texas	**4,453**	395	263	**658**	**3,796**
Utah	**289**	27	11	**37**	**251**
Vermont	**77**	5	–	**5**	**72**
Virginia	**943**	95	79	**174**	**769**
Washington	**935**	–	82	**82**	**853**
West Virginia	**257**	14	20	**34**	**224**
Wisconsin	**693**	32	85	**117**	**576**
Wyoming	**49**	1	4	**5**	**44**

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 August 14, 2023, and may be revised at a later date.

– Dash indicates zero.

[1] North Dakota did not report the number of children with Medicaid coverage for FY 2022, so the state's FY 2021 amount was included in this exhibit.

Source: MACPAC, 2023, analysis of CHIP Statistical Enrollment Data System data as of August 14, 2023.

EXHIBIT 33. CHIP Spending by State, FY 2022 (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	**$462.4**	$392.9	$69.5	**$192.3**	$163.3	$29.0	**$260.2**	$221.2	$39.0	**$9.9**	$8.4	$1.5	–
Alaska	**26.3**	18.4	7.9	**23.8**	16.7	7.2	**–**	–	–	**2.5**	1.7	0.8	–
Arizona	**407.9**	339.0	68.8	**217.8**	180.9	36.9	**178.4**	148.5	30.0	**11.6**	9.7	2.0	–
Arkansas	**232.1**	196.0	36.0	**100.5**	84.9	15.6	**126.4**	106.7	19.6	**5.2**	4.4	0.8	–
California	**4,265.9**	2,973.9	1,292.0	**4,028.8**	2,809.2	1,219.6	**147.1**	102.2	44.9	**90.1**	62.6	27.5	–
Colorado	**344.9**	240.0	104.9	**176.9**	123.7	53.3	**158.7**	110.0	48.8	**9.2**	6.4	2.8	–
Connecticut	**50.4**	57.3	-6.9	**–**	–	–	**45.4**	31.5	13.9	**5.0**	3.5	1.5	$22.3
Delaware	**34.8**	26.0	8.9	**9.3**	6.9	2.3	**24.3**	18.1	6.2	**1.2**	0.9	0.3	–
District of Columbia	**61.1**	50.9	10.2	**59.6**	49.6	9.9	**-0.0**	-0.0	-0.0	**1.5**	1.3	0.3	–
Florida	**787.3**	606.4	180.8	**448.0**	345.2	102.9	**307.5**	236.8	70.7	**31.8**	24.5	7.3	–
Georgia	**581.3**	469.5	111.8	**151.3**	122.1	29.2	**416.5**	336.6	80.0	**13.4**	10.9	2.6	–
Hawaii	**71.5**	51.3	20.3	**68.9**	49.4	19.5	**-0.0**	-0.0	-0.0	**2.6**	1.9	0.7	–
Idaho	**109.3**	91.2	18.1	**-4.1**	-3.4	-0.7	**109.8**	91.6	18.2	**3.6**	3.0	0.6	–
Illinois	**712.3**	499.6	212.7	**266.3**	186.6	79.6	**379.4**	266.2	113.2	**66.6**	46.8	19.9	–
Indiana	**269.3**	217.5	51.8	**175.3**	141.5	33.8	**85.1**	68.8	16.3	**8.9**	7.2	1.7	–
Iowa	**171.0**	132.6	38.4	**44.4**	34.6	9.8	**118.8**	92.1	26.8	**7.8**	6.0	1.7	–
Kansas	**180.2**	137.9	42.3	**38.5**	29.4	9.1	**124.4**	95.2	29.2	**17.4**	13.3	4.1	–
Kentucky	**412.9**	350.3	62.6	**238.8**	202.5	36.4	**160.2**	136.1	24.2	**13.8**	11.7	2.1	–
Louisiana	**509.2**	418.2	91.0	**401.1**	329.7	71.4	**88.7**	72.6	16.1	**19.4**	15.9	3.5	–
Maine	**45.3**	35.8	9.5	**29.6**	23.4	6.2	**13.9**	11.0	3.0	**1.8**	1.4	0.4	–
Maryland	**444.7**	308.4	136.3	**439.4**	304.6	134.7	**-17.8**	-12.4	-5.4	**23.2**	16.1	7.0	–
Massachusetts	**884.4**	614.4	270.0	**391.6**	272.2	119.4	**404.5**	280.9	123.6	**88.3**	61.3	27.0	**–**
Michigan	**337.8**	270.9	66.9	**305.8**	245.3	60.5	**7.1**	5.7	1.4	**24.8**	19.9	4.9	–
Minnesota	**20.0**	73.4	-53.4	**1.5**	1.1	0.5	**16.6**	11.6	5.0	**1.9**	1.3	0.6	59.5
Mississippi	**207.7**	176.7	31.1	**86.2**	73.4	12.8	**118.5**	100.7	17.8	**3.0**	2.5	0.4	–
Missouri	**366.3**	294.1	72.2	**184.0**	148.6	35.3	**191.6**	152.9	38.7	**-9.2**	-7.4	-1.9	–
Montana	**111.8**	89.2	22.6	**18.6**	14.9	3.8	**87.5**	69.8	17.7	**5.7**	4.5	1.2	–
Nebraska	**111.6**	83.1	28.5	**96.2**	71.6	24.6	**9.8**	7.3	2.5	**5.5**	4.1	1.4	–
Nevada	**107.0**	83.6	23.4	**59.7**	46.6	13.0	**44.2**	34.6	9.7	**3.1**	2.4	0.7	–
New Hampshire	**58.3**	48.6	9.6	**58.3**	40.4	17.9	**–**	–	–	**0.0**	0.0	0.0	8.2

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	**$833.8**	$580.7	$253.1	**$358.9**	$250.2	$108.7	**$396.8**	$276.1	$120.7	**$78.2**	$54.4	$23.8	–
New Mexico	**131.0**	111.3	19.8	**129.9**	110.3	19.6	**-0.0**	-0.0	-0.0	**1.2**	1.0	0.2	–
New York	**1,816.9**	1,260.1	556.7	**868.1**	601.9	266.2	**766.9**	532.0	234.9	**181.9**	126.2	55.7	–
North Carolina	**763.9**	624.2	139.7	**568.0**	464.2	103.8	**181.7**	148.4	33.3	**14.2**	11.6	2.6	–
North Dakota	**26.7**	19.1	7.6	**25.0**	17.9	7.1	**-0.0**	-0.0	-0.0	**1.7**	1.2	0.5	–
Ohio	**694.1**	552.5	141.5	**658.0**	524.0	134.0	**–**	–	–	**36.0**	28.5	7.5	–
Oklahoma	**284.5**	233.8	50.7	**291.0**	239.1	51.8	**-24.0**	-19.7	-4.3	**17.5**	14.3	3.1	–
Oregon	**604.0**	461.9	142.1	**147.6**	112.9	34.7	**440.0**	336.4	103.5	**16.4**	12.5	3.9	–
Pennsylvania	**706.0**	502.9	203.1	**411.8**	293.3	118.5	**275.8**	196.5	79.3	**18.5**	13.2	5.3	–
Rhode Island	**130.6**	94.9	35.7	**103.5**	75.2	28.3	**25.6**	18.6	7.0	**1.4**	1.0	0.4	–
South Carolina	**223.5**	187.5	36.1	**216.1**	181.2	34.9	**-1.7**	-1.5	-0.3	**9.2**	7.7	1.5	–
South Dakota	**37.1**	28.0	9.1	**29.5**	22.2	7.3	**7.1**	5.4	1.7	**0.5**	0.4	0.1	–
Tennessee	**403.6**	326.2	77.4	**254.4**	205.7	48.8	**145.6**	117.7	28.0	**3.5**	2.8	0.7	–
Texas	**1,667.5**	1,280.9	386.5	**1,328.0**	1,021.7	306.3	**315.9**	241.3	74.6	**23.5**	18.0	5.6	–
Utah	**128.4**	104.3	24.2	**102.9**	83.5	19.4	**20.0**	16.3	3.7	**5.5**	4.5	1.0	–
Vermont	**16.6**	15.8	0.8	**15.0**	11.1	3.9	**-0.0**	-0.0	-0.0	**1.7**	1.2	0.4	$3.5
Virginia	**523.3**	362.3	161.0	**222.4**	153.6	68.8	**277.2**	192.3	84.9	**23.7**	16.4	7.3	–
Washington	**240.3**	224.8	15.5	**28.1**	19.5	8.6	**204.4**	139.0	65.4	**7.8**	5.3	2.5	61.0
West Virginia	**88.4**	75.1	13.3	**34.0**	28.9	5.1	**48.4**	41.2	7.3	**6.0**	5.1	0.9	–
Wisconsin	**305.3**	245.4	60.0	**108.5**	83.2	25.4	**170.6**	130.4	40.2	**26.2**	20.0	6.2	11.8
Wyoming	**9.2**	6.3	2.8	**8.8**	6.1	2.7	**0.0**	0.0	0.0	**0.3**	0.2	0.1	–
Subtotal (states)	**$22,019.3**	**$16,645.0**	**$5,374.3**	**$14,218.1**	**$10,620.5**	**$3,597.6**	**$6,856.9**	**$5,166.3**	**$1,690.6**	**$944.3**	**$691.8**	**$252.5**	**$166.4**
American Samoa	**8.4**	7.4	0.9	**8.4**	7.4	0.9	**–**	–	–	**–**	–	–	–
Guam	**1.3**	1.3	–	**1.3**	1.3	–	**–**	–	–	**–**	–	–	–
Northern Mariana Islands	**19.7**	16.9	2.8	**19.7**	16.9	2.8	**–**	–	–	**–**	–	–	–
Puerto Rico	**217.0**	184.9	32.2	**217.0**	184.9	32.2	**–**	–	–	**–**	–	–	–
Virgin Islands	**3.2**	2.7	0.5	**3.2**	2.7	0.5	**–**	–	–	**–**	–	–	–
Total	**$22,268.9**	**$16,858.3**	**$5,410.6**	**$14,467.7**	**$10,833.8**	**$3,633.9**	**$6,856.9**	**$5,166.3**	**$1,690.6**	**$944.3**	**$691.8**	**$252.5**	**$166.4**

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] Seven states (Colorado, Kentucky, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia) use CHIP funds to provide coverage for pregnant women (MACPAC uses the term "pregnant women" as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as 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 in which 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 and Minnesota).

Source: MACPAC, 2023, analysis of Medicaid and CHIP Budget Expenditure System data from CMS as of October 9, 2023.

EXHIBIT 34. Federal CHIP Allotments, FYs 2021–2023 (millions)

State	FY 2021 federal CHIP allotments	FY 2022 federal CHIP allotments[1]	FY 2023 federal CHIP allotments
Alabama	$368.1	$390.8	$434.9
Alaska	25.7	27.6	20.3
Arizona	248.9	264.6	375.0
Arkansas	208.8	221.2	216.8
California	3,346.6	3,548.3	3,294.1
Colorado	279.6	300.5	265.7
Connecticut	73.5	77.8	64.0
Delaware	37.4	39.6	28.7
District of Columbia	61.1	65.2	56.3
Florida	781.9	831.0	671.6
Georgia	418.6	493.8	519.4
Hawaii	55.3	59.0	56.7
Idaho	85.7	91.2	101.9
Illinois	536.0	567.9	552.6
Indiana	272.4	288.8	241.2
Iowa	166.6	185.7	146.7
Kansas	146.4	155.3	152.5
Kentucky	253.4	293.9	387.5
Louisiana	393.7	418.7	462.6
Maine	35.7	37.8	39.6
Maryland	285.4	302.4	341.1
Massachusetts	682.1	725.8	679.9
Michigan	271.5	288.8	299.7
Minnesota	114.8	121.6	81.2
Mississippi	270.8	287.6	195.6
Missouri	326.9	346.6	325.6
Montana	86.6	92.1	98.8
Nebraska	81.6	86.5	91.9
Nevada	82.6	87.6	92.5
New Hampshire	47.8	50.6	53.8
New Jersey	614.7	661.3	643.0
New Mexico	115.4	122.3	123.2
New York	1,603.9	1,699.4	1,394.0
North Carolina	555.9	590.6	690.8
North Dakota	18.4	19.6	21.1
Ohio	521.2	555.5	611.2
Oklahoma	262.6	278.4	258.6

EXHIBIT 34. (continued)

State	FY 2021 federal CHIP allotments	FY 2022 federal CHIP allotments[1]	FY 2023 federal CHIP allotments
Oregon	$429.7	$455.2	$510.9
Pennsylvania	695.2	736.6	559.0
Rhode Island	75.6	80.1	105.0
South Carolina	207.9	220.7	207.5
South Dakota	29.5	31.2	30.9
Tennessee	304.4	323.4	361.3
Texas	1,355.6	1,440.7	1,417.0
Utah	127.3	135.1	115.3
Vermont	20.8	22.0	17.5
Virginia	378.6	403.3	400.8
Washington	247.7	263.5	250.7
West Virginia	78.9	83.7	83.1
Wisconsin	250.5	265.7	271.4
Wyoming	12.2	12.9	7.0
Subtotal (states)	**$17,951.4**	**$19,149.8**	**$18,427.7**
American Samoa	6.3	7.4	8.9
Guam	30.7	32.5	1.5
Northern Mariana Islands	17.2	18.2	18.7
Puerto Rico	117.4	127.0	204.5
Virgin Islands	12.2	12.9	3.0
Total (states and territories)	**$18,135.2**	**$19,347.9**	**$18,664.3**

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-number years beginning in FY 2010 and ending in FY 2029 (§ 2104(m)(7) of the Social Security Act). The FY 2022 allotment for a state may differ from previously published allotments for the fiscal year because the state received such an allotment increase.

Sources: MACPAC, 2023, analysis of Medicaid and CHIP Budget Expenditure System data as of October 10, 2023.

SECTION 4:

Medicaid and CHIP Eligibility

Section 4: Medicaid and CHIP Eligibility

Key Points

- Thirty-nine 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) (Exhibit 36). One state has approved Medicaid expansion but has not implemented it as of July 2023.
- 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 2022 and 2023 (Exhibit 37).
- In 2023, in the lower 48 states and the District of Columbia, 100 percent federal poverty level (FPL) is $14,580 for an individual plus $5,140 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 2023

State	CHIP program type[1] (as of July 2023)	Medicaid coverage[2]						Separate CHIP coverage		Medicaid and CHIP coverage
		Infants under age 1		Age 1–5		Age 6–18				
		Medicaid funded	CHIP funded	Medicaid funded	CHIP funded	Medicaid funded	CHIP funded	Birth through age 18[3]	Unborn children[4]	Pregnant women and deemed newborns[5]
Alabama	Combination	141%	–	141%	–	141%	107–141%	312%	–	141%
Alaska	Medicaid expansion	177	159–203%	177	159–203%	177	124–203	–	–	200
Arizona	Combination	147	–	141	–	133	104–133	200	–	156
Arkansas	Combination	142	–	142	–	142	107–142	211	209%	209
California	Combination	208	208–261	142	142–261	133	108–261	–[6]	317	208
Colorado	Combination	142	–	142	–	142	108–142	260	–	195; 260
Connecticut	Separate	196	–	196	–	196	–	318	258	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	142–313	142	142–313	142	108–313	–	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	250	–	166
Kentucky	Combination	195	195- 213	142	142–213	133	109–213	–	–	195; 213
Louisiana	Combination	142	142–212	142	142–212	142	108–212	250	209	133
Maine	Combination	208	191-208	208	140–208	208	132–208	–	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
New Hampshire	Medicaid expansion	196	196–318	196	196–318	196	196–318	–	–	196

EXHIBIT 35. (continued)

State	CHIP program type[1] (as of July 2023)	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 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	Medicaid expansion	211	194–211	211	141–211	211	107–133	–	–	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[9]	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	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 2023, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $14,580 for an individual plus $5,140 for each additional family member. Before 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 2023. 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.

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.

EXHIBIT 35. (continued)

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. Eleven states (Alaska, Hawaii, Maryland, New Hampshire, New Mexico, North Carolina, 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-seven 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 six states with combination programs (Illinois, 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 (MACPAC uses the term "pregnant women" as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women). 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 above 261 percent FPL up to 317 percent FPL are covered statewide, and children in three counties are covered above 261 percent FPL up to 317 percent FPL through a separate CHIP program.

[7] In Delaware, Florida, Iowa, and Wisconsin, separate CHIP covers children age 1 through 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] 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, 2023, analysis of CMS, 2023, 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, 2023, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2023, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2023, *Medicaid and CHIP eligibility, enrollment, and renewal policies as states prepare for the unwinding of the pandemic-era continuous enrollment provision*, San Francisco, CA: KFF, https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf; 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 2023

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	130	133%
Arizona	106	133
Arkansas	13	133
California	109	133
Colorado	68	133
Connecticut	155	133
Delaware	87	133
District of Columbia	216	210 (age 19–20 only: 216)
Florida	24	Age 19–20 only: 24
Georgia	28	–
Hawaii	105	133
Idaho	19	133
Illinois	133	133
Indiana	15	133
Iowa	44	133
Kansas	33	–
Kentucky	19	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	19	–
Missouri	15	133
Montana	24	133
Nebraska	58	133
Nevada	26	133
New Hampshire	55	133
New Jersey	26	133
New Mexico	37	133
New York	133[3]	133[3]
North Carolina	36	Age 19–20 only: 36
North Dakota	43	133
Ohio	90	133
Oklahoma	33[4]	133[5]
Oregon	33	133

EXHIBIT 36. (continued)

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Pennsylvania	33%	133%
Rhode Island	116	133
South Carolina	95	–[5]
South Dakota	46	133
Tennessee	84	–
Texas	12	–
Utah	36[4]	133[5]
Vermont	43	133
Virginia	49	133
Washington	33	133
West Virginia	16	133
Wisconsin	95	95
Wyoming	45	–

Notes: As of January 2023, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $14,580 for an individual plus $5,140 for each additional family member. Before 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 2023. 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.

– 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 5.

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

EXHIBIT 36. (continued)

[5] 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, 2023, analysis of CMS, 2023, 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, 2023, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2023, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2023, *Medicaid and CHIP eligibility, enrollment, and renewal policies as states prepare for the unwinding of the pandemic-era continuous enrollment provision*, San Francisco, CA: KFF, https://files.kff.org/attachment/REPORT-Medicaid-and-CHIP-Eligibility-Enrollment-and-Renewal-Policies-as-States-Prepare-for-the-Unwinding-of-the-Pandemic-Era-Continuous-Enrollment-Provision.pdf; 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, 2023

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
Alabama	§ 1634	75%	–	–	–	226%
Alaska	SSI criteria	60[6]	–	–	–	181
Arizona	§ 1634	75	–	–	–	226
Arkansas	§ 1634	75	–	80% (aged only)	9%	226
California	§ 1634	75	–	138[7]	43	–
Colorado	§ 1634	75	–	–	–	226
Connecticut	§ 209(b)	–	58%	–	58	226
Delaware	§ 1634	75	–	–	–	188
District of Columbia	§ 1634	75	–	100	64	226
Florida	§ 1634	75	–	88	15	226
Georgia	§ 1634	75	–	–	26	226
Hawaii	§ 209(b)	–	65	100	34	–
Idaho	SSI criteria	75	–	78	–	226
Illinois	§ 209(b)	–	100	100	100	–
Indiana	§ 1634	75	–	100	–	226
Iowa	§ 1634	75	–	–	40	226
Kansas	SSI criteria	75	–	–	39	226
Kentucky	§ 1634	75	–	–	18	226
Louisiana	§ 1634	75	–	–	8	226
Maine	§ 1634	75	–	100	26	226
Maryland	§ 1634	75	–	–	29	226
Massachusetts[8]	§ 1634	75	–	100 (aged); 133 (disabled)	43	226
Michigan	§ 1634	75	–	100	34	226
Minnesota	§ 209(b)	–	100	100	40	226
Mississippi	§ 1634	75	–	–	–	226
Missouri	§ 209(b)	–	85	85	85	132
Montana	§ 1634	75	–	75	43	–
Nebraska	SSI criteria	75	–	100	32	–

EXHIBIT 37. (continued)

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
Nevada	SSI criteria	75%	–	–	–	226%
New Hampshire	§ 209(b)	–	76%	–	73%	226
New Jersey	§ 1634	75	–	100%	30	226
New Mexico	§ 1634	75	–	–	–	226
New York	§ 1634	75	–	–	138	–
North Carolina	§ 1634	75	–	100	20	–
North Dakota	§ 209(b)	–	83	–	83[9]	–
Ohio	§ 1634	75	–	–	–	226
Oklahoma	SSI criteria	75	–	100	–	226
Oregon	SSI criteria	75	–	–	–	226
Pennsylvania	§ 1634	75	–	100	35	226
Rhode Island	§ 1634	75	–	100	90	226
South Carolina	§ 1634	75	–	100	–	226
South Dakota	§ 1634	75	–	–	–	226
Tennessee	§ 1634	75	–	–	–	226
Texas	§ 1634	75	–	–	–	226
Utah	SSI criteria	75	–	100	100	226
Vermont	§ 1634	75	–	–	96	226
Virginia	§ 209(b)	–	75	80	50	226
Washington	§ 1634	75	–	–	75	226
West Virginia	§ 1634	75	–	–	16	226
Wisconsin	§ 1634	75	–	82	100	226
Wyoming	§ 1634	75	–	–	–	226

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 2023, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $14,580 for an individual and $5,140 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.

EXHIBIT 37. (continued)

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.

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 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 from last year because the FPL increased by 7.3 percent but the SSI federal benefit rate increased by 8.7 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. Four states (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 226 percent FPL in 2023). 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] California disregards income between 100 percent and 138 percent of FPL, effectively raising the poverty level income limit to 138 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 44 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, 2023, analysis of eligibility information from state websites and Medicaid state plans as of November 2023.

EXHIBIT 38. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2023

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%	$14,580	$19,720	$24,860	$30,000	$5,140	$1,215	$1,643	$2,072	$2,500	$428
	133	19,391	26,228	33,064	39,900	6,836	1,616	2,186	2,755	3,325	570
	138	20,120	27,214	34,307	41,400	7,093	1,677	2,268	2,859	3,450	591
	150	21,870	29,580	37,290	45,000	7,710	1,823	2,465	3,108	3,750	643
	185	26,973	36,482	45,991	55,500	9,509	2,248	3,040	3,833	4,625	792
	200	29,160	39,440	49,720	60,000	10,280	2,430	3,287	4,143	5,000	857
	250	36,450	49,300	62,150	75,000	12,850	3,038	4,108	5,179	6,250	1,071
	300	43,740	59,160	74,580	90,000	15,420	3,645	4,930	6,215	7,500	1,285
	400	58,320	78,880	99,440	120,000	20,560	4,860	6,573	8,287	10,000	1,713
Alaska	100%	$18,210	$24,640	$31,070	$37,500	$6,430	$1,518	$2,053	$2,589	$3,125	$536
	133	24,219	32,771	41,323	49,875	8,552	2,018	2,731	3,444	4,156	713
	138	25,130	34,003	42,877	51,750	8,873	2,094	2,834	3,573	4,313	739
	150	27,315	36,960	46,605	56,250	9,645	2,276	3,080	3,884	4,688	804
	185	33,689	45,584	57,480	69,375	11,896	2,807	3,799	4,790	5,781	991
	200	36,420	49,280	62,140	75,000	12,860	3,035	4,107	5,178	6,250	1,072
	250	45,525	61,600	77,675	93,750	16,075	3,794	5,133	6,473	7,813	1,340
	300	54,630	73,920	93,210	112,500	19,290	4,553	6,160	7,768	9,375	1,608
	400	72,840	98,560	124,280	150,000	25,720	6,070	8,213	10,357	12,500	2,143

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%	$16,770	$22,680	$28,590	$34,500	$5,910	$1,398	$1,890	$2,383	$2,875	$493
	133	22,304	30,164	38,025	45,885	7,860	1,859	2,514	3,169	3,824	655
	138	23,143	31,298	39,454	47,610	8,156	1,929	2,608	3,288	3,968	680
	150	25,155	34,020	42,885	51,750	8,865	2,096	2,835	3,574	4,313	739
	185	31,025	41,958	52,892	63,825	10,934	2,585	3,497	4,408	5,319	911
	200	33,540	45,360	57,180	69,000	11,820	2,795	3,780	4,765	5,750	985
	250	41,925	56,700	71,475	86,250	14,775	3,494	4,725	5,956	7,188	1,231
	300	50,310	68,040	85,770	103,500	17,730	4,193	5,670	7,148	8,625	1,478
	400	67,080	90,720	114,360	138,000	23,640	5,590	7,560	9,530	11,500	1,970

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services (HHS) 2023 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, 2023, Annual update of the HHS poverty guidelines, *Federal Register* 88, no. 12 (January 19): 3424–3425.

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 wellness visit within the past year 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 (Exhibit 42). 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 (Exhibits 42).
- Children with Medicaid or CHIP are less likely than those with private coverage but more likely than those who are uninsured to have had a dental care visit in the past 12 months (Exhibit 41).
- Adults age 19 to 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 to 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 44–46).
- Adults age 19 to 64 whose primary coverage is Medicaid are less likely to report having a usual source of care than those with private and Medicare coverage (Exhibit 47). Among adults age 19 to 64 with health coverage (i.e., excluding the uninsured), adults whose primary coverage source is Medicaid report lower rates of delayed care due to cost compared to those with Medicare coverage but higher than those with private insurance (Exhibit 47).
- Children and adults age 19 to 64 whose primary coverage is Medicaid or CHIP are as likely to report not having difficulty reaching their usual medical provider by phone during business hours as those covered by private insurance but are more likely to report having a difficult time reaching their usual medical provider after hours for urgent medical needs compared to those with private insurance (Exhibits 43 and 48).
- 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, 2022

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%**	**54.6%**	**36.8%**	**4.2%**
Coverage				
Length of time with any coverage during the year				
Full year	**94.6***	98.2	97.9	–
Part year	**3.1***	1.8	2.1	35.3*
No coverage during year	**2.3***	–	–	64.7*
Demographics				
Age				
0–5	**29.5***	27.0*	33.5	25.1*
6–11	**31.1**	31.3	30.5	31.2
12–18	**39.3***	41.6*	36.0	43.7*
Gender				
Male	**51.1**	51.8	50.6	52.0
Female	**48.9**	48.2	49.4	48.0
Race				
Hispanic	**25.6***	16.8*	36.9	43.0
White, non-Hispanic	**51.0***	64.2*	32.7	41.2*
Black, non-Hispanic	**12.4***	7.5*	20.5	7.0*
American Indian, non-Hispanic	**†**	†	†	†
Asian, non-Hispanic	**4.6***	5.5*	3.4	5.0
Other single and multiple races, non-Hispanic	**5.4**	5.6	4.9	†
Parents present in family				
0 parents	**2.3***	0.6*	4.8	†
1 parent	**27.9***	17.8*	43.3	28.6*
2 or more parents	**69.8***	81.6*	51.9	69.9*
Family income				
Has income less than 138 percent FPL	**25.3***	5.4*	54.9	32.5*
Has income in ranges shown below				
Less than 100 percent FPL	**15.4***	2.9*	34.0	21.6*
100–199 percent FPL	**22.1***	9.2*	40.4	25.1*
200–399 percent FPL	**29.0***	32.9*	21.2	37.6*
400 percent FPL or higher	**33.5***	55.0*	4.4	15.7*

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	**97.1%**	98.5%*	97.1%	80.2%*
Born outside U.S.	**4.4**	2.8*	4.6	21.9*
Number of years spent in the U.S. (among those born outside U.S.)				
Less than 5 years	**45.4**	33.9	45.0	66.1*
5–9 years	**36.4**	40.1	35.9	28.8
10 years or more	**18.3**	25.9	19.1	†
Lives in a family that receives				
SSI or SSDI	**6.1***	2.5*	11.7	†
SSI	**3.1***	0.9*	6.7	†
SSDI	**3.7***	1.8*	6.5	†
WIC	**12.8***	3.1*	28.0	9.1*
SNAP	**23.3***	6.1*	51.3	10.4*
Public assistance	**6.8***	1.9*	14.5	†
Any school-aged child in family received free or reduced-cost meals at school in past 12 months	**59.6***	45.9*	80.9	56.5*
Health				
Current health status				
Excellent or very good	**86.0***	90.6*	79.5	81.1
Good	**11.2***	7.9*	15.5	16.0
Fair or poor	**2.8***	1.4*	5.0	†
School days lost due to illness or injury, past 12 months				
None	**35.2***	31.3*	39.7	48.8*
1 day	**7.4**	8.2	6.6	†
2–5 days	**34.9***	38.2*	29.4	27.5
6–10 days	**13.4**	14.1	12.7	13.7
11–20 days	**6.4***	6.0*	7.8	†
Over 20 days	**2.8***	2.3*	3.8	†
Special needs, impairments, and health conditions				
Receives special education or early intervention services[6]	**9.9***	8.6*	12.9	†
Uses a hearing aid	**0.7**	0.5	1.0	†
Uses special equipment for walking	**0.7**	0.4*	1.0	†

EXHIBIT 39. (continued)

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Uses glasses	**25.0%**	25.3%	25.2%	21.9%
Washington Group on Disability Statistics indicator for kids 2–4[7]	**4.3***	†	6.6	†
Washington Group on Disability Statistics indicator for kids 5–17[7]	**13.4***	11.8*	17.2	7.9*
Ever been told he or she has selected conditions				
ADHD/ADD[8]	**9.7**	9.3	10.7	6.3*
Asthma	**10.4***	9.2*	12.7	9.0
Autism[8]	**3.8**	3.4	4.4	†
Diabetes	**0.4**	0.3	†	–
Intellectual disability[6]	**1.7**	1.6	1.9	†
Other developmental delay[6]	**5.4***	4.5*	6.7	†

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 in the Excel version of this exhibit at https://www.macpac.gov/publication/coverage-demographic-and-health-characteristics-of-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

The NHIS underwent a substantial 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, or 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.

EXHIBIT 39. (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 (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] This measure is different from previous measures of disability and special health care needs among children published in prior measures of MACStats. Washington Group on Disability Statistics questions focus on several domains of functioning that identify children who are at greater risk than the general population of experiencing restrictions in participation because of difficulties performing certain universal, basic actions. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

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

Source: MACPAC, 2023, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2022, 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%**	**54.6%**	**36.8%**	**4.2%**
Contact with health care professionals (past 12 months)				
Saw selected health professional				
Saw doctor or other health care professional	**93.9***	94.5	95.0	75.3*
Had eye exam	**40.4**	42.6*	38.6	30.5*
Received counseling/therapy from mental health professional[6]	**12.5**	13.1	12.7	7.3*
Dental exam/cleaning[7]	**82.1***	85.2*	79.6	57.5*
Had at least 1 overnight hospital stay[7]	**2.6***	2.1*	3.5	†
Used prescription medication	**35.9**	35.8	37.4	23.8*
Had a medical appointment by video or phone	**16.5**	18.2*	15.0	10.3*
Receipt of appropriate care (past 12 months)				
Interval since last wellness visit[8]				
Within the past year	**92.5**	92.7	93.6	78.5*
More than 1 year ago but less than 2 years	**5.6**	5.7	4.9	11.4*
More than 2 years ago	**1.8**	1.6	1.4	9.2*
Never	**†**	†	†	†
Number of emergency room visits				
None	**83.7***	88.0*	77.2	88.3*
At least 1	**16.3***	12.0*	22.8	11.7*
1	**11.0***	8.9*	14.3	8.3*
2–3	**4.3***	2.6*	6.7	†
4 or more	**0.9***	0.5*	1.7	†
Number of urgent care visits				
None	**70.9**	68.5*	73.1	81.5*
At least 1	**29.1**	31.5*	26.9	18.5*
1	**16.1***	18.2*	13.9	10.8
2–3	**10.3**	10.8	9.9	†
4 or more	**2.7**	2.5	3.2	†

EXHIBIT 40. (continued)

Notes: NHIS is National Health Interview Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not sum to 100 percent. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-data-from-national-health-interview-survey/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the NHIS is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

The NHIS underwent a substantial 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, or 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.

[8] Prior versions of MACStats reported whether an individual received a well-child visit in the past year. This version of MACStats reports the time that has elapsed since the individual's last well-child visit.

Source: MACPAC, 2023, analysis of NHIS data.

EXHIBIT 41. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2021, 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%**	**56.2%**	**36.7%**	**5.1%**
Child has special health care needs	**14.1**	13.3	15.8	9.8*
Contact with health care professionals (past 12 months)				
Number of office-based visits to a doctor or other health professional, excluding dental visits and inpatient hospital stays				
None	**27.3***	20.3*	35.1	44.4
At least 1	**72.7***	79.7*	64.9	55.6
1	**21.4***	20.1*	24.0	17.7*
2–3	**23.4**	25.2*	21.3	19.5
4 or more	**27.9***	34.4*	19.6	18.3
Had at least 1 dental care visit[6]	**50.6***	58.7*	41.8	24.7*
Received care at home	**1.3***	0.8*	2.1	†
Receipt of appropriate care (past 12 months)				
Had more than 15 office-based or hospital outpatient visits	**5.4**	6.1	4.6	†
Annual total number of days received visits from paid/unpaid home health care providers				
None	**98.7**	99.2*	97.9	97.8
1	**†**	†	†	†
2–30	**0.9**	†	1.4	†
31–90	**†**	†	†	†
91–200	**†**	†	†	†
More than 200	**†**	†	†	†
Number of emergency room visits				
None	**91.4***	93.6*	88.1	93.3*
At least 1	**8.6***	6.4*	11.9	6.7*
1	**7.2***	5.6*	9.5	†
2–3	**1.4***	0.7*	2.3	†
4 or more	**†**	†	†	†
Had at least 1 overnight hospital stay	**1.4**	1.0*	2.0	†

EXHIBIT 41. (continued)

Characteristics	Primary coverage source at time of most recent interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Count of all prescribed medications purchased during the year, including initial purchases and refills				
None	**69.1%**	68.2%	68.4%	81.0%*
1	**10.9**	11.8	10.3	†
2	**5.5**	5.9	5.2	†
3–5	**6.6**	6.8	6.5	†
6–2	**4.5**	4.5	5.2	†
13–24	**2.1**	1.6*	2.7	†
More than 24	**1.3**	1.1	1.6	†

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-data-from-medical-expenditures-panel-survey/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the MEPS. For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

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

[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, or 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 to other dental measures included in databooks before 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, 2023, analysis of MEPS data.

EXHIBIT 42. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2022, 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%**	**54.6%**	**36.8%**	**4.2%**
Connection to the health care system (past 12 months)				
Has a usual source of care[6]	**96.8**	98.3*	96.5	78.6*
Kind of usual place for medical care				
Doctor's office or health center	**95.8**	96.5	95.7	87.9*
Urgent care/ walk-in clinic	**3.7**	3.3	3.7	8.1*
Other	**0.5**	†	†	†
Timeliness of care (past 12 months)				
Delayed medical care because of costs	**1.2**	0.7	0.9	10.6*
Delayed getting dental care	**4.4**	3.0	3.7	26.6*
Delayed filling prescription to save money	**1.7**	1.9	†	†
Unmet need for selected types of care due to cost				
Medical care	**0.9**	0.4	0.7	8.5*
Mental health care or counseling[7]	**1.0**	0.9	0.6	†
Dental care[8]	**3.1**	1.9*	3.2	17.0*
Prescription drugs	**0.9**	0.9	0.8	†
Problems paying or unable to pay medical bills, past 12 months	**11.9***	9.1*	15.4	16.9

Notes: NHIS is National Health Interview Survey. Percentage calculations for each item in the table exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not sum to 100 percent. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/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 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 a substantial 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.

EXHIBIT 42. (continued)

[1] Total includes all non-institutionalized children under age 19, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or 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] 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, 2023, analysis of NHIS data.

EXHIBIT 43. Access to and Experience of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2021, 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%**	**56.2%**	**36.7%**	**5.1%**
Access to Care				
Has usual place for medical care	**86.1**	88.3	86.3	63.8*
Travel time to usual source of care				
Less than 15 minutes	**63.4**	63.2	63.4	62.2
15–30 minutes	**28.6**	29.2	27.8	30.9
31–60 minutes	**7.2**	6.8	7.8	†
More than an hour	**0.9**	†	†	†
Difficulty reaching usual medical provider by phone during business hours				
Very difficult	**2.9**	2.4	3.6	†
Somewhat difficult	**12.0**	9.5*	14.6	†
Not too difficult	**27.7**	30.0*	24.6	22.5
Not at all difficult	**57.5**	58.0	57.2	50.9
Difficulty reaching usual medical provider after hours for urgent medical needs				
Very difficult	**16.6***	11.6*	22.4	37.0
Somewhat difficult	**18.2**	18.6	18.7	†
Not too difficult	**29.8***	33.8*	23.5	29.2
Not at all difficult	**35.3**	36.1	35.5	25.8
Usual medical provider has night or weekend availability	**47.6**	51.1*	44.0	36.2
Usual medical provider speaks preferred language or provides translator, among those with limited English abilities in family	**88.8**	100.0	83.7	100.0
Usual medical provider asks person to help decide between choice of treatments				
Never	**5.5***	3.2*	9.0	†
Sometimes	**10.6**	9.0*	12.5	†
Usually	**16.5**	18.0	14.4	11.4
Always	**67.3**	69.8*	64.1	69.0
Usual medical provider presents and explains all options	**97.7**	98.2	96.7	99.4*

EXHIBIT 43. (continued)

Notes: MEPS is the Medical Expenditure Panel Survey. Access to care variables are fielded for only a subset of MEPS respondents (to be eligible to receive the access to care section questions, individuals had to be current, non-institutionalized members of the responding unit in round two for panel members in relative year one and round four for panel members in relative year two). 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/exhibit-43-access-to-and-experience-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-meps-data/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the MEPS. For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

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

[1] Total includes all non-institutionalized individuals age 0–18, 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, or 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 (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

Source: MACPAC, 2023, analysis of MEPS data.

EXHIBIT 44. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2022

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%**	**4.2%**	**66.8%**	**13.1%**	**12.6%**
Coverage					
Length of time with any coverage during year					
Full year	**84.2***	97.9*	95.5*	93.5	–
Part year	**7.1**	2.1*	4.5*	6.5	25.8*
No coverage during year	**8.7***	–	–	–	74.2*
Demographics					
Age					
19–25	**14.8***	3.9*	13.7*	21.4	17.1*
26–44	**42.8***	16.7*	41.9*	47.6	52.1*
45–54	**20.7***	21.6*	22.4*	14.5	17.8*
55–64	**21.7***	57.8*	22.1*	16.6	13.0*
Gender					
Male	**49.5***	50.0*	50.3*	37.1	57.3*
Female	**50.5***	50.0*	49.7*	62.9	42.7*
Sexual orientation					
Heterosexual	**94.5***	94.7	94.6*	92.7	95.8*
Lesbian/gay	**2.3**	2.3	2.6	2.4	1.2*
Bisexual	**3.2***	2.9*	2.8*	4.9	3.0*
Race					
Hispanic	**19.4***	12.1*	14.4*	24.4	44.0*
White, non-Hispanic	**58.6***	64.2*	65.4*	43.4	35.4*
Black, non-Hispanic	**12.6***	16.7	10.4*	20.1	13.6*
American Indian, non-Hispanic	**0.8**	†	0.4	†	1.4
Asian, non-Hispanic	**6.4**	3.9*	7.2	6.6	3.5*
Other single and multiple races, non-Hispanic	**2.3**	2.3	2.1*	3.1	2.0

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Marital status					
Married	**51.2%***	41.4%*	58.5%*	28.4%	37.7%*
Widowed	**1.7***	6.1*	1.2*	2.5	1.7*
Divorced or separated	**9.0***	19.0*	7.6*	12.3	9.1*
Living with partner	**10.9***	7.0*	9.3*	14.6	18.3*
Never married	**27.3***	26.6*	23.5*	42.3	33.2*
Family income					
Less than 138 percent FPL	**17.0***	40.5*	5.9*	51.7	33.3*
Has income in ranges below					
Less than 100 percent FPL	**10.1***	24.4*	3.1*	32.9	19.5*
100–199 percent FPL	**16.9***	33.5	9.2*	37.2	31.2*
200–399 percent FPL	**28.3***	25.3	28.3*	22.7	33.6*
400 percent FPL or higher	**44.7***	16.8*	59.4*	7.2	15.7*
Education					
Less than high school	**9.5***	19.4	4.1*	20.1	25.1*
High school diploma/GED	**26.4***	39.6	21.3*	37.7	38.3
Some college	**29.9**	28.1	30.1	31.9	24.7*
College or graduate degree	**34.2***	12.9	44.5*	10.3	11.9
Other demographic characteristics					
Citizen of United States	**90.4**	95.9*	94.1*	89.5	67.7*
Born outside U.S.	**19.8**	13.1*	16.7*	21.3	40.0*
Number of years spent in the U.S. (among those born outside U.S.)					
Less than 5 years	**8.9**	†	7.0*	11.4	13.4
5–9 years	**15.0**	†	13.0	16.4	19.9
10 years or more	**76.1**	95.2*	80.1*	72.2	66.7

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Parent of a dependent child	**34.0%***	12.4%*	33.3%*	42.7%	36.1%*
Currently working	**76.9***	16.4*	86.5*	53.7	72.3*
Working full time (usually works 35 hours or more per week)	**87.9***	91.4*	89.9*	80.7	84.8*
Working part time (less than 35 hours per week)	**11.9***	8.4*	10.0*	19.1	14.7*
Veteran	**5.2***	6.9*	4.1*	1.8	2.9*
Lives in a family that receives					
SSI or SSDI	**8.8***	70.9*	3.6*	20.1	5.2*
SSI	**3.8***	23.7*	1.6*	11.2	2.5*
SSDI	**6.0***	59.8*	2.4*	11.0	3.1*
WIC	**6.5***	8.1*	3.0*	19.2	11.6*
SNAP	**14.1***	35.2*	5.1*	52.0	18.1*
Public assistance	**4.0***	10.2*	1.6*	14.5	4.4*
Any school-aged child in family received free or reduced-cost meals at school in past 12 months	**56.7***	72.6	46.5*	82.0	71.5*
Health					
Current health status					
Excellent or very good	**59.3***	17.8*	65.9*	42.7	56.2*
Good	**28.6***	29.6*	26.9*	34.1	30.5*
Fair or poor	**12.1***	52.7*	7.2*	23.2	13.3*
BMI					
Healthy weight (BMI less than 25)	**32.4**	23.5*	33.5	32.4	29.8
Overweight (BMI 25–29)	**33.2***	30.9	33.8*	29.4	35.0*
Obese (BMI 30 or higher)	**34.4***	45.6*	32.8*	38.1	35.2
Smoking status					
Current smoker	**12.7***	25.0	9.0*	21.7	19.7
Former smoker	**19.1***	25.8*	19.7*	16.5	15.7

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Never smoked	**68.2%***	49.2%*	71.4%*	61.7%	64.6%
Current e-cigarette user	**7.4***	4.6*	6.6*	11.3	8.7*
Former e-cigarette user	**16.4***	18.3	15.5*	19.4	16.6*
Never used e-cigarettes	**76.1***	77.2*	77.8*	69.3	74.7*
Limitations and health conditions					
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[6]	**10.6***	50.2*	6.3*	21.9	8.4*
Any complex activity limitation[7]	**17.7***	82.0*	10.9*	33.3	14.0*
Either one	**20.7***	82.8*	13.6*	38.4	17.1*
Washington Group on Disability Statistics indicator for adults 18 and older[8]	**6.6***	38.7*	3.4*	14.3	4.6*
Has difficulty walking 100 yards without equipment	**3.1***	26.3*	1.0*	8.0	1.6*
Has mobility or hearing problem that requires special equipment	**4.4***	29.7*	2.6*	7.1	2.3*
Unable to work now due to health problem	**6.7***	63.1*	1.5*	17.9	3.5*
Limited in amount or kind of work due to health	**16.1***	75.0*	10.1*	29.4	12.4*
Needs assistance with dressing and bathing	**0.7***	5.5*	0.2*	1.9	†
Work loss days due to illness or injury in past 12 months					
0 days	**50.8**	55.2	48.9	51.7	60.6*
1 day	**6.2**	†	6.6	5.1	4.3
2–5 days	**24.3**	19.3	25.8*	21.9	18.0*
6–10 days	**9.1**	†	9.5	8.6	7.7
11–20 days	**5.1**	†	4.9	5.8	5.1
More than 20 days	**4.6***	12.4	4.2*	6.9	4.3*
Health conditions					
Currently pregnant[9]	**2.7**	–	2.7	3.6	†

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Ever been told he or she has selected conditions					
Hypertension	**23.9***	55.3*	22.5*	26.8	17.1*
Coronary heart disease	**2.1***	10.1*	1.6*	2.8	1.2*
Heart attack	**1.5%***	8.5%*	1.0%*	2.2%	0.8%*
Stroke	**1.4***	8.8*	0.7*	3.4	1.2*
Cancer	**5.1***	12.2*	5.4*	3.6	1.8*
Diabetes	**6.7***	24.8*	5.7*	8.9	4.1*
Arthritis	**14.4***	47.0*	12.7*	17.8	7.0*
Asthma	**15.2***	22.6	14.4*	20.9	11.6*
Chronic bronchitis, COPD, or emphysema	**3.1***	17.2*	1.8*	6.7	1.8*
Dementia	**0.2***	†	†	†	†
High cholesterol	**20.2***	46.7*	20.2	18.4	12.5*
Anxiety disorder	**19.3***	40.4*	17.1*	28.7	11.4*
Depression	**18.8***	45.3*	16.0*	29.5	11.8*

Notes: FPL is federal poverty level. GED is general educational development test. 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 add to 100 percent. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/exhibit-44-coverage-demographic-and-health-characteristics-of-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the Medical Expenditures Panel Survey (MEPS). For purposes of comparing groups of individuals (as in this exhibit), the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

The NHIS underwent a substantial 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.

EXHIBIT 44. (continued)

[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, or 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] Captures limitations or difficulties in movement (walking, reaching overhead, and using the hands and fingers) and limitations or difficulties in sensory (seeing or hearing), emotional (serious psychological distress), and cognitive difficulties. Because composite measures of mental health are available on a rotating basis starting in 2019, this measure may not be directly comparable to prior MACStats exhibits.

[7] 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."

[8] Washington Group on Disability Statistics questions focus on several domains of functioning that identify individuals who are at greater risk than the general population of experiencing restrictions in participation because of difficulties performing certain universal, basic actions, which include trouble with vision, trouble with hearing, difficulty walking or climbing steps, difficulty communicating in usual language, difficulty washing or dressing, or difficulty remembering or concentrating.

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

Source: MACPAC, 2023, analysis of NHIS data.

EXHIBIT 45. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2022, 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%**	**4.2%**	**66.8%**	**13.1%**	**12.6%**
Contact with health care professionals (past 12 months)					
Saw selected health professionals in past year					
Saw doctor or other health care professional[6]	**79.8***	92.0*	83.1	83.0	52.4*
Received counseling/therapy from mental health professional	**14.5***	27.4*	13.6*	20.1	6.6*
Now sees a counselor, psychiatrist, psychologist, or social worker regularly (among those who have received counseling)	**63.9**	76.7	61.4*	68.6	51.4*
Had at least 1 overnight hospital stay	**7.0***	17.6*	5.3*	13.8	4.3*
Received care at home	**1.8***	11.9*	1.2*	3.1	†
Used prescription medication	**61.8***	89.8*	64.4	64.7	34.4*
Had a medical appointment by video or phone	**30.1***	46.2*	31.6	33.7	11.2*
Dental exam	**62.7***	49.1	70.8*	49.2	36.7*
Eye exam	**45.7***	50.6*	50.4*	39.3	24.2*
Receipt of appropriate care (past 12 months)					
Had flu shot					
All individuals	**40.7***	51.9*	45.5*	33.7	17.5*
Individuals age 50–64	**50.3***	56.5*	53.4*	44.8	22.9*
Interval since last wellness visit					
Within the past year	**73.5***	88.2*	76.5	78.1	45.2*
More than 1 year ago but less than 2 years	**11.9**	4.5*	11.7	10.6	17.5*
2–5 years	**9.5***	4.1*	8.4	7.8	19.4*
5–10 years	**2.5**	†	1.7	1.9	7.9*
More than 10 years ago	**2.2***	†	1.5	1.4	7.9*
Never	**0.5**	†	0.3	†	2.0*

EXHIBIT 45. (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	**81.1%***	66.0%	85.1%*	66.4%	81.8%*
At least 1	**18.9***	34.0	14.9*	33.6	18.2*
1	**12.2***	19.6	10.5*	18.5	11.7*
2–3	**5.2***	9.3	3.7*	11.1	5.3*
4 or more	**1.4***	5.1	0.7*	4.0	1.2*
Number of urgent care visits					
None	**65.8**	70.8*	63.2	64.6	78.1*
At least 1	**34.2**	29.2*	36.8	35.4	21.9*
1	**18.1***	12.4	20.1*	14.8	12.5
2–3	**12.4***	11.3*	12.9*	15.7	7.7*
4 or more	**3.7***	5.4	3.8	4.8	1.8*

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 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-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 a substantial 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, or 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.

EXHIBIT 45. (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 or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

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

Source: MACPAC, 2023, analysis of NHIS data.

EXHIBIT 46. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2021, 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%**	**3.8%**	**68.7%**	**12.7%**	**12.6%**
Contact with health care professionals (past 12 months)					
Number of office-based visits to a doctor or other health professional, excluding dental visits and inpatient hospital stays					
None	**25.9***	11.4*	20.8*	30.0	55.6*
At least 1	**74.1***	88.6*	79.2*	70.0	44.4*
1	**13.5**	8.7*	13.4	14.0	14.2
2–3	**19.6**	15.2	20.9*	17.4	14.8
4 or more	**41.0**	64.7*	44.9*	38.5	15.4*
Had at least 1 dental care visit[6]	**38.8***	31.3*	46.5*	22.6	15.9*
Received care at home	**1.6***	13.6*	0.8*	3.2	†
Receipt of appropriate care					
Had more than 15 office-based or hospital outpatient visits	**12.7***	29.4*	13.0	14.9	2.9*
Annual total of days received visits from paid/unpaid home health care providers					
None	**98.4***	86.4*	99.2*	96.8*	99.4*
1	**0.3**	†	†	†	†
2–30	**0.6**	4.0*	0.5	0.9	†
31–90	**0.2***	2.1*	†	†	†
91–200	**0.1**	†	†	†	†
More than 200	**0.3***	4.8*	†	0.9	†
Number of emergency room visits					
None	**89.0***	75.2	91.1*	79.1	92.8*
At least 1	**11.0***	24.8	8.9*	20.9	7.2*
1	**8.4***	17.1	7.1*	14.8	5.7*
2–3	**2.2***	6.4	1.7*	4.6	1.4*
4 or more	**0.4***	†	0.2*	1.4	†
Had at least 1 overnight hospital stay	**4.9***	12.4	4.1*	9.5	2.3*

EXHIBIT 46. (continued)

Characteristics	Primary coverage source at time of most recent interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Count of all prescribed medications purchased during the year, including initial purchases and refills					
None	**44.4%***	10.2%*	43.0%*	39.2%	69.6%*
1	**7.9**	2.0*	8.3	8.0	7.1
2	**5.3**	2.5*	5.6	5.6	3.6*
3–5	**10.2***	9.9	11.2*	8.6	6.8
6–12	**13.4**	12.7	14.8*	12.1	6.3*
13–24	**9.4**	18.0*	10.0	8.6	4.1*
More than 24	**9.4***	44.6*	7.0*	17.9	2.5*

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage-data-from-medical-expenditures-panel-survey/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the MEPS. For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

† 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, or 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.

EXHIBIT 46. (continued)

[6] This measure should not be compared to other dental measures included in databooks before 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, 2023, analysis of MEPS data.

EXHIBIT 47. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2022, 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%**	**4.2%**	**66.8%**	**13.1%**	**12.6%**
Connection to the health care system (past 12 months)					
Has a usual source of care[6]	**85.1**	93.0*	89.2*	86.5	56.9*
Kind of usual place for medical care					
Doctor's office or health center	**87.8**	93.5*	89.8	88.3	77.5*
Urgent care/ walk-in clinic	**9.9**	3.7*	9.3	11.0	19.1*
Veterans Affairs facility	**1.5***	2.5*	0.4	†	†
Other	**0.8**	†	0.6	†	3.1*
Timeliness of care (past 12 months)					
Delayed because of costs	**8.4**	9.9*	5.7*	7.3	25.0*
Delayed getting dental care	**20.8***	29.5	14.5*	26.9	45.8*
Delayed filling prescription to save money	**6.6**	9.9	5.2*	7.7	17.4*
Unmet need for selected types of care due to cost					
Medical care	**7.5**	9.6	4.8*	7.8	22.1*
Mental health care or counseling	**6.2**	6.8	5.4*	7.1	9.5*
Dental care	**16.8***	28.1	11.2*	25.3	35.1*
Prescription drugs	**5.9**	12.8*	4.5*	6.9	10.9*
Problems paying or unable to pay medical bills, past 12 months	**11.6**	23.1*	9.5*	12.1	19.4*
Other barriers to care in the past 12 months					
Lack of transportation kept you from medical appointments, meetings, work, other needs for daily living	**6.1***	13.0	3.8*	14.5	7.8*

Notes: NHIS is National Health Interview Survey. Percentage calculations for each item in the table exclude individuals with missing and unknown values. The individual components listed under the subcategories are not mutually exclusive and may not sum to 100 percent. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/measures-of-access-to-care-for-non-institutionalized-individuals-age-19-64-by-source-of-health-coverage/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the NHIS is known to produce higher estimates of service use than the Medical

EXHIBIT 47. (continued)

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 a substantial 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, or 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] Excludes emergency room.

Source: MACPAC, 2023, analysis of NHIS data.

EXHIBIT 48. Access to and Experience of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2021, 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%**	**3.8%**	**68.7%**	**12.7%**	**12.6%**
Access to Care					
Has usual place for medical care	**66.4**	86.0*	69.7	68.4	37.6*
Travel time to usual source of care					
Less than 15 minutes	**58.4**	53.3	59.1	58.4	59.6
15–30 minutes	**32.7**	32.6	32.8	33.0	30.3
31–60 minutes	**7.4**	10.7*	6.8	6.8	8.5
More than an hour	**1.5**	3.5	1.2	1.8	†
Difficulty reaching usual medical provider by phone during business hours					
Very difficult	**4.6**	6.4	4.1	5.6	6.3
Somewhat difficult	**13.6**	12.2	12.9	16.3	14.9
Not too difficult	**31.5**	29.7	31.8	31.3	32.6
Not at all difficult	**50.3**	51.7	51.2	46.7	46.2
Difficulty reaching usual medical provider after hours for urgent medical needs					
Very difficult	**24.8***	24.7*	22.3*	32.2	32.4
Somewhat difficult	**20.6**	15.1*	21.0	21.6	20.7
Not too difficult	**25.4***	22.8	26.7*	21.1	23.7
Not at all difficult	**29.2**	37.4*	30.0*	25.1	23.3
Usual medical provider has night or weekend availability	**32.3**	24.1*	33.8	30.7	29.9
Usual medical provider speaks preferred language or provides translator, among those with limited English abilities in family	**93.2**	99.2*	93.4	89.4	95.6

EXHIBIT 48. (continued)

Characteristics	Primary coverage source at time of most recent interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Usual medical provider asks person to help decide between choice of treatments					
Never	**7.4%***	13.0%	5.8%*	12.6%	9.3%
Sometimes	**13.7***	15.7	12.0*	19.0	21.3
Usually	**21.9***	22.8	22.7*	17.6	19.2
Always	**57.1***	48.5	59.4*	50.7	50.2
Usual medical provider presents and explains all options	**96.5***	94.4	97.0*	94.0	97.2*
Experience with care					
How often providers give easy-to-understand information					
Always	**69.6***	57.1	71.9*	62.2	66.9
Most of the time or usually	**25.4**	35.7*	24.7	27.0	22.3
Some of the time or sometimes	**4.1***	6.8	3.0*	8.7	6.5
None of the time or never	**0.9**	†	0.5*	†	†
Doctor gave instructions, past 12 months	**71.2**	82.8*	71.1	69.7	61.8*

Notes: MEPS is the Medical Expenditure Panel Survey. Access to care variables are fielded for only a subset of MEPS respondents (to be eligible to receive the access to care section questions, individuals had to be current, non-institutionalized members of the responding unit in round two for panel members in relative year one and round four for panel members in relative year two). 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/exhibit-48-access-to-and-experience-of-care-among-non-institutionalized-individuals-age-19-64-by-primary-source-of-health-coverage-meps-data/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the MEPS. For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

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

[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, or 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.

EXHIBIT 48. (continued)

[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.

Source: MACPAC, 2023, analysis of MEPS 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 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 been working 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 considerably 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 all years of TAF data that have been released.[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. Before 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 before 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. Before 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, although the measure remains in the MEPS.

Beginning with the 2022 edition of MACStats, NHIS data are reported using the Washington Group on Disability Statistics measures. The measures describe the functional status of individuals across domains of seeing; hearing; mobility; communication; cognition; self-care; anxiety; depression; dexterity; playing; learning; relationships; and kicking, biting, or hitting others. The questions ask about the level of difficulty in basic domains of functioning and, when used with other questions on the survey, can evaluate if adults and children with functional limitations are able to participate in everyday activities at levels similar to their peers without functional limitations.[12]

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.[13] 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.[14] 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 49.

EXHIBIT 49. 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, 76	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, 76	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, 76	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 Idaho and Virginia appear to classify their new adult group under eligibility code 71, we assign eligibility code 71 to the new adult group for Idaho and Virginia.

[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, pregnancy).

Source: MACPAC, 2023, 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.[15] 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 51). 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 51).

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 incorporated 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 before 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 mapped 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.[16] 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.[17] 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 50 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 51 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).[18]

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, KFF, 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 50. Medicaid Benefit Spending in T-MSIS and CMS-64 Data by State, FY 2021 (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	**$669,408**	**$699,301**	**95.7%**	**$16,961**	**$10,935**
Alabama	5,440	6,257	86.9	409	–
Alaska	2,315	2,146	107.9	25	–
Arizona	16,430	17,403	94.4	124	61
Arkansas	6,544	7,162	91.4	9	–
California[2]	98,822	105,889	93.3	510	3,157
Colorado	9,324	10,568	88.2	219	–
Connecticut	9,377	9,180	102.1	170	–
Delaware	2,757	2,422	113.8	–	–
District of Columbia	3,325	3,254	102.2	104	–
Florida	26,384	26,723	98.7	342	1,067
Georgia	11,882	11,850	100.3	433	–
Hawaii[3]	2,821	2,823	99.9	10	–
Idaho	3,017	2,876	104.9	26	–
Illinois	19,142	26,392	72.5	528	–
Indiana	15,776	15,506	101.7	139	–
Iowa	6,066	5,934	102.2	65	–
Kansas	4,127	3,934	104.9	76	81
Kentucky	13,386	14,238	94.0	266	–
Louisiana	13,055	12,489	104.5	911	–
Maine	3,127	3,398	92.0	58	–
Maryland	13,237	13,278	99.7	189	–
Massachusetts	18,426	19,038	96.8	–	1,044
Michigan	17,204	20,635	83.4	218	–
Minnesota	15,087	14,912	101.2	54	–
Mississippi	5,457	5,523	98.8	235	–
Missouri	10,105	10,607	95.3	908	–
Montana	1,944	2,183	89.1	0	–
Nebraska	2,977	3,035	98.1	30	–
Nevada	4,549	4,666	97.5	95	–
New Hampshire	2,106	2,152	97.8	242	0
New Jersey	18,042	17,990	100.3	1,148	–
New Mexico	6,569	6,844	96.0	34	12
New York	71,901	71,252	100.9	4,162	–

EXHIBIT 50. (continued)

State	Benefit spending totals included in analysis			Amounts excluded from CMS-64 benefit spending totals	
	Unadjusted T-MSIS	CMS-64[1]	T-MSIS as a percentage of CMS-64	DSH	Incentive and uncompensated care pool waivers
North Carolina	$15,577	$16,436	94.8%	$443	–
North Dakota[2]	1,124	1,378	81.5	1	–
Ohio	27,466	26,956	101.9	688	–
Oklahoma	4,830	5,788	83.5	55	–
Oregon	8,439	11,165	75.6	86	–
Pennsylvania	26,935	36,392	74.0	996	–
Rhode Island	2,571	2,809	91.5	142	$67
South Carolina	6,624	6,726	98.5	517	–
South Dakota	1,036	1,004	103.2	1	–
Tennessee	10,611	10,671	99.4	72	417
Texas	38,850	39,271	98.9	1,801	4,854
Utah[2]	3,759	3,528	106.5	30	–
Vermont	1,415	1,533	92.3	23	118
Virginia	18,796	16,008	117.4	-44	–
Washington	14,659	21,652	67.7	205	57
West Virginia	15,531	4,575	339.5	70	–
Wisconsin	9,888	10,253	96.4	138	–
Wyoming	572	598	95.5	0	–

Notes: T-MSIS is Transformed Medicaid Statistical Information System. FY is fiscal year. DSH is disproportionate share hospital. Includes federal and state funds. T-MSIS and CMS-64 data reflect unadjusted amounts as reported by states. Both sources exclude spending on administration, the territories, and Medicaid-expansion CHIP enrollees; in addition, CMS-64 amounts exclude $14.7 billion in offsetting collections from third-party liability, estate, and other recoveries. For greater detail on the difference between T-MSIS and CMS-64, please see the Methodology for Adjusting Benefit Spending Data section. DSH payments and incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act have also been excluded from CMS-64 totals. For informational purposes, the DSH and waiver expenditure amounts that were excluded are shown here.

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

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

[2] State has a state plan amendment (SPA) that allows the state to receive the enhanced federal medical assistance percentage (FMAP) for children enrolled in Medicaid who would have, before 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 $681.9 million, North Dakota's T-MSIS spending by approximately $9.3 million, and Utah's T-MSIS spending by approximately $33.5 million.

[3] The CMS-64 total for Hawaii excludes $0.5 million in fee-for-service (FFS) drug spending because the state did not report any FFS drug spending in T-MSIS.

Source: MACPAC, 2023, analysis of T-MSIS data as of February 2023, and CMS-64 financial management report net expenditure data as of June 2022.

EXHIBIT 51. Service Categories Used to Adjust FY 2021 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 • EHR payments to provider (on hospital claim)	• 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 • Enabling services • Sterilizations	• 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 • COVID-19 vaccines and administration • MAT treatment services for OUD • Care not otherwise categorized

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
Non-hospital acute care (continued)	• 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 • EHR payments to provider in outpatient setting (not on hospital claim) • COVID-19 in vitro diagnostic products or testing-related services • MAT and drugs for evidenced-based treatment of OUD (not on a pharmacy claim) • Residential pediatric recovery center • Other care	
Drugs	• Prescribed drugs • Over-the-counter medications (on a pharmacy claim) • Medical equipment and prosthetic (on a pharmacy claim) • EHR payments to pharmacy provider • MAT and drugs for evidence-based treatment of OUD (on a pharmacy claim)	• Prescribed drugs • Drug rebates (national, state sidebar, ACA offset—fee for service) • MAT drugs for OUD • MAT 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 • Per member, per month (PMPM) payments for health home services; Medicare Parts A, B, or D premiums; Medicare Advantage dual special needs plans • PMPM payments for other payments	• MCO (i.e., comprehensive risk-based managed care) • MCO drug rebates (national, state sidebar, ACA offset—MCO) • MCO MAT drug rebates (national, state sidebar, ACA offset—MCO) • 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, ACIP vaccines, and services subject to electronic visit verification requirements • Premium assistance for private coverage

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
LTSS non-institutional	Type of service: • Home health, including nursing; home health aide; and physical, occupational, speech, and hearing therapy • Personal care • Residential care • HCBS waiver • Payments to individuals for personal assistance services under 1915(j) 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 health clinic
LTSS institutional	• Nursing facility • Inpatient hospital and nursing facility services for individuals age 65 and older in IMD • Intermediate care facility • Inpatient psychiatric or skilled nursing facility for individuals under age 21 • Inpatient and residential substance abuse treatment • EHR payments to LTSS institutional provider • Inpatient psychiatric services for beneficiaries ages 22 to 64 who receive services in an IMD	• 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. EHR is electronic health record. EPSDT is early and periodic screening, diagnostic, and treatment. USPSTF is U.S. Preventive Services Task Force. ACIP is Advisory Committee on Immunization Practices. MAT is medication-assisted treatment. OUD is opioid use disorder. 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. MCO is managed care organization. PCCM is primary care case management. 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. IMD is institution for mental disease. 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).

EXHIBIT 51. (continued)

[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 before 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 2020 Medicare data. See MedPAC and MACPAC, 2023, Table 5: Fee-for-service Medicare Part A and Part B cost sharing incurred by dual-eligible and non-dual Medicare beneficiaries (dollars in billions), CY 2020, in *Data book: Beneficiaries dually eligible for Medicare and Medicaid*, Washington, DC: MedPAC and MACPAC, https://www.macpac.gov/wp-content/uploads/2023/02/Feb23_MedPAC_MACPAC_DualsDataBook-WEB-508.pdf.

Source: MACPAC, 2023, 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.[19]
- 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 before 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 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 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, 2022, 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 Expenditures 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] IPUMS Health Surveys. 2019. User note: Washington Group on Disability Statistics Measures. https://nhis.ipums.org/nhis/userNotes_washingtongroup.shtml.

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

[14] 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, pregnancy).

[15] 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.

[16] 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.

[17] 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.

[18] 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.

[19] 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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Advising Congress on Medicaid and CHIP Policy

1800 M Street NW
Suite 650 South
Washington, DC 20036

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