MACStats: Medicaid and CHIP Data Book

DECEMBER 2024

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.

MACStats: Medicaid and CHIP Data Book

DECEMBER 2024

MACPAC
Medicaid and CHIP Payment and Access Commission

Commission Members and Terms

Verlon Johnson, MPA, *Chair*
Olympia Fields, IL

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

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
Independent Consultant
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

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
Elevance Health
Tampa, FL

Jami Snyder, MA
JSN Strategies, LLC
Phoenix, AZ

Term Expires April 2027

Heidi L. Allen, PhD, MSW
Columbia University School of Social Work
New York, NY

Doug Brown, RPh, MBA
COEUS Consulting
Glen Allen, VA

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

Michael Nardone, MPA
The Nardone Group
Philadelphia, PA

Commission Staff

Kate Massey, MPA
Executive Director

Kiswana Williams
Executive Assistant

Communications

Caroline Broder
Director of Communications

Melanie Raible-Tocci
Communications Specialist

Carolyn Kaneko
Graphic Designer

Policy Directors

Kirstin Blom, MIPA
Policy Director

Chris Park, MS
Policy Director and Data Analytics Advisor

Joanne Jee, MPH
Policy Director

Principal Analysts

Allison M. Reynolds, JD

Janice Llanos-Velazquez, MPH
Principal Data Analyst

Melinda Becker Roach, MS

Melissa Schober, MPM

Senior Analysts

Tamara Huson, MSPH
Senior Analyst and Contracting Officer

Emma Liebman, MPH

Linn Jennings, MS

Audrey Nuamah, MPH

Analysts

Drew Gerber, MPH

Sheila Shaheed, MSPH

Patrick Jones, MA

Asher Wang

Brian O'Gara

Research Assistants

Gabby Ballweg

Ava Williams, MA

Operations and Finance

Annie Andrianasolo, MBA
Chief Administrative Officer

Ken Pezzella, CGFM
Chief Financial Officer

Nick Ngo
Chief Information Officer

Katherine Rogers, MPH, PhD
Deputy Director and Congressional Liaison

Kevin Ochieng
Senior IT Specialist

Erica Williams
Human Resources Specialist

Steve Pereyra
Financial Management Analyst

Table of Contents

Introduction

This 2024 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 32 percent of the U.S. population in 2023 (Exhibit 1). About 39 percent of children had Medicaid or CHIP coverage in 2023 (Exhibit 2). As of July 2024, 79.6 million people were enrolled in Medicaid and CHIP. Enrollment decreased by 13.7 percent from July 2023 to July 2024 as states began to disenroll beneficiaries after 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 spending continues to account for a smaller share of the federal budget in fiscal year (FY) 2023 (10.0 percent) than Medicare (13.7 percent) (Exhibit 4). The recent growth in the share of federal spending on Medicaid and CHIP from the prior fiscal year reflects both the growth in federal spending as enrollment and the federal share of Medicaid and CHIP increased under the provisions of the FFCRA as well as a decrease in other federal spending associated with pandemic-related relief.

Total Medicaid spending was $900.3 billion in FY 2023 (Exhibit 16). Spending for CHIP was $23.4 billion (Exhibit 33). The increase in Medicaid spending for FY 2023 was driven almost equally by increases in enrollment and spending per full-year equivalent enrollee (Exhibit 10). In FY 2022, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 20 percent of Medicaid enrollees but about 51 percent of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports. Spending for people who are dually eligible for Medicaid and Medicare accounted for more than $244 billion in spending in FY 2022 (Exhibit 21). In addition, more than half of Medicaid spending for enrollees was for capitation payments to managed care plans (Exhibits 17 and 18).

MACStats continues to include tables on access to and experience of care among non-institutionalized individuals. 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). Adults age 19 to 64 whose primary coverage is Medicaid are as likely to report having a usual source of care as those with private coverage and less likely than those with Medicare coverage (Exhibit 47).

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 2023, more than 32 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: 100.1 million in Medicaid and 8.9 million in CHIP (Exhibit 1). About 39 percent of children had Medicaid or CHIP coverage in 2023 (Exhibit 2).
- About 35 percent of individuals enrolled in Medicaid or CHIP in 2023 had family incomes below 100 percent of the federal poverty level (FPL). About half of all individuals (49.6 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 18.5 percent of national health expenditures in calendar year 2022, less than either Medicare (21.2 percent) or private insurance (28.9 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) 2023, the share of federal spending on Medicaid and CHIP (10.3 percent) increased from the prior fiscal year (9.7 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 associated with pandemic-related relief (Exhibit 4).
- In FY 2023, Medicaid continued to account for a smaller share of the federal budget (10.0 percent) than Medicare (13.7 percent) (Exhibit 4).
- Medicaid spending as a share of state budgets varies depending on whether federal funds are included. Considering only the state-funded portion of state budgets (i.e., the portion states must finance on their own through taxes and other means), Medicaid's share was 14.2 percent in state fiscal year (SFY) 2022. When federal funds are included, Medicaid's share was 28.8 percent in SFY 2022 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2023 (millions)

Population	Ever during FY 2023	Point in time during FY 2023	Point in time during CY 2023
	Estimates based on administrative data (CMS)[1]		**Survey data (NHIS)[2]**
Medicaid enrollees	100.1[3]	92.2[3]	Not available
CHIP enrollees	8.9[4]	7.2[5]	Not available
Totals for Medicaid and CHIP	**109.0**	**99.4**	**66.6**
	U.S. Census Bureau data		**Survey data (NHIS)[2]**
U.S. population	335.3[6]	334.5[6]	328.8
	Administrative and Census Bureau data		**Survey data (NHIS)[2]**
Medicaid and CHIP enrollment as a percentage of U.S. population	32.5%[1]	29.7%	20.2%

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

[1] Estimates based on administrative data are from the Transformed Medicaid Statistical Information System (T-MSIS), 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 1.7 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 2023 T-MSIS data as of February 2024.

[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 2025 president's budget.

[6] The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of September 2023 (the month with the largest count in FY 2023); 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 2023.

Sources: MACPAC, 2024, analysis of the following: T-MSIS data as of February 2024; CHIP SEDS data as of September 24, 2024; HHS, 2024, FY 2025 president's budget for HHS, Baltimore, MD, https://www.hhs.gov/sites/default/files/fy-2025-budget-in-brief.pdf; NHIS data; and U.S. Census Bureau, 2024, Monthly population estimates for the United States: April 1, 2020, to December 1, 2024 (NA-EST2023-POP) https://www2.census.gov/programs-surveys/popest/tables/2020-2023/national/totals/NA-EST2023-POP.xlsx.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2023

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%**	**24.2%**	**61.3%**	**20.2%**	**7.5%**	**100.0%**	**55.2%**	**38.8%**	**4.0%**
Coverage									
Length of time with any coverage during year									
Full year	**90.0***	98.9*	96.2	96.6	–	**94.9***	98.2	98.2	–
Part year	**5.2***	1.1*	3.8	3.4	29.1*	**3.1***	1.8	1.8	40.6*
No coverage during year	**4.8***	–	–	–	70.9*	**2.0***	–	–	59.4*
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/ CHIP combination[6]	**2.1***	11.1	–	10.4	–	**–**	–	–	–
Yes, any private and Medicaid/CHIP combination	**0.8***	–	1.3*	3.8	–	**1.8***	3.2*	4.6	–
Yes, any other combination	**7.4***	39.3*	12.1*	1.3	–	**–**	–	–	–
No	**89.7***	49.6*	86.6*	84.6	100.0*	**98.2***	96.8*	95.4	100.0*
Demographics									
Age									
0–18	**23.1***	†	20.8*	44.4	12.3*	**100.0**	100.0	100.0	100.0
19–64	**59.1***	11.9*	66.5*	47.6	86.1*	**–**	–	–	–
65 or older	**17.8***	88.0*	12.6*	8.0	1.6*	**–**	–	–	–
Gender									
Male	**49.3***	45.4	50.3*	43.8	57.0*	**51.2**	51.2	51.6	51.5
Female	**50.7***	54.6	49.7*	56.2	43.0*	**48.8**	48.8	48.4	48.5
Race									
Hispanic	**19.4***	9.6*	13.5*	31.5	45.8*	**26.5***	16.1*	38.3	49.3*
White, non-Hispanic	**59.5***	73.9*	66.8*	40.3	36.1*	**50.7***	63.3*	34.6	33.3
Black, non-Hispanic	**11.8***	10.6*	9.7*	18.4	11.4*	**12.0***	8.5*	17.5	8.6*
American Indian or Alaska Native, non-Hispanic	**0.6**	0.4	0.4	†	1.5	**†**	0.3	†	†
Asian, non-Hispanic	**6.0***	4.4	7.0*	4.9	2.6*	**4.9***	6.4*	3.1	2.6
Other single and multiple races, non-Hispanic	**2.7***	1.0*	2.6*	3.8	2.6*	**5.4**	5.4	5.7	†

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%**	**3.8%**	**68.9%**	**16.3%**	**10.9%**	**100.0%**	**93.6%**	**43.6%**	**9.1%**
Coverage									
Length of time with any coverage during year									
Full year	**85.5***	97.3*	95.0	94.7	–	**98.5**	99.1	99.3	98.6
Part year	**7.3***	2.7*	5.0	5.3	27.7*	**1.1**	0.9	0.7	†
No coverage during year	**7.3***	–	–	–	72.3*	**0.4***	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/ CHIP combination[6]	**1.3***	34.8*	–	8.1	–	**7.4***	7.9*	–	81.3
Yes, any private and Medicaid/ CHIP combination	**0.6***	–	0.9*	3.7	–	**†**	–	†	†
Yes, any other combination	**0.7**	18.0*	1.0	0.9	–	**39.5***	42.2*	90.6*	10.2
No	**97.4***	47.2*	98.1*	87.2	100.0*	**53.1***	49.9*	9.4	8.4
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	**49.7***	50.6*	50.8*	37.3	57.7*	**45.4***	44.7*	45.8*	38.8
Female	**50.3***	49.4*	49.2*	62.7	42.3*	**54.6***	55.3*	54.2*	61.2
Race									
Hispanic	**19.6***	13.6*	14.4*	25.5	45.4*	**9.5***	8.9*	4.4*	29.6
White, non-Hispanic	**58.4***	60.7*	64.8*	45.7	36.3*	**74.6***	75.8*	83.6*	40.2
Black, non-Hispanic	**12.5***	20.0	10.6*	19.4	11.9*	**9.5***	9.3*	7.1*	17.6
American Indian or Alaska Native, non-Hispanic	**0.7**	†	0.4	†	†	**0.4**	0.4	†	†
Asian, non-Hispanic	**6.7**	2.4*	7.8*	5.5	2.6*	**5.2***	4.7*	3.8*	11.0
Other single and multiple races, non-Hispanic	**2.2**	2.3	2.0	2.5	2.5	**0.9**	0.9	0.8	†

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	**10.1%***	13.6%*	4.8%*	22.7%	25.7%	–	–	–	–
High school diploma/GED	**26.8***	29.8*	22.5*	37.7	36.6	–	–	–	–
Some college	**29.4**	29.4	29.9	28.5	23.8*	–	–	–	–
College or graduate degree	**33.7***	27.2*	42.9*	11.1	13.9*	–	–	–	–
Marital status[7]									
Married	**52.5***	54.5*	59.0*	29.1	37.0*	–	–	–	–
Widowed	**5.9**	19.6*	3.9*	5.6	1.7*	–	–	–	–
Divorced or separated	**10.0***	14.5	8.2*	13.4	10.9*	–	–	–	–
Living with partner	**9.0***	3.1*	8.3*	12.6	17.0*	–	–	–	–
Never married	**22.7***	8.3*	20.7*	39.3	33.3*	–	–	–	–
Family income									
Has income less than 138 percent FPL	**18.7***	20.4*	6.4*	49.6	33.5*	**24.7%***	5.8%*	51.7%	40.5%
Has income in ranges shown below									
Less than 100 percent FPL	**11.9***	11.8*	3.5*	35.0	21.2	**16.5***	3.1*	36.0	25.6
100–199 percent FPL	**20.0***	24.6*	†	35.6	31.2	**22.5***	†	36.8	32.3
200–399 percent FPL	**30.9**	32.8	33.0	21.9	30.7	**30.2**	36.1	20.9	27.8
400 percent FPL or higher	**37.1***	30.5	†	†	17.2	**31.2***	†	†	15.0
Other demographic characteristics									
Citizen of United States	**92.7**	97.8*	94.8*	93.4	66.0*	**96.6***	97.6	97.3	75.9*
Parent of a dependent child[7]	**26.1***	1.8*	27.7*	33.7	34.5	–	–	–	–
Currently working[7]	**64.0***	17.1*	76.4*	45.3	70.1*	–	–	–	–
Veteran[7]	**7.6***	14.6*	6.0*	2.5	2.0	–	–	–	–
Family receives SSI or SSDI	**8.9***	17.2*	4.5*	21.3	5.4*	**6.8***	2.5*	13.1	†
Health									
Current health status									
Excellent or very good	**62.4***	39.2*	67.9*	56.5	58.9	**86.1***	90.6*	79.1	84.5*
Good	**25.3**	32.8*	23.8	25.2	29.4*	**11.6***	8.0*	17.1	12.5*
Fair or poor	**12.3***	28.0*	8.3*	18.3	11.6*	**2.3***	1.4*	3.8	†

EXHIBIT 2. (continued)

Characteristic	Selected coverage source at time of interview, age 19–64[1]					Selected coverage source at time of interview, age 65 or older[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid or CHIP[3]
Education[7]									
Less than high school	**9.1%***	19.2%	4.2%*	19.4%	25.4%*	**13.2%***	12.8%*	7.5%*	42.5%
High school diploma/GED	**26.3***	38.4	21.8*	38.9	36.7	**28.4**	28.6	26.1*	31.0
Some college	**29.6**	31.7	29.8	30.3	24.1*	**28.8***	29.1*	30.5*	17.3
College or graduate degree	**35.0***	10.7	44.3*	11.4	13.9*	**29.6***	29.4*	35.8*	9.2
Marital status[7]									
Married	**51.1***	36.7*	58.3*	28.6	36.9*	**56.9***	56.9*	62.5*	32.1
Widowed	**1.4***	6.2*	1.0*	2.3	1.5*	**21.0***	21.4*	19.0*	25.3
Divorced or separated	**8.9***	20.7*	7.6*	11.3	10.8	**13.7***	13.7*	11.5*	25.8
Living with partner	**10.8***	6.9*	9.3*	14.0	17.3*	**2.7**	2.6	2.5	4.0
Never married	**27.8***	29.5*	23.8*	43.7	33.5*	**5.8***	5.4*	4.5*	12.8
Family income									
Has income less than 138 percent FPL	**17.0***	45.5	6.7*	47.6	32.7*	**16.8***	17.0*	†	43.6
Has income in ranges shown below									
Less than 100 percent FPL	**10.9***	29.3	3.6*	33.9	20.5	**9.5***	9.4*	†	35.2
100–199 percent FPL	**18.2***	35.5	†	34.5	31.2	**22.6**	23.0	†	†
200–399 percent FPL	**30.3**	23.3	32.1	22.7	31.1	**33.9**	34.1	†	†
400 percent FPL or higher	**40.6***	†	†	†	17.4	**33.4**	32.8	†	†
Other demographic characteristics									
Citizen of United States	**89.8**	95.6*	93.3*	90.4	64.8*	**97.0***	98.1*	98.3*	88.9
Parent of a dependent child[7]	**33.7***	11.7*	32.9*	39.3	35.1*	**0.7**	0.5	0.7	†
Currently working[7]	**77.4***	16.3*	86.2*	50.9	70.6*	**19.6***	17.2*	24.8*	11.7
Veteran[7]	**5.2***	6.6*	4.5*	2.2	2.0	**15.7***	15.7*	14.2*	4.4
Family receives SSI or SSDI	**9.3***	70.2*	4.7*	27.0	5.6*	**10.1***	10.2*	6.6*	35.8
Health									
Current health status									
Excellent or very good	**59.2***	18.7*	64.7*	42.0	55.7*	**42.2***	42.0*	47.5*	17.5
Good	**28.2***	29.0	26.9*	31.4	31.7	**33.5**	33.3	33.7	33.0
Fair or poor	**12.6***	52.3*	8.5*	26.6	12.6*	**24.2***	24.7*	18.9*	49.5

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 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- 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, 2024, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2022

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	**$4,464,573**	**$805,732**	**$23,509**	**$944,318**	**$1,289,806**	**$148,106**	**$781,744**	**$471,357**
Hospital care	**1,355,009**	262,556	5,746	353,212	485,911	81,484	130,721	35,380
Physician and clinical services	**884,854**	110,107	4,846	234,091	341,957	40,554	85,963	67,336
Dental services	**165,276**	16,966	2,810	6,216	67,987	2,217	2,434	66,646
Other professional services[3]	**140,600**	10,578	520	39,447	41,090	–	15,819	33,145
Home health care	**132,874**	46,882	65	47,507	18,559	971	3,537	15,353
Other non-durable medical products[4]	**115,401**	–	–	2,524	–	–	–	112,877
Prescription drugs	**405,894**	45,252	2,580	129,793	154,993	10,843	5,711	56,721
Durable medical equipment[5]	**67,070**	9,681	225	14,146	13,927	–	1,255	27,837
Nursing care facilities and continuing care retirement communities[6]	**191,270**	58,507	15	42,185	18,185	6,279	17,830	48,269
Other health, residential, and personal care services[7]	**246,504**	149,349	2,169	4,153	15,887	1,080	66,071	7,794
Administration[8]	**333,627**	95,854	4,534	71,043	131,310	4,679	26,208	–
Public health activity	**208,405**	–	–	–	–	–	208,406	–
Investment	**217,791**	–	–	–	–	–	217,790	–

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%**	**18.0%**	**0.5%**	**21.2%**	**28.9%**	**3.3%**	**17.5%**	**10.6%**
Hospital care	**100.0**	19.4	0.4	26.1	35.9	6.0	9.6	2.6
Physician and clinical services	**100.0**	12.4	0.5	26.5	38.6	4.6	9.7	7.6
Dental services	**100.0**	10.3	1.7	3.8	41.1	1.3	1.5	40.3
Other professional services[3]	**100.0**	7.5	0.4	28.1	29.2	–	11.3	23.6
Home health care	**100.0**	35.3	0.0	35.8	14.0	0.7	2.7	11.6
Other non-durable medical products[4]	**100.0**	–	–	2.2	–	–	–	97.8
Prescription drugs	**100.0**	11.1	0.6	32.0	38.2	2.7	1.4	14.0
Durable medical equipment[5]	**100.0**	14.4	0.3	21.1	20.8	–	1.9	41.5
Nursing care facilities and continuing care retirement communities[6]	**100.0**	30.6	0.0	22.1	9.5	3.3	9.3	25.2
Other health, residential, and personal care services[7]	**100.0**	60.6	0.9	1.7	6.4	0.4	26.8	3.2
Administration[8]	**100.0**	28.7	1.4	21.3	39.4	1.4	7.9	–
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, 2023, *National health expenditures by type of service and source of funds: Calendar years 1960–2022*, Baltimore, MD: OACT, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2022.zip. OACT, 2023, *National health expenditure accounts: Methodology paper*, 2022, 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 1965–2023

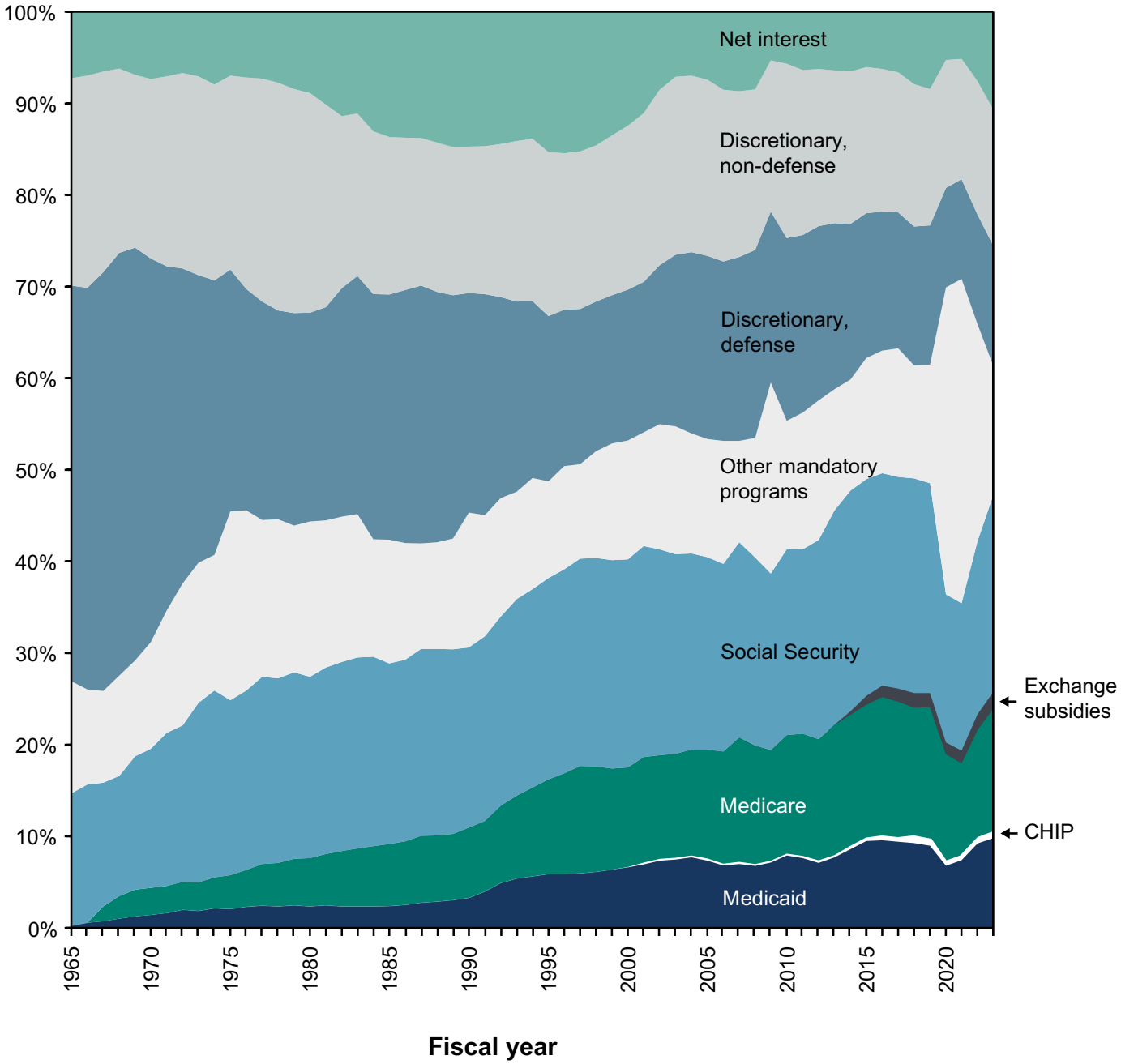


EXHIBIT 4. (continued)

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
2023	10.0	0.3	13.7	1.3	22.0	13.9	13.1	14.9	10.7

Notes: FY is fiscal year.

– Dash indicates zero.

Source: MACPAC, 2024, 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 2025*, Washington, DC: OMB, https://www.govinfo.gov/app/details/BUDGET-2025-TAB/context.

EXHIBIT 5. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, SFY 2022

State	Total budget (including state and federal funds)				State-funded budget			
	Dollars (millions)	Total spending as a share of total budget[1]			Dollars (millions)	State-funded spending as a share of state-funded budget[1]		
		Medicaid	Elementary and secondary education	Higher education		Medicaid	Elementary and secondary education	Higher education
Total	**$2,793,772**	**28.8%**	**19.5%**	**8.7%**	**$1,724,280**	**14.2%**	**24.6%**	**11.9%**
Alabama	37,905	21.9	24.8	18.2	21,452	8.7	27.1	24.7
Alaska	14,446	17.2	9.6	3.8	7,794	7.8	17.6	5.3
Arizona	80,508	22.9	11.8	10.0	60,029	5.7	11.1	11.6
Arkansas	32,047	27.6	14.0	14.4	19,783	7.1	16.1	22.0
California	442,236	26.9	21.6	6.3	270,694	12.8	29.7	7.8
Colorado	35,187	38.0	18.2	13.1	23,371	20.3	24.7	19.7
Connecticut	41,539	22.5	12.9	11.1	31,772	14.7	12.3	14.0
Delaware	14,377	19.8	22.3	3.5	10,415	8.3	26.7	4.0
District of Columbia	17,877	21.5	18.9	0.6	11,768	6.9	23.3	0.9
Florida	103,229	32.9	18.0	8.3	60,934	20.1	22.5	13.7
Georgia	67,527	22.2	23.3	17.6	41,343	9.3	28.6	22.3
Hawaii	18,819	15.3	12.3	4.7	13,643	6.4	13.6	6.4
Idaho	11,077	31.4	29.8	7.4	6,108	16.3	36.8	13.2
Illinois	122,625	20.3	12.1	1.9	89,704	5.9	11.5	2.4
Indiana	48,188	33.5	24.4	4.4	25,898	14.6	37.2	8.1
Iowa	28,508	25.2	16.7	24.4	17,547	13.5	20.7	35.6
Kansas	22,517	21.2	27.8	14.8	14,931	9.7	35.1	18.8
Kentucky	45,399	32.8	16.8	20.2	24,337	10.4	22.8	33.5
Louisiana	39,652	37.5	17.4	7.8	19,900	15.9	20.5	15.4
Maine	12,517	31.5	16.5	3.1	7,434	14.9	21.5	5.0
Maryland	62,833	21.2	20.6	12.0	36,308	12.3	23.7	16.8
Massachusetts	74,038	28.9	15.0	2.3	51,271	20.9	16.2	3.2
Michigan	75,633	28.2	22.8	3.8	40,439	12.9	36.4	6.8
Minnesota	53,813	31.4	22.5	3.6	34,256	19.0	29.6	5.6
Mississippi	23,090	22.8	17.0	18.4	12,714	6.7	20.7	30.4

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	$32,143	38.0%	23.7%	3.9%	$19,284	26.9%	27.3%	5.9%
Montana	8,728	28.3	15.3	8.0	4,629	10.6	20.6	14.7
Nebraska	15,391	21.4	12.6	21.5	10,423	10.1	12.8	25.1
Nevada	20,101	26.1	29.8	5.0	13,019	10.2	37.6	7.6
New Hampshire	7,822	33.7	19.1	2.1	4,188	22.8	27.5	3.9
New Jersey	86,999	24.8	23.2	7.0	60,999	11.2	29.8	10.0
New Mexico	22,545	36.5	17.8	14.1	12,564	10.7	28.0	20.3
New York	209,339	35.4	17.9	5.6	129,856	20.7	23.7	8.4
North Carolina	58,975	34.3	28.7	19.2	33,791	18.7	35.6	21.3
North Dakota	8,088	17.9	18.4	18.7	4,997	8.1	22.4	27.1
Ohio	90,050	39.0	16.8	3.3	50,691	18.4	21.4	5.9
Oklahoma	27,147	29.7	18.7	14.3	14,338	13.6	24.9	22.5
Oregon	67,770	19.1	10.8	2.6	44,919	6.5	13.2	3.8
Pennsylvania	121,277	39.6	18.3	1.7	63,493	26.8	22.3	3.2
Rhode Island	13,203	25.0	13.4	9.6	7,876	13.6	18.0	15.9
South Carolina	32,263	24.3	21.0	19.5	19,623	9.5	24.1	30.8
South Dakota	7,127	17.9	15.4	14.8	3,586	10.8	18.4	25.2
Tennessee	43,363	32.3	18.9	13.3	23,935	19.0	24.4	23.7
Texas	138,559	40.0	27.6	15.3	75,915	23.6	40.5	17.7
Utah	20,893	21.5	24.9	12.5	13,934	8.6	30.8	18.7
Vermont	7,621	23.9	31.7	2.1	4,345	12.8	50.3	2.7
Virginia	74,922	24.9	14.4	12.3	50,042	12.0	16.3	15.3
Washington	66,493	25.3	26.1	11.8	44,932	11.3	32.0	17.4
West Virginia	18,830	27.5	14.5	10.4	12,099	6.8	16.9	15.1
Wisconsin	62,901	21.1	15.6	12.1	42,294	12.2	19.9	13.4
Wyoming	5,636	11.8	16.2	6.5	4,662	5.5	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 2021–2023 report, 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, 2023, 2023 *State expenditure report: fiscal years 2021–2023*, Washington, DC: NASBO, https://www.nasbo.org/reports-data/state-expenditure-report/state-expenditure-archives.

EXHIBIT 6. Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages by State, FYs 2022–2025

State	FMAPs for Medicaid[1]						E-FMAPs for CHIP					
	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 2025	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]	FY 2025
Alabama	78.57%	78.63%	77.43%	74.93%	73.12%	72.84%	85.00%	85.04%	84.20%	82.45%	81.18%	80.99%
Alaska	56.20	56.20	55.00	52.50	50.01	51.54	69.34	69.34	68.50	66.75	65.01	66.08
Arizona	76.21	75.76	74.56	72.06	66.29	64.89	83.35	83.03	82.19	80.44	76.40	75.42
Arkansas	77.82	77.51	76.31	73.81	72.00	71.14	84.47	84.26	83.42	81.67	80.40	79.80
California	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
Colorado	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
Connecticut	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
Delaware	63.92	64.69	63.49	60.99	59.71	60.15	74.74	75.28	74.44	72.69	71.80	72.11
District of Columbia	76.20	76.20	75.00	72.50	70.00	70.00	83.34	83.34	82.50	80.75	79.00	79.00
Florida	67.23	66.25	65.05	62.55	57.96	57.17	77.06	76.38	75.54	73.79	70.57	70.02
Georgia	73.05	72.22	71.02	68.52	65.89	66.04	81.14	80.55	79.71	77.96	76.12	76.23
Hawaii	59.84	62.26	61.06	58.56	58.56	59.08	71.89	73.58	72.74	70.99	70.99	71.36
Idaho	76.41	76.31	75.11	72.61	69.72	67.59	83.49	83.42	82.58	80.83	78.80	77.31
Illinois	57.29	56.20	55.00	52.50	51.09	51.38	70.10	69.34	68.50	66.75	65.76	65.97
Indiana	72.50	71.86	70.66	68.16	65.62	64.90	80.75	80.30	79.46	77.71	75.93	75.43
Iowa	68.34	69.33	68.13	65.63	64.13	63.25	77.84	78.53	77.69	75.94	74.89	74.28
Kansas	66.36	65.96	64.76	62.26	60.97	61.87	76.45	76.17	75.33	73.58	72.68	73.31
Kentucky	78.95	78.37	77.17	74.67	71.78	71.48	85.27	84.86	84.02	82.27	80.25	80.04
Louisiana	74.22	73.48	72.28	69.78	67.67	68.06	81.95	81.44	80.60	78.85	77.37	77.64
Maine	70.20	69.49	68.29	65.79	62.65	62.06	79.14	78.64	77.80	76.05	73.86	73.44
Maryland	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
Massachusetts	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
Michigan	71.68	70.91	69.71	67.21	64.94	65.13	80.18	79.64	78.80	77.05	75.46	75.59
Minnesota	56.71	56.99	55.79	53.29	51.49	51.16	69.70	69.89	69.05	67.30	66.04	65.81
Mississippi	84.51	84.06	82.86	80.36	77.27	76.90	89.16	88.84	88.00	86.25	84.09	83.83
Missouri	72.56	72.01	70.81	68.31	66.07	65.31	80.79	80.41	79.57	77.82	76.25	75.72
Montana	71.10	70.32	69.12	66.62	63.91	62.37	79.77	79.22	78.38	76.63	74.74	73.66
Nebraska	64.00	64.07	62.87	60.37	58.60	57.52	74.80	74.85	74.01	72.26	71.02	70.26

EXHIBIT 6. (continued)

State	FMAPs for Medicaid[1]						E-FMAPs for CHIP					
	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 2025	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]	FY 2025
Nevada	68.79%	68.85%	67.65%	65.15%	60.77%	60.22%	78.15%	78.20%	77.36%	75.61%	72.54%	72.15%
New Hampshire	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
New Jersey	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
New Mexico	79.91	79.46	78.26	75.76	72.59	71.68	85.94	85.62	84.78	83.03	80.81	80.18
New York	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
North Carolina	73.85	73.91	72.71	70.21	65.91	65.06	81.70	81.74	80.90	79.15	76.14	75.54
North Dakota	59.79	57.75	56.55	54.05	53.82	50.97	71.85	70.43	69.59	67.84	67.67	65.68
Ohio	70.30	69.78	68.58	66.08	64.30	64.60	79.21	78.85	78.01	76.26	75.01	75.22
Oklahoma	74.51	73.56	72.36	69.86	67.53	67.08	82.16	81.49	80.65	78.90	77.27	76.96
Oregon	66.42	66.52	65.32	62.82	59.31	59.00	76.49	76.56	75.72	73.97	71.52	71.30
Pennsylvania	58.88	58.20	57.00	54.50	54.12	55.09	71.22	70.74	69.90	68.15	67.88	68.56
Rhode Island	61.08	60.16	58.96	56.46	55.01	56.31	72.76	72.11	71.27	69.52	68.51	69.42
South Carolina	76.95	76.78	75.58	73.08	69.53	69.67	83.87	83.75	82.91	81.16	78.67	78.77
South Dakota	64.89	62.94	61.74	59.24	54.98	53.07	75.42	74.06	73.22	71.47	68.49	67.15
Tennessee	72.56	72.30	71.10	68.60	65.28	64.81	80.79	80.61	79.77	78.02	75.70	75.37
Texas	67.00	66.07	64.87	62.37	60.15	60.00	76.90	76.25	75.41	73.66	72.11	72.00
Utah	73.03	72.10	70.90	68.40	65.90	64.36	81.12	80.47	79.63	77.88	76.13	75.05
Vermont	62.67	62.02	60.82	58.32	56.75	58.19	73.87	73.41	72.57	70.82	69.73	70.73
Virginia	56.20	56.85	55.65	53.15	51.22	50.99	69.34	69.80	68.96	67.21	65.85	65.69
Washington	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
West Virginia	80.88	80.22	79.02	76.52	74.10	73.84	86.62	86.15	85.31	83.56	81.87	81.69
Wisconsin	66.08	66.30	65.10	62.60	60.66	60.43	76.26	76.41	75.57	73.82	72.46	72.30
Wyoming	56.20	56.20	55.00	52.50	50.00	50.00	69.34	69.34	68.50	66.75	65.00	65.00
American Samoa[7]	89.20	89.20	88.00	85.50	83.00	83.00	92.44	92.44	91.60	89.85	85.00	85.00
Guam[7]	89.20	89.20	88.00	85.50	83.00	83.00	92.44	92.44	91.60	89.85	85.00	85.00
N. Mariana Islands[7]	89.20	89.20	88.00	85.50	83.00	83.00	92.44	92.44	91.60	89.85	85.00	85.00
Puerto Rico[7]	82.20	82.20	81.00	78.50	76.00	76.00	87.54	87.54	86.70	84.95	83.20	83.20
Virgin Islands[7]	89.20	89.20	88.00	85.50	83.00	83.00	92.44	92.44	91.60	89.85	85.00	85.00

EXHIBIT 6. (continued)

Notes: FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. FY is fiscal year. 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. For FY 2020, the E-FMAPs are then increased by a set number of percentage points determined by statute.[5]

[1] For certain newly eligible individuals under the Medicaid expansion beginning in 2014, there is an increased FMAP (100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and subsequent years). An increased FMAP is also available for certain states that expanded eligibility to low-income parents and non-pregnant adults without children before enactment of the Patient Protection and Affordable Care Act (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 in order to qualify for the FMAP increase. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Services facility that already receive a higher matching rate.

[3] Because the public health emergency period was in effect for all of FY 2022, this exhibit only displays the FY 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. As discussed in footnote 4, the FMAPs for the first quarter of FY 2024 would receive a 1.5 percentage point increase under the Consolidated Appropriations Act, 2023.

[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–December 3, 2021 and January 1, 2022–September 30, 2027 but would receive it's normal FMAP of 55 percent between December 4, 2021 and December 31, 2021. The E-FMAPs for FYs 2022–2025 were calculated off of these increased FMAPs.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for FYs 2022–2025; 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 decreased for the first time since 2019 as states began to disenroll beneficiaries after the end of 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 2023 to July 2024, enrollment in Medicaid and the State Children's Health Insurance Program (CHIP) decreased by 13.7 percent. Only two states that expanded Medicaid in 2023 reported an increase in enrollment from July 2023 to July 2024 (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 9.4 percent from FY 2013 through FY 2022.
  - Individuals age 65 and older generally have the slowest growth rate regardless of time period (Exhibit 7).
- Medicaid's share of state-funded budgets (excluding federal funds) and total state budgets (including federal funds) has varied over time. In state fiscal year 2015, Medicaid's share of total state budgets increased, but its share of state-funded budgets decreased slightly—the decrease can be attributed to 100 percent federal funding made available for low-income adults not otherwise eligible on the basis of disability, who became newly eligible for Medicaid under the ACA. Most recently, Medicaid's share of state-funded budgets (excluding federal funds) decreased from 2018 to 2022 due to additional states expanding Medicaid and the FMAP increase under the FFCRA; however, Medicaid's share of total state budgets (including federal funds) increased from 2021 to 2022 in part due to a decrease in other federal spending associated with pandemic-related relief (Exhibit 13).
- Medicaid and CHIP expenditures as a share of national health expenditures are projected to decrease from 18.6 percent in 2022 to about 17.9 percent in 2032. Medicare's share is projected to increase from 21.2 percent to 25.1 percent during the same time period (Exhibit 12).

EXHIBIT 7. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FYs 1975–2022 (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
2004	**54,250**	25,415	12,325	8,123	4,349	4,037

EXHIBIT 7. (continued)

Fiscal year	Total	Child	Adult[1]	Disabled	Aged	Unknown
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
2022	**91,173**	33,000	37,835	8,673	7,191	4,473

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 the Transformed Medicaid Statistical Information System (T-MSIS), age must be used to separate beneficiaries eligible on the basis of age from those eligible based on disability. This means that the beneficiary count for the disabled category in 2018 and subsequent years no longer includes anyone age 65 and older. Generally, individuals whose eligibility group is unknown are persons who were enrolled in the prior year but had a Medicaid claim paid in the current year.

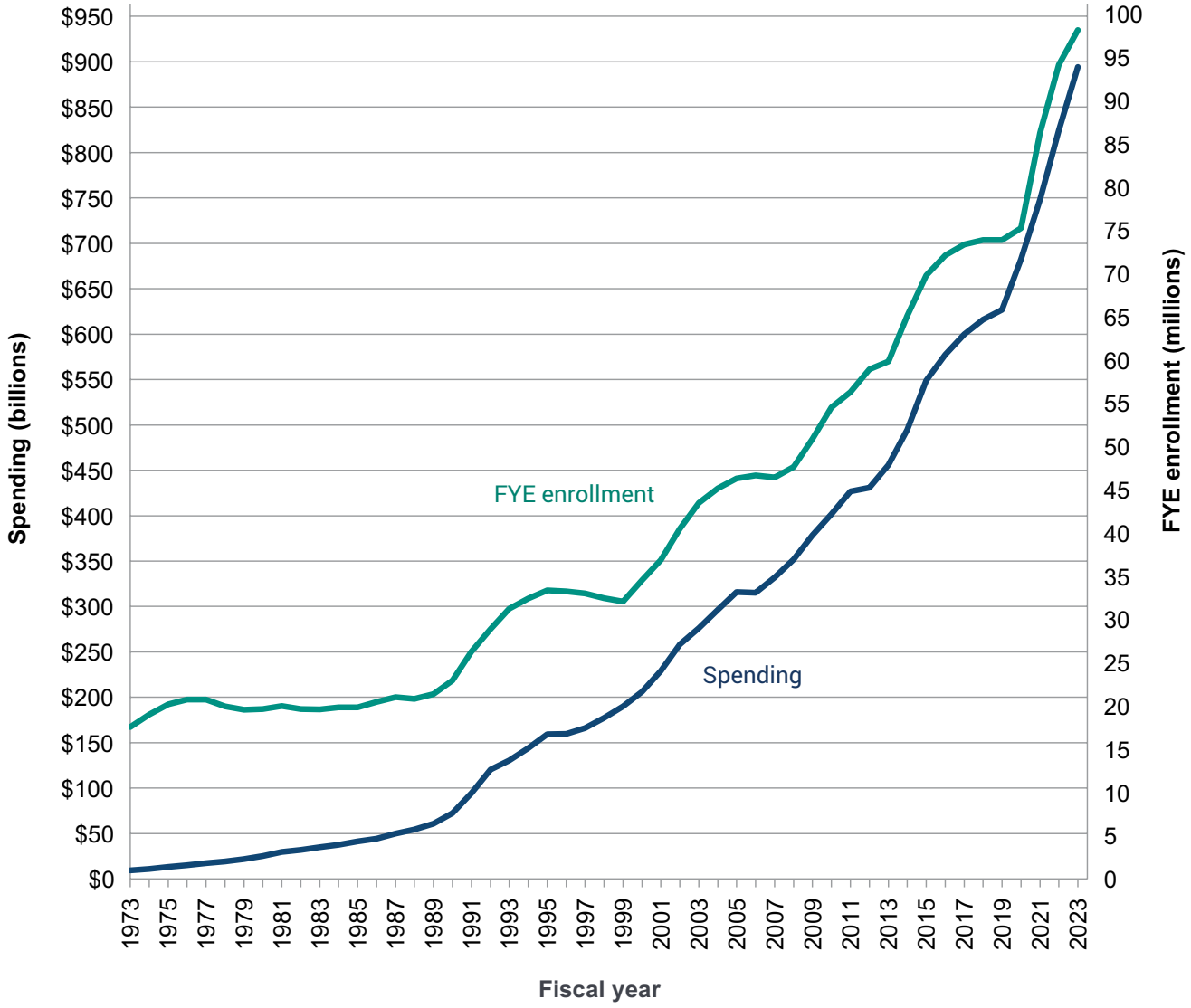
For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and sex. The national enrollment counts shown here are unduplicated using this national 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 2022: MACPAC, 2024, analysis of T-MSIS data as of February 2024. 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.

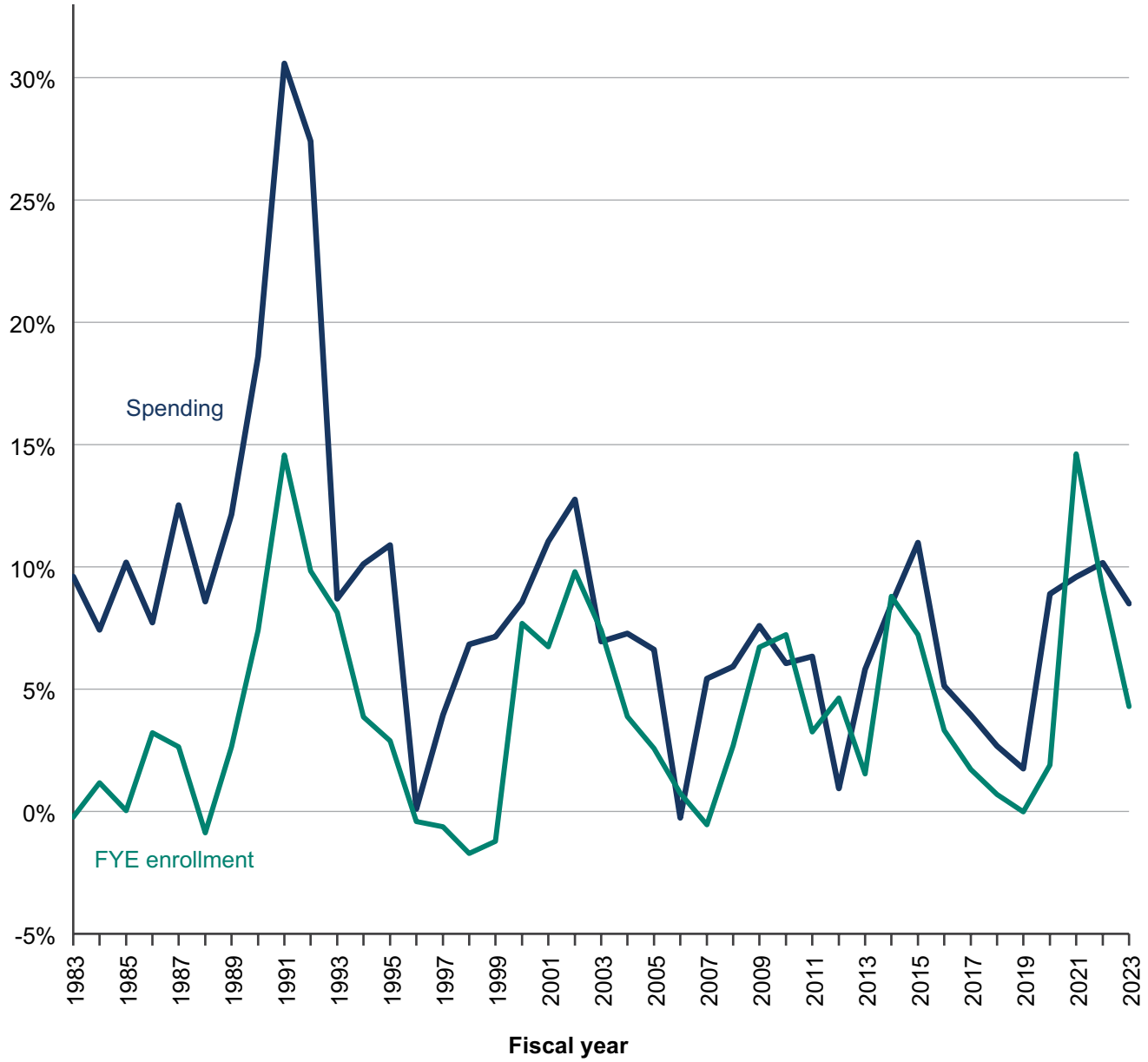
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1973–2023



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 1999–2023 include estimates for the territories.

Sources: For FY 2023: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 enrollment reports as of October 15, 2024. 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 1983–2023



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 1999–2023 include estimates for the territories.

Sources: For FY 2023: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 enrollment reports as of October 15, 2024. 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 1973–2023

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
2004	296	45.2	6,560	7.3	3.9	3.3

EXHIBIT 10. (continued)

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
2023	894	98.2	9,109	8.5	4.3	4.0

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 FYE 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 1999–2023 include estimates for the territories.

Sources: For FY 2023: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 enrollment reports as of October 15, 2024. 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 2013–2024

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2021	July 2022	July 2023	July 2024	July 2021–July 2022	July 2022–July 2023	July 2023–July 2024	July–September 2013 average to July 2024
Total	**56,511,799**[1]	**83,972,641**	**90,203,221**	**92,147,828**	**79,560,396**	**7.4%**	**2.2%**	**-13.7%**	**38.5%**[2]
Alabama	799,176[3]	1,055,463	1,138,406	1,192,748	966,928	7.9	4.8	-18.9	49.2
Alaska	122,334	251,024	261,816	262,806	250,740	4.3	0.4	-4.6	114.8
Arizona	1,201,770	2,072,102	2,227,971	2,134,921	2,004,314	7.5	-4.2	-6.1	77.6
Arkansas	556,851	985,204	1,050,577	936,514	821,866	6.6	-10.9	-12.2	68.2
California	7,755,381	12,983,442	13,744,043	14,399,877	13,442,757	5.9	4.8	-6.6	85.7
Colorado	783,420	1,532,326	1,646,836	1,649,658	1,159,484	7.5	0.2	-29.7	110.6
Connecticut	–	960,844	979,293	996,632	938,940	1.9	1.8	-5.8	–
Delaware	223,324	271,159	290,979	310,479	250,910	7.3	6.7	-19.2	39.0
District of Columbia	235,786[4,5]	270,938	286,672	292,976	264,053	5.8	2.2	-9.9	24.3
Florida	3,695,306	4,350,511	4,734,996	4,632,565	3,796,877	8.8	-2.2	-18.0	25.4
Georgia	1,535,090	2,214,237	2,405,477	2,539,809	1,986,892	8.6	5.6	-21.8	65.5
Hawaii	288,357	424,531	452,696	438,194	407,427	6.6	-3.2	-7.0	52.0
Idaho	238,150	399,433	430,307	363,567	318,274	7.7	-15.5	-12.5	52.7
Illinois	2,626,943	3,440,508	3,675,203	3,872,945	3,263,880	6.8	5.4	-15.7	47.4
Indiana	1,120,674	1,786,580	1,954,908	1,978,780	1,774,156	9.4	1.2	-10.3	76.6
Iowa	493,515	786,223	828,281	802,222	675,902	5.3	-3.1	-15.7	62.6
Kansas	378,160	450,537	491,794	474,225	407,215	9.2	-3.6	-14.1	25.4
Kentucky	606,805	1,489,474	1,576,193	1,583,958	1,391,092	5.8	0.5	-12.2	161.0
Louisiana	1,019,787	1,766,777	1,858,130	1,895,058	1,523,006	5.2	2.0	-19.6	85.8
Maine	–	325,876	355,437	379,435	366,751	9.1	6.8	-3.3	–
Maryland	856,297	1,534,076	1,645,951	1,697,247	1,568,561	7.3	3.1	-7.6	98.2
Massachusetts	1,296,359	1,797,825	1,923,683	2,017,535	1,686,910	7.0	4.9	-16.4	55.6
Michigan	1,912,009	2,777,203	2,965,223	3,127,754	2,344,131	6.8	5.5	-25.1	63.6
Minnesota	873,040[6]	1,239,326	1,332,742	1,408,658	1,172,883	7.5	5.7	-16.7	61.4
Mississippi	615,556	693,700	742,600	772,413	597,977	7.0	4.0	-22.6	25.5

EXHIBIT 11. (continued)

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2021	July 2022	July 2023	July 2024	July 2021–July 2022	July 2022–July 2023	July 2023–July 2024	July–September 2013 average to July 2024
Missouri	846,084	1,093,102	1,379,791	1,504,652	1,262,279	26.2%	9.0%	-16.1%	77.8%
Montana	148,974	291,578	313,837	297,145	224,067	7.6	-5.3	-24.6	99.5
Nebraska	244,600	335,065	374,026	397,567	344,920	11.6	6.3	-13.2	62.5
Nevada	332,560	800,436	868,971	835,888	766,157	8.6	-3.8	-8.3	151.3
New Hampshire	127,082	225,025	242,720	194,105	184,257	7.9	-20.0	-5.1	52.7
New Jersey	1,283,851	2,007,346	2,148,004	2,298,852	1,806,032	7.0	7.0	-21.4	79.1
New Mexico	457,678	847,066	876,177	823,720	783,431	3.4	-6.0	-4.9	80.0
New York	5,678,417	6,910,492	7,249,900	7,583,252	6,682,313	4.9	4.6	-11.9	33.5
North Carolina	1,595,952	2,108,582	2,240,057	2,303,785	2,731,810	6.2	2.8	18.6	44.4
North Dakota	69,980[7]	113,589	123,776	120,309	103,337	9.0	-2.8	-14.1	71.9
Ohio	2,130,322	3,086,656	3,270,899	3,295,451	2,883,680	6.0	0.8	-12.5	54.7
Oklahoma	790,051	1,020,015	1,231,239	1,267,103	966,492	20.7	2.9	-23.7	60.4
Oregon	626,356[8]	1,219,271	1,334,459	1,462,700	1,285,144	9.4	9.6	-12.1	133.5
Pennsylvania	2,386,046	3,422,966	3,621,759	3,644,466	3,094,061	5.8	0.6	-15.1	52.7
Rhode Island	190,833	338,291	353,502	373,260	315,965	4.5	5.6	-15.3	95.6
South Carolina	889,744	1,185,531[9]	1,269,341	1,264,991	1,053,713	7.1	-0.3	-16.7	42.2
South Dakota	115,501	129,870	140,676	116,043	135,981	8.3	-17.5	17.2	0.5
Tennessee	1,244,516	1,600,939	1,719,939	1,783,668	1,447,311	7.4	3.7	-18.9	43.3
Texas	4,203,449	5,077,158	5,643,143	5,627,147	4,177,181	11.1	-0.3	-25.8	33.9
Utah	294,029[5]	420,000[5]	465,497[5]	435,900	335,097	10.8	-6.4	-23.1	48.3
Vermont	161,081	180,359	189,194	182,922	159,484	4.9	-3.3	-12.8	13.6
Virginia	935,434	1,750,410	1,934,368	2,008,101	1,826,149	10.5	3.8	-9.1	114.7
Washington	1,117,576	1,993,221	2,120,740	2,048,891	1,836,318	6.4	-3.4	-10.4	83.3
West Virginia	354,544	593,834	631,256	596,525	513,609	6.3	-5.5	-13.9	68.3
Wisconsin	985,531[10]	1,292,431	1,380,418	1,434,591	1,194,063	6.8	3.9	-16.8	45.6
Wyoming	67,518	70,089	79,318	85,818	65,619	13.2	8.2	-23.5	27.1

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, 2024, analysis of CMS, 2024, State Medicaid and CHIP applications, eligibility determinations, and enrollment data, accessed on October 31, 2024, 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 1970–2032

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	**2,856**	458	16.1	589	20.6	879	30.8	92	3.2	506	17.7	331	11.6
2014	**3,002**	511	17.0	617	20.6	923	30.7	99	3.3	511	17.0	340	11.3
2015	**3,164**	558	17.6	648	20.5	977	30.9	106	3.4	523	16.5	353	11.1
2016	**3,305**	582	17.6	676	20.4	1,030	31.2	109	3.3	544	16.5	365	11.0
2017	**3,444**	597	17.3	705	20.5	1,080	31.4	114	3.3	578	16.8	370	10.7
2018	**3,601**	615	17.1	750	20.8	1,128	31.3	118	3.3	604	16.8	386	10.7
2019	**3,756**	635	16.9	802	21.4	1,156	30.8	125	3.3	636	16.9	402	10.7
2020	**4,156**	693	16.7	832	20.0	1,146	27.6	136	3.3	951	22.9	398	9.6
2021	**4,289**	758	17.7	892	20.8	1,218	28.4	144	3.4	835	19.5	442	10.3
2022	**4,465**	829	18.6	944	21.2	1,290	28.9	148	3.3	782	17.5	471	10.6

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	
Projected													
2023	**$4,799**	$876	18.3%	$1,024	21.3%	$1,433	29.9%	$164	3.4%	$793	16.5%	$509	10.6%
2024	**5,049**	859	17.0	1,086	21.5	1,550	30.7	174	3.4	837	16.6	542	10.7
2025	**5,295**	900	17.0	1,148	21.7	1,632	30.8	183	3.5	870	16.4	563	10.6
2026	**5,560**	960	17.3	1,246	22.4	1,671	30.1	193	3.5	907	16.3	584	10.5
2027	**5,890**	1,022	17.4	1,358	23.1	1,753	29.8	203	3.4	944	16.0	610	10.3
2028	**6,216**	1,090	17.5	1,455	23.4	1,837	29.6	213	3.4	984	15.8	636	10.2
2029	**6,575**	1,155	17.6	1,581	24.0	1,926	29.3	225	3.4	1,026	15.6	662	10.1
2030	**6,932**	1,224	17.7	1,692	24.4	2,019	29.1	236	3.4	1,070	15.4	690	10.0
2031	**7,307**	1,297	17.7	1,809	24.8	2,117	29.0	248	3.4	1,118	15.3	719	9.8
2032	**7,705**	1,376	17.9	1,937	25.1	2,217	28.8	261	3.4	1,166	15.1	749	9.7

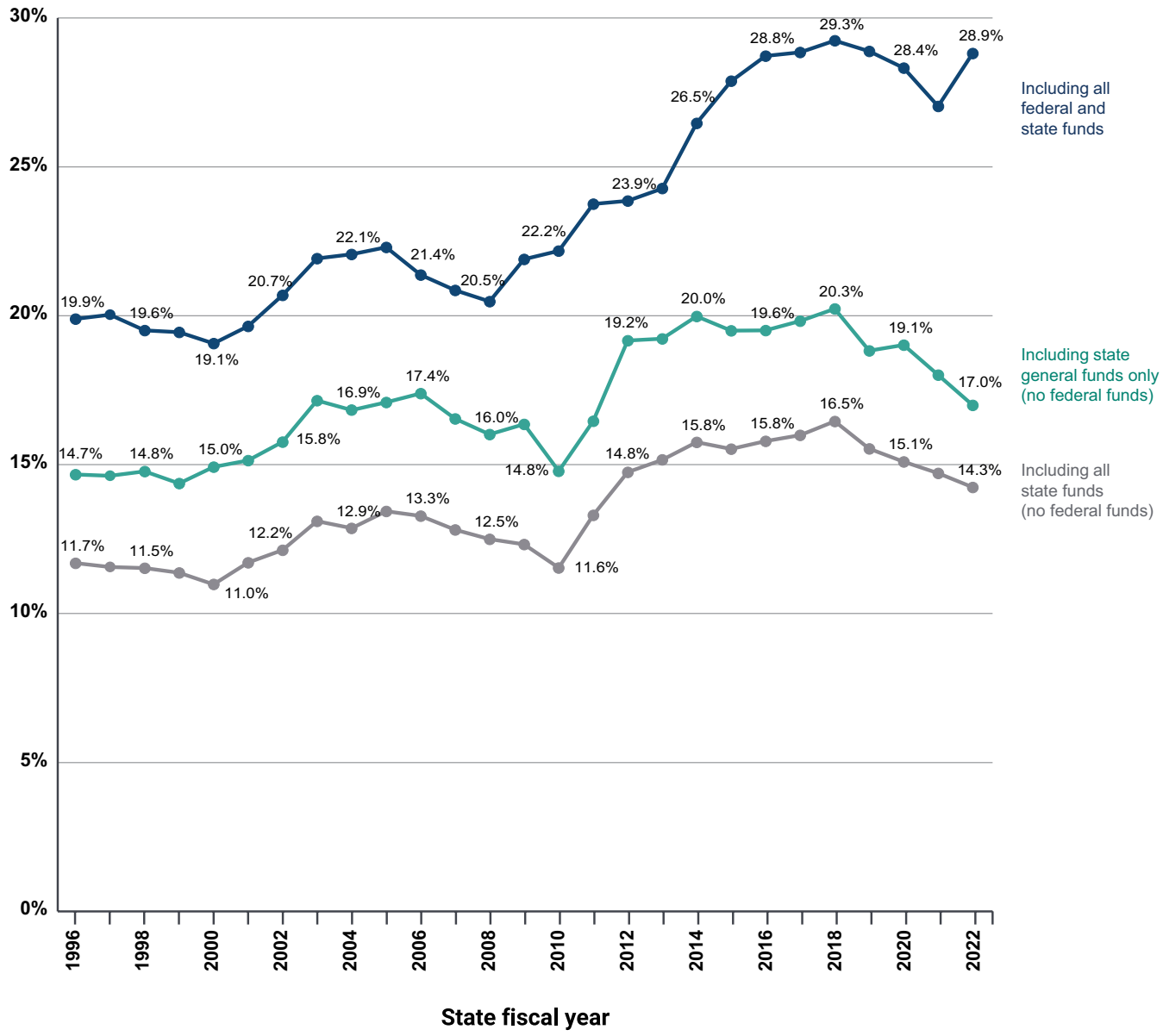
Notes: CY is calendar year. Components may not sum to total due to rounding. The latest projections begin after the latest historical year (2022) and go through 2032.

[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, 2024, analysis of Office of the Actuary (OACT), CMS, 2023, *National health expenditures by type of service and source of funds: Calendar years 1960–2022*, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2022.zip. For projected data: MACPAC, 2024, analysis of OACT, 2024, *National health expenditures by type of expenditure and source of funds: Calendar years 1960 to 2032*, https://www.cms.gov/files/zip/nhe-historical-and-projections-data.zip; and OACT, 2024, *Table 17: Health insurance enrollment and enrollment growth rates, calendar years, 2013–2032*, 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 1996–2022



Section 2

MACStats

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
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	27.1	18.1	14.7
2022	28.9	17.0	14.3

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 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: Source: MACPAC, 2024, 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 $900.3 billion in fiscal year (FY) 2023 (Exhibit 16). Spending for the State Children's Health Insurance Program (CHIP) was $23.4 billion (Exhibit 33).
- The federal share was 69.0 percent of total Medicaid benefit spending in FY 2023, 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 2022, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 20 percent of Medicaid enrollees but about 51 percent of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports (LTSS). LTSS users under a fee-for-service arrangement accounted for only 4.8 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 26 percent of enrollees and 23 percent of spending in FY 2022 (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 (54.1 percent) of enrollees who are eligible on the basis of disability and more than one-third (37.5 percent) of enrollees age 65 and older were enrolled in comprehensive managed care in FY 2022, 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 (51.2 percent) in FY 2023 (Exhibit 28). About three-fifths (59.2 percent) of Medicaid gross spending for drugs occurred under managed care in FY 2023 (Exhibit 26).
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for more than half (53.0 percent) of fee-for-service payments to hospitals in FY 2023 (Exhibit 24).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2022 (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	**93,900**	**33,694**	**24,678**	**17,022**	**9,461**	**9,046**	**13,740**	**8,718**	**10,244**	**6,354**	**3,496**	**2,363**
Alabama	**1,238**	614	–	259	222	144	**249**	143	**103**	54	**147**	89
Alaska	**267**	107	75	54	16	15	**25**	15	**24**	14	**1**	1
Arizona	**2,439**	819	747	486	182	206	**314**	199	**255**	156	**59**	44
Arkansas	**1,203**	530	412	13	161	87	**167**	90	**100**	56	**67**	34
California[5]	**14,742**	3,821	5,165	3,306	874	1,576	**1,851**	1,441	**1,815**	1,410	**36**	30
Colorado	**1,699**	562	737	200	107	93	**166**	105	**122**	73	**43**	32
Connecticut	**1,261**	383	390	263	63	162	**223**	162	**87**	53	**136**	109
Delaware	**318**	113	98	60	25	21	**34**	21	**17**	10	**17**	11
District of Columbia[6]	**291**	82	91	58	31	30	**43**	30	**31**	21	**12**	10
Florida	**5,626**	2,732	–	1,446	663	786	**1,103**	776	**656**	449	**447**	326
Georgia	**2,616**	1,405	–	555	366	290	**433**	283	**187**	116	**246**	167
Hawaii	**459**	146	185	60	22	47	**62**	43	**55**	38	**7**	5
Idaho	**465**	182	150	45	53	35	**61**	34	**38**	19	**22**	14
Illinois[6]	**3,590**	717	2,172	156	206	340	**483**	307	**432**	270	**52**	36
Indiana	**2,111**	805	523	456	181	145	**284**	150	**216**	109	**67**	41
Iowa	**848**	306	270	136	85	51	**111**	55	**87**	39	**24**	16
Kansas	**487**	272	–	85	81	49	**87**	46	**57**	29	**30**	17
Kentucky	**1,689**	479	708	165	219	119	**239**	120	**135**	67	**104**	53
Louisiana	**1,889**	603	770	108	238	169	**295**	171	**169**	92	**126**	79
Maine	**457**	125	110	94	62	67	**78**	51	**40**	30	**38**	21
Maryland	**1,641**	601	467	320	142	111	**182**	111	**114**	64	**69**	46
Massachusetts	**2,163**	477	509	585	341	250	**410**	233	**374**	198	**36**	34
Michigan	**3,126**	1,048	1,066	459	343	210	**405**	218	**361**	191	**45**	27
Minnesota	**1,428**	631	318	256	121	102	**168**	94	**154**	84	**14**	10
Mississippi	**849**	429	–	149	164	107	**181**	107	**93**	52	**88**	55

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[6,7]	**1,456**	708	272	162	194	121	**236**	115	**197**	92	**39**	23
Montana	**308**	111	123	32	23	19	**36**	21	**27**	15	**9**	6
Nebraska	**368**	166	82	51	41	28	**49**	27	**43**	22	**7**	4
Nevada	**958**	345	395	94	62	62	**101**	68	**47**	30	**54**	38
New Hampshire	**262**	87	100	29	27	20	**42**	19	**29**	13	**13**	6
New Jersey	**2,090**	703	787	231	180	189	**305**	190	**277**	169	**28**	21
New Mexico	**1,001**	361	313	174	79	74	**122**	77	**59**	32	**63**	45
New York	**7,657**	2,049	2,856	1,245	617	890	**1,255**	886	**1,056**	730	**199**	157
North Carolina	**2,740**	1,132	–	1,015	362	230	**382**	221	**296**	163	**86**	58
North Dakota[5]	**134**	55	39	17	13	11	**19**	11	**17**	9	**3**	2
Ohio	**3,291**	1,119	961	548	400	264	**422**	229	**284**	151	**138**	78
Oklahoma	**1,312**	607	339	163	118	84	**147**	81	**114**	62	**33**	18
Oregon	**1,404**	351	747	62	121	122	**192**	117	**118**	68	**74**	49
Pennsylvania	**3,608**	1,078	1,183	408	598	341	**607**	343	**505**	280	**102**	64
Rhode Island	**350**	98	110	71	40	30	**59**	35	**52**	30	**7**	5
South Carolina	**1,468**	675	–	506	175	112	**185**	102	**175**	96	**10**	7
South Dakota[8]	**142**	80	0	26	21	14	**24**	13	**15**	8	**9**	5
Tennessee	**1,805**	889	–	486	266	164	**313**	165	**193**	85	**120**	80
Texas[8]	**6,176**	3,687	0	1,185	709	595	**841**	567	**438**	284	**403**	283
Utah[5]	**502**	216	140	70	49	28	**46**	24	**41**	22	**6**	3
Vermont	**207**	71	79	15	20	22	**31**	18	**23**	12	**8**	6
Virginia	**2,008**	672	717	293	182	144	**269**	144	**201**	105	**68**	40
Washington	**2,288**	875	884	188	182	159	**273**	164	**199**	118	**74**	46
West Virginia	**668**	210	250	64	89	54	**109**	58	**68**	35	**41**	23
Wisconsin	**1,511**	537	–	618	194	162	**212**	112	**198**	101	**14**	11
Wyoming	**89**	50	–	17	12	10	**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 sex. 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 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 261,700, North Dakota's child enrollment by approximately 3,200, and Utah's child enrollment by approximately 12,800.

[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 34 percent less than the benchmark, Illinois's average monthly enrollment was 108 percent more than the benchmark, and Missouri's average monthly enrollment was 33 percent more than the benchmark.

[7] State reported a large shift of enrollees between eligibility groups. Missouri reported a 355 percent increase in the new adult group and a 15 percent decrease in the other adult group.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2022.

Source: MACPAC, 2024, analysis of T-MSIS data as of February 2024.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2022 (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	**87,680**	**80,305**	**31,499**	**31,320**	**23,003**	**22,419**	**15,653**	**12,439**	**9,183**	**8,092**	**8,342**	**6,036**
Alabama	**1,154**	**948**	566	566	–	–	243	174	212	158	132	50
Alaska	**250**	**249**	100	100	71	71	50	50	15	15	13	13
Arizona	**2,266**	**2,074**	752	742	692	646	458	383	173	159	191	144
Arkansas	**1,137**	**1,073**	498	497	390	389	12	12	157	125	80	48
California[4]	**13,610**	**11,980**	3,537	3,491	4,781	4,362	2,967	1,894	852	846	1,474	1,387
Colorado	**1,535**	**1,485**	518	517	673	672	159	149	102	91	85	55
Connecticut	**1,176**	**1,012**	359	356	369	368	239	206	61	35	150	47
Delaware	**294**	**264**	104	102	91	91	56	44	24	18	19	8
District of Columbia[5]	**278**	**266**	76	76	86	86	57	57	30	28	29	19
Florida	**5,180**	**4,595**	2,569	2,558	–	–	1,260	1,107	630	515	722	415
Georgia	**2,409**	**2,094**	1,296	1,296	–	–	506	416	344	271	264	111
Hawaii	**428**	**422**	137	137	171	171	56	56	21	20	44	39
Idaho	**414**	**394**	160	160	133	133	40	40	50	42	32	19
Illinois[5]	**3,307**	**3,202**	674	672	1,983	1,982	146	93	197	183	307	270
Indiana	**1,949**	**1,787**	744	727	485	478	415	343	175	150	131	89
Iowa	**772**	**745**	274	273	249	247	122	120	81	74	46	31
Kansas	**446**	**415**	252	252	–	–	76	74	75	62	43	27
Kentucky	**1,605**	**1,501**	452	452	674	673	156	154	213	163	110	59
Louisiana	**1,785**	**1,661**	567	566	730	730	100	98	231	184	157	83
Maine	**417**	**337**	109	105	101	99	86	50	60	45	61	38
Maryland	**1,543**	**1,458**	567	567	440	440	295	276	138	117	102	59
Massachusetts	**2,006**	**1,694**	440	396	470	443	540	351	324	321	233	183
Michigan	**2,918**	**2,842**	961	957	999	982	434	421	333	317	191	165
Minnesota	**1,325**	**1,295**	592	590	290	288	234	221	117	113	92	82
Mississippi	**784**	**673**	391	390	–	–	138	111	156	124	99	48

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[5,6]	**1,328**	**1,292**	666	666	221	220	146	146	186	171	109	87
Montana	**287**	**277**	105	105	114	114	30	28	22	19	17	12
Nebraska	**330**	**324**	151	151	70	70	45	45	39	36	25	21
Nevada	**856**	**804**	308	308	353	353	81	79	57	42	56	21
New Hampshire	**242**	**219**	81	80	90	90	27	18	26	20	18	11
New Jersey	**1,918**	**1,890**	639	639	728	728	203	201	174	168	173	154
New Mexico	**928**	**832**	326	326	293	288	164	136	76	55	69	27
New York	**7,104**	**6,920**	1,901	1,900	2,672	2,671	1,119	1,114	597	558	816	677
North Carolina	**2,487**	**1,945**	1,011	996	–	–	920	480	345	314	211	156
North Dakota[4]	**118**	**115**	47	47	34	34	15	15	12	12	10	8
Ohio	**3,094**	**2,963**	1,053	1,053	897	896	519	519	387	330	239	165
Oklahoma	**1,105**	**1,064**	491	491	284	280	142	132	113	101	75	60
Oregon	**1,241**	**1,096**	282	279	676	643	56	18	115	93	111	64
Pennsylvania	**3,338**	**3,222**	985	982	1,088	1,085	380	366	575	538	310	251
Rhode Island	**324**	**316**	87	87	102	102	67	66	39	36	29	24
South Carolina	**1,394**	**1,153**	643	637	–	–	480	258	167	163	104	94
South Dakota[7]	**130**	**122**	74	74	0	0	24	24	19	16	12	7
Tennessee	**1,691**	**1,580**	824	824	–	–	463	463	254	216	150	76
Texas[7]	**5,772**	**4,964**	3,474	3,474	0	0	1,081	650	677	563	539	278
Utah[4]	**455**	**433**	197	194	126	125	62	49	46	43	24	21
Vermont	**194**	**187**	67	67	74	74	14	14	19	18	20	14
Virginia	**1,843**	**1,724**	605	605	663	657	269	221	175	148	130	92
Washington	**2,092**	**2,017**	802	802	807	807	163	158	175	149	144	102
West Virginia	**625**	**584**	196	196	233	233	60	58	86	69	49	28
Wisconsin	**1,409**	**1,344**	498	497	–	–	576	527	187	184	148	137
Wyoming	**79**	**74**	46	46	–	–	15	15	11	10	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 sex. 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 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 240,900, North Dakota's child FYE enrollment by approximately 2,800, and Utah's child FYE enrollment by approximately 12,000.

[5] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 34 percent less than the benchmark, Illinois's average monthly enrollment was 108 percent more than the benchmark, and Missouri's average monthly enrollment was 33 percent more than the benchmark.

[6] State reported a large shift of enrollees between eligibility groups. Missouri reported a 1,325 percent increase in the new adult group and a 13 percent decrease in the other adult group.

[7] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2022.

Source: MACPAC, 2024, analysis of T-MSIS data as of February 2024.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2023 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$7,830**	$6,079	$1,751	**$259**	$153	$106	**$8,089**	$6,232	$1,857
Alaska	**2,530**	1,975	555	**176**	105	71	**2,706**	2,080	626
Arizona	**22,184**	17,906	4,278	**316**	197	119	**22,500**	18,102	4,397
Arkansas	**8,605**	6,954	1,651	**528**	352	176	**9,133**	7,306	1,827
California	**122,734**	80,518	42,216	**7,400**	4,438	2,962	**130,134**	84,956	45,178
Colorado	**12,804**	8,148	4,656	**843**	484	358	**13,647**	8,633	5,014
Connecticut	**10,326**	6,555	3,771	**412**	257	155	**10,738**	6,812	3,926
Delaware	**3,340**	2,404	936	**127**	81	47	**3,467**	2,485	982
District of Columbia	**4,129**	3,230	898	**189**	116	73	**4,317**	3,346	971
Florida	**34,194**	22,297	11,897	**648**	400	248	**34,842**	22,697	12,145
Georgia	**15,937**	11,356	4,580	**672**	427	245	**16,609**	11,783	4,825
Hawaii	**2,998**	2,195	803	**108**	70	38	**3,107**	2,265	841
Idaho	**3,539**	2,830	709	**141**	91	50	**3,681**	2,921	760
Illinois	**32,191**	21,002	11,189	**1,116**	688	428	**33,307**	21,690	11,617
Indiana	**17,278**	13,035	4,243	**541**	327	214	**17,820**	13,363	4,457
Iowa	**6,777**	4,922	1,855	**151**	95	56	**6,928**	5,017	1,911
Kansas	**5,193**	3,368	1,825	**243**	153	90	**5,437**	3,521	1,915
Kentucky	**16,299**	13,315	2,984	**343**	222	121	**16,642**	13,537	3,105
Louisiana	**16,207**	12,883	3,323	**422**	273	149	**16,629**	13,156	3,473
Maine	**4,101**	2,963	1,138	**186**	123	62	**4,287**	3,086	1,201
Maryland	**16,917**	10,745	6,172	**635**	403	232	**17,552**	11,148	6,404
Massachusetts	**23,228**	14,118	9,110	**1,260**	733	526	**24,488**	14,851	9,637
Michigan	**22,991**	17,486	5,506	**750**	473	277	**23,742**	17,959	5,783
Minnesota	**18,315**	11,670	6,646	**798**	452	345	**19,113**	12,122	6,991
Mississippi	**6,324**	5,220	1,104	**223**	151	72	**6,548**	5,371	1,176
Missouri	**15,865**	12,456	3,409	**493**	303	190	**16,358**	12,759	3,599

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Montana	**$2,339**	$1,870	$469	**$106**	$74	$32	**$2,445**	$1,944	$502
Nebraska	**3,749**	2,612	1,137	**182**	117	65	**3,931**	2,729	1,202
Nevada	**5,572**	4,297	1,275	**198**	124	75	**5,770**	4,421	1,350
New Hampshire	**2,444**	1,497	948	**149**	102	46	**2,593**	1,599	994
New Jersey	**22,310**	14,301	8,009	**1,023**	624	398	**23,332**	14,926	8,407
New Mexico	**8,106**	6,716	1,390	**367**	243	124	**8,473**	6,959	1,514
New York	**92,445**	58,919	33,526	**2,157**	1,226	931	**94,602**	60,145	34,456
North Carolina	**19,326**	14,082	5,243	**1,126**	697	429	**20,452**	14,779	5,673
North Dakota	**1,515**	1,001	514	**98**	67	31	**1,613**	1,069	545
Ohio	**31,666**	23,437	8,229	**1,186**	723	463	**32,852**	24,160	8,691
Oklahoma	**8,605**	7,046	1,559	**249**	149	100	**8,854**	7,195	1,659
Oregon	**14,668**	11,084	3,584	**660**	382	278	**15,328**	11,466	3,862
Pennsylvania	**43,767**	27,824	15,943	**1,204**	729	476	**44,971**	28,553	16,419
Rhode Island	**3,449**	2,285	1,164	**237**	150	87	**3,685**	2,435	1,250
South Carolina	**8,451**	6,370	2,081	**420**	269	151	**8,872**	6,639	2,233
South Dakota	**1,173**	802	371	**90**	59	31	**1,264**	861	403
Tennessee	**12,470**	8,847	3,623	**964**	686	278	**13,434**	9,533	3,901
Texas	**56,514**	36,907	19,608	**1,909**	1,169	740	**58,423**	38,075	20,348
Utah	**4,531**	3,421	1,111	**197**	128	69	**4,728**	3,548	1,180
Vermont	**1,997**	1,311	686	**178**	113	64	**2,175**	1,425	750
Virginia	**21,122**	14,067	7,054	**478**	313	164	**21,599**	14,381	7,218
Washington	**18,341**	12,219	6,122	**1,157**	629	528	**19,499**	12,848	6,651
West Virginia	**5,427**	4,443	984	**263**	199	64	**5,690**	4,642	1,048
Wisconsin	**11,984**	7,810	4,174	**549**	348	201	**12,533**	8,157	4,375
Wyoming	**716**	420	296	**62**	44	18	**778**	464	313
Subtotal (states)	**$855,523**	**$589,217**	**$266,306**	**$34,190**	**$20,934**	**$13,256**	**$889,712**	**$610,151**	**$279,561**

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
American Samoa	**$60**	$53	$7	**$2**	$1	$1	**$62**	$54	$8
Guam	**180**	160	20	**6**	4	2	**186**	163	23
Northern Mariana Islands	**86**	76	10	**3**	2	1	**89**	79	10
Puerto Rico	**3,869**	3,343	526	**147**	104	43	**4,015**	3,446	569
Virgin Islands	**164**	146	18	**15**	11	4	**180**	158	22
Subtotal (states and territories)	**$859,882**	**$592,995**	**$266,887**	**$34,363**	**$21,056**	**$13,307**	**$894,244**	**$614,051**	**$280,193**
State Medicaid Fraud Control Units	**–**	–	–	**440**	330	110	**440**	330	110
Medicaid survey and certification of nursing and intermediate care facilities	**–**	–	–	**437**	327	109	**437**	327	109
Vaccines for Children program	**–**	–	–	**–**	–	–	**5,217**	5,217	–
Total	**$859,882**	**$592,995**	**$266,887**	**$35,240**	**$21,714**	**$13,526**	**$900,338[2]**	**$619,925[2]**	**$280,415**

Notes: FY is fiscal year. Total federal spending shown here ($619,925 million) will differ from total federal outlays shown in FY 2025 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 29, 2024. 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, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024. For all other spending (MFCUs, survey and certification, VFC program): CMS, 2024, *Fiscal year 2025 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/files/document/fy2024-cms-congressional-justification-estimates-appropriations-committees.pdf.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2023 (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	**$7,830**	$3,005	$638	$92	$140	$133	$759	$451	$1,304	$729	$164	$465	-$48
Alaska	**2,530**	707	174	98	43	575	218	74	233	391	0	46	-30
Arizona	**22,184**	1,414	79	6	25	1,386	1,071	317	113	8	17,227	540	-1
Arkansas	**8,605**	1,417	364	1	33	92	862	132	1,080	1,184	3,068	409	-38
California	**122,734**	11,760	740	1,531	40	4,427	10,023	7,854	3,167	25,231	55,727	3,562	-1,330
Colorado	**12,804**	3,820	466	379	0	1,208	591	535	816	2,823	2,065	257	-155
Connecticut	**10,326**	3,014	537	173	334	338	900	698	1,699	2,038	23	671	-100
Delaware[2]	**3,340**	77	10	63	1	3	124	-33	56	291	2,688	64	-4
District of Columbia	**4,129**	201	28	5	6	337	219	101	527	731	1,918	86	-28
Florida	**34,194**	2,720	273	385	46	279	534	183	2,379	1,960	23,471	2,409	-447
Georgia	**15,937**	2,413	418	17	137	21	885	406	1,739	2,078	7,143	750	-71
Hawaii	**2,998**	98	0	36	1	32	287	1	11	188	2,337	53	-46
Idaho	**3,539**	1,057	197	–	59	58	272	232	175	658	784	87	-42
Illinois	**32,191**	3,017	205	19	30	54	1,311	19	1,414	3,459	21,974	781	-92
Indiana	**17,278**	1,205	301	24	12	372	723	223	3,220	2,631	8,208	428	-69
Iowa	**6,777**	126	14	0	2	50	133	7	35	54	6,293	209	-147
Kansas[2]	**5,193**	187	6	0	0	1	61	-2	95	0	4,723	151	-29
Kentucky	**16,299**	227	39	3	12	406	534	57	1,534	1,559	11,612	337	-21
Louisiana	**16,207**	614	34	–	1	33	317	128	1,776	1,270	11,676	539	-181
Maine	**4,101**	985	138	33	105	140	780	174	589	926	31	282	-81
Maryland	**16,917**	1,224	160	254	576	147	1,984	271	1,937	2,933	7,005	498	-72
Massachusetts	**23,228**	3,567	308	430	48	264	1,485	242	2,025	3,896	10,322	820	-179
Michigan	**22,991**	1,143	269	36	21	334	803	760	2,537	1,098	15,540	821	-371
Minnesota[2]	**18,315**	573	174	24	308	177	956	-309	1,350	5,453	9,521	281	-192
Mississippi	**6,324**	783	184	25	12	94	300	49	1,191	655	2,704	350	-23
Missouri	**15,865**	2,624	7	8	29	496	923	745	1,615	3,556	5,449	493	-80
Montana	**2,339**	945	159	31	78	123	315	129	185	298	37	64	-25
Nebraska[2]	**3,749**	42	1	0	0	0	73	-0	575	726	2,287	62	-18
Nevada	**5,572**	578	200	33	42	96	686	175	428	417	2,685	265	-34
New Hampshire[2]	**2,444**	256	4	22	1	1	159	-84	493	461	1,098	49	-15

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	**$22,310**	$1,467	$64	$0	$26	$539	$1,275	$4	$1,083	$2,727	$14,863	$608	-$346
New Mexico[2]	**8,106**	440	20	7	55	6	149	-11	37	768	6,438	217	-19
New York	**92,445**	9,288	320	12	207	1,261	4,175	658	8,391	10,503	60,049	2,999	-5,418
North Carolina	**19,326**	1,934	269	356	49	166	1,041	284	2,553	1,151	10,945	694	-117
North Dakota	**1,515**	171	41	16	24	19	63	54	438	297	380	22	-9
Ohio	**31,666**	1,525	140	21	12	195	920	409	2,428	4,001	21,353	850	-188
Oklahoma	**8,605**	3,065	847	220	79	869	799	1,442	1,041	853	111	244	-964
Oregon	**14,668**	427	24	6	20	480	517	108	736	3,524	8,601	358	-131
Pennsylvania	**43,767**	1,987	34	7	1	77	540	24	1,396	4,208	34,686	1,036	-228
Rhode Island[2]	**3,449**	344	9	9	0	19	226	-8	299	476	1,993	101	-18
South Carolina	**8,451**	1,264	125	145	17	93	426	70	1,000	1,153	4,276	345	-462
South Dakota	**1,173**	294	76	31	8	64	96	100	212	258	2	47	-15
Tennessee	**12,470**	1,003	36	229	0	121	772	623	291	776	8,131	579	-91
Texas	**56,514**	8,271	154	10	627	22	2,507	456	1,763	2,873	38,784	1,817	-770
Utah	**4,531**	419	98	23	24	18	367	58	509	543	2,446	60	-35
Vermont	**1,997**	246	61	31	44	42	824	92	190	407	5	58	-3
Virginia[2]	**21,122**	3,633	295	383	7	110	326	-47	432	3,485	12,761	449	-713
Washington[2]	**18,341**	829	210	261	13	1,369	1,031	-48	1,174	4,765	19,012	582	-10,856
West Virginia	**5,427**	214	29	4	203	15	198	373	1,053	580	2,596	208	-46
Wisconsin	**11,984**	850	32	125	42	400	1,127	645	910	1,524	5,968	450	-89
Wyoming	**716**	163	47	14	10	54	33	49	151	179	3	24	-10
Subtotal	**$855,523**	**$87,634**	**$9,058**	**$5,636**	**$3,609**	**$17,616**	**$45,700**	**$18,870**	**$60,383**	**$112,751**	**$491,183**	**$27,579**	**-$24,496**
American Samoa	**60**	39	1	–	–	5	13	1	–	0	–	2	–
Guam	**180**	102	16	4	0	1	31	22	1	0	–	3	–
N. Mariana Islands	**86**	58	–	4	–	8	7	6	–	1	–	2	–
Puerto Rico[2]	**3,869**	–	–	–	–	191	40	-133	–	–	3,772	–	-1
Virgin Islands	**164**	63	12	18	4	13	12	35	0	7	–	1	-0
Total	**$859,882**	**$87,896**	**$9,086**	**$5,662**	**$3,613**	**$17,834**	**$45,803**	**$18,800**	**$60,384**	**$112,760**	**$494,955**	**$27,587**	**-$24,497**
Percent of total, exclusive of collections	**–**	**9.9%**	**1.0%**	**0.6%**	**0.4%**	**2.0%**	**5.2%**	**2.1%**	**6.8%**	**12.8%**	**56.0%**	**3.1%**	**–**

EXHIBIT 17. (continued)

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

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

Additional detail on categories:

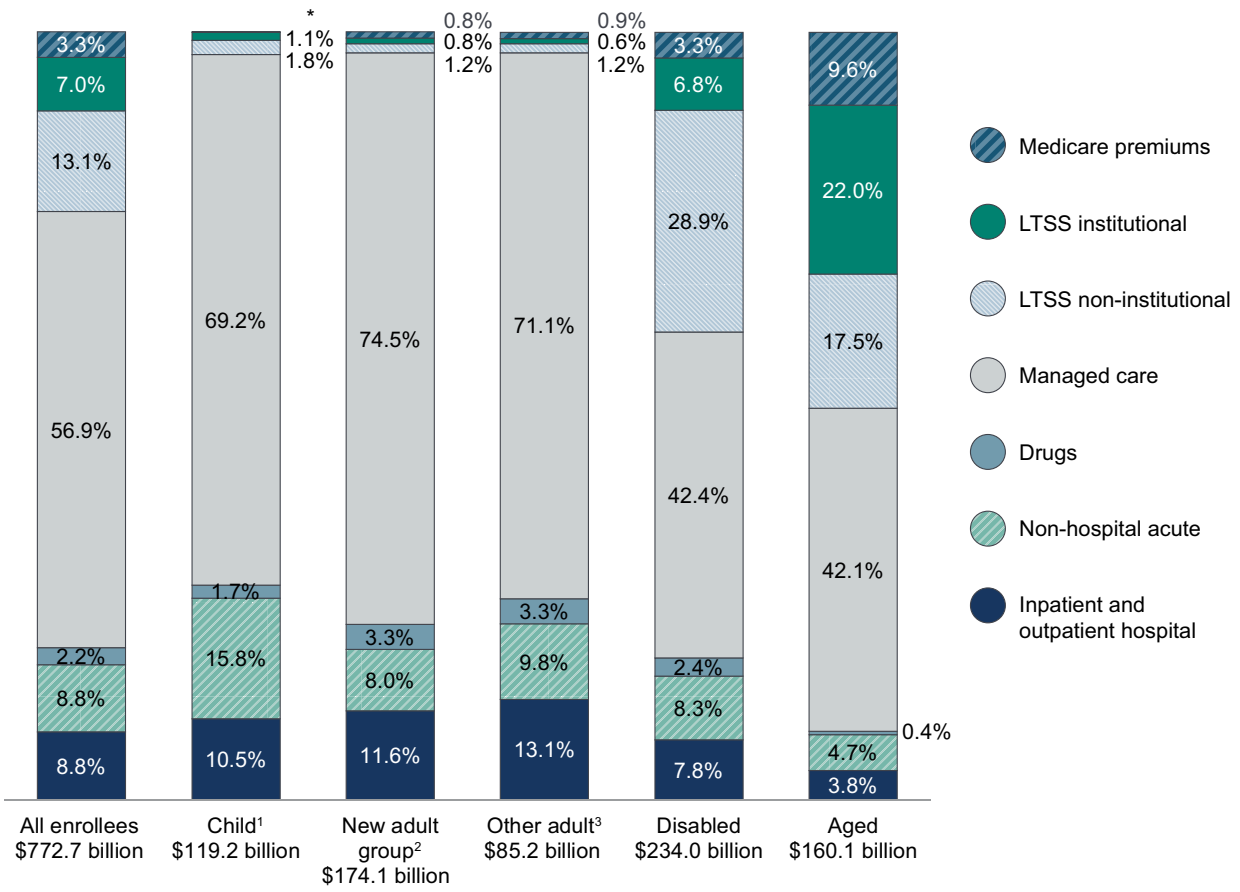
- Hospital includes inpatient, outpatient, critical access hospital, and emergency hospital services as well as related disproportionate share hospital payments.
- Physician includes physician and surgical services.
- Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center (FQHC), and freestanding birth center.
- Other acute includes lab or X-ray; sterilizations; abortions; early and periodic screening, diagnostic, and treatment screenings; 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; health home for children with medically complex conditions; opioid use disorder (OUD) medication-assisted treatment (MAT) services; COVID-19 vaccine and administration; qualified community-based mobile crisis intervention; 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 over 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 29, 2024. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[2] State reports negative fee-for-service (FFS) drug spending after the application of drug rebates. The negative net amount may reflect 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.

Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2022



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.

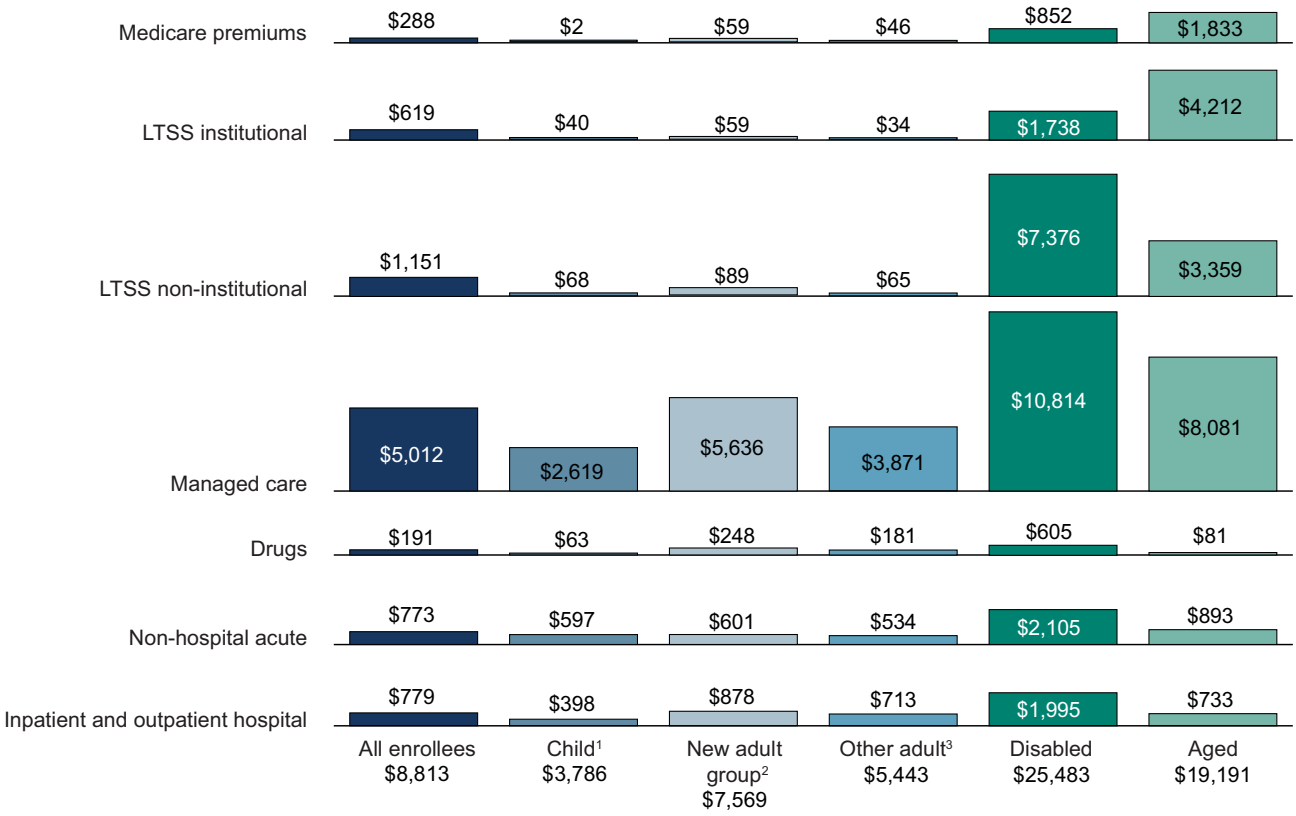
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset 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 $699.1 million.

[2] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who 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, 2024, analysis of T-MSIS data as of February 2024 and analysis of CMS-64 financial management report net expenditure data as of June 2023.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2022



Notes: FY is fiscal year. LTSS is long-term services and supports. 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. 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).

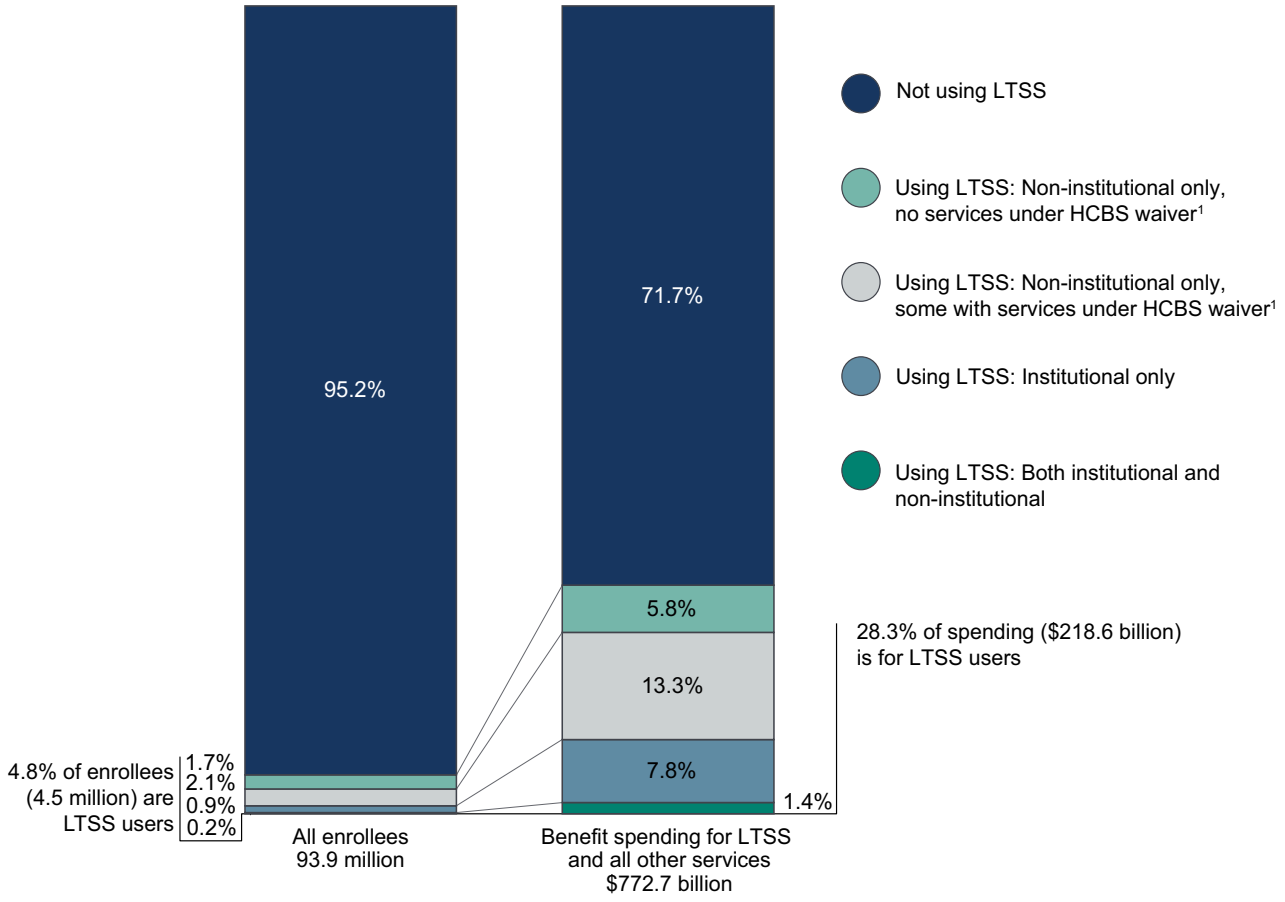
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset 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 enrollment by 255,700 and spending by $699.1 million.

[2] Includes both newly eligible and not newly eligible adults who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act. Newly eligible adults include those who 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, 2024, analysis of T-MSIS data as of February 2024 and analysis of CMS-64 financial management report net expenditure data as of June 2023.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2022



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 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 255,700 and spending by $699.1 million.

[1] All states have HCBS waiver programs that provide a range of LTSS for targeted populations of non-institutionalized enrollees who require institutional levels of care. The number of HCBS waiver enrollees and associated spending may be different from other sources such as the CMS-372 report (a state-reported source containing aggregate spending and enrollment for HCBS waivers).

Sources: MACPAC, 2024, analysis of T-MSIS data as of February 2024 and analysis of CMS-64 financial management report net expenditure data as of June 2023.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2022 (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	**$772,691**	**15.4%**	**22.5%**	**11.0%**	**30.3%**	**20.7%**	**$244,478**	**61.4%**	**$233,346**	**61.3%**	**$11,131**	**63.8%**
Alabama	**6,892**	23.0	–	12.2	43.1	21.8	**2,239**	66.2	**1,899**	67.4	**340**	59.5
Alaska	**2,449**	24.0	26.2	16.0	21.2	12.6	**548**	54.5	**546**	54.4	**2**	78.5
Arizona	**19,995**	14.6	34.2	14.5	26.7	10.0	**3,663**	50.3	**3,555**	49.6	**109**	71.6
Arkansas	**8,545**	24.2	31.5	0.1	30.3	13.8	**2,162**	55.6	**1,975**	56.4	**187**	46.6
California[5]	**114,962**	10.8	28.9	12.6	25.2	22.5	**32,539**	70.7	**32,159**	70.7	**380**	74.8
Colorado	**11,778**	15.4	33.3	7.8	27.8	15.7	**2,952**	62.5	**2,866**	62.2	**86**	71.2
Connecticut	**9,583**	14.5	26.1	11.8	22.0	25.7	**3,647**	61.5	**3,223**	60.1	**424**	72.3
Delaware[6]	**3,098**	17.7	28.0	16.2	25.4	12.7	**715**	53.7	**683**	53.2	**32**	64.4
District of Columbia[7]	**3,527**	10.7	19.3	12.4	35.5	22.1	**1,049**	69.2	**1,009**	68.8	**40**	78.2
Florida	**31,473**	24.0	–	15.1	34.9	26.0	**11,903**	65.5	**10,679**	65.2	**1,224**	67.7
Georgia	**13,860**	25.2	–	16.9	36.1	21.8	**4,184**	69.0	**3,666**	69.3	**518**	67.0
Hawaii[8]	**3,037**	16.4	35.1	10.0	17.8	20.7	**844**	63.4	**836**	63.2	**8**	82.6
Idaho	**3,198**	14.8	24.1	8.0	38.3	14.8	**978**	43.3	**923**	42.5	**55**	56.9
Illinois[7]	**25,445**	9.0	53.8	2.4	12.6	22.2	**6,505**	65.6	**6,390**	65.5	**115**	69.2
Indiana	**16,334**	13.2	24.3	21.6	21.9	19.0	**5,464**	61.4	**5,309**	61.5	**156**	58.1
Iowa	**6,688**	13.6	25.6	11.5	33.9	15.4	**2,238**	47.2	**2,174**	46.7	**65**	63.7
Kansas	**4,226**	21.9	–	11.4	43.8	23.0	**1,696**	51.4	**1,615**	51.3	**82**	52.2
Kentucky	**14,568**	14.1	37.5	8.4	28.3	11.7	**3,025**	54.7	**2,698**	56.1	**327**	42.5
Louisiana	**13,584**	14.5	38.9	5.1	28.4	13.1	**2,941**	57.5	**2,610**	57.5	**332**	58.1
Maine	**3,814**	13.1	17.5	7.7	40.1	21.6	**1,050**	55.3	**153**	70.0	**896**	52.8
Maryland	**14,248**	14.7	26.5	14.0	29.4	15.4	**3,770**	55.2	**3,549**	54.6	**220**	64.3
Massachusetts	**20,187**	9.1	19.0	11.9	34.7	25.4	**8,819**	55.5	**8,741**	55.2	**78**	95.9
Michigan	**20,712**	12.6	28.4	10.3	29.9	18.8	**6,640**	58.9	**6,546**	58.9	**94**	58.5
Minnesota	**16,246**	14.7	19.1	10.0	37.0	19.2	**5,695**	49.7	**5,663**	49.6	**32**	70.4
Mississippi	**5,724**	22.8	–	10.9	43.3	23.1	**2,072**	63.1	**1,837**	63.7	**235**	58.8

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[7,9]	**$12,257**	23.6%	13.0%	7.2%	39.1%	17.1%	**$4,212**	44.3%	**$4,135**	44.0%	**$77**	57.6%
Montana	**2,367**	20.8	37.6	8.7	20.2	12.8	**570**	55.8	**541**	55.4	**29**	63.0
Nebraska	**3,306**	14.9	21.1	9.8	33.3	20.9	**1,098**	54.8	**1,085**	54.7	**13**	62.0
Nevada	**4,943**	16.2	42.7	8.2	21.7	11.2	**851**	64.8	**718**	64.5	**133**	66.7
New Hampshire	**2,224**	18.9	22.1	4.5	31.1	23.4	**966**	51.5	**930**	51.6	**36**	46.6
New Jersey	**20,226**	12.7	26.8	7.8	30.9	21.8	**7,121**	58.1	**7,066**	58.0	**55**	76.2
New Mexico[6]	**8,227**	19.4	29.0	13.4	26.1	12.2	**1,837**	54.2	**1,682**	52.9	**155**	68.5
New York	**79,319**	9.2	23.3	8.6	27.6	31.3	**34,122**	70.1	**33,595**	70.0	**527**	78.2
North Carolina	**18,121**	20.1	–	19.1	42.1	18.7	**5,483**	59.8	**5,311**	59.7	**171**	65.2
North Dakota[5]	**1,531**	12.3	27.6	5.3	30.1	24.8	**653**	57.9	**634**	57.3	**19**	77.7
Ohio	**30,046**	13.2	25.2	11.2	32.2	18.2	**8,425**	53.0	**8,101**	52.9	**324**	55.0
Oklahoma[6]	**8,190**	25.9	25.8	9.3	25.4	13.7	**1,838**	55.6	**1,758**	56.1	**80**	45.2
Oregon	**13,059**	9.9	42.8	2.0	21.2	24.2	**4,307**	69.7	**3,737**	70.2	**570**	66.9
Pennsylvania	**40,163**	11.2	21.1	6.4	38.7	22.7	**15,780**	57.6	**15,555**	57.5	**225**	61.1
Rhode Island	**2,790**	20.9	24.0	12.3	30.4	12.4	**1,007**	60.5	**994**	60.4	**13**	68.4
South Carolina	**7,246**	22.6	–	16.2	41.9	19.2	**2,405**	55.3	**2,370**	55.2	**35**	67.5
South Dakota[6,10]	**1,255**	18.7	–	12.6	46.3	22.4	**537**	51.6	**511**	51.4	**26**	55.2
Tennessee	**11,283**	28.2	–	20.4	34.1	17.4	**3,554**	53.7	**3,307**	52.9	**247**	64.9
Texas[6,10]	**48,520**	31.4	–	14.2	36.2	18.2	**12,657**	65.8	**10,920**	65.4	**1,737**	67.8
Utah[5]	**4,212**	17.9	26.6	10.0	33.1	12.3	**1,089**	44.9	**1,014**	45.5	**76**	36.3
Vermont	**1,722**	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]
Virginia	**18,619**	12.2	31.4	6.6	33.3	16.5	**5,961**	45.7	**5,771**	45.4	**189**	54.8
Washington	**21,705**	14.7	35.8	8.0	26.0	15.5	**5,736**	57.4	**5,518**	57.2	**218**	61.8
West Virginia	**5,133**	15.0	29.4	7.4	27.2	21.1	**1,708**	63.7	**1,616**	64.3	**92**	54.1
Wisconsin	**11,375**	13.5	–	25.2	39.2	22.1	**4,457**	54.4	**4,433**	54.3	**24**	77.0
Wyoming	**677**	24.6	–	13.8	39.5	22.2	**269**	54.2	**258**	54.1	**11**	58.2

EXHIBIT 21. (continued)

Notes: FY is fiscal year. Includes federal and state funds. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals. With regard to methods, spending totals exclude disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of Section 1115 of the Social Security Act (the Act), which were previously included 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 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 $651.5 million, North Dakota's child spending by approximately $10.4 million, and Utah's child spending by approximately $37.2 million.

[6] State reported CMS-64 spending that shows a difference greater than 20 percent when compared to the prior year. Delaware's spending on the CMS-64 was 27.9 percent higher compared with 2021. New Mexico's spending on the CMS-64 was 20.2 percent higher compared with 2021. Oklahoma's spending on the CMS-64 was 41.5 percent higher compared with 2021. South Dakota's spending on the CMS-64 was 25.0 percent higher compared with 2021. Texas's spending on the CMS-64 was 23.6 percent higher compared with 2021.

[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 34 percent less than the benchmark, Illinois's average monthly enrollment was 108 percent more than the benchmark, and Missouri's average monthly enrollment was 33 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 a large shift of enrollees between eligibility groups. Missouri reported a 355 percent increase in the new adult group and a 15 percent decrease in the other adult group.

[10] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2022.

[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, 2024, analysis of T-MSIS data as of February 2024 and analysis of CMS-64 financial management report net expenditure data as of June 2023.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2022

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	**$8,813**	**$9,361**	**$3,786**	**$3,798**	**$7,569**	**$7,641**	**$5,443**	**$6,431**	**$25,483**	**$28,363**	**$19,191**	**$25,177**
Alabama	**5,974**	**6,877**	2,798	2,798	–	–	3,459	4,660	13,965	17,906	11,368	25,987
Alaska	**9,786**	**9,821**	5,878	5,878	8,980	8,980	7,819	7,819	34,042	34,557	22,862	24,314
Arizona	**8,824**	**9,474**	3,879	3,923	9,890	10,424	6,349	7,358	30,809	33,377	10,425	13,053
Arkansas	**7,517**	**7,792**	4,162	4,161	6,916	6,916	788	787	16,472	19,874	14,772	22,692
California[4]	**8,447**	**9,143**	3,521	3,538	6,957	7,142	4,866	6,399	34,015	34,125	17,527	18,044
Colorado	**7,671**	**7,869**	3,513	3,517	5,824	5,826	5,767	6,109	32,282	35,570	21,857	32,403
Connecticut	**8,147**	**8,989**	3,865	3,891	6,794	6,714	4,723	5,349	34,487	57,384	16,455	45,807
Delaware[5]	**10,542**	**11,548**	5,271	5,357	9,500	9,508	9,025	11,097	32,751	42,049	20,867	44,641
District of Columbia[6]	**12,704**	**13,114**	5,004	5,004	7,882	7,882	7,718	7,704	41,368	44,464	27,143	38,955
Florida	**6,076**	**6,465**	2,939	2,938	–	–	3,769	3,908	17,440	20,476	11,344	17,655
Georgia	**5,752**	**6,274**	2,696	2,691	–	–	4,640	5,249	14,524	17,721	11,467	24,030
Hawaii[7]	**7,094**	**7,132**	3,637	3,636	6,249	6,152	5,445	5,402	25,582	27,131	14,337	15,961
Idaho	**7,716**	**7,983**	2,968	2,968	5,781	5,781	6,433	6,433	24,546	28,349	14,926	23,812
Illinois[6]	**7,694**	**7,866**	3,387	3,392	6,903	6,892	4,179	5,319	16,339	17,301	18,389	20,619
Indiana	**8,379**	**8,887**	2,892	2,943	8,202	8,255	8,515	9,676	20,437	23,398	23,677	33,472
Iowa	**8,667**	**8,861**	3,332	3,331	6,882	6,880	6,270	6,337	27,853	30,166	22,520	32,270
Kansas	**9,476**	**9,926**	3,667	3,661	–	–	6,315	6,361	24,768	28,964	22,608	34,066
Kentucky	**9,077**	**9,444**	4,543	4,541	8,092	8,058	7,844	7,813	19,402	24,147	15,540	26,314
Louisiana	**7,611**	**7,959**	3,485	3,482	7,234	7,235	6,931	7,042	16,737	20,082	11,280	19,056
Maine	**9,147**	**8,648**	4,575	4,763	6,582	6,687	3,419	5,417	25,629	25,037	13,540	9,416
Maryland	**9,236**	**9,500**	3,691	3,676	8,598	8,601	6,761	6,641	30,307	35,152	21,502	34,971
Massachusetts	**10,062**	**11,647**	4,160	4,576	8,153	8,578	4,456	6,103	21,611	21,790	22,028	27,222
Michigan	**7,099**	**7,230**	2,711	2,721	5,897	5,955	4,917	5,013	18,600	19,423	20,365	23,193
Minnesota	**12,265**	**12,477**	4,026	4,029	10,713	10,703	6,945	7,246	51,215	53,053	33,845	37,522
Mississippi	**7,302**	**8,120**	3,338	3,339	–	–	4,517	5,423	15,848	19,189	13,333	24,700
Missouri[6,8]	**9,232**	**9,430**	4,339	4,339	7,231	7,228	6,036	6,036	25,771	27,752	19,328	23,578
Montana	**8,239**	**8,432**	4,701	4,701	7,799	7,802	6,937	7,315	21,866	24,606	17,594	24,454
Nebraska	**10,023**	**10,170**	3,256	3,253	9,909	9,904	7,284	7,280	28,465	30,082	27,847	32,624

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	**$5,778**	**$5,951**	$2,606	$2,606	$5,976	$5,974	$4,987	$4,865	$18,674	$24,470	$9,879	$21,370
New Hampshire	**9,209**	**9,964**	5,196	5,231	5,456	5,457	3,745	5,491	26,329	33,880	29,580	44,349
New Jersey	**10,546**	**10,563**	4,024	4,012	7,454	7,334	7,740	7,448	35,814	37,013	25,497	28,248
New Mexico[5]	**8,866**	**9,611**	4,887	4,889	8,130	8,176	6,726	7,960	28,377	37,707	14,437	32,841
New York	**11,166**	**11,385**	3,826	3,826	6,913	6,914	6,120	6,141	36,705	39,033	30,439	36,082
North Carolina	**7,286**	**9,049**	3,603	3,651	–	–	3,766	6,780	22,100	23,749	16,068	20,978
North Dakota[4]	**13,001**	**13,106**	3,987	3,987	12,453	12,419	5,570	5,570	37,070	39,182	39,134	45,762
Ohio	**9,710**	**10,017**	3,758	3,756	8,431	8,414	6,484	6,454	25,007	28,889	22,960	32,042
Oklahoma[5]	**7,412**	**7,597**	4,317	4,317	7,419	7,416	5,377	5,615	18,479	20,318	14,880	18,286
Oregon	**10,522**	**11,286**	4,586	4,613	8,258	8,569	4,591	12,665	24,013	27,992	28,367	43,245
Pennsylvania	**12,031**	**12,388**	4,573	4,588	7,793	7,800	6,736	6,976	26,991	28,669	29,357	35,747
Rhode Island	**8,623**	**8,762**	6,706	6,698	6,567	6,567	5,125	5,182	21,977	22,958	11,917	13,854
South Carolina	**5,199**	**6,168**	2,551	2,565	–	–	2,447	4,255	18,158	18,436	13,451	14,569
South Dakota[5,9]	**9,683**	**10,102**	3,164	3,164	–	–	6,584	6,568	29,991	35,647	23,395	36,094
Tennessee	**6,671**	**6,987**	3,853	3,853	–	–	4,957	4,957	15,154	17,429	13,091	23,628
Texas[5,9]	**8,406**	**9,227**	4,391	4,377	3,058	3,058	6,377	9,839	25,915	29,761	16,355	26,843
Utah[4]	**9,262**	**9,457**	3,838	3,885	8,891	8,916	6,863	8,161	30,355	30,883	21,229	22,705
Vermont	**8,856**	**10**	10	10	10	10	10	10	10	10	10	10
Virginia	**10,104**	**10,647**	3,758	3,758	8,812	8,804	4,577	5,515	35,378	41,283	23,669	32,089
Washington	**10,375**	**10,531**	3,974	3,976	9,630	9,628	10,645	9,776	32,251	37,255	23,311	31,401
West Virginia	**8,218**	**8,626**	3,931	3,932	6,456	6,455	6,328	6,461	16,140	19,641	22,109	37,479
Wisconsin	**8,072**	**8,403**	3,090	3,096	–	–	4,969	5,349	23,788	24,140	17,059	18,213
Wyoming	**8,590**	**9,008**	3,646	3,648	–	–	6,265	6,315	23,447	27,650	21,776	35,105

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 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 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 240,900 and spending by $651.5 million, North Dakota's child FYE enrollment by approximately 2,800 and spending by $10.4 million, and Utah's child FYE enrollment by approximately 12,000 and spending by $37.2 million.

[5] State reported CMS-64 spending that shows a difference greater than 20 percent when compared to the prior year. Delaware's spending on the CMS-64 was 27.9 percent higher compared with 2021. New Mexico's spending on the CMS-64 was 20.2 percent higher compared with 2021. Oklahoma's spending on the CMS-64 was 41.5 percent higher compared with 2021. South Dakota's spending on the CMS-64 was 25.0 percent higher compared with 2021. Texas's spending on the CMS-64 was 23.6 percent higher compared with 2021.

[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 34 percent less than the benchmark, Illinois's average monthly enrollment was 108 percent more than the benchmark, and Missouri's average monthly enrollment was 33 percent more than the benchmark.

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

[8] State reported a large shift of enrollees between eligibility groups. Missouri reported a 1,325 percent increase in the new adult group and a 13 percent decrease in the other adult group.

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2022.

[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, 2024, analysis of T-MSIS data as of February 2024 and analysis of CMS-64 financial management report net expenditure data as of June 2023.

EXHIBIT 23. Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2023

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	1,340,134	$7,829,656,078	$5,842	–	–	–
Alaska	256,815	2,530,260,279	9,852	74,027	$657,260,322	$8,879
Arizona	2,455,833	22,183,972,139	9,033	184,834	918,140,619	4,967
Arkansas	1,007,775	8,605,196,491	8,539	303,164	2,496,225,448	8,234
California	15,171,753	122,733,821,782	8,090	5,172,842	34,111,721,248	6,594
Colorado	1,666,236	12,804,321,510	7,685	601,624	3,164,514,406	5,260
Connecticut	1,166,878	10,325,691,733	8,849	342,760	2,441,534,415	7,123
Delaware	292,944	3,339,783,691	11,401	15,622	136,419,130	8,733
District of Columbia	292,546	4,128,553,265	14,112	92,837	776,872,355	8,368
Florida	5,532,360	34,193,930,124	6,181	–	–	–
Georgia	2,554,857	15,936,633,577	6,238	–	–	–
Hawaii	467,372	2,998,266,333	6,415	31,627	776,317,914	24,546
Idaho	441,628	3,539,117,454	8,014	130,583	865,650,762	6,629
Illinois	3,452,162	32,190,728,327	9,325	926,261	8,302,954,537	8,964
Indiana	2,050,792	17,278,391,501	8,425	601,258	4,370,056,541	7,268
Iowa	774,069	6,776,760,824	8,755	195,894	1,404,302,176	7,169
Kansas	459,392	5,193,350,486	11,305	–	–	–
Kentucky	1,570,850	16,298,820,904	10,376	640,133	5,797,598,728	9,057
Louisiana	2,040,184	16,206,573,085	7,944	770,795	6,082,378,130	7,891
Maine	405,908	4,100,961,967	10,103	90,584	–	–
Maryland	1,594,059	16,916,738,529	10,612	461,094	4,064,559,825	8,815
Massachusetts	2,241,829	23,228,189,899	10,361	–	–	–
Michigan	3,071,844	22,991,355,684	7,485	995,580	6,230,916,167	6,259
Minnesota	1,399,722	18,315,485,685	13,085	318,028	3,626,596,382	11,403
Mississippi	839,861	6,324,317,586	7,530	–	–	–
Missouri	1,462,579	15,864,615,465	10,847	327,194	2,815,967,559	8,606

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	301,080	$2,338,762,637	$7,768	118,051	$1,018,009,844	$8,624
Nebraska	392,960	3,748,830,826	9,540	80,769	826,420,072	10,232
Nevada	837,633	5,571,967,956	6,652	373,229	2,236,490,516	5,992
New Hampshire	218,871	2,444,300,232	11,168	82,660	443,886,240	5,370
New Jersey	2,119,729	22,309,832,720	10,525	768,094	5,831,872,397	7,593
New Mexico	962,008	8,105,771,112	8,426	292,736	2,265,997,535	7,741
New York	7,827,430	92,444,864,932	11,810	436,127	2,961,173,425	6,790
North Carolina	2,949,835	19,325,608,483	6,551	–	–	–
North Dakota	131,063	1,515,216,578	11,561	33,890	392,243,271	11,574
Ohio	3,564,661	31,665,985,589	8,883	883,584	8,092,364,317	9,159
Oklahoma	1,218,172	8,604,968,217	7,064	360,886	2,813,654,165	7,797
Oregon	1,325,146	14,667,985,607	11,069	625,654	5,040,699,627	8,057
Pennsylvania	3,624,914	43,766,971,978	12,074	1,100,196	8,095,693,101	7,358
Rhode Island	357,706	3,448,572,775	9,641	100,604	790,123,492	7,854
South Carolina	1,583,495	8,451,464,561	5,337	–	–	–
South Dakota	124,865	1,173,484,201	9,398	1,814	13,881,209	7,653
Tennessee	1,876,906	12,469,838,770	6,644	–	–	–
Texas	6,007,624	56,514,110,478	9,407	–	–	–
Utah	498,683	4,531,351,223	9,087	135,319	1,103,131,296	8,152
Vermont	199,857	1,997,411,908	9,994	–	–	–
Virginia	1,965,042	21,121,573,951	10,749	732,601	6,955,424,497	9,494
Washington	2,136,992	18,341,376,203	8,583	794,597	10,517,116,499	13,236
West Virginia	643,245	5,427,180,909	8,437	237,730	1,424,430,032	5,992
Wisconsin	1,556,261	11,983,836,909	7,700	–	–	–
Wyoming	85,753	715,906,959	8,349	–	–	–
Subtotal (states)	**96,520,315**	**$855,522,670,112**	**$8,864**	**19,435,282**	**$149,862,598,199**	**$7,711**

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	33,887	$59,932,077	$1,769	–	–	–
Guam	44,116	180,050,749	4,081	–	–	–
Northern Mariana Islands	19,438	86,034,771	4,426	–	–	–
Puerto Rico	1,513,588	3,868,555,513	2,556	–	–	–
Virgin Islands	37,081	164,402,805	4,434	–	–	–
Total (states and territories)	**98,168,426**	**$859,881,646,027**	**$8,759**	**19,435,282**	**$149,862,598,199**	**$7,711**

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 through March 2023 enrollment was taken from the submission quarter ending December 31, 2023). 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 29, 2024. 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 2023.

Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 enrollment reports as of October 15, 2024.

EXHIBIT 24. Medicaid Supplemental Payments to Hospital Providers by State, FY 2023 (millions)

State[1]	Inpatient and outpatient hospitals[2]				
	Total Medicaid payments	DSH payments	Non-DSH supplemental payments	Section 1115 waiver authority payments	Supplemental payments as % of total
Total	**$90,102.8**	**$13,956.5**	**$23,579.5**	**$10,257.7**	**53.0%**
Alabama	**3,004.6**	206.0	1,564.2	–	58.9
Alaska[3]	**707.4**	-1.3	–	–	-0.2
Arizona	**1,414.3**	137.2	413.9	–	39.0
Arkansas	**1,417.3**	22.8	524.4	–	38.6
California[4]	**14,060.9**	805.8	5,335.7	2,300.4	60.0
Colorado	**3,819.6**	244.7	1,537.6	–	46.7
Connecticut	**3,014.1**	124.2	601.5	–	24.1
Delaware	**76.7**	10.0	–	–	13.0
District of Columbia	**200.9**	55.9	–	–	27.8
Florida[4]	**2,720.4**	235.7	601.3	1,271.0	77.5
Georgia	**2,413.5**	537.0	245.5	–	32.4
Hawaii	**98.3**	44.1	–	–	44.9
Idaho	**1,056.9**	12.3	247.2	–	24.6
Illinois	**3,016.7**	354.5	1,133.6	–	49.3
Indiana	**1,205.4**	202.2	72.5	–	22.8
Iowa	**126.4**	18.1	72.5	–	71.6
Kansas[4]	**187.0**	75.1	0.4	81.7	84.1
Kentucky	**227.3**	5.0	6.5	–	5.0
Louisiana	**614.0**	338.9	84.4	–	68.9
Maine	**985.2**	–	148.9	–	15.1
Maryland	**1,223.7**	116.5	60.7	–	14.5
Massachusetts[4,5,6]	**3,735.2**	–	656.1	642.8	34.8
Michigan	**1,143.1**	323.8	501.1	–	72.2
Minnesota	**573.1**	54.8	124.7	–	31.3
Mississippi	**782.7**	163.9	182.3	–	44.2
Missouri	**2,623.9**	558.1	520.3	–	41.1
Montana	**944.6**	–	377.8	–	40.0
Nebraska	**41.6**	32.6	–	–	78.4
Nevada	**578.0**	22.2	257.0	–	48.3
New Hampshire	**256.5**	213.4	23.5	–	92.4
New Jersey	**1,467.2**	766.5	242.1	–	68.7
New Mexico	**439.6**	36.1	219.0	–	58.0
New York	**9,287.8**	3,298.6	981.3	–	46.1
North Carolina	**1,934.0**	60.0	420.6	–	24.8
North Dakota	**171.5**	0.9	1.9	–	1.6
Ohio	**1,525.3**	683.6	–	–	44.8
Oklahoma	**3,065.2**	67.2	1,126.5	–	38.9

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	**$427.0**	$72.4	$153.0	–	52.8%
Pennsylvania	**1,986.6**	998.3	594.7	–	80.2
Rhode Island[6]	**344.1**	157.8	10.1	$37.6	59.7
South Carolina	**1,263.7**	549.3	195.4	–	58.9
South Dakota	**294.0**	0.9	8.0	–	3.0
Tennessee[4]	**1,002.6**	94.8	80.0	806.0	97.8
Texas[4,5]	**8,270.7**	1,762.8	617.6	5,118.3	90.7
Utah	**419.5**	9.8	34.3	–	10.5
Vermont	**245.9**	22.7	–	–	9.2
Virginia[3]	**3,633.3**	-6.3	3,334.4	–	91.6
Washington[5]	**828.8**	268.8	149.9	0.0	50.5
West Virginia	**214.0**	55.4	14.8	–	32.8
Wisconsin	**850.1**	142.9	52.4	–	23.0
Wyoming	**162.7**	0.5	50.1	–	31.1

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 29, 2024. 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 supplemental payments through an uncompensated care pool under Section 1115 waiver expenditure authority.

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

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

Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 Schedule C waiver report data as of August 2, 2024.

EXHIBIT 25. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2023 (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	**$8,123.0**	**$3,751.8**	**46.2%**	**$52,260.0**	**$2,943.9**	**5.6%**	**$12,191.2**	**$2,646.8**	**21.7%**
Alabama	**83.7**	3.2	3.8	**1,219.9**	–	–	**684.1**	130.8	19.1
Alaska	**29.7**	17.6	59.3	**203.6**	–	–	**217.2**	–	–
Arizona	**36.0**	28.5	79.0	**76.8**	11.6	15.2	**87.9**	–	–
Arkansas	**16.7**	–	–	**1,063.0**	–	–	**392.4**	48.1	12.3
California	**517.0**	0.2	0.0	**2,650.2**	273.2	10.3	**776.8**	194.4	25.0
Colorado	**9.9**	–	–	**805.9**	121.4	15.1	**465.9**	220.4	47.3
Connecticut	**264.7**	105.6	39.9	**1,434.2**	–	–	**871.4**	24.1	2.8
Delaware	**20.2**	6.2	30.8	**36.0**	–	–	**10.6**	–	–
District of Columbia	**101.4**	7.0	6.9	**425.8**	0.1	0.0	**29.7**	4.5	15.2
Florida[5]	**1,671.8**	120.1	7.2	**706.8**	–	–	**318.3**	177.7	55.8
Georgia	**18.3**	–	–	**1,720.7**	84.4	4.9	**555.0**	133.4	24.0
Hawaii	**–**	–	–	**10.6**	–	–	**1.4**	–	–
Idaho	**5.5**	–	–	**169.8**	62.8	37.0	**256.5**	–	–
Illinois	**106.9**	89.4	83.6	**1,307.4**	–	–	**215.0**	–	–
Indiana	**85.8**	–	–	**3,134.4**	803.3	25.6	**311.5**	61.9	19.9
Iowa	**0.8**	–	–	**34.5**	–	–	**15.1**	5.4	35.8
Kansas	**23.8**	23.3	97.8	**71.2**	–	–	**6.5**	2.4	36.5
Kentucky	**36.1**	31.6	87.5	**1,497.5**	0.6	0.0	**45.5**	11.3	24.8
Louisiana	**141.1**	134.2	95.1	**1,634.8**	3.8	0.2	**34.2**	2.1	6.1
Maine	**134.5**	57.5	42.8	**454.1**	–	–	**214.9**	1.1	0.5
Maryland	**474.9**	67.8	14.3	**1,461.8**	–	–	**657.7**	373.3	56.8
Massachusetts[6]	**242.4**	207.3	85.5	**1,782.4**	196.1	11.0	**326.5**	0.3	0.1
Michigan	**374.0**	340.4	91.0	**2,163.2**	422.0	19.5	**278.0**	144.0	51.8
Minnesota	**155.0**	15.0	9.7	**1,195.0**	–	–	**452.7**	59.1	13.1
Mississippi	**19.0**	–	–	**1,172.1**	10.5	0.9	**195.0**	23.2	11.9

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	**$226.3**	$208.6	92.2%	**$1,388.4**	$6.3	0.5%	**$35.1**	–	–
Montana	**20.8**	–	–	**164.3**	13.7	8.3	**234.4**	–	–
Nebraska	**1.8**	1.8	100.0	**573.3**	23.7	4.1	**1.3**	–	–
Nevada	**45.2**	–	–	**383.0**	150.0	39.2	**213.7**	$27.1	12.7%
New Hampshire	**63.4**	63.4	99.9	**429.1**	174.2	40.6	**4.2**	–	–
New Jersey	**507.0**	357.9	70.6	**575.6**	9.9	1.7	**69.3**	–	–
New Mexico	**3.4**	–	–	**33.4**	–	–	**74.9**	3.7	5.0
New York	**951.4**	605.0	63.6	**7,439.8**	19.1	0.3	**527.0**	–	–
North Carolina	**366.2**	365.8	99.9	**2,187.2**	–	–	**277.0**	34.5	12.5
North Dakota	**17.6**	1.0	5.8	**420.4**	–	–	**56.9**	–	–
Ohio	**93.4**	93.4	100.0	**2,334.2**	–	–	**151.3**	19.8	13.1
Oklahoma	**96.4**	3.3	3.4	**944.4**	144.2	15.3	**924.2**	37.5	4.1
Oregon	**5.3**	5.0	94.3	**730.7**	89.6	12.3	**36.4**	2.2	6.0
Pennsylvania	**391.0**	298.5	76.4	**1,004.5**	42.6	4.2	**34.7**	–	–
Rhode Island[5,6,7]	**3.5**	0.9	24.9	**295.2**	7.9	2.7	**9.2**	1.4	15.1
South Carolina	**63.6**	60.9	95.7	**935.9**	15.9	1.7	**134.4**	40.1	29.9
South Dakota	**2.4**	0.8	30.9	**209.8**	0.2	0.1	**83.8**	–	–
Tennessee	**63.9**	–	–	**227.5**	–	–	**35.6**	–	–
Texas[5]	**306.5**	304.5	99.4	**1,456.4**	7.2	0.5	**770.6**	582.5	75.6
Utah	**23.2**	0.9	4.0	**485.9**	122.6	25.2	**113.7**	22.2	19.5
Vermont	**17.5**	–	–	**172.5**	–	–	**103.7**	–	–
Virginia	**97.4**	–	–	**335.0**	21.7	6.5	**301.8**	246.9	81.8
Washington	**127.3**	106.8	83.9	**1,046.9**	6.1	0.6	**222.9**	7.3	3.3
West Virginia	**26.0**	18.4	70.8	**1,027.5**	–	–	**226.9**	–	–
Wisconsin	**25.7**	–	–	**883.8**	58.9	6.7	**72.9**	–	–
Wyoming	**7.3**	–	–	**143.7**	40.4	28.1	**55.6**	4.1	7.3

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 29, 2024. 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 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.

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

Source: MACPAC, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024, and CMS-64 Schedule C waiver report data as of August 2, 2024.

EXHIBIT 26. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2023 (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]	**$104,859.3**	**84.8%**	**15.0%**	**0.2%**	**$42,768.4**	**86.5%**	**13.4%**	**0.0%**	**$62,090.8**	**83.6%**	**16.1%**	**0.3%**
Alabama	**1,061.3**	**87.3**	**12.7**	**0.0**	**1,061.3**	87.3	12.7	0.0	**–**	–	–	–
Alaska	**211.4**	**86.8**	**13.2**	**0.0**	**211.4**	86.8	13.2	0.0	**–**	–	–	–
Arizona	**2,003.1**	**87.7**	**12.2**	**0.0**	**45.5**	80.2	19.7	0.1	**1,957.6**	87.9	12.1	0.0
Arkansas	**540.1**	**83.3**	**16.7**	**0.0**	**434.6**	82.6	17.3	0.0	**105.5**	85.9	14.1	0.0
California	**13,689.1**	**83.7**	**16.2**	**0.0**	**13,089.3**	83.5	16.5	0.0	**599.8**	89.5	10.5	0.1
Colorado	**1,533.6**	**90.6**	**9.3**	**0.0**	**1,473.2**	90.7	9.2	0.0	**60.4**	87.8	12.1	0.0
Connecticut	**1,848.8**	**90.7**	**9.2**	**0.1**	**1,848.8**	90.7	9.2	0.1	**–**	–	–	–
Delaware	**278.5**	**86.7**	**13.3**	**0.0**	**1.4**	95.4	4.6	–	**277.1**	86.6	13.4	0.0
District of Columbia	**253.7**	**92.6**	**7.4**	**0.0**	**150.8**	98.0	2.0	0.0	**103.0**	84.6	15.4	0.0
Florida	**3,924.6**	**90.0**	**10.0**	**0.0**	**258.3**	94.6	5.4	0.0	**3,666.4**	89.7	10.3	0.0
Georgia	**1,506.8**	**85.9**	**14.1**	**0.1**	**872.6**	90.4	9.5	0.0	**634.1**	79.5	20.3	0.1
Hawaii	**244.7**	**84.6**	**15.4**	**0.0**	**0.2**	–	100.0	–	**244.4**	84.6	15.3	0.0
Idaho	**572.8**	**90.1**	**9.8**	**0.1**	**572.8**	90.1	9.8	0.1	**–**	–	–	–
Illinois	**3,777.0**	**90.5**	**9.5**	**0.0**	**137.3**	85.9	14.1	0.0	**3,639.6**	90.7	9.3	0.0
Indiana	**2,757.6**	**87.6**	**12.3**	**0.0**	**503.1**	91.2	8.8	0.1	**2,254.4**	86.9	13.1	0.0
Iowa	**840.4**	**92.5**	**7.5**	**0.0**	**5.4**	89.3	10.6	0.1	**835.0**	92.5	7.5	0.0
Kansas	**378.7**	**81.1**	**18.8**	**0.0**	**0.6**	83.9	16.1	–	**378.1**	81.1	18.9	0.0
Kentucky	**1,589.5**	**90.5**	**9.4**	**0.1**	**84.5**	81.0	18.7	0.3	**1,505.0**	91.1	8.8	0.1
Louisiana	**2,730.9**	**87.7**	**12.3**	**0.0**	**82.9**	84.1	15.8	0.1	**2,648.0**	87.8	12.1	0.0
Maine	**498.2**	**91.0**	**9.0**	**0.0**	**498.2**	91.0	9.0	0.0	**–**	–	–	–
Maryland	**1,691.4**	**88.9**	**11.0**	**0.0**	**564.6**	85.6	14.4	0.0	**1,126.8**	90.6	9.4	0.0
Massachusetts	**2,277.7**	**88.8**	**11.0**	**0.1**	**871.8**	88.9	11.0	0.1	**1,405.9**	88.8	11.1	0.1
Michigan	**3,830.7**	**90.3**	**9.7**	**0.0**	**1,489.8**	88.7	11.3	0.0	**2,340.8**	91.3	8.7	0.0
Minnesota	**1,506.9**	**84.9**	**14.9**	**0.2**	**173.9**	71.1	28.2	0.7	**1,333.1**	86.7	13.1	0.2
Mississippi	**679.8**	**84.6**	**15.3**	**0.0**	**171.3**	82.6	17.4	0.1	**508.5**	85.3	14.6	0.0

EXHIBIT 26. (continued)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Missouri	$1,774.9	86.9%	13.1%	0.0%	$1,774.9	86.9%	13.1%	0.0%	–	–	–	–
Montana	423.2	88.6	11.3	0.1	423.2	88.6	11.3	0.1	–	–	–	–
Nebraska	491.1	86.9	13.1	0.0	0.0	76.5	23.5	–	$491.1	86.9%	13.1%	0.0%
Nevada	438.1	88.6	11.1	0.3	273.9	88.0	11.8	0.2	164.2	89.8	9.8	0.4
New Hampshire	268.1	86.1	13.9	0.0	3.4	98.0	1.9	0.1	264.7	85.9	14.1	0.0
New Jersey	1,988.4	87.5	12.5	0.0	7.4	84.7	15.2	0.1	1,981.0	87.5	12.5	0.0
New Mexico	568.4	73.0	27.0	0.0	110.4	31.8	68.1	0.1	458.0	82.9	17.1	0.0
New York	8,548.7	86.3	13.6	0.1	4,931.3	85.6	14.3	0.1	3,617.4	87.3	12.6	0.1
North Carolina	2,617.9	89.9	10.0	0.1	829.1	90.3	9.6	0.2	1,788.8	89.8	10.2	0.0
North Dakota	107.8	86.7	13.3	0.0	100.4	86.5	13.5	0.0	7.5	89.5	10.5	0.0
Ohio	4,906.9	86.3	13.7	0.0	324.2	83.4	16.6	0.0	4,582.7	86.5	13.5	0.0
Oklahoma	1,028.5	86.3	13.7	0.0	1,028.5	86.3	13.7	0.0	–	–	–	–
Oregon	867.5	82.8	17.2	0.0	128.7	74.1	25.9	0.0	738.7	84.3	15.7	0.0
Pennsylvania	4,661.4	86.2	13.8	0.0	33.6	82.1	17.9	0.0	4,627.9	86.2	13.7	0.0
Rhode Island	341.1	83.5	16.5	–	6.6	86.0	14.0	–	334.5	83.4	16.6	–
South Carolina	784.3	86.7	13.3	0.1	122.2	88.4	11.4	0.2	662.1	86.3	13.6	0.0
South Dakota	145.3	84.2	15.6	0.2	145.3	84.2	15.6	0.2	–	–	–	–
Tennessee	1,628.4	88.3	11.6	0.1	1,478.4	87.4	12.4	0.1	149.9	97.1	2.8	0.0
Texas	4,081.4	86.4	13.6	0.0	37.0	82.6	16.5	0.9	4,044.4	86.4	13.5	0.0
Utah	378.9	89.6	10.4	0.0	227.7	89.0	11.0	0.0	151.2	90.4	9.6	0.0
Vermont	203.5	88.8	11.2	0.0	203.5	88.8	11.2	0.0	0.0	99.4	0.6	–
Virginia[5]	6,619.8	47.7	50.1	2.2	19.8	88.5	11.1	0.4	6,600.1	47.6	50.3	2.2
Washington	1,615.3	90.9	9.1	0.0	116.4	93.4	6.6	0.0	1,498.9	90.7	9.3	0.0
West Virginia	931.9	88.2	11.8	0.0	913.9	88.0	12.0	0.0	18.1	96.8	3.2	0.0
Wisconsin	2,023.8	88.5	11.5	0.0	2,023.8	88.5	11.5	0.0	–	–	–	–
Wyoming	50.2	86.2	13.8	0.0	50.2	86.2	13.8	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 the Centers for Medicare & Medicaid Services (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 fewer than 11 counts, as obligated by the Privacy Act of 1974 (5 U.S.C. § 552a) and the Health Insurance Portability and Accountability Act 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 2023 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, 2024, analysis of Medicaid drug product data and state drug rebate utilization data as of September 2024.

EXHIBIT 27. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2023 (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]	**789,021**	**14.0%**	**85.7%**	**0.3%**	**295,317**	**14.5%**	**85.2%**	**0.3%**	**493,704**	**13.7%**	**86.0%**	**0.3%**
Alabama	**8,075**	**15.0**	**84.9**	**0.1**	**8,075**	15.0	84.9	0.1	**–**	–	–	–
Alaska	**1,382**	**16.7**	**83.1**	**0.2**	**1,382**	16.7	83.1	0.2	**–**	–	–	–
Arizona	**16,527**	**12.7**	**87.0**	**0.4**	**308**	14.2	85.4	0.4	**16,219**	12.6	87.0	0.4
Arkansas	**6,019**	**13.3**	**86.6**	**0.1**	**4,889**	13.1	86.8	0.1	**1,130**	14.2	85.7	0.1
California	**91,290**	**14.6**	**85.3**	**0.1**	**84,422**	12.9	87.0	0.0	**6,868**	35.4	64.3	0.3
Colorado	**8,915**	**16.8**	**83.0**	**0.2**	**8,400**	17.0	82.8	0.2	**515**	13.9	85.8	0.3
Connecticut	**9,627**	**20.9**	**79.0**	**0.1**	**9,627**	20.9	79.0	0.1	**–**	–	–	–
Delaware	**2,800**	**14.9**	**84.9**	**0.1**	**7**	53.8	46.2	–	**2,793**	14.9	85.0	0.1
District of Columbia	**1,425**	**15.4**	**84.5**	**0.1**	**238**	30.1	69.8	0.0	**1,187**	12.5	87.4	0.1
Florida	**29,420**	**15.8**	**84.1**	**0.1**	**946**	17.6	82.3	0.1	**28,474**	15.8	84.2	0.1
Georgia	**17,976**	**11.8**	**87.9**	**0.4**	**6,876**	15.6	84.2	0.2	**11,100**	9.3	90.1	0.5
Hawaii	**2,069**	**12.2**	**87.5**	**0.3**	**17**	–	100.0	–	**2,052**	12.3	87.4	0.3
Idaho	**4,259**	**16.2**	**83.6**	**0.1**	**4,259**	16.2	83.6	0.1	**–**	–	–	–
Illinois	**29,328**	**13.9**	**86.1**	**0.0**	**1,592**	14.7	85.2	0.0	**27,736**	13.8	86.2	0.0
Indiana	**21,136**	**13.9**	**85.8**	**0.2**	**2,980**	13.5	85.9	0.6	**18,156**	14.0	85.8	0.2
Iowa	**8,504**	**14.4**	**85.6**	**0.0**	**57**	18.5	81.5	0.0	**8,447**	14.4	85.6	0.0
Kansas	**4,014**	**14.2**	**85.7**	**0.1**	**8**	15.3	84.7	–	**4,006**	14.2	85.7	0.1
Kentucky	**17,076**	**10.6**	**88.7**	**0.7**	**1,142**	8.8	89.2	2.0	**15,933**	10.8	88.6	0.6
Louisiana	**21,867**	**13.3**	**86.5**	**0.2**	**857**	11.6	88.2	0.3	**21,009**	13.4	86.4	0.2
Maine	**3,028**	**25.4**	**74.5**	**0.1**	**3,028**	25.4	74.5	0.1	**–**	–	–	–
Maryland	**15,439**	**14.7**	**85.3**	**0.1**	**5,237**	16.9	83.0	0.0	**10,202**	13.5	86.4	0.1
Massachusetts	**16,565**	**18.0**	**80.7**	**1.3**	**6,685**	17.5	81.0	1.5	**9,880**	18.3	80.5	1.1
Michigan	**31,863**	**13.6**	**86.0**	**0.3**	**9,834**	14.4	85.5	0.1	**22,030**	13.3	86.2	0.4
Minnesota	**12,468**	**15.0**	**81.6**	**3.5**	**1,630**	12.4	79.8	7.8	**10,838**	15.4	81.8	2.8
Mississippi	**6,057**	**12.8**	**87.0**	**0.2**	**1,946**	11.4	88.3	0.3	**4,111**	13.4	86.4	0.2
Missouri	**15,757**	**14.4**	**85.5**	**0.1**	**15,757**	14.4	85.5	0.1	**–**	–	–	–

EXHIBIT 27. (continued)

State	Total				Fee for service				Managed care			
	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]	Total	Brand[1]	Generic[2]	Unknown[3]
Montana	3,199	16.0%	83.8%	0.2%	3,199	16.0%	83.8%	0.2%	–	–	–	–
Nebraska	4,483	14.7	85.1	0.2	0	44.9	55.1	–	4,483	14.7%	85.1%	0.2%
Nevada	2,924	14.6	83.9	1.5	1,699	14.0	85.0	1.0	1,225	15.4	82.4	2.2
New Hampshire	2,327	13.3	86.4	0.3	8	18.0	78.9	3.1	2,319	13.3	86.4	0.3
New Jersey	22,928	10.8	89.1	0.1	126	15.2	84.8	0.0	22,801	10.8	89.1	0.1
New Mexico	5,697	11.4	88.5	0.1	272	21.2	78.7	0.1	5,425	10.9	89.0	0.1
New York	77,702	12.4	86.8	0.7	41,529	12.4	86.7	0.9	36,173	12.4	87.0	0.6
North Carolina	16,969	18.8	80.8	0.4	4,980	20.5	78.5	1.0	11,989	18.1	81.7	0.2
North Dakota	1,021	15.8	84.1	0.1	939	14.8	85.1	0.1	82	26.9	72.8	0.2
Ohio	41,870	13.4	86.6	0.1	3,520	11.3	88.7	0.0	38,350	13.6	86.4	0.1
Oklahoma	8,820	11.9	88.0	0.1	8,820	11.9	88.0	0.1	–	–	–	–
Oregon	10,813	10.9	89.0	0.1	2,462	4.6	95.3	0.1	8,351	12.7	87.2	0.1
Pennsylvania	37,810	13.4	86.5	0.0	498	11.1	88.9	0.0	37,312	13.5	86.5	0.0
Rhode Island	3,982	10.8	89.2	–	110	9.9	90.1	–	3,872	10.8	89.2	–
South Carolina	7,825	12.8	86.8	0.4	1,008	14.6	84.5	0.9	6,817	12.6	87.1	0.3
South Dakota	871	14.7	84.8	0.5	871	14.7	84.8	0.5	–	–	–	–
Tennessee	14,905	16.7	82.7	0.6	13,082	13.8	85.8	0.5	1,823	37.4	61.0	1.6
Texas	35,902	13.2	86.8	0.0	406	18.6	81.2	0.2	35,496	13.1	86.9	0.0
Utah	2,824	16.7	83.3	0.0	1,581	18.6	81.4	0.0	1,243	14.3	85.6	0.0
Vermont	1,636	20.8	79.2	0.0	1,616	20.8	79.2	0.0	20	22.5	77.5	–
Virginia	24,604	13.2	86.3	0.6	200	20.6	77.3	2.1	24,404	13.1	86.3	0.6
Washington	14,443	12.2	87.7	0.1	960	12.5	87.4	0.1	13,483	12.1	87.8	0.1
West Virginia	9,106	16.0	84.0	0.1	8,842	15.7	84.2	0.0	263	23.8	76.0	0.2
Wisconsin	13,486	18.4	81.5	0.1	13,486	18.4	81.5	0.1	–	–	–	–
Wyoming	453	14.6	85.4	0.0	453	14.6	85.4	0.0	–	–	–	–

EXHIBIT 27. (continued)

Notes: FY is fiscal year. Drug utilization in this exhibit reflects the number of prescriptions reported in the state drug utilization data that states submit to the Centers for Medicare & Medicaid Services (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 fewer than 11 counts, as obligated by the Privacy Act of 1974 (5 U.S.C. § 552a) and the Health Insurance Portability and Accountability Act 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 2023 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, 2024, analysis of Medicaid drug product data and state drug rebate utilization data as of September 2024.

EXHIBIT 28. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2023 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total[1]	**$104,859.3**	**$42,768.4**	**$62,090.8**	**-$53,684.5**	**-$26,272.7**	**-$27,411.7**
Alabama	**1,061.3**	1,061.3	–	**-589.4**	-589.4	–
Alaska	**211.4**	211.4	–	**-163.0**	-163.0	–
Arizona	**2,003.1**	45.5	1,957.6	**-1,336.6**	-45.5	-1,291.1
Arkansas[2]	**540.1**	434.6	105.5	**-377.9**	-343.7	-34.3
California	**13,689.1**	13,089.3	599.8	**-6,365.5**	-6,195.3	-170.3
Colorado	**1,533.6**	1,473.2	60.4	**-1,061.0**	-1,023.6	-37.4
Connecticut	**1,848.8**	1,848.8	–	**-1,233.0**	-1,233.0	–
Delaware	**278.5**	1.4	277.1	**-207.2**	-34.5	-172.7
District of Columbia	**253.7**	150.8	103.0	**-139.4**	-72.8	-66.6
Florida	**3,924.6**	258.3	3,666.4	**-2,119.8**	-104.1	-2,015.7
Georgia	**1,506.8**	872.6	634.1	**-817.0**	-543.1	-273.9
Hawaii	**244.7**	0.2	244.4	**-157.7**	-0.6	-157.1
Idaho	**572.8**	572.8	–	**-366.6**	-366.6	–
Illinois	**3,777.0**	137.3	3,639.6	**-1,939.6**	-117.0	-1,822.6
Indiana	**2,757.6**	503.1	2,254.4	**-1,308.9**	-269.0	-1,040.0
Iowa	**840.4**	5.4	835.0	**-568.8**	-12.8	-556.0
Kansas	**378.7**	0.6	378.1	**-241.6**	-2.4	-239.2
Kentucky	**1,589.5**	84.5	1,505.0	**-1,501.0**	-75.5	-1,425.5
Louisiana	**2,730.9**	82.9	2,648.0	**-1,628.1**	-48.0	-1,580.1
Maine	**498.2**	498.2	–	**-352.0**	-352.0	–
Maryland	**1,691.4**	564.6	1,126.8	**-854.1**	-340.8	-513.3
Massachusetts	**2,277.7**	871.8	1,405.9	**-1,564.0**	-743.1	-820.8
Michigan	**3,830.7**	1,489.8	2,340.8	**-2,466.1**	-871.6	-1,594.5
Minnesota	**1,506.9**	173.9	1,333.1	**-923.4**	-519.0	-404.4
Mississippi	**679.8**	171.3	508.5	**-298.5**	-158.0	-140.6

EXHIBIT 28. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Missouri	**$1,774.9**	$1,774.9	–	**-$1,150.7**	-$1,150.7	–
Montana	**423.2**	423.2	–	**-288.8**	-288.8	–
Nebraska	**491.1**	0.0	$491.1	**-334.0**	-0.2	-$333.8
Nevada	**438.1**	273.9	164.2	**-464.1**	-228.4	-235.7
New Hampshire	**268.1**	3.4	264.7	**-175.2**	-93.1	-82.2
New Jersey	**1,988.4**	7.4	1,981.0	**-947.1**	-10.0	-937.1
New Mexico	**568.4**	110.4	458.0	**-259.2**	-33.7	-225.5
New York[3,4]	**8,548.7**	4,931.3	3,617.4	**-4,425.8**	-4,449.2	23.4
North Carolina	**2,617.9**	829.1	1,788.8	**-1,627.0**	-586.4	-1,040.6
North Dakota	**107.8**	100.4	7.5	**-86.8**	-83.6	-3.2
Ohio	**4,906.9**	324.2	4,582.7	**-2,123.3**	-194.5	-1,928.8
Oklahoma	**1,028.5**	1,028.5	–	**-681.3**	-681.3	–
Oregon	**867.5**	128.7	738.7	**-483.7**	-85.0	-398.7
Pennsylvania	**4,661.4**	33.6	4,627.9	**-2,767.4**	-43.8	-2,723.6
Rhode Island	**341.1**	6.6	334.5	**-178.0**	-16.9	-161.1
South Carolina	**784.3**	122.2	662.1	**-426.4**	-96.0	-330.4
South Dakota	**145.3**	145.3	–	**-56.6**	-56.6	–
Tennessee[2]	**1,628.4**	1,478.4	149.9	**-1,110.6**	-1,110.6	–
Texas	**4,081.4**	37.0	4,044.4	**-2,305.2**	-35.9	-2,269.3
Utah	**378.9**	227.7	151.2	**-283.7**	-215.0	-68.6
Vermont	**203.5**	203.5	0.0	**-179.2**	-179.2	–
Virginia[5]	**6,619.8**	19.8	6,600.1	**-1,375.7**	-67.1	-1,308.6
Washington	**1,615.3**	116.4	1,498.9	**-1,319.0**	-301.6	-1,017.4
West Virginia	**931.9**	913.9	18.1	**-643.9**	-629.5	-14.5
Wisconsin	**2,023.8**	2,023.8	–	**-1,365.0**	-1,364.9	-0.1
Wyoming	**50.2**	50.2	–	**-46.4**	-46.4	–

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 the Centers for Medicare & Medicaid Services (CMS) for rebate purposes and are different from the CMS-64 Financial Management Report (FMR) and Transformed Medicaid Statistical Information System (T-MSIS) data that serve as our usual sources of expenditure data. Spending shown in the drug utilization data may differ from these other sources due to differences in timing and run-out of data used. In addition, the drug rebate data may include physician-administered drugs for which rebates are available; the spending for these drugs are typically reported under the physician services category instead of the outpatient prescription drug category in other data. The state drug utilization data provide both fee-for-service (FFS) and managed care drug utilization and spending information at the national drug code (NDC) level, which is not available in CMS-64 data. The state drug utilization data are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-programs-data-and-resources.html.

Since October 2016, CMS has suppressed all records in the state drug utilization data that are fewer than 11 counts, as obligated by the Privacy Act of 1974 (5 U.S.C. § 552a) and the Health Insurance Portability and Accountability Act 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 2023 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 fee-for-service rebates.

[3] New York carved prescription drugs out of managed care beginning April 1, 2023, resulting in anomalous distributions in spending and rebates between FFS and managed care.

[4] New York reported prior period adjustments for managed care that ultimately result 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, 2024, analysis of Medicaid state drug rebate utilization data as of September 2024 and CMS-64 FMR net expenditure data as of May 29, 2024.

EXHIBIT 29. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2022

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	**96,422,657**	**74.6%**	**0.4%**	**8.8%**	**17.3%**	**12.5%**	**2.2%**	**6.4%**
Alabama	**1,287,819**	0.0	–	–	–	–	–	79.8
Alaska[2]	**254,283**	–	–	–	–	–	–	–
Arizona	**2,412,424**	80.4	2.7	2.6	–	–	–	–
Arkansas	**1,763,975**	3.6	–	–	44.8	60.5	–	52.3
California	**15,136,020**	84.4	–	–	6.3	–	–	–
Colorado	**1,608,310**	0.3	–	–	–	–	–	94.0
Connecticut[2]	**1,140,225**	–	–	–	–	–	–	–
Delaware	**302,869**	86.4	–	–	–	88.5	–	–
District of Columbia	**300,381**	86.3	–	–	–	9.9	–	–
Florida	**5,399,695**	77.8	–	–	78.5	5.3	9.9	–
Georgia	**2,734,003**	73.4	–	–	–	79.0	2.3	–
Hawaii	**450,268**	100.0	–	–	–	–	–	–
Idaho	**424,893**	6.0	–	89.1	95.1	95.1	–	77.4
Illinois	**3,726,082**	75.1	–	–	–	–	–	–
Indiana	**2,070,992**	80.1	–	–	–	–	–	–
Iowa	**803,050**	93.8	–	–	94.7	1.5	–	–
Kansas	**525,725**	84.4	–	–	–	–	–	–
Kentucky	**1,651,543**	90.5	–	–	–	90.5	–	–
Louisiana	**1,985,537**	85.3	–	7.1	92.6	–	–	–
Maine	**393,783**	–	–	–	–	87.7	–	–
Maryland	**1,734,624**	86.3	–	–	–	–	–	–
Massachusetts	**2,091,955**	40.5	–	29.9	–	–	–	26.9
Michigan	**3,092,404**	99.4	0.4	93.7	37.5	–	–	–
Minnesota	**1,348,563**	87.5	–	–	–	–	–	–
Mississippi	**858,687**	42.5	–	–	–	–	–	–
Missouri	**1,278,851**	79.5	–	–	–	21.3	–	–

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	**289,659**	–	–	–	–	–	–	85.5%
Nebraska	**374,783**	99.7%	–	–	99.4%	–	–	–
Nevada	**923,168**	75.7	–	–	75.7	91.0%	–	–
New Hampshire	**256,087**	92.5	–	–	–	–	–	–
New Jersey	**2,022,155**	99.9	–	–	–	74.1	–	–
New Mexico	**984,008**	82.8	–	–	–	–	–	–
New York	**7,589,766**	74.3	3.3%	–	–	–	–	–
North Carolina	**2,804,306**	60.6	–	19.1%	–	–	–	19.5
North Dakota	**133,631**	27.6	–	–	–	–	–	50.8
Ohio	**3,425,876**	86.5	–	–	–	–	–	–
Oklahoma	**1,273,948**	0.1	–	–	–	100.0	–	64.7
Oregon[3]	**1,393,623**	86.0	–	–	4.8	–	–	–
Pennsylvania	**3,534,344**	93.1	–	94.1	–	21.0	0.0%	–
Rhode Island	**357,304**	84.2	–	–	37.5	98.0	–	–
South Carolina	**1,550,759**	67.4	–	–	–	–	–	0.1
South Dakota	**149,096**	–	–	–	–	–	–	70.1
Tennessee[4]	**1,817,119**	93.4	–	–	55.6	–	84.3	–
Texas	**5,543,480**	95.5	–	–	72.6	–	–	–
Utah	**477,832**	83.0	–	75.8	48.9	79.5	–	–
Vermont[5]	**199,989**	67.2	–	–	–	–	–	–
Virginia	**1,978,005**	90.7	–	–	–	–	–	–
Washington	**2,229,539**	85.0	–	8.2	–	–	–	0.1
West Virginia	**660,068**	78.9	–	–	–	89.1	–	–
Wisconsin	**1,593,772**	69.4	3.3	0.1	–	–	0.2	–
Wyoming[2]	**83,379**	–	–	–	–	–	–	–

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. 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, Connecticut, and Wyoming's total Medicaid enrollment as of July 1, 2022, was taken from the July through September 2022 enrollment data collected through the Medicaid Budget and Expenditure System, accessed April 18, 2024.

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

[4] 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.

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

Source: MACPAC, 2024, analysis of data from CMS, *Medicaid managed care enrollment and program characteristics*, 2022, 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 2022

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	**93,900**	**73.4%**	**85.3%**	**82.3%**	**66.5%**	**54.1%**	**37.5%**	**40.2%**	**48.9%**	**33.4%**	**32.4%**	**46.9%**	**34.0%**
Alabama	**1,238**	**0.0**	–	–	–	0.0	0.1	**8.2**	0.0	–	0.3	21.1	37.7
Alaska	**267**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Arizona	**2,439**	**91.2**	98.6	93.3	84.0	91.3	71.4	**0.0**	0.0	0.0	0.0	0.0	0.0
Arkansas	**1,203**	**0.1**	–	0.0	–	0.0	0.6	**86.9**	95.3	88.9	45.9	78.2	47.7
California[6]	**14,742**	**82.0**	91.7	89.2	61.9	85.7	74.6	**6.3**	6.2	7.8	5.1	6.5	3.8
Colorado	**1,699**	**10.9**	7.3	13.9	9.2	10.6	13.5	**92.9**	98.7	98.1	75.1	89.1	58.7
Connecticut	**1,261**	**0.0**	–	0.0	–	–	–	**84.7**	98.5	100.0	78.8	60.5	33.7
Delaware	**318**	**87.0**	95.9	95.1	76.9	74.6	44.7	**89.0**	97.2	98.6	78.6	76.1	44.1
District of Columbia[7]	**291**	**81.9**	94.6	95.0	96.6	54.6	7.2	**21.5**	9.5	14.0	9.0	45.8	75.7
Florida	**5,626**	**78.9**	97.3	–	76.3	63.4	32.8	**93.5**	99.2	–	92.7	87.6	80.2
Georgia	**2,616**	**73.5**	98.5	–	94.5	3.7	0.0	**84.2**	98.1	–	82.7	68.6	39.2
Hawaii	**459**	**98.4**	99.9	99.9	99.9	93.9	88.3	**1.3**	0.0	0.9	0.4	13.0	2.2
Idaho	**465**	**–**	–	–	–	–	–	**95.0**	99.9	99.7	98.1	85.6	60.2
Illinois[7]	**3,590**	**80.7**	91.2	86.8	53.8	56.1	47.3	**–**	–	–	–	–	–
Indiana	**2,111**	**79.6**	92.0	100.0	77.7	28.8	6.8	**17.8**	13.8	0.2	11.8	63.1	65.6
Iowa	**848**	**94.2**	98.4	96.2	93.0	89.9	69.0	**95.9**	99.8	97.7	96.1	92.0	69.1
Kansas	**487**	**93.1**	99.9	–	95.9	84.2	65.6	**–**	–	–	–	–	–
Kentucky	**1,689**	**88.4**	98.3	94.9	94.5	69.4	36.7	**91.2**	98.0	94.8	95.4	79.9	57.5
Louisiana	**1,889**	**92.4**	99.9	98.9	93.2	80.1	53.3	**92.7**	99.9	99.0	93.6	81.6	53.8
Maine	**457**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Maryland	**1,641**	**84.7**	98.4	93.9	86.9	56.9	1.9	**–**	–	–	–	–	–
Massachusetts	**2,163**	**41.1**	48.8	50.4	34.5	32.9	33.7	**32.6**	43.5	41.3	27.2	35.9	2.1
Michigan	**3,126**	**78.5**	86.2	82.8	82.9	64.1	31.9	**96.5**	99.5	96.3	96.8	94.7	85.1
Minnesota	**1,428**	**86.2**	90.0	94.1	85.9	55.4	75.7	**–**	–	–	–	–	–
Mississippi	**849**	**57.8**	79.8	–	52.6	41.7	1.5	**1.8**	0.2	–	0.7	4.8	5.3

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[7,8]	1,456	75.1%	97.7%	92.3%	91.2%	1.8%	0.2%	97.0%	100.0%	99.2%	98.6%	91.8%	80.7%
Montana	308	–	–	–	–	–	–	–	–	–	–	–	–
Nebraska	368	98.1	99.9	99.6	99.6	94.7	85.3	97.9	99.7	99.5	99.4	94.5	84.6
Nevada	958	75.4	86.1	87.0	84.8	3.1	0.3	92.4	99.6	97.8	95.0	71.6	33.5
New Hampshire	262	88.6	98.7	98.1	65.6	67.7	58.5	0.3	0.1	0.3	0.3	0.7	1.0
New Jersey	2,090	93.9	95.9	96.0	88.2	93.9	84.7	98.7	100.0	100.0	100.0	96.4	88.8
New Mexico	1,001	84.0	92.8	91.6	73.5	71.9	46.4	–	–	–	–	–	–
New York	7,657	74.6	94.2	90.3	59.5	51.4	15.9	3.8	0.0	0.5	0.6	6.9	25.5
North Carolina	2,740	58.6	90.9	–	44.7	31.2	3.9	24.0	10.2	–	13.7	66.2	70.5
North Dakota[6]	134	30.3	0.1	96.4	12.9	4.8	4.7	–	–	–	–	–	–
Ohio	3,291	80.6	95.8	89.3	91.4	48.6	10.2	5.1	0.0	0.0	2.0	16.0	34.7
Oklahoma	1,312	0.1	–	–	–	0.2	0.8	–	–	–	–	–	–
Oregon	1,404	84.4	92.9	89.7	31.7	77.0	61.8	6.9	6.7	7.5	5.5	7.8	3.9
Pennsylvania	3,608	92.2	96.7	95.0	92.2	86.9	77.9	95.0	98.3	98.3	94.5	92.5	78.4
Rhode Island	350	82.9	83.4	97.7	89.9	69.7	28.1	92.2	90.8	99.2	92.7	92.6	69.4
South Carolina	1,468	67.4	94.7	–	50.9	41.3	18.2	81.8	99.1	–	54.4	94.7	81.8
South Dakota[9]	142	–	–	–	–	–	–	–	–	–	–	–	–
Tennessee	1,805	92.8	99.5	–	99.6	84.1	50.8	–	–	–	–	–	–
Texas[9]	6,176	81.8	96.8	–	60.6	72.9	41.7	61.2	94.8	–	5.5	26.8	5.0
Utah[6]	502	80.3	87.3	77.8	68.5	81.7	66.4	89.1	97.6	80.2	77.5	95.7	86.4
Vermont	207	–	–	–	–	–	–	64.4	81.9	73.1	67.7	32.6	3.9
Virginia	2,008	75.3	98.0	86.4	77.5	1.5	1.6	15.9	0.2	9.7	1.8	81.6	66.6
Washington	2,288	86.5	96.9	96.4	91.9	52.0	7.4	9.0	0.9	2.9	2.4	34.0	67.0
West Virginia	668	83.0	99.0	96.1	95.0	49.0	2.8	93.9	100.0	100.0	100.0	79.6	58.5
Wisconsin	1,511	72.9	91.4	–	85.8	32.2	11.1	85.1	88.8	–	87.1	93.4	55.5
Wyoming	89	0.0	–	–	–	–	0.0	0.4	0.5	–	0.0	0.9	–

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	**93,900**	**7.3%**	**8.8%**	**7.4%**	**5.4%**	**8.4%**	**3.4%**
Alabama	**1,238**	**78.6**	96.8	–	92.2	53.4	15.6
Alaska	**267**	**–**	–	–	–	–	–
Arizona	**2,439**	**–**	–	–	–	–	–
Arkansas	**1,203**	**53.1**	83.5	17.8	55.2	64.1	13.0
California[6]	**14,742**	**–**	–	–	–	–	–
Colorado	**1,699**	**92.1**	98.0	97.2	74.6	88.5	58.2
Connecticut	**1,261**	**–**	–	–	–	–	–
Delaware	**318**	**–**	–	–	–	–	–
District of Columbia[7]	**291**	**–**	–	–	–	–	–
Florida	**5,626**	**–**	–	–	–	–	–
Georgia	**2,616**	**–**	–	–	–	–	–
Hawaii	**459**	**–**	–	–	–	–	–
Idaho	**465**	**86.7**	96.3	94.1	92.7	67.8	27.0
Illinois[7]	**3,590**	**–**	–	–	–	–	–
Indiana	**2,111**	**–**	–	–	–	–	–
Iowa	**848**	**0.0**	0.0	0.0	0.1	0.2	0.0
Kansas	**487**	**–**	–	–	–	–	–
Kentucky	**1,689**	**–**	–	–	–	–	–
Louisiana	**1,889**	**–**	–	–	–	–	–
Maine	**457**	**65.8**	85.7	84.2	50.7	63.9	21.4
Maryland	**1,641**	**–**	–	–	–	–	–
Massachusetts	**2,163**	**27.5**	33.3	40.3	25.8	23.2	0.7
Michigan	**3,126**	**–**	–	–	–	–	–
Minnesota	**1,428**	**–**	–	–	–	–	–
Mississippi	**849**	**–**	–	–	–	–	–

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[7,8]	1,456	–	–	–	–	–	–
Montana	308	83.4%	94.0%	94.8%	80.5%	40.7%	3.7%
Nebraska	368	–	–	–	–	–	–
Nevada	958	–	–	–	–	–	–
New Hampshire	262	–	–	–	–	–	–
New Jersey	2,090	–	–	–	–	–	–
New Mexico	1,001	–	–	–	–	–	–
New York	7,657	–	–	–	–	–	–
North Carolina	2,740	16.0	7.5	–	6.9	50.1	44.4
North Dakota[6]	134	52.7	89.5	14.4	97.2	1.1	0.0
Ohio	3,291	–	–	–	–	–	–
Oklahoma	1,312	94.6	99.1	97.6	88.3	84.8	76.2
Oregon	1,404	21.9	21.0	22.9	15.1	25.2	18.1
Pennsylvania	3,608	–	–	–	–	–	–
Rhode Island	350	–	–	–	–	–	–
South Carolina	1,468	0.1	0.0	–	–	0.5	–
South Dakota[9]	142	75.2	89.8	–	93.6	38.1	11.2
Tennessee	1,805	–	–	–	–	–	–
Texas[9]	6,176	–	–	–	–	–	–
Utah[6]	502	–	–	–	–	–	–
Vermont	207	–	–	–	–	–	–
Virginia	2,008	–	–	–	–	–	–
Washington	2,288	0.1	0.1	0.1	0.1	0.3	0.0
West Virginia	668	–	–	–	–	–	–
Wisconsin	1,511	–	–	–	–	–	–
Wyoming	89	–	–	–	–	–	–

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 sex. 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 261,700, North Dakota's child enrollment by approximately 3,200, and Utah's child enrollment by approximately 12,800.

[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 34 percent less than the benchmark, Illinois's average monthly enrollment was 108 percent more than the benchmark, and Missouri's average monthly enrollment was 33 percent more than the benchmark.

[8] State reported a large shift of enrollees between eligibility groups. Missouri reported a 355 percent increase in the new adult group and a 15 percent decrease in the other adult group.

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2022.

Source: MACPAC, 2024, analysis of T-MSIS data as of February 2024.

EXHIBIT 31. Total Medicaid Administrative Spending by State and Category, FY 2023 (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	**$259**	$45	$27	$0	$9	$178	–
Alaska	**176**	45	10	–	6	115	–
Arizona	**316**	36	159	-0	12	108	–
Arkansas	**528**	146	123	–	69	190	-$1
California	**7,400**	565	2,443	-0	288	4,105	-1
Colorado	**843**	103	143	-1	12	586	-0
Connecticut	**412**	50	113	0	29	220	-0
Delaware	**127**	39	19	–	4	65	–
District of Columbia	**189**	38	42	2	8	100	–
Florida	**648**	121	111	1	39	376	–
Georgia	**672**	147	165	0	22	338	-0
Hawaii	**108**	23	31	0	5	49	–
Idaho	**141**	32	24	–	27	59	–
Illinois	**1,116**	70	340	0	77	629	–
Indiana	**541**	98	110	0	16	316	–
Iowa	**151**	26	63	0	12	51	-0
Kansas	**243**	53	69	0	4	117	–
Kentucky	**343**	79	86	-0	22	156	–
Louisiana	**422**	101	124	-3	10	191	-0
Maine	**186**	59	41	0	13	72	-0
Maryland	**635**	156	134	-1	27	319	–
Massachusetts	**1,260**	167	142	–	55	897	-0
Michigan	**750**	167	177	1	23	384	-1
Minnesota	**798**	74	153	0	15	555	–
Mississippi	**223**	96	46	0	8	73	–
Missouri	**493**	88	117	0	13	275	–
Montana	**106**	48	18	0	6	34	-0
Nebraska	**182**	43	43	–	7	89	–
Nevada	**198**	38	73	–	10	78	–
New Hampshire	**149**	56	46	–	6	41	–

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	**$1,023**	$104	$311	–	$26	$581	-$0
New Mexico	**367**	99	94	–	18	156	–
New York	**2,157**	289	163	$2	77	1,627	–
North Carolina	**1,126**	118	426	1	74	508	–
North Dakota	**98**	39	27	-0	2	31	–
Ohio	**1,186**	294	188	1	20	682	-1
Oklahoma	**249**	59	11	–	25	155	–
Oregon	**660**	56	118	-0	20	465	-0
Pennsylvania	**1,204**	129	361	-0	27	688	–
Rhode Island	**237**	54	53	-0	2	127	-0
South Carolina	**420**	105	75	1	20	218	–
South Dakota	**90**	15	21	–	4	50	–
Tennessee	**964**	362	281	-0	18	306	-3
Texas	**1,909**	372	533	4	24	985	-9
Utah	**197**	48	44	-0	12	93	–
Vermont	**178**	45	33	0	10	90	–
Virginia	**478**	72	229	0	30	147	-0
Washington	**1,157**	89	119	1	30	917	-0
West Virginia	**263**	127	46	–	27	63	–
Wisconsin	**549**	140	125	0	8	276	-1
Wyoming	**62**	22	21	–	2	16	-0
Subtotal (states)	**$34,190**	**$5,449**	**$8,471**	**$10**	**$1,331**	**$18,946**	**-$18**
American Samoa	**2**	–	–	–	–	2	–
Guam	**6**	1	–	–	1	4	–
Northern Mariana Islands	**3**	2	–	–	–	1	–
Puerto Rico	**147**	61	26	5	–	56	–
Virgin Islands	**15**	10	4	–	–	1	–
Subtotal (states and territories)	**$34,363**	**$5,523**	**$8,501**	**$15**	**$1,332**	**$19,010**	**-$18**

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]	**$440**	–	–	–	$440	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	**437**	–	–	–	437	–	–
Total	**$35,240**	**$5,523**	**$8,501**	**$15**	**$2,209**	**$19,010**	**-$18**
Percent of total, exclusive of collections	**–**	**15.7%**	**24.1%**	**0.0%**	**6.3%**	**53.9%**	**–**

Notes: FY is fiscal year. MMIS is Medicaid Management Information Systems. EHR is electronic health record. Includes federal and state funds. Excludes administrative activities performed by Medicaid managed care plans (which are included in the capitation payments that states make to these plans) and activities that are exclusively federal, such as program oversight by CMS staff. Collections may include, for example, donations made by hospitals to compensate for the cost of on-site stationing of state or local Medicaid agency personnel to determine eligibility or provide outreach. For more information on specific items from the Medicaid and CHIP Budget Expenditure System (MBES CBES) noted in this exhibit, see CMS, 2014, MBES CBES category of service line definitions for the 64.10 base form, https://www.medicaid.gov/medicaid/downloads/cms-6410-admin-category-of-services-definition-2-14.pdf.

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

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of May 29, 2024. 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 Unit (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 (TANF, 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, 2024, analysis of CMS-64 FMR net expenditure data as of May 29, 2024. For all other spending (MFCUs, survey and certification, Vaccines for Children program): CMS, 2024, *Fiscal year 2025 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/files/document/fy2025-cms-congressional-justification-estimates-appropriations-committees.pdf.

EXHIBIT 32. Child Enrollment in CHIP and Medicaid by State, FY 2023 (thousands)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
Total	**48,017**	**6,013**	**2,905**	**8,917**	**39,099**
Alabama	**848**	113	99	**212**	**636**
Alaska	**132**	17	–	**17**	**115**
Arizona	**1,092**	75	72	**147**	**945**
Arkansas	**546**	44	53	**97**	**448**
California	**6,300**	1,521	83	**1,605**	**4,695**
Colorado	**683**	101	62	**162**	**520**
Connecticut	**438**	–	21	**21**	**417**
Delaware	**135**	2	8	**10**	**125**
District of Columbia	**105**	16	–	**16**	**89**
Florida	**3,032**	188	161	**349**	**2,684**
Georgia	**1,870**	90	255	**345**	**1,525**
Hawaii	**189**	24	–	**24**	**165**
Idaho	**184**	1	42	**43**	**140**
Illinois	**1,805**	337	43	**380**	**1,426**
Indiana	**971**	105	41	**146**	**824**
Iowa	**474**	19	74	**93**	**381**
Kansas	**359**	16	54	**70**	**289**
Kentucky	**692**	126	6	**132**	**560**
Louisiana	**895**	202	12	**214**	**681**
Maine	**213**	34	0	**35**	**178**
Maryland	**764**	139	–	**139**	**625**
Massachusetts	**848**	129	119	**248**	**600**
Michigan	**1,335**	159	4	**163**	**1,171**
Minnesota	**701**	1	5	**5**	**696**
Mississippi	**577**	72	47	**120**	**458**
Missouri	**782**	53	60	**113**	**669**
Montana	**156**	8	23	**31**	**125**
Nebraska	**248**	60	2	**63**	**186**
Nevada	**444**	47	37	**84**	**360**
New Hampshire	**113**	25	–	**25**	**88**
New Jersey	**1,090**	124	166	**290**	**800**
New Mexico	**419**	8	–	**8**	**411**

EXHIBIT 32. (continued)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
New York	**2,955**	290	376	**666**	**2,290**
North Carolina	**1,663**	316	68	**385**	**1,278**
North Dakota[1]	**62**	4	–	**4**	**59**
Ohio	**1,612**	268	–	**268**	**1,344**
Oklahoma	**790**	250	8	**258**	**532**
Oregon	**695**	82	193	**275**	**419**
Pennsylvania	**1,688**	121	155	**276**	**1,412**
Rhode Island	**146**	32	3	**35**	**111**
South Carolina	**801**	109	–	**109**	**692**
South Dakota	**95**	15	5	**20**	**75**
Tennessee	**1,135**	112	53	**166**	**970**
Texas	**4,601**	381	213	**594**	**4,007**
Utah	**308**	32	13	**45**	**263**
Vermont	**77**	5	–	**5**	**72**
Virginia	**984**	102	92	**194**	**790**
Washington	**952**	–	78	**78**	**874**
West Virginia	**287**	14	26	**40**	**246**
Wisconsin	**671**	18	69	**88**	**583**
Wyoming	**55**	6	–	**6**	**49**

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. 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 September 24, 2024, 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, 2024, analysis of CHIP Statistical Enrollment Data System data as of September 24, 2024.

EXHIBIT 33. CHIP Spending by State, FY 2023 (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	**$472.5**	$397.5	$75.0	**$207.2**	$174.2	$33.0	**$252.5**	$212.6	$39.9	**$12.8**	$10.8	$2.0	–
Alaska	**26.0**	17.8	8.2	**23.4**	16.0	7.4	**–**	–	–	**2.6**	1.8	0.8	–
Arizona	**404.2**	332.2	72.0	**206.8**	169.9	36.8	**183.9**	151.1	32.8	**13.5**	11.1	2.4	–
Arkansas	**207.7**	173.2	34.5	**98.7**	82.4	16.4	**102.9**	85.7	17.2	**6.1**	5.1	1.0	–
California	**4,887.1**	3,362.2	1,524.8	**3,906.0**	2,664.8	1,241.2	**899.4**	639.4	260.0	**81.6**	58.0	23.6	–
Colorado	**350.5**	239.2	111.3	**186.5**	127.2	59.3	**156.5**	106.9	49.6	**7.6**	5.2	2.4	–
Connecticut	**48.3**	56.0	-7.8	**–**	–	–	**44.5**	30.4	14.0	**3.8**	2.6	1.2	$23.0
Delaware	**24.5**	18.0	6.6	**10.5**	7.8	2.7	**12.8**	9.2	3.5	**1.3**	0.9	0.3	–
District of Columbia	**56.9**	46.9	10.0	**55.7**	45.9	9.8	**-0.0**	-0.0	-0.0	**1.2**	1.0	0.2	–
Florida	**797.6**	602.5	195.0	**505.4**	381.6	123.8	**264.8**	200.2	64.6	**27.4**	20.7	6.7	–
Georgia	**633.0**	504.5	128.5	**165.2**	131.7	33.5	**451.4**	359.8	91.7	**16.3**	13.0	3.3	–
Hawaii	**70.3**	51.0	19.4	**68.0**	49.3	18.7	**-0.2**	-0.1	-0.0	**2.5**	1.9	0.7	–
Idaho	**101.4**	83.9	17.5	**-4.8**	-4.0	-0.8	**102.8**	85.0	17.7	**3.5**	2.9	0.6	–
Illinois	**737.9**	503.7	234.2	**551.7**	375.3	176.4	**112.7**	77.7	35.0	**73.5**	50.7	22.8	–
Indiana	**331.0**	262.7	68.2	**237.6**	188.5	49.1	**77.1**	61.3	15.8	**16.3**	12.9	3.3	–
Iowa	**167.1**	129.7	37.4	**50.9**	39.5	11.4	**109.5**	84.9	24.5	**6.8**	5.2	1.5	–
Kansas	**174.2**	131.3	42.9	**38.1**	28.7	9.4	**122.7**	92.5	30.2	**13.4**	10.1	3.3	–
Kentucky	**443.2**	370.9	72.2	**398.4**	333.3	65.1	**34.9**	29.4	5.5	**9.8**	8.3	1.6	–
Louisiana	**706.2**	569.7	136.6	**614.3**	495.4	118.9	**65.7**	53.1	12.7	**26.2**	21.2	5.0	–
Maine	**51.4**	40.0	11.4	**39.8**	31.0	8.9	**10.4**	8.1	2.3	**1.2**	0.9	0.3	–
Maryland	**518.6**	355.1	163.5	**494.5**	338.7	155.8	**-2.3**	-1.5	-0.7	**26.3**	17.9	8.4	–
Massachusetts	**1,085.0**	745.0	340.1	**480.6**	329.5	151.0	**495.3**	340.4	154.9	**109.2**	75.0	34.2	**–**
Michigan	**407.3**	321.3	86.0	**375.5**	296.2	79.3	**3.6**	2.8	0.8	**28.2**	22.3	5.9	–
Minnesota	**25.0**	81.4	-56.4	**1.4**	1.0	0.4	**21.1**	14.5	6.6	**2.5**	1.7	0.8	64.2
Mississippi	**212.1**	180.4	31.6	**85.6**	72.8	12.8	**124.0**	105.6	18.4	**2.4**	2.1	0.4	–
Missouri	**471.6**	375.2	96.4	**237.7**	189.1	48.6	**220.1**	175.2	44.9	**13.8**	11.0	2.8	–
Montana	**111.5**	87.5	24.0	**18.2**	14.2	4.0	**87.4**	68.6	18.8	**6.0**	4.7	1.3	–
Nebraska	**114.5**	84.3	30.2	**99.3**	73.1	26.2	**11.7**	8.6	3.0	**3.5**	2.6	0.9	–
Nevada	**117.8**	91.2	26.6	**71.7**	55.6	16.1	**45.2**	34.9	10.3	**0.9**	0.7	0.2	–
New Hampshire	**67.8**	55.4	12.3	**67.8**	46.5	21.3	**–**	–	–	**-0.0**	-0.0	-0.0	9.0

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	**$947.5**	$649.7	$297.8	**$369.8**	$253.6	$116.2	**$494.9**	$339.3	$155.6	**$82.8**	$56.7	$26.0	–
New Mexico	**136.2**	115.1	21.1	**135.2**	114.3	20.9	**-0.2**	-0.1	-0.0	**1.1**	1.0	0.2	–
New York	**1,658.2**	1,149.5	508.7	**857.8**	587.7	270.1	**636.7**	446.9	189.8	**163.7**	114.9	48.8	–
North Carolina	**827.3**	669.5	157.8	**758.1**	613.0	145.1	**51.9**	42.4	9.5	**17.3**	14.1	3.2	–
North Dakota	**29.4**	20.4	9.0	**27.6**	19.1	8.5	**-0.0**	-0.0	-0.0	**1.9**	1.3	0.6	–
Ohio	**762.8**	593.0	169.8	**712.2**	555.4	156.8	**–**	–	–	**50.7**	37.6	13.1	–
Oklahoma	**341.3**	274.6	66.7	**351.3**	282.7	68.6	**-30.0**	-24.2	-5.8	**20.0**	16.2	3.9	–
Oregon	**699.4**	529.8	169.7	**153.1**	115.9	37.2	**523.2**	396.3	126.9	**23.2**	17.6	5.6	–
Pennsylvania	**706.5**	495.1	211.4	**428.4**	300.4	128.0	**248.0**	173.6	74.4	**30.1**	21.1	9.0	–
Rhode Island	**147.7**	105.1	42.5	**113.3**	80.7	32.6	**31.9**	22.7	9.2	**2.4**	1.7	0.7	–
South Carolina	**208.6**	173.0	35.6	**201.1**	166.8	34.4	**-1.1**	-0.9	-0.2	**8.6**	7.2	1.5	–
South Dakota	**44.1**	32.2	11.9	**36.1**	26.3	9.8	**7.5**	5.5	2.0	**0.5**	0.4	0.1	–
Tennessee	**479.6**	375.9	103.7	**366.1**	284.8	81.3	**110.4**	88.6	21.8	**3.1**	2.5	0.6	–
Texas	**1,004.8**	756.8	247.9	**705.4**	531.8	173.6	**289.4**	217.5	71.9	**10.0**	7.5	2.5	–
Utah	**127.2**	101.0	26.2	**103.6**	82.3	21.3	**18.6**	14.7	3.9	**5.1**	4.0	1.1	–
Vermont	**16.7**	15.9	0.9	**15.1**	11.0	4.1	**-0.0**	-0.0	-0.0	**1.6**	1.2	0.5	$3.7
Virginia	**643.2**	443.4	199.8	**298.4**	205.9	92.5	**314.0**	216.3	97.7	**30.8**	21.2	9.6	–
Washington	**219.2**	148.2	70.9	**16.3**	11.3	5.0	**197.2**	135.3	61.9	**5.7**	3.9	1.8	-2.3
West Virginia	**92.1**	77.9	14.2	**33.9**	28.7	5.2	**52.0**	43.9	8.0	**6.2**	5.3	1.0	–
Wisconsin	**301.1**	240.6	60.5	**107.6**	81.0	26.6	**168.3**	127.1	41.2	**25.2**	19.0	6.2	13.4
Wyoming	**10.0**	6.8	3.2	**10.0**	6.8	3.2	**–**	–	–	**–**	–	–	–
Subtotal (states)	**$23,224.9**	**$17,243.2**	**$5,981.6**	**$15,091.9**	**$11,114.4**	**$3,977.4**	**$7,122.8**	**$5,281.3**	**$1,841.5**	**$1,010.2**	**$736.5**	**$273.7**	**$111.0**
American Samoa	**10.8**	9.4	1.3	**10.8**	9.4	1.3	**–**	–	–	**–**	–	–	–
Guam	**1.3**	1.3	–	**1.3**	1.3	–	**–**	–	–	**–**	–	–	–
Northern Mariana Islands	**15.2**	12.9	2.2	**15.2**	12.9	2.2	**–**	–	–	**–**	–	–	–
Puerto Rico	**152.3**	129.6	22.7	**152.3**	129.6	22.7	**–**	–	–	**–**	–	–	–
Virgin Islands	**-9.1**	-7.7	-1.4	**-9.1**	-7.7	-1.4	**–**	–	–	**–**	–	–	–
Total (states and territories)	**$23,395.3**	**$17,388.8**	**$6,006.5**	**$15,262.4**	**$11,260.1**	**$4,002.3**	**$7,122.8**	**$5,281.3**	**$1,841.5**	**$1,010.2**	**$736.5**	**$273.7**	**$111.0**

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, 2024, analysis of Medicaid and CHIP Budget Expenditure System data from CMS as of August 23, 2024.

EXHIBIT 34. Federal CHIP Allotments, FYs 2022–2024 (millions)

State	FY 2022 federal CHIP allotments[1]	FY 2023 federal CHIP allotments	FY 2024 federal CHIP allotments
Alabama	$390.8	$434.8	$457.8
Alaska	27.6	20.4	21.5
Arizona	264.6	375.9	413.2
Arkansas	221.2	216.8	230.0
California	3,548.3	3,289.9	3,473.5
Colorado	300.5	266.4	280.1
Connecticut	77.8	63.4	66.7
Delaware	39.6	28.7	30.4
District of Columbia	65.2	56.3	59.3
Florida	831.0	671.5	714.6
Georgia	493.8	519.4	546.6
Hawaii	59.0	57.0	60.0
Idaho	91.2	101.9	107.6
Illinois	567.9	557.6	586.3
Indiana	288.8	240.7	253.1
Iowa	185.7	146.7	162.1
Kansas	155.3	152.6	160.8
Kentucky	293.9	387.5	407.4
Louisiana	418.7	462.9	487.4
Maine	37.8	39.9	41.9
Maryland	302.4	341.1	670.3
Massachusetts	725.8	682.6	718.6
Michigan	288.8	301.5	317.0
Minnesota	121.6	81.2	85.4
Mississippi	287.6	196.9	207.8
Missouri	346.6	325.5	342.3
Montana	92.1	98.8	104.3
Nebraska	86.5	91.9	96.6
Nevada	87.6	92.5	97.2
New Hampshire	50.6	53.8	56.6
New Jersey	661.3	644.5	678.4
New Mexico	122.3	123.7	130.0
New York	1,699.4	1,394.0	1,469.1
North Carolina	590.6	694.1	741.4
North Dakota	19.6	21.1	30.9
Ohio	555.5	610.4	641.7
Oklahoma	278.4	258.7	272.7

EXHIBIT 34. (continued)

State	FY 2022 federal CHIP allotments[1]	FY 2023 federal CHIP allotments	FY 2024 federal CHIP allotments
Oregon	$455.2	$514.2	$540.6
Pennsylvania	736.6	556.3	587.2
Rhode Island	80.1	105.0	147.9
South Carolina	220.7	207.5	220.1
South Dakota	31.2	30.9	32.7
Tennessee	323.4	360.9	381.8
Texas	1,440.7	1,417.3	1,501.7
Utah	135.1	115.4	121.3
Vermont	22.0	17.5	18.4
Virginia	403.3	401.9	422.5
Washington	263.5	250.2	263.8
West Virginia	83.7	83.1	92.5
Wisconsin	265.7	271.8	286.0
Wyoming	12.9	7.0	7.4
Subtotal (states)	**$19,149.8**	**$18,441.4**	**$19,844.5**
American Samoa	7.4	8.8	9.2
Guam	32.5	1.5	1.6
Northern Mariana Islands	18.2	18.7	19.7
Puerto Rico	127.0	205.2	215.8
Virgin Islands	12.9	3.0	3.1
Total (states and territories)	**$19,347.9**	**$18,678.7**	**$20,093.9**

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, 2024, analysis of Medicaid and CHIP Budget Expenditure System data as of September 27, 2024.

SECTION 4:

Medicaid and CHIP Eligibility

Section 4: Medicaid and CHIP Eligibility

Key Points

- Forty 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).
- 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 2023 and 2024 (Exhibit 37).
- In 2024, in the lower 48 states and the District of Columbia, 100 percent federal poverty level (FPL) was $15,060 for an individual plus $5,380 for each additional family member (Exhibit 38).

EXHIBIT 35. Medicaid and CHIP Income Eligibility Levels as a Percentage of the Federal Poverty Level for Children and Pregnant Women by State, July 2024

State	Medicaid coverage[1]						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[2]	From conception to the end of pregnancy[3]	Pregnant women and deemed newborns[4]
Alabama	141%	–	141%	–	141%	107–141%	312%	312%	141%
Alaska	177	159–203%	177	159–203%	177	124–203	–	–	200
Arizona	147	–	141	–	133	104–133	225	–	156
Arkansas	142	–	142	–	142	107–142	211	209	209
California	208	208–261	142	142–261	133	108–261	–[5]	317	208
Colorado	142	–	142	–	142	108–142	260	–	195; 260
Connecticut	196	–	196	–	196	–	318	258	258
Delaware	212	194–212	142	–	133	110–133	212[6]	–	212
District of Columbia	319	206–319	319	146–319	319	112–319	–	319	319
Florida	206	192–206	140	–	133	112–133	210[6]	–	191
Georgia	205	–	149	–	133	113–133	247	–	220
Hawaii	191	191–308	139	139–308	133	133–308	–	–	191
Idaho	142	–	142	–	133	107–133	185	–	133
Illinois	142	142–313	142	142–313	142	108–313	–	208	208
Indiana	208	157–208	158	141–158	158	106–158	250	–	208
Iowa	375	240–375	167	–	167	122–167	302[6]	–	375
Kansas	166	–	149	–	133	113–133	250	–	166
Kentucky	195	195–213	142	142–213	133	109–213	–	–	195; 213
Louisiana	142	142–212	142	142–212	142	108–212	250	209	133
Maine	300	191–208	300	140–208	300	132–208	–	208	209
Maryland	194	194–317	138	138–317	133	109–317	–	259	259
Massachusetts	200	185–200	150	133–150	150	114–150	300	200	200
Michigan	195	195–212	160	143–212	160	109–212	–	195	195
Minnesota	275	275–283[7]	275	–	275	–	–	278	278
Mississippi	194	–	143	–	133	107–133	209	–	194
Missouri	196	–	148	148–150	148	110–150	300	300	196; 300
Montana	143	–	143	–	133	109–143	261	–	157
Nebraska	162	162–213	145	145–213	133	109–213	–	197	194

EXHIBIT 35. (continued)

State	Medicaid coverage[1]						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[2]	From conception to the end of pregnancy[3]	Pregnant women and deemed newborns[4]
Nevada	160%	–	160%	–	133%	122–133%	200%	–	185%
New Hampshire	196	196–318%	196	196–318%	196	196–318	–	–	196
New Jersey	194	–	142	–	142	107–142	350	–	194; 200
New Mexico	240	200–300	240	200–300	190	138–240	–	–	250
New York	218	–	149	–	149	110–149	400	218%	218
North Carolina	211	194–211	211	141–211	211	107–211	–	–	196
North Dakota	147	147–200	147	147–200	133	111–200	–	–	170
Ohio	156	141–206	156	141–206	156	107–206	–	–	200
Oklahoma	205	169–205	205	151–205	205	115–205	–	205	205
Oregon	185	133–185	133	–	133	100–133	300	185	185
Pennsylvania	215	–	157	–	133	119–133	314	–	215
Rhode Island	190	190–261	142	142–261	133	109–261	–	253	190; 253
South Carolina	194	194–208	143	143–208	133	107–208	–	–	194
South Dakota	182	147–182	182	147–182	182	111–182	204	133	133
Tennessee[8]	195	–	142	–	133	109–133	250	250	250
Texas	198	–	144	–	133	109–133	201	202	198
Utah	139	–	139	–	133	105–133	200	–	139
Vermont	312	237–312	312	237–312	312	237–312	–	–	208
Virginia	143	–	143	–	143	109–143	200	200	143; 200
Washington	210	–	210	–	210	–	312	193	193
West Virginia	158	–	141	–	133	108–133	300	–	185; 300
Wisconsin	301	–	186	–	133	101–151	301[6]	301	301
Wyoming	154	154–200	154	154–200	133	119–200	–	–	154

Notes: As of January 2024, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $15,060 for an individual plus $5,380 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 2024. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income disregard that applies to an individual's eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

EXHIBIT 35. (continued)

Medicaid (Title XIX of the Social Security Act (the Act)) funding continues to finance Medicaid coverage of children under age 19 in families with incomes below state eligibility levels in effect as of March 31, 1997. Any expansion of eligibility to uninsured children above those levels—through expansions of Medicaid or through a separate CHIP—is generally financed by CHIP (Title XXI of the Act) funding. CHIP funding is not permitted for children with other coverage. Thus, where Medicaid coverage in this table shows overlapping eligibility levels for Medicaid funding and CHIP funding, children with no other coverage are funded by CHIP, while children with other coverage are funded by Medicaid. Pregnant women can receive Medicaid- or CHIP-funded services through regular state plan eligibility pathways or through waivers under Section 1115 of the Act; in addition, the unborn children of pregnant women may receive CHIP-funded coverage under a state plan option.

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

[1] Under 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 through 13 and 14 through 18, this table shows only the levels for children age 6 through 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 in this table).

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

[3] Formerly known as the unborn child option. For this pathway, there is no lower threshold for income eligibility if the mother is not eligible for Medicaid.

[4] 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.

[5] 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.

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

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

[8] 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, 2024, 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, 2024, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2024, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; KFF, 2024, *A look at Medicaid and CHIP eligibility, enrollment, and renewal policies during the unwinding of continuous enrollment and beyond*, San Francisco, CA: KFF, https://www.kff.org/medicaid/report/a-look-at-medicaid-and-chip-eligibility-enrollment-and-renewal-policies-during-the-unwinding-of-continuous-enrollment-and-beyond/; 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 2024

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	129	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	95[3]
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: 300)
Maryland	123	133
Massachusetts	133	133 (age 19–20 only: 150)
Michigan	54	133
Minnesota	133[4]	133[4]
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[5]	133[5]
North Carolina	36	133
North Dakota	43	133
Ohio	90	133
Oklahoma	33[6]	133[3]
Oregon	33	133[4]

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	–
South Dakota	46	133
Tennessee	100	–
Texas	12	–
Utah	36[6]	133[3]
Vermont	43	133
Virginia	49	133
Washington	33	133
West Virginia	16	133
Wisconsin	95	95[3]
Wyoming	45	–

Notes: As of January 2024, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $15,060 for an individual plus $5,380 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 2024. 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 to 20, and other individuals age 19 through 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 through 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 to 20 where indicated; and Section 1115 waiver coverage that is not subject to the limitations indicated in note 5.

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

[4] In Minnesota and Oregon, individuals with incomes that are greater than 133 percent FPL but do not exceed 200 percent FPL are covered under the Basic Health Program.

[5] In New York, individuals with incomes that are greater than 133 percent FPL but do not exceed 250 percent FPL are covered under the Essential Plan Expansion using a Section 1332 waiver.

EXHIBIT 36. (continued)

[6] 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.

Source: MACPAC, 2024, 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, 2024, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2024, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; KFF, 2024, *A look at Medicaid and CHIP eligibility, enrollment, and renewal policies during the unwinding of continuous enrollment and beyond*, San Francisco, CA: KFF, https://www.kff.org/medicaid/report/a-look-at-medicaid-and-chip-eligibility-enrollment-and-renewal-policies-during-the-unwinding-of-continuous-enrollment-and-beyond/; 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, 2024

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
Alabama	§ 1634	75%	–	–	–	225%
Alaska	SSI criteria	60[6]	–	–	–	180
Arizona	§ 1634	75	–	–	–	225
Arkansas	§ 1634	75	–	80% (aged only)	9%	225
California	§ 1634	75	–	138[7]	41	–
Colorado	§ 1634	75	–	–	–	225
Connecticut	§ 209(b)	–	58%	–	58	225
Delaware	§ 1634	75	–	–	–	188
District of Columbia	§ 1634	75	–	100	64	225
Florida	§ 1634	75	–	88	14	225
Georgia	§ 1634	75	–	–	25	225
Hawaii	§ 209(b)	–	65	100	33	–
Idaho	SSI criteria	75	–	78	–	225
Illinois	§ 209(b)	–	100	100	100	–
Indiana	§ 1634	75	–	100	–	225
Iowa	§ 1634	75	–	–	38	225
Kansas	SSI criteria	75	–	–	38	225
Kentucky	§ 1634	75	–	–	19	225
Louisiana	§ 1634	75	–	–	8	225
Maine	§ 1634	75	–	100	25	225
Maryland	§ 1634	75	–	–	28	225
Massachusetts[8]	§ 1634	75	–	100 (aged); 133 (disabled)	42	225
Michigan	§ 1634	75	–	100	33	225
Minnesota	§ 209(b)	–	100	100	38	225
Mississippi	§ 1634	75	–	–	–	225
Missouri	§ 209(b)	–	85	85	85	131
Montana	§ 1634	75	–	75	42	–
Nebraska	SSI criteria	75	–	100	31	–

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%	–	–	–	225%
New Hampshire	§ 209(b)	–	76%	–	71%	225
New Jersey	§ 1634	75	–	100%	29	225
New Mexico	§ 1634	75	–	–	–	225
New York	§ 1634	75	–	–	138	–
North Carolina	§ 1634	75	–	100	19	–
North Dakota	§ 209(b)	–	90	–	90[9]	–
Ohio	§ 1634	75	–	–	–	225
Oklahoma	SSI criteria	75	–	100	–	225
Oregon	SSI criteria	75	–	–	–	225
Pennsylvania	§ 1634	75	–	100	34	225
Rhode Island	§ 1634	75	–	100	90	225
South Carolina	§ 1634	75	–	100	–	225
South Dakota	§ 1634	75	–	–	–	225
Tennessee	§ 1634	75	–	–	–	225
Texas	§ 1634	75	–	–	–	225
Utah	SSI criteria	75	–	100	100	225
Vermont	§ 1634	75	–	–	112	225
Virginia	§ 209(b)	–	75	80	48	225
Washington	§ 1634	75	–	–	75	225
West Virginia	§ 1634	75	–	–	16	225
Wisconsin	§ 1634	75	–	82	100	225
Wyoming	§ 1634	75	–	–	–	225

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 2024, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $15,060 for an individual and $5,380 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 either hospice services or are in the Program for All Inclusive Care for the Elderly; 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 remained the same as last year because the FPL increased by 3.3 percent and the SSI federal benefit rate increased by 3.2 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 225 percent FPL in 2024). 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 40 percent FPL) and 90 percent FPL for its aged, blind, and disabled medically needy group. This effectively raises the medically needy income limit to 90 percent FPL.

Source: MACPAC, 2024, analysis of eligibility information from state websites and Medicaid state plans as of September 2024.

EXHIBIT 38. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2024

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%	$15,060	$20,440	$25,820	$31,200	$5,380	$1,255	$1,703	$2,152	$2,600	$448
	133	20,030	27,185	34,341	41,496	7,155	1,669	2,265	2,862	3,458	596
	138	20,783	28,207	35,632	43,056	7,424	1,732	2,351	2,969	3,588	619
	150	22,590	30,660	38,730	46,800	8,070	1,883	2,555	3,228	3,900	673
	185	27,861	37,814	47,767	57,720	9,953	2,322	3,151	3,981	4,810	829
	200	30,120	40,880	51,640	62,400	10,760	2,510	3,407	4,303	5,200	897
	250	37,650	51,100	64,550	78,000	13,450	3,138	4,258	5,379	6,500	1,121
	300	45,180	61,320	77,460	93,600	16,140	3,765	5,110	6,455	7,800	1,345
	400	60,240	81,760	103,280	124,800	21,520	5,020	6,813	8,607	10,400	1,793
Alaska	100%	$18,810	$25,540	$32,270	$39,000	$6,730	$1,568	$2,128	$2,689	$3,250	$561
	133	25,017	33,968	42,919	51,870	8,951	2,085	2,831	3,577	4,323	746
	138	25,958	35,245	44,533	53,820	9,287	2,163	2,937	3,711	4,485	774
	150	28,215	38,310	48,405	58,500	10,095	2,351	3,193	4,034	4,875	841
	185	34,799	47,249	59,700	72,150	12,451	2,900	3,937	4,975	6,013	1,038
	200	37,620	51,080	64,540	78,000	13,460	3,135	4,257	5,378	6,500	1,122
	250	47,025	63,850	80,675	97,500	16,825	3,919	5,321	6,723	8,125	1,402
	300	56,430	76,620	96,810	117,000	20,190	4,703	6,385	8,068	9,750	1,683
	400	75,240	102,160	129,080	156,000	26,920	6,270	8,513	10,757	13,000	2,243

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%	$17,310	$23,500	$29,690	$35,880	$6,190	$1,443	$1,958	$2,474	$2,990	$516
	133	23,022	31,255	39,488	47,720	8,233	1,919	2,605	3,291	3,977	686
	138	23,888	32,430	40,972	49,514	8,542	1,991	2,703	3,414	4,126	712
	150	25,965	35,250	44,535	53,820	9,285	2,164	2,938	3,711	4,485	774
	185	32,024	43,475	54,927	66,378	11,452	2,669	3,623	4,577	5,532	954
	200	34,620	47,000	59,380	71,760	12,380	2,885	3,917	4,948	5,980	1,032
	250	43,275	58,750	74,225	89,700	15,475	3,606	4,896	6,185	7,475	1,290
	300	51,930	70,500	89,070	107,640	18,570	4,328	5,875	7,423	8,970	1,548
	400	69,240	94,000	118,760	143,520	24,760	5,770	7,833	9,897	11,960	2,063

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services (HHS) 2024 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, 2024, Annual update of the HHS poverty guidelines, *Federal Register* 89, no. 11 (January 17): 2961–2963.

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, although most children whose primary coverage source is Medicaid or CHIP had a usual source of care, they were less likely to have one compared with children with private coverage (Exhibit 42).
- 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 as likely to report having a usual source of care as those with private coverage and less likely than those with 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 are as likely to report delayed care due to cost as those covered by private insurance but less likely than those with Medicare coverage (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 very 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, 2023

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.1%***	**37.1%**	**4.0%***
Coverage				
Length of time with any coverage during the year				
Full year	**94.9***	98.2	98.2	–
Part year	**3.1***	1.8	1.8	40.6*
No coverage during year	**2.0***	–	–	59.4*
Demographics				
Age				
0–5	**29.5***	28.5*	31.4	22.0*
6–11	**31.2**	30.1*	33.1	30.6
12–18	**39.2***	41.4*	35.5	47.4*
Gender				
Male	**51.2**	51.2	51.7	51.5
Female	**48.8**	48.8	48.3	48.5
Race				
Hispanic	**26.5***	16.1*	39.3	49.3*
White, non-Hispanic	**50.7***	63.3*	33.5	33.3
Black, non-Hispanic	**12.0***	8.5*	17.8	8.6*
American Indian or Alaska Native, non-Hispanic	**†**	0.3	†	†
Asian, non-Hispanic	**4.9***	6.4*	3.1	2.6
Other single and multiple races, non-Hispanic	**5.4**	5.4	5.4	†
Parents present in family				
0 parents	**2.2***	0.7*	4.4	†
1 parent	**27.5***	16.4*	43.5	34.4*
2 or more parents	**70.3***	82.9*	52.1	62.9*
Family income				
Has income less than 138 percent FPL	**24.7***	5.8*	51.7	40.5
Has income in ranges shown below				
Less than 100 percent FPL	**16.5***	3.1*	36.0	25.6
100–199 percent FPL	**22.5***	†	36.8	32.3
200–399 percent FPL	**30.2**	36.1	20.9	27.8
400 percent FPL or higher	**31.2***	†	†	15.0

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	**96.6%**	97.6%	97.2%	75.9%*
Born outside U.S.	**4.9**	3.6	4.2	28.1*
Number of years spent in the U.S. (among those born outside U.S.)				
Less than 5 years	**46.0**	41.3	42.0	58.6*
5–9 years	**34.7**	29.9	39.6	33.4
10 or more years	**19.3**	28.8	18.4	†
Lives in a family that receives				
SSI or SSDI	**6.8***	2.5*	13.3	†
SSI	**3.5***	1.0*	7.2	†
SSDI	**3.9***	1.6*	7.5	†
WIC	**13.2***	3.2*	28.2	13.5*
SNAP	**22.4***	5.1*	49.2	20.6*
Public assistance	**6.1***	1.6*	12.9	†
Any school-aged child in family received free or reduced-cost meals at school in past 12 months	**51.2***	32.7*	78.3	52.3*
Health				
Current health status				
Excellent or very good	**86.1***	90.6*	79.4	84.5
Good	**11.6***	8.0*	16.9	12.5
Fair or poor	**2.3***	1.4*	3.7	†
School days lost due to illness or injury, past 12 months				
None	**30.7***	26.9*	35.4	43.5
1 day	**7.5***	8.5*	6.2	†
2–5 days	**40.4***	44.1*	35.2	35.5
6–10 days	**13.8**	14.0	13.4	11.5
11–20 days	**5.7***	4.9*	7.3	†
Over 20 days	**1.9**	1.6	2.5	†
Special needs, impairments, and health conditions				
Receives special education or early intervention services[6]	**10.6***	8.8*	13.9	5.1*
Uses a hearing aid	**0.6**	0.6	0.7	–
Uses special equipment for walking	**0.8**	0.6	1.1	†

EXHIBIT 39. (continued)

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Uses glasses	**26.3%**	26.6%	27.0%	19.4%*
Washington Group on Disability Statistics indicator for kids 2–4[7]	**4.6***	2.0*	8.3	†
Washington Group on Disability Statistics indicator for kids 5–17[7]	**13.7***	11.1*	17.9	11.7*
Ever been told he or she has selected conditions				
ADHD/ADD[8]	**11.3**	11.2	11.9	†
Asthma	**10.7***	9.9*	12.3	8.8
Autism[8]	**4.3***	3.3*	5.9	†
Diabetes	**0.4***	†	0.8	–
Intellectual disability[6]	**1.7***	0.9*	3.0	†
Other developmental delay[6]	**6.3***	5.8*	7.7	†

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 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, and uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

EXHIBIT 39. (continued)

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

[5] Because a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid or CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] 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, 2024, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2023, NHIS Data

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.1%**	**37.1%**	**4.0%**
Contact with health care professionals (past 12 months)				
Saw selected health professional				
Saw doctor or other health care professional	**94.5**	95.9	94.9	70.9*
Had eye exam	**40.2**	42.1*	38.6	26.6*
Received counseling/therapy from mental health professional[6]	**12.1**	12.3	12.1	7.2*
Dental exam/cleaning[7]	**82.4***	85.7*	80.5	56.1*
Had at least 1 overnight hospital stay[7]	**2.8***	2.3*	3.6	†
Used prescription medication	**40.8**	43.1*	39.5	22.8*
Had a medical appointment by video or phone	**14.9**	16.5*	13.6	5.1*
Receipt of appropriate care (past 12 months)				
Interval since last wellness visit[8]				
Within the past year	**93.2**	94.5	93.7	69.1*
More than 1 year ago but less than 2 years	**4.7**	4.0	4.7	15.1*
More than 2 years ago	**1.9**	1.4	1.6	13.4*
Never	**†**	†	†	†
Number of emergency room visits				
None	**82.4***	85.6*	76.9	89.4*
At least 1	**17.6***	14.4*	23.1	10.6*
1	**11.7***	10.4*	13.8	6.9*
2–3	**5.0***	3.3*	7.9	†
4 or more	**0.9***	0.6*	1.4	†
Number of urgent care visits				
None	**69.4***	66.7*	72.0	84.9*
At least 1	**30.6***	33.3*	28.0	15.1*
1	**16.3***	18.5*	13.7	8.2*
2–3	**11.2**	11.8	10.5	6.6*
4 or more	**3.1**	2.9	3.8	†

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 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, and uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

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

[5] Because a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid or CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

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

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

[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, 2024, analysis of NHIS data.

EXHIBIT 41. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2022, 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%**	**56.4%**	**37.6%**	**3.9%**
Child has special health care needs	**14.4**	14.1	15.4	†
Contact with health care professionals (past 12 months)				
Number of office-based visits to a doctor or other health professional, excluding dental visits and inpatient hospital stays				
None	**27.5***	21.7*	33.4	54.6*
At least 1	**72.5***	78.3*	66.6	45.4*
1	**21.4**	19.8	23.3	23.0
2–3	**24.2**	25.1	24.6	†
4 or more	**26.8***	33.4*	18.7	13.8
Had at least 1 dental care visit[6]	**52.9***	59.6*	44.7	32.3*
Received care at home	**1.6***	1.1*	2.5	†
Receipt of appropriate care (past 12 months)				
Had more than 15 office-based or hospital outpatient visits	**5.5**	5.7	5.5	†
Annual total of days received visits from paid/unpaid home health care providers				
None	**98.4**	98.9*	97.5	99.7*
1	**†**	†	†	†
2–30	**0.7**	†	†	†
31–90	**†**	†	†	†
91–200	**†**	†	†	†
More than 200	**†**	†	†	†
Number of emergency room visits				
None	**91.1**	92.4*	89.5	92.9
At least 1	**8.9***	7.6*	10.5	†
1	**7.2**	6.5	7.8	†
2–3	**1.5***	1.0*	2.3	†
4 or more	**†**	†	†	†
Had at least 1 overnight hospital stay	**1.6**	1.4	1.9	†

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	**65.3%**	63.4%	66.5%	84.8%*
1	**12.9**	14.2*	11.5	†
2	**5.8**	6.5	5.0	†
3–5	**6.8**	6.8	7.0	†
6–2	**5.1**	5.5	4.6	†
13–24	**2.7**	2.5	3.2	†
More than 24	**1.5**	1.1*	2.2	†

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-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.

The NHIS underwent 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, and uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other federal government-sponsored programs. Coverage source is defined as of the time of the 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, 2024, analysis of MEPS data.

EXHIBIT 42. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2023, NHIS Data

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.1%**	**37.1%**	**4.0%**
Connection to the health care system (past 12 months)				
Has a usual source of care[6]	**96.4**	98.1*	95.9	76.6*
Kind of usual place for medical care				
Doctor's office or health center	**94.9**	96.3*	94.1	81.0*
Urgent care/walk-in clinic	**4.6**	3.5*	5.4	16.3*
Other	**0.4**	†	0.4	†
Timeliness of care (past 12 months)				
Delayed medical care because of costs	**1.1**	0.6	0.8	11.3*
Delayed getting dental care	**4.2**	3.0	3.7	23.5*
Delayed filling prescription to save money	**2.0**	1.7	2.2	†
Unmet need for selected types of care due to cost				
Medical care	**1.2**	0.7	1.1	10.6*
Mental health care or counseling[7]	**1.2**	1.2	0.9	†
Dental care[8]	**3.0**	2.2	2.8	16.5*
Prescription drugs	**1.0**	0.6*	1.3	†
Problems paying or unable to pay medical bills, past 12 months	**12.6***	10.2*	16.2	19.5

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 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, and uninsured. Not separately shown are the estimates for those covered by Medicare (generally children with end-stage renal disease), any type of military health plan, or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

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

[5] Because a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid or CHIP percentages shown in this row exclude individuals who also have Medicare (which is rare for children) or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] 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, 2024, 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, 2022, 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%**	**56.4%**	**37.6%**	**3.9%**
Access to Care				
Has usual place for medical care	**86.9**	89.8*	85.4	55.2*
Travel time to usual source of care				
Less than 15 minutes	**61.5**	62.5	61.0	47.6
15–30 minutes	**31.2**	31.7	30.1	43.1
31–60 minutes	**6.6**	5.4	7.9	†
More than an hour	**0.7**	†	†	†
Difficulty reaching usual medical provider by phone during business hours				
Very difficult	**3.4**	3.1	3.9	†
Somewhat difficult	**12.8**	11.6	14.5	†
Not too difficult	**28.5**	30.9*	25.5	31.8
Not at all difficult	**55.4**	54.4	56.1	55.2
Difficulty reaching usual medical provider after hours for urgent medical needs				
Very difficult	**21.6***	15.9*	30.5	†
Somewhat difficult	**18.3**	18.3	16.7	†
Not too difficult	**29.4***	32.8*	24.4	34.1
Not at all difficult	**30.6**	33.1	28.4	†
Usual medical provider has night or weekend availability	**45.4***	50.3*	39.2	41.3
Usual medical provider speaks preferred language or provides translator, among those with limited English abilities in family	**93.0**	†	100.0	100.0*
Usual medical provider asks person to help decide between choice of treatments				
Never	**7.0***	3.6*	12.0	†
Sometimes	**11.0**	9.8	12.8	†
Usually	**19.8**	21.1	17.4	26.1
Always	**62.2**	65.4*	57.8	47.7
Usual medical provider presents and explains all options	**97.0**	98.0*	95.7	89.7

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.

The NHIS underwent 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 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, and uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the 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, 2024, analysis of MEPS data.

EXHIBIT 44. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2023

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%**	**3.8%**	**68.2%**	**14.2%**	**10.9%**
Coverage					
Length of time with any coverage during year					
Full year	**85.5***	97.3*	95.0*	94.1	–
Part year	**7.3***	2.7*	5.0*	5.9	27.7*
No coverage during year	**7.3***	–	–	–	72.3*
Demographics					
Age					
19–25	**15.5***	5.3*	14.1*	23.1	17.4*
26–44	**42.9***	18.9*	42.1*	48.2	50.6
45–54	**20.5***	20.8*	22.0*	14.5	18.1*
55–64	**21.2***	55.0*	21.7*	14.2	13.8
Gender					
Male	**49.7***	50.6*	50.9*	36.6	57.7*
Female	**50.3***	49.4*	49.1*	63.4	42.3*
Sexual orientation					
Heterosexual	**94.5***	96.8*	94.6*	92.5	95.6*
Lesbian/gay	**2.3**	†	2.5	2.4	1.9
Bisexual	**3.1***	†	2.9*	5.0	2.6*
Race					
Hispanic	**19.6***	13.6*	14.5*	27.3	45.4*
White, non-Hispanic	**58.4***	60.7*	64.7*	43.1	36.3*
Black, non-Hispanic	**12.5***	20.0	10.5*	19.4	11.9*
American Indian or Alaska Native, non-Hispanic	**0.7**	†	0.4	†	†
Asian, non-Hispanic	**6.7**	2.4*	7.9*	6.2	2.6*
Other single and multiple races, non-Hispanic	**2.2**	2.3	2.0	2.6	2.5

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	**51.1%***	36.7%*	58.4%*	28.7%	36.9%*
Widowed	**1.4**	6.2*	1.0*	1.9	1.5
Divorced or separated	**8.9***	20.7*	7.5*	10.3	10.8
Living with partner	**10.8***	6.9*	9.4*	14.9	17.3
Never married	**27.8***	29.5*	23.8*	44.2	33.5*
Family income					
Less than 138 percent FPL	**17.0***	45.5	6.7*	47.6	32.7*
Has income in ranges below					
Less than 100 percent FPL	**10.9***	29.3	3.6*	33.9	20.5
100–199 percent FPL	**18.2***	35.5	†	34.5	31.2
200–399 percent FPL	**30.3**	23.3	32.1	22.7	31.1
400 percent FPL or higher	**40.6***	†	†	†	17.4
Education					
Less than high school	**9.1***	19.2	4.1*	19.2	25.4*
High school diploma/GED	**26.3***	38.4	21.6*	38.4	36.7
Some college	**29.6**	31.7	29.7	30.8	24.1*
College or graduate degree	**35.0***	10.7	44.5*	11.6	13.9*
Other demographic characteristics					
Citizen of United States	**89.8**	95.6*	93.2*	89.5	64.8*
Born outside U.S.	**20.4**	11.8*	17.5*	21.6	42.8*
Number of years spent in the U.S. (among those born outside U.S.)					
Less than 5 years	**11.3**	†	9.0	10.5	18.7*
5–9 years	**13.3**	†	12.3	15.1	14.7
10 years or more	**75.5**	84.1	78.7	74.4	66.6*

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	**33.7%***	11.7%*	33.1%*	41.6%	35.1%*
Currently working	**77.4***	16.3*	86.9*	54.9	70.6*
Working full time (usually works 35 hours or more per week)	**82.4***	50.2	86.6*	58.7	77.9*
Working part time (less than 35 hours per week)	**17.6***	49.8	13.4*	41.3	22.1*
Veteran	**5.2***	6.6*	4.5*	1.9	2.0
Lives in a family that receives					
SSI or SSDI	**9.3***	70.2*	4.1*	21.5	5.6*
SSI	**4.3***	21.6*	1.9*	13.1	2.3*
SSDI	**6.2***	61.1*	2.6*	11.2	3.5*
WIC	**6.7***	7.1*	2.9*	20.1	12.4*
SNAP	**13.9***	42.2*	5.0*	48.3	16.5*
Public assistance	**3.9***	10.7	1.6*	13.2	3.7*
Any school-aged child in family received free or reduced-cost meals at school in past 12 months	**49.2***	72.3	37.7*	77.5	67.2*
Health					
Current health status					
Excellent or very good	**59.2***	18.7*	65.1*	45.0	55.7*
Good	**28.2***	29.0	26.9*	31.9	31.7
Fair or poor	**12.6***	52.3*	8.1*	23.1	12.6*
BMI					
Healthy weight (BMI less than 25)	**31.2**	23.6*	31.5	31.3	32.8
Overweight (BMI 25–29)	**33.4***	28.3	34.2*	29.6	34.0*
Obese (BMI 30 or higher)	**35.5***	48.1*	34.2*	39.1	33.2*
Smoking status					
Current smoker	**11.8***	24.9*	8.7*	18.2	17.2
Former smoker	**19.0***	26.5*	19.0	17.1	17.3

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Never smoked	**69.2%***	48.5%*	72.3%*	64.7%	65.5%
Current e-cigarette user	**8.2***	5.0*	6.9*	12.6	10.7
Former e-cigarette user	**16.5**	15.9	16.1	17.8	17.7
Never used e-cigarettes	**75.3***	79.1*	77.0*	69.6	71.5
Limitations and health conditions					
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[6]	**17.2***	57.2*	12.9*	27.7	14.5*
Any complex activity limitation[7]	**17.7***	82.7*	11.2*	32.4	13.8*
Either one	**26.1***	86.6*	19.7*	41.6	23.0*
Washington Group on Disability Statistics indicator for adults 18 and older[8]	**6.7***	39.4*	3.6*	13.5	5.0*
Has difficulty walking 100 yards without equipment	**2.9***	26.6*	1.2*	6.1	1.2*
Has mobility or hearing problem that requires special equipment	**4.6***	33.9*	2.8*	6.8	2.1*
Unable to work now due to health problem	**6.7***	64.8*	1.6*	17.3	3.5*
Limited in amount or kind of work due to health	**15.9***	73.9*	10.3*	27.9	12.2*
Needs assistance with dressing and bathing	**0.9***	8.0*	0.2*	2.7	†
Work loss days due to illness or injury in past 12 months					
0 days	**49.7***	53.4	47.4*	55.4	59.6
1 day	**6.7***	†	7.2*	4.5	4.7
2–5 days	**28.0***	24.4	29.8*	21.9	23.2
6–10 days	**8.4**	†	8.8	7.2	7.0
11–20 days	**3.4***	†	3.1*	4.5	2.9*
More than 20 days	**3.9***	†	3.7*	6.5	2.6*
Health conditions					
Currently pregnant[9]	**3.3***	†	3.0*	4.7	†

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	**24.2%**	54.6%*	23.5%*	25.6%	14.7%*
Coronary heart disease	**2.0**	10.0*	1.6*	2.4	1.0*
Heart attack	**1.6***	10.3*	1.1*	2.3	0.8*
Stroke	**1.6***	11.2*	0.9*	2.9	0.9*
Cancer	**5.2***	11.8*	5.6*	4.3	2.0*
Diabetes	**6.9***	27.4*	5.5*	9.7	4.4*
Arthritis	**13.9**	46.2*	12.6*	15.4	6.7*
Asthma	**16.0***	27.9*	14.7*	23.1	10.2*
Chronic bronchitis, COPD, or emphysema	**2.8***	17.6*	1.6*	4.9	2.0*
Dementia	**0.2***	1.3	0.1*	0.6	†
High cholesterol	**21.5**	47.3*	21.5	19.7	13.9*
Anxiety disorder	**20.0***	41.7*	18.0*	27.8	12.5*
Depression	**19.7***	45.7*	16.9*	28.9	13.9*

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 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, and uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

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

[5] Because a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid or CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] 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, 2024, analysis of NHIS data.

EXHIBIT 45. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2023, 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%**	**3.8%**	**68.2%**	**14.2%**	**10.9%**
Contact with health care professionals (past 12 months)					
Saw selected health professionals in past year					
Saw doctor or other health care professional[6]	**81.2***	93.6*	84.2	83.8	53.4*
Received counseling/therapy from mental health professional	**15.5***	23.3*	15.5*	18.9	6.3*
Now sees a counselor, psychiatrist, psychologist, or social worker regularly (among those who have received counseling)	**66.0**	81.3*	64.6	69.5	48.7*
Had at least 1 overnight hospital stay	**7.1***	18.3*	5.6*	13.3	5.0*
Received care at home	**1.8***	11.6*	1.3*	3.1	†
Used prescription medication	**62.8**	88.2*	65.3	65.0	33.9*
Had a medical appointment by video or phone	**27.1**	38.3*	28.8	27.0	10.4*
Dental exam	**65.1***	54.5	72.3*	52.9	38.8*
Eye exam	**47.4***	56.7*	52.3*	38.9	23.3*
Receipt of appropriate care (past 12 months)					
Had cholesterol checked					
All individuals	**68.1**	85.1*	70.8	69.2	41.5*
Men age 35–64	**72.6**	85.5*	75.4	72.0	43.0*
Individuals with elevated risk of cardiac disease[7]	**78.4**	87.6*	82.1*	76.6	49.1*
Had flu shot					
All individuals	**41.1***	51.4*	44.9*	35.0	20.6*
Individuals age 50–64	**49.6***	53.4*	52.9*	43.8	23.7*
Had any test for colorectal cancer in past year (age 50–64)	**22.2**	29.4*	22.1	23.7	11.5*

EXHIBIT 45. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Had Pap smear or test for cervical cancer in past year (women age 21–60)	**49.2%**	34.2%*	50.7%	51.2%	35.9%*
Interval since last wellness visit					
Within the past year	**75.5***	88.7*	78.3	78.4	46.2*
More than 1 year ago but less than 2 years	**10.9***	5.4*	10.6	9.2	18.0*
2–5 years	**8.2**	3.0*	7.2	8.3	17.2*
5–10 years	**2.6**	†	2.0	2.2	7.6*
More than 10 years ago	**2.4***	†	1.6	1.6	9.0*
Never	**0.5**	†	0.3	†	2.1*
Number of emergency room visits					
None	**80.6***	64.5	84.7*	65.8	81.1*
At least 1	**19.4***	35.5	15.3*	34.2	18.9*
1	**12.7***	16.4	11.0*	19.1	12.3*
2–3	**5.6***	14.2	3.8*	11.7	5.6*
4 or more	**1.2***	4.9	0.5*	3.4	1.0*
Number of urgent care visits					
None	**67.1**	67.7	65.8	65.0	78.0*
At least 1	**32.9**	32.3	34.2	35.0	22.0*
1	**18.0***	14.1	19.7*	15.5	12.5*
2–3	**11.8***	12.3	11.9*	14.2	7.6*
4 or more	**3.1***	6.0	2.6*	5.3	1.9*

Notes: NHIS is the National Health Interview Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not sum to 100 percent. Standard errors are available 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 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/.

EXHIBIT 45. (continued)

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

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

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

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

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

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

[5] Because a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid or CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

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

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

Source: MACPAC, 2024, analysis of NHIS data.

EXHIBIT 46. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2022, 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%**	**3.3%**	**67.8%**	**13.3%**	**13.5%**
Contact with health care professionals (past 12 months)					
Number of office-based visits to a doctor or other health professional, excluding dental visits and inpatient hospital stays					
None	**32.1***	11.3*	25.6*	37.9	63.6*
At least 1	**67.9***	88.7*	74.4*	62.1	36.4*
1	**15.4**	11.1	16.0	14.8	14.1
2–3	**17.0***	14.4	19.1*	13.7	10.5*
4 or more	**35.6**	63.2*	39.4*	33.7	11.8*
Had at least 1 dental care visit[6]	**40.5***	30.6	48.7*	25.5	16.4*
Received care at home	**1.8***	12.8*	1.0*	4.4	†
Receipt of appropriate care					
Had more than 15 office-based or hospital outpatient visits	**11.7**	28.4*	12.3	12.3	4.1*
Annual total of days received visits from paid/unpaid home health care providers					
None	**98.2***	87.2*	99.0*	95.6	99.5*
1	**0.3**	†	†	†	†
2–30	**0.7***	†	0.5*	1.6	†
31–90	**0.3**	†	0.2*	0.4	†
91–200	**0.2***	†	†	†	†
More than 200	**0.3***	3.6*	†	1.4	†
Number of emergency room visits					
None	**89.0***	69.5*	91.0*	80.4	92.8*
At least 1	**11.0***	30.5*	9.0*	19.6	7.2*
1	**8.1***	18.0*	7.2*	13.2	4.9*
2–3	**2.4***	11.1*	1.5*	5.1	2.2*
4 or more	**0.5***	†	0.4*	1.3	†
Had at least 1 overnight hospital stay	**4.5***	17.4*	3.5*	8.8	2.2*

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	**43.5%**	11.8%*	40.4%	42.1%	68.6%*
1	**8.1**	†	8.8	7.0	7.1
2	**5.2**	†	5.6	5.3	4.1
3–5	**11.7***	10.4	13.1*	9.8	6.8*
6–12	**13.3***	10.9	15.1*	11.2	6.4*
13–24	**9.5***	19.1*	10.5*	7.8	3.5*
More than 24	**8.8***	42.5*	6.5*	17.0	3.3*

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-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.

The NHIS underwent 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, and uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the 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, 2024, analysis of MEPS data.

EXHIBIT 47. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2023, 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%**	**3.8%**	**68.2%**	**14.2%**	**10.9%**
Connection to the health care system (past 12 months)					
Has a usual source of care[6]	**85.2***	92.9*	88.6	87.5	56.9*
Kind of usual place for medical care					
Doctor's office or health center	**87.2**	94.1*	88.7	88.0	76.4*
Urgent care/walk-in clinic	**10.7**	4.4*	10.2	10.9	20.4*
Veterans Affairs facility	**1.3***	†	0.5	†	†
Other	**0.8**	†	0.6	†	2.7*
Timeliness of care (past 12 months)					
Delayed because of costs	**8.7***	11.4*	6.4	7.4	24.7*
Delayed getting dental care	**20.8***	28.4	15.6*	26.9	43.8*
Delayed filling prescription to save money	**7.8**	12.9*	6.3*	8.2	21.9*
Unmet need for selected types of care due to cost					
Medical care	**7.6**	10.9*	5.3*	7.1	22.6*
Mental health care or counseling	**6.8**	7.1	6.4	6.8	9.8*
Dental care	**16.9***	27.1	11.9*	24.5	36.0*
Prescription drugs	**6.5**	14.8*	4.9*	7.7	12.7*
Problems paying or unable to pay medical bills, past 12 months	**11.9**	23.3*	10.0*	12.2	19.5*
Other barriers to care in the past 12 months					
Lack of transportation kept you from medical appointments, meetings, work, other needs for daily living	**7.1***	14.9	4.6*	15.9	9.1*

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 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, and uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. Because an individual may have multiple coverage sources or changes over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this exhibit.

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

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

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

[5] Because a hierarchy was used in this exhibit to assign individuals with multiple coverage sources to a primary source (see note 1), the Medicaid or CHIP percentages shown in this row exclude individuals who also have Medicare or private coverage. Components do not sum to 100 percent because not all coverage sources are shown.

[6] Excludes emergency room.

Source: MACPAC, 2024, 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, 2022, 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%**	**3.3%**	**67.8%**	**13.3%**	**13.5%**
Access to Care					
Has usual place for medical care	**63.9**	79.0*	68.2	64.4	36.4*
Travel time to usual source of care					
Less than 15 minutes	**58.4**	51.4*	59.2	60.1	56.1
15–30 minutes	**33.4**	36.4	33.6	30.2	34.0
31–60 minutes	**6.8**	8.7	6.2	7.4	8.1
More than an hour	**1.3**	†	0.9	†	†
Difficulty reaching usual medical provider by phone during business hours					
Very difficult	**5.0**	8.9	4.6	5.6	4.8
Somewhat difficult	**14.0***	14.6	12.8*	17.4	16.3
Not too difficult	**32.6**	27.0	33.9	31.1	27.9
Not at all difficult	**48.4**	49.5	48.7	45.9	50.9
Difficulty reaching usual medical provider after hours for urgent medical needs					
Very difficult	**28.3***	29.3*	25.7*	39.8	27.6*
Somewhat difficult	**21.7**	22.1	21.4	19.2	25.4
Not too difficult	**25.6***	18.8	28.1*	19.5	23.3
Not at all difficult	**24.3**	29.7	24.9	21.5	23.8
Usual medical provider has night or weekend availability	**31.4**	25.2	32.1	30.4	33.1
Usual medical provider speaks preferred language or provides translator, among those with limited English abilities in family	**95.6**	100.0	91.2	97.1	98.8

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%***	10.9%	5.5%*	12.5%	13.4%
Sometimes	**15.6**	15.1	14.2*	18.7	22.6
Usually	**22.3**	17.8	23.4	20.5	20.5
Always	**54.8***	56.2*	57.0*	48.3	43.5
Usual medical provider presents and explains all options	**96.4***	95.4	97.2*	94.3	93.0

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-careamong-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.

The NHIS underwent 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, and uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the 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.

EXHIBIT 48. (continued)

[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, 2024, 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 new administrative data sources on enrollment in 2014, referred to here as performance indicator enrollment data and CMS-64 enrollment data.[2] These sources differ in the timing of the reports and the enrollees covered. Performance indicator enrollment data are published monthly by CMS and include only full-benefit Medicaid and CHIP enrollees. CMS-64 enrollment data are published quarterly and include Medicaid enrollees with limited benefits but exclude CHIP enrollees.

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

T-MSIS. T-MSIS is the updated version of the Medicaid Statistical Information System (MSIS) and 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 dataset 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. After 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]	72, 73, 74, 75	Any age
Other adult[2]	05, 09, 34, 53	Any age
	01, 02, 03, 04, 27, 33, 35, 36, 56, 70	Age 19 and older
	32, 69, 71, 76	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] 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, 2024, 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 sex. 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 map services between the two systems. This is particularly true for non-institutional LTSS. Previously in MSIS, we relied on program type, because home- and community-based services (HCBS) was not a separate type of service. We still use program type, but we can now also capture claims with an HCBS type of service or a Title XIX service category. This expansion of the algorithm may result in our capturing more claims as non-institutional LTSS.
- State practices for classifying enrollees and services in T-MSIS may change over time as states become more familiar with the T-MSIS reporting structure and requirements. Future changes in enrollment and spending, particularly across eligibility groups or service categories, may reflect changes in reporting in addition to changes in policy. Finally, enrollment and spending amounts for a particular year could change over time if states correct reporting errors and anomalies for past years.

Methodology for Adjusting Benefit Spending Data

The Medicaid benefit spending amounts presented in this data book were calculated based on T-MSIS data that have been adjusted to match total benefit spending reported by states in CMS-64 data.[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 2022 (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	**$726,010**	**$772,691**	**94.0%**	**$17,897**	**$13,479**
Alabama	5,871	6,892	85.2	312	–
Alaska	2,554	2,449	104.3	11	–
Arizona	18,760	19,995	93.8	156	108
Arkansas	7,043	8,545	82.4	27	–
California[2]	97,237	114,962	84.6	596	3,329
Colorado	10,480	11,778	89.0	210	–
Connecticut	10,070	9,583	105.1	185	–
Delaware	3,123	3,098	100.8	43	–
District of Columbia	3,648	3,527	103.4	125	–
Florida	27,967	31,473	88.9	368	1,247
Georgia	12,835	13,860	92.6	564	–
Hawaii[3]	3,024	3,037	99.5	–	–
Idaho	3,225	3,198	100.8	28	–
Illinois	22,899	25,445	90.0	597	–
Indiana	17,682	16,334	108.3	578	–
Iowa	6,420	6,688	96.0	10	–
Kansas	4,479	4,226	106.0	84	14
Kentucky	14,470	14,568	99.3	49	–
Louisiana	13,821	13,584	101.7	1,172	–
Maine	3,336	3,814	87.5	59	–
Maryland	14,667	14,248	102.9	198	–
Massachusetts	20,006	20,187	99.1	–	866
Michigan	18,167	20,712	87.7	609	–
Minnesota	17,142	16,246	105.5	50	–
Mississippi	5,781	5,724	101.0	246	–
Missouri	12,044	12,257	98.3	835	–
Montana	2,119	2,367	89.5	–	–
Nebraska	3,534	3,306	106.9	40	–
Nevada	4,998	4,943	101.1	145	–
New Hampshire	2,211	2,224	99.4	246	0
New Jersey	19,027	20,226	94.1	928	–
New Mexico	7,236	8,227	88.0	34	12
New York	75,612	79,319	95.3	3,926	–

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	$18,483	$18,121	102.0%	$462	–
North Dakota[2]	1,529	1,531	99.9	2	–
Ohio	29,375	30,046	97.8	211	–
Oklahoma	6,522	8,190	79.6	65	–
Oregon	9,450	13,059	72.4	89	–
Pennsylvania	40,357	40,163	100.5	1,224	–
Rhode Island	3,068	2,790	109.9	160	$458
South Carolina	7,116	7,246	98.2	592	–
South Dakota	1,148	1,255	91.4	2	–
Tennessee	11,289	11,283	100.1	72	–
Texas	46,362	48,520	95.6	1,855	7,330
Utah[2]	4,193	4,212	99.6	35	–
Vermont	1,727	1,722	100.3	46	117
Virginia	20,803	18,619	111.7	42	–
Washington	16,214	21,705	74.7	377	–
West Virginia	5,299	5,133	103.2	90	–
Wisconsin	10,968	11,375	96.4	143	–
Wyoming	618	677	91.3	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 $16.9 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 $651.5 million, North Dakota's T-MSIS spending by approximately $10.4 million, and Utah's T-MSIS spending by approximately $37.2 million.

[3] The CMS-64 total for Hawaii excludes $0.2 million in fee-for-service (FFS) drug spending because the state did not report any FFS drug spending in T-MSIS.

Source: MACPAC, 2024, analysis of T-MSIS data as of February 2024, and CMS-64 financial management report net expenditure data as of May 2023.

EXHIBIT 51. Service Categories Used to Adjust FY 2022 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 • Electronic health record (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 hospital base and supplemental payments
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 base and supplemental payments • 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 base and supplemental payments • 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

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 • Medication assisted treatment (MAT) and drugs for evidenced-based treatment of Opioid Use Disorder (OUD) (not on a pharmacy claim) • Residential pediatric recovery center • Other care	• COVID-19 vaccines and administration • MAT treatment services for OUD • Qualified community-based mobile crisis intervention • Care not otherwise categorized
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, certified community behavior health clinics, 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 behavior health clinic
LTSS institutional	• Nursing facility • Inpatient hospital and nursing facility services for individuals age 65 and older in institution for mental disease (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. 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. 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 selected 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, 2024, 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 2021, in Data book: Beneficiaries dually eligible for Medicare and Medicaid, Washington, DC: MedPAC and MACPAC, https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf.

Source: MACPAC, 2024, 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 new Medicaid and CHIP performance indicator enrollment data do not identify newly eligible individuals for whom there is a higher federal matching rate, CMS is using a separate process to collect monthly Medicaid enrollment by eligibility category when states submit their CMS-64 quarterly expenditures. Specifically, a new CMS-64 enrollment form has been created to accompany the current expenditure forms. Although enrollment is submitted at the same time as expenditures, there is not a direct link between the amount of federal expenditures claimed by states and the number of enrollees reported. Instead, CMS uses CMS-64 enrollment data for monitoring and oversight purposes.

[3] The Data Quality Atlas can be found at https://www.medicaid.gov/dq-atlas/welcome.

[4] The timing of each state's transition from MSIS to T-MSIS can be found at https://www.medicaid.gov/medicaid/data-and-systems/downloads/macbis/taf-rif-availability-chart.pdf.

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

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

[7] States make capitated payments for all individuals enrolled in managed care plans even if no health care services are used. Therefore, all managed care enrollees currently are counted as beneficiaries or persons served, regardless of whether they have used any health services.

[8] Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2023. 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.

Printed on recycled material

MACPAC
Advising Congress on Medicaid and CHIP Policy

1800 M Street NW
Suite 650 South
Washington, DC 20036

www.macpac.gov
202-350-2000