MACStats: Medicaid and CHIP Data Book

FEBRUARY 2026

MACPAC
Medicaid and CHIP Payment and Access Commission

MACPAC

About MACPAC

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

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, Section 1900 of the Social Security Act, outlines a number of areas for analysis, including:

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

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

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Introduction

This 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 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. The release of this year's data book was delayed due to the government shutdown in 2025.

Medicaid and CHIP covered more than 31 percent of the U.S. population in 2024 (Exhibit 1). About 37 percent of children had Medicaid or CHIP coverage in 2024 (Exhibit 2). As of July 2025, 78.0 million people were enrolled in Medicaid and CHIP. Enrollment decreased by 2.8 percent from July 2024 to July 2025 as states continued to disenroll beneficiaries following the end of the continuous coverage requirement that was attached to the federal medical assistance percentage (FMAP) increase under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) (Exhibit 11).

Although the share of the federal budget devoted to Medicaid and Medicare has grown steadily since the programs were enacted in 1965, in fiscal year (FY) 2024, the share of federal spending on Medicaid and CHIP (9.4 percent) decreased from the prior fiscal year (10.3 percent) due to the expiration of the temporary increase in the FMAP and the end of the continuous coverage requirement under the FFCRA (Exhibit 4). Medicaid spending continues to account for a smaller share of the federal budget in FY 2024 (9.1 percent) than Medicare (12.8 percent).

Total Medicaid spending was $957.4 billion in FY 2024 (Exhibit 16). Spending for CHIP was $28.2 billion (Exhibit 33). The federal share of spending was 64.7 percent of total Medicaid benefit spending in FY 2024, compared with a federal share of 69 percent of total Medicaid benefit spending in FY 2023. This decrease in federal spending is due to the expiration of the 6.2 percentage point increase in the FMAP under the FFCRA (Exhibit 16).

In FY 2023, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 19 percent of Medicaid enrollees but about 50 percent of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports (LTSS). Spending for people who are dually eligible for Medicaid and Medicare accounted for more than $271 billion in spending in FY 2023 (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 less likely to report having a usual source of care than those with private coverage and 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.

Beginning in 2025, MACPAC implemented a new method for classifying a claim as non-institutional LTSS (Exhibit 51). Building on recent MACPAC work to compare different approaches to identify home- and community-based services (HCBS) and to calculate HCBS spending and utilization, we adapted the methodology developed for the Centers for Medicare & Medicaid Services' LTSS Expenditures and Users Reports and KFF State Health Facts. Due to these changes, exhibits showing spending and users of non-institutional LTSS using Transformed Medicaid Statistical Information System (T-MSIS) data may not be directly comparable to prior editions of MACStats. Additionally, readers should note that the number of LTSS users displayed in Exhibit 20 now includes enrollees using LTSS under managed care arrangements, whereas prior editions included only those users receiving LTSS under fee-for-service arrangements. See the technical guide for a more detailed description of these changes.

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 2024, more than 31 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: 98.7 million in Medicaid and 9.2 million in CHIP (Exhibit 1). About 37 percent of children had reported Medicaid or CHIP coverage in 2024 (Exhibit 2).
- About 36 percent of individuals enrolled in Medicaid or CHIP in 2024 had family incomes below 100 percent of the federal poverty level (FPL). About half of all individuals (51.9 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 18.4 percent of national health expenditures in calendar year 2023, less than either Medicare (21.2 percent) or private insurance (30.1 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. However, in fiscal year (FY) 2024, the share of federal spending on Medicaid and CHIP (9.4 percent) decreased from the prior fiscal year (10.3 percent) due to the expiration of the temporary increase in the federal medical assistance percentage (FMAP) and the end of the continuous coverage requirement under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) (Exhibit 4).
- In FY 2024, Medicaid continued to account for a smaller share of the federal budget (9.1 percent) than Medicare (12.8 percent) (Exhibit 4).
- Medicaid spending as a share of state budgets varies depending on whether federal funds are included. Considering only the state-funded portion of state budgets (i.e., the portion states must finance on their own through taxes and other means), Medicaid's share was 15.1 percent in state fiscal year (SFY) 2023. When federal funds are included, Medicaid's share was 30.0 percent in SFY 2023 (Exhibit 5).

EXHIBIT 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2024 (millions)

Population	Ever during FY 2024	Point in time during FY 2024	Point in time during CY 2024
	Estimates based on administrative data (CMS)[1]		**Survey data (NHIS)[2]**
Medicaid enrollees	98.7[3]	82.8[3]	Not available
CHIP enrollees	9.2[4]	7.4[5]	Not available
Totals for Medicaid and CHIP	**107.9**	**90.2**	**61.8**
	U.S. Census Bureau data		**Survey data (NHIS)[2]**
U.S. population	340.5[6]	339.1[6]	330.8
	Administrative and Census Bureau data		**Survey data (NHIS)[2]**
Medicaid and CHIP enrollment as a percentage of U.S. population	31.7%[1]	26.6%	18.7%

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 National Health Expenditure (NHE) data from the CMS Office of the Actuary (OACT). Medicaid and CHIP enrollment numbers obtained from administrative data include individuals who received limited benefits (e.g., emergency services only). Combining administrative totals from Medicaid and CHIP may cause some individuals to be double-counted if they were enrolled in both programs during the year. Overcounting of enrollees in the administrative data may occur for other reasons—for example, individuals may move and be enrolled in two states' Medicaid programs during the year. Excludes about 1.5 million individuals in the territories.

[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 2024 T-MSIS data as of February 2025.

[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 OACT NHE projections for CYs 2013–2033.

[6] The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of September 2024 (the month with the largest count in FY 2024); 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 2024.

Sources: MACPAC, 2025, analysis of the following: T-MSIS data as of February 2025; CHIP SEDS data as of September 3, 2025; Office of the Actuary (OACT), CMS, 2025, Health insurance enrollment and enrollment growth rates, Calendar years 2013–2033, Baltimore, MD: OACT, https://www.cms.gov/files/zip/nhe-projections-tables.zip; NHIS data; and U.S. Census Bureau, 2024, Monthly population estimates for the United States: April 1, 2020 to December 1, 2025 (NA-EST2024-POP) https://www2.census.gov/programs-surveys/popest/tables/2020-2024/national/totals/NA-EST2024-POP.xlsx.

EXHIBIT 2. Characteristics of Non-Institutionalized Individuals by Age and Source of Health Coverage, 2024

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%**	**24.4%**	**61.7%**	**18.7%**	**8.2%**	**100.0%**	**55.6%**	**36.9%**	**5.3%**
Coverage									
Length of time with any coverage during year									
Full year	**88.8***	99.0*	96.2*	93.9	–	**92.7***	97.8*	95.8	–
Part year	**6.1**	1.0*	3.8*	6.1	32.2*	**4.8**	2.2*	4.2	46.0*
No coverage during year	**5.2***	–	–	–	67.8*	**2.5***	–	–	54.0*
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/ CHIP combination[6]	**1.9***	9.9	–	10.1	–	**–**	–	–	–
Yes, any private and Medicaid/ CHIP combination	**0.8***	–	1.3*	4.1	–	**1.7***	3.1*	4.7	–
Yes, any other combination	**7.5***	39.3*	12.2*	1.2	–	**–**	–	–	–
No	**89.8***	50.8*	86.6*	84.6	100.0*	**98.3***	96.9*	95.3	100.0*
Demographics									
Age									
0–18	**23.1***	–	20.8*	45.7	14.9*	**100.0***	100.0*	100.0	100.0*
19–64	**58.8***	10.9*	66.4*	46.2	83.8*	**–**	–	–	–
65 or older	**18.1***	89.1*	12.7*	8.1	1.4*	**–**	–	–	–
Sex									
Male	**49.2***	46.0	50.0*	44.3	55.1*	**51.0**	51.0	51.2	50.6
Female	**50.8***	54.0	50.0*	55.7	44.9*	**49.0**	49.0	48.8	49.4
Race									
Hispanic	**19.8***	9.2*	14.4*	32.3	44.2*	**26.4***	17.2*	38.2	43.5
White, non-Hispanic	**58.7***	73.3*	65.7*	37.2	38.3	**50.0***	62.3*	32.9	40.4*
Black, non-Hispanic	**12.0***	10.9*	9.8*	20.2	10.6*	**12.5***	8.4*	19.0	7.0*
American Indian or Alaska Native, non-Hispanic	**0.6**	0.6	0.4*	†	1.3	**0.6**	0.3*	†	†
Asian, non-Hispanic	**5.9***	4.8	7.0*	4.6	3.2*	**4.6***	6.2*	2.7	2.8
Other single and multiple races, non-Hispanic	**3.0***	1.3*	2.8*	4.7	2.3*	**5.9**	5.6	6.2	5.5

EXHIBIT 2. (continued)

Characteristic	Selected coverage source at time of interview, age 19–64[1]					Selected coverage source at time of interview, age 65 or older[1]			
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]	Total	Medicare	Private[2]	Medicaid or CHIP[3]
Total (percent distribution across coverage sources)[5]	**100.0%**	**3.5%**	**69.6%**	**14.7%**	**11.7%**	**100.0%**	**94.1%**	**43.5%**	**8.4%**
Coverage									
Length of time with any coverage during year									
Full year	**84.1***	96.2*	95.1*	91.2	–	**98.8**	99.3	99.5	98.5
Part year	**8.2**	3.8*	4.9*	8.8	30.0*	**0.9**	0.7	0.5	†
No coverage during year	**7.7***	–	–	–	70.0*	**0.4***	–	–	–
Multiple coverage sources at time of interview									
Yes, any Medicare and Medicaid/ CHIP combination[6]	**1.1***	32.0*	–	7.7	–	**6.8***	7.2*	–	81.1
Yes, any private and Medicaid/ CHIP combination	**0.6***	–	0.9*	4.3	–	**†**	–	†	†
Yes, any other combination	**0.7**	19.2*	1.0	0.7	–	**39.3***	41.8*	90.6*	10.2
No	**97.6***	48.8*	98.1*	87.3	100.0*	**53.9***	51.0*	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
Sex									
Male	**49.6***	50.7*	50.3*	39.0	55.8*	**45.6***	45.4*	46.6*	35.9
Female	**50.4***	49.3*	49.7*	61.0	44.2*	**54.4***	54.6*	53.4*	64.1
Race									
Hispanic	**20.3***	11.4*	15.2*	26.8	44.2*	**9.8***	8.9*	5.4*	29.8
White, non-Hispanic	**57.3***	58.1*	63.7*	41.5	38.3	**74.0***	75.1*	81.5*	36.1
Black, non-Hispanic	**12.5***	21.8	10.6*	21.2	11.3*	**9.7***	9.6*	7.3*	21.1
American Indian or Alaska Native, non-Hispanic	**0.7**	†	0.5	†	1.4	**0.5**	0.5	0.3	†
Asian, non-Hispanic	**6.7**	3.5	7.8*	5.4	3.1*	**5.1***	4.9*	4.5*	10.2
Other single and multiple races, non-Hispanic	**2.5***	3.9	2.2*	3.7	1.8*	**0.9**	1.0	0.9	1.7

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	**9.8%***	11.9%*	4.9%*	22.4%	25.3%	–	–	–	–
High school diploma/GED	**26.9***	29.2*	22.4*	38.4	37.8	–	–	–	–
Some college	**29.0**	29.6	29.3	28.0	23.8*	–	–	–	–
College or graduate degree	**34.3***	29.3*	43.4*	11.3	13.1	–	–	–	–
Marital status[7]									
Married	**53.4***	55.9*	59.7*	27.5	39.1*	–	–	–	–
Widowed	**5.8**	19.0*	3.8*	5.8	1.6*	–	–	–	–
Divorced or separated	**9.6***	14.1	8.0*	13.8	8.9*	–	–	–	–
Living with partner	**8.7***	3.0*	8.1*	13.3	15.4	–	–	–	–
Never married	**22.5***	8.0*	20.4*	39.7	35.1*	–	–	–	–
Family income									
Has income less than 138 percent FPL	**18.7***	19.4*	7.1*	51.9	33.3*	**24.6%***	6.0%*	51.6%	34.6%*
Has income in ranges shown below									
Less than 100 percent FPL	**11.9***	11.4*	3.9*	36.0	21.4	**16.0***	†	34.8	24.8
100–199 percent FPL	**19.5***	22.3*	†	36.4	32.1	**22.9***	†	38.5	30.2
200–399 percent FPL	**30.8**	32.6*	32.9	20.2	30.9	**29.5**	34.5	20.4	31.3
400 percent FPL or higher	**37.8***	33.5	†	†	15.8	**31.8***	†	†	14.2
Other demographic characteristics									
Citizen of United States	**92.4**	98.0*	94.5*	92.2	70.0*	**96.4**	97.6*	96.3	83.0*
Parent of a dependent child[7]	**26.0***	1.9*	28.2*	32.3	32.2	–	–	–	–
Currently working[7]	**63.8***	16.5*	75.8*	44.2	73.1*	–	–	–	–
Veteran[7]	**7.6***	15.2*	5.9*	2.5	1.6*	–	–	–	–
Family receives SSI or SSDI	**8.1***	16.1*	4.3*	20.0	5.0*	**6.0***	3.0*	11.2	2.7*
Health									
Current health status									
Excellent or very good	**61.4***	38.6*	66.9*	56.2	57.6	**85.1***	89.5*	78.3	83.3*
Good	**26.5**	34.3*	24.8	26.1	30.3*	**12.3***	9.1*	17.1	13.9
Fair or poor	**12.1***	27.1*	8.3*	17.7	12.1*	**2.6***	1.4*	4.6	†

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%***	15.8%	4.5%*	19.3%	25.0%*	**12.0%***	11.5%*	7.0%*	40.2%
High school diploma/GED	**26.9***	43.0	21.9*	40.1	38.1	**27.2**	27.5	25.1	28.4
Some college	**28.9**	30.0	29.2	29.4	23.9*	**29.2***	29.6*	29.6*	19.8
College or graduate degree	**35.2***	11.2	44.4*	11.2	13.0	**31.6***	31.5*	38.4*	11.6
Marital status[7]									
Married	**51.9***	37.0*	58.9*	26.9	38.9*	**58.2***	58.2*	63.6*	30.6
Widowed	**1.3***	4.7*	1.1*	1.9	1.1*	**20.4***	20.7*	18.1*	27.6
Divorced or separated	**8.4***	20.2*	7.3*	12.0	8.9*	**13.5***	13.4*	11.8*	23.4
Living with partner	**10.7***	7.9*	9.2*	14.9	15.5	**2.5***	2.4*	2.2*	4.1
Never married	**27.7***	30.2*	23.5*	44.2	35.5*	**5.5***	5.3*	4.2*	14.2
Family income									
Has income less than 138 percent FPL	**17.0***	42.7	7.1*	50.7	33.1*	**16.5***	16.6*	8.8*	60.2
Has income in ranges shown below									
Less than 100 percent FPL	**11.1***	29.3	4.1*	35.9	20.8*	**9.3***	9.2*	†	43.3
100–199 percent FPL	**17.8***	32.9	†	34.4	32.4	**20.7**	21.0	†	35.2
200–399 percent FPL	**30.6**	24.7	32.2	21.0	30.9	**33.3***	33.6*	33.8*	14.2
400 percent FPL or higher	**40.6***	†	†	†	16.0	**36.5**	35.9	†	†
Other demographic characteristics									
Citizen of United States	**89.4**	97.3*	92.7*	88.3	68.1*	**97.3***	98.1*	98.6*	89.9
Parent of a dependent child[7]	**33.8***	12.4*	33.5*	37.8	32.7*	**0.7**	0.6	0.6	†
Currently working[7]	**77.8***	17.9*	85.7*	50.5	73.6*	**18.4***	16.3*	23.4*	8.7
Veteran[7]	**5.0***	8.8*	4.2*	1.6	1.6	**15.8***	16.0*	14.9*	7.3
Family receives SSI or SSDI	**8.4***	68.6*	4.3*	25.9	5.4*	**9.8***	9.8*	6.5*	38.0
Health									
Current health status									
Excellent or very good	**58.3***	19.7*	63.9*	40.8	53.2*	**41.2***	40.9*	45.6*	18.8
Good	**29.5***	31.5	27.8*	34.3	33.2	**34.5***	34.6*	34.8*	30.6
Fair or poor	**12.1***	48.8*	8.3*	24.9	13.6*	**24.3***	24.5*	19.5*	50.6

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.

* 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, 2025, analysis of NHIS data.

EXHIBIT 3. National Health Expenditures by Type and Payer, 2023

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	**$4,866,494**	**$871,678**	**$24,693**	**$1,029,788**	**$1,464,648**	**$167,815**	**$802,187**	**$505,684**
Hospital care	**1,519,693**	283,103	5,934	378,970	559,430	95,394	158,624	38,238
Physician and clinical services	**978,016**	120,190	5,046	254,926	386,050	42,568	95,971	73,265
Dental services	**173,844**	18,921	3,037	10,342	69,140	2,669	2,116	67,620
Other professional services[3]	**159,881**	11,984	617	46,129	48,054	–	15,204	37,893
Home health care	**147,845**	51,193	74	51,757	21,520	1,535	4,035	17,730
Other non-durable medical products[4]	**124,096**	–	–	4,680	–	–	–	119,416
Prescription drugs	**449,732**	51,041	2,876	144,636	175,528	12,320	5,047	58,283
Durable medical equipment[5]	**72,828**	10,388	236	15,928	15,921	–	1,157	29,198
Nursing care facilities and continuing care retirement communities[6]	**211,261**	64,234	17	43,978	20,604	7,450	19,872	55,105
Other health, residential, and personal care services[7]	**270,159**	162,796	2,395	4,475	17,621	1,132	72,805	8,935
Administration[8]	**360,212**	97,827	4,461	73,968	150,781	4,747	28,428	–
Public health activity	**160,170**	–	–	–	–	–	160,171	–
Investment	**238,758**	–	–	–	–	–	238,757	–

EXHIBIT 3. (continued)

Type of expenditure	Payer amount (millions) and share of total							
	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third-party payers[2]	Out of pocket
Total payer share of expenditures	**100.0%**	**17.9%**	**0.5%**	**21.2%**	**30.1%**	**3.4%**	**16.5%**	**10.4%**
Hospital care	**100.0**	18.6	0.4	24.9	36.8	6.3	10.4	2.5
Physician and clinical services	**100.0**	12.3	0.5	26.1	39.5	4.4	9.8	7.5
Dental services	**100.0**	10.9	1.7	5.9	39.8	1.5	1.2	38.9
Other professional services[3]	**100.0**	7.5	0.4	28.9	30.1	–	9.5	23.7
Home health care	**100.0**	34.6	0.1	35.0	14.6	1.0	2.7	12.0
Other non-durable medical products[4]	**100.0**	–	–	3.8	–	–	–	96.2
Prescription drugs	**100.0**	11.3	0.6	32.2	39.0	2.7	1.1	13.0
Durable medical equipment[5]	**100.0**	14.3	0.3	21.9	21.9	–	1.6	40.1
Nursing care facilities and continuing care retirement communities[6]	**100.0**	30.4	0.0	20.8	9.8	3.5	9.4	26.1
Other health, residential, and personal care services[7]	**100.0**	60.3	0.9	1.7	6.5	0.4	26.9	3.3
Administration[8]	**100.0**	27.2	1.2	20.5	41.9	1.3	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, 2024, *National health expenditures by type of service and source of funds: Calendar years 1960–2023*, Baltimore, MD: OACT, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2023.zip. OACT, 2024, *National health expenditure accounts: Methodology paper, 2023*, 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 1965–2024

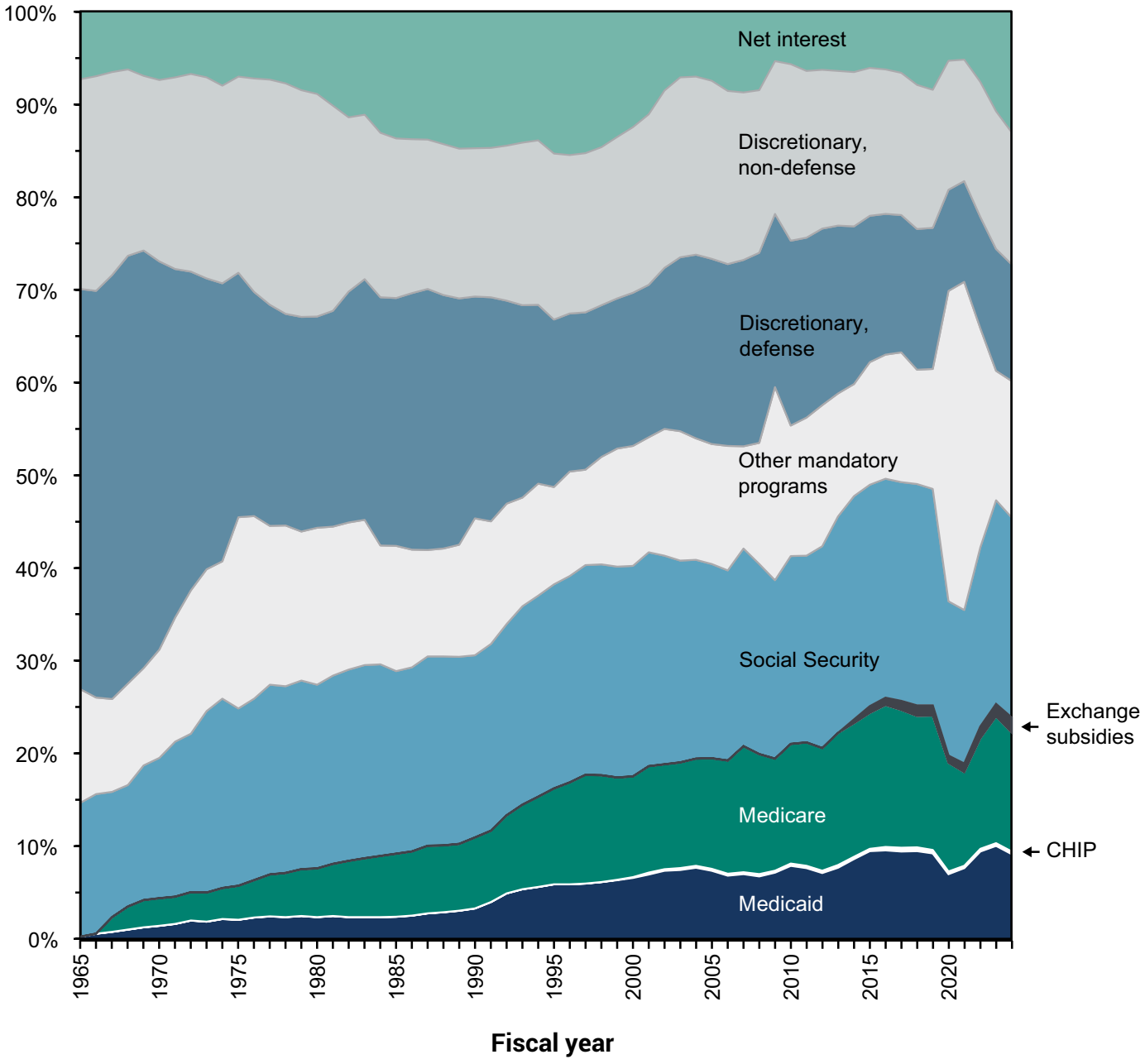


EXHIBIT 4. (continued)

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	12.9	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
2024	9.1	0.3	12.8	1.6	21.5	14.7	12.6	14.2	13.0

Notes: FY is fiscal year.

– Dash indicates zero.

Source: MACPAC, 2025, 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 2026*, Washington, DC: OMB, https://www.govinfo.gov/app/details/BUDGET-2026-TAB/context.

EXHIBIT 5. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, SFY 2023

State	Total budget (including state and federal funds)				State-funded budget			
		Total spending as a share of total budget[1]				State-funded spending as a share of state-funded budget[1]		
	Dollars (millions)	Medicaid	Elementary and secondary education	Higher education	Dollars (millions)	Medicaid	Elementary and secondary education	Higher education
Total	**$2,904,833**	**30.0%**	**18.6%**	**8.9%**	**$1,873,579**	**15.1%**	**23.0%**	**11.9%**
Alabama	40,552	22.3	27.7	20.1	23,631	8.6	29.0	27.4
Alaska	15,824	17.1	12.6	6.3	10,024	6.1	15.0	7.9
Arizona	111,291	23.2	9.1	8.1	84,787	6.5	9.1	9.2
Arkansas	33,773	28.9	13.4	14.1	21,581	9.2	15.0	21.7
California	413,783	32.4	17.9	6.5	274,041	16.1	24.4	7.4
Colorado	37,859	35.8	18.7	13.3	25,171	19.5	23.9	19.8
Connecticut	42,571	23.7	15.0	9.3	31,686	15.8	16.2	11.5
Delaware	15,467	21.3	22.9	3.4	11,450	8.5	27.0	3.9
District of Columbia	18,656	22.5	20.6	0.1	13,401	7.1	24.5	0.2
Florida	119,078	31.3	16.9	8.7	75,240	18.2	19.2	11.8
Georgia	75,144	23.2	22.2	16.3	44,231	10.7	27.5	22.2
Hawaii	19,231	16.5	16.6	3.6	14,902	5.7	18.6	4.7
Idaho	12,480	32.5	27.1	7.7	6,996	16.6	35.5	12.6
Illinois	121,178	16.5	12.1	2.4	96,948	6.7	10.2	2.9
Indiana	53,568	33.1	28.2	5.1	32,277	13.4	39.5	8.5
Iowa	29,584	26.3	16.0	25.5	18,893	14.4	20.1	37.0
Kansas	24,272	22.5	27.3	14.8	16,423	11.1	33.7	18.6
Kentucky	49,638	33.4	14.4	22.4	28,981	10.4	18.1	34.9
Louisiana	43,019	37.8	17.2	7.5	21,870	15.2	20.3	14.6
Maine	13,010	32.5	16.3	3.4	8,112	15.2	20.7	5.3
Maryland	67,723	20.8	15.3	12.3	44,581	11.0	19.3	15.7
Massachusetts	81,007	29.6	14.8	2.2	56,018	20.1	14.1	3.2
Michigan	81,538	28.7	25.8	3.8	48,728	12.0	35.1	6.0
Minnesota	54,139	32.6	22.3	3.5	34,961	18.6	29.8	5.4
Mississippi	23,715	24.9	18.8	18.5	12,884	7.7	22.9	32.4

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	$38,171	40.9%	21.7%	3.5%	$21,938	25.5%	26.2%	5.5%
Montana	10,473	22.8	13.6	7.1	5,355	8.8	18.6	13.6
Nebraska	17,207	23.3	11.4	20.6	11,763	10.6	11.8	25.0
Nevada	18,291	32.0	36.9	5.9	10,796	14.4	51.7	9.9
New Hampshire	8,311	31.4	18.7	1.9	4,546	22.0	25.4	3.5
New Jersey	87,153	25.3	23.0	8.3	60,959	20.1	31.0	11.3
New Mexico	26,372	33.8	17.2	15.5	15,083	10.3	26.7	21.3
New York	220,462	37.6	18.9	5.5	135,554	22.5	24.3	8.6
North Carolina	63,384	31.4	26.2	17.2	39,592	15.0	31.2	19.7
North Dakota	8,240	18.9	18.5	18.1	5,094	10.1	22.2	26.1
Ohio	93,380	38.9	16.5	3.2	53,820	17.9	20.7	5.5
Oklahoma	29,289	33.8	15.2	13.4	14,512	16.8	21.9	22.4
Oregon	53,922	26.9	14.4	3.5	35,594	9.9	18.3	5.1
Pennsylvania	113,613	40.1	16.8	2.2	67,517	23.9	23.4	3.5
Rhode Island	12,776	26.1	15.9	10.4	7,524	15.4	20.9	17.5
South Carolina	38,752	22.2	18.5	17.9	23,489	9.1	21.5	28.6
South Dakota	6,100	19.3	14.7	14.9	3,892	9.9	16.7	21.1
Tennessee	48,258	30.7	17.7	15.7	28,202	16.2	20.9	26.5
Texas	137,108	41.6	25.3	15.0	79,280	25.4	35.7	17.5
Utah	23,455	19.9	23.7	12.5	16,322	8.7	28.9	17.9
Vermont	7,893	25.5	30.9	2.1	4,659	15.0	46.6	3.0
Virginia	79,950	28.1	15.0	12.2	55,188	13.8	17.0	15.0
Washington	73,096	25.7	24.3	12.7	51,284	12.2	29.5	18.0
West Virginia	23,208	23.3	12.2	8.8	16,637	5.8	12.7	11.9
Wisconsin	62,516	22.0	15.9	12.1	42,801	12.4	20.1	13.5
Wyoming	5,353	13.4	17.0	6.4	4,361	7.1	20.9	7.8

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. Beginning with the 2019–2021 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, 2024, *2024 State expenditure report: fiscal years 2022–2024*, 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 2023–2026

State	FMAPs for Medicaid[1]						E-FMAPs for CHIP					
	FY 2023 Q1-2 (Emergency)[2,3]	FY 2023 Q3 (Emergency)[2,3]	FY 2023 Q4 (Emergency)[2,3]	FY 2024[4]	FY 2025	FY 2026	FY 2023 Q1-2 (Emergency)[3,5]	FY 2023 Q3 (Emergency)[3,5]	FY 2023 Q4 (Emergency)[3,5]	FY 2024[4,5]	FY 2025	FY 2026
Alabama	78.63%	77.43%	74.93%	73.12%	72.84%	72.63%	85.04%	84.20%	82.45%	81.18%	80.99%	80.84%
Alaska	56.20	55.00	52.50	50.01	51.54	52.42	69.34	68.50	66.75	65.01	66.08	66.69
Arizona	75.76	74.56	72.06	66.29	64.89	64.34	83.03	82.19	80.44	76.40	75.42	75.04
Arkansas	77.51	76.31	73.81	72.00	71.14	69.23	84.26	83.42	81.67	80.40	79.80	78.46
California	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
Colorado	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
Connecticut	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
Delaware	64.69	63.49	60.99	59.71	60.15	59.41	75.28	74.44	72.69	71.80	72.11	71.59
District of Columbia	76.20	75.00	72.50	70.00	70.00	70.00	83.34	82.50	80.75	79.00	79.00	79.00
Florida	66.25	65.05	62.55	57.96	57.17	57.22	76.38	75.54	73.79	70.57	70.02	70.05
Georgia	72.22	71.02	68.52	65.89	66.04	66.40	80.55	79.71	77.96	76.12	76.23	76.48
Hawaii	62.26	61.06	58.56	58.56	59.08	59.68	73.58	72.74	70.99	70.99	71.36	71.78
Idaho	76.31	75.11	72.61	69.72	67.59	66.91	83.42	82.58	80.83	78.80	77.31	76.84
Illinois	56.20	55.00	52.50	51.09	51.38	51.82	69.34	68.50	66.75	65.76	65.97	66.27
Indiana	71.86	70.66	68.16	65.62	64.90	64.74	80.30	79.46	77.71	75.93	75.43	75.32
Iowa	69.33	68.13	65.63	64.13	63.25	62.70	78.53	77.69	75.94	74.89	74.28	73.89
Kansas	65.96	64.76	62.26	60.97	61.87	60.67	76.17	75.33	73.58	72.68	73.31	72.47
Kentucky	78.37	77.17	74.67	71.78	71.48	71.41	84.86	84.02	82.27	80.25	80.04	79.99
Louisiana	73.48	72.28	69.78	67.67	68.06	67.83	81.44	80.60	78.85	77.37	77.64	77.48
Maine	69.49	68.29	65.79	62.65	62.06	61.29	78.64	77.80	76.05	73.86	73.44	72.90
Maryland	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
Massachusetts	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
Michigan	70.91	69.71	67.21	64.94	65.13	65.30	79.64	78.80	77.05	75.46	75.59	75.71
Minnesota	56.99	55.79	53.29	51.49	51.16	50.68	69.89	69.05	67.30	66.04	65.81	65.48
Mississippi	84.06	82.86	80.36	77.27	76.90	76.90	88.84	88.00	86.25	84.09	83.83	83.83
Missouri	72.01	70.81	68.31	66.07	65.31	64.44	80.41	79.57	77.82	76.25	75.72	75.11
Montana	70.32	69.12	66.62	63.91	62.37	61.47	79.22	78.38	76.63	74.74	73.66	73.03
Nebraska	64.07	62.87	60.37	58.60	57.52	55.94	74.85	74.01	72.26	71.02	70.26	68.05

EXHIBIT 6. (continued)

State	FMAPs for Medicaid[1]						E-FMAPs for CHIP					
	FY 2023 Q1-2 (Emergency)[2,3]	FY 2023 Q3 (Emergency)[2,3]	FY 2023 Q4 (Emergency)[2,3]	FY 2024[4]	FY 2025	FY 2026	FY 2023 Q1-2 (Emergency)[3,5]	FY 2023 Q3 (Emergency)[3,5]	FY 2023 Q4 (Emergency)[3,5]	FY 2024[4,5]	FY 2025	FY 2026
Nevada	68.85%	67.65%	65.15%	60.77%	60.22%	59.80%	78.20%	77.36%	75.61%	72.54%	72.15%	71.86%
New Hampshire	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
New Jersey	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
New Mexico	79.46	78.26	75.76	72.59	71.68	71.66	85.62	84.78	83.03	80.81	80.18	80.16
New York	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
North Carolina	73.91	72.71	70.21	65.91	65.06	64.62	81.74	80.90	79.15	76.14	75.54	75.23
North Dakota	57.75	56.55	54.05	53.82	50.97	50.99	70.43	69.59	67.84	67.67	65.68	65.69
Ohio	69.78	68.58	66.08	64.30	64.60	64.85	78.85	78.01	76.26	75.01	75.22	75.40
Oklahoma	73.56	72.36	69.86	67.53	67.08	66.47	81.49	80.65	78.90	77.27	76.96	76.53
Oregon	66.52	65.32	62.82	59.31	59.00	57.75	76.56	75.72	73.97	71.52	71.30	70.43
Pennsylvania	58.20	57.00	54.50	54.12	55.09	56.06	70.74	69.90	68.15	67.88	68.56	69.24
Rhode Island	60.16	58.96	56.46	55.01	56.31	57.50	72.11	71.27	69.52	68.51	69.42	70.25
South Carolina	76.78	75.58	73.08	69.53	69.67	69.53	83.75	82.91	81.16	78.67	78.77	78.67
South Dakota	62.94	61.74	59.24	54.98	53.07	51.01	74.06	73.22	71.47	68.49	67.15	65.71
Tennessee	72.30	71.10	68.60	65.28	64.81	64.16	80.61	79.77	78.02	75.70	75.37	74.91
Texas	66.07	64.87	62.37	60.15	60.00	59.83	76.25	75.41	73.66	72.11	72.00	71.88
Utah	72.10	70.90	68.40	65.90	64.36	62.46	80.47	79.63	77.88	76.13	75.05	73.72
Vermont	62.02	60.82	58.32	56.75	58.19	59.01	73.41	72.57	70.82	69.73	70.73	71.31
Virginia	56.85	55.65	53.15	51.22	50.99	50.39	69.80	68.96	67.21	65.85	65.69	65.27
Washington	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
West Virginia	80.22	79.02	76.52	74.10	73.84	74.22	86.15	85.31	83.56	81.87	81.69	81.95
Wisconsin	66.30	65.10	62.60	60.66	60.43	60.68	76.41	75.57	73.82	72.46	72.30	72.48
Wyoming	56.20	55.00	52.50	50.00	50.00	50.00	69.34	68.50	66.75	65.00	65.00	65.00
American Samoa[6]	89.20	88.00	85.50	83.00	83.00	83.00	92.44	91.60	89.85	85.00	85.00	85.00
Guam[6]	89.20	88.00	85.50	83.00	83.00	83.00	92.44	91.60	89.85	85.00	85.00	85.00
N. Mariana Islands[6]	89.20	88.00	85.50	83.00	83.00	83.00	92.44	91.60	89.85	85.00	85.00	85.00
Puerto Rico[6]	82.20	81.00	78.50	76.00	76.00	76.00	87.54	86.70	84.95	83.20	83.20	83.20
Virgin Islands[6]	89.20	88.00	85.50	83.00	83.00	83.00	92.44	91.60	89.85	85.00	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.

[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 to qualify for the FMAP increase. The FMAP increase does not apply to the Medicaid expansion population or other services such as those received at an Indian Health Service facility that already receive a higher matching rate.

[3] 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 (Q4 of FY 2023), the FMAP increase is 2.5 percentage points. 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.

[4] 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 3, the FMAPs for the first quarter of FY 2024 would receive a 1.5 percentage point increase under the Consolidated Appropriations Act, 2023.

[5] 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 and subsequent phasedown under the Consolidated Appropriations Act, 2023.

[6] 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 its normal FMAP of 55 percent between December 4, 2021 and December 31, 2021. The E-FMAPs for FYs 2023–2026 were calculated off of these increased FMAPs.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for FYs 2023–2026; 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 in 2024 and 2025 as states continued to disenroll beneficiaries following 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 2024 to July 2025, enrollment in Medicaid and CHIP decreased by 2.8 percent (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 9.3 percent from FY 2013 through FY 2023.
  - 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 but increased from 2022 to 2023 due to the phasedown of the temporary FMAP increase. Medicaid's share of total state budgets (including federal funds) increased from 2021 to 2023 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 increase from 18.4 percent in 2023 to about 19.5 percent in 2033. Medicare's share is projected to increase from 21.2 percent to 25.5 percent during the same time period (Exhibit 12).

EXHIBIT 7. Medicaid Beneficiaries (Persons Served) by Eligibility Group, FYs 1975–2023 (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
2023	**96,883**	35,081	40,877	8,532	7,761	4,632

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 a 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.

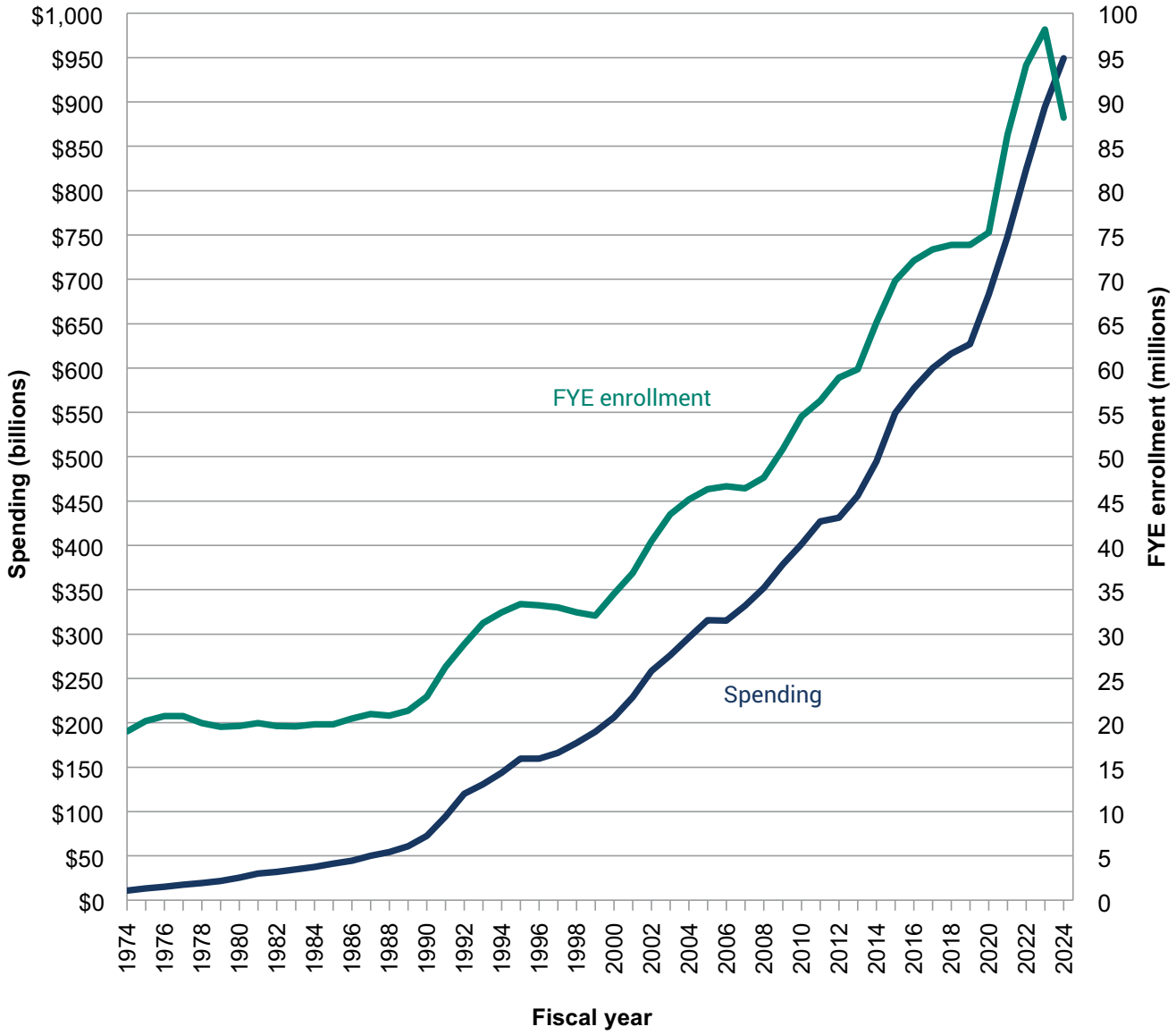
For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and sex. The national enrollment counts shown here are unduplicated using this national 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 FYs 2018–2023: MACPAC, 2025, analysis of T-MSIS data; 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.

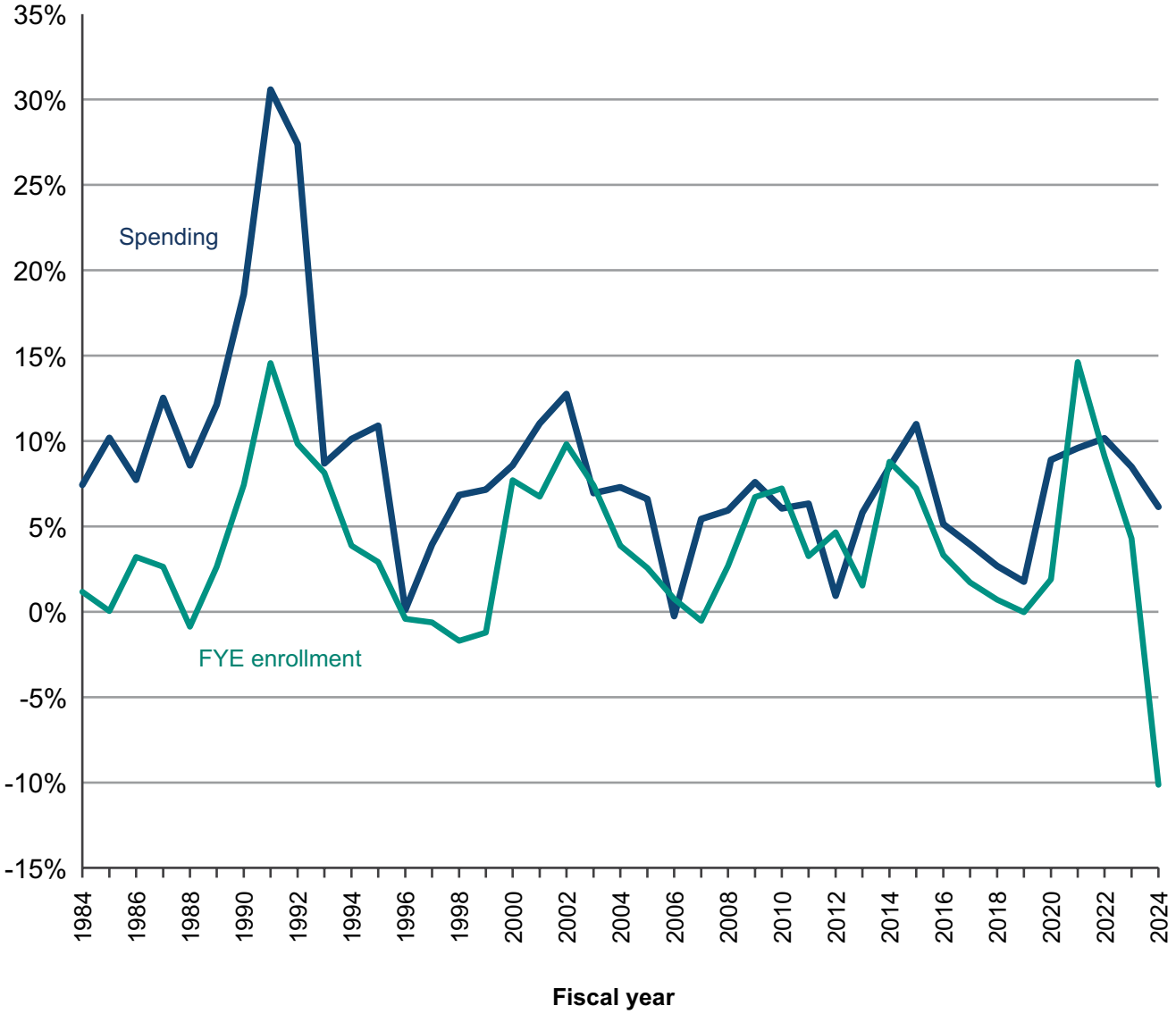
EXHIBIT 8. Medicaid Enrollment and Spending, FYs 1974–2024



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 1999–2024 include estimates for the territories.

Sources: For FY 2024: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025, and CMS-64 enrollment reports as of November 25, 2025. 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 1984–2024



Notes: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as "average monthly enrollment." All numbers exclude CHIP-financed coverage. The amounts shown in this exhibit may differ from those published elsewhere due to slight differences in the timing of data and the treatment of certain adjustments. The amounts may also differ from prior versions of MACStats due to changes in methodology by the CMS Office of the Actuary (OACT). Spending consists of federal and state Medicaid expenditures for benefits and administration, excluding the Vaccines for Children program. Enrollment counts are FYEs and, for fiscal years 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 1999–2024 include estimates for the territories.

Sources: For FY 2024: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025, and CMS-64 enrollment reports as of November 25, 2025. 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 1974–2024

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
2005	316	46.3	6,819	6.6	2.6	3.9

EXHIBIT 10. (continued)

Fiscal year	Spending (billions)	FYE enrollment (millions)	Spending per FYE enrollee	Annual growth		
				Spending	FYE enrollment	Spending per FYE enrollee
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
2024	949	88.2	10,760	6.1	-10.1	18.1

Notes: FY is fiscal year. FYE is full-year equivalent, which also may be referred to as "average monthly enrollment." All numbers exclude CHIP-financed coverage. Data 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 data for FYs 1999–2024 include estimates for the territories.

Sources: For FY 2024: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025, and CMS-64 enrollment reports as of November 25, 2025. 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 2013–2025

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2022	July 2023	July 2024	July 2025	July 2022–July 2023	July 2023–July 2024	July 2024–July 2025	July–September 2013 average to July 2025
Total	**56,511,799**[1]	**90,283,567**	**92,202,188**	**80,228,368**	**78,015,804**	**2.1%**	**-13.0%**	**-2.8%**	**35.8%**[2]
Alabama	799,176[3]	1,131,447	1,184,172	975,887	948,369	4.7	-17.6	-2.8	22.1
Alaska	122,334	261,816	262,806	252,541	220,373	0.4	-3.9	-12.7	106.4
Arizona	1,201,770	2,227,971	2,134,921	2,004,314	1,788,695	-4.2	-6.1	-10.8	66.8
Arkansas	556,851	1,050,577	936,514	832,794	818,956	-10.9	-11.1	-1.7	49.6
California	7,755,381	13,744,043	14,399,877	13,554,050	13,394,082	4.8	-5.9	-1.2	74.8
Colorado	783,420	1,646,836	1,649,658	1,172,019	1,205,045	0.2	-29.0	2.8	49.6
Connecticut	–	979,293	996,632	941,447	915,836	1.8	-5.5	-2.7	–
Delaware	223,324	290,979	310,479	250,910	244,501	6.7	-19.2	-2.6	12.4
District of Columbia	235,786[4,5]	286,672	292,976	260,958	259,767	2.2	-10.9	-0.5	10.7
Florida	3,695,306	4,734,996	4,632,565	3,796,877	3,671,259	-2.2	-18.0	-3.3	2.7
Georgia	1,535,090	2,405,477	2,539,809	2,022,501	1,919,391	5.6	-20.4	-5.1	31.8
Hawaii	288,357	452,696	438,194	407,552	392,938[6]	-3.2	-7.0	-3.6	41.3
Idaho	238,150	430,307	363,567	321,164	316,230	-15.5	-11.7	-1.5	34.9
Illinois	2,626,943	3,675,203	3,872,945	3,283,600	3,113,340	5.4	-15.2	-5.2	25.0
Indiana	1,120,674	1,954,908	1,978,780	1,790,270	1,656,610	1.2	-9.5	-7.5	59.7
Iowa	493,515	828,281	802,222	685,050	671,481	-3.1	-14.6	-2.0	38.8
Kansas	378,160	491,794	474,225	418,827	408,122	-3.6	-11.7	-2.6	10.8
Kentucky	606,805	1,576,193	1,583,958	1,398,791	1,370,654	0.5	-11.7	-2.0	130.5
Louisiana	1,019,787	1,858,130	1,895,058	1,534,922	1,462,342	2.0	-19.0	-4.7	50.5
Maine	–	355,437	379,435	368,390	343,220	6.8	-2.9	-6.8	–
Maryland	856,297	1,645,951	1,697,247	1,576,007	1,424,578	3.1	-7.1	-9.6	84.0
Massachusetts	1,296,359	1,923,683	2,017,535	1,690,301	1,608,884	4.9	-16.2	-4.8	30.4
Michigan	1,912,009	2,965,223	3,127,754	2,374,185	2,349,132	5.5	-24.1	-1.1	24.2
Minnesota	873,040[7]	1,332,742	1,408,658	1,185,727	1,185,263	5.7	-15.8	-0.0	35.8
Mississippi	615,556	742,600	772,413	609,320	599,061	4.0	-21.1	-1.7	-1.0

EXHIBIT 11. (continued)

State	Number of individuals enrolled					Annual and cumulative growth			
	July–September 2013 average	July 2022	July 2023	July 2024	July 2025	July 2022–July 2023	July 2023–July 2024	July 2024–July 2025	July–September 2013 average to July 2025
Missouri	846,084	1,379,791	1,504,652	1,289,648	1,260,863	9.0%	-14.3%	-2.2%	52.4%
Montana	148,974	313,837	297,145	226,910	217,768	-5.3	-23.6	-4.0	52.3
Nebraska	244,600	374,026	397,567	350,106	340,661	6.3	-11.9	-2.7	43.1
Nevada	332,560	868,971	835,888	766,157	749,193	-3.8	-8.3	-2.2	130.4
New Hampshire	127,082	242,720	194,105	186,122	185,960[6]	-20.0	-4.1	-0.1	46.5
New Jersey	1,283,851	2,148,004	2,272,885	1,809,109	1,769,135	5.8	-20.4	-2.2	40.9
New Mexico	457,678	876,177	823,720	783,431	694,763	-6.0	-4.9	-11.3	71.2
New York	5,678,417	7,249,900	7,583,252	6,705,425	6,551,887	4.6	-11.6	-2.3	18.1
North Carolina	1,595,952	2,327,362	2,392,688	2,745,218	2,887,045	2.8	14.7	5.2	72.0
North Dakota	69,980[8]	123,776	120,309	105,346	107,198	-2.8	-12.4	1.8	50.5
Ohio	2,130,322	3,270,899	3,295,451	2,883,680	2,777,854	0.8	-12.5	-3.7	35.4
Oklahoma	790,051	1,231,239	1,267,103	987,674	1,002,153	2.9	-22.1	1.5	25.0
Oregon	626,356[9]	1,334,459	1,462,700	1,287,121	1,317,200	9.6	-12.0	2.3	105.5
Pennsylvania	2,386,046	3,621,759	3,644,466	3,118,882	3,054,730	0.6	-14.4	-2.1	30.7
Rhode Island	190,833	353,502	373,260	318,081	307,370	5.6	-14.8	-3.4	66.7
South Carolina	889,744	1,269,341	1,264,991	1,087,398[6]	1,013,106	-0.3	-14.0	-6.8	22.2
South Dakota	115,501	140,676	116,043	135,981	139,110	-17.5	17.2	2.3	17.7
Tennessee	1,244,516	1,719,939	1,783,668	1,459,868	1,438,184	3.7	-18.2	-1.5	17.3
Texas	4,203,449	5,643,143	5,627,147	4,305,215	4,200,014	-0.3	-23.5	-2.4	2.4
Utah	294,029[5]	465,497[5]	435,900	341,019	339,046	-6.4	-21.8	-0.6	16.0
Vermont	161,081	189,194	182,922	160,189	154,784	-3.3	-12.4	-3.4	-0.6
Virginia	935,434	1,934,368	2,008,101	1,840,540	1,723,777	3.8	-8.3	-6.3	96.8
Washington	1,117,576	2,120,740	2,048,891	1,844,244	1,799,915	-3.4	-10.0	-2.4	65.0
West Virginia	354,544	631,256	596,525	513,609	501,077	-5.5	-13.9	-2.4	44.9
Wisconsin	985,531[10]	1,380,418	1,434,591	1,202,371	1,132,861	3.9	-16.2	-5.8	22.0
Wyoming	67,518	79,318	85,818	66,620	62,021	8.2	-22.4	-6.9	-1.3

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 may be 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] Includes retroactive enrollment.

[7] May include duplicates.

[8] Data are for July 2013 only.

[9] Includes emergency Medicaid population.

[10] Excludes retroactive enrollment.

Source: MACPAC, 2025, analysis of CMS, 2025, State Medicaid and CHIP applications, eligibility determinations, and enrollment data, accessed on December 10, 2025, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data.

EXHIBIT 12. Historical and Projected National Health Expenditures by Payer for Selected Years, CYs 1970–2033

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	**3,166**	558	17.6	648	20.5	976	30.8	106	3.4	525	16.6	353	11.1
2016	**3,308**	582	17.6	676	20.4	1,028	31.1	109	3.3	549	16.6	365	11.0
2017	**3,446**	597	17.3	705	20.5	1,078	31.3	114	3.3	583	16.9	370	10.7
2018	**3,604**	615	17.1	752	20.9	1,124	31.2	118	3.3	609	16.9	386	10.7
2019	**3,762**	635	16.9	805	21.4	1,153	30.6	125	3.3	641	17.1	403	10.7
2020	**4,154**	694	16.7	835	20.1	1,148	27.6	136	3.3	944	22.7	398	9.6
2021	**4,328**	759	17.5	896	20.7	1,230	28.4	144	3.3	858	19.8	441	10.2
2022	**4,526**	831	18.4	952	21.0	1,314	29.0	148	3.3	809	17.9	472	10.4
2023	**4,866**	896	18.4	1,030	21.2	1,465	30.1	168	3.4	802	16.5	506	10.4

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													
2024	**$5,263**	$954	18.1%	$1,115	21.2%	$1,617	30.7%	$177	3.4%	$858	16.3%	$543	10.3%
2025	**5,635**	1,025	18.2	1,201	21.3	1,740	30.9	191	3.4	901	16.0	577	10.2
2026	**5,940**	1,095	18.4	1,311	22.1	1,798	30.3	205	3.5	934	15.7	597	10.1
2027	**6,281**	1,169	18.6	1,425	22.7	1,879	29.9	216	3.4	970	15.4	621	9.9
2028	**6,622**	1,243	18.8	1,537	23.2	1,961	29.6	226	3.4	1,009	15.2	646	9.8
2029	**6,986**	1,325	19.0	1,661	23.8	2,045	29.3	237	3.4	1,048	15.0	670	9.6
2030	**7,356**	1,404	19.1	1,784	24.3	2,133	29.0	248	3.4	1,091	14.8	696	9.5
2031	**7,740**	1,489	19.2	1,903	24.6	2,228	28.8	260	3.4	1,136	14.7	724	9.4
2032	**8,133**	1,579	19.4	2,025	24.9	2,323	28.6	272	3.3	1,182	14.5	752	9.2
2033	**8,585**	1,675	19.5	2,192	25.5	2,422	28.2	285	3.3	1,231	14.3	782	9.1

Notes: CY is calendar year. Components may not sum to total due to rounding. The latest projections begin after the latest historical year (2023) and go through 2033.

[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, 2025, analysis of Office of the Actuary (OACT), CMS, 2024, *National health expenditures by type of service and source of funds: Calendar years 1960–2023*, https://www.cms.gov/files/zip/national-health-expenditures-type-service-and-source-funds-cy-1960-2023.zip. For projected data: MACPAC, 2025, analysis of OACT, 2025, *National health expenditures by type of expenditure and source of funds: Calendar years 1960 to 2033*, https://www.cms.gov/files/zip/nhe-historical-and-projections-data.zip; and OACT, 2025, *Table 17: Health insurance enrollment and enrollment growth rates, calendar years, 2013–2033*, 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 1997–2023

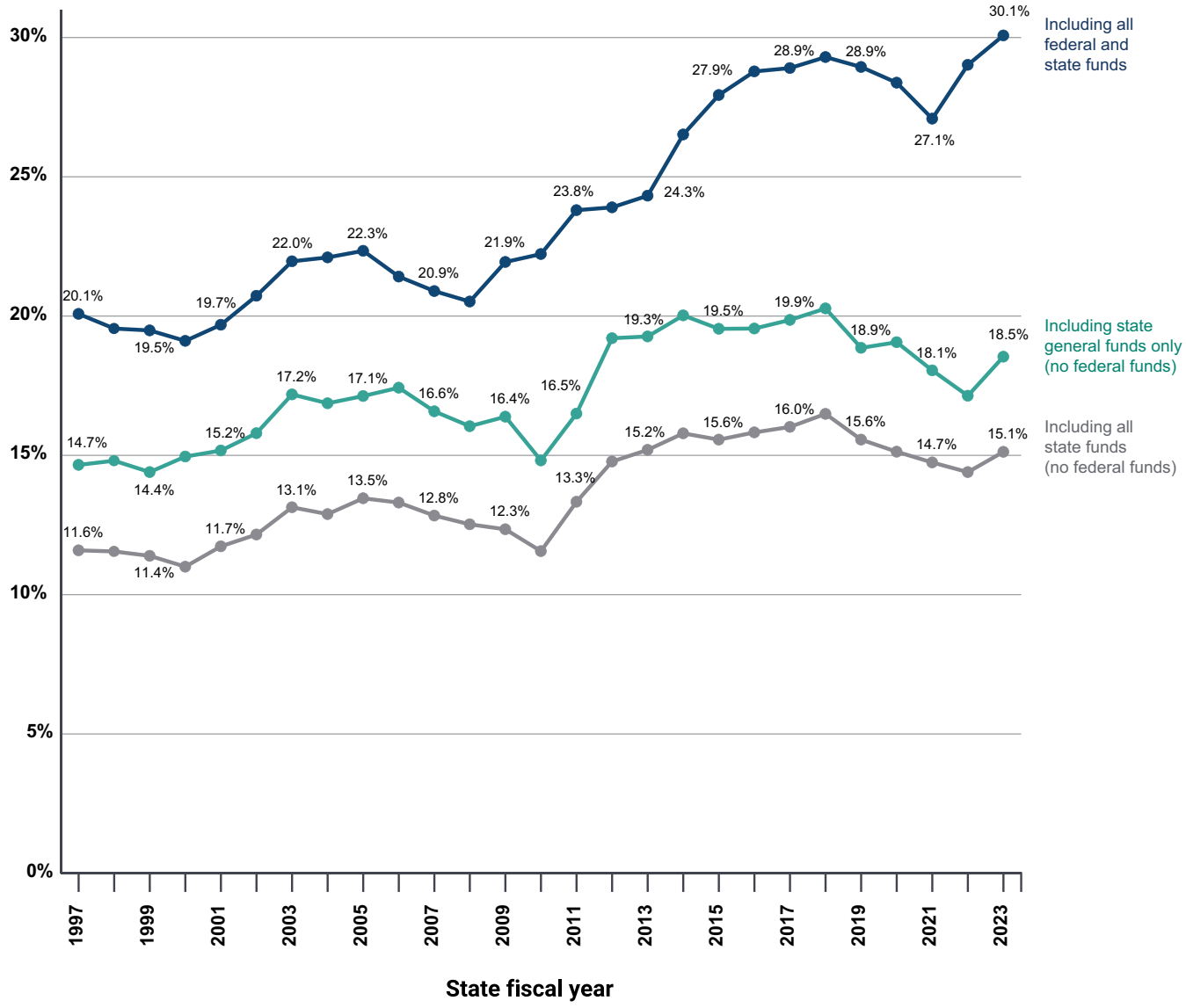


EXHIBIT 13. (continued)

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
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	29.0	17.1	14.4
2023	30.1	18.5	15.1

Notes: SFY is state fiscal year. Amounts shown here reflect the most recent information available in cases in which data for a given year were published and then updated in a subsequent report.

The all federal and state funds category reflects amounts from any source. The state general funds only category reflects amounts from revenues raised through income, sales, and other broad-based state taxes and excludes federal funds. The all state funds category reflects amounts from any non-federal source; these include state general funds, other state funds (amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects) and excludes federal funds.

Source: MACPAC, 2025, 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 $957.4 billion in fiscal year (FY) 2024 (Exhibit 16). Spending for the State Children's Health Insurance Program (CHIP) was $28.2 billion (Exhibit 33).
- The federal share was 64.7 percent of total Medicaid benefit spending in FY 2024, compared with a federal share of 69.0 percent of total Medicaid benefit spending in FY 2023. This decrease in federal spending is due to the expiration of the 6.2 percentage point increase in the federal medical assistance percentage (FMAP) under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) (Exhibit 16).
- In FY 2023, individuals eligible on the basis of disability and enrollees age 65 and older accounted for about 19 percent of Medicaid enrollees but about 50 percent of program spending (Exhibits 14 and 21). Many of these individuals were users of long-term services and supports (LTSS). LTSS users accounted for only 6.6 percent of Medicaid enrollees but over one-third of all Medicaid spending (Exhibit 20). This number of LTSS users reflects a change in the way non-institutional LTSS is identified and includes those who use LTSS under managed care arrangements. MACStats exhibits before 2025 identified only LTSS users under fee-for-service arrangements.
- 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 2023 (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.
- Over half of Medicaid spending for enrollees was for capitation payments to managed care plans (Exhibits 17 and 18). Spending for enrollees who are eligible on the basis of disability and enrollees age 65 and older has been shifting to managed care. Over half (55.1 percent) of enrollees who are eligible on the basis of disability and over one-third (40.8 percent) of enrollees age 65 and older were enrolled in comprehensive managed care in FY 2023, including in plans that provide managed LTSS (Exhibit 30).
- Medicaid benefit spending per enrollee varies substantially across states (Exhibit 22). This variation reflects many factors, including the underlying costs of delivering health care services in specific geographic areas, the breadth of covered benefits, and enrollee characteristics, such as health status, that affect their use of services.
- Drug rebates reduced gross drug spending by over half (54.9 percent) in FY 2024 (Exhibit 28). More than half (55.0 percent) of Medicaid gross spending for drugs occurred under managed care in FY 2024 (Exhibit 26).
- Disproportionate share hospital (DSH), upper payment limit, and other types of supplemental payments accounted for over half (52.1 percent) of fee-for-service payments to hospitals in FY 2024 (Exhibit 24).

EXHIBIT 14. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status, FY 2023 (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	**99,966**	**35,822**	**25,957**	**19,246**	**9,289**	**9,652**	**14,300**	**9,345**	**10,718**	**6,849**	**3,582**	**2,497**
Alabama	**1,313**	655	–	286	222	150	**257**	150	**108**	57	**150**	93
Alaska	**277**	111	80	55	16	16	**26**	16	**24**	15	**1**	1
Arizona	**2,590**	841	829	513	185	222	**328**	213	**263**	165	**65**	48
Arkansas	**1,171**	515	396	9	159	91	**172**	95	**98**	57	**74**	38
California[5]	**15,683**	3,948	5,722	3,457	860	1,697	**1,953**	1,554	**1,924**	1,530	**29**	24
Colorado	**1,834**	587	810	232	106	98	**175**	115	**130**	81	**45**	35
Connecticut	**1,346**	399	420	275	83	170	**232**	172	**93**	59	**139**	113
Delaware	**342**	119	110	66	25	22	**41**	25	**24**	14	**17**	12
District of Columbia[6]	**309**	87	99	61	30	32	**45**	33	**33**	22	**13**	10
Florida	**6,119**	2,912	–	1,726	662	819	**1,118**	805	**667**	467	**451**	338
Georgia	**2,793**	1,499	–	623	363	307	**450**	301	**191**	120	**259**	181
Hawaii	**480**	148	198	62	21	50	**65**	46	**58**	41	**7**	6
Idaho	**494**	188	169	47	53	37	**62**	35	**35**	19	**27**	17
Illinois[7]	**3,813**	1,294	1,243	696	185	395	**526**	349	**474**	310	**53**	38
Indiana	**2,283**	851	600	497	178	156	**298**	164	**225**	118	**73**	46
Iowa	**896**	320	292	145	85	54	**113**	59	**87**	41	**26**	18
Kansas	**517**	290	–	95	81	52	**86**	47	**53**	28	**33**	19
Kentucky	**1,735**	509	724	175	206	121	**235**	128	**134**	72	**101**	55
Louisiana	**1,954**	608	820	115	232	179	**304**	183	**174**	98	**130**	85
Maine	**492**	135	127	99	61	70	**111**	70	**64**	34	**47**	37
Maryland	**1,729**	628	503	342	138	118	**185**	116	**113**	67	**71**	49
Massachusetts	**2,332**	466	581	664	347	273	**433**	253	**387**	209	**45**	43
Michigan[7]	**3,288**	1,084	1,135	629	214	226	**428**	238	**378**	207	**50**	30
Minnesota	**1,537**	662	357	282	123	112	**181**	106	**168**	96	**14**	10
Mississippi	**868**	431	–	163	163	111	**184**	110	**95**	54	**89**	57

EXHIBIT 14. (continued)

State	Total	Basis of eligibility[1]					Dually eligible status[2]					
							All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri	**1,628**	750	392	174	186	127	**246**	123	**205**	98	**41**	25
Montana	**326**	116	130	38	22	19	**38**	22	**28**	16	**9**	6
Nebraska	**396**	172	101	53	41	30	**52**	28	**46**	25	**6**	4
Nevada	**1,015**	355	433	100	60	66	**108**	75	**50**	33	**58**	41
New Hampshire	**273**	87	110	29	28	21	**44**	21	**28**	13	**16**	8
New Jersey	**2,238**	751	834	277	180	196	**308**	203	**279**	181	**29**	23
New Mexico	**1,029**	361	343	166	80	79	**127**	82	**58**	33	**69**	49
New York	**8,217**	2,159	3,078	1,384	619	977	**1,323**	977	**1,143**	826	**180**	151
North Carolina	**2,909**	1,163	–	1,142	363	241	**404**	238	**315**	176	**90**	62
North Dakota[5]	**144**	58	43	18	13	12	**20**	12	**18**	10	**2**	2
Ohio	**3,438**	1,137	1,068	565	391	276	**435**	244	**291**	159	**144**	84
Oklahoma	**1,444**	625	433	176	121	89	**152**	85	**117**	65	**35**	20
Oregon	**1,495**	345	818	81	118	134	**210**	129	**157**	91	**53**	38
Pennsylvania	**3,791**	1,107	1,289	431	605	360	**600**	352	**501**	288	**99**	64
Rhode Island	**365**	102	118	74	39	33	**62**	38	**55**	33	**8**	6
South Carolina	**1,566**	710	–	564	175	116	**181**	102	**173**	96	**9**	6
South Dakota[6]	**156**	82	12	26	20	14	**24**	14	**15**	9	**9**	6
Tennessee	**1,918**	949	–	527	269	172	**322**	172	**199**	89	**123**	83
Texas[8]	**6,865**	4,182	0	1,349	713	621	**864**	592	**447**	294	**417**	299
Utah[5]	**551**	227	166	77	50	32	**53**	28	**47**	25	**6**	4
Vermont	**215**	72	84	15	22	23	**32**	19	**24**	12	**9**	7
Virginia	**2,186**	710	815	313	195	153	**284**	156	**212**	114	**71**	43
Washington	**2,425**	905	948	218	179	175	**286**	180	**200**	123	**85**	56
West Virginia	**699**	219	270	64	89	58	**108**	59	**62**	33	**46**	26
Wisconsin	**1,608**	563	–	681	193	170	**219**	119	**204**	107	**15**	12
Wyoming	**97**	55	–	19	13	9	**14**	8	**9**	4	**6**	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 266,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 14,000.

[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 33 percent less than the benchmark, and South Dakota's average monthly enrollment was 29 percent more than the benchmark.

[7] State reported a large shift of enrollees between eligibility groups from the prior year. Illinois reported an 81 percent increase in the child group, a 43 percent decrease in the new adult group, and a 346 percent increase in the other adult group. Michigan reported a 37 percent increase in the other adult group and a 38 percent decrease in the disabled group.

[8] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2023.

Source: MACPAC, 2025, analysis of T-MSIS data as of February 2025.

EXHIBIT 15. Medicaid Full-Year Equivalent Enrollment by State and Eligibility Group, FY 2023 (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	**91,860**	**84,088**	**32,816**	**32,590**	**23,876**	**23,336**	**17,282**	**13,698**	**8,984**	**7,939**	**8,902**	**6,526**
Alabama	**1,216**	**1,004**	599	599	–	–	265	193	213	160	139	53
Alaska	**256**	**255**	101	101	75	75	51	51	15	15	14	13
Arizona	**2,326**	**2,121**	747	736	736	684	464	388	175	160	205	153
Arkansas	**1,021**	**952**	443	443	335	334	7	7	153	120	83	48
California[4]	**14,373**	**13,023**	3,621	3,574	5,288	4,991	3,045	2,083	838	833	1,580	1,542
Colorado	**1,658**	**1,559**	533	528	729	721	206	159	101	92	89	59
Connecticut	**1,218**	**1,062**	367	365	390	390	231	208	75	50	156	49
Delaware	**315**	**282**	109	107	102	101	60	46	24	19	20	9
District of Columbia[5]	**291**	**279**	80	80	93	93	59	59	29	27	31	21
Florida	**5,376**	**4,565**	2,559	2,534	–	–	1,438	1,081	627	518	752	431
Georgia	**2,519**	**2,177**	1,349	1,349	–	–	544	442	343	270	282	115
Hawaii	**447**	**441**	139	139	183	183	58	58	20	19	47	42
Idaho	**411**	**387**	155	155	136	136	38	38	49	40	33	18
Illinois[6]	**3,511**	**3,365**	1,216	1,215	1,164	1,163	591	499	178	165	363	323
Indiana	**2,058**	**1,867**	754	733	544	538	447	357	172	146	142	94
Iowa	**794**	**764**	280	280	258	255	127	124	81	74	48	31
Kansas	**458**	**426**	258	258	–	–	81	79	74	61	45	28
Kentucky	**1,626**	**1,526**	478	478	674	672	163	161	199	156	112	60
Louisiana	**1,841**	**1,712**	569	569	774	774	107	103	224	180	166	87
Maine	**436**	**363**	116	112	117	113	82	58	59	50	62	29
Maryland	**1,610**	**1,524**	591	590	470	469	307	290	134	113	108	62
Massachusetts	**2,126**	**1,748**	427	375	524	470	600	390	324	321	250	193
Michigan[6]	**3,053**	**2,951**	993	987	1,061	1,039	584	556	207	189	208	179
Minnesota	**1,423**	**1,392**	621	619	324	321	257	244	120	116	102	92
Mississippi	**811**	**697**	402	402	–	–	150	120	156	125	103	50

EXHIBIT 15. (continued)

State	Total		Child		New adult group[1]		Other adult[2]		Disabled		Aged	
	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]	All enrollees	Full-benefit enrollees[3]
Missouri	**1,495**	**1,456**	701	701	343	342	159	159	178	164	114	91
Montana	**294**	**283**	105	105	116	116	34	32	21	19	18	12
Nebraska	**356**	**351**	157	157	87	87	47	47	39	37	26	23
Nevada	**889**	**834**	311	311	378	378	85	83	56	41	60	22
New Hampshire	**229**	**208**	77	77	86	86	22	16	26	18	18	11
New Jersey	**2,038**	**1,993**	665	649	773	772	247	245	174	168	180	159
New Mexico	**934**	**827**	321	320	314	310	152	113	74	56	73	28
New York	**7,500**	**7,341**	1,973	1,972	2,822	2,821	1,209	1,204	601	574	896	769
North Carolina	**2,634**	**2,044**	1,037	1,023	–	–	1,029	544	347	316	222	162
North Dakota[4]	**125**	**123**	50	50	37	37	16	16	13	12	10	9
Ohio	**3,190**	**3,052**	1,056	1,056	976	971	527	527	379	325	252	175
Oklahoma	**1,199**	**1,159**	490	490	364	361	148	141	115	103	81	63
Oregon	**1,332**	**1,206**	289	287	746	703	62	32	113	98	123	86
Pennsylvania	**3,458**	**3,345**	996	993	1,162	1,160	394	378	579	546	327	268
Rhode Island	**338**	**329**	90	90	108	108	70	69	38	36	31	26
South Carolina	**1,466**	**1,202**	664	658	–	–	526	282	168	165	108	98
South Dakota[5]	**125**	**117**	69	69	6	6	20	20	18	15	12	7
Tennessee	**1,768**	**1,654**	856	856	–	–	495	495	259	221	158	82
Texas[7]	**6,280**	**5,385**	3,820	3,819	0	0	1,216	709	681	570	562	288
Utah[4]	**465**	**446**	195	192	139	139	61	49	45	44	26	23
Vermont	**201**	**193**	67	67	78	78	14	14	21	19	21	15
Virginia	**1,991**	**1,838**	632	632	750	731	289	232	181	146	139	97
Washington	**2,157**	**2,072**	817	817	828	828	185	179	170	144	156	105
West Virginia	**634**	**590**	198	198	241	241	57	56	86	66	53	28
Wisconsin	**1,473**	**1,407**	516	515	–	–	616	565	186	183	155	143
Wyoming	**84**	**78**	48	48	–	–	17	16	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 244,000, North Dakota's child FYE enrollment by approximately 3,000, 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 33 percent less than the benchmark, and South Dakota's average monthly enrollment was 29 percent more than the benchmark.

[6] State reported a large shift of enrollees between eligibility groups from the prior year. Illinois reported an 80 percent increase in the child group, a 41 percent decrease in the new adult group, and a 304 percent increase in the other adult group. Michigan reported a 35 percent increase in the other adult group and a 38 percent decrease in the disabled group.

[7] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2023.

Source: MACPAC, 2025, analysis of T-MSIS data as of February 2025.

EXHIBIT 16. Medicaid Spending by State, Category, and Source of Funds, FY 2024 (millions)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$8,109**	$5,977	$2,132	**$293**	$174	$119	**$8,402**	$6,151	$2,252
Alaska	**2,715**	2,074	641	**189**	108	80	**2,904**	2,183	721
Arizona	**19,966**	15,122	4,844	**422**	268	154	**20,388**	15,391	4,998
Arkansas	**7,789**	6,023	1,767	**524**	348	176	**8,313**	6,370	1,943
California	**148,773**	92,044	56,729	**8,325**	5,011	3,314	**157,098**	97,055	60,043
Colorado	**13,754**	8,068	5,686	**920**	546	374	**14,674**	8,614	6,060
Connecticut	**10,835**	6,441	4,395	**460**	282	178	**11,295**	6,723	4,573
Delaware	**3,201**	2,149	1,052	**139**	91	48	**3,340**	2,240	1,100
District of Columbia	**4,138**	3,054	1,084	**234**	145	89	**4,372**	3,199	1,173
Florida	**34,969**	20,334	14,636	**937**	568	369	**35,906**	20,902	15,004
Georgia	**14,870**	9,896	4,974	**707**	452	255	**15,577**	10,348	5,229
Hawaii	**3,048**	2,188	861	**187**	128	60	**3,236**	2,315	921
Idaho	**3,893**	2,934	959	**157**	101	56	**4,051**	3,035	1,015
Illinois	**32,464**	19,879	12,585	**1,283**	801	482	**33,747**	20,680	13,067
Indiana	**19,424**	13,701	5,723	**597**	354	243	**20,021**	14,055	5,966
Iowa	**8,689**	6,182	2,508	**185**	118	66	**8,874**	6,300	2,574
Kansas	**5,168**	3,169	1,999	**245**	153	92	**5,413**	3,322	2,091
Kentucky	**17,879**	14,024	3,855	**424**	271	153	**18,302**	14,295	4,008
Louisiana	**16,665**	12,742	3,923	**515**	333	182	**17,180**	13,076	4,104
Maine	**4,527**	3,046	1,481	**205**	134	71	**4,732**	3,179	1,553
Maryland	**17,751**	10,560	7,191	**704**	456	248	**18,455**	11,016	7,439
Massachusetts	**24,810**	13,893	10,917	**1,383**	815	568	**26,193**	14,708	11,485
Michigan	**24,460**	17,595	6,865	**901**	565	337	**25,361**	18,159	7,202
Minnesota	**18,408**	10,681	7,727	**921**	520	401	**19,329**	11,201	8,127
Mississippi	**7,154**	5,446	1,709	**203**	130	73	**7,357**	5,576	1,781
Missouri	**15,892**	11,273	4,618	**554**	340	214	**16,445**	11,614	4,832

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Montana	**$2,370**	$1,809	$560	**$135**	$93	$42	**$2,504**	$1,902	$602
Nebraska	**3,646**	2,337	1,309	**193**	126	68	**3,840**	2,463	1,377
Nevada	**5,915**	4,343	1,572	**260**	163	97	**6,176**	4,507	1,669
New Hampshire	**2,454**	1,379	1,075	**168**	110	57	**2,622**	1,489	1,133
New Jersey	**23,110**	13,910	9,201	**1,107**	670	436	**24,217**	14,580	9,637
New Mexico	**7,924**	6,243	1,680	**567**	389	177	**8,490**	6,633	1,857
New York	**94,461**	54,318	40,143	**3,717**	2,049	1,667	**98,178**	56,368	41,810
North Carolina	**28,887**	21,229	7,658	**1,326**	812	515	**30,213**	22,041	8,173
North Dakota	**1,403**	854	549	**123**	82	41	**1,526**	936	590
Ohio	**33,988**	23,874	10,114	**1,215**	699	516	**35,203**	24,573	10,630
Oklahoma	**9,039**	6,838	2,201	**285**	166	119	**9,325**	7,005	2,320
Oregon	**16,040**	11,410	4,630	**953**	544	409	**16,993**	11,954	5,039
Pennsylvania	**43,222**	26,099	17,122	**1,210**	742	468	**44,432**	26,841	17,591
Rhode Island	**3,509**	2,176	1,333	**216**	145	71	**3,725**	2,321	1,404
South Carolina	**9,727**	6,790	2,936	**513**	330	183	**10,240**	7,121	3,119
South Dakota	**1,498**	1,039	459	**102**	65	37	**1,600**	1,104	496
Tennessee	**13,226**	8,717	4,509	**1,119**	782	337	**14,345**	9,499	4,846
Texas	**47,155**	28,476	18,679	**2,244**	1,429	814	**49,398**	29,905	19,494
Utah	**4,907**	3,561	1,346	**197**	122	75	**5,104**	3,683	1,421
Vermont	**2,133**	1,318	814	**204**	132	72	**2,336**	1,450	887
Virginia	**21,784**	13,977	7,806	**571**	362	209	**22,354**	14,339	8,015
Washington	**20,038**	12,585	7,453	**1,280**	690	590	**21,318**	13,275	8,043
West Virginia	**4,890**	3,804	1,086	**221**	161	60	**5,111**	3,965	1,146
Wisconsin	**12,226**	7,461	4,765	**544**	343	202	**12,771**	7,804	4,967
Wyoming	**759**	420	338	**72**	50	22	**831**	471	360
Subtotal (states)	**$903,665**	**$583,465**	**$320,200**	**$40,154**	**$24,471**	**$15,683**	**$943,819**	**$607,936**	**$335,883**

EXHIBIT 16. (continued)

State[1]	Benefits			State program administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
American Samoa	**$57**	$49	$8	**$2**	$1	$1	**$59**	$50	$9
Guam	**188**	163	25	**5**	3	2	**193**	166	27
Northern Mariana Islands	**93**	80	14	**2**	2	1	**96**	81	14
Puerto Rico	**4,709**	3,906	803	**184**	132	52	**4,893**	4,038	855
Virgin Islands	**126**	111	15	**12**	9	3	**139**	120	19
Subtotal (states and territories)	**$908,839**	**$587,774**	**$321,065**	**$40,360**	**$24,618**	**$15,742**	**$949,199**	**$612,392**	**$336,807**
State Medicaid Fraud Control Units	**–**	–	–	**497**	373	124	**497**	373[2]	124
Medicaid survey and certification of nursing and intermediate care facilities	**–**	–	–	**468**	351	117	**468**	351	117
Vaccines for Children program	**–**	–	–	**–**	–	–	**7,239**	7,239	–
Total	**$908,839**	**$587,774**	**$321,065**	**$41,325**	**$25,342**	**$15,983**	**$957,403[3]**	**$620,355[3]**	**$337,048**

Notes: FY is fiscal year. Total federal spending shown here ($620,355 million) will differ from total federal outlays shown in FY 2026 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] The CMS FY 2026 budget justification does not report the actual spending for state Medicaid fraud control units in FY 2024; this amount reported here reflects the estimated FY 2024 amount from the CMS FY 2025 budget justification.

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

Sources: For state and territory spending: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025. For all other spending (MFCUs, survey and certification, VFC program): CMS, 2025, *Fiscal year 2026 justification of estimates for appropriations committees*, Baltimore, MD, https://www.cms.gov/files/document/fy2026-cms-congressional-justification-estimates-appropriations-committees.pdf; CMS, 2024, *Fiscal year 2025 justification of estimates for appropriations committees*, Baltimore, MD, https://us.pagefreezer.com/en-US/wa/browse/97b01e00-724d-46ac-9417-9e52cd82c5a5?url=https%3A%2F%2Fwww.cms.gov%2Ffiles%2Fdocument%2Ffy2025-cms-congressional-justification-estimates-appropriations-committees.pdf&timestamp=2025-03-28T00%3A40%3A51Z.

EXHIBIT 17. Total Medicaid Benefit Spending by State and Category, FY 2024 (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	**$8,109**	$3,125	$626	$89	$157	$131	$752	$454	$1,319	$867	$170	$467	-$47
Alaska	**2,715**	756	179	102	45	659	173	88	229	452	1	47	-14
Arizona	**19,966**	1,364	65	6	22	205	644	380	110	6	16,618	546	-0
Arkansas	**7,789**	1,370	350	1	31	112	918	159	1,145	728	2,612	406	-43
California	**148,773**	11,524	1,436	2,008	207	5,852	16,573	8,172	1,855	30,178	68,909	3,698	-1,641
Colorado	**13,754**	3,889	569	456	1	1,281	653	547	988	3,347	1,960	228	-164
Connecticut	**10,835**	3,063	538	176	367	385	801	751	1,720	2,431	36	698	-132
Delaware[2]	**3,201**	86	9	68	0	2	129	-38	61	320	2,508	62	-7
District of Columbia	**4,138**	297	30	6	14	362	226	89	501	735	1,802	86	-10
Florida	**34,969**	3,327	258	302	63	255	495	165	3,008	2,026	23,101	2,537	-570
Georgia	**14,870**	2,661	389	17	87	20	993	373	1,867	2,271	5,610	720	-136
Hawaii	**3,048**	70	0	55	0	39	138	4	11	170	2,577	51	-66
Idaho	**3,893**	1,198	180	0	57	62	308	264	244	735	786	102	-41
Illinois	**32,464**	3,187	244	21	34	66	1,627	93	1,490	2,558	22,406	817	-82
Indiana	**19,424**	1,365	276	25	17	446	723	133	3,043	3,839	9,267	414	-123
Iowa	**8,689**	119	13	0	2	56	126	12	43	60	8,189	194	-125
Kansas[2]	**5,168**	118	7	0	0	1	61	-1	106	0	4,753	147	-25
Kentucky	**17,879**	360	40	4	15	444	520	77	1,755	1,782	12,588	341	-48
Louisiana	**16,665**	425	19	–	1	12	339	77	2,000	1,091	12,351	603	-253
Maine	**4,527**	1,013	148	41	147	269	687	217	672	1,078	38	301	-84
Maryland	**17,751**	1,157	155	315	487	163	2,421	297	2,017	3,650	6,709	478	-97
Massachusetts	**24,810**	3,340	281	408	37	252	2,077	175	2,026	4,228	11,349	863	-225
Michigan	**24,460**	1,050	237	29	25	376	791	724	2,907	1,689	16,332	818	-517
Minnesota[2]	**18,408**	598	165	25	412	170	998	-229	1,485	6,392	8,386	280	-275
Mississippi[2]	**7,154**	642	153	4	26	61	254	-57	1,366	813	3,576	349	-33
Missouri	**15,892**	2,671	9	10	32	525	992	661	1,781	4,198	4,668	483	-138
Montana	**2,370**	918	154	50	84	97	271	143	224	357	34	59	-21
Nebraska[2]	**3,646**	42	1	0	0	0	70	-0	586	848	2,035	86	-22
Nevada	**5,915**	705	195	30	60	118	581	153	450	466	2,924	274	-40
New Hampshire	**2,454**	265	4	24	1	1	152	7	537	551	880	42	-11
New Jersey	**23,110**	1,594	92	1	37	564	1,285	16	1,269	3,094	14,882	593	-316

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 Mexico[2]	**$7,924**	$464	$23	$7	$64	$11	$188	-$16	$44	$846	$6,089	$222	-$18
New York	**94,461**	9,132	366	12	253	1,823	5,776	2,318	9,000	12,808	51,588	2,949	-1,564
North Carolina	**28,887**	1,940	243	401	50	251	1,260	221	2,522	1,193	20,008	713	-82
North Dakota	**1,403**	163	42	14	26	21	74	50	467	332	209	25	-18
Ohio[2]	**33,988**	2,476	156	16	12	215	809	-70	3,184	5,227	21,384	850	-273
Oklahoma	**9,039**	2,538	647	113	61	727	470	988	1,067	1,114	1,908	243	-835
Oregon	**16,040**	472	23	6	33	536	550	189	824	3,970	9,205	360	-127
Pennsylvania[2]	**43,222**	1,443	43	7	1	75	612	-15	1,514	4,757	34,071	1,026	-314
Rhode Island	**3,509**	207	9	8	0	18	239	4	353	597	1,986	105	-18
South Carolina	**9,727**	818	125	146	21	97	461	53	1,104	1,171	5,728	361	-359
South Dakota	**1,498**	402	100	37	9	71	117	150	275	305	3	48	-18
Tennessee	**13,226**	678	45	182	2	131	849	744	348	817	8,981	537	-88
Texas	**47,155**	9,467	229	23	666	26	1,703	400	2,112	3,102	31,563	1,683	-3,820
Utah	**4,907**	616	117	29	43	23	329	132	575	677	2,318	84	-36
Vermont	**2,133**	212	48	42	38	43	850	111	266	443	22	58	-1
Virginia	**21,784**	4,178	302	427	11	289	329	17	545	3,681	12,097	435	-530
Washington	**20,038**	2,281	45	257	12	1,304	2,130	53	1,323	5,281	8,204	612	-1,462
West Virginia[2]	**4,890**	222	30	5	-167	22	229	286	1,141	823	2,145	208	-52
Wisconsin	**12,226**	989	31	154	43	442	1,262	680	988	1,649	5,812	436	-260
Wyoming	**759**	169	60	14	10	57	32	50	156	193	3	24	-9
Subtotal	**$903,665**	**$91,166**	**$9,508**	**$6,173**	**$3,657**	**$19,168**	**$55,045**	**$20,251**	**$64,626**	**$129,944**	**$491,382**	**$27,768**	**-$15,188**
American Samoa	**57**	37	0	–	–	4	13	1	–	0	–	2	–
Guam	**188**	107	18	5	0	2	18	35	1	1	–	1	–
N. Mariana Islands	**93**	72	–	1	–	7	7	4	–	2	–	1	–
Puerto Rico[2]	**4,709**	–	–	–	–	107	5	-117	–	–	4,715	–	-1
Virgin Islands	**126**	61	8	8	3	8	10	31	1	5	–	2	-11
Total	**$908,839**	**$91,443**	**$9,534**	**$6,186**	**$3,660**	**$19,295**	**$55,098**	**$20,206**	**$64,628**	**$129,952**	**$496,097**	**$27,774**	**-$15,201**
Percent of total, exclusive of collections	–	**9.9%**	**1.0%**	**0.7%**	**0.4%**	**2.1%**	**6.0%**	**2.2%**	**7.0%**	**14.1%**	**53.7%**	**3.0%**	–

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 (DSH) 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 more than 90 percent of spending in the managed care category. Managed care also includes rebates for drugs (including OUD MAT drugs) provided by managed care plans and managed care payments associated with the Community First Choice option, USPSTF grade A or B preventive services, ACIP vaccines, certified community behavioral health clinic, and services subject to electronic visit verification requirements.

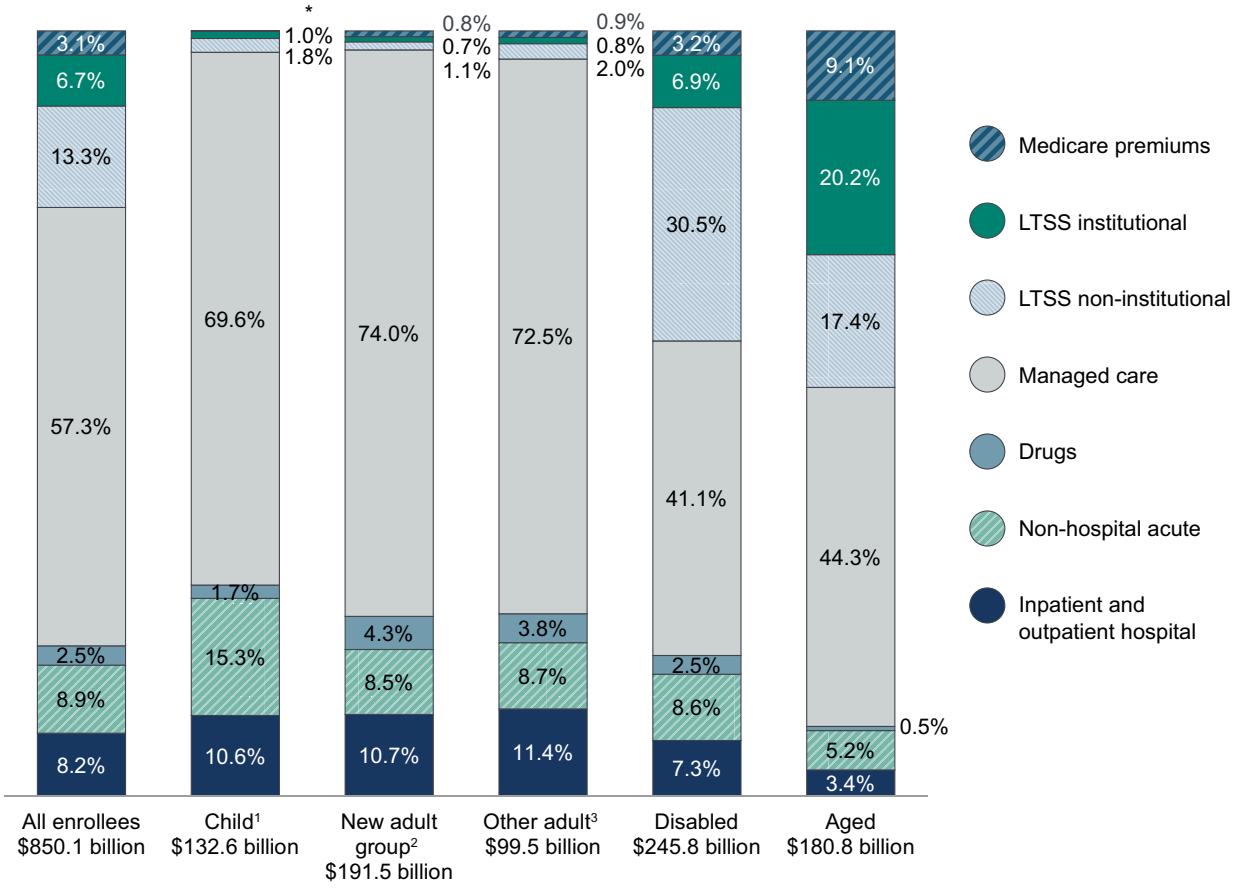
[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 3, 2025. Figures presented in this exhibit may change if states revise their expenditure data after this date.

[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.

[3] State or territory reports negative spending in a category due to prior period adjustments. West Virginia reports negative spending for other practitioner services.

Source: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025.

EXHIBIT 18. Distribution of Medicaid Benefit Spending by Eligibility Group and Service Category, FY 2023



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. Additionally, figures shown here may not be directly comparable to data books before 2025 due to a change in the method used to identify non-institutional LTSS. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

* Values less than 0.1 percent are not shown.

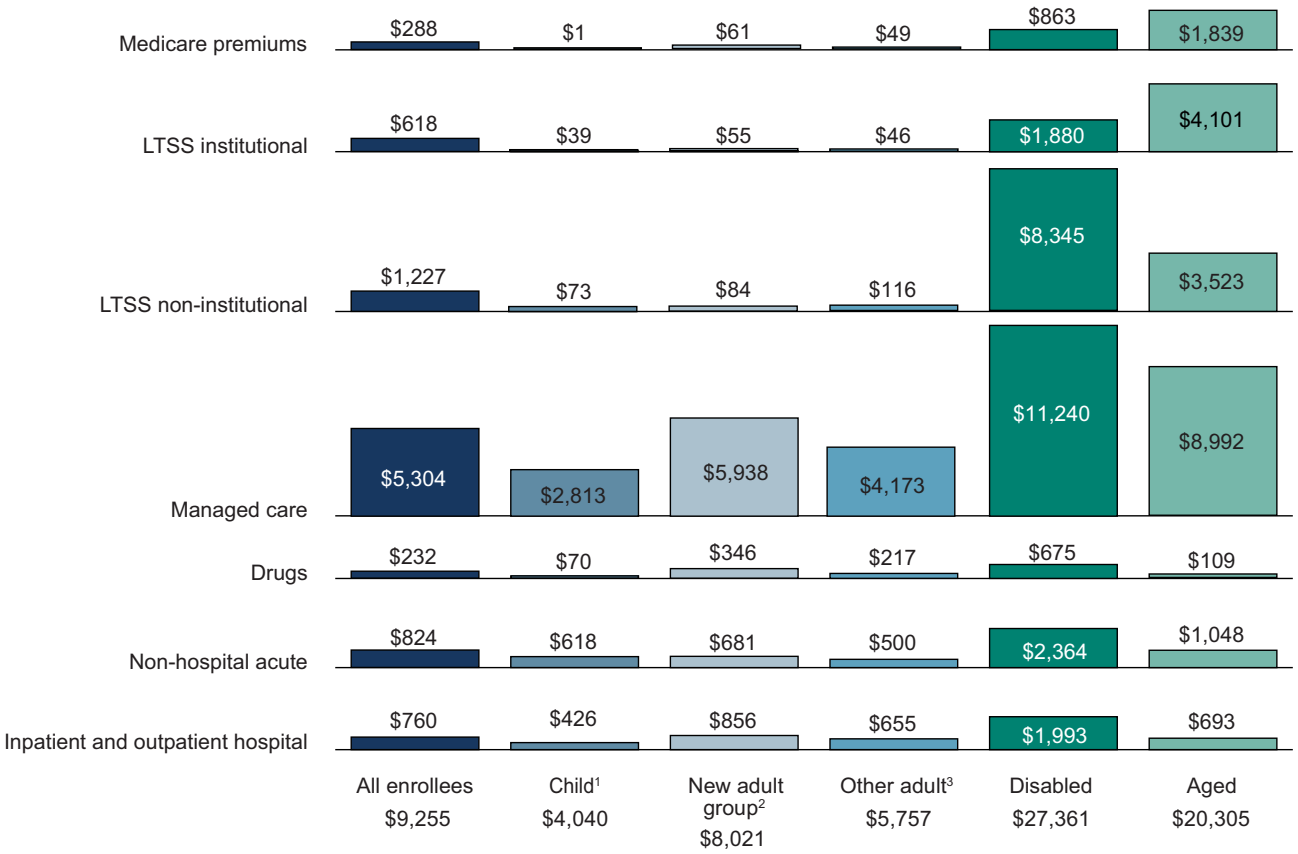
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset 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 $833.3 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, 2025, analysis of T-MSIS data as of February 2025 and analysis of CMS-64 financial management report net expenditure data as of June 2024.

EXHIBIT 19. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by Eligibility Group and Service Category, FY 2023



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. Additionally, figures shown here may not be directly comparable to data books before 2025 due to a change in the method used to identify non-institutional LTSS. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

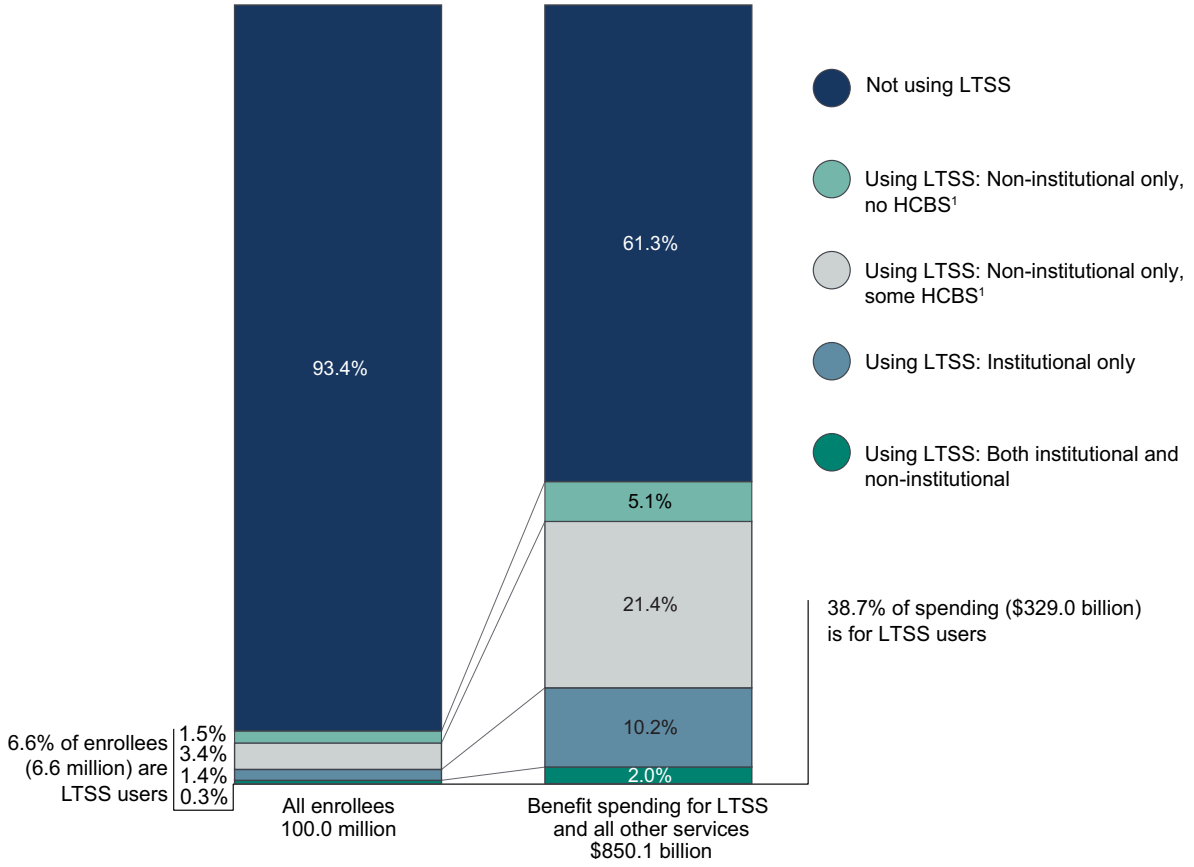
[1] California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the CHIP enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset 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 259,000 and spending by $833.3 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, 2025, analysis of T-MSIS data as of February 2025 and analysis of CMS-64 financial management report net expenditure data as of June 2024.

EXHIBIT 20. Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, FY 2023



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. Additionally, figures shown here may not be directly comparable to data books before 2025 due to a change in the method used to identify non-institutional LTSS. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

LTSS users are defined here as enrollees using at least one LTSS service during the year. 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. Beginning in 2025, this figure includes enrollees who received LTSS through a managed care plan as a user; this is a change from prior years that only identified users receiving services through a fee-for-service arrangement. As such, this figure may not be directly comparable to data books before 2025 due to this change.

California, North Dakota, and Utah have a state plan amendment (SPA) that allows the state to receive the enhanced federal medical assistance percentage (FMAP) for Medicaid children who would have, before January 1, 2014, been enrolled in CHIP if not for the elimination of the Medicaid asset test. These children cannot be separately identified in the T-MSIS data. Because the state claims the spending for these children as Medicaid-expansion CHIP, we reduced child enrollment and spending in these states based on the proportion reported in their SPA. Correspondingly, we reduced child FYE enrollment by 259,000 and spending by $833.3 million.

[1] All states provide a range of HCBS for targeted populations of non-institutionalized enrollees who require institutional levels of care. The number of enrollees using HCBS 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, 2025, analysis of T-MSIS data as of February 2025 and analysis of CMS-64 financial management report net expenditure data as of June 2024.

EXHIBIT 21. Medicaid Spending by State, Eligibility Group, and Dually Eligible Status, FY 2023 (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	**$850,130**	**15.6%**	**22.5%**	**11.7%**	**28.9%**	**21.3%**	**$271,717**	**62.7%**	**$260,840**	**62.5%**	**$10,877**	**66.5%**
Alabama	**7,668**	23.1	–	12.4	42.8	21.7	**2,527**	65.2	**2,149**	66.0	**378**	61.1
Alaska	**2,544**	23.8	25.7	15.0	22.4	13.1	**608**	53.2	**605**	53.1	**3**	74.7
Arizona	**21,971**	13.1	35.4	14.6	26.7	10.1	**4,005**	51.0	**3,853**	50.3	**151**	67.2
Arkansas	**8,620**	18.0	33.0	0.4	28.4	20.3	**2,763**	63.1	**2,512**	64.7	**251**	47.5
California[5]	**120,957**	11.0	29.8	11.7	24.8	22.7	**34,704**	71.4	**34,299**	71.4	**405**	74.2
Colorado	**12,715**	15.4	31.9	7.4	29.6	15.7	**3,254**	61.3	**3,152**	61.0	**102**	72.4
Connecticut	**10,196**	14.3	27.4	11.8	21.1	25.4	**3,760**	62.8	**3,314**	61.3	**446**	74.1
Delaware	**3,327**	17.4	28.7	16.2	25.2	12.5	**793**	53.0	**755**	52.4	**38**	66.4
District of Columbia[6]	**4,094**	10.0	18.1	11.8	35.8	24.4	**1,375**	67.8	**1,330**	67.4	**45**	80.2
Florida	**32,362**	23.5	–	14.6	34.0	27.9	**12,765**	67.3	**11,610**	66.9	**1,155**	71.3
Georgia	**15,470**	28.3	–	19.7	31.7	20.3	**4,379**	68.9	**3,815**	68.9	**564**	68.7
Hawaii[7]	**2,999**	18.1	35.0	9.5	17.9	19.5	**805**	61.3	**795**	61.1	**11**	76.5
Idaho	**3,568**	15.9	24.4	7.7	38.5	13.5	**1,014**	41.6	**905**	40.5	**108**	50.3
Illinois[8,9]	**31,839**	14.9	29.6	17.9	12.8	24.7	**9,890**	64.0	**9,731**	63.9	**159**	71.7
Indiana	**17,145**	13.8	23.1	21.1	21.7	20.2	**6,007**	63.5	**5,812**	63.6	**195**	60.5
Iowa	**6,906**	13.5	26.1	11.2	33.2	16.0	**2,305**	49.1	**2,228**	48.6	**77**	62.3
Kansas	**5,042**	21.0	–	10.9	44.3	23.8	**2,052**	52.5	**1,954**	52.6	**98**	49.9
Kentucky	**16,284**	15.2	37.7	8.8	26.9	11.4	**3,104**	58.4	**2,854**	59.2	**249**	49.1
Louisiana	**15,915**	14.9	39.5	5.3	27.7	12.6	**3,341**	57.7	**3,032**	57.2	**309**	62.2
Maine	**4,125**	14.2	18.1	8.4	39.2	20.1	**1,611**	50.7	**1,492**	48.8	**120**	74.7
Maryland	**16,804**	14.4	25.7	13.7	29.9	16.2	**4,647**	55.4	**4,394**	54.8	**252**	65.2
Massachusetts	**22,408**	8.7	19.0	13.2	33.0	26.2	**9,722**	57.1	**9,585**	56.6	**136**	95.8
Michigan[9]	**22,698**	14.0	28.4	22.3	16.3	19.0	**7,155**	60.6	**7,011**	60.8	**143**	53.8
Minnesota	**18,438**	14.3	19.9	10.1	35.8	19.9	**6,478**	52.2	**6,450**	52.1	**28**	64.2
Mississippi	**6,183**	22.3	–	11.5	41.8	24.4	**2,312**	64.7	**2,072**	65.2	**240**	60.6

EXHIBIT 21. (continued)

State	Total	Basis of eligibility[1]					Dually eligible status[2]					
							All dually eligible enrollees		Dually eligible with full benefits		Dually eligible with limited benefits	
		Child	New adult group[3]	Other adult[4]	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Missouri[8]	**$15,178**	22.4%	18.7%	6.7%	35.6%	16.7%	**$5,158**	43.9%	**$5,061**	43.8%	**$97**	53.3%
Montana	**2,364**	20.6	36.4	10.2	20.0	12.9	**571**	55.7	**543**	55.4	**28**	62.3
Nebraska	**3,732**	14.6	23.8	9.5	31.8	20.3	**1,194**	54.6	**1,185**	54.5	**10**	67.7
Nevada	**5,583**	16.5	41.3	8.1	22.8	11.3	**959**	65.4	**812**	64.8	**146**	68.5
New Hampshire	**2,182**	17.3	23.0	4.4	30.2	25.2	**956**	54.7	**912**	55.2	**43**	44.6
New Jersey	**21,531**	12.8	26.6	8.8	30.3	21.6	**7,360**	59.6	**7,296**	59.4	**63**	77.4
New Mexico	**8,089**	18.8	29.6	12.1	27.0	12.5	**1,845**	54.4	**1,678**	53.0	**167**	68.1
New York	**93,959**	9.2	23.7	8.7	25.6	32.8	**40,857**	73.0	**40,327**	72.9	**531**	82.9
North Carolina	**19,017**	19.6	–	19.5	41.5	19.4	**6,025**	60.9	**5,844**	60.7	**180**	67.5
North Dakota[5]	**1,522**	12.4	25.1	5.6	30.2	26.6	**672**	59.7	**663**	59.6	**9**	60.6
Ohio	**31,077**	14.4	26.1	11.3	28.9	19.4	**8,850**	57.4	**8,497**	57.5	**354**	56.1
Oklahoma	**9,499**	24.4	28.9	9.4	24.2	13.2	**2,027**	56.0	**1,929**	56.7	**98**	42.3
Oregon	**14,722**	9.1	42.4	2.9	20.0	25.6	**5,075**	69.7	**4,957**	69.7	**118**	67.6
Pennsylvania	**42,698**	10.6	21.0	5.7	38.6	24.1	**16,385**	61.5	**16,147**	61.5	**238**	63.1
Rhode Island	**2,414**	19.9	21.6	11.4	34.3	12.9	**967**	55.4	**951**	55.2	**16**	66.2
South Carolina	**8,303**	23.1	–	17.9	40.1	19.0	**2,622**	55.5	**2,586**	55.4	**36**	69.6
South Dakota[6]	**1,187**	19.8	5.0	10.7	42.2	22.4	**489**	54.1	**462**	53.9	**27**	56.4
Tennessee	**11,650**	30.1	–	20.5	32.5	17.0	**3,539**	54.4	**3,286**	53.5	**252**	66.2
Texas[10]	**49,976**	33.0	–	14.0	35.7	17.4	**12,781**	64.3	**10,740**	63.3	**2,041**	69.5
Utah[5]	**4,555**	18.5	27.1	10.1	31.7	12.5	**1,201**	45.0	**1,189**	44.9	**12**	56.4
Vermont	**1,894**	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]	[11]
Virginia	**21,841**	10.7	35.0	5.9	32.5	15.9	**6,849**	44.9	**6,594**	44.6	**255**	52.9
Washington[8]	**28,822**	16.6	38.1	8.6	23.2	13.5	**6,459**	58.0	**6,167**	57.8	**292**	61.9
West Virginia	**5,399**	14.8	29.9	6.5	26.6	22.2	**1,790**	65.9	**1,660**	66.8	**130**	53.7
Wisconsin	**11,930**	13.3	–	24.1	41.8	20.8	**4,792**	49.6	**4,760**	49.5	**32**	75.3
Wyoming	**725**	24.5	–	14.0	38.7	22.8	**281**	54.2	**270**	53.9	**12**	60.6

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. Additionally, figures shown here may not be directly comparable to data books before 2025 due to a change in the method used to identify non-institutional long-term services and supports. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

– 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 $785.6 million, North Dakota's child spending by approximately $10.8 million, and Utah's child spending by approximately $36.9 million.

[6] State reported enrollment for the new adult group that shows a difference of greater than 20 percent when compared to the CMS-64 enrollment report. The District of Columbia's average monthly enrollment was 33 percent less than the benchmark, and South Dakota's average monthly enrollment was 29 percent more than the benchmark.

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

[8] State reported CMS-64 spending that shows a difference greater than 20 percent when compared to the prior year. Illinois's spending on the CMS-64 was 25.1 percent higher compared with 2022. Missouri's spending on the CMS-64 was 23.8 percent higher compared with 2022. Washington's spending on the CMS-64 was 32.8 percent higher compared with 2022.

[9] State reported a large shift of enrollees between eligibility groups from the prior year. Illinois reported an 81 percent increase in the child group, a 43 percent decrease in the new adult group, and a 346 percent increase in the other adult group. Michigan reported a 37 percent increase in the other adult group and a 38 percent decrease in the disabled group.

[10] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2023.

[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, 2025, analysis of T-MSIS data as of February 2025 and analysis of CMS-64 financial management report net expenditure data as of June 2024.

EXHIBIT 22. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2023

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	**$9,255**	**$9,859**	**$4,040**	**$4,057**	**$8,021**	**$8,099**	**$5,757**	**$6,817**	**$27,361**	**$30,436**	**$20,305**	**$26,484**
Alabama	**6,306**	**7,217**	2,957	2,957	–	–	3,584	4,712	15,377	19,616	11,992	27,220
Alaska	**9,939**	**9,975**	5,965	5,965	8,737	8,737	7,566	7,566	38,229	38,835	23,247	24,746
Arizona	**9,445**	**10,172**	3,858	3,905	10,584	11,206	6,925	8,050	33,544	36,403	10,836	13,635
Arkansas	**8,446**	**8,792**	3,496	3,495	8,482	8,477	5,215	5,216	16,000	19,359	21,125	34,115
California[4]	**8,416**	**9,036**	3,675	3,697	6,810	7,000	4,653	5,992	35,816	35,894	17,373	17,607
Colorado	**7,667**	**8,061**	3,680	3,707	5,567	5,603	4,543	5,729	37,333	40,785	22,253	32,574
Connecticut	**8,369**	**9,123**	3,981	4,002	7,158	7,073	5,210	5,706	28,774	40,738	16,667	45,675
Delaware	**10,570**	**11,561**	5,296	5,387	9,397	9,406	8,925	11,114	35,152	44,196	21,016	43,870
District of Columbia[5]	**14,057**	**14,507**	5,114	5,114	7,986	7,986	8,238	8,230	49,978	53,614	32,488	46,505
Florida	**6,020**	**6,579**	2,967	2,969	–	–	3,283	3,415	17,558	20,535	12,020	18,960
Georgia	**6,141**	**6,731**	3,244	3,241	–	–	5,593	6,367	14,300	17,481	11,139	23,767
Hawaii[6]	**6,702**	**6,676**	3,898	3,896	5,731	5,549	4,964	4,915	26,118	27,544	12,488	13,669
Idaho	**8,672**	**8,941**	3,653	3,653	6,411	6,411	7,258	7,255	27,794	32,821	14,661	24,274
Illinois[7,8]	**9,068**	**9,348**	3,899	3,901	8,108	8,107	9,648	11,040	22,991	24,443	21,708	23,953
Indiana	**8,330**	**8,890**	3,146	3,218	7,279	7,316	8,101	9,417	21,714	24,965	24,441	35,062
Iowa	**8,693**	**8,900**	3,330	3,329	6,985	6,989	6,081	6,161	28,231	30,776	23,117	33,741
Kansas	**10,998**	**11,565**	4,091	4,086	–	–	6,806	6,859	30,169	35,830	26,576	41,082
Kentucky	**10,015**	**10,478**	5,187	5,185	9,112	9,094	8,763	8,794	22,049	27,332	16,593	28,938
Louisiana	**8,646**	**9,096**	4,174	4,173	8,115	8,116	7,852	8,024	19,679	23,812	12,088	20,952
Maine	**9,457**	**11,020**	5,044	5,207	6,412	6,573	4,219	5,925	27,546	31,591	13,266	25,149
Maryland	**10,438**	**10,699**	4,101	4,084	9,210	9,211	7,490	7,152	37,580	43,759	25,159	41,248
Massachusetts	**10,541**	**12,413**	4,564	5,099	8,108	8,892	4,912	6,659	22,787	22,968	23,464	29,292
Michigan[8]	**7,436**	**7,597**	3,195	3,210	6,071	6,147	8,683	8,977	17,884	19,211	20,783	23,629
Minnesota	**12,953**	**13,183**	4,246	4,250	11,329	11,348	7,232	7,555	55,167	56,974	36,082	39,671
Mississippi	**7,622**	**8,483**	3,431	3,431	–	–	4,737	5,687	16,586	19,912	14,627	27,299
Missouri[7]	**10,154**	**10,354**	4,845	4,845	8,270	8,266	6,452	6,451	30,231	32,702	22,118	27,153
Montana	**8,052**	**8,241**	4,648	4,648	7,421	7,422	7,089	7,454	22,133	24,824	17,090	23,689
Nebraska	**10,495**	**10,608**	3,472	3,470	10,185	10,166	7,591	7,575	30,643	31,798	28,986	33,113

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	**$6,279**	**$6,480**	$2,967	$2,967	$6,102	$6,100	$5,336	$5,214	$22,718	$29,999	$10,515	$23,526
New Hampshire	**9,517**	**10,269**	4,875	4,897	5,839	5,843	4,276	5,756	25,518	34,680	30,681	49,178
New Jersey	**10,563**	**10,628**	4,131	4,203	7,414	7,248	7,658	7,351	37,485	38,688	25,794	28,650
New Mexico	**8,658**	**9,422**	4,747	4,749	7,613	7,663	6,444	7,849	29,386	37,901	13,764	31,913
New York	**12,528**	**12,725**	4,397	4,399	7,885	7,886	6,723	6,742	40,095	41,779	34,420	39,499
North Carolina	**7,219**	**9,009**	3,589	3,630	–	–	3,611	6,338	22,753	24,395	16,651	21,916
North Dakota[4]	**12,154**	**12,303**	3,824	3,824	10,357	10,344	5,390	5,389	36,414	38,580	39,408	45,325
Ohio	**9,742**	**10,055**	4,223	4,222	8,294	8,314	6,644	6,619	23,695	27,215	23,952	33,423
Oklahoma	**7,923**	**8,096**	4,737	4,737	7,532	7,495	5,991	6,168	19,898	21,938	15,457	19,234
Oregon	**11,051**	**11,843**	4,631	4,647	8,381	8,583	6,856	11,523	26,163	29,579	30,586	42,499
Pennsylvania	**12,347**	**12,683**	4,531	4,539	7,717	7,724	6,195	6,406	28,494	30,041	31,418	37,812
Rhode Island	**7,152**	**7,260**	5,319	5,320	4,817	4,815	3,932	3,974	21,829	22,860	9,959	11,493
South Carolina	**5,662**	**6,766**	2,883	2,904	–	–	2,819	4,865	19,771	20,020	14,639	15,894
South Dakota[5]	**9,478**	**9,903**	3,402	3,402	10,360	10,358	6,290	6,290	27,402	32,692	21,808	33,834
Tennessee	**6,588**	**6,889**	4,094	4,094	–	–	4,810	4,810	14,635	16,719	12,519	22,222
Texas[9]	**7,958**	**8,701**	4,310	4,299	67,810	67,810	5,736	8,770	26,187	29,954	15,475	24,874
Utah[4]	**9,790**	**10,107**	4,341	4,394	8,888	8,905	7,528	8,952	32,117	32,754	22,115	24,180
Vermont	**9,404**	**10**	10	10	10	10	10	10	10	10	10	10
Virginia	**10,969**	**11,264**	3,698	3,698	10,200	9,762	4,439	5,215	39,105	46,799	25,079	32,947
Washington[7]	**13,365**	**13,673**	5,869	5,870	13,250	13,249	13,378	13,037	39,349	45,757	24,914	34,858
West Virginia	**8,514**	**8,935**	4,050	4,051	6,674	6,675	6,203	6,292	16,736	20,673	22,837	39,942
Wisconsin	**8,099**	**8,411**	3,065	3,069	–	–	4,673	4,991	26,799	27,190	15,997	17,080
Wyoming	**8,652**	**9,084**	3,674	3,678	–	–	6,049	6,110	24,420	28,857	23,248	39,152

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. Additionally, figures shown here may not be directly comparable to data books before 2025 due to a change in the method used to identify non-institutional long-term services and supports. See https://www.macpac.gov/macstats/data-sources-and-methods/ for additional information.

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 244,000 and spending by $785.6 million, North Dakota's child FYE enrollment by approximately 3,000 and spending by $10.8 million, and Utah's child FYE enrollment by approximately 12,000 and spending by $36.9 million.

[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 33 percent less than the benchmark, and South Dakota's average monthly enrollment was 29 percent more than the benchmark.

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

[7] State reported CMS-64 spending that shows a difference greater than 20 percent when compared to the prior year. Illinois's spending on the CMS-64 was 25.1 percent higher compared with 2022. Missouri's spending on the CMS-64 was 23.8 percent higher compared with 2022. Washington's spending on the CMS-64 was 32.8 percent higher compared with 2022.

[8] State reported a large shift of enrollees between eligibility groups from the prior year. Illinois reported an 80 percent increase in the child group, a 41 percent decrease in the new adult group, and a 304 percent increase in the other adult group. Michigan reported a 35 percent increase in the other adult group and a 38 percent decrease in the disabled group.

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2023.

[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, 2025, analysis of T-MSIS data as of February 2025 and analysis of CMS-64 financial management report net expenditure data as of June 2024.

EXHIBIT 23. Medicaid Benefit Spending per Full-Year Equivalent Enrollee for Newly Eligible Adult and All Enrollees by State, FY 2024

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	1,164,515	$8,109,366,769	$6,964	–	–	–
Alaska	244,591	2,715,115,339	11,101	72,799	$732,063,338	$10,056
Arizona	2,167,231	19,966,362,750	9,213	125,739	582,775,375	4,635
Arkansas	811,854	7,789,473,294	9,595	239,641	1,952,400,223	8,147
California	14,778,462	148,772,636,090	10,067	5,016,669	39,835,656,662	7,941
Colorado	1,253,647	13,754,375,105	10,971	401,819	2,922,907,868	7,274
Connecticut	1,103,469	10,835,314,555	9,819	308,078	2,410,033,741	7,823
Delaware	255,479	3,201,110,676	12,530	11,619	101,825,715	8,764
District of Columbia	272,039	4,137,819,497	15,210	81,741	698,035,988	8,540
Florida	4,594,421	34,969,221,636	7,611	–	–	–
Georgia	2,212,823	14,870,296,553	6,720	–	–	–
Hawaii	461,456	3,048,230,386	6,606	25,909	660,206,478	25,482
Idaho	384,962	3,893,210,477	10,113	95,534	923,413,399	9,666
Illinois	3,127,960	32,464,090,021	10,379	819,934	8,281,611,124	10,100
Indiana	1,881,580	19,423,914,901	10,323	575,524	3,626,696,722	6,302
Iowa	620,676	8,689,318,601	14,000	181,109	2,271,793,852	12,544
Kansas	400,675	5,167,987,458	12,898	–	–	–
Kentucky	1,442,491	17,878,704,523	12,394	531,020	6,321,661,966	11,905
Louisiana	2,001,443	16,665,231,244	8,327	632,505	6,428,911,105	10,164
Maine	398,587	4,526,919,083	11,357	89,483	–	–
Maryland	1,498,394	17,750,977,838	11,847	431,274	4,043,907,154	9,377
Massachusetts	2,071,208	24,810,177,871	11,979	–	–	–
Michigan	2,581,131	24,459,688,035	9,476	784,689	6,256,807,927	7,974
Minnesota	1,255,388	18,407,749,783	14,663	257,859	2,862,509,038	11,101
Mississippi	714,638	7,154,286,312	10,011	–	–	–
Missouri	1,302,603	15,891,669,916	12,200	333,562	2,724,330,914	8,167

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	233,288	$2,369,609,304	$10,157	84,723	$944,620,935	$11,149
Nebraska	357,557	3,646,271,928	10,198	73,605	581,408,840	7,899
Nevada	771,113	5,915,435,332	7,671	334,136	2,448,170,143	7,327
New Hampshire	182,124	2,454,248,383	13,476	60,480	378,651,177	6,261
New Jersey	1,859,011	23,110,303,360	12,432	642,804	5,700,237,665	8,868
New Mexico	888,508	7,923,702,120	8,918	285,764	2,361,115,253	8,262
New York	7,265,755	94,460,795,749	13,001	359,439	3,003,703,925	8,357
North Carolina	3,022,900	28,887,230,741	9,556	377,328	3,113,136,791	8,250
North Dakota	110,046	1,403,466,725	12,753	25,322	216,535,920	8,551
Ohio	3,212,578	33,987,517,237	10,580	765,257	7,401,926,343	9,672
Oklahoma	999,316	9,039,451,464	9,046	252,348	2,639,582,054	10,460
Oregon	1,296,432	16,040,344,828	12,373	560,702	5,234,615,514	9,336
Pennsylvania	3,142,092	43,221,817,294	13,756	863,712	6,900,296,543	7,989
Rhode Island	325,524	3,508,782,597	10,779	81,907	652,805,448	7,970
South Carolina	1,429,409	9,726,541,323	6,805	–	–	–
South Dakota	120,831	1,498,274,373	12,400	21,465	249,464,176	11,622
Tennessee	1,641,587	13,226,205,968	8,057	–	–	–
Texas	4,544,855	47,154,858,551	10,375	–	–	–
Utah	360,385	4,907,092,673	13,616	87,463	1,288,591,507	14,733
Vermont	176,378	2,132,603,719	12,091	–	91,816	–
Virginia	1,888,457	21,783,535,305	11,535	708,937	7,397,140,547	10,434
Washington	1,902,294	20,038,047,659	10,534	630,822	5,861,283,324	9,292
West Virginia	534,848	4,890,332,627	9,143	177,434	1,058,467,815	5,965
Wisconsin	1,331,532	12,226,482,492	9,182	–	–	–
Wyoming	73,680	758,941,018	10,301	–	–	–
Subtotal (states)	**86,672,221**	**$903,665,141,483**	**$10,426**	**17,410,157**	**$151,069,394,325**	**$8,677**

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	33,746	$56,924,210	$1,687	–	–	–
Guam	40,410	188,113,389	4,655	–	–	–
Northern Mariana Islands	18,367	93,499,284	5,091	–	–	–
Puerto Rico	1,429,830	4,709,128,934	3,293	–	–	–
Virgin Islands	24,451	126,276,257	5,164	–	–	–
Total (states and territories)	**88,219,026**	**$908,839,083,557**	**$10,302**	**17,410,157**	**$151,069,394,325**	**$8,677**

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 2024 enrollment was taken from the submission quarter ending December 31, 2024). Unlike other MACStats exhibits that show spending per FYE, this exhibit includes spending for disproportionate share hospital (DSH) and certain incentive and uncompensated care pool payments made under waiver expenditure authority of the Social Security Act (the Act).

– Dash indicates zero.

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 3, 2025. 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 2024.

Source: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025 and CMS-64 enrollment reports as of November 25, 2025.

EXHIBIT 24. Medicaid Supplemental Payments to Hospital Providers by State, FY 2024 (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	**$94,625.4**	**$12,584.6**	**$26,637.4**	**$10,109.3**	**52.1%**
Alabama	**3,125.1**	295.0	1,634.0	–	61.7
Alaska[3]	**755.6**	-0.0	–	–	-0.0
Arizona	**1,364.4**	31.2	452.5	–	35.4
Arkansas	**1,370.0**	27.5	481.1	–	37.1
California[4]	**14,764.2**	658.0	5,741.0	3,240.1	65.3
Colorado	**3,889.5**	257.2	1,546.0	–	46.4
Connecticut	**3,062.7**	147.5	609.9	–	24.7
Delaware	**86.4**	9.2	–	–	10.7
District of Columbia	**297.3**	45.9	58.6	–	35.1
Florida[4]	**3,327.3**	240.7	1,083.2	1,293.6	78.7
Georgia	**2,660.6**	567.1	404.7	–	36.5
Hawaii	**69.7**	23.0	0.2	–	33.3
Idaho[3]	**1,198.0**	-1.7	385.9	–	32.1
Illinois	**3,186.9**	522.5	945.2	–	46.1
Indiana	**1,365.0**	319.0	58.9	–	27.7
Iowa[3]	**119.4**	-2.6	76.7	–	62.1
Kansas[4]	**118.1**	68.0	0.6	12.7	68.8
Kentucky[3]	**360.4**	-29.3	136.7	–	29.8
Louisiana	**424.8**	230.5	73.3	–	71.5
Maine	**1,013.0**	–	99.2	–	9.8
Maryland	**1,157.1**	109.6	85.4	–	16.8
Massachusetts[4,5,6]	**3,471.8**	–	305.1	771.1	31.0
Michigan	**1,049.6**	6.0	483.9	–	46.7
Minnesota	**597.6**	51.2	70.5	–	20.4
Mississippi	**641.6**	33.0	258.8	–	45.5
Missouri	**2,670.6**	622.3	661.6	–	48.1
Montana	**918.1**	–	368.7	–	40.2
Nebraska	**42.4**	35.4	–	–	83.4
Nevada	**704.8**	13.1	368.4	–	54.1
New Hampshire	**265.1**	220.0	23.3	–	91.8
New Jersey	**1,593.5**	626.6	352.0	–	61.4
New Mexico	**464.2**	39.8	237.1	–	59.7
New York	**9,131.6**	2,530.3	536.1	–	33.6
North Carolina[3]	**1,940.0**	-4.2	439.0	–	22.4
North Dakota[3]	**163.0**	-1.2	2.3	–	0.7
Ohio	**2,476.3**	1,528.0	–	–	61.7
Oklahoma	**2,537.8**	40.5	881.5	–	36.3

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	**$472.3**	$74.9	$208.0	–	59.9%
Pennsylvania	**1,443.5**	534.0	520.3	–	73.0
Rhode Island[6]	**209.7**	14.6	13.4	$34.3	29.7
South Carolina	**817.6**	130.4	139.2	–	33.0
South Dakota	**401.8**	0.6	3.5	–	1.0
Tennessee[4]	**678.4**	81.4	76.8	508.2	98.2
Texas[4,5]	**9,551.8**	1,837.3	2,743.9	4,249.3	92.4
Utah	**616.0**	24.9	105.6	–	21.2
Vermont	**211.6**	22.7	–	–	10.7
Virginia	**4,178.1**	17.9	3,753.0	–	90.3
Washington	**2,280.9**	350.7	78.5	–	18.8
West Virginia	**221.7**	53.0	14.9	–	30.6
Wisconsin	**989.1**	182.4	54.1	–	23.9
Wyoming	**169.4**	0.6	65.0	–	38.7

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 June 3, 2025. 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, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025, and CMS-64 Schedule C waiver report data as of August 8, 2025.

EXHIBIT 25. Medicaid Supplemental Payments to Non-Hospital Providers by State, FY 2024 (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	**$8,121.8**	**$3,159.4**	**38.9%**	**$56,504.1**	**$2,833.2**	**5.0%**	**$12,610.8**	**$2,559.1**	**20.3%**
Alabama	**73.2**	3.2	4.4	**1,245.6**	–	–	**685.4**	126.8	18.5
Alaska	**30.1**	17.6	58.5	**198.5**	–	–	**223.7**	–	–
Arizona	**37.6**	28.5	75.7	**72.9**	8.8	12.0	**76.5**	–	–
Arkansas	**17.0**	–	–	**1,128.2**	–	–	**376.2**	52.4	13.9
California	**527.0**	0.1	0.0	**1,328.2**	255.1	19.2	**1,640.7**	209.6	12.8
Colorado	**8.7**	–	–	**979.6**	156.8	16.0	**569.7**	277.6	48.7
Connecticut	**254.6**	105.6	41.5	**1,465.6**	–	–	**905.0**	43.9	4.9
Delaware	**23.8**	7.1	30.0	**36.9**	–	–	**9.2**	–	–
District of Columbia	**107.4**	6.5	6.1	**393.3**	–	–	**40.4**	4.5	11.1
Florida[5]	**2,172.8**	135.5	6.2	**835.6**	–	–	**318.8**	184.1	57.7
Georgia	**17.8**	–	–	**1,849.4**	100.1	5.4	**475.5**	54.0	11.4
Hawaii	**–**	–	–	**10.8**	–	–	**0.6**	–	–
Idaho	**5.8**	–	–	**238.1**	114.1	47.9	**236.0**	–	–
Illinois[6]	**59.9**	89.4	149.2	**1,430.5**	48.6	3.4	**252.7**	–	–
Indiana	**111.6**	–	–	**2,931.3**	787.8	26.9	**289.4**	22.9	7.9
Iowa	**0.7**	–	–	**42.7**	–	–	**14.6**	5.1	35.1
Kansas	**22.5**	22.3	99.1	**83.0**	–	–	**7.0**	1.1	15.8
Kentucky	**31.4**	27.6	87.8	**1,723.6**	0.6	0.0	**47.7**	15.8	33.2
Louisiana	**136.7**	132.4	96.8	**1,863.5**	6.7	0.4	**20.0**	–	–
Maine	**151.7**	74.6	49.2	**520.5**	–	–	**260.0**	11.2	4.3
Maryland	**441.8**	72.3	16.4	**1,575.0**	–	–	**541.8**	236.3	43.6
Massachusetts[7]	**216.4**	177.6	82.1	**1,809.7**	1.7	0.1	**295.8**	–	–
Michigan	**183.8**	161.2	87.7	**2,723.7**	521.7	19.2	**246.7**	104.5	42.3
Minnesota	**177.6**	–	–	**1,307.3**	–	–	**544.2**	26.8	4.9
Mississippi	**14.0**	–	–	**1,352.2**	3.5	0.3	**172.6**	29.2	16.9

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	**$232.8**	$207.3	89.0%	**$1,548.1**	$18.8	1.2%	**$40.5**	–	–
Montana	**22.4**	–	–	**201.6**	16.2	8.0	**235.8**	–	–
Nebraska	**1.8**	1.8	100.0	**584.3**	21.4	3.7	**0.9**	–	–
Nevada	**56.8**	–	–	**393.6**	108.4	27.5	**211.0**	$14.2	6.8%
New Hampshire	**92.5**	91.1	98.5	**444.9**	169.4	38.1	**4.6**	–	–
New Jersey	**513.2**	363.0	70.7	**755.6**	7.2	1.0	**98.1**	–	–
New Mexico	**3.8**	–	–	**39.9**	–	–	**86.4**	2.0	2.3
New York	**689.4**	302.5	43.9	**8,310.9**	75.9	0.9	**619.7**	–	–
North Carolina	**210.0**	210.0	100.0	**2,311.6**	–	–	**251.1**	16.4	6.5
North Dakota	**15.6**	1.0	6.3	**451.1**	3.9	0.9	**58.2**	–	–
Ohio	**187.0**	186.9	100.0	**2,997.3**	–	–	**168.1**	36.1	21.4
Oklahoma	**90.4**	3.3	3.6	**976.2**	5.3	0.5	**707.8**	32.8	4.6
Oregon	**43.2**	39.5	91.4	**780.9**	18.4	2.4	**48.9**	13.7	28.1
Pennsylvania	**427.9**	332.4	77.7	**1,086.5**	35.6	3.3	**43.2**	–	–
Rhode Island[5,7,8]	**6.1**	1.0	16.2	**347.1**	9.6	2.8	**9.5**	1.8	18.9
South Carolina	**63.7**	60.9	95.5	**1,040.5**	9.3	0.9	**136.2**	35.2	25.8
South Dakota	**4.0**	0.8	18.9	**271.2**	–	–	**108.6**	–	–
Tennessee	**118.9**	–	–	**229.3**	–	–	**47.0**	–	–
Texas[5]	**279.1**	277.7	99.5	**1,832.9**	6.6	0.4	**882.8**	657.9	74.5
Utah	**20.3**	–	–	**555.2**	237.6	42.8	**148.2**	62.0	41.8
Vermont	**50.1**	0.0	0.0	**216.0**	–	–	**84.6**	–	–
Virginia	**104.0**	–	–	**441.5**	23.7	5.4	**313.1**	254.2	81.2
Washington	**–**	–	–	**1,322.7**	3.4	0.3	**57.3**	7.3	12.7
West Virginia	**27.9**	18.9	67.8	**1,113.1**	–	–	**-143.3**	–	–
Wisconsin	**26.0**	–	–	**962.2**	23.7	2.5	**73.8**	–	–
Wyoming	**11.3**	–	–	**144.6**	33.3	23.0	**68.5**	19.8	28.9

EXHIBIT 25. (continued)

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

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

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 3, 2025. 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 non-DSH payments to mental health facilities through an uncompensated care pool or other non-DSH supplemental payments under Section 1115 waiver expenditure authority.

[6] Illinois reported negative base payments for mental health facilities due to prior period adjustments, resulting in a supplemental payment percentage above 100 percent.

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

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

Source: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025, and CMS-64 Schedule C waiver report data as of August 8, 2025.

EXHIBIT 26. Medicaid Gross Spending for Drugs by Delivery System and Brand or Generic Status, FY 2024 (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]	**$106,395.0**	**85.8%**	**14.0%**	**0.2%**	**$47,917.4**	**87.7%**	**12.3%**	**0.1%**	**$58,477.6**	**84.4%**	**15.4%**	**0.3%**
Alabama	**1,017.8**	**87.0**	**13.0**	**0.0**	**1,017.8**	87.0	13.0	0.0	**–**	–	–	–
Alaska	**194.1**	**87.0**	**12.9**	**0.1**	**194.1**	87.0	12.9	0.1	**–**	–	–	–
Arizona	**1,988.3**	**89.5**	**10.3**	**0.1**	**45.2**	87.9	12.1	0.0	**1,943.1**	89.6	10.3	0.1
Arkansas	**462.5**	**83.1**	**16.8**	**0.1**	**376.8**	82.7	17.3	0.1	**85.7**	85.1	14.9	0.0
California	**14,988.4**	**87.4**	**12.5**	**0.0**	**14,498.9**	87.4	12.6	0.0	**489.5**	89.7	10.1	0.2
Colorado	**1,459.2**	**90.5**	**9.5**	**0.1**	**1,414.7**	90.7	9.2	0.1	**44.4**	83.2	16.8	0.0
Connecticut	**1,899.8**	**90.5**	**9.5**	**0.0**	**1,899.8**	90.5	9.5	0.0	**–**	–	–	–
Delaware	**260.9**	**87.3**	**12.6**	**0.1**	**1.3**	91.9	8.1	–	**259.6**	87.3	12.6	0.1
District of Columbia	**243.2**	**93.9**	**6.1**	**0.0**	**152.9**	97.9	2.1	0.0	**90.3**	87.0	12.9	0.0
Florida	**3,313.2**	**90.4**	**9.4**	**0.2**	**222.7**	94.7	5.2	0.1	**3,090.5**	90.1	9.7	0.2
Georgia	**1,274.0**	**87.0**	**12.9**	**0.2**	**784.6**	90.4	9.5	0.1	**489.3**	81.4	18.4	0.3
Hawaii	**287.2**	**87.5**	**12.5**	**0.0**	**0.4**	0.1	99.9	–	**286.8**	87.6	12.4	0.0
Idaho	**553.1**	**90.8**	**9.1**	**0.1**	**553.1**	90.8	9.1	0.1	**–**	–	–	–
Illinois	**3,285.2**	**90.5**	**9.5**	**0.0**	**144.7**	86.7	13.3	0.0	**3,140.5**	90.7	9.3	0.0
Indiana	**2,732.4**	**89.4**	**10.6**	**0.0**	**510.2**	91.2	8.7	0.1	**2,222.2**	89.0	11.0	0.0
Iowa	**791.9**	**92.7**	**7.3**	**0.0**	**6.6**	89.6	10.3	0.1	**785.3**	92.7	7.3	0.0
Kansas	**337.8**	**80.5**	**19.5**	**0.0**	**0.4**	77.7	22.1	0.2	**337.4**	80.5	19.5	0.0
Kentucky[5]	**4,282.4**	**87.8**	**12.2**	**0.0**	**96.4**	80.4	19.5	0.1	**4,186.0**	88.0	12.0	0.0
Louisiana	**2,467.0**	**86.2**	**13.7**	**0.1**	**62.4**	83.9	16.1	0.0	**2,404.6**	86.3	13.7	0.1
Maine	**490.6**	**90.5**	**9.5**	**0.0**	**490.6**	90.5	9.5	0.0	**–**	–	–	–
Maryland	**1,661.0**	**89.6**	**10.4**	**0.0**	**596.3**	86.3	13.7	0.0	**1,064.8**	91.4	8.5	0.0
Massachusetts	**2,262.6**	**90.1**	**9.5**	**0.3**	**626.0**	88.6	10.9	0.4	**1,636.6**	90.7	9.0	0.3
Michigan	**3,613.5**	**90.6**	**9.3**	**0.1**	**1,441.8**	88.5	11.5	0.0	**2,171.7**	92.1	7.8	0.1
Minnesota	**1,001.0**	**82.5**	**17.1**	**0.4**	**142.4**	67.1	32.2	0.7	**858.6**	85.1	14.6	0.3
Mississippi	**596.1**	**83.0**	**16.9**	**0.0**	**99.2**	82.6	17.3	0.1	**496.8**	83.1	16.8	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	$1,816.3	87.2%	12.7%	0.0%	$1,816.3	87.2%	12.7%	0.0%	–	–	–	–
Montana	374.5	88.9	11.0	0.1	374.5	88.9	11.0	0.1	–	–	–	–
Nebraska	433.1	89.4	10.5	0.0	0.0	–	100.0	–	$433.1	89.4%	10.5%	0.0%
Nevada	542.9	87.0	12.8	0.2	284.2	86.0	14.0	0.0	258.7	88.1	11.5	0.3
New Hampshire	235.4	87.2	12.6	0.2	3.3	87.6	1.0	11.4	232.2	87.2	12.8	0.0
New Jersey	1,954.5	88.3	11.7	0.0	17.9	84.9	15.1	0.0	1,936.6	88.3	11.7	0.0
New Mexico	591.3	71.7	28.2	0.1	107.2	32.5	67.4	0.1	484.1	80.4	19.5	0.1
New York	10,330.6	87.3	12.6	0.1	9,813.6	86.7	13.2	0.1	517.0	98.1	1.6	0.3
North Carolina	2,925.9	90.0	9.9	0.1	692.1	90.2	9.7	0.1	2,233.8	89.9	10.0	0.1
North Dakota	96.8	86.7	13.3	0.0	92.0	86.7	13.2	0.0	4.9	85.6	14.4	–
Ohio	4,421.5	87.4	12.6	0.0	326.5	83.7	16.3	0.0	4,094.9	87.7	12.3	0.0
Oklahoma	807.2	87.1	12.9	0.0	726.2	87.1	12.8	0.0	81.0	86.5	13.5	0.0
Oregon	895.5	82.5	16.9	0.6	126.8	74.4	25.6	0.0	768.7	83.9	15.5	0.6
Pennsylvania	4,482.8	88.6	11.4	0.0	29.3	80.5	19.5	0.0	4,453.4	88.6	11.4	0.0
Rhode Island	307.9	85.0	15.0	0.0	7.5	86.1	13.9	–	300.4	84.9	15.1	0.0
South Carolina	695.5	87.0	12.9	0.1	127.5	88.3	11.6	0.1	568.0	86.7	13.2	0.1
South Dakota	229.1	71.1	28.4	0.5	229.1	71.1	28.4	0.5	–	–	–	–
Tennessee	1,488.5	88.4	11.5	0.1	1,347.3	87.4	12.5	0.1	141.2	97.8	2.2	0.0
Texas	3,518.5	86.3	13.7	0.0	31.3	80.2	19.7	0.1	3,487.2	86.3	13.7	0.0
Utah	336.6	87.4	12.6	0.0	219.6	86.0	14.0	0.0	117.1	89.9	10.1	0.0
Vermont	179.4	88.1	11.9	0.0	179.4	88.1	11.9	0.0	0.0	98.8	1.2	–
Virginia[6]	6,194.8	49.1	49.2	1.7	18.4	85.3	14.3	0.4	6,176.4	49.0	49.3	1.7
Washington	1,638.8	89.1	10.9	0.0	132.5	86.5	13.5	0.0	1,506.3	89.4	10.6	0.0
West Virginia	834.3	88.4	11.5	0.0	817.9	88.3	11.7	0.0	16.4	97.3	2.7	0.0
Wisconsin	1,953.6	89.5	10.5	0.0	1,953.6	89.5	10.5	0.0	–	–	–	–
Wyoming	34.7	86.3	13.7	0.0	34.7	86.3	13.7	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 2024 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] Kentucky reported an anomalous amount of spending in the third quarter of FY 2024.

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

Source: MACPAC, 2025, analysis of Medicaid drug product data and state drug rebate utilization data as of November 2025.

EXHIBIT 27. Medicaid Drug Prescriptions by Delivery System and Brand or Generic Status, FY 2024 (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]	**757,293**	**13.9%**	**85.8%**	**0.3%**	**311,099**	**14.3%**	**85.3%**	**0.4%**	**446,194**	**13.6%**	**86.1%**	**0.3%**
Alabama	**7,265**	**14.4**	**85.5**	**0.2**	**7,265**	14.4	85.5	0.2	**–**	–	–	–
Alaska	**1,228**	**16.6**	**83.3**	**0.1**	**1,228**	16.6	83.3	0.1	**–**	–	–	–
Arizona	**15,407**	**12.4**	**87.2**	**0.4**	**279**	15.4	84.2	0.3	**15,128**	12.3	87.3	0.4
Arkansas	**5,333**	**13.1**	**86.8**	**0.1**	**4,327**	13.4	86.5	0.1	**1,006**	12.1	87.9	0.1
California	**89,719**	**15.3**	**84.7**	**0.1**	**83,926**	14.1	85.9	0.0	**5,793**	32.8	66.9	0.3
Colorado	**8,027**	**16.3**	**83.5**	**0.2**	**7,560**	16.6	83.2	0.2	**467**	11.8	88.2	0.0
Connecticut	**9,370**	**20.6**	**79.3**	**0.1**	**9,370**	20.6	79.3	0.1	**–**	–	–	–
Delaware	**2,465**	**14.6**	**85.3**	**0.1**	**8**	39.6	60.4	–	**2,456**	14.5	85.4	0.1
District of Columbia	**1,383**	**15.1**	**84.7**	**0.2**	**260**	27.1	72.8	0.1	**1,123**	12.4	87.4	0.2
Florida	**23,766**	**15.6**	**84.2**	**0.3**	**782**	16.2	83.7	0.1	**22,983**	15.6	84.2	0.3
Georgia	**14,853**	**11.5**	**88.1**	**0.3**	**6,131**	15.6	84.2	0.2	**8,723**	8.7	90.9	0.4
Hawaii	**2,710**	**14.8**	**85.1**	**0.1**	**24**	0.0	100.0	–	**2,686**	14.9	85.0	0.1
Idaho	**3,888**	**16.2**	**83.6**	**0.2**	**3,888**	16.2	83.6	0.2	**–**	–	–	–
Illinois	**25,096**	**13.7**	**86.2**	**0.0**	**1,601**	14.4	85.5	0.1	**23,495**	13.7	86.3	0.0
Indiana	**19,204**	**13.7**	**85.8**	**0.5**	**2,823**	12.5	86.0	1.5	**16,380**	14.0	85.7	0.3
Iowa	**8,341**	**12.8**	**87.2**	**0.0**	**60**	16.5	83.5	0.0	**8,280**	12.8	87.2	0.0
Kansas	**3,443**	**12.3**	**87.7**	**0.0**	**8**	11.0	88.6	0.4	**3,436**	12.3	87.6	0.0
Kentucky[5]	**43,344**	**13.3**	**86.6**	**0.1**	**1,457**	9.0	90.4	0.6	**41,887**	13.5	86.5	0.1
Louisiana	**18,706**	**13.1**	**86.7**	**0.2**	**648**	12.5	87.3	0.2	**18,058**	13.1	86.7	0.2
Maine	**2,975**	**22.7**	**77.1**	**0.1**	**2,975**	22.7	77.1	0.1	**–**	–	–	–
Maryland	**15,208**	**14.2**	**85.7**	**0.1**	**5,232**	16.6	83.4	0.0	**9,976**	13.0	86.9	0.1
Massachusetts	**15,038**	**18.7**	**79.8**	**1.5**	**4,842**	17.1	80.8	2.1	**10,196**	19.5	79.3	1.2
Michigan	**29,358**	**13.4**	**86.2**	**0.5**	**9,168**	13.3	86.5	0.1	**20,190**	13.4	86.0	0.6
Minnesota	**9,009**	**12.5**	**83.2**	**4.3**	**1,514**	10.7	81.5	7.8	**7,495**	12.9	83.6	3.6
Mississippi	**5,561**	**11.3**	**88.4**	**0.3**	**1,149**	11.3	88.4	0.3	**4,412**	11.3	88.4	0.3
Missouri	**15,874**	**14.0**	**85.9**	**0.1**	**15,874**	14.0	85.9	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	**2,896**	**15.3%**	**84.3%**	**0.4%**	**2,896**	15.3%	84.3%	0.4%	**–**	–	–	–
Nebraska	**3,832**	**14.6**	**85.2**	**0.2**	**0**	–	100.0	–	**3,832**	14.6%	85.2%	0.2%
Nevada	**4,272**	**13.1**	**86.2**	**0.6**	**1,995**	14.1	85.6	0.3	**2,277**	12.3	86.8	0.9
New Hampshire	**2,085**	**12.1**	**87.6**	**0.3**	**8**	15.2	56.5	28.2	**2,076**	12.1	87.7	0.2
New Jersey	**21,152**	**10.4**	**89.5**	**0.1**	**245**	14.3	85.6	0.1	**20,906**	10.4	89.6	0.1
New Mexico	**5,094**	**11.5**	**88.5**	**0.1**	**241**	22.3	77.6	0.1	**4,853**	10.9	89.0	0.1
New York	**74,475**	**13.1**	**86.0**	**0.9**	**72,429**	12.5	86.7	0.8	**2,046**	36.5	61.7	1.8
North Carolina	**18,821**	**17.2**	**82.6**	**0.2**	**4,184**	19.2	80.6	0.2	**14,637**	16.7	83.2	0.2
North Dakota	**899**	**15.0**	**84.8**	**0.1**	**834**	14.3	85.6	0.1	**66**	24.3	75.6	0.1
Ohio	**37,723**	**13.2**	**86.8**	**0.1**	**3,508**	11.1	88.8	0.1	**34,214**	13.4	86.6	0.1
Oklahoma	**8,063**	**12.6**	**87.3**	**0.1**	**5,756**	12.5	87.4	0.1	**2,307**	12.9	87.0	0.1
Oregon	**10,977**	**10.1**	**89.7**	**0.3**	**2,487**	4.0	96.0	0.0	**8,490**	11.8	87.8	0.3
Pennsylvania	**34,984**	**13.1**	**86.8**	**0.0**	**448**	9.4	90.5	0.1	**34,536**	13.2	86.8	0.0
Rhode Island	**3,574**	**10.5**	**89.5**	**0.0**	**119**	9.4	90.6	–	**3,456**	10.5	89.5	0.0
South Carolina	**7,424**	**11.4**	**88.2**	**0.4**	**1,075**	13.4	85.8	0.9	**6,349**	11.0	88.7	0.3
South Dakota	**1,106**	**13.3**	**86.2**	**0.5**	**1,106**	13.3	86.2	0.5	**–**	–	–	–
Tennessee	**13,178**	**16.0**	**83.4**	**0.6**	**11,501**	13.2	86.3	0.5	**1,677**	34.9	63.7	1.4
Texas	**28,261**	**12.9**	**86.6**	**0.5**	**409**	16.8	82.9	0.3	**27,853**	12.8	86.7	0.5
Utah	**2,760**	**13.9**	**86.1**	**0.0**	**1,649**	14.6	85.4	0.0	**1,111**	12.9	87.1	0.0
Vermont	**1,435**	**19.9**	**80.1**	**0.0**	**1,415**	19.8	80.1	0.0	**20**	20.5	79.5	–
Virginia	**23,604**	**13.6**	**85.9**	**0.5**	**221**	14.9	83.5	1.6	**23,382**	13.6	85.9	0.5
Washington	**13,406**	**11.3**	**88.6**	**0.1**	**835**	10.6	89.1	0.2	**12,571**	11.4	88.6	0.1
West Virginia	**7,782**	**15.7**	**84.3**	**0.1**	**7,599**	15.5	84.5	0.0	**183**	24.7	74.7	0.5
Wisconsin	**12,945**	**18.6**	**81.3**	**0.1**	**12,945**	18.6	81.3	0.1	**–**	–	–	–
Wyoming	**325**	**13.3**	**86.7**	**0.0**	**325**	13.3	86.7	0.0	**–**	–	–	–

EXHIBIT 27. (continued)

Notes: FY is fiscal year. Drug utilization in this exhibit reflects the number of prescriptions reported in the state drug utilization data that states submit to 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 2024 national file is not known, a comparison of totals from previous years may be instructive. A comparison of the updated FY 2014 files with data suppression to prior versions without suppression indicates that about 4 million prescriptions, or 0.7 percent of prescriptions, were suppressed in the FY 2014 data.

[5] Kentucky reported an anomalous amount of prescriptions in the third quarter of FY 2024.

Source: MACPAC, 2025, analysis of Medicaid drug product data and state drug rebate utilization data as of November 2025.

EXHIBIT 28. Medicaid Gross Spending and Rebates for Drugs by Delivery System, FY 2024 (millions)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Total[1]	**$106,395.0**	**$47,917.4**	**$58,477.6**	**-$58,406.1**	**-$29,506.0**	**-$28,900.1**
Alabama	**1,017.8**	1,017.8	–	**-564.4**	-564.4	–
Alaska	**194.1**	194.1	–	**-140.2**	-140.2	–
Arizona	**1,988.3**	45.2	1,943.1	**-1,305.4**	-46.6	-1,258.8
Arkansas	**462.5**	376.8	85.7	**-343.0**	-272.2	-70.8
California	**14,988.4**	14,498.9	489.5	**-7,124.8**	-6,849.0	-275.8
Colorado	**1,459.2**	1,414.7	44.4	**-1,023.1**	-983.5	-39.7
Connecticut	**1,899.8**	1,899.8	–	**-1,269.6**	-1,269.6	–
Delaware	**260.9**	1.3	259.6	**-245.3**	-40.5	-204.8
District of Columbia	**243.2**	152.9	90.3	**-152.7**	-83.0	-69.7
Florida	**3,313.2**	222.7	3,090.5	**-2,229.1**	-94.5	-2,134.6
Georgia	**1,274.0**	784.6	489.3	**-754.5**	-519.9	-234.6
Hawaii	**287.2**	0.4	286.8	**-169.0**	-0.6	-168.4
Idaho	**553.1**	553.1	–	**-322.7**	-322.7	–
Illinois	**3,285.2**	144.7	3,140.5	**-1,671.1**	-94.1	-1,576.9
Indiana	**2,732.4**	510.2	2,222.2	**-1,464.2**	-381.0	-1,083.1
Iowa	**791.9**	6.6	785.3	**-458.0**	-8.5	-449.5
Kansas	**337.8**	0.4	337.4	**-200.1**	-1.6	-198.6
Kentucky[2]	**4,282.4**	96.4	4,186.0	**-1,391.3**	-71.4	-1,319.9
Louisiana	**2,467.0**	62.4	2,404.6	**-1,524.0**	-52.7	-1,471.4
Maine	**490.6**	490.6	–	**-311.2**	-311.2	–
Maryland	**1,661.0**	596.3	1,064.8	**-795.2**	-321.7	-473.5
Massachusetts	**2,262.6**	626.0	1,636.6	**-1,626.8**	-544.5	-1,082.3
Michigan	**3,613.5**	1,441.8	2,171.7	**-2,539.9**	-837.6	-1,702.3
Minnesota	**1,001.0**	142.4	858.6	**-879.3**	-443.7	-435.6
Mississippi	**596.1**	99.2	496.8	**-652.0**	-199.8	-452.3

EXHIBIT 28. (continued)

State	Gross spending			Rebates		
	Total	Fee for service	Managed care	Total	Fee for service	Managed care
Missouri	**$1,816.3**	$1,816.3	–	**-$1,299.7**	-$1,299.7	–
Montana	**374.5**	374.5	–	**-244.1**	-242.8	-$1.4
Nebraska	**433.1**	0.0	$433.1	**-328.2**	-0.3	-327.9
Nevada	**542.9**	284.2	258.7	**-508.6**	-242.3	-266.3
New Hampshire	**235.4**	3.3	232.2	**-205.1**	-4.9	-200.2
New Jersey	**1,954.5**	17.9	1,936.6	**-999.6**	-12.2	-987.4
New Mexico	**591.3**	107.2	484.1	**-332.0**	-38.5	-293.5
New York[3]	**10,330.6**	9,813.6	517.0	**-7,888.9**	-7,888.9	0.0
North Carolina	**2,925.9**	692.1	2,233.8	**-1,658.9**	-520.2	-1,138.7
North Dakota	**96.8**	92.0	4.9	**-85.1**	-82.0	-3.1
Ohio	**4,421.5**	326.5	4,094.9	**-3,628.3**	-277.0	-3,351.2
Oklahoma	**807.2**	726.2	81.0	**-681.6**	-633.1	-48.5
Oregon[3]	**895.5**	126.8	768.7	**62.6**	-7.3	69.9
Pennsylvania	**4,482.8**	29.3	4,453.4	**-2,996.1**	-41.3	-2,954.8
Rhode Island	**307.9**	7.5	300.4	**-167.3**	-7.1	-160.1
South Carolina	**695.5**	127.5	568.0	**-464.8**	-127.7	-337.1
South Dakota	**229.1**	229.1	–	**-61.9**	-61.9	–
Tennessee[4]	**1,488.5**	1,347.3	141.2	**-904.5**	-904.5	–
Texas	**3,518.5**	31.3	3,487.2	**-2,113.7**	-51.3	-2,062.5
Utah	**336.6**	219.6	117.1	**-175.3**	-153.9	-21.4
Vermont	**179.4**	179.4	0.0	**-140.1**	-140.1	–
Virginia[5]	**6,194.8**	18.4	6,176.4	**-1,272.8**	-15.4	-1,257.4
Washington	**1,638.8**	132.5	1,506.3	**-1,110.5**	-264.1	-846.4
West Virginia	**834.3**	817.9	16.4	**-642.5**	-635.4	-7.1
Wisconsin	**1,953.6**	1,953.6	–	**-1,361.6**	-1,359.0	-2.6
Wyoming	**34.7**	34.7	–	**-40.6**	-40.6	–

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 is 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 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 2024 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] Kentucky reported an anomalous amount of spending in the third quarter of FY 2024.

[3] State reported prior period adjustments for managed care that ultimately resulted in a positive managed care rebate amount.

[4] State generally carves out prescription drugs from the managed care program. State managed care spending may reflect physician-administered drugs; however, minimal or no rebates for these managed care expenditures have been reported in the CMS-64 data and are likely to have been reported with the FFS rebates.

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

Sources: MACPAC, 2025, analysis of Medicaid state drug rebate utilization data as of September 2025 and CMS-64 FMR net expenditure data as of June 3, 2025.

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.

^Values have not been updated from those published in the December 2024 data book due to a delay in the release of Medicaid managed care enrollment data.

– 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 2023

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	**99,966**	**74.1%**	**85.7%**	**82.2%**	**67.4%**	**55.1%**	**40.8%**	**41.7%**	**49.8%**	**36.0%**	**33.7%**	**49.5%**	**35.3%**
Alabama	**1,313**	**0.0**	–	–	0.0	0.0	0.1	**9.1**	0.0	–	0.5	23.9	43.4
Alaska	**277**	**–**	–	–	–	–	–	**–**	–	–	–	–	–
Arizona	**2,590**	**91.2**	98.4	93.1	84.2	91.9	72.2	**0.0**	0.0	0.0	0.0	0.0	0.0
Arkansas	**1,171**	**5.3**	6.2	0.7	2.0	15.9	1.8	**91.4**	98.1	97.9	91.3	78.4	47.6
California[6]	**15,683**	**85.0**	91.6	90.0	63.6	96.1	90.7	**6.7**	6.2	7.8	5.3	9.0	6.1
Colorado	**1,834**	**10.4**	7.1	13.1	8.5	10.3	13.1	**91.9**	98.1	97.1	71.6	90.7	60.5
Connecticut	**1,346**	**–**	–	–	–	–	–	**84.2**	96.5	100.0	77.4	70.0	34.0
Delaware	**342**	**86.2**	95.7	92.9	74.9	76.4	46.1	**89.3**	97.1	99.1	77.1	78.6	46.2
District of Columbia[7]	**309**	**82.3**	94.4	94.9	96.2	55.8	9.2	**21.0**	11.2	11.6	9.1	45.0	76.4
Florida	**6,119**	**79.2**	96.9	–	77.2	64.7	32.6	**94.3**	98.9	–	93.2	89.8	83.8
Georgia	**2,793**	**74.2**	98.2	–	94.1	4.2	0.0	**84.5**	97.9	–	83.9	69.0	38.6
Hawaii	**480**	**98.5**	99.9	99.8	99.9	94.4	89.0	**1.3**	0.0	1.0	0.3	12.8	2.2
Idaho	**494**	**–**	–	–	–	–	–	**95.3**	99.9	99.5	97.9	86.8	61.3
Illinois[8]	**3,813**	**78.1**	90.4	86.4	64.7	49.0	49.3	**–**	–	–	–	–	–
Indiana	**2,283**	**79.9**	91.9	100.0	76.4	28.5	7.6	**18.1**	16.0	0.4	11.1	64.9	66.5
Iowa	**896**	**94.2**	98.4	96.1	93.0	89.7	68.8	**95.9**	99.8	97.5	96.1	91.9	68.9
Kansas	**517**	**93.2**	99.8	–	94.9	84.7	66.1	**–**	–	–	–	–	–
Kentucky	**1,735**	**89.8**	99.0	96.8	96.6	68.1	36.0	**93.2**	99.2	97.3	98.1	80.2	57.7
Louisiana	**1,954**	**92.4**	99.8	98.8	92.6	80.3	53.7	**92.7**	99.8	98.7	92.9	82.0	54.7
Maine	**492**	**–**	–	–	–	–	–	**72.5**	95.6	93.5	57.7	61.8	19.7
Maryland	**1,729**	**84.6**	98.4	92.8	87.0	56.3	2.1	**–**	–	–	–	–	–
Massachusetts	**2,332**	**50.2**	60.4	60.8	43.9	44.0	33.5	**34.1**	44.5	40.8	29.9	41.9	2.6
Michigan[8]	**3,288**	**75.9**	84.8	79.8	79.8	45.1	31.6	**95.9**	99.4	96.0	94.6	92.2	86.0
Minnesota	**1,537**	**85.9**	89.4	93.0	85.3	57.1	75.8	**–**	–	–	–	–	–
Mississippi	**868**	**50.2**	69.1	–	42.0	41.5	1.4	**84.8**	99.9	–	82.9	78.6	37.8

EXHIBIT 30. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care											
		Comprehensive managed care[1]						Limited-benefit plans[2]					
		Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged	Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged
Missouri	1,628	78.6%	98.6%	94.9%	93.7%	2.6%	0.5%	97.7%	100.0%	99.9%	99.9%	92.4%	81.5%
Montana	326	–	–	–	–	–	–	–	–	–	–	–	–
Nebraska	396	98.1	99.9	99.4	99.6	94.9	84.9	97.9	99.8	99.3	99.4	94.7	84.3
Nevada	1,015	75.7	86.1	86.4	85.0	3.6	1.1	92.9	99.7	98.6	95.4	72.4	34.3
New Hampshire	273	89.1	98.7	98.2	67.7	68.6	58.1	49.5	0.6	82.1	60.1	61.5	52.5
New Jersey	2,238	92.5	91.3	95.9	89.4	94.3	85.0	97.7	97.0	100.0	100.0	96.6	88.7
New Mexico	1,029	83.7	93.1	91.5	73.5	70.7	40.9	–	–	–	–	–	–
New York	8,217	73.4	93.1	88.3	57.4	52.8	18.4	3.8	0.0	0.6	0.6	7.1	24.5
North Carolina	2,909	59.9	91.4	–	48.0	33.5	4.5	23.3	10.6	–	12.1	67.5	71.1
North Dakota[6]	144	30.2	–	93.2	12.2	4.8	4.5	–	–	–	–	–	–
Ohio	3,438	83.6	98.4	93.5	94.6	49.6	10.5	5.0	0.0	0.0	1.9	16.2	35.5
Oklahoma	1,444	0.1	–	–	–	0.2	0.8	2.7	3.6	1.7	2.7	3.0	1.2
Oregon	1,495	87.0	92.8	92.8	54.1	78.1	64.6	7.0	6.8	7.6	5.7	7.7	4.3
Pennsylvania	3,791	92.5	97.1	95.3	92.2	87.2	77.6	94.8	98.1	97.8	94.2	92.4	78.2
Rhode Island	365	83.4	84.4	97.7	90.5	69.5	29.2	93.1	92.3	99.3	93.4	93.8	72.2
South Carolina	1,566	67.4	94.6	–	52.1	41.3	15.2	82.1	98.9	–	56.7	95.5	82.9
South Dakota[7]	156	–	–	–	–	–	–	–	–	–	–	–	–
Tennessee	1,918	93.1	99.4	–	99.5	84.6	51.4	45.3	7.5	–	98.2	71.3	50.7
Texas[9]	6,865	83.8	98.2	33.3	63.5	74.2	42.6	62.4	95.4	5.1	5.6	27.1	4.4
Utah[6]	551	79.1	86.9	77.4	65.3	80.4	62.7	85.5	96.3	73.9	74.4	94.2	81.3
Vermont	215	–	–	–	–	–	–	67.6	83.9	77.4	72.2	39.2	5.0
Virginia	2,186	75.0	98.1	84.4	79.3	1.8	2.0	29.5	9.3	27.2	31.5	78.5	69.5
Washington	2,425	86.4	97.1	96.2	91.1	51.4	7.7	9.2	0.8	3.2	2.5	35.8	66.6
West Virginia	699	81.0	97.0	93.2	92.2	47.2	3.7	94.3	100.0	100.0	100.0	80.6	60.6
Wisconsin	1,608	73.2	91.1	–	85.2	32.0	12.1	4.2	0.2	–	0.3	16.4	19.3
Wyoming	97	–	–	–	–	–	–	0.5	0.6	–	0.0	1.2	–

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	**99,966**	**7.0%**	**8.2%**	**7.5%**	**5.2%**	**8.2%**	**3.2%**
Alabama	**1,313**	**79.1**	97.0	–	91.2	53.5	15.7
Alaska	**277**	**–**	–	–	–	–	–
Arizona	**2,590**	**–**	–	–	–	–	–
Arkansas	**1,171**	**43.7**	77.7	9.9	41.1	41.6	2.4
California[6]	**15,683**	**–**	–	–	–	–	–
Colorado	**1,834**	**91.1**	97.2	96.3	71.2	90.0	60.0
Connecticut	**1,346**	**–**	–	–	–	–	–
Delaware	**342**	**–**	–	–	–	–	–
District of Columbia[7]	**309**	**–**	–	–	–	–	–
Florida	**6,119**	**–**	–	–	–	–	–
Georgia	**2,793**	**–**	–	–	–	–	–
Hawaii	**480**	**–**	–	–	–	–	–
Idaho	**494**	**83.6**	94.7	92.0	90.9	58.3	15.7
Illinois[8]	**3,813**	**–**	–	–	–	–	–
Indiana	**2,283**	**–**	–	–	–	–	–
Iowa	**896**	**0.0**	0.0	0.0	0.0	0.1	0.0
Kansas	**517**	**–**	–	–	–	–	–
Kentucky	**1,735**	**–**	–	–	–	–	–
Louisiana	**1,954**	**–**	–	–	–	–	–
Maine	**492**	**46.9**	64.2	44.5	33.7	59.4	25.5
Maryland	**1,729**	**–**	–	–	–	–	–
Massachusetts	**2,332**	**29.0**	34.2	39.8	28.1	27.5	1.1
Michigan[8]	**3,288**	**–**	–	–	–	–	–
Minnesota	**1,537**	**–**	–	–	–	–	–
Mississippi	**868**	**–**	–	–	–	–	–

EXHIBIT 30. (continued)

State	Total Medicaid enrollees (thousands)	Percentage of enrollees in managed care					
		Primary care case management[3]					
		Total	Child	New adult group[4]	Other adult[5]	Disabled	Aged
Missouri	1,628	–	–	–	–	–	–
Montana	326	83.5%	94.0%	93.6%	82.6%	41.2%	3.3%
Nebraska	396	–	–	–	–	–	–
Nevada	1,015	–	–	–	–	–	–
New Hampshire	273	–	–	–	–	–	–
New Jersey	2,238	–	–	–	–	–	–
New Mexico	1,029	–	–	–	–	–	–
New York	8,217	–	–	–	–	–	–
North Carolina	2,909	15.7	7.8	–	6.9	50.3	43.7
North Dakota[6]	144	52.2	89.7	13.0	97.5	1.8	0.0
Ohio	3,438	–	–	–	–	–	–
Oklahoma	1,444	95.2	98.9	97.8	92.4	84.9	76.2
Oregon	1,495	21.2	20.1	22.0	16.8	24.6	18.1
Pennsylvania	3,791	–	–	–	–	–	–
Rhode Island	365	–	–	–	–	–	–
South Carolina	1,566	0.1	0.0	–	0.0	0.6	–
South Dakota[7]	156	74.3	90.1	62.6	92.3	37.9	11.2
Tennessee	1,918	–	–	–	–	–	–
Texas[9]	6,865	–	–	–	–	–	–
Utah[6]	551	–	–	–	–	–	–
Vermont	215	–	–	–	–	–	–
Virginia	2,186	–	–	–	–	–	–
Washington	2,425	0.1	0.1	0.1	0.1	0.3	0.0
West Virginia	699	–	–	–	–	–	–
Wisconsin	1,608	–	–	–	–	–	–
Wyoming	97	–	–	–	–	–	–

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.

[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 266,000, North Dakota's child enrollment by approximately 3,000, and Utah's child enrollment by approximately 14,000.

[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 33 percent less than the benchmark, and South Dakota's average monthly enrollment was 29 percent more than the benchmark.

[8] State reported a large shift of enrollees between eligibility groups from the prior year. Illinois reported an 81 percent increase in the child group, a 43 percent decrease in the new adult group, and a 346 percent increase in the other adult group. Michigan reported a 37 percent increase in the other adult group and a 38 percent decrease in the disabled group.

[9] State reported enrollment for the new adult group even though it had not expanded coverage in FY 2023.

Source: MACPAC, 2025, analysis of T-MSIS data as of February 2025.

EXHIBIT 31. Total Medicaid Administrative Spending by State and Category, FY 2024 (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	**$293**	$53	$29	–	$12	$199	-$0
Alaska	**189**	40	7	–	7	134	–
Arizona	**422**	80	163	–	20	159	–
Arkansas	**524**	167	129	–	37	191	-1
California	**8,325**	647	2,495	–	316	4,868	-1
Colorado	**920**	145	170	–	14	592	-0
Connecticut	**460**	45	113	-$0	35	267	–
Delaware	**139**	42	30	–	5	62	–
District of Columbia	**234**	42	65	–	10	116	–
Florida	**937**	167	113	–	51	606	–
Georgia	**707**	147	180	-0	23	359	-1
Hawaii	**187**	56	53	–	5	74	-0
Idaho	**157**	45	26	–	23	64	–
Illinois	**1,283**	94	408	–	82	700	–
Indiana	**597**	112	120	–	16	349	–
Iowa	**185**	27	84	–	13	61	-0
Kansas	**245**	50	69	–	6	119	–
Kentucky	**424**	89	110	-0	23	202	–
Louisiana	**515**	98	169	–	10	238	-0
Maine	**205**	55	49	–	13	88	-0
Maryland	**704**	172	180	-0	38	314	–
Massachusetts	**1,383**	189	189	–	57	947	-0
Michigan	**901**	165	260	0	18	459	-1
Minnesota	**921**	91	186	–	15	629	–
Mississippi	**203**	56	56	–	8	83	–
Missouri	**554**	92	139	–	16	306	–
Montana	**135**	49	36	–	7	43	-0
Nebraska	**193**	49	41	–	8	95	–
Nevada	**260**	62	93	–	9	96	–
New Hampshire	**168**	49	52	–	6	60	–

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	**$1,107**	$117	$314	–	$29	$647	-$0
New Mexico	**567**	142	220	–	19	186	–
New York	**3,717**	316	266	$0	96	3,039	–
North Carolina	**1,326**	120	507	–	76	623	–
North Dakota	**123**	40	37	–	4	43	–
Ohio	**1,215**	144	189	–	48	836	-2
Oklahoma	**285**	59	14	–	21	191	–
Oregon	**953**	59	166	–	29	698	-0
Pennsylvania	**1,210**	126	323	–	87	675	–
Rhode Island	**216**	54	70	–	2	90	-0
South Carolina	**513**	118	151	–	23	221	–
South Dakota	**102**	20	22	–	5	56	–
Tennessee	**1,119**	392	358	–	20	352	-2
Texas	**2,244**	466	742	0	44	996	-4
Utah	**197**	30	51	-1	16	101	–
Vermont	**204**	54	39	–	11	100	–
Virginia	**571**	85	222	-0	29	235	-0
Washington	**1,280**	75	134	–	34	1,038	-0
West Virginia	**221**	74	49	–	35	62	–
Wisconsin	**544**	133	122	–	11	280	-1
Wyoming	**72**	30	21	–	2	18	-0
Subtotal (states)	**$40,154**	**$5,828**	**$9,833**	**-$0**	**$1,543**	**$22,966**	**-$15**
American Samoa	**2**	–	0	–	–	2	–
Guam	**5**	–	–	–	1	5	–
Northern Mariana Islands	**2**	1	0	–	–	1	–
Puerto Rico	**184**	57	63	–	3	62	–
Virgin Islands	**12**	5	5	–	–	2	–
Subtotal (states and territories)	**$40,360**	**$5,891**	**$9,901**	**-$0**	**$1,546**	**$23,037**	**-$15**

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[6,7]	**$497**	–	–	–	$497	–	–
Medicaid survey and certification of nursing and intermediate care facilities[6]	**468**	–	–	–	468	–	–
Total	**$41,325**	**$5,891**	**$9,901**	**-$0**	**$2,511**	**$23,037**	**-$15**
Percent of total, exclusive of collections	**–**	**14.3%**	**24.0%**	**0.0%**	**6.1%**	**55.7%**	**–**

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

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

[1] All states had certified their CMS-64 Financial Management Report (FMR) submissions as of June 3, 2025. 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). These EHR incentive payments generally ended in 2021.

[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.

[7] The CMS FY 2026 budget justification does not report the actual spending for state Medicaid fraud control units in FY 2024; this amount reported here reflects the estimated FY 2024 amount from the CMS FY 2025 budget justification.

Sources: For state and territory spending: MACPAC, 2025, analysis of CMS-64 FMR net expenditure data as of June 3, 2025. For all other spending (MFCUs, survey and certification, VFC program): CMS, 2025, Fiscal year 2026 justification of estimates for appropriations committees, Baltimore, MD, https://www.cms.gov/files/document/fy2026-cms-congressional-justification-estimates-appropriations-committees.pdf; CMS, 2024, Fiscal year 2025 justification of estimates for appropriations committees, Baltimore, MD, https://us.pagefreezer.com/en-US/wa/browse/97b01e00-724d-46ac-9417-9e52cd82c5a5?url=https%3A%2F%2Fwww.cms.gov%2Ffiles%2Fdocument%2Ffy2025-cms-congressional-justification-estimates-appropriations-committees.pdf&timestamp=2025-03-28T00%3A40%3A51Z.

EXHIBIT 32. Child Enrollment in CHIP and Medicaid by State, FY 2024 (thousands)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
Total	**47,176**	**5,886**	**3,330**	**9,216**	**37,960**
Alabama	**831**	112	121	**233**	**598**
Alaska	**128**	18	–	**18**	**109**
Arizona	**1,030**	72	72	**143**	**886**
Arkansas	**496**	40	51	**91**	**405**
California	**6,542**	1,737	52	**1,789**	**4,753**
Colorado	**657**	72	112	**185**	**472**
Connecticut	**440**	–	27	**27**	**413**
Delaware	**137**	2	11	**14**	**123**
District of Columbia[1]	**105**	16	–	**16**	**89**
Florida	**2,852**	187	161	**348**	**2,504**
Georgia	**1,815**	81	245	**327**	**1,488**
Hawaii	**191**	27	–	**27**	**164**
Idaho	**199**	1	29	**30**	**169**
Illinois	**1,808**	336	49	**385**	**1,422**
Indiana	**1,003**	113	54	**168**	**835**
Iowa	**467**	24	94	**118**	**349**
Kansas	**346**	18	72	**90**	**256**
Kentucky	**706**	117	2	**118**	**587**
Louisiana[2]	**680**	202	12	**214**	**680**
Maine	**238**	46	0	**47**	**192**
Maryland	**619**	1	–	**1**	**619**
Massachusetts	**877**	102	161	**262**	**615**
Michigan	**1,320**	204	5	**209**	**1,111**
Minnesota	**704**	1	4	**5**	**699**
Mississippi	**568**	88	64	**151**	**416**
Missouri	**773**	72	109	**180**	**593**
Montana	**139**	8	22	**31**	**109**
Nebraska	**250**	64	3	**67**	**183**
Nevada	**441**	34	53	**87**	**354**
New Hampshire	**103**	22	–	**22**	**81**
New Jersey	**1,118**	123	203	**326**	**792**
New Mexico	**417**	12	–	**12**	**405**

EXHIBIT 32. (continued)

State	CHIP and Medicaid	CHIP-funded coverage			Medicaid-funded coverage
	Total	Medicaid expansion	Separate CHIP	Total	Total
New York	**3,164**	347	568	**915**	**2,249**
North Carolina	**1,609**	348	–	**348**	**1,261**
North Dakota	**75**	10	–	**10**	**65**
Ohio	**1,558**	277	–	**277**	**1,281**
Oklahoma	**675**	193	8	**200**	**474**
Oregon	**520**	84	15	**99**	**421**
Pennsylvania	**1,726**	109	221	**330**	**1,395**
Rhode Island	**151**	34	3	**37**	**114**
South Carolina	**863**	146	–	**146**	**716**
South Dakota	**89**	14	5	**19**	**71**
Tennessee	**1,142**	126	61	**187**	**954**
Texas	**4,449**	278	359	**637**	**3,812**
Utah	**275**	28	18	**46**	**229**
Vermont	**74**	6	–	**6**	**68**
Virginia	**1,000**	110	110	**221**	**779**
Washington	**937**	–	82	**82**	**855**
West Virginia	**268**	13	28	**40**	**228**
Wisconsin	**652**	21	76	**96**	**556**
Wyoming	**55**	7	–	**7**	**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 3, 2025, and may be revised at a later date.

– Dash indicates zero.

[1] The District of Columbia's child enrollment in CHIP and Medicaid, CHIP-funded coverage, and Medicaid-funded coverage reflect reported amounts for FY 2023 because complete data were not available for FY 2024 as of the time of analysis.

[2] Louisiana's child enrollment in CHIP-funded coverage reflects reported amounts for FY 2023 because complete data were not available for FY 2024 as of the time of analysis.

Source: MACPAC, 2025, analysis of CHIP Statistical Enrollment Data System data as of September 3, 2025.

EXHIBIT 33. CHIP Spending by State, FY 2024 (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	**$515.2**	$419.1	$96.1	**$187.2**	$152.0	$35.1	**$316.2**	$257.4	$58.7	**$11.9**	$9.7	$2.2	–
Alaska	**35.9**	23.4	12.5	**32.3**	21.1	11.2	**–**	–	–	**3.6**	2.3	1.2	–
Arizona	**390.8**	297.6	93.2	**205.1**	156.8	48.3	**169.9**	128.8	41.1	**15.7**	11.9	3.8	–
Arkansas	**233.8**	188.4	45.4	**102.0**	82.0	20.1	**125.3**	101.2	24.1	**6.5**	5.2	1.2	–
California	**6,000.7**	3,952.7	2,048.0	**5,226.2**	3,443.4	1,782.8	**678.1**	445.9	232.2	**96.4**	63.4	33.0	–
Colorado	**432.0**	280.0	152.0	**165.9**	106.5	59.5	**255.2**	166.5	88.7	**10.9**	7.1	3.8	–
Connecticut	**62.9**	65.7	-2.8	**–**	–	–	**58.8**	38.3	20.5	**4.1**	2.7	1.4	$24.7
Delaware	**47.8**	34.5	13.4	**9.2**	6.7	2.6	**37.6**	27.1	10.5	**1.0**	0.7	0.3	–
District of Columbia	**68.3**	54.1	14.2	**66.8**	52.9	13.9	**–**	–	–	**1.5**	1.2	0.3	–
Florida	**1,043.4**	738.6	304.8	**511.7**	361.7	150.1	**495.2**	351.1	144.1	**36.5**	25.9	10.6	–
Georgia	**560.3**	428.4	132.0	**123.2**	94.1	29.1	**418.3**	319.9	98.5	**18.8**	14.4	4.4	–
Hawaii	**75.5**	53.7	21.8	**71.5**	50.8	20.7	**–**	–	–	**4.0**	2.9	1.2	–
Idaho	**83.9**	66.2	17.6	**4.2**	3.3	0.9	**77.8**	61.4	16.4	**1.9**	1.5	0.4	–
Illinois	**812.8**	534.1	278.8	**649.7**	427.0	222.7	**93.1**	61.1	32.0	**70.0**	45.9	24.1	–
Indiana	**423.6**	323.6	99.9	**284.2**	217.2	67.0	**126.1**	96.3	29.8	**13.3**	10.2	3.1	–
Iowa	**249.7**	187.8	61.9	**80.4**	60.5	19.9	**159.1**	119.6	39.5	**10.2**	7.6	2.5	–
Kansas	**189.6**	138.1	51.5	**41.3**	30.1	11.3	**136.6**	99.5	37.1	**11.7**	8.6	3.2	–
Kentucky	**496.5**	397.2	99.3	**468.7**	374.9	93.8	**16.2**	13.0	3.2	**11.6**	9.3	2.3	–
Louisiana	**758.0**	587.1	170.9	**662.3**	513.1	149.2	**70.7**	54.7	16.0	**25.0**	19.4	5.7	–
Maine	**79.3**	58.7	20.6	**75.4**	55.8	19.5	**0.7**	0.5	0.2	**3.2**	2.4	0.8	–
Maryland	**682.9**	445.7	237.2	**565.2**	368.9	196.3	**95.6**	62.4	33.2	**22.2**	14.5	7.7	–
Massachusetts	**1,141.3**	751.1	390.2	**379.5**	249.2	130.4	**645.5**	425.3	220.2	**116.2**	76.6	39.6	**–**
Michigan	**626.9**	475.1	151.8	**582.3**	441.3	141.0	**14.8**	11.2	3.6	**29.8**	22.5	7.2	–
Minnesota	**38.4**	101.2	-62.8	**0.3**	0.2	0.1	**34.3**	22.7	11.6	**3.8**	2.5	1.3	75.8
Mississippi	**237.1**	199.8	37.3	**81.2**	68.1	13.1	**151.9**	128.3	23.7	**4.0**	3.4	0.6	–
Missouri	**589.9**	450.9	139.0	**269.8**	206.4	63.4	**303.5**	231.9	71.7	**16.5**	12.6	3.9	–
Montana	**105.5**	79.1	26.4	**23.6**	17.7	6.0	**73.8**	55.4	18.4	**8.1**	6.1	2.0	–
Nebraska	**129.6**	92.0	37.6	**111.9**	79.4	32.6	**12.2**	8.8	3.5	**5.5**	3.9	1.6	–
Nevada	**121.7**	88.7	33.0	**52.7**	38.6	14.2	**64.3**	46.8	17.5	**4.6**	3.4	1.3	–
New Hampshire	**55.4**	45.8	9.6	**55.4**	36.1	19.3	**-0.0**	-0.0	-0.0	**0.0**	0.0	0.0	9.7

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	**$1,022.9**	$668.3	$354.7	**$344.9**	$225.3	$119.7	**$579.6**	$378.8	$200.9	**$98.3**	$64.2	$34.1	–
New Mexico	**144.0**	116.6	27.4	**142.6**	115.5	27.1	**-0.3**	-0.2	-0.1	**1.7**	1.4	0.3	–
New York	**2,868.6**	1,891.1	977.6	**1,554.5**	1,027.8	526.7	**1,026.2**	674.1	352.1	**287.9**	189.1	98.8	–
North Carolina	**1,150.6**	881.1	269.6	**1,111.0**	850.4	260.6	**1.6**	1.2	0.4	**38.0**	29.4	8.6	–
North Dakota	**35.0**	24.0	11.0	**32.9**	22.5	10.3	**-0.2**	-0.1	-0.1	**2.4**	1.6	0.8	–
Ohio	**829.3**	625.3	204.0	**785.6**	590.6	194.9	**–**	–	–	**43.7**	34.7	9.0	–
Oklahoma	**303.5**	234.7	68.8	**296.5**	229.7	66.9	**-13.6**	-9.8	-3.8	**20.6**	14.9	5.7	–
Oregon	**760.7**	545.8	214.9	**544.5**	389.8	154.7	**190.2**	137.2	53.0	**26.0**	18.8	7.2	–
Pennsylvania	**827.8**	565.8	261.9	**362.6**	247.3	115.3	**416.7**	285.4	131.3	**48.4**	33.2	15.3	–
Rhode Island	**158.4**	109.0	49.4	**137.7**	94.8	42.9	**18.5**	12.8	5.8	**2.1**	1.5	0.7	–
South Carolina	**221.1**	174.5	46.6	**215.0**	169.7	45.3	**-1.2**	-0.9	-0.3	**7.2**	5.7	1.6	–
South Dakota	**51.3**	35.1	16.2	**34.9**	23.8	11.1	**15.9**	10.9	5.0	**0.4**	0.3	0.1	–
Tennessee	**545.3**	414.3	131.0	**393.7**	299.1	94.6	**147.7**	112.2	35.5	**3.9**	3.0	0.9	–
Texas	**1,299.6**	937.4	362.2	**760.7**	549.1	211.6	**523.0**	376.8	146.1	**16.0**	11.5	4.5	–
Utah	**163.0**	124.3	38.7	**124.5**	95.0	29.5	**32.4**	24.7	7.7	**6.1**	4.7	1.5	–
Vermont	**19.8**	17.5	2.3	**18.0**	12.6	5.4	**-0.0**	-0.0	-0.0	**1.9**	1.3	0.6	$3.6
Virginia	**701.0**	461.1	239.9	**280.5**	185.6	94.9	**396.1**	259.5	136.6	**24.4**	16.0	8.4	–
Washington	**200.9**	128.8	72.1	**15.6**	10.3	5.4	**176.3**	115.0	61.3	**8.9**	5.8	3.1	-2.3
West Virginia	**114.0**	93.6	20.4	**31.9**	26.2	5.7	**75.4**	61.9	13.5	**6.7**	5.5	1.2	–
Wisconsin	**320.4**	245.7	74.7	**115.3**	83.7	31.6	**179.1**	130.1	49.0	**26.1**	19.0	7.1	13.0
Wyoming	**11.6**	7.5	4.1	**11.6**	7.5	4.1	**–**	–	–	**–**	–	–	–
Subtotal (states)	**$28,037.8**	**$19,860.2**	**$8,177.7**	**$18,403.8**	**$12,971.9**	**$5,431.9**	**$8,394.4**	**$5,904.6**	**$2,489.8**	**$1,239.6**	**$859.2**	**$380.3**	**$124.4**
American Samoa	**8.2**	8.2	–	**8.2**	8.2	–	**–**	–	–	**–**	–	–	–
Guam	**35.7**	32.0	3.6	**35.7**	32.0	3.6	**–**	–	–	**–**	–	–	–
Northern Mariana Islands	**17.9**	15.8	2.1	**17.9**	15.8	2.1	**–**	–	–	**–**	–	–	–
Puerto Rico	**95.5**	79.7	15.8	**95.5**	79.7	15.8	**–**	–	–	**–**	–	–	–
Virgin Islands	**27.1**	23.1	4.0	**27.1**	23.1	4.0	**–**	–	–	**–**	–	–	–
Total (states and territories)	**$28,222.3**	**$20,019.1**	**$8,203.2**	**$18,588.2**	**$13,130.8**	**$5,457.5**	**$8,394.4**	**$5,904.6**	**$2,489.8**	**$1,239.6**	**$859.2**	**$380.3**	**$124.4**

EXHIBIT 33. (continued)

Notes: FY is fiscal year. Components may not add to total due to rounding. Federal CHIP spending on administration is generally limited to 10 percent of a state's total federal CHIP spending for the year. States with Medicaid-expansion CHIP may elect to receive reimbursement for administrative spending from Medicaid rather than CHIP funds; Medicaid funds are not shown in this exhibit.

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

[1] Seven states (Colorado, Kentucky, Missouri, New Jersey, Rhode Island, Virginia, and West Virginia) use CHIP funds to provide coverage for pregnancy.

[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 CHIP. 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, 2025, analysis of Medicaid and CHIP Budget Expenditure System data from CMS as of September 9, 2025.

EXHIBIT 34. Federal CHIP Allotments, FYs 2023–2025 (millions)

State	FY 2023 federal CHIP allotments	FY 2024 federal CHIP allotments[1]	FY 2025 federal CHIP allotments
Alabama	$434.8	$457.9	$441.3
Alaska	20.4	21.5	24.6
Arizona	375.9	413.2	313.2
Arkansas	216.8	232.1	198.3
California	3,289.9	3,473.0	4,159.4
Colorado	266.4	280.1	294.7
Connecticut	63.4	66.7	69.1
Delaware	28.7	30.4	36.3
District of Columbia	56.3	59.3	57.2
Florida	671.5	715.2	782.5
Georgia	519.4	546.6	450.8
Hawaii	57.0	60.0	56.5
Idaho	101.9	107.6	69.7
Illinois	557.6	586.7	562.0
Indiana	240.7	253.2	340.6
Iowa	146.7	162.2	197.6
Kansas	152.6	160.8	145.4
Kentucky	387.5	407.4	418.0
Louisiana	462.9	486.6	617.8
Maine	39.9	41.9	61.8
Maryland	341.1	670.1	469.0
Massachusetts	682.6	719.3	790.3
Michigan	301.5	317.7	499.9
Minnesota	81.2	85.4	106.5
Mississippi	196.9	208.1	210.2
Missouri	325.5	342.2	474.4
Montana	98.8	104.3	83.2
Nebraska	91.9	96.6	96.8
Nevada	92.5	97.2	93.4
New Hampshire	53.8	56.6	48.2
New Jersey	644.5	678.6	703.2
New Mexico	123.7	130.0	122.7
New York	1,394.0	1,466.3	1,990.0
North Carolina	694.1	736.1	928.7
North Dakota	21.1	31.7	25.2
Ohio	610.4	641.7	658.0
Oklahoma	258.7	272.7	247.0

EXHIBIT 34. (continued)

State	FY 2023 federal CHIP allotments	FY 2024 federal CHIP allotments[1]	FY 2025 federal CHIP allotments
Oregon	$514.2	$540.7	$574.3
Pennsylvania	556.3	587.0	595.4
Rhode Island	105.0	147.9	114.7
South Carolina	207.5	220.1	184.6
South Dakota	30.9	32.7	36.9
Tennessee	360.9	381.7	436.9
Texas	1,417.3	1,499.6	990.8
Utah	115.4	121.3	130.8
Vermont	17.5	18.4	18.4
Virginia	401.9	422.6	485.2
Washington	250.2	263.6	135.5
West Virginia	83.1	92.5	98.5
Wisconsin	271.8	285.9	258.6
Wyoming	7.0	7.4	7.9
Subtotal (states)	**$18,441.4**	**$19,838.3**	**$20,912.1**
American Samoa	8.8	9.2	8.7
Guam	1.5	1.6	33.7
Northern Mariana Islands	18.7	19.7	16.7
Puerto Rico	205.2	216.3	83.9
Virgin Islands	3.0	3.1	16.2
Total (states and territories)	**$18,678.7**	**$20,088.2**	**$21,071.2**

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 2024 allotment for a state may differ from previously published allotments for the fiscal year because the state received such an allotment increase.

Sources: MACPAC, 2025, analysis of Medicaid and CHIP Budget Expenditure System data as of September 9, 2025.

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 2024 and 2025 (Exhibit 37).
- In 2025, in the lower 48 states and the District of Columbia, 100 percent of the federal poverty level (FPL) was is $15,650 for an individual plus $5,500 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 2025

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	–	–	225
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	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	300	240–300	167	–	167	122–167	302	–	215
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%	–	200%
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	133–300	133	133–300	133	100–300	–	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	210	210
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 2025, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $15,650 for an individual plus $5,500 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 2025. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income disregard that applies to an individual's eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

EXHIBIT 35. (continued)

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

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

[1] Under Medicaid-funded coverage, there is no lower threshold for income eligibility. The eligibility levels listed are the highest income levels under which each age group of children is covered under the Medicaid state plan. The eligibility levels listed under CHIP-funded Medicaid coverage are the income levels to which Medicaid has expanded using CHIP funds (which became available when CHIP was created in 1997). For states that set different CHIP-funded eligibility levels for children age 6–13 and age 14–18, this table shows only the levels for children age 6–13. In addition, Section 2105(g) of the Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed, uninsured children whose family income exceeds 133 percent FPL (not separately noted on this table).

[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. 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 program.

[6] In Delaware, Florida, 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, 2025, 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, 2025, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2025, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2025, Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations, San Francisco, CA: KFF, https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision; 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 2025

State	Parents and caretaker relatives of dependent children[1]	Additional individuals age 19–64[2]
Alabama	13%	–
Alaska	128	133%
Arizona	106	133
Arkansas	12	133
California	109	133
Colorado	68	133
Connecticut	133	133
Delaware	87	133
District of Columbia	216	210 (age 19–20 only: 216)
Florida	22	Age 19–20 only: 22
Georgia	26	95[3]
Hawaii	105	133
Idaho	18	133
Illinois	133	133
Indiana	14	133
Iowa	41	133
Kansas	33	–
Kentucky	18	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	133[4]
Mississippi	17	–
Missouri	14	133
Montana	24	133
Nebraska	58	133
Nevada	24	133
New Hampshire	51	133
New Jersey	24	133
New Mexico	35	133
New York	133	133[5]
North Carolina	33	133
North Dakota	40	133
Ohio	90	133
Oklahoma	31[6]	133[3]
Oregon	31	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	43	133
Tennessee	100	–
Texas	11	–
Utah	34[6]	133[3]
Vermont	40	133
Virginia	49	133
Washington	30	133
West Virginia	14	133
Wisconsin	95	95[3]
Wyoming	42	–

Notes: As of January 2025, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia was $15,650 for an individual plus $5,500 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 2025. Under federal regulations, the effective income limits may be 5 percentage points higher than the percentage of FPL shown in this table to account for a general income disregard that applies to an individual's eligibility under the group with the highest income standard, rather than for particular eligibility groups within Medicaid or CHIP.

States are required to provide Medicaid coverage for parents and other caretaker relatives (and their dependent children) at or above the state's 1988 Aid to Families with Dependent Children eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents and caretaker relatives, children age 19–20, and other individuals age 19–64 who have incomes less than or equal to 133 percent FPL and are not pregnant or eligible for Medicare. Certain states provide coverage through Section 1115 waivers, which allow them to operate their Medicaid programs with fewer statutory requirements. As noted in this table, the covered benefits under these waivers may be more limited than those provided under regular state plan rules and might not be available to all individuals at the income levels shown.

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

[1] In states that use dollar amounts rather than percentage of FPL to determine eligibility for parents, dollar amounts were converted to percentage of FPL, and the highest percentage was selected to reflect eligibility level for the group. Parents and caretaker relatives with income above the reported threshold for this group may be eligible for coverage under the new adult group (under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)) in states that have adopted the expansion.

[2] Reflects state plan coverage under Section 1902(a)(10)(A)(i)(VIII) of the Act for individuals who are age 19–64, have incomes less than or equal to 133 percent FPL, and are not pregnant or eligible for Medicare; state plan coverage for children age 19–20 where indicated; and Section 1115 waiver coverage that is not subject to the limitations indicated in note 5.

[3] 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.

Sources: MACPAC, 2025, 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, 2025, Medicaid state plan amendments, https://www.medicaid.gov/state-resource-center/medicaid-state-plan-amendments/index.html; CMS, 2025, CHIP state plan amendments, https://www.medicaid.gov/chip/state-program-information/index.html; Kaiser Family Foundation (KFF), 2025, Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations, San Francisco, CA: KFF, https://www.kff.org/medicaid/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-following-the-unwinding-of-the-pandemic-era-continuous-enrollment-provision; 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, 2025

State	State eligibility type[1]	SSI recipients[2]	§ 209(b) eligibility	Poverty level[3]	Medically needy[4]	Special income level[5]
Alabama	§ 1634	74%	–	–	–	222%
Alaska	SSI criteria	59[6]	–	–	–	178
Arizona	§ 1634	74	–	–	–	222
Arkansas	§ 1634	74	–	80% (aged only)	8%	222
California	§ 1634	74	–	138[7]	138	–
Colorado	§ 1634	74	–	–	–	222
Connecticut	§ 209(b)	–	64%	–	64	222
Delaware	§ 1634	74	–	–	–	185
District of Columbia	§ 1634	74	–	100	64	222
Florida	§ 1634	74	–	88	14	222
Georgia	§ 1634	74	–	–	24	222
Hawaii	§ 209(b)	–	65	100	31	–
Idaho	SSI criteria	74	–	77	–	222
Illinois	§ 209(b)	–	100	100	100	–
Indiana	§ 1634	74	–	100	–	222
Iowa	§ 1634	74	–	–	37	222
Kansas	SSI criteria	74	–	–	74	222
Kentucky	§ 1634	74	–	–	18	222
Louisiana	§ 1634	74	–	–	8	222
Maine	§ 1634	74	–	100	24	222
Maryland	§ 1634	74	–	–	27	222
Massachusetts[8]	§ 1634	74	–	100 (aged); 133 (disabled)	40	222
Michigan	§ 1634	74	–	100	31	222
Minnesota	§ 209(b)	–	100	100	100[9]	222
Mississippi	§ 1634	74	–	–	–	222
Missouri	§ 209(b)	–	85	85	85	130
Montana	§ 1634	74	–	74	40	–
Nebraska	SSI criteria	74	–	100	30	–

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	74%	–	–	–	222%
New Hampshire	§ 209(b)	–	75%	–	72%	222
New Jersey	§ 1634	74	–	100%	28	222
New Mexico	§ 1634	74	–	–	–	222
New York	§ 1634	74	–	–	138	–
North Carolina	§ 1634	74	–	100	19	–
North Dakota	§ 209(b)	–	90	–	90[9]	–
Ohio	§ 1634	74	–	–	–	222
Oklahoma	SSI criteria	74	–	100	–	222
Oregon	SSI criteria	74	–	–	–	222
Pennsylvania	§ 1634	74	–	100	33	222
Rhode Island	§ 1634	74	–	100	89	222
South Carolina	§ 1634	74	–	100	–	222
South Dakota	§ 1634	74	–	–	–	222
Tennessee	§ 1634	74	–	–	–	222
Texas	§ 1634	74	–	–	–	222
Utah	SSI criteria	74	–	100	100	222
Vermont	§ 1634	74	–	–	110	222
Virginia	§ 209(b)	–	74	80	47	222
Washington	§ 1634	74	–	–	74	222
West Virginia	§ 1634	74	–	–	15	222
Wisconsin	§ 1634	74	–	81	100	222
Wyoming	§ 1634	74	–	–	–	222

Notes: SSI is Supplemental Security Income. § 209(b) refers to Section 209(b) of the Social Security Act Amendments of 1972. § 1634 refers to Section 1634 of the Social Security Act. In 2025, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $15,650 for an individual and $5,500 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 either are receiving 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 decreased from last year because the FPL increased by 3.9 percent but the SSI federal benefit rate increased by 2.5 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 222 percent FPL in 2025). 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] State has an income disregard equal to the difference between the medically needy income limit and a specified percentage of the FPL. Minnesota disregards income between the medically needy income limit ($482 per month or approximately 37 percent FPL) and 100 percent FPL for its aged, blind, and disabled medically needy group, and North Dakota disregards income between the medically needy income limit ($500 per month or approximately 38 percent FPL) and 90 percent FPL for its aged, blind, and disabled medically needy group. This effectively raises the medically needy income limit to 100 percent FPL in Minnesota and 90 percent FPL in North Dakota.

Source: MACPAC, 2025, analysis of eligibility information from state websites and Medicaid state plans as of September 2025.

EXHIBIT 38. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2025

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%	$15,650	$21,150	$26,650	$32,150	$5,500	$1,304	$1,763	$2,221	$2,679	$458
	133	20,815	28,130	35,445	42,760	7,315	1,735	2,344	2,954	3,563	610
	138	21,597	29,187	36,777	44,367	7,590	1,800	2,432	3,065	3,697	633
	150	23,475	31,725	39,975	48,225	8,250	1,956	2,644	3,331	4,019	688
	185	28,953	39,128	49,303	59,478	10,175	2,413	3,261	4,109	4,956	848
	200	31,300	42,300	53,300	64,300	11,000	2,608	3,525	4,442	5,358	917
	250	39,125	52,875	66,625	80,375	13,750	3,260	4,406	5,552	6,698	1,146
	300	46,950	63,450	79,950	96,450	16,500	3,913	5,288	6,663	8,038	1,375
	400	62,600	84,600	106,600	128,600	22,000	5,217	7,050	8,883	10,717	1,833
Alaska	100%	$19,550	$26,430	$33,310	$40,190	$6,880	$1,629	$2,203	$2,776	$3,349	$573
	133	26,002	35,152	44,302	53,453	9,150	2,167	2,929	3,692	4,454	763
	138	26,979	36,473	45,968	55,462	9,494	2,248	3,039	3,831	4,622	791
	150	29,325	39,645	49,965	60,285	10,320	2,444	3,304	4,164	5,024	860
	185	36,168	48,896	61,624	74,352	12,728	3,014	4,075	5,135	6,196	1,061
	200	39,100	52,860	66,620	80,380	13,760	3,258	4,405	5,552	6,698	1,147
	250	48,875	66,075	83,275	100,475	17,200	4,073	5,506	6,940	8,373	1,433
	300	58,650	79,290	99,930	120,570	20,640	4,888	6,608	8,328	10,048	1,720
	400	78,200	105,720	133,240	160,760	27,520	6,517	8,810	11,103	13,397	2,293

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%	$17,990	$24,320	$30,650	$36,980	$6,330	$1,499	$2,027	$2,554	$3,082	$528
	133	23,927	32,346	40,765	49,183	8,419	1,994	2,695	3,397	4,099	702
	138	24,826	33,562	42,297	51,032	8,735	2,069	2,797	3,525	4,253	728
	150	26,985	36,480	45,975	55,470	9,495	2,249	3,040	3,831	4,623	791
	185	33,282	44,992	56,703	68,413	11,711	2,773	3,749	4,725	5,701	976
	200	35,980	48,640	61,300	73,960	12,660	2,998	4,053	5,108	6,163	1,055
	250	44,975	60,800	76,625	92,450	15,825	3,748	5,067	6,385	7,704	1,319
	300	53,970	72,960	91,950	110,940	18,990	4,498	6,080	7,663	9,245	1,583
	400	71,960	97,280	122,600	147,920	25,320	5,997	8,107	10,217	12,327	2,110

Notes: FPL is federal poverty level. The FPLs shown here are based on the U.S. Department of Health and Human Services (HHS) 2025 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, 2025, Annual update of the HHS poverty guidelines, *Federal Register* 90, no. 11 (January 17): 5917–5918.

SECTION 5:

Beneficiary Health, Service Use, and Access to Care

Section 5: Beneficiary Health, Service Use, and Access to Care

Key Points

- Children whose primary coverage source is Medicaid or the State Children's Health Insurance Program (CHIP) are less likely to be in excellent or very good health than those who have private coverage (Exhibit 39).
- Children whose primary coverage source is Medicaid or CHIP are as likely to report seeing a doctor or having a wellness visit within the past year as those with private coverage and more likely than those who are uninsured (Exhibit 40). Children whose primary coverage source is Medicaid or CHIP are as likely to experience delayed care because of cost as children with private coverage (Exhibit 42). However, while most children whose primary coverage source is Medicaid or CHIP had a usual source of care, they were less likely to have one compared with children with private coverage (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 less likely to report having a usual source of care than those with private and Medicare coverage (Exhibit 47). Among adults age 19 to 64 with health coverage (i.e., excluding the uninsured), adults whose primary coverage source is Medicaid report lower rates of delayed care due to cost compared to those with private and 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 children with Medicaid or CHIP 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, 2024

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.6%***	**35.2%**	**5.3%***
Coverage				
Length of time with any coverage during the year				
Full year	**92.7***	97.8*	95.9	–
Part year	**4.8**	2.2*	4.1	46.0*
No coverage during year	**2.5***	–	–	54.0*
Demographics				
Age				
0–5	**28.8***	28.4	30.7	22.1*
6–11	**31.8**	30.5	33.1	33.1
12–18	**39.4***	41.1*	36.2	44.7*
Sex				
Male	**51.0**	51.0	51.1	50.6
Female	**49.0**	49.0	48.9	49.4
Race				
Hispanic	**26.4***	17.2*	38.9	43.5
White, non-Hispanic	**50.0***	62.3*	32.1	40.4*
Black, non-Hispanic	**12.5***	8.4*	19.3	7.0*
American Indian or Alaska Native, non-Hispanic	**0.6**	0.3*	†	†
Asian, non-Hispanic	**4.6***	6.2*	2.6	2.8
Other single and multiple races, non-Hispanic	**5.9**	5.6	6.0	5.5
Parents present in family				
0 parents	**1.5***	0.6*	3.0	†
1 parent	**27.6***	17.4*	44.9	23.2*
2 or more parents	**70.8***	82.0*	52.1	74.9*
Family income				
Has income less than 138 percent FPL	**24.6***	6.0*	52.9	34.6*
Has income in ranges shown below				
Less than 100 percent FPL	**16.0***	†	36.0	24.8
100–199 percent FPL	**22.9***	†	38.4	30.2
200–399 percent FPL	**29.5**	34.5	19.7	31.3
400 percent FPL or higher	**31.8***	†	†	14.2

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	**96.4%**	97.6%*	96.2%	83.0%*
Born outside U.S.	**5.2**	3.7*	5.1	20.4*
Number of years spent in the U.S. (among those born outside U.S.)				
Less than 5 years	**48.7**	40.0	50.5	63.3
5–9 years	**30.8**	36.4	29.9	23.2
10 or more years	**20.5**	23.6	19.6	†
Lives in a family that receives				
SSI or SSDI	**6.0***	3.0*	11.3	2.7*
SSI	**3.2***	1.3*	6.7	†
SSDI	**3.4***	1.9*	6.0	†
WIC	**12.7***	3.3*	28.2	9.4*
SNAP	**21.5***	5.6*	48.8	10.8*
Public assistance	**6.1***	1.5*	14.2	†
Any school-aged child in family received free or reduced-cost meals at school in past 12 months	**50.3***	33.4*	77.6	44.2*
Health				
Current health status				
Excellent or very good	**85.1***	89.5*	78.3	83.3*
Good	**12.3***	9.1*	17.0	13.9
Fair or poor	**2.6***	1.4*	4.7	†
School days lost due to illness or injury, past 12 months				
None	**33.1***	28.7*	37.8	48.2*
1 day	**8.1**	9.3*	7.0	5.6
2–5 days	**39.3***	43.0*	34.0	33.8
6–10 days	**13.1**	13.6	13.0	10.2
11–20 days	**4.6***	3.8*	6.2	†
Over 20 days	**1.7**	1.7	2.1	†
Special needs, impairments, and health conditions				
Receives special education or early intervention services[6]	**11.2***	9.2*	15.0	6.3*
Uses a hearing aid	**0.7**	0.7	0.9	†
Uses special equipment for walking	**0.7**	0.6	0.9	†

EXHIBIT 39. (continued)

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Uses glasses	**23.7%***	22.5%*	25.9%	21.6%
Washington Group on Disability Statistics indicator for children age 2–4[7]	**4.2***	2.6*	6.8	†
Washington Group on Disability Statistics indicator for children age 5–17[7]	**13.1***	10.3*	18.0	9.7*
Ever been told he or she has selected conditions				
ADHD/ADD[8]	**11.4***	10.5*	13.3	6.7*
Asthma	**10.0***	9.4*	11.7	8.0*
Autism[8]	**4.4***	3.4*	6.2	†
Diabetes	**0.5**	0.4	0.6	–
Intellectual disability[6]	**1.9***	1.2*	3.1	†
Other developmental delay[6]	**5.9***	4.6*	8.2	3.6*

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.

EXHIBIT 39. (continued)

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

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

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

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

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

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

Source: MACPAC, 2025, analysis of NHIS data.

EXHIBIT 40. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2024, NHIS Data

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.6%**	**35.2%**	**5.3%**
Contact with health care professionals (past 12 months)				
Saw selected health professional				
Saw doctor or other health care professional	**94.7***	95.8	96.0	78.2*
Received counseling/therapy from mental health professional[6]	**12.6**	12.3	13.8	8.6*
Had at least 1 overnight hospital stay[7]	**3.0**	2.7	3.7	†
Used prescription medication	**41.5**	44.0*	39.4	29.5*
Had a medical appointment by video or phone	**12.5***	14.1*	11.0	6.3*
Receipt of appropriate care (past 12 months)				
Interval since last wellness visit[8]				
Within the past year	**93.7**	95.1	94.6	75.5*
More than 1 year ago but less than 2 years	**4.2**	3.8	3.8	9.4*
More than 2 years ago	**1.7**	1.0	1.4	10.9*
Never	**†**	†	†	†
Number of emergency room visits				
None	**82.6***	86.0*	77.1	84.1*
At least 1	**17.4***	14.0*	22.9	15.9*
1	**11.9***	10.6*	14.0	11.5
2–3	**4.8***	3.0*	7.8	†
4 or more	**0.7***	0.4*	1.1	†
Number of urgent care visits				
None	**71.5***	69.1*	74.6	76.1
At least 1	**28.5***	30.9*	25.4	23.9
1	**15.0**	16.2*	13.6	13.5
2–3	**11.1***	12.3*	9.6	8.6
4 or more	**2.4**	2.5	2.2	†

EXHIBIT 40. (continued)

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

The NHIS underwent 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, 2025, analysis of NHIS data.

EXHIBIT 41. Use of Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2023, 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%**	**55.8%**	**35.1%**	**7.3%**
Child has special health care needs	**17.3**	18.5	16.9	10.1*
Contact with health care professionals (past 12 months)				
Number of office-based visits to a doctor or other health professional, excluding dental visits and inpatient hospital stays				
None	**27.6***	19.9*	34.6	49.9*
At least 1	**72.4***	80.1*	65.4	50.1*
1	**22.8**	22.6	24.2	20.1
2–3	**22.5**	23.2	22.1	18.4
4 or more	**27.1***	34.4*	19.1	11.6*
Had at least 1 dental care visit[6]	**53.9***	62.9*	44.0	35.1*
Received care at home	**1.5**	1.7	1.3	†
Receipt of appropriate care (past 12 months)				
Had more than 15 office-based or hospital outpatient visits	**7.1***	9.1*	4.8	†
Annual total of days received visits from paid/unpaid home health care providers				
None	**98.5**	98.3	98.7	99.3
1	**†**	†	†	†
2–30	**0.8**	1.0	†	†
31–90	**0.4**	†	†	†
91–200	**†**	†	†	†
More than 200	**†**	†	†	†
Number of emergency room visits				
None	**88.2***	89.8*	86.1	89.9
At least 1	**11.8***	10.2*	13.9	10.1
1	**9.4**	8.5	10.7	8.5
2–3	**2.3**	1.7*	3.1	†
4 or more	**†**	†	†	†
Had at least 1 overnight hospital stay	**2.3**	2.0	2.7	†

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	**61.0%**	58.2%*	63.7%	73.8%*
1	**14.3**	15.6	12.5	10.2
2	**7.1**	8.4*	5.7	4.1
3–5	**8.2**	8.4	7.7	7.6
6–2	**5.8**	6.0	6.0	†
13–24	**2.1**	2.1	2.3	†
More than 24	**1.5**	1.3	2.2	†

Notes: MEPS is the Medical Expenditure Panel Survey. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/use-of-care-among-non-institutionalized-individuals-age-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, 2025, analysis of MEPS data.

EXHIBIT 42. Measures of Access to Care among Non-Institutionalized Individuals Age 0–18 by Primary Source of Health Coverage, 2024, NHIS Data

Characteristics	Primary coverage source at time of interview[1]			
	Total	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Total (percent distribution across coverage sources)[5]	**100.0%**	**55.6%**	**35.2%**	**5.3%**
Connection to the health care system (past 12 months)				
Has a usual source of care[6]	**96.3**	98.4*	96.4	74.3*
Kind of usual place for medical care				
Doctor's office or health center	**94.8**	95.8	95.1	83.8*
Urgent care/walk-in clinic	**4.5**	4.0	4.1	12.9*
Other	**0.6**	†	0.8	†
Timeliness of care (past 12 months)				
Delayed medical care because of costs	**1.6**	1.0	1.2	10.3*
Delayed getting dental care	**1.3**	1.4	1.1	†
Delayed filling prescription to save money	**1.7**	1.3	1.9	†
Unmet need for selected types of care due to cost				
Medical care	**1.3**	0.7	1.1	9.6*
Mental health care or counseling[7]	**1.2**	1.1	1.2	†
Prescription drugs	**1.1**	0.8	0.9	5.3*
Problems paying or unable to pay medical bills, past 12 months	**13.0***	10.5*	15.7	22.9*

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

The NHIS underwent 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

EXHIBIT 42. (continued)

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.

Source: MACPAC, 2025, 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, 2023, 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%**	**55.8%**	**35.1%**	**7.3%**
Access to Care				
Has usual place for medical care	**85.3**	88.9*	83.9	66.5*
Travel time to usual source of care				
Less than 15 minutes	**58.9**	57.9	60.8	58.1
15–30 minutes	**32.9**	35.7	28.9	29.2
31–60 minutes	**7.3**	5.6*	9.3	11.4
More than an hour	**0.9**	†	†	†
Difficulty reaching usual medical provider by phone during business hours				
Very difficult	**4.5**	4.5	3.6	†
Somewhat difficult	**12.5**	10.8	14.6	14.8
Not too difficult	**30.1**	31.7	28.3	29.4
Not at all difficult	**52.9**	53.1	53.5	48.3
Difficulty reaching usual medical provider after hours for urgent medical needs				
Very difficult	**19.6***	15.1*	25.1	27.6
Somewhat difficult	**19.8**	20.2	20.0	18.4
Not too difficult	**28.6***	33.2*	22.6	21.7
Not at all difficult	**32.0**	31.6	32.3	32.3
Usual medical provider has night or weekend availability	**45.7***	50.4*	37.6	46.4
Usual medical provider speaks preferred language or provides translator, among those with limited English abilities in family	**92.2**	†	89.2	†
Usual medical provider asks person to help decide between choice of treatments				
Never	**6.3***	3.3*	11.0	†
Sometimes	**10.5**	10.0	10.6	†
Usually	**15.6**	16.0	13.6	22.2
Always	**67.6**	70.6	64.8	56.5
Usual medical provider presents and explains all options	**97.7**	98.1	97.0	98.4

EXHIBIT 43. (continued)

Notes: MEPS is the Medical Expenditure Panel Survey. Access to care variables are fielded for only a subset of MEPS respondents (to be eligible to receive the access to care section questions, individuals had to be current, non-institutionalized members of the responding unit in round two for panel members in relative year one and round four for panel members in relative year two). Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. Standard errors are available in the Excel version of this exhibit at https://www.macpac.gov/publication/exhibit-43-access-to-and-experience-of-care-among-non-institutionalized-individuals-age-0-18-by-primary-source-of-health-coverage-2020-meps-data/. Due to differences in methodology (such as the wording of questions, length of recall periods, and prompts or probes used to elicit responses), estimates obtained from different survey data sources will vary. For example, the National Health Interview Survey (NHIS) is known to produce higher estimates of service use than the MEPS. For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

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

[1] Total includes all non-institutionalized individuals age 0–18, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, 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, 2025, analysis of MEPS data.

EXHIBIT 44. Coverage, Demographic, and Health Characteristics of Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2024

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%**	**3.5%**	**68.9%**	**12.8%**	**11.7%**
Coverage					
Length of time with any coverage during year					
Full year	**84.1***	96.2*	95.1*	90.5	–
Part year	**8.2**	3.8*	4.9*	9.5	30.0*
No coverage during year	**7.7***	–	–	–	70.0*
Demographics					
Age					
19–25	**15.1***	†	13.6*	22.5	20.5
26–44	**43.3***	19.9*	42.7*	48.1	49.4
45–54	**20.5***	20.1*	22.0*	14.0	18.1*
55–64	**21.1***	56.8*	21.7*	15.3	12.1*
Sex					
Male	**49.6***	50.7*	50.3*	38.8	55.8*
Female	**50.4***	49.3*	49.7*	61.2	44.2*
Sexual orientation					
Heterosexual	**93.9**	94.7	93.7	93.6	94.8
Lesbian/gay	**2.4**	2.7	2.6	2.0	1.3
Bisexual	**3.8**	2.6*	3.7	4.4	3.9
Race					
Hispanic	**20.3***	11.4*	15.3*	28.2	44.2*
White, non-Hispanic	**57.3***	58.1*	63.6*	40.0	38.3
Black, non-Hispanic	**12.5***	21.8	10.6*	21.0	11.3*
American Indian or Alaska Native, non-Hispanic	**0.7**	†	0.4	†	1.4
Asian, non-Hispanic	**6.7**	3.5*	7.8*	5.8	3.1*
Other single and multiple races, non-Hispanic	**2.5***	3.9	2.2*	3.7	1.8*

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	**51.9%***	37.0%*	59.0%*	27.3%	38.9%*
Widowed	**1.3**	4.7*	1.1*	1.7	1.1
Divorced or separated	**8.4***	20.2*	7.2*	11.1	8.9*
Living with partner	**10.7***	7.9*	9.3*	15.2	15.5
Never married	**27.7***	30.2*	23.4*	44.8	35.5*
Family income					
Less than 138 percent FPL	**17.0***	42.7	6.9*	50.7	33.1*
Has income in ranges below					
Less than 100 percent FPL	**11.1***	29.3	4.0*	35.8	20.8*
100–199 percent FPL	**17.8***	32.9	†	34.6	32.4
200–399 percent FPL	**30.6**	24.7	32.2	21.2	30.9
400 percent FPL or higher	**40.6***	†	†	†	16.0
Education					
Less than high school	**9.1***	15.8	4.4*	19.3	25.0*
High school diploma/GED	**26.9***	43.0	21.8*	40.1	38.1
Some college	**28.9**	30.0	29.2	29.1	23.9*
College or graduate degree	**35.2***	11.2	44.6*	11.5	13.0
Other demographic characteristics					
Citizen of United States	**89.4**	97.3*	92.6*	87.4	68.1*
Born outside U.S.	**20.9**	11.2*	18.1*	22.8	39.8*
Number of years spent in the U.S. (among those born outside U.S.)					
Less than 5 years	**12.5**	†	9.4*	16.5	19.1
5–9 years	**12.9**	†	13.5	14.2	11.3
10 years or more	**74.6***	87.9*	77.0*	69.4	69.5
Parent of a dependent child	**33.8***	12.4*	33.7*	40.1	32.7*

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Currently working	**77.8%***	17.9%*	86.4%*	53.4%	73.6%*
Working full time (usually works 35 hours or more per week)	**82.2***	40.7*	86.4*	60.0	75.3*
Working part time (less than 35 hours per week)	**17.8***	59.3*	13.6*	40.0	24.7*
Not currently working	**22.2***	82.1*	13.6*	46.6	26.4*
Unemployed, laid off, looking for work	**2.4***	†	1.3*	5.6	5.9
Caring for family or house	**5.7***	†	3.8*	12.7	9.1*
Going to school	**2.5***	†	2.3*	4.2	2.3*
Retired	**3.6***	16.7*	3.3*	2.3	1.9
Unable to work for health reasons or disabled	**6.0***	59.1*	1.7*	17.1	2.8*
Other reason not listed	**1.9***	2.4*	1.0*	4.5	4.2
Veteran	**5.0***	8.8*	4.1*	1.4	1.6
Lives in a family that receives					
SSI or SSDI	**8.4***	68.6*	3.7*	20.4	5.4*
SSI	**3.7***	20.1*	1.5*	12.2	2.6*
SSDI	**5.7***	58.7*	2.5*	10.2	3.5*
WIC	**5.9***	†	2.8*	18.7	9.8*
SNAP	**12.9***	35.7*	5.0*	48.3	16.9*
Public assistance	**3.6***	11.6	1.6*	12.2	3.7*
Any school-aged child in family received free or reduced-cost meals at school in past 12 months	**48.2***	69.2	38.3*	75.4	64.7*
Health					
Current health status					
Excellent or very good	**58.3***	19.7*	64.4*	43.1	53.2*
Good	**29.5***	31.5	27.7*	34.8	33.2
Fair or poor	**12.1***	48.8*	8.0*	22.1	13.6*

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
BMI					
Healthy weight (BMI less than 25)	**32.0%**	28.2%*	32.1%	33.1%	31.8%
Overweight (BMI 25–29)	**32.9***	26.3	33.9*	29.0	33.5*
Obese (BMI 30 or higher)	**35.1***	45.4*	34.0*	37.8	34.7
Smoking status					
Current smoker	**10.8***	23.8*	8.0*	18.2	15.2*
Former smoker	**18.6**	25.7*	18.7	17.1	15.5
Never smoked	**70.6***	50.5*	73.3*	64.7	69.3*
Current e-cigarette user	**8.8***	6.9*	7.4*	13.0	12.5
Former e-cigarette user	**16.2**	15.8	15.9*	18.0	15.8
Never used e-cigarettes	**74.9***	77.3*	76.7*	68.9	71.8
Limitations and health conditions					
Has basic action difficulty or complex activity limitation					
Any basic action difficulty[6]	**10.6***	47.4*	7.0*	19.3	10.0*
Any complex activity limitation[7]	**16.5***	80.3*	10.6*	30.1	13.4*
Either one	**20.4***	81.6*	14.3*	34.6	18.7*
Washington Group on Disability Statistics indicator for adults age 18 and older[8]	**6.9***	37.7*	4.3*	12.7	5.4*
Has difficulty walking 100 yards without equipment	**2.7***	24.2*	1.2*	6.0	1.5*
Has mobility or hearing problem that requires special equipment	**4.3***	31.6*	2.7*	6.8	2.2*
Unable to work now due to health problem	**6.0***	59.1*	1.7*	17.1	2.8*
Limited in amount or kind of work due to health	**14.7***	72.5*	9.5*	25.6	12.1*
Needs assistance with dressing and bathing	**0.7***	5.7*	0.3*	1.9	†

EXHIBIT 44. (continued)

Characteristic	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Work loss days due to illness or injury in past 12 months					
0 days	**53.3%***	58.8%	51.2%*	58.4%	61.7%
1 day	**7.1**	†	7.4*	5.6	6.9
2–5 days	**26.9***	24.5	28.7*	21.6	20.7
6–10 days	**6.7**	†	6.8	6.7	5.4
11–20 days	**2.7**	†	2.6	2.7	2.7
More than 20 days	**3.4***	†	3.3*	5.0	2.6*
Health conditions					
Currently pregnant[9]	**3.3**	†	3.3	3.7	2.6
Ever been told he or she has selected conditions					
Hypertension	**23.2**	51.8*	22.6	24.0	15.5*
Coronary heart disease	**2.0***	10.0*	1.5*	3.1	1.1*
Heart attack	**1.5***	7.8*	1.0*	2.6	1.2*
Stroke	**1.6***	9.9*	1.0*	2.9	1.5*
Cancer	**5.4***	15.0*	5.7*	4.2	2.1*
Diabetes	**6.9***	25.3*	6.0*	8.7	4.6*
Arthritis	**13.7**	44.5*	12.1*	15.2	9.0*
Asthma	**15.7***	22.7*	15.4*	18.3	12.6*
Chronic bronchitis, COPD, or emphysema	**2.5***	16.4*	1.5*	4.5	1.3*
Dementia	**0.2**	†	0.1*	†	†
High cholesterol	**21.3**	45.2*	21.7	20.2	11.4*
Anxiety disorder	**20.4***	37.4*	18.6*	26.0	16.0*
Depression	**19.8***	42.0*	17.4*	28.2	15.8*

Notes: FPL is federal poverty level. GED is general educational development test. SSI is Supplemental Security Income. SSDI is Social Security Disability Insurance. WIC is Supplemental Nutrition Program for Women, Infants, and Children. SNAP is Supplemental Nutrition Assistance Program, formerly referred to as "food stamps." BMI is body mass index. COPD is chronic obstructive pulmonary disease. Percentage calculations for each item in the exhibit exclude individuals with missing and unknown values. The individual components listed under the subcategories are not always mutually exclusive and may not add to 100 percent.

EXHIBIT 44. (continued)

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-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.

[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, 2025, analysis of NHIS data.

EXHIBIT 45. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2024, 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%**	**3.5%**	**68.9%**	**12.8%**	**11.7%**
Contact with health care professionals (past 12 months)					
Saw selected health professionals in past year					
Saw doctor or other health care professional[6]	**81.8***	93.7*	85.2	85.2	53.3*
Received counseling/therapy from mental health professional	**16.2***	24.0*	16.2*	19.7	7.4*
Now sees a counselor, psychiatrist, psychologist, or social worker regularly (among those who have received counseling)	**63.0**	70.9	63.1	67.1	45.0*
Had at least 1 overnight hospital stay	**6.5***	18.4*	5.1*	11.3	4.7*
Used prescription medication	**64.6**	86.1*	67.8*	64.5	37.3*
Had a medical appointment by video or phone	**25.7**	36.5*	27.2*	24.1	11.6*
Receipt of appropriate care (past 12 months)					
Had flu shot					
All individuals	**35.9***	48.2*	39.8*	30.4	13.1*
Individuals age 50–64	**44.9***	52.1*	47.5*	38.9	17.0*
Interval since last wellness visit					
Within the past year	**76.9***	91.1*	80.1	80.6	47.7*
More than 1 year ago but less than 2 years	**10.8**	4.7*	10.0	9.8	18.5*
2–5 years	**7.4***	2.7*	6.6	5.6	16.4*
5–10 years	**2.6**	†	1.8	2.2	8.9*
More than 10 years ago	**2.0**	†	1.2	1.5	7.4*
Never	**0.3**	†	0.2	†	1.2*
Number of emergency room visits					
None	**80.5***	66.2	83.7*	67.5	82.4*
At least 1	**19.5***	33.8	16.3*	32.5	17.6*

EXHIBIT 45. (continued)

Characteristics	Primary coverage source at time of interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
1	**12.8%***	18.8%	11.6%*	17.8%	11.3%*
2–3	**5.2***	9.6	3.9*	10.9	4.9*
4 or more	**1.4***	5.4	0.7*	3.8	1.4*
Number of urgent care visits					
None	**71.0**	74.8*	69.4	69.1	80.6*
At least 1	**29.0**	25.2*	30.6	30.9	19.4*
1	**17.2**	12.0*	18.8*	15.8	11.1*
2–3	**9.6***	10.3	9.8	11.3	7.1*
4 or more	**2.2***	2.9	2.0*	3.8	1.3*

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/.

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

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

[1] Total includes all non-institutionalized individuals age 19–64, regardless of coverage source. In this exhibit, the following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, uninsured. Not separately shown are the estimates for those covered by any type of military health plan or other federal government-sponsored programs. Coverage source is defined as of the time of the survey interview. 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.

EXHIBIT 45. (continued)

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

Source: MACPAC, 2025, analysis of NHIS data.

EXHIBIT 46. Use of Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2023, 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%**	**3.7%**	**67.0%**	**12.1%**	**14.7%**
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**	12.8*	26.0*	34.4	62.2*
At least 1	**67.9**	87.2*	74.0*	65.6	37.8*
1	**13.7**	5.9*	14.2	14.0	13.2
2–3	**17.4**	20.4*	19.4*	15.1	9.8*
4 or more	**36.8**	60.9*	40.4*	36.4	14.8*
Had more than 15 office-based or hospital outpatient visits	**13.1**	27.8*	14.1	13.6	5.1*
Had at least 1 dental care visit[6]	**40.7***	36.8*	49.1*	25.9	16.8*
Received care at home	**1.8***	13.2*	1.0*	3.8	†
Receipt of appropriate care					
Needed to see a specialist	**38.7***	62.3*	42.5*	33.6	13.7*
How often easy to see a specialist					
Never	**7.0**	6.8	6.9	7.9	†
Sometimes	**20.6**	16.5*	19.8	26.6	22.1
Usually	**34.0**	38.1	34.2	29.3	36.0
Always	**38.4**	38.6	39.1	36.1	33.5
Annual total of days received visits from paid/unpaid home health care providers					
None	**98.2***	86.8*	99.0*	96.2	99.1*
1	**0.2**	†	†	†	†
2–30	**0.8**	3.6*	0.6	1.2	†
31–90	**0.2**	†	†	†	†
91–200	**0.3***	3.4	–	†	†
More than 200	**†**	†	†	†	†

EXHIBIT 46. (continued)

Characteristics	Primary coverage source at time of most recent interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
Number of emergency room visits					
None	**87.4%***	68.3%*	89.6%*	79.1%	89.8%*
At least 1	**12.6***	31.7*	10.4*	20.9	10.2*
1	**9.4***	21.0*	8.1*	13.7	8.4*
2–3	**2.7***	8.4	2.1*	5.7	1.5*
4 or more	**0.5***	2.3	†	†	†
Had at least 1 overnight hospital stay	**5.2***	15.1*	4.5*	9.0	3.3*
Count of all prescribed medications purchased during the year, including initial purchases and refills					
None	**41.5**	12.5*	37.8	40.8	67.7*
1	**8.2**	3.1*	9.2*	6.5	6.3
2	**6.3**	†	6.8	7.4	3.8*
3–5	**10.8**	5.1*	12.0	9.8	7.1*
6–12	**14.3***	15.4*	16.6*	10.5	6.9*
13–24	**10.0**	21.1*	10.4	9.5	5.3*
More than 24	**8.9***	40.0*	7.2*	15.5	3.0*

Notes: 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 Medical Expenditure Panel Survey (MEPS). For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

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

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

– Dash indicates zero

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

EXHIBIT 46. (continued)

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

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

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

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

[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, 2025, analysis of MEPS data.

EXHIBIT 47. Measures of Access to Care among Non-Institutionalized Individuals Age 19–64 by Primary Source of Health Coverage, 2024, 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%**	**3.5%**	**68.9%**	**12.8%**	**11.7%**
Connection to the health care system (past 12 months)					
Has a usual source of care[6]	**86.3***	92.6*	89.9*	88.0	59.2*
Kind of usual place for medical care					
Doctor's office or health center	**86.0**	90.2	87.9	87.7	74.9*
Urgent care/walk-in clinic	**11.7**	6.7*	11.2	11.1	21.4*
Veterans Affairs facility	**1.4***	2.5*	0.4	†	†
Other	**0.9**	†	0.6	1.0	3.2*
Timeliness of care (past 12 months)					
Delayed because of costs	**10.5***	10.7*	8.6*	6.8	27.1*
Delayed getting dental care	**8.0***	5.9	7.5	6.3	13.5*
Delayed filling prescription to save money	**8.0***	11.4*	6.9	6.0	23.2*
Unmet need for selected types of care due to cost					
Medical care	**9.1***	9.4	6.9	7.0	25.1*
Mental health care or counseling	**7.4**	6.2	6.7	6.4	13.6*
Prescription drugs	**7.1**	13.0*	5.5*	7.3	14.8*
Problems paying or unable to pay medical bills, past 12 months	**12.3***	20.7*	10.7	10.5	21.5*
Other barriers to care in the past 12 months					
Lack of transportation prevented attendance at medical appointments, meetings, work, or other needs for daily living	**6.4***	11.5	4.1*	13.9	10.8*

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

EXHIBIT 47. (continued)

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, 2025, 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, 2023, 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%**	**3.7%**	**67.0%**	**12.1%**	**14.7%**
Access to Care					
Has usual place for medical care	**65.1**	84.6*	69.5	66.7	36.3*
Travel time to usual source of care					
Less than 15 minutes	**57.6**	54.2	57.7	61.4	58.6
15–30 minutes	**33.0**	34.0	33.8*	28.1	29.7
31–60 minutes	**7.8**	8.8	7.0	8.5	9.7
More than an hour	**1.7**	†	1.5	2.0	†
Difficulty reaching usual medical provider by phone during business hours					
Very difficult	**6.6**	10.1	6.1	7.2	6.3
Somewhat difficult	**14.7**	16.4	13.6*	17.4	17.4
Not too difficult	**32.2**	21.4*	33.1	31.7	32.2
Not at all difficult	**46.6**	52.0*	47.2	43.7	44.1
Difficulty reaching usual medical provider after hours for urgent medical needs					
Very difficult	**29.4**	33.7	27.4	32.3	34.7
Somewhat difficult	**20.5**	18.1	21.1	21.2	17.1
Not too difficult	**26.6**	22.2	28.0	24.4	22.6
Not at all difficult	**23.5**	26.0	23.5	22.1	25.5
Usual medical provider has night or weekend availability	**30.9**	22.1*	31.4	30.8	29.5
Usual medical provider speaks preferred language or provides translator, among those with limited English abilities in family	**91.2**	†	90.6*	98.9	81.3

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	**7.5%***	9.4%	5.8%*	12.7%	11.5%
Sometimes	**14.6***	18.9	13.2*	18.6	16.2
Usually	**22.3***	16.7	23.3*	18.9	22.7
Always	**55.5***	55.0	57.7*	49.7	49.5
Usual medical provider presents and explains all options	**96.7***	95.3	97.4*	94.0	96.2
Experience with care in the past 12 months					
How often provider gives easy-to-understand information					
Always	**65.6***	58.2	67.9*	55.4	62.4
Usually	**28.3**	28.5	27.5	32.0	33.3
Sometimes or never	**6.1***	13.3	4.6*	12.6	†
Provider gave instructions	**76.5**	85.4*	76.9	75.2	66.2*
How often provider listens					
Always	**50.7**	48.2	51.5	47.4	49.9
Usually	**36.7**	32.2	37.1	36.0	32.8
Sometimes or never	**12.6***	19.6	11.4*	16.6	17.3
How often provider explains information					
Always	**52.7**	51.2	53.8*	48.0	50.2
Usually	**36.7**	33.9	37.1	37.9	35.7
Sometimes or never	**10.6**	14.9	9.1*	14.1	14.1
How often provider shows respect					
Always	**58.3**	58.8	58.9	56.8	55.7
Usually	**32.1**	24.7	33.1*	28.2	30.9
Sometimes or never	**9.6***	16.5	8.1*	15.1	13.4

EXHIBIT 48. (continued)

Characteristics	Primary coverage source at time of most recent interview[1]				
	Total	Medicare	Private[2]	Medicaid or CHIP[3]	Uninsured[4]
How often provider spends enough time					
Always	**42.5%**	47.2%	42.2%	41.1%	46.9%
Usually	**40.8**	35.3	42.4	37.9	30.4
Sometimes or never	**16.7***	17.5	15.5*	21.0	22.7

Notes: Access to care variables are fielded for only a subset of Medical Expenditure Panel Survey (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 Medical Expenditure Panel Survey (MEPS). For purposes of comparing groups of individuals, the NHIS provides the most recent information available. For other purposes, such as measuring levels of use relative to a particular benchmark or goal, it may be appropriate to consult estimates from MEPS or another source.

* Difference from Medicaid 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.

Source: MACPAC, 2025, 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 statuses.[10]

However, the NHIS is known to produce higher estimates of service use than the MEPS.[11] As a result, MACStats includes estimates of service use from both sources. For purposes of comparing groups of individuals, the NHIS has the advantage of providing the most recent information available; for other purposes, such as measuring levels of service use relative to a particular benchmark or goal, consulting estimates from the MEPS or another source might be more appropriate.

The NHIS has some limitations. As in most surveys, respondents in the NHIS do not always accurately report information about participation in programs such as Medicaid, CHIP, Medicare, Supplemental Security Income, and Social Security Disability Insurance. As a result, survey data may not match estimates of program participation computed from the programs' own administrative data. In addition, although the NHIS asks about participation in Medicaid and CHIP in two different questions, program participation estimates from the survey are not reported separately. One reason for this is that many states' CHIP and Medicaid programs use the same name, so respondents may not necessarily know which program funds their children's coverage. Even when the programs have different names, it may be difficult for respondents and interviewers to correctly categorize the coverage. As a result, separate survey questions regarding participation in Medicaid and CHIP are generally used to minimize the undercounting of Medicaid and CHIP enrollees, not to produce valid estimates separately for each program. Thus, survey data analyses typically combine Medicaid and CHIP into a single category.

In previous editions of MACStats, NHIS data allowed MACPAC to use responses to several questions to

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

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

Methodology for T-MSIS Analysis

As noted above, MACStats uses T-MSIS data to create exhibits on Medicaid enrollment and spending by eligibility group. Although we used the raw T-MSIS data instead of the TAF, our process of identifying final action records is similar and should produce similar results as the TAF. We relied on the final action indicator CMS appends to claims as part of its TAF development process. Additionally, claims are organized by service date (ending date of service) to assign a claim to a particular time period, which is similar to the TAF.[13] Our tabulations of the raw T-MSIS data produced similar totals to the TAF; however, there were some differences due to a difference in how many months of claims run-out were included.

Our process of assigning enrollee characteristics is similar to prior years, relying on the most recent valid value for a particular characteristic. T-MSIS includes a new eligibility group variable that expands the number of groups reported and is more specific than the basis-of-eligibility variable reported in MSIS. As such, we developed a new algorithm to aggregate these more granular eligibility codes into our larger groupings of child, adult, disabled, and aged. In addition, we further split adults into the new adult group and other adults.[14] Furthermore, the new T-MSIS eligibility groups do not specifically separate individuals who qualify on the basis of a disability from the aged and do not separate children from adults in many categories. We included age as another identifier to assign enrollees to our larger groupings. The assignment of beneficiaries is shown in Exhibit 49.

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.

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

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

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

[2] 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, 2025, analysis of T-MSIS data.

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.

Beginning in 2025, we implemented a new method for classifying a claim as non-institutional LTSS (Exhibit 51). Building on recent MACPAC work to compare different approaches to identify home- and community-based services (HCBS) and to calculate HCBS spending and utilization, we adapted the methodology developed for CMS's LTSS Expenditures and Users Reports and KFF State Health Facts (MACPAC 2025, 2024; Stepanczuk et al. 2024; Chidambaram and Burns 2023). To identify HCBS claims, we started with the approach used in the TAF-based LTSS Expenditure and User Reports to determine whether a claim was paid for by an HCBS authority (i.e., Sections 1915(c), 1915(i), 1915(j), and 1915(k) of the Act) (Stepanczuk et al. 2024). We relied on the claim's program type, waiver type, HCBS service type, or benefit type. Because what a state reports in these four data elements can conflict, we employed a hierarchical approach tested and validated by the LTSS Expenditure and User Reports, which prioritize the program type code found on the claim, followed by the waiver type code, HCBS service code, and benefit type code. For four states without Section 1915(c) waivers—Arizona, New Jersey, Rhode Island, and Vermont—we adapted the KFF State Health Facts methodology to identify claims under their Section 1115 demonstrations (Chidambaram and Burns 2023). Furthermore, we used HCBS taxonomy to isolate these Section 1115 demonstration claims to HCBS (Rooney et al. 2023). For more information on the various methodological approaches to identifying HCBS users and expenditures, please see MACPAC's publication on *Methodological Approaches for Analyzing Use and Spending in Medicaid Long-Term Services and Supports: A Comparative Review* (MACPAC 2024).

To estimate the effect of this change in how we classify non-institutional LTSS, we compared the new method to the prior method that 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). In FY 2023, the new method identified about 5 percent less non-institutional LTSS spending nationally across both FFS and managed care claims. Approximately 98 percent of spending identified under the new method overlapped with the prior method.

With the update to the method in classifying non-institutional LTSS, we also used managed care encounter claims to identify users of non-institutional LTSS displayed in Exhibit 20, compared to the prior method that only identified users based on FFS claims. This inclusion of enrollees using non-institutional LTSS under managed care arrangements increased the overall number of LTSS users displayed in Exhibit 20 compared to prior years. However, the new method in classifying non-institutional LTSS identified approximately 27 percent fewer users across FFS and managed care than the prior method. While the new method led to a large decrease in users in several states compared to the prior method, the result is in greater alignment with other analyses such as the CMS LTSS Expenditure and User Report. Managed care encounter claims were used only to identify LTSS users; the paid amount on encounter claims is not used in any MACStats exhibits.

Due to these changes, exhibits showing spending and users of non-institutional LTSS using T-MSIS data (Exhibits 18, 19, 20) may not be directly comparable to prior editions of MACStats.

Additionally, 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 mean 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 HCBS was not a separate type of service. We still use program type, and we use a hierarchical approach involving several additional variables. 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 other amounts such as certain managed care state directed payments.[17] Although states may report DSH and other supplemental payments through T-MSIS, most states are not reporting these data consistently 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 consistently 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 2023 (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	**$793,963**	**$850,130**	**93.4%**	**$17,609**	**$12,279**
Alabama	6,466	7,668	84.3	209	–
Alaska	2,672	2,544	105.0	16	–
Arizona	20,309	21,971	92.4	166	49
Arkansas	6,436	8,620	74.7	23	–
California[2]	118,778	120,957	98.2	806	2,301
Colorado	11,848	12,715	93.2	245	–
Connecticut	10,788	10,196	105.8	230	–
Delaware	3,493	3,327	105.0	16	–
District of Columbia	4,020	4,094	98.2	63	–
Florida	29,826	32,362	92.2	356	1,923
Georgia	13,443	15,470	86.9	537	–
Hawaii[3]	2,924	2,999	97.5	44	–
Idaho	3,619	3,568	101.4	12	–
Illinois	24,920	31,839	78.3	444	–
Indiana	21,175	17,145	123.5	202	–
Iowa	6,893	6,906	99.8	18	–
Kansas	4,807	5,042	95.3	98	82
Kentucky	15,713	16,284	96.5	37	–
Louisiana	14,192	15,915	89.2	473	–
Maine	3,855	4,125	93.5	58	–
Maryland	16,271	16,804	96.8	184	–
Massachusetts	21,995	22,408	98.2	109	891
Michigan	19,344	22,698	85.2	664	–
Minnesota	18,694	18,438	101.4	70	–
Mississippi	5,616	6,183	90.8	164	–
Missouri	15,211	15,178	100.2	767	–
Montana	2,203	2,364	93.2	–	–
Nebraska	3,948	3,732	105.8	34	–
Nevada	5,064	5,583	90.7	22	–
New Hampshire	2,226	2,182	102.0	277	–
New Jersey	20,623	21,531	95.8	1,124	–
New Mexico	7,596	8,089	93.9	36	–
New York	83,328	93,959	88.7	3,904	–

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	19,589	19,017	103.0	426	–
North Dakota[2]	1,708	1,522	112.2	2	–
Ohio	27,769	31,077	89.4	777	–
Oklahoma	7,684	9,499	80.9	71	–
Oregon	10,692	14,722	72.6	77	–
Pennsylvania	43,189	42,698	101.1	1,297	–
Rhode Island	3,361	2,414	139.2	158	894
South Carolina	7,522	8,303	90.6	610	–
South Dakota	1,084	1,187	91.3	2	–
Tennessee	12,218	11,650	104.9	95	816
Texas	48,045	49,976	96.1	2,067	5,241
Utah[2]	4,161	4,555	91.3	11	–
Vermont	1,804	1,894	95.2	23	83
Virginia	21,454	21,841	98.2	-6	–
Washington	17,707	28,822	61.4	376	0
West Virginia	5,619	5,399	104.1	74	–
Wisconsin	11,399	11,930	95.6	143	–
Wyoming	664	725	91.6	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 $24.5 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 $785.6 million, North Dakota's T-MSIS spending by approximately $10.8 million, and Utah's T-MSIS spending by approximately $36.9 million.

[3] The CMS-64 total for Hawaii excludes $1.0 million in fee-for-service (FFS) drug spending because the state did not report any FFS drug spending in T-MSIS.

Sources: MACPAC, 2025, analysis of T-MSIS data as of February 2025; CMS-64 financial management report net expenditure data as of June 2024.

EXHIBIT 51. Service Categories Used to Adjust FY 2023 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	• 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

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
Non-hospital acute care (continued)	• Sterilizations • Prenatal care and prepregnancy family planning • Other pregnancy-related procedures • Hospice • Disposable medical supplies • Indian Health Service—family plan • Religious non-medical health care institutions • 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	• Health home for children with medically complex conditions • Tobacco cessation for pregnant women • 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, 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	Based on the following hierarchy: 1) Program type: • HCBS waiver • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) 2) If program type is missing waiver type: • 1915(c) waiver (values 06–20) • 1115 managed LTSS or other demonstration in Arizona, New Jersey, Rhode Island, and Vermont* 3) If program type and waiver type are missing, HCBS service code: • 1915(c) • 1915(i) • 1915(j) • 1915(k) 1115 waiver in Arizona, New Jersey, Rhode Island, and Vermont* 4) If program type, waiver type, and HCBS service code are missing, benefit type is: • Self-directed personal assistance under 1915(j) Community First Choice 1915(k) 5) If all variables above are missing, 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) * For Arizona, New Jersey, Rhode Island, and Vermont, a claim selected using waiver type or HCBS service code must also have at least one line with a procedure code mapped to a HCBS taxonomy in CMS's Data Quality Atlas methodology brief no. 7061.	• Home health • Personal care • Personal care—1915(j) • HCBS waiver • HCBS—1915(i) • HCBS—1915(j) • HCBS—1915(k) • Certified community behavior health clinic

EXHIBIT 51. (continued)

Service category	T-MSIS service types[1]	CMS-64 service types
LTSS institutional	• Nursing facility • Inpatient hospital and nursing facility services for individuals age 65 and older in an 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 • Intermediate care facility for persons with intellectual disabilities • Intermediate care facility for persons with intellectual disabilities 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).

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

[2] Emergency services for non-qualified aliens are reported under individual service types throughout T-MSIS but primarily as inpatient and outpatient hospital. As a result, we include this CMS-64 amount in the hospital category.

[3] Medicare premiums are not reported in T-MSIS. We distribute CMS-64 amounts proportionately across dually eligible enrollees identified in the T-MSIS for each state.

[4] Medicare coinsurance and deductibles are reported under individual service types throughout T-MSIS. We distribute CMS-64 amounts for QMBs across CMS-64 spending in the hospital, non-hospital acute, and LTSS institutional categories before calculating state-level adjustment factors based on the distribution of Medicare cost sharing for hospital, Part B, and skilled nursing facility services among QMBs using 2020 Medicare data. See MedPAC and MACPAC, 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.

Sources: MACPAC, 2025, analysis of T-MSIS and CMS-64 financial management report net expenditure data. Greener, E., A. Carpenter, and L. Nolan. 2023. *Identifying enrollees who use home and community-based services in the TAF* (TAF DQ brief #7061). Baltimore, MD: CMS and https://www.medicaid.gov/dq-atlas/downloads/supplemental/HCBS-In-TAF-Supplement.xlsx.

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 Report

The Medicaid Managed Care Enrollment 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 the number of enrollees ever enrolled in managed care during a fiscal year or other period of time.

Endnotes

[1] For technical guides to earlier editions of MACStats, see the MACStats archive page of the MACPAC website at 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, managed care state directed payments, and drug rebates, are lump sums that are not paid on a claim-by-claim basis for individual Medicaid enrollees. Nonetheless, we refer to these CMS-64 amounts as benefit spending, and the adjustment methodology described here distributes them across Medicaid enrollees with T-MSIS spending in the relevant service categories.

[18] The sum of adjusted T-MSIS benefit spending for all service categories is equal to CMS-64 benefit spending, exclusive of offsetting collections from third-party liability, estate, and other recoveries. These collections are not reported by type of service in the CMS-64 and are not reported at all in the T-MSIS.

[19] We generally exclude children enrolled in Medicaid-expansion CHIP from Medicaid analyses because their funding stream (Title XXI of the Act) differs from that of other Medicaid enrollees (Title XIX of the Act). In addition, spending (and often enrollment) for the Medicaid-expansion CHIP population is reported by CMS in CHIP statistics along with information on separate CHIP enrollees.

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