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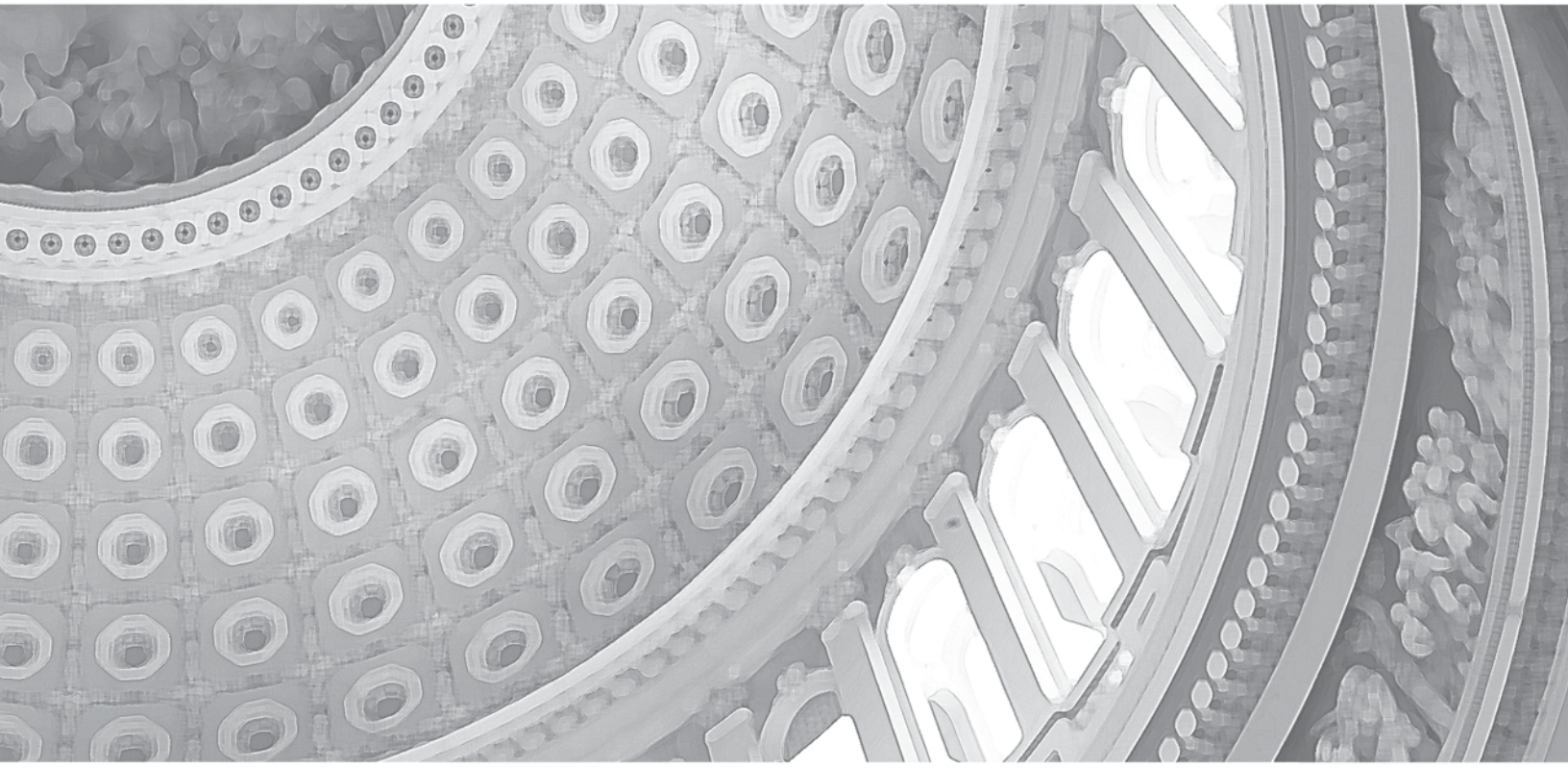
Medicaid and CHIP Payment and Access Commission



MACStats: Medicaid and CHIP Program Statistics

March 2014

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Overview

MACStats, a standing section in all Commission reports to the Congress, presents data and information on the Medicaid and CHIP programs that otherwise can be difficult to find and are spread across multiple sources. In this report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, and federal medical assistance percentages (FMAPs). It also details benefits and permissible cost sharing under Medicaid and the dollar amounts of common federal poverty levels (FPLs) used to determine eligibility for Medicaid and CHIP. In addition, it provides information that places these programs in the broader context of state budgets and national health expenditures.

New in this report are five tables presenting access to care measures for individuals with Medicaid/CHIP and other types of coverage. The measures reflect five access domains: provider availability, connection with the health care system, contact with health professionals, timeliness of care, and receipt of appropriate care.

Key points in this report include:

- Total Medicaid spending grew by about 6 percent in fiscal year (FY) 2013, reaching $460.3 billion (Table 6). Total CHIP spending grew by about 8 percent, reaching $13.2 billion (Table 8).
- The estimated number of individuals ever covered by Medicaid remained steady at 72.7 million in FY 2013, compared to 72.2 million in FY 2012 (MACPAC communication with Office of the Actuary, Centers for Medicare & Medicaid Services; includes about one million individuals in the U.S. territories). CHIP enrollment also remained steady at 8.4 million (Table 3).
- Medicaid as a share of state budgets varies depending on how it is measured (Table 15). Looking only at the state-funded portion of state budgets (that is, the portion financed from their own revenues), Medicaid's share was 14.8 percent in state fiscal year (SFY) 2012. After including federal funds in state budgets, a typical practice in other data sources, Medicaid's share was 23.7 percent in SFY 2012.
- The Medicaid and CHIP programs together accounted for 15.5 percent of national health expenditures in calendar year 2012, and their share is projected to reach 17 percent in the next decade (Tables 16 and 17).
- Medicaid and CHIP eligibility levels for most child and adult populations have been converted as of 2014 to reflect the application of uniform modified adjusted gross income (MAGI) rules across states, and half of states are covering a new group of low-income adults (Tables 9 and 10). Eligibility for individuals with disabilities and those age 65 and older was largely unchanged (Table 11).

TABLE 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2013

Medicaid and CHIP Enrollment	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	71.7 million[1]	58.1 million[1]	Not available
CHIP	8.4 million	5.8 million	Not available
Totals for Medicaid and CHIP	80.1 million[1]	63.9 million[1]	52.1 million
U.S. Population	**Census Bureau**		**Survey Data (NHIS)**
	317.1 million	316.1 million	310.2 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	25.3%	20.2%	16.8%

Notes: Excludes U.S. territories. Medicaid and CHIP enrollment numbers obtained from administrative data include individuals who received limited benefits (e.g., emergency services only). Administrative data are estimates for fiscal year (FY) 2013 (October 2012 through September 2013) from the President's budget for FY 2015. By combining administrative totals from Medicaid and CHIP, some individuals may 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. National Health Interview Survey (NHIS) data are based on interviews conducted between January and June 2013. NHIS excludes individuals in institutions, such as nursing homes, and active-duty military; in addition, surveys such as NHIS generally do not count limited benefits as Medicaid/CHIP coverage and respondents are known to underreport Medicaid and CHIP coverage. The Census Bureau number in the ever-enrolled column was the estimated U.S. resident population as of December 2013 (the month with the largest count); 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 2013.

For more detailed discussion of why Medicaid and CHIP enrollment numbers can vary, see Table 1 in MACPAC's March 2012 MACStats. As indicated here, reasons include differences in the sources of data (e.g., administrative records versus interviews), the 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 home), and the enrollment period examined (e.g., ever during the year versus at a point in time).

1 Excludes about one million individuals in the U.S. territories. All other figures in the table exclude individuals in the U.S. territories, but the number of excluded individuals is not available.

Sources: MACPAC analysis based on the following: MACPAC communication with Office of the Actuary, Centers for Medicare & Medicaid Services; National Center for Health Statistics analysis of NHIS data for MACPAC (see Table 18); CHIP Statistical Enrollment Data (SEDS) data (see Table 3); and Bureau of the Census, *Population estimates, National totals: Vintage 2013*. http://www.census.gov/popest/data/national/totals/2013/index.html.

TABLE 2. Medicaid Enrollment by State and Selected Characteristics, FY 2011 (thousands)

		Basis of Eligibility[1]				Dual Eligible Status[2]					
						All dual-eligible enrollees		Dual-eligible enrollees with full benefits		Dual-eligible enrollees with limited benefits	
State	Total	Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
Total	**67,605**	**32,038**	**19,163**	**9,952**	**6,452**	**10,179**	**6,010**	**7,552**	**4,478**	**2,627**	**1,532**
Alabama	**1,061**	539	184	221	118	**212**	117	**97**	51	**115**	66
Alaska	**135**	74	34	18	9	**15**	8	**15**	8	**0**	0
Arizona	**1,283**	571	481	139	91	**148**	86	**118**	64	**30**	22
Arkansas	**693**	357	115	151	71	**128**	68	**70**	42	**58**	27
California	**11,690**	4,563	5,049	1,043	1,034	**1,295**	909	**1,260**	882	**35**	26
Colorado	**762**	437	162	103	60	**94**	55	**69**	42	**25**	13
Connecticut	**785**	317	283	77	107	**155**	103	**83**	48	**72**	55
Delaware	**243**	97	104	26	15	**27**	14	**12**	7	**15**	8
District of Columbia	**232**	82	93	38	19	**23**	15	**16**	10	**7**	5
Florida	**3,983**	2,010	844	622	508	**739**	479	**387**	267	**352**	213
Georgia	**1,953**	1,139	309	322	183	**306**	179	**158**	93	**148**	86
Hawaii	**280**	115	111	28	26	**37**	25	**32**	22	**4**	3
Idaho	**267**	165	39	43	19	**40**	18	**27**	12	**13**	6
Illinois	**2,883**	1,515	816	323	228	**372**	209	**333**	185	**40**	24
Indiana	**1,189**	656	253	188	93	**173**	83	**107**	57	**66**	26
Iowa	**589**	275	186	84	44	**88**	44	**71**	33	**17**	11
Kansas	**416**	236	61	80	39	**72**	36	**49**	26	**23**	10
Kentucky	**937**	449	147	242	99	**195**	98	**113**	58	**82**	40
Louisiana	**1,292**	682	254	238	118	**204**	116	**113**	63	**91**	54
Maine	**435**	129	116	123	67	**104**	62	**59**	27	**45**	35
Maryland	**1,036**	487	319	149	80	**129**	72	**84**	46	**45**	26
Massachusetts	**1,519**	384	633	347	156	**259**	134	**237**	113	**22**	21
Michigan	**2,340**	1,181	637	374	147	**291**	134	**249**	113	**42**	22
Minnesota	**1,106**	460	410	137	99	**149**	79	**135**	70	**15**	9
Mississippi	**781**	406	115	170	90	**162**	90	**84**	49	**78**	41
Missouri	**1,138**	577	239	224	98	**194**	93	**168**	80	**26**	13
Montana	**135**	76	23	23	13	**25**	13	**17**	9	**8**	5
Nebraska	**254**	148	49	41	17	**37**	16	**37**	15	**0**	0
Nevada	**395**	239	76	49	31	**51**	30	**24**	16	**26**	14
New Hampshire	**171**	100	24	31	16	**35**	15	**23**	10	**12**	5

TABLE 2, Continued

State	Total	Basis of Eligibility[1]				Dual Eligible Status[2]					
						All dual-eligible enrollees		Dual-eligible enrollees with full benefits		Dual-eligible enrollees with limited benefits	
		Child	Adult	Disabled	Aged	Total	Age 65+	Total	Age 65+	Total	Age 65+
New Jersey	**1,194**	629	216	190	159	**236**	148	**206**	127	**30**	21
New Mexico	**651**	367	168	72	45	**74**	44	**41**	25	**33**	19
New York	**5,790**	2,127	2,321	697	646	**844**	571	**724**	481	**120**	90
North Carolina	**1,948**	1,007	411	341	189	**340**	185	**263**	142	**77**	43
North Dakota	**85**	45	18	12	9	**16**	9	**13**	7	**3**	2
Ohio	**2,339**	1,111	633	401	194	**374**	181	**255**	127	**120**	53
Oklahoma	**907**	492	221	126	68	**124**	65	**101**	53	**23**	12
Oregon	**729**	351	212	103	62	**109**	60	**68**	39	**40**	21
Pennsylvania	**2,529**	1,107	532	638	252	**444**	240	**367**	193	**77**	47
Rhode Island	**199**	90	43	41	26	**41**	23	**35**	19	**6**	4
South Carolina	**961**	477	232	166	87	**163**	87	**140**	74	**23**	13
South Dakota	**132**	77	23	20	13	**22**	13	**14**	8	**8**	4
Tennessee	**1,533**	795	322	270	146	**279**	144	**156**	79	**123**	65
Texas	**5,136**	3,258	717	690	470	**714**	460	**435**	289	**278**	171
Utah	**372**	218	91	45	17	**36**	16	**31**	14	**5**	2
Vermont	**201**	68	85	25	23	**37**	22	**28**	16	**8**	6
Virginia	**1,045**	566	180	186	113	**192**	107	**127**	74	**65**	32
Washington	**1,397**	787	297	212	101	**181**	98	**132**	76	**48**	22
West Virginia	**440**	208	65	124	43	**87**	43	**51**	26	**36**	17
Wisconsin	**1,274**	497	461	169	147	**227**	142	**206**	129	**21**	14
Wyoming	**89**	58	13	12	6	**12**	6	**7**	4	**4**	2

Notes: 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.

Due to the unavailability of several states' Medicaid Statistical Information System (MSIS) Annual Person Summary (APS) data for fiscal year (FY) 2011, which is the source used in prior editions of this table, MACPAC calculated enrollment from the full MSIS data files that are used to create the APS files. As a result, figures shown here are not directly comparable to earlier years. For MACPAC's analysis, Medicaid enrollees were assigned a unique national identification (ID) number using an algorithm that incorporates state-specific ID numbers and beneficiary characteristics such as date of birth and gender. The state and national enrollment counts shown here are unduplicated using this national ID.

Although state-level information is not yet available, the estimated number of individuals ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 71.2 million for FY 2012 and 71.7 million for FY 2013. These FY 2012–FY 2013 figures exclude about 1 million enrollees in the territories (MACPAC communication with CMS Office of the Actuary, March 2014).

1 Children and adults under age 65 who qualify for Medicaid on the basis of a disability are included in the disabled category. About 706,000 enrollees age 65 and older are identified in the data as disabled; given that disability is not an eligibility pathway for individuals age 65 and older, MACPAC recodes these enrollees as aged.

2 Dual-eligible enrollees are covered by both Medicaid and Medicare; those with limited benefits only receive Medicaid assistance with Medicare premiums and cost sharing.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) data as of February 2014.

TABLE 3. CHIP Enrollment by State, FY 2013

State	Program Type[1] (as of January 1, 2014)	Children			Adults			Total CHIP Enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Parents	Pregnant women	Total adults enrolled	
Total	–	**2,481,333**	**5,649,460**	**8,130,793**	**209,324**	**10,149**	**219,473**	**8,350,266**
Alabama	Separate	–	113,490	**113,490**	–	–	–	**113,490**
Alaska	Medicaid Expansion	16,566	–	**16,566**	–	–	–	**16,566**
Arizona	Separate	–	80,238	**80,238**	–	–	–	**80,238**
Arkansas	Combination	106,413	2,888	**109,301**	10,425	–	**10,425**	**119,726**
California	Combination	510,424	1,092,859	**1,603,283**	–	–	–	**1,603,283**
Colorado[2, 3]	Combination	–	126,169	**126,169**	–	4,873	**4,873**	**131,042**
Connecticut	Separate	–	18,999	**18,999**	–	–	–	**18,999**
Delaware	Combination	79	13,101	**13,180**	–	–	–	**13,180**
District of Columbia	Medicaid Expansion	9,057	–	**9,057**	–	–	–	**9,057**
Florida	Combination	1,072	472,343	**473,415**	–	–	–	**473,415**
Georgia	Separate	–	269,906	**269,906**	–	–	–	**269,906**
Hawaii	Medicaid Expansion	30,979	–	**30,979**	–	–	–	**30,979**
Idaho[4]	Combination	19,881	25,518	**45,399**	392	–	**392**	**45,791**
Illinois	Combination	162,134	174,963	**337,097**	–	–	–	**337,097**
Indiana	Combination	105,655	46,760	**152,415**	–	–	–	**152,415**
Iowa	Combination	22,159	61,511	**83,670**	–	–	–	**83,670**
Kansas	Separate	–	76,164	**76,164**	–	–	–	**76,164**
Kentucky	Combination	51,391	32,678	**84,069**	–	–	–	**84,069**
Louisiana	Combination	140,876	9,092	**149,968**	–	–	–	**149,968**
Maine	Combination	19,071	10,641	**29,712**	–	–	–	**29,712**
Maryland	Medicaid Expansion	135,454	–	**135,454**	–	–	–	**135,454**
Massachusetts	Combination	69,113	79,606	**148,719**	–	–	–	**148,719**
Michigan	Combination	19,229	70,441	**89,670**	–	–	–	**89,670**
Minnesota	Combination	91	3,744	**3,835**	–	–	–	**3,835**
Mississippi	Separate	–	93,120	**93,120**	–	–	–	**93,120**
Missouri	Combination	55,017	37,901	**92,918**	–	–	–	**92,918**
Montana[3]	Combination	–	31,496	**31,496**	–	–	–	**31,496**
Nebraska	Combination	53,790	1,993	**55,783**	–	–	–	**55,783**
Nevada[3]	Combination	–	20,277	**20,277**	–	–	–	**20,277**
New Hampshire	Medicaid Expansion	19,450	–	**19,450**	–	–	–	**19,450**

TABLE 3, Continued

State	Program Type[1] (as of January 1, 2014)	Children			Adults			Total CHIP Enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Parents	Pregnant women	Total adults enrolled	
New Jersey	Combination	90,512	116,249	**206,761**	183,717	291	**184,008**	**390,769**
New Mexico	Medicaid Expansion	9,368	–	**9,368**	14,790	–	**14,790**	**24,158**
New York[3]	Combination	–	490,114	**490,114**	–	–	–	**490,114**
North Carolina	Combination	81,656	201,916	**283,572**	–	–	–	**283,572**
North Dakota	Combination	2,331	8,950	**11,281**	–	–	–	**11,281**
Ohio	Medicaid Expansion	286,817	–	**286,817**	–	–	–	**286,817**
Oklahoma	Combination	140,373	7,538	**147,911**	–	–	–	**147,911**
Oregon	Separate	–	128,061	**128,061**	–	–	–	**128,061**
Pennsylvania	Separate	–	267,073	**267,073**	–	–	–	**267,073**
Rhode Island	Combination	24,508	2,069	**26,577**	–	349	**349**	**26,926**
South Carolina	Medicaid Expansion	76,191	–	**76,191**	–	–	–	**76,191**
South Dakota	Combination	13,357	4,275	**17,632**	–	–	–	**17,632**
Tennessee	Combination	22,906	83,567	**106,473**	–	–	–	**106,473**
Texas	Separate	–	1,034,613	**1,034,613**	–	–	–	**1,034,613**
Utah	Separate	–	63,001	**63,001**	–	–	–	**63,001**
Vermont	Separate	–	7,393	**7,393**	–	–	–	**7,393**
Virginia	Combination	92,690	104,221	**196,911**	–	4,636	**4,636**	**201,547**
Washington	Separate	–	44,073	**44,073**	–	–	–	**44,073**
West Virginia	Separate	–	37,065	**37,065**	–	–	–	**37,065**
Wisconsin	Combination	92,723	74,569	**167,292**	–	–	–	**167,292**
Wyoming	Separate	–	8,815	**8,815**	–	–	–	**8,815**

Notes: Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but a separate CHIP program for the second half), the individual would only be counted in the most recent category. CHIP-funded coverage of childless adults was prohibited after December 31, 2009. New Jersey and Rhode Island cover targeted low-income pregnant women under a CHIP state plan option; all other CHIP-funded coverage of adults shown in the table was permitted through waivers. Data shown in the table are as of March 4, 2014; states may subsequently revise their current or historical data.

1 Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches. In 2014, all states are eligible to receive CHIP funding for at least some Medicaid-enrolled children due to a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid, and a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid eligibility levels by 5 percentage points. See Table 9 for more information.

2 Colorado data are from fiscal year (FY) 2012.

3 Montana, Nevada, and New York were combination programs in FY 2013 but did not report any Medicaid-expansion enrollees in the CHIP Statistical Enrollment Data System (SEDS). Colorado became a combination program in FY 2013 but had not yet reported any SEDS data for that year as of March 4, 2014; as a result, FY 2012 data shown here do not include Medicaid-expansion enrollees.

4 Data on adults are from FY 2012 for Idaho.

Sources: For numbers of children: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) from Centers for Medicare & Medicaid Services (CMS) as of March 4, 2014; for numbers of adults: CMS analysis for MACPAC of SEDS as of February 28, 2014, as reported by states; for CHIP program type: MACPAC analysis of CHIP state plan amendments on the CMS website and CMS, *Children's Health Insurance Program: Plan activity as of January 1, 2014.*

TABLE 4. Child Enrollment in Medicaid-Financed Coverage by State, and CHIP-Financed Coverage by State and Family Income, FY 2013

State	Medicaid-Financed Children[1]	CHIP-Financed Children (Medicaid-expansion and Separate CHIP Coverage)						
		At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		
	All incomes	Number	Percentage	Number	Percentage	Number	Percentage	All incomes
Total	**38,731,044**	**7,223,757**	**88.8%**	**697,169**	**8.6%**	**209,867**	**2.6%**	**8,130,793**
Alabama	**616,718**	91,633	80.7	15,453	13.6	6,404	5.6	**113,490**
Alaska	**86,926**	16,566	100.0	–	–	–	–	**16,566**
Arizona	**913,271**	80,238	100.0	–	–	–	–	**80,238**
Arkansas	**513,534**	109,301	100.0	–	–	–	–	**109,301**
California	**5,318,080**	1,369,661	85.4	223,271	13.9	10,351	0.6	**1,603,283**
Colorado[2]	**484,882**	103,468	82.0	22,701	18.0	–	–	**126,169**
Connecticut	**325,414**	3,577	18.8	9,646	50.8	5,776	30.4	**18,999**
Delaware[3]	**96,916**	13,180	100.0	–	–	–	–	**13,180**
District of Columbia	**91,712**	–	–	9,057	100.0	–	–	**9,057**
Florida	**2,119,324**	473,415	100.0	–	–	–	–	**473,415**
Georgia	**1,162,529**	233,303	86.4	36,603	13.6	–	–	**269,906**
Hawaii	**138,258**	26,375	85.1	3,426	11.1	1,178	3.8	**30,979**
Idaho	**211,607**	45,399	100.0	–	–	–	–	**45,399**
Illinois	**2,352,202**	337,097	100.0	–	–	–	–	**337,097**
Indiana	**701,804**	138,324	90.8	14,091	9.2	–	–	**152,415**
Iowa	**318,377**	69,836	83.5	1,752	2.1	12,082	14.4	**83,670**
Kansas[3]	**237,026**	69,691	91.5	6,473	8.5	–	–	**76,164**
Kentucky	**485,286**	84,069	100.0	–	–	–	–	**84,069**
Louisiana	**670,729**	145,012	96.7	4,956	3.3	–	–	**149,968**
Maine	**175,128**	29,712	100.0	–	–	–	–	**29,712**
Maryland	**490,009**	39,279	29.0	90,793	67.0	5,382	4.0	**135,454**
Massachusetts	**544,851**	117,462	79.0	19,798	13.3	11,459	7.7	**148,719**
Michigan	**1,195,649**	89,670	100.0	–	–	–	–	**89,670**
Minnesota	**505,264**	3,663	95.5	70	1.8	102	2.7	**3,835**
Mississippi	**467,918**	93,120	100.0	–	–	–	–	**93,120**
Missouri	**559,265**	79,904	86.0	9,068	9.8	3,946	4.2	**92,918**
Montana	**83,447**	31,496	100.0	–	–	–	–	**31,496**
Nebraska	**165,038**	55,783	100.0	–	–	–	–	**55,783**
Nevada[3]	**256,109**	20,277	100.0	–	–	–	–	**20,277**

TABLE 4, Continued

State	Medicaid-Financed Children[1]	CHIP-Financed Children (Medicaid-expansion and Separate CHIP Coverage)						
		At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		
	All incomes	Number	Percentage	Number	Percentage	Number	Percentage	All incomes
New Hampshire	**85,562**	7,339	37.7%	7,511	38.6%	4,600	23.7%	**19,450**
New Jersey	**662,198**	157,727	76.3	27,636	13.4	21,398	10.3	**206,761**
New Mexico	**380,290**	4,308	46.0	5,060	54.0	–	–	**9,368**
New York	**2,309,571**	289,919	59.2	104,921	21.4	95,274	19.4	**490,114**
North Carolina[3]	**2,517,188**	283,572	100.0	–	–	–	–	**283,572**
North Dakota	**50,957**	11,281	100.0	–	–	–	–	**11,281**
Ohio	**1,483,176**	286,817	100.0	–	–	–	–	**286,817**
Oklahoma[3]	**558,262**	147,911	100.0	–	–	–	–	**147,911**
Oregon	**401,721**	112,675	88.0	10,556	8.2	4,830	3.8	**128,061**
Pennsylvania	**1,309,862**	225,995	84.6	29,068	10.9	12,010	4.5	**267,073**
Rhode Island	**112,002**	23,304	87.7	3,273	12.3	–	–	**26,577**
South Carolina[3]	**582,293**	76,191	100.0	–	–	–	–	**76,191**
South Dakota[3]	**46,948**	17,632	100.0	–	–	–	–	**17,632**
Tennessee	**790,923**	92,276	86.7	14,197	13.3	–	–	**106,473**
Texas[4]	**3,518,832**	1,034,613	100.0	–	–	–	–	**1,034,613**
Utah	**283,213**	63,001	100.0	–	–	–	–	**63,001**
Vermont	**72,512**	–	–	3,726	50.4	3,667	49.6	**7,393**
Virginia	**648,173**	196,911	100.0	–	–	–	–	**196,911**
Washington	**768,387**	11,934	27.1	20,731	47.0	11,408	25.9	**44,073**
West Virginia	**260,326**	33,924	91.5	3,141	8.5	–	–	**37,065**
Wisconsin	**542,731**	167,101	99.9	191	0.1	–	–	**167,292**
Wyoming	**58,644**	8,815	100.0	–	–	–	–	**8,815**

Notes: Enrollment numbers generally include children ever enrolled during the year, even if for a single month; however, in the event children were in multiple categories during the year (for example, in Medicaid for the first half of the year but in a separate CHIP program for the second half), the child would only be counted in the most recent category. The definition in this table for Medicaid-financed children may differ from that used elsewhere in this report. This table includes children with and without disabilities; in tables using Medicaid eligibility categories, children qualifying on the basis of a disability are counted in the disabled category, not the child category. In 2014, 200 percent of the federal poverty level (FPL) is $23,340 for an individual and $8,120 for each additional family member in the lower 48 states and the District of Columbia. For additional information, see MACStats Table 19. Data shown in the table are as of March 4, 2014; states may subsequently revise their current or historical data.

1 MACPAC analysis of Statistical Enrollment Data System (SEDS), as reported by states, found that 99.4 percent of Medicaid-financed children were at or below 200 percent FPL.

2 Colorado data are from fiscal year (FY) 2012.

3 In SEDS, Delaware, Nevada, North Carolina, Oklahoma, South Carolina, and South Dakota reported CHIP enrollees above 200 percent FPL, and Kansas reported CHIP enrollees above 250 percent FPL; however, their CHIP programs are reported to only cover individuals at or below these levels. The numbers here were altered to put all of these enrollees at or below 200 (250 in the case of Kansas) percent FPL.

4 Data on Medicaid-financed children are from FY 2012 for Texas.

Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from CMS as of March 4, 2014.

TABLE 5. Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2013

State	Total[1]	Managed Care		Fee for Service		Primary Care Case Management	
		Number	Percentage	Number	Percentage	Number	Percentage
Total	**5,649,460**	**4,528,414**	**80.2%**	**919,723**	**16.3%**	**201,323**	**3.6%**
Alabama	**113,490**	–	–	113,490	100.0	–	–
Alaska	–	–	–	–	–	–	–
Arizona	**80,238**	75,609	94.2	4,629	5.8	–	–
Arkansas	**2,888**	–	–	2,888	100.0	–	–
California	**1,092,859**	977,885	89.5	114,974	10.5	–	–
Colorado[2]	**126,169**	126,169	100.0	–	–	–	–
Connecticut	**18,999**	–	–	18,999	100.0	–	–
Delaware	**13,101**	12,940	98.8	–	–	161	1.2
District of Columbia	–	–	–	–	–	–	–
Florida	**472,343**	459,381	97.3	5,414	1.1	7,548	1.6
Georgia	**269,906**	255,890	94.8	14,016	5.2	–	–
Hawaii	–	–	–	–	–	–	–
Idaho	**25,518**	–	–	–	–	25,518	100.0
Illinois	**174,963**	6,156	3.5	46,265	26.4	122,542	70.0
Indiana	**46,760**	41,212	88.1	5,548	11.9	–	–
Iowa	**61,511**	61,511	100.0	–	–	–	–
Kansas	**76,164**	76,118	99.9	46	0.1	–	–
Kentucky	**32,678**	32,558	99.6	120	0.4	–	–
Louisiana	**9,092**	1,590	17.5	4,797	52.8	2,705	29.8
Maine	**10,641**	–	–	3,277	30.8	7,364	69.2
Maryland	–	–	–	–	–	–	–
Massachusetts	**79,606**	29,255	36.7	29,053	36.5	21,298	26.8
Michigan	**70,441**	62,895	89.3	7,546	10.7	–	–
Minnesota	**3,744**	3,138	83.8	606	16.2	–	–
Mississippi	**93,120**	93,120	100.0	–	–	–	–
Missouri	**37,901**	14,914	39.3	22,987	60.7	–	–
Montana	**31,496**	–	–	31,496	100.0	–	–
Nebraska	**1993**	–	–	1,993	100.0	–	–

TABLE 5, Continued

State	Total[1]	Managed Care		Fee for Service		Primary Care Case Management	
		Number	Percentage	Number	Percentage	Number	Percentage
Nevada	**20,277**	17,716	87.4%	2,561	12.6%	–	–
New Hampshire	–	–	–	–	–	–	–
New Jersey	**116,249**	113,437	97.6	2,812	2.4	–	–
New Mexico	–	–	–	–	–	–	–
New York	**490,114**	489,456	99.9	658	0.1	–	–
North Carolina	**201,916**	–	–	201,916	100.0	–	–
North Dakota	**8,950**	4,754	53.1	–	–	4,196	46.9%
Ohio	–	–	–	–	–	–	–
Oklahoma	**7,538**	190	2.5	7,348	97.5	–	–
Oregon	**128,061**	14,950	11.7	113,101	88.3	10	0.0
Pennsylvania	**267,073**	267,073	100.0	–	–	–	–
Rhode Island	**2,069**	2,069	100.0	–	–	–	–
South Carolina	–	–	–	–	–	–	–
South Dakota	**4,275**	–	–	1,477	34.5	2,798	65.5
Tennessee	**83,567**	–	–	83,567	100.0	–	–
Texas	**1,034,613**	1,034,613	100.0	–	–	–	–
Utah	**63,001**	63,001	100.0	–	–	–	–
Vermont	**7,393**	–	–	411	5.6	6,982	94.4
Virginia	**104,221**	92,284	88.5	11,937	11.5	–	–
Washington	**44,073**	28,352	64.3	15,520	35.2	201	0.5
West Virginia	**37,065**	–	–	37,065	100.0	–	–
Wisconsin	**74,569**	61,363	82.3	13,206	17.7	–	–
Wyoming	**8,815**	8,815	100.0	–	–	–	–

Notes: Enrollment numbers generally include children ever enrolled during the year, even if for a single month; however, in the event children were in multiple categories during the year (for example, in Medicaid for the first half of the year but in a separate CHIP program for the second half), the child would only be counted in the most recent category. Categorizations of the types of delivery system are based on states' definitions and Statistical Enrollment Data System (SEDS) instructions to states. According to SEDS instructions, managed care includes arrangements under which the state contracts with a health maintenance or health insuring organization to provide a comprehensive set of services; enrollees choose a plan and a primary care provider (PCP) who will be responsible for managing their care. Under fee for service, providers submit claims to the state and are paid a specific amount for each service performed. Under primary care case management, providers are paid generally on a fee-for-service basis, but PCPs are paid an additional flat monthly fee for each patient assigned to them for case management. Data shown in the table are as of March 4, 2014; states may subsequently revise their current or historical data.

1 Because this table shows enrollment only in separate CHIP programs, these totals do not include child enrollment in Medicaid-expansion CHIP programs.

2 Colorado data are from fiscal year (FY) 2012.

Source: MACPAC analysis of CHIP Statistical Enrollment Data System (SEDS) data from CMS as of March 4, 2014.

TABLE 6. Medicaid Spending by State, Category, and Source of Funds, FY 2013 (millions)

State	Benefits			State Program Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**$5,000**	$3,454	$1,546	**$217**	$139	$78	**$5,216**	$3,592	$1,624
Alaska	**1,341**	776	565	**105**	73	33	**1,446**	849	598
Arizona	**8,437**	5,727	2,710	**233**	159	74	**8,670**	5,886	2,784
Arkansas	**4,156**	2,937	1,220	**272**	171	101	**4,428**	3,108	1,320
California	**61,426**	31,501	29,925	**4,631**	2,614	2,017	**66,057**	34,115	31,942
Colorado	**5,048**	2,536	2,512	**267**	167	99	**5,315**	2,703	2,612
Connecticut	**6,415**	3,243	3,172	**308**	177	131	**6,723**	3,420	3,303
Delaware	**1,558**	867	690	**98**	71	27	**1,655**	938	717
District of Columbia	**2,276**	1,592	684	**121**	70	52	**2,397**	1,661	736
Florida	**18,411**	10,742	7,670	**820**	514	306	**19,231**	11,255	7,976
Georgia	**8,888**	5,889	2,999	**471**	307	164	**9,359**	6,196	3,163
Hawaii	**1,586**	825	761	**110**	81	29	**1,697**	907	790
Idaho	**1,642**	1,167	475	**120**	94	25	**1,762**	1,262	500
Illinois	**15,494**	7,834	7,660	**1,039**	658	382	**16,533**	8,492	8,041
Indiana	**7,931**	5,349	2,582	**437**	272	165	**8,367**	5,620	2,747
Iowa	**3,623**	2,186	1,436	**183**	131	52	**3,806**	2,317	1,489
Kansas	**2,545**	1,443	1,102	**176**	114	61	**2,721**	1,557	1,163
Kentucky	**5,726**	4,047	1,680	**209**	148	61	**5,935**	4,195	1,740
Louisiana	**6,889**	4,514	2,375	**293**	188	105	**7,181**	4,701	2,480
Maine	**2,827**	1,778	1,049	**132**	92	41	**2,959**	1,870	1,089
Maryland	**7,688**	3,900	3,788	**365**	224	141	**8,053**	4,124	3,929
Massachusetts	**12,999**	6,520	6,479	**687**	418	270	**13,687**	6,937	6,749
Michigan	**12,308**	8,180	4,129	**662**	413	250	**12,971**	8,593	4,378
Minnesota	**8,781**	4,440	4,342	**563**	327	236	**9,344**	4,766	4,577
Mississippi	**4,709**	3,484	1,224	**171**	121	50	**4,879**	3,605	1,274
Missouri	**8,863**	5,504	3,359	**347**	220	127	**9,210**	5,724	3,486
Montana	**997**	671	325	**78**	53	25	**1,075**	725	350
Nebraska	**1,790**	1,000	790	**116**	79	37	**1,906**	1,079	827
Nevada	**1,797**	1,083	714	**121**	82	39	**1,919**	1,165	754
New Hampshire	**1,189**	603	585	**103**	70	34	**1,292**	673	619
New Jersey	**10,481**	5,259	5,222	**663**	381	282	**11,144**	5,639	5,505
New Mexico	**3,281**	2,303	978	**189**	134	55	**3,470**	2,437	1,033
New York	**52,490**	26,473	26,017	**1,703**	1,037	667	**54,193**	27,510	26,683
North Carolina	**11,722**	7,719	4,003	**741**	493	248	**12,463**	8,212	4,251
North Dakota	**775**	411	365	**61**	41	21	**836**	451	385
Ohio	**16,628**	10,615	6,014	**609**	394	214	**17,237**	11,009	6,228

TABLE 6, Continued

State	Benefits			State Program Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Oklahoma	**$4,482**	$2,916	$1,566	**$270**	$177	$94	**$4,752**	$3,092	$1,660
Oregon	**5,071**	3,185	1,886	**530**	308	221	**5,600**	3,493	2,107
Pennsylvania	**20,922**	11,375	9,548	**777**	476	301	**21,699**	11,850	9,849
Rhode Island	**1,909**	988	921	**109**	73	37	**2,018**	1,061	958
South Carolina	**4,690**	3,317	1,373	**232**	157	75	**4,922**	3,473	1,448
South Dakota	**758**	459	299	**62**	40	22	**820**	499	321
Tennessee	**8,678**	5,784	2,894	**344**	220	124	**9,022**	6,005	3,018
Texas	**27,752**	16,596	11,156	**1,334**	832	502	**29,086**	17,428	11,658
Utah	**2,087**	1,454	633	**142**	92	51	**2,229**	1,546	684
Vermont	**1,452**	816	636	**35**	30	5	**1,487**	846	641
Virginia	**7,218**	3,654	3,565	**387**	257	130	**7,605**	3,911	3,694
Washington	**7,806**	3,915	3,891	**602**	357	244	**8,407**	4,272	4,135
West Virginia	**3,007**	2,169	838	**174**	120	54	**3,181**	2,289	892
Wisconsin	**7,035**	4,222	2,812	**356**	233	123	**7,391**	4,456	2,935
Wyoming	**547**	279	267	**48**	33	15	**595**	312	283
Subtotal (States)	**$431,130**	**$247,698**	**$183,432**	**$22,821**	**$14,128**	**$8,693**	**$453,952**	**$261,826**	**$192,126**
American Samoa	**25**	**14**	11	**1**	**1**	0	**26**	**14**	**11**
Guam	**60**	**33**	27	**3**	**2**	1	**63**	**35**	**28**
Northern Mariana Islands	**31**	**18**	14	**2**	**2**	0	**34**	**20**	**14**
Puerto Rico	**1,837**	**1,011**	827	**107**	**81**	26	**1,944**	**1,091**	**853**
Virgin Islands	**25**	**14**	11	**4**	**2**	1	**29**	**16**	**13**
Subtotal (States & Territories)	**$433,110**	**$248,788**	**$184,322**	**$22,938**	**$14,216**	**$8,722**	**$456,048**	**$263,003**	**$193,045**
State Medicaid Fraud Control Units (MFCUs)	–	–	–	**296**	**222**	74	**296**	**222**	**74**
Medicaid survey and certification of nursing and intermediate care facilities	–	–	–	**307**	**230**	77	**307**	**230**	**77**
Vaccines for Children (VFC) program	–	–	–	–	–	–	**3,607**	**3,607**	**-**
Total	**$433,110**	**$248,788**	**$184,322**	**$23,541**	**$14,668**	**$8,873**	**$460,258**[1]	**$267,063**[1]	**$193,196**

Notes: Total federal spending shown here ($267.063 billion) will differ from total federal outlays shown in fiscal year (FY) 2013 budget documents due to slight differences in the timing of data for the states and the treatment of certain adjustments. Benefits and Administration columns do not sum to Total Medicaid due to the inclusion of VFC in Total Medicaid. Federal spending in the territories is capped; however, they 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 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. VFC 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. All states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 12, 2014. Figures presented in this table may change if states revise their expenditure data after this date. Zeroes indicate amounts less than $0.5 million that round to zero. Dashes indicate amounts that are true zeroes.

1 Amount exceeds the sum of Benefits and State Program Administration columns due to the inclusion of VFC.

Sources: For state and territory spending: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014; for all other (MFCUs, survey and certification, VFC): Centers for Medicare & Medicaid Services (CMS), Fiscal year 2014 justification of estimates for Appropriations Committees, Baltimore, MD, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf.

TABLE 7. Total Medicaid Benefit Spending by State and Category, FY 2013 (millions)

State	Total	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	**$5,000**	$1,891	$360	$85	$42	$84	$481	$294	$972	$460	$116	$253	-$39
Alaska	**1,341**	303	106	62	20	185	99	25	160	373	0	23	-16
Arizona	**8,437**	1,467	32	4	5	122	257	5	68	6	6,301	171	-0
Arkansas	**4,156**	990	298	73	19	113	798	159	965	478	19	296	-50
California	**61,426**	16,291	827	402	93	2,720	7,634	740	5,885	8,881	16,162	2,269	-478
Colorado	**5,048**	1,713	358	122	–	131	313	166	695	872	624	100	-44
Connecticut	**6,415**	1,721	314	155	101	241	432	306	1,738	1,351	2	364	-310
Delaware	**1,558**	51	12	33	1	40	64	60	38	101	1,130	34	-5
District of Columbia	**2,276**	359	46	29	2	142	122	61	327	462	702	36	-13
Florida	**18,411**	5,104	1,231	257	40	223	1,585	565	3,299	1,522	3,412	1,324	-150
Georgia	**8,888**	2,199	375	44	35	9	766	239	1,420	907	2,642	324	-73
Hawaii	**1,586**	118	1	20	0	25	4	-0	9	108	1,288	58	-44
Idaho	**1,642**	506	79	0	11	160	215	56	290	266	48	42	-30
Illinois	**15,494**	6,498	813	178	108	323	1,366	374	2,972	1,675	964	388	-165
Indiana	**7,931**	1,858	277	170	10	353	267	349	1,996	935	1,589	163	-37
Iowa	**3,623**	793	196	58	21	71	347	105	910	760	305	142	-86
Kansas	**2,545**	328	47	12	3	13	79	-17	243	422	1,366	83	-33
Kentucky	**5,726**	457	49	2	3	106	314	32	1,055	618	2,970	215	-96
Louisiana	**6,889**	2,202	317	112	–	106	357	182	1,453	843	1,311	265	-258
Maine	**2,827**	997	103	29	49	255	282	57	439	435	5	236	-60
Maryland	**7,688**	993	93	121	18	50	793	132	1,322	1,044	2,965	249	-93
Massachusetts	**12,999**	2,120	337	192	19	322	1,949	241	1,749	2,077	3,741	419	-167
Michigan	**12,308**	1,722	278	81	8	207	167	263	1,798	962	6,491	411	-78
Minnesota	**8,781**	603	177	29	182	39	491	103	998	2,194	3,925	177	-138
Mississippi	**4,709**	1,660	216	6	25	88	386	125	1,123	296	607	204	-28
Missouri	**8,863**	2,981	38	15	11	487	837	655	1,319	1,174	1,116	318	-88
Montana	**997**	268	50	25	16	15	184	31	191	185	7	34	-10
Nebraska	**1,790**	216	38	34	5	72	78	73	434	341	436	107	-43
Nevada	**1,797**	539	98	28	13	17	194	55	254	163	353	110	-26
New Hampshire	**1,189**	156	56	20	12	36	252	33	332	276	0	30	-14
New Jersey	**10,481**	1,740	46	11	3	179	598	66	2,961	1,056	3,616	331	-125
New Mexico	**3,281**	366	51	13	41	35	48	-94	31	325	2,399	80	-14
New York	**52,490**	8,760	346	114	240	1,419	3,199	-1,281	10,670	8,626	21,032	1,296	-1,931
North Carolina	**11,722**	3,461	896	305	86	221	1,227	739	1,660	948	1,948	425	-193
North Dakota	**775**	139	51	11	8	10	41	23	312	173	5	11	-9
Ohio	**16,628**	2,494	339	53	27	54	748	183	3,875	2,317	6,333	381	-175

TABLE 7, Continued

State	Total	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			
Oklahoma	**$4,482**	$1,544	$479	$123	$38	$389	$345	$297	$746	$511	$192	$133	-$314
Oregon	**5,071**	348	24	1	23	57	534	66	354	1,159	2,396	148	-40
Pennsylvania	**20,922**	1,726	151	43	4	111	261	-37	4,850	3,217	10,198	567	-169
Rhode Island	**1,909**	351	11	10	1	23	572	1	346	2	564	40	-11
South Carolina	**4,690**	1,156	214	88	26	202	288	74	774	470	1,441	173	-216
South Dakota	**758**	188	62	14	2	90	53	27	167	133	2	28	-8
Tennessee	**8,678**	1,171	27	166	1	42	217	290	284	700	5,478	340	-39
Texas	**27,752**	4,918	1,130	93	240	35	2,855	283	3,565	2,149	12,044	1,025	-587
Utah	**2,087**	458	99	42	3	12	113	46	247	224	848	37	-43
Vermont	**1,452**	44	2	0	0	1	1,361	-67	116	8	3	7	-21
Virginia	**7,218**	1,011	178	139	35	52	980	27	1,292	1,229	2,118	228	-73
Washington	**7,806**	1,033	101	134	38	447	800	40	883	1,553	2,823	319	-366
West Virginia	**3,007**	588	147	56	14	31	242	103	716	572	440	115	-17
Wisconsin	**7,035**	743	57	45	24	296	604	321	1,042	799	2,921	253	-71
Wyoming	**547**	123	48	13	18	28	27	19	135	130	0	13	-8
Subtotal	**$431,130**	**$89,465**	**$11,676**	**$3,872**	**$1,743**	**$10,490**	**$36,229**	**$6,599**	**$69,478**	**$56,488**	**$137,398**	**$14,795**	**-$7,103**
American Samoa	**25**	51	–	–	–	–	-26	1	–	–	–	–	–
Guam	**60**	14	6	1	0	0	23	13	1	0	–	1	–
N. Mariana Islands	**31**	12	–	2	–	6	6	3	–	1	–	0	–
Puerto Rico	**1,837**	–	–	–	–	–	40	–	–	–	1,798	–	–
Virgin Islands	**25**	12	2	0	–	5	1	3	2	–	–	0	–
Total	**$433,110**	**$89,555**	**$11,684**	**$3,875**	**$1,743**	**$10,501**	**$36,273**	**$6,618**	**$69,481**	**$56,489**	**$139,196**	**$14,797**	**-$7,103**
Percent of Total, Exclusive of Collections	–	**20.3%**	**2.7%**	**0.9%**	**0.4%**	**2.4%**	**8.2%**	**1.5%**	**15.8%**	**12.8%**	**31.6%**	**3.4%**	–

Notes: Includes federal and state funds. Service category definitions and spending amounts shown here may differ from other Centers for Medicare & Medicaid Services(CMS) data sources, such as the Medicaid Statistical Information System (MSIS). The specific services included in each category have changed over time and therefore may not be directly comparable to earlier editions of MACStats. LTSS is long-term services and supports. Hospital includes inpatient, outpatient, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments. Physician includes physician and surgical services, both regular payments and those associated with the primary care physician payment increase. Other practitioner includes nurse midwife, nurse practitioner, and other. Clinic and health center includes non-hospital outpatient clinic, rural health clinic, federally qualified health center, and freestanding birth center. Other acute includes lab/X-ray; sterilizations; abortions; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; preventive services with U.S. Preventive Services Task Force (USPSTF) Grade A or B 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; and other care not otherwise categorized. Drugs are net of rebates. Institutional LTSS includes nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility. Home and community-based services includes home health, waiver and state plan services, and personal care. Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management (PCCM), employer-sponsored premium assistance programs, and Programs of All-inclusive Care for the Elderly (PACE); comprehensive plans account for about 90 percent of spending in the managed care category. Managed care also includes rebates for drugs provided by managed care plans and managed care payments associated with the primary care physician payment increase, Community First Choice option, and preventive services with USPSTF Grade A or B and ACIP vaccines. Collections includes third-party liability, estate, and other recoveries. All states had certified their CMS-64 Financial Management Report (FMR) submissions as of February 12, 2014. Figures presented in this table may change if states revise their expenditure data after this date. Zeroes indicate amounts less than $0.5 million that round to zero. Dashes indicate amounts that are true zeroes.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

TABLE 8. CHIP Spending by State, FY 2013 (millions)

State	Total CHIP[1]			Benefits						State Program Administration			2105(g) Spending[1]
				Medicaid-expansion CHIP programs			Separate CHIP programs and adult coverage waivers						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
Alabama	**$193.4**	$150.8	$42.6	–	–	–	**$186.5**	$145.4	$41.1	**$6.9**	$5.4	$1.5	–
Alaska	**32.8**	21.3	11.5	**$31.5**	$20.5	$11.0	–	–	–	**1.3**	0.8	0.4	–
Arizona	**73.9**	56.1	17.7	–	–	–	**70.6**	53.7	17.0	**3.3**	2.5	0.8	–
Arkansas	**122.8**	95.4	27.4	**91.1**	72.1	19.0	**26.0**	19.1	6.9	**5.6**	4.1	1.5	–
California	**2,126.8**	1,382.4	744.4	**1,046.9**	680.5	366.4	**985.4**	640.6	344.9	**94.4**	61.4	33.0	–
Colorado	**227.3**	147.7	79.5	**12.1**	7.9	4.2	**205.8**	133.8	72.0	**9.4**	6.1	3.3	–
Connecticut	**28.0**	35.2	-7.2	–	–	–	**25.2**	16.4	8.8	**2.8**	1.8	1.0	$17.0
Delaware	**24.6**	17.0	7.6	**0.3**	0.2	0.1	**21.8**	15.1	6.8	**2.4**	1.7	0.8	–
District of Columbia	**18.4**	14.5	3.9	**18.2**	14.4	3.8	–	–	–	**0.2**	0.1	0.0	–
Florida	**520.7**	367.5	153.2	**3.4**	2.4	1.0	**465.6**	328.6	137.0	**51.7**	36.5	15.2	–
Georgia	**413.3**	313.6	99.7	–	–	–	**383.2**	290.8	92.4	**30.1**	22.9	7.3	–
Hawaii	**40.3**	26.6	13.7	**37.1**	24.4	12.7	–	–	–	**3.2**	2.1	1.1	–
Idaho	**60.7**	48.3	12.4	**23.4**	18.6	4.8	**35.4**	28.1	7.2	**2.0**	1.6	0.4	–
Illinois	**517.7**	336.4	181.3	**148.0**	95.8	52.1	**332.1**	216.1	116.0	**37.6**	24.4	13.1	–
Indiana	**157.4**	121.2	36.2	**102.7**	79.1	23.6	**48.4**	37.2	11.1	**6.4**	4.9	1.5	–
Iowa	**134.2**	96.2	38.0	**29.2**	20.9	8.3	**96.7**	69.3	27.3	**8.3**	5.9	2.3	–
Kansas	**75.5**	52.5	23.0	–	–	–	**69.0**	48.0	21.0	**6.5**	4.5	2.0	–
Kentucky	**184.8**	146.7	38.1	**116.7**	92.6	24.0	**64.6**	51.3	13.3	**3.5**	2.8	0.7	–
Louisiana	**203.3**	148.1	55.2	**172.6**	125.7	46.8	**18.3**	13.3	5.0	**12.5**	9.1	3.4	–
Maine	**37.2**	27.5	9.7	**21.9**	16.2	5.7	**13.8**	10.2	3.6	**1.6**	1.2	0.4	–
Maryland	**258.4**	168.0	90.4	**245.5**	159.5	85.9	–	–	–	**13.0**	8.4	4.5	–
Massachusetts	**573.7**	372.9	200.8	**292.8**	190.3	102.5	**226.6**	147.3	79.3	**54.3**	35.3	19.0	–
Michigan	**147.1**	112.5	34.7	**19.4**	14.8	4.6	**124.4**	95.1	29.3	**3.3**	2.5	0.8	–
Minnesota	**19.5**	32.2	-12.7	**0.1**	0.0	0.0	**19.1**	12.5	6.6	**0.4**	0.3	0.1	19.4
Mississippi	**207.5**	168.9	38.6	–	–	–	**205.2**	167.1	38.2	**2.3**	1.9	0.4	–
Missouri	**170.0**	124.1	45.8	**113.9**	83.1	30.8	**43.8**	32.0	11.7	**12.3**	9.0	3.3	–
Montana	**91.5**	69.7	21.8	**21.6**	16.5	5.1	**65.1**	49.6	15.5	**4.8**	3.6	1.1	–
Nebraska	**70.1**	48.2	21.9	**59.8**	41.1	18.7	**7.1**	4.9	2.2	**3.2**	2.2	1.0	–
Nevada	**37.2**	26.8	10.5	**1.8**	1.3	0.5	**33.2**	23.9	9.3	**2.3**	1.6	0.6	–
New Hampshire	**16.7**	14.9	1.9	**16.3**	10.6	5.7	–	–	–	**0.4**	0.3	0.1	4.0
New Jersey	**958.0**	586.6	371.5	**194.4**	126.4	68.1	**660.3**	397.9	262.4	**103.3**	62.3	41.1	–
New Mexico	**144.9**	110.0	35.0	**67.1**	52.6	14.5	**75.7**	55.8	19.9	**2.1**	1.5	0.5	–

TABLE 8, Continued

State	Total CHIP[1]			Benefits						State Program Administration			2105(g) Spending[1]
				Medicaid-expansion CHIP programs			Separate CHIP programs and adult coverage waivers						
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal
New York	**$959.9**	$624.0	$335.9	**$291.0**	$189.1	$101.8	**$658.4**	$428.0	$230.4	**$10.5**	$6.8	$3.7	–
North Carolina	**398.0**	302.0	96.1	**78.4**	59.5	18.9	**304.1**	230.7	73.4	**15.5**	11.8	3.8	–
North Dakota	**26.6**	17.7	8.9	**12.0**	8.0	4.0	**13.4**	8.9	4.4	**1.3**	0.8	0.4	–
Ohio	**381.3**	284.1	97.2	**376.4**	280.5	95.9	–	–	–	**4.8**	3.6	1.2	–
Oklahoma	**172.6**	129.1	43.5	**159.0**	119.0	40.1	**9.7**	7.2	2.4	**3.8**	2.9	1.0	–
Oregon	**209.4**	154.3	55.0	–	–	–	**188.4**	138.9	49.5	**20.9**	15.4	5.5	–
Pennsylvania	**428.0**	291.1	136.9	–	–	–	**420.3**	285.9	134.5	**7.7**	5.2	2.4	–
Rhode Island	**81.1**	53.7	27.4	**67.9**	45.0	22.9	**11.1**	7.3	3.8	**2.1**	1.4	0.7	–
South Carolina	**132.5**	105.1	27.4	**120.9**	95.8	25.0	–	–	–	**11.6**	9.2	2.4	–
South Dakota	**24.6**	17.0	7.6	**17.8**	12.3	5.5	**6.4**	4.4	2.0	**0.4**	0.3	0.1	–
Tennessee	**259.6**	198.0	61.6	**43.7**	33.4	10.4	**209.5**	159.8	49.7	**6.4**	4.9	1.5	–
Texas	**1,285.0**	918.8	366.2	**40.4**	28.7	11.7	**1,173.9**	839.5	334.4	**70.7**	50.6	20.1	–
Utah	**68.6**	54.0	14.6	–	–	–	**62.6**	49.3	13.3	**6.0**	4.7	1.3	–
Vermont	**9.0**	13.0	-4.0	–	–	–	**8.3**	5.8	2.6	**0.7**	0.5	0.2	$6.8
Virginia	**301.0**	195.7	105.4	**122.2**	79.4	42.8	**166.3**	108.1	58.2	**12.5**	8.1	4.4	–
Washington	**122.9**	95.5	27.3	**2.2**	1.4	0.8	**116.0**	75.4	40.5	**4.7**	3.1	1.7	15.6
West Virginia	**57.9**	46.5	11.3	–	–	–	**53.4**	43.0	10.5	**4.4**	3.6	0.9	–
Wisconsin	**140.3**	106.2	34.1	**58.7**	42.1	16.6	**69.9**	50.2	19.7	**11.7**	8.4	3.3	5.5
Wyoming	**16.4**	10.7	5.7	–	–	–	**15.7**	10.3	5.5	**0.7**	0.5	0.2	–
Subtotal	**$12,962.4**	**$9,056.2**	**$3,906.2**	**$4,278.4**	**$2,961.8**	**$1,316.6**	**$7,996.2**	**$5,555.6**	**$2,440.6**	**$687.8**	**$470.5**	**$217.3**	**$68.3**
American Samoa	**1.6**	1.3	0.3	**1.6**	1.3	0.3	–	–	–	–	–	–	–
Guam	**6.3**	4.5	1.8	**6.3**	4.5	1.8	–	–	–	–	–	–	–
N. Mariana Islands	**1.1**	0.9	0.1	**1.1**	0.9	0.1	–	–	–	–	–	–	–
Puerto Rico	**194.9**	133.5	61.4	**194.9**	133.5	61.4	–	–	–	–	–	–	–
Virgin Islands	–	–	–	–	–	–	–	–	–	–	–	–	–
Total	**$13,166.3**	**$9,196.5**	**$3,969.8**	**$4,482.3**	**$3,102.0**	**$1,380.3**	**$7,996.2**	**$5,555.6**	**$2,440.6**	**$687.8**	**$470.5**	**$217.3**	**$68.3**

Notes: Components may not add to total due to rounding. As shown in Table 3, some states have waivers under Section 1115 of the Social Security Act that use CHIP funds to provide coverage for adults (pregnant women and parents). Federal CHIP spending on administration is generally limited to 10 percent of a state's total federal CHIP spending for the year. States with a Medicaid-expansion CHIP program may elect to receive reimbursement for administrative spending from Medicaid rather than CHIP funds; Medicaid funds are not shown in this table.

1 Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed children whose family income exceeds 133 percent of the federal poverty level. Although these are CHIP funds, they effectively reduce state spending on children in Medicaid and do not require a state match within the CHIP program. In cases where the sum of 2105(g) federal CHIP spending (for Medicaid enrollees) and regular federal CHIP spending (for CHIP enrollees) exceeds total spending for CHIP enrollees, states are shown in this table as having negative state CHIP spending (Connecticut, Minnesota, and Vermont).

Source: MACPAC analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data from the Centers for Medicare & Medicaid Services as of February 2014.

TABLE 9. Medicaid and CHIP Income Eligibility Levels as a Percentage of the Federal Poverty Level for Children and Pregnant Women by State, January 2014

Medicaid coverage of children under age 19 with incomes below states' eligibility levels in effect as of March 31, 1997, continues to be financed by Medicaid. Any expansion above those levels—through expansions of Medicaid or through separate CHIP programs—is generally financed by CHIP. Adult pregnant women can receive Medicaid- or CHIP-funded services through regular state plan eligibility pathways or Section 1115 waivers; in addition, the unborn children of pregnant women may receive CHIP-funded coverage under a state plan option. Deemed newborns are infants up to age 1 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.

	Medicaid Coverage							Separate CHIP Coverage		Medicaid/CHIP Coverage
	Infants under age 1		Age 1 through 5		Age 6 through 18					
State	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2014)	Birth through age 18	Unborn children[3]	Pregnant women and deemed newborns[4]
Alabama	141%	146%	141%	146%	107%	146%	Separate	317%	–	146%
Alaska	159	208	159	208	124	208	Medicaid Expansion	–	–	205
Arizona	147	152	141	146	104	138	Separate	205[5]	–	161
Arkansas	142	216	142	216	107	216	Combination	–	216%	214
California[6]	208	266	142	266	108	266	Combination	321/416[7]	313	213
Colorado	142	147	142	147	108	147	Combination	265	–	200/265
Connecticut	196	201	196	201	196	201	Separate	323	–	263
Delaware	194	217	142	147	110	138	Combination	217	–	217
District of Columbia	206	324	146	324	112	324	Medicaid Expansion	–	–	324
Florida	192	211	140	145	112	138	Combination	215	–	196
Georgia	205	210	149	154	113	138	Separate	252	–	225
Hawaii	191	313	139	313	105	313	Medicaid Expansion	–	–	196
Idaho	142	147	142	147	107	138	Combination	190	–	138
Illinois	142	147	142	147	108	147	Combination	318	205	205
Indiana	157	213	141	163	106	163	Combination	255	–	213
Iowa	240	380	167	172	122	172	Combination	307	–	380
Kansas	166	171	149	154	113	138	Separate	250	–	171
Kentucky	195	200	142	164	109	164	Combination	218	–	200
Louisiana	142	217	142	217	108	217	Combination	255	205	138
Maine	191	196	140	162	132	162	Combination	213	–	214
Maryland	194	322	138	322	109	322	Medicaid Expansion	–	–	264
Massachusetts	185	205	133	155	114	155	Combination	305	205	205

TABLE 9, Continued

State	Medicaid Coverage: Infants under age 1 Medicaid funded[1]	Infants under age 1 CHIP funded[1]	Age 1 through 5 Medicaid funded[1]	Age 1 through 5 CHIP funded[1]	Age 6 through 18 Medicaid funded[1]	Age 6 through 18 CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2014)	Separate CHIP Coverage: Birth through age 18	Separate CHIP Coverage: Unborn children[3]	Medicaid/CHIP Coverage: Pregnant women and deemed newborns[4]
Michigan	195%	200%	143%	165%	109%	165%	Combination	217%	190%	200%
Minnesota	275	288[8]	275	280	275	280	Combination	–	283	283
Mississippi	194	199	143	148	107	138	Separate	214	–	199
Missouri	196	201	148	153	110	153	Combination	305	–	201
Montana	143	148	143	148	109	148	Combination	266	–	162
Nebraska	162	218	147	218	111	218	Combination	–	202	199
Nevada[9]	159	164	159	164	122	138	Combination	205	–	164
New Hampshire	196	323	196	323	196	323	Medicaid Expansion	–	–	201
New Jersey	194	199	142	147	107	147	Combination	355	–	199/205
New Mexico	200	305	200	305	138	245	Medicaid Expansion	–	–	255
New York	196	223	149	154	110	154	Combination	405	–	223
North Carolina	194	215	141	215	107	138	Combination	216	–	201
North Dakota[10]	147	152	147	152	111	138	Combination	175	–	152
Ohio	141	211	141	211	107	211	Medicaid Expansion	–	–	205
Oklahoma	169	210	151	210	115	210	Combination	–	190	138
Oregon	185	190	133	138	133	138	Separate	305	190	190/305
Pennsylvania	215	220	157	162	119	138	Separate	319	–	220
Rhode Island	261	266	261	266	109	266	Combination	–	258	195/258
South Carolina[11]	194	213	143	213	107	213	Medicaid Expansion	–	–	199
South Dakota	177	187	177	187	124	187	Combination	209	–	138
Tennessee[12]	195	200	142	147	109	138	Combination	255	255	200
Texas[13]	198	203	144	149	100	138	Separate	206	205	203
Utah[14]	139	144	139	144	105	138	Separate	205	–	144
Vermont[15]	237	318	237	318	237	318	Separate	317	–	213
Virginia	143	148	143	148	109	148	Combination	205	–	148
Washington	207	212	207	212	207	212	Separate	305	198	198
West Virginia	158	163	141	146	108	138	Separate	305	–	163
Wisconsin	188	306	186	191	101	156	Combination	306	305	306
Wyoming	154	159	154	159	119	138	Separate	205	–	159

TABLE 9, Continued

Notes: In 2014, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $11,670 for an individual and $4,060 for each additional family member. For additional information, see MACStats Table 19. When determining Medicaid and CHIP eligibility prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing. Beginning in 2014, uniform modified adjusted gross income (MAGI) rules must be used to determine Medicaid and CHIP eligibility for most non-disabled children and adults under age 65, 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 plus a mandatory income disregard equal to 5 percent FPL that effectively raises eligibility levels by 5 percentage points. Under federal regulations, the 5 percent disregard applies to an individual's determination of eligibility for Medicaid and CHIP overall, rather than for particular eligibility groups within Medicaid or CHIP. All information is based on state decisions as of February 26, 2014.

1 The eligibility levels listed under Medicaid funded are generally the Medicaid eligibility thresholds as of March 31, 1997. Many states had different eligibility levels for children age 6 through 13 and age 14 through 18 in 1997; in such cases, this table shows the 1997 levels for children age 6 through 13. The eligibility levels listed under CHIP funded are the income levels to which Medicaid has expanded with CHIP funding since its creation in 1997. In 2014, all states are eligible to receive CHIP funding for at least some Medicaid-enrolled children due to a mandatory transition of 6- to 18-year-olds between 100 and 133 percent FPL in separate CHIP programs to Medicaid, and a mandatory income disregard equal to 5 percent FPL that effectively raises Medicaid eligibility levels by 5 percentage points. In addition, 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 FPL (see MACStats Table 8 for states that currently claim CHIP funds under this provision).

2 Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches. Although all states will have at least some Medicaid-enrolled children who are eligible for CHIP funding as of 2014 due to the implementation of ACA requirements, 14 states are still categorized as separate programs in this table because they did not have approved state plan amendments on the Centers for Medicare & Medicaid Services (CMS) website indicating whether they will characterize themselves as combination states.

3 MAGI-converted eligibility levels for the unborn child option under CHIP were not readily available for Illinois, Louisiana, Massachusetts, Michigan, Oklahoma, Oregon, Tennessee, Texas, and Wisconsin. Converted levels may or may not differ from those shown here, depending in part on whether the state used a gross income counting methodology (similar to MAGI) for determining eligibility prior to 2014.

4 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 a Section 1115 waiver. When two values are shown in this column, the first is for Medicaid and the second is for CHIP.

5 Although Arizona's separate CHIP program up to 200 percent FPL (KidsCare) has been closed to new enrollment since January 2010, thousands of children were added to the state's CHIP-funded coverage through the state's KidsCare II waiver, which was in effect from May 2012 through January 2014.

6 During 2013, California transitioned most of its separate CHIP children into a Medicaid-expansion CHIP program.

7 California has a separate CHIP program in three counties that covers children up to 321 percent FPL and in one county up to 416 percent FPL.

8 In Minnesota, infants are defined as being under age 2. Only infants are eligible for the Medicaid-expansion CHIP program.

9 Nevada's CHIP-funded Medicaid levels include children who became eligible for Medicaid when the state eliminated the Medicaid asset test.

10 North Dakota's CHIP-funded Medicaid levels include children who became eligible for Medicaid when the state eliminated the Medicaid asset test.

11 South Carolina's CHIP-funded Medicaid levels may include children who will become eligible for Medicaid due to the mandatory elimination of Medicaid asset tests in 2014.

12 Tennessee covers children with CHIP-funded Medicaid, called TennCare Standard, but this Section 1115 waiver is currently capped except for children who roll over from traditional Medicaid. This includes children with a family income above Medicaid income levels, but at or below 216 percent FPL, who are losing TennCare Medicaid eligibility.

13 Texas's CHIP-funded Medicaid levels may include children who will become eligible for Medicaid due to the mandatory elimination of Medicaid asset tests in 2014.

14 Utah's CHIP-funded Medicaid levels may include children who will become eligible for Medicaid due to the mandatory elimination of Medicaid asset tests in 2014.

15 Vermont covers children from 238 percent FPL up to 317 percent FPL with CHIP-funded Medicaid if they have other insurance, and with separate CHIP if they are uninsured.

Sources: MACPAC communication with the Centers for Medicare & Medicaid Services (CMS) and MACPAC analysis of: CMS, *Medicaid moving forward 2014, State-specific documents, MAGI conversion plans* and *SIPP-based MAGI conversion results*. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html; CMS, *State Medicaid and CHIP income eligibility standards effective January 1, 2014 (For MAGI groups, based on state decisions as of February 26, 2014)*; CMS, *Children's Health Insurance Program: Plan activity as of January 1, 2014*; CHIP state plan amendments on the CMS website; and state websites.

TABLE 10. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-Aged, Non-Disabled, Non-Pregnant Adults by State, January 2014

States are required to provide Medicaid coverage for parents (and their dependent children), at a minimum, at their 1996 Aid to Families with Dependent Children eligibility levels. Under regular Medicaid state plan rules, states may opt to cover additional parents (via Section 1931 of the Social Security Act) and other adults under age 65 who are not pregnant, not eligible for Medicare, and have incomes at or below 138 percent of the federal poverty level (via Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act). States may also provide coverage under Section 1115 waivers, which allow them to operate their Medicaid programs without regard to certain 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 may not be available to all individuals at the income levels shown.

State	Parents of Dependent Children[1]	Other Adults[2]	Medicaid Expansion State[3]
Alabama	18%	–	No
Alaska	136	–[4]	No
Arizona	138	138%	Yes
Arkansas	138	138	Yes
California	138	138	Yes
Colorado	138	138	Yes
Connecticut	201	138	Yes
Delaware	138	138	Yes
District of Columbia	221	215	Yes
Florida	36	–[4]	No
Georgia	41	–	No
Hawaii	138	138	Yes
Idaho	29[5]	–[6]	No
Illinois	138	138	Yes
Indiana	25[5]	–[6]	No
Iowa	138	138	Yes
Kansas	38	–	No
Kentucky	138	138	Yes
Louisiana	24[5]	–[6]	No
Maine	105	–[4, 6]	No
Maryland	138	138	Yes
Massachusetts	138	138[4]	Yes
Michigan	138	138	Yes[7]
Minnesota	205	205	Yes
Mississippi	29	–	No
Missouri	24[5]	–[6]	No
Montana	53	–[6]	No
Nebraska	64	–	No
Nevada	138	138	Yes

TABLE 10, Continued

State	Parents of Dependent Children[1]	Other Adults[2]	Medicaid Expansion State[3]
New Hampshire	75%	–	No
New Jersey	138	138%	Yes
New Mexico	138	138	Yes
New York	138	138[4]	Yes
North Carolina	51	–[4]	No
North Dakota	138	138	Yes
Ohio	138	138	Yes
Oklahoma	48[5]	–[6]	No
Oregon	138	138	Yes
Pennsylvania	38	–[4]	No
Rhode Island	138	138	Yes
South Carolina	67	–	No
South Dakota	64	–	No
Tennessee	111	–	No
Texas	20	–	No
Utah	56[5]	–[6]	No
Vermont	138	138	Yes
Virginia	54	–	No
Washington	138	138	Yes
West Virginia	138	138	Yes
Wisconsin	95[5]	100	No
Wyoming	62	–	No

Notes: In 2014, 100 percent of the federal poverty level (FPL) in the lower 48 states and the District of Columbia is $11,670 for an individual and $4,060 for each additional family member. For additional information, see MACStats Table 19. When determining Medicaid and CHIP eligibility prior to 2014, states had the flexibility to disregard income sources and amounts of their choosing. Beginning in 2014, uniform modified adjusted gross income (MAGI) rules must be used to determine Medicaid and CHIP eligibility for most non-disabled children and adults under age 65, 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 plus a mandatory income disregard equal to 5 percent FPL that effectively raises eligibility levels by 5 percentage points. Under federal regulations, the 5 percent disregard applies to an individual's determination of eligibility for Medicaid and CHIP overall, rather than for particular eligibility groups within Medicaid or CHIP. All information is based on state decisions as of February 26, 2014.

1 In states that use dollar amounts rather than percentages of the FPL to determine eligibility for parents, those amounts were converted to a percent of the FPL for 2013, and the highest percentage was selected to reflect eligibility level for the group.

2 Includes coverage under the new adult group (Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act) for individuals under age 65 who are not pregnant, not eligible for Medicare, and have incomes at or below 138 percent FPL.

3 Medicaid expansion states are those that have opted to cover adults under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

4 The state covers some 19- and 20-year-olds at income levels not shown in the table: Alaska (129 percent FPL), Florida (31 percent FPL), Maine (156 percent FPL), Massachusetts (150 percent FPL), New York (150 percent FPL), North Carolina (46 percent FPL), and Pennsylvania (33 percent FPL).

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

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

7 Michigan has a Medicaid expansion as of April 1, 2014.

Source: MACPAC communication with the Centers for Medicare & Medicaid Services (CMS) and MACPAC analysis of CMS, *State Medicaid and CHIP income eligibility standards effective January 1, 2014 (For MAGI groups, based on state decisions as of February 26, 2014).*

TABLE 11. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Individuals Age 65 and Older and Persons with Disabilities by State, 2014

In most states, enrollment in the Supplemental Security Income (SSI) program for individuals age 65 and older and persons with disabilities automatically qualifies them for Medicaid. However, 11 (10 as of June 2014) 209(b) states may use more restrictive criteria than SSI when determining Medicaid eligibility. In all states, additional people with low incomes or high medical expenses may be covered, at the state's option, through poverty level, medically needy, special income level, and other eligibility pathways.

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
Alabama	1634	74%	–	–	–	222%
Alaska[5]	SSI Criteria	59	–	–	–	178
Arizona	1634	74	–	100%	–	222
Arkansas	1634	74	–	80 (Aged only)	11%	222
California	1634	74	–	100	62	–
Colorado	1634	74	–	–	–	222
Connecticut	209(b)	–	63%	–	63	222
Delaware	1634	74	–	–	–	185
District of Columbia	1634	74	–	100	64	222
Florida	1634	74	–	88	19	222
Georgia	1634	74	–	–	33	222
Hawaii	209(b)	–	64	100	42	–
Idaho	SSI Criteria	74	–	–	–	222
Illinois	209(b)	–	100	100	100	–
Indiana[6]	1634	74	–	100	–	222
Iowa	1634	74	–	–	50	222
Kansas	SSI Criteria	74	–	–	49	222
Kentucky	1634	74	–	–	22	222
Louisiana	1634	74	–	74	10	222
Maine	1634	74	–	100	32	222
Maryland	1634	74	–	–	36	222
Massachusetts[7]	1634	74	–	100 (Aged)/133 (Disabled)	54	222
Michigan	1634	74	–	100	42	222
Minnesota	209(b)	–	75	100	75	222
Mississippi	1634	74	–	–	–	222
Missouri	209(b)	–	84	85	84	130
Montana	1634	74	–	–	64	–
Nebraska	SSI Criteria	74	–	100	40	–
Nevada	SSI Criteria	74	–	–	–	222

TABLE 11, Continued

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
New Hampshire	209(b)	–	76%	–	61%	222%
New Jersey	1634	74%	–	100%	38	222
New Mexico	1634	74	–	–	–	222
New York	1634	74	–	83	83	–
North Carolina	1634	74	–	100	25	–
North Dakota	209(b)	–	82	–	82	–
Ohio	209(b)	–	61	–	61	222
Oklahoma	209(b)	–	77	100	77	222
Oregon	SSI Criteria	74	–	–	–	222
Pennsylvania	1634	74	–	100	44	222
Rhode Island	1634	74	–	100	88	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	99	222
Vermont	1634	74	–	–	110	222
Virginia	209(b)	–	74	80	46	222
Washington	1634	74	–	–	73	222
West Virginia	1634	74	–	–	21	222
Wisconsin	1634	74	–	–	61	222
Wyoming	1634	74	–	–	–	222

Notes: In 2014, the federal poverty level (100 percent FPL) is $11,670 for an individual and $4,060 for each additional family member in the lower 48 states and the District of Columbia. For additional information, see MACStats Table 19. Eligibility levels shown here apply to countable income; for some eligibility pathways, states may use various income disregards that result in different amounts of countable income. The eligibility levels listed in this table are for individuals; the eligibility levels for couples differ for certain categories.

1 Both Section 1634 and SSI-criteria states use SSI criteria for Medicaid eligibility. 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 more restrictive than the SSI program but may not use more restrictive criteria than those in effect in the state on January 1, 1972; if they do not have a separate medically needy standard, they must also allow individuals with higher incomes to spend down to the 209(b) income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes. Indiana is a 209(b) state until June 2014, at which point it will become a 1634 state.

2 Under the poverty level option, states may choose to provide Medicaid coverage to persons who are aged or disabled and whose income is above the SSI or 209(b) level, but at or below the FPL.

3 Under the medically needy option, individuals with higher incomes can spend down to the medically needy income level shown here by deducting incurred medical expenses from the amount of income that is counted for Medicaid eligibility purposes. Five states (Connecticut, Louisiana, Michigan, Vermont, and Virginia) have a medically needy income standard that varies by location. In these instances, the highest income standard is listed.

4 Under the special income level option, states have the option to provide Medicaid benefits to people who require at least 30 days of nursing home or other institutional care and have incomes up to 300 percent of the SSI benefit rate (which is about 222 percent FPL in 2014). The income standard listed in this column may be for institutional services, home and community-based waiver services, or both.

5 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 (see MACStats Table 19), resulting in a lower percentage.

6 Indiana is a 209(b) state until June 2014, at which point it will become a 1634 state. The state's poverty level group is also effective as of June 2014.

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

Sources: MACPAC analysis of eligibility information from state websites and Medicaid state plans as of February 2014.

TABLE 12. Mandatory and Optional Medicaid Benefits

Although mandatory and optional Medicaid benefits are listed in federal statute, the breadth of coverage (i.e., amount, duration, and scope) varies by state. When designing a benefit, states may elect to place no limits on a benefit, or they may choose to limit a benefit by requiring prior approval of the service, restricting the place of service, or employing utilization controls or dollar caps. For example, while most states cover dental services, and some even cover annual dental exams, others limit this benefit to trauma care or emergency treatment for pain relief and infection, require that services be provided in a specific setting (such as an emergency room), require that certain services have prior approval, or place dollar caps on the total amount of services an enrollee can receive each year. The result is that the same benefit can be designed and implemented in a number of different ways across states.

The table on the following page lists mandatory and optional Medicaid benefits that are described in federal statute or regulations. No single source of information currently provides an up-to-date, comprehensive picture of the optional benefits covered by states and the circumstances under which a given benefit is covered. Readers may instead refer to a number of sources including, for example:

- Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, *State Medicaid benefits matrix*, December 2010 and January 2011. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/StateMedicaidBenefitsMatrix042011.zip.
- Kaiser Family Foundation, *Medicaid benefits: Online database*. http://medicaidbenefits.kff.org/.
- Kaiser Commission on Medicaid and the Uninsured, *Coverage of preventive services for adults in Medicaid*, September 2012. http://www.kff.org/medicaid/upload/8359.pdf.
- S. Wilensky, and E. Gray, *Coverage of Medicaid preventive services for adults – A national review*, The George Washington University, November 2012. http://sphhs.gwu.edu/departments/healthpolicy/publications/coverage.pdf.
- Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, *State profiles of mental health and substance abuse services in Medicaid*, January 2005. http://store.samhsa.gov/product/State-Profiles-of-Mental-Health-and-Substance-Abuse-Services-in-Medicaid/NMH05-0202; and SAMHSA, *Behavioral health, United States, 2012*. http://www.samhsa.gov/data/2012BehavioralHealthUS/2012-BHUS.pdf.
- Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Understanding Medicaid home and community-based services: A primer*, 2010 edition. http://aspe.hhs.gov/daltcp/reports/2010/primer10.pdf.

TABLE 12, Continued

Mandatory Medicaid Benefits

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21 (screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state)
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Laboratory and X-ray services
- Nursing facility services (for ages 21 and over)
- Nurse midwife services (to the extent authorized to practice under state law or regulation)
- Certified pediatric or family nurse practitioner services (to the extent authorized to practice under state law or regulation)
- Rural heath clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Non-emergency transportation to medical care[1]

Optional Medicaid Benefits

- Prescribed drugs
- Intermediate care facility services for individuals with intellectual disabilities
- Clinic services
- Occupational therapy services
- Optometry services
- Physical therapy services
- Targeted case management services
- Prosthetic devices
- Hospice services
- Inpatient psychiatric services for individuals under age 21
- Dental services
- Eyeglasses
- Speech, hearing, and language disorder services
- Inpatient hospital and nursing facility services for individuals age 65 or older in institutions for mental diseases
- Emergency hospital services in a hospital not meeting certain Medicare or Medicaid requirements[2]
- Dentures
- Personal care services
- Private duty nursing services
- Program of All-inclusive Care for the Elderly (PACE) services
- Chiropractic services
- Critical access hospital services
- Respiratory care for ventilator-dependent individuals
- Primary care case management services
- Services furnished in a religious nonmedical health care institution
- Tuberculosis-related services
- Home and community-based services
- Health homes for enrollees with chronic conditions
- Other licensed practitioners' services
- Other diagnostic, screening, preventive, and rehabilitative services

Notes:

1 Federal regulations require states to provide transportation services; they may do so as an administrative function or as part of the Medicaid benefits package.

2 Federal regulations define these services as being those that are necessary to prevent the death or serious impairment of the health of the recipient and, because of the threat to life, necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet Medicare's participation requirements or the definition of inpatient or outpatient hospital services under Medicaid rules.

Source: Centers for Medicare & Medicaid Services, Medicaid benefits, as of February 2014. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.

TABLE 13. Maximum Allowable Medicaid Premiums and Cost Sharing, FY 2014

	At or Below 100% FPL	From 100% through 150% FPL	Above 150% FPL
Exemptions from Premiums and Cost Sharing			
Exempt Populations	Populations exempt from most types of cost sharing include most children under age 18, pregnant women, beneficiaries receiving hospice care, certain beneficiaries in institutions such as nursing facilities and intermediate care facilities, American Indians who are furnished a Medicaid item or service through an Indian Health Service provider or through a contract health service referral, and individuals eligible for Medicaid under the Breast and Cervical Cancer Act pathway. Except for certain pregnant women above 150% FPL, these populations are also exempt from premiums.		
Exempt Services	Emergency services, family planning services and supplies, preventive services for children regardless of family income, pregnancy-related services, and services related to provider-preventable conditions are excluded from cost sharing.		
Aggregate Limit on Allowable Premiums and Cost Sharing			
Aggregate limit for all populations	The total amount of premiums and cost sharing incurred by all individuals in a Medicaid household may not exceed 5% of the family's monthly or quarterly income.		
Allowable Premiums			
Specified populations	Up to $20 per month for individuals eligible under a medically needy pathway. Sliding scale based on income for individuals eligible under certain disability pathways for children and working adults.		Same as rules at or below 150% FPL for medically needy and disability pathways. Up to 10% of amount by which income exceeds 150% FPL for certain pregnant women.
All other populations	Not permitted		No specific limit
Allowable Cost Sharing			
Outpatient services	Up to $4.00	Up to 10% of the amount the Medicaid agency pays	Up to 20% of the amount the Medicaid agency pays
Inpatient stays	Up to $75.00	Up to 10% of the amount the Medicaid agency pays	Up to 20% of the amount the Medicaid agency pays
Non-emergency use of the emergency department	Up to $8.00		No specific limit
Prescribed drugs	Preferred drugs: Up to $4.00 Non-preferred: Up to $8.00		Preferred drugs: Up to $4.00 Non-preferred: Up to 20% of the amount the Medicaid agency pays

Notes: In 2014, the federal poverty level (100 percent FPL) is $11,670 for an individual and $4,060 for each additional family member in the lower 48 states and the District of Columbia. FY is fiscal year. For additional information, see MACStats Table 19. Beginning October 1, 2015, maximum allowable cost-sharing amounts will be increased annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). This table does not reflect amounts that states may have implemented under a Section 1115 waiver.

Source: Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Medicaid and Children's Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; Exchanges: Eligibility and enrollment; Final rule, *Federal Register* 78 (July 15): 42160, 2013. http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

TABLE 14. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, Selected Periods in FY 2011–FY 2015

State	FMAPs for Medicaid						E-FMAPs for CHIP			
	First quarter of FY 2011[1]	Fourth quarter of FY 2011[1]	FY 2012	FY 2013	FY 2014[2]	FY 2015[2]	FY 2012	FY 2013	FY 2014	FY 2015
Alabama	78.00%	68.54%	68.62%	68.53%	68.12%	68.99%	78.03%	77.97%	77.68%	78.29%
Alaska	62.46	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Arizona	75.93	65.85	67.30	65.68	67.23	68.46	77.11	75.98	77.06	77.92
Arkansas	81.18	71.37	70.71	70.17	70.10	70.88	79.50	79.12	79.07	79.62
California	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Colorado	61.59	50.00	50.00	50.00	50.00	51.01	65.00	65.00	65.00	65.71
Connecticut	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Delaware	64.38	53.15	54.17	55.67	55.31	53.63	67.92	68.97	68.72	67.54
District of Columbia	79.29	70.00	70.00	70.00	70.00	70.00	79.00	79.00	79.00	79.00
Florida	67.64	55.45	56.04	58.08	58.79	59.72	69.23	70.66	71.15	71.80
Georgia	75.16	65.33	66.16	65.56	65.93	66.94	76.31	75.89	76.15	76.86
Hawaii	67.35	51.79	50.48	51.86	51.85	52.23	65.34	66.30	66.30	66.56
Idaho	79.18	68.85	70.23	71.00	71.64	71.75	79.16	79.70	80.15	80.23
Illinois	61.88	50.20	50.00	50.00	50.00	50.76	65.00	65.00	65.00	65.53
Indiana	76.21	66.52	66.96	67.16	66.92	66.52	76.87	77.01	76.84	76.56
Iowa	72.55	62.63	60.71	59.59	57.93	55.54	72.50	71.71	70.55	68.88
Kansas	69.68	59.05	56.91	56.51	56.91	56.63	69.84	69.56	69.84	69.64
Kentucky	80.61	71.49	71.18	70.55	69.83	69.94	79.83	79.39	78.88	78.96
Louisiana[3]	81.48	68.04	69.78	65.51	62.11	62.05	72.76	72.87	72.69	73.44
Maine	74.86	63.80	63.27	62.57	61.55	61.88	74.29	73.80	73.09	73.32
Maryland	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Massachusetts	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Michigan	75.57	65.79	66.14	66.39	66.32	65.54	76.30	76.47	76.42	75.88
Minnesota	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Mississippi	84.86	74.73	74.18	73.43	73.05	73.58	81.93	81.40	81.14	81.51
Missouri	74.43	63.29	63.45	61.37	62.03	63.45	74.42	72.96	73.42	74.42
Montana	77.99	66.81	66.11	66.00	66.33	65.90	76.28	76.20	76.43	76.13
Nebraska	68.76	58.44	56.64	55.76	54.74	53.27	69.65	69.03	68.32	67.29
Nevada	63.93	51.61	56.20	59.74	63.10	64.36	69.34	71.82	74.17	75.05
New Hampshire	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
New Jersey	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
New Mexico	80.49	69.78	69.36	69.07	69.20	69.65	78.55	78.35	78.44	78.76
New York	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
North Carolina	74.98	64.71	65.28	65.51	65.78	65.88	75.70	75.86	76.05	76.12
North Dakota	69.95	60.35	55.40	52.27	50.00	50.00	68.78	66.59	65.00	65.00
Ohio	73.71	63.69	64.15	63.58	63.02	62.64	74.91	74.51	74.11	73.85

TABLE 14, Continued

State	FMAPs for Medicaid						E-FMAPs for CHIP			
	First quarter of FY 2011[1]	Fourth quarter of FY 2011[1]	FY 2012	FY 2013	FY 2014[2]	FY 2015[2]	FY 2012	FY 2013	FY 2014	FY 2015
Oklahoma	76.73%	64.94%	63.88%	64.00%	64.02%	62.30%	74.72%	74.80%	74.81%	73.61%
Oregon	72.97	62.85	62.91	62.44	63.14	64.06	74.04	73.71	74.20	74.84
Pennsylvania	66.58	55.64	55.07	54.28	53.52	51.82	68.55	68.00	67.46	66.27
Rhode Island	64.22	52.97	52.12	51.26	50.11	50.00	66.48	65.88	65.08	65.00
South Carolina	79.58	70.04	70.24	70.43	70.57	70.64	79.17	79.30	79.40	79.45
South Dakota	70.80	61.25	59.13	56.19	53.54	51.64	71.39	69.33	67.48	66.15
Tennessee	75.62	65.85	66.36	66.13	65.29	64.99	76.45	76.29	75.70	75.49
Texas	70.94	60.56	58.22	59.30	58.69	58.05	70.75	71.51	71.08	70.64
Utah	80.78	71.13	70.99	69.61	70.34	70.56	79.69	78.73	79.24	79.39
Vermont	69.96	58.71	57.58	56.04	55.11	54.01	70.31	69.23	68.58	67.81
Virginia	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
Washington	62.94	50.00	50.00	50.00	50.00	50.03	65.00	65.00	65.00	65.02
West Virginia	83.05	73.24	72.62	72.04	71.09	71.35	80.83	80.43	79.76	79.95
Wisconsin	70.63	60.16	60.53	59.74	59.06	58.27	72.37	71.82	71.34	70.79
Wyoming	61.59	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00
American Samoa	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Guam	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Northern Mariana Islands	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Puerto Rico	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50
Virgin Islands	50.00	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50

Notes: The federal government's share of most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), with some exceptions. For Medicaid administrative costs, the federal share does not vary by state and is generally 50 percent. The enhanced 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 relative 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 formula for a given state is: FMAP = 1 - ((State per capita income squared / U.S. per capita income squared) x 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). Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent.

1 From the first quarter of fiscal year (FY) 2009 through the third quarter of FY 2011, subject to certain requirements, states received a temporary FMAP increase (P.L. 111-5 and P.L. 111-226). Under the formula used to calculate the temporary increase, states reached their highest FMAPs by the first quarter of FY 2011 (shown here). The temporary increase then phased down in the second and third quarters of FY 2011. FMAPs returned to their regular formula levels in the fourth quarter of FY 2011. The temporary increase did not apply to CHIP.

2 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 previously expanded eligibility to low-income parents and non-pregnant adults without children prior to enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). (See §§1905(y) and (z) of the Social Security Act.)

3 Louisiana receives a disaster-recovery state FMAP adjustment for the fourth quarter of FY 2011, and FY 2012-FY 2014 (section 1905(aa) of the Social Security Act). P.L. 112-96 and P.L. 112-141 revised the disaster relief formula, effective October 1, 2012. As a result, the FY 2013 disaster-recovery FMAP adjustment for Louisiana that was published in the *Federal Register* on November 30, 2011 has been revised. No state qualifies for a disaster-recovery FMAP adjustment in FY 2015.

Source: *Federal Register* notices from the U.S. Department of Health and Human Services.

TABLE 15. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, State FY 2012

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
All states	**$1,644,020**	**23.7%**	**20.0%**	**10.5%**	**$1,127,809**	**14.8%**	**24.1%**	**13.4%**
Alabama	24,178	23.3	20.9	20.1	14,870	12.3	27.5	24.2
Alaska	11,789	11.6	13.4	9.3	8,772	6.5	15.3	10.5
Arizona	28,540	32.0	19.0	13.5	16,241	20.5	26.0	18.8
Arkansas	20,688	21.4	16.3	16.2	14,410	8.9	19.2	23.1
California	199,424	21.6	19.9	7.0	126,361	13.1	26.5	7.2
Colorado	28,777	20.7	25.3	9.0	21,086	16.0	31.4	10.2
Connecticut	27,558	21.4	13.9	10.3	24,927	23.6	13.2	9.9
Delaware	8,942	15.9	24.6	4.5	7,165	8.9	27.3	4.6
District of Columbia[2]	–	–	–	–	–	–	–	–
Florida	62,989	30.6	18.8	7.1	38,374	21.7	25.2	11.3
Georgia	41,127	20.3	24.0	18.7	28,658	9.6	26.6	26.6
Hawaii	11,494	12.3	15.6	11.3	9,562	6.3	15.8	13.3
Idaho	6,267	27.2	25.7	8.1	3,885	16.5	33.9	13.0
Illinois	65,730	19.7	15.8	5.5	46,323	14.6	14.7	7.2
Indiana	26,305	27.3	32.9	6.5	17,033	14.5	43.5	10.0
Iowa	18,940	19.6	16.8	25.0	12,389	13.2	22.1	33.7
Kansas	14,396	18.6	25.8	16.9	10,243	11.5	31.7	17.1
Kentucky	25,649	22.5	19.8	25.7	16,962	10.0	24.5	33.5
Louisiana	27,073	26.7	18.4	9.9	16,457	14.4	23.5	15.3
Maine	8,106	28.8	13.1	3.4	5,457	16.3	19.2	5.0
Maryland	34,877	21.5	19.5	14.5	25,819	14.4	22.6	18.3
Massachusetts	59,271	20.7	10.7	9.3	43,114	12.8	12.0	12.8
Michigan	47,286	26.1	27.2	4.1	29,737	14.0	36.8	6.2
Minnesota	31,329	27.6	23.8	9.7	23,159	18.2	28.8	13.1
Mississippi	18,386	23.4	16.9	16.8	10,441	10.8	22.2	27.8
Missouri	23,364	35.0	22.6	4.7	15,825	24.9	26.5	6.9
Montana	5,919	16.8	15.5	9.8	3,788	8.5	19.6	14.1
Nebraska	9,877	16.7	15.3	23.5	6,889	10.4	16.2	28.1

TABLE 15, 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
Nevada	$7,623	25.4%	23.6%	9.7%	$5,069	18.3%	30.5%	14.5%
New Hampshire	4,975	23.9	23.5	2.7	3,325	18.1	29.0	4.0
New Jersey	48,612	21.6	24.7	7.8	37,614	12.9	29.6	10.1
New Mexico	14,164	24.7	19.7	19.3	8,556	12.2	27.7	24.3
New York	133,504	29.4	19.8	7.6	93,193	15.9	23.1	10.6
North Carolina	46,567	24.7	23.2	9.0	32,054	12.4	29.2	13.0
North Dakota	6,027	12.1	13.8	17.7	4,143	7.5	16.3	22.4
Ohio	57,921	24.4	20.6	4.2	44,786	26.1	21.7	5.3
Oklahoma	20,931	23.9	16.5	23.1	14,213	16.3	19.0	30.5
Oregon	27,014	18.2	14.0	2.5	19,261	9.4	16.3	3.2
Pennsylvania	66,948	33.2	18.4	2.8	42,771	23.3	23.1	4.4
Rhode Island	7,907	25.0	14.2	13.2	5,308	17.9	16.7	19.2
South Carolina	22,088	21.7	15.9	21.0	12,804	10.6	21.0	30.7
South Dakota	3,698	20.9	14.3	17.7	2,210	13.0	16.3	25.4
Tennessee	30,419	30.7	17.7	12.8	17,613	18.9	23.3	20.9
Texas	92,963	30.1	28.7	15.8	61,427	19.2	35.5	20.0
Utah	11,822	17.5	24.7	11.9	8,234	8.6	29.7	16.9
Vermont	5,017	25.3	31.1	1.8	3,186	17.3	44.6	2.9
Virginia	43,425	16.2	16.0	13.1	34,213	10.4	16.3	13.1
Washington	34,943	12.1	22.9	17.8	26,894	7.7	26.4	22.8
West Virginia	21,821	12.7	10.8	14.1	17,757	4.4	11.2	15.6
Wisconsin	41,324	16.5	16.7	14.1	30,752	8.9	19.7	12.9
Wyoming	6,026	9.5	3.9	5.5	4,479	6.2	3.1	6.8

Notes: FY is fiscal year. Total budget includes federal and all other funds. State-funded budget includes state general funds, other state funds, and bonds. 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. 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, Connecticut reports all of its Medicaid spending as state-funded spending due to the direct deposit of federal funds into the State Treasury. In addition, some functions—particularly elementary and secondary education—may be partially funded outside of the state budget by local governments.

2 NASBO does not collect information for the District of Columbia.

Sources: National Association of State Budget Officers (NASBO), *State expenditure report: Examining fiscal 2011-2013 state spending,* December 2013. http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202011-2013%20Data%29.pdf.

TABLE 16. National Health Expenditures by Type and Payer, 2012

	Dollars (billions)							
Type of Expenditure	Total	Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
National health expenditures	**$2,793.4**	**$421.2**	**$12.6**	**$572.5**	**$917.0**	**$91.1**	**$450.8**	**$328.2**
Hospital	**882.3**	156.4	3.4	239.8	320.9	49.6	82.4	29.8
Physician and clinical	**565.0**	45.6	3.2	128.1	258.3	20.7	54.2	54.9
Dental	**110.9**	7.3	1.3	0.4	53.4	1.3	0.5	46.8
Other professional	**76.4**	4.7	0.2	16.9	28.2	–	6.9	19.4
Home health	**77.8**	28.9	0.0	33.8	5.6	1.0	2.4	6.0
Other non-durable medical products	**53.7**	–	–	3.1	–	–	0.0	50.6
Prescription drugs	**263.3**	19.6	1.5	68.2	117.0	7.7	2.5	46.8
Durable medical equipment	**41.3**	4.6	0.1	8.2	4.7	–	0.6	23.1
Nursing care facilities and continuing care retirement communities	**151.5**	46.3	0.0	34.4	12.0	4.4	11.1	43.3
Other health, residential, and personal care	**138.2**	72.9	0.9	5.1	6.9	3.2	41.7	7.5
Administration	**197.9**	34.9	2.0	34.5	109.9	3.3	13.4	–
Public health activity	**75.0**	–	–	–	–	–	75.0	–
Investment	**160.0**	–	–	–	–	–	160.0	–

TABLE 16, Continued

Type of Expenditure	Total	Share of Total						
		Medicaid	CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
National health expenditures	**100%**	**15.1%**	**0.5%**	**20.5%**	**32.8%**	**3.3%**	**16.1%**	**11.7%**
Hospital	**100**	17.7	0.4	27.2	36.4	5.6	9.3	3.4
Physician and clinical	**100**	8.1	0.6	22.7	45.7	3.7	9.6	9.7
Dental	**100**	6.6	1.2	0.3	48.1	1.2	0.5	42.2
Other professional	**100**	6.2	0.3	22.2	37.0	–	9.0	25.4
Home health	**100**	37.2	0.0	43.4	7.2	1.3	3.1	7.8
Other non-durable medical products	**100**	–	–	5.8	–	–	0.0	94.2
Prescription drugs	**100**	7.5	0.6	25.9	44.4	2.9	0.9	17.8
Durable medical equipment	**100**	11.1	0.3	19.9	11.4	–	1.4	55.9
Nursing care facilities and continuing care retirement communities	**100**	30.6	0.0	22.7	7.9	2.9	7.3	28.6
Other health, residential, and personal care	**100**	52.7	0.7	3.7	5.0	2.3	30.2	5.5
Administration	**100**	17.6	1.0	17.4	55.5	1.6	6.8	–
Public health activity	**100**	–	–	–	–	–	100.0	–
Investment	**100**	–	–	–	–	–	100.0	–

Notes: Figures for nursing care facilities and continuing retirement communities and other health, residential, and personal care reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40 percent of nursing home expenditures and about three-quarters of other personal health care expenditures. Other professional 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, among others. Other non-durable medical products includes the retail sales of non-prescription drugs and medical sundries. Durable medical equipment 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. Nursing care facilities and continuing care retirement communities 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. Other health, residential, and personal care 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. Administration 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). Zeroes indicate amounts less than $0.05 billion or 0.05 percent that round to zero. Dashes indicate amounts that are true zeroes.

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: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, *National health expenditures by type of service and source of funds: Calendar years 1960-2012,* January 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip. OACT, *National health expenditure accounts: Methodology paper, 2012,* 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf.

TABLE 17. Historical and Projected National Health Expenditures by Payer for Selected Years, 1970–2022

	Dollars						
	Total	Medicaid and CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Historical							
1970	**$75**	$5	$8	$15	$3	$18	$25
1975	**134**	13	16	30	6	30	37
1980	**256**	26	37	69	10	55	58
1985	**445**	41	72	131	15	89	96
1990	**724**	74	110	234	21	146	139
1995	**1,027**	145	184	327	27	198	146
2000	**1,377**	203	225	459	33	255	202
2005	**2,035**	317	340	703	57	351	267
2006	**2,167**	315	404	740	62	369	277
2007	**2,303**	335	433	778	66	397	294
2008	**2,412**	355	468	808	72	408	301
2009	**2,504**	387	500	833	79	405	301
2010	**2,599**	410	520	860	84	420	306
2011	**2,693**	420	546	889	89	433	316
2012	**2,793**	434	572	917	91	451	328
Projected							
2013	**2,915**	450	604	962	101	468	329
2014	**3,093**	503	635	1,036	108	487	324
2015	**3,273**	545	669	1,100	114	511	334
2016	**3,458**	586	715	1,156	122	536	342
2017	**3,660**	622	767	1,215	130	570	356
2018	**3,889**	655	828	1,287	140	609	371
2019	**4,142**	698	886	1,374	149	646	390
2020	**4,416**	747	955	1,459	160	683	412
2021	**4,702**	796	1,029	1,549	171	722	434
2022	**5,009**	847	1,123	1,636	183	761	458

TABLE 17, Continued

	Total	Share of Total					
		Medicaid and CHIP	Medicare	Private insurance	Other health insurance[1]	Other third party payers[2]	Out of pocket
Historical							
1970	**100%**	7.1%	10.2%	20.6%	4.4%	24.2%	33.4%
1975	**100**	10.1	12.2	22.8	4.5	22.5	28.0
1980	**100**	10.2	14.6	27.0	3.8	21.6	22.8
1985	**100**	9.2	16.2	29.5	3.4	20.1	21.6
1990	**100**	10.2	15.2	32.3	3.0	20.2	19.1
1995	**100**	14.1	17.9	31.8	2.6	19.3	14.2
2000	**100**	14.8	16.3	33.3	2.4	18.5	14.6
2005	**100**	15.6	16.7	34.5	2.8	17.3	13.1
2006	**100**	14.5	18.6	34.2	2.8	17.0	12.8
2007	**100**	14.6	18.8	33.8	2.9	17.3	12.8
2008	**100**	14.7	19.4	33.5	3.0	16.9	12.5
2009	**100**	15.4	20.0	33.3	3.2	16.2	12.0
2010	**100**	15.8	20.0	33.1	3.2	16.1	11.8
2011	**100**	15.6	20.3	33.0	3.3	16.1	11.7
2012	**100**	15.5	20.5	32.8	3.3	16.1	11.7
Projected							
2013	**100**	15.4	20.7	33.0	3.5	16.1	11.3
2014	**100**	16.3	20.5	33.5	3.5	15.8	10.5
2015	**100**	16.7	20.4	33.6	3.5	15.6	10.2
2016	**100**	17.0	20.7	33.4	3.5	15.5	9.9
2017	**100**	17.0	21.0	33.2	3.6	15.6	9.7
2018	**100**	16.8	21.3	33.1	3.6	15.7	9.5
2019	**100**	16.8	21.4	33.2	3.6	15.6	9.4
2020	**100**	16.9	21.6	33.0	3.6	15.5	9.3
2021	**100**	16.9	21.9	32.9	3.6	15.4	9.2
2022	**100**	16.9	22.4	32.7	3.7	15.2	9.1

Notes: Historical data were released in 2014; projected data were released in 2013 and may therefore reflect different assumptions than those used to produce the current historical data.

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: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, *National health expenditures by type of service and source of funds: Calendar years 1960–2012*, January 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip. For projected: MACPAC communication with OACT, February 2014, and OACT, *National health expenditure (NHE) amounts by type of expenditure and source of funds: Calendar years 1970–2022 in projections format*, September 2013. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/nhe65-22.zip.

TABLE 18. Characteristics of Non-Institutionalized Individuals by Source of Health Insurance, 2013

	All Ages					Age 0–18				
	Total all ages	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 0–18	Private	Medicaid/ CHIP	Medicare	Uninsured
Within Age Group[1]										
Number of People (millions)	**310.2**	185.2	52.1	48.1	45.3	**78.0**	41.5	29.1	0.3	5.9
Share of Population	**100%**	59.7%*	16.8%	15.5%*	14.6%*	**100%**	53.2%*	37.3%	0.4%*	7.5%*
Within Insurance Coverage Type										
Gender (%)										
Male	**48.8***	48.8*	44.4	44.0	54.4*	**51.1**	51.4	50.5	50.0	49.9
Female	**51.2***	51.2*	55.6	56.0	45.6*	**48.9**	48.6	49.5	50.0	50.1
Family Income (%)[2]										
<100% of poverty	**15.1***	3.8*	47.1	11.7*	27.2*	**21.6***	3.1*	47.5	34.1	28.4*
100–199% of poverty	**19.1***	10.7*	32.4	24.5*	33.5	**21.8***	11.2*	35.1	39.1	32.7
200+% of poverty	**65.8***	85.6*	20.5	63.8*	39.3*	**56.6***	85.7*	17.3	26.8	39.0*
Race/Ethnicity (%)										
Hispanic	**17.1***	10.2*	29.3	7.5*	34.5*	**23.8***	12.5*	36.4	40.1	39.8
White, non-Hispanic	**63.2***	72.8*	41.6	78.4*	44.5	**53.5***	68.5*	34.7	29.8	41.3*
Black, non-Hispanic	**12.0***	9.0*	21.1	9.4*	14.3*	**13.8***	9.1*	21.2	26.3	11.7*
Other races and multiple races	**7.7**	7.9	8.0	4.8*	6.8	**8.9**	9.9*	7.7	–[†]	7.2
Health Status (%)										
Excellent or very good	**66.2***	73.5*	59.7	40.7*	57.6	**83.7***	89.9*	75.7	68.9	77.0
Good	**23.6***	20.4*	25.3	32.1*	30.7*	**14.3***	9.2*	20.8	26.1	20.3
Fair or poor	**10.1***	6.1*	15.0	27.2*	11.7*	**2.0***	0.9*	3.5	–[†]	2.7
Place of Residence (%)[3]										
Large MSA	**53.7**	55.1	51.4	47.8	52.5	**53.8**	56.3*	50.6	47.5	52.4
Small MSA	**30.5**	30.5	29.6	30.8	29.7	**30.9**	31.1	30.3	36.9	29.5
Not in MSA	**15.8***	14.4*	19.1	21.4	17.8	**15.3***	12.7*	19.1	–[†]	18.1

TABLE 18, Continued

	Age 19–64					Age 65 and Over				
	Total age 19–64	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 65 and over	Private	Medicaid/ CHIP	Medicare	Uninsured
Within Age Group[1]										
Number of People (millions)	**189.2**	122.0	19.3	7.2	39.0	**43.0**	21.8	3.6	40.5	0.4
Share of Population	**100%**	64.5%*	10.2%	3.8%*	20.6%*	**100%**	50.6%*	8.4%	94.1%*	1.0%*
Within Insurance Coverage Type										
Gender (%)										
Male	**49.0***	48.8*	37.2	45.4*	55.1*	**44.1***	44.0*	33.6	43.6*	48.5*
Female	**51.0***	51.2*	62.8	54.6*	44.9*	**55.9***	56.0*	66.4	56.4*	51.5*
Family Income (%)[2]										
<100% of poverty	**13.8***	4.1*	48.2	30.0*	26.9*	**8.6***	3.2*	37.6	8.2*	32.6
100–199% of poverty	**17.3***	9.5*	28.9	35.7*	33.6*	**22.1***	16.3*	28.5	22.3*	36.1
200+% of poverty	**68.9***	86.4*	22.9	34.3*	39.5*	**69.3***	80.5*	33.9	69.6*	31.3
Race/Ethnicity (%)										
Hispanic	**16.5***	10.6*	20.5	10.3*	33.6*	**7.5***	3.6*	18.9	6.7*	44.7*
White, non-Hispanic	**63.6***	71.7*	49.6	68.1*	45.2*	**79.1***	87.2*	54.0	80.6*	29.6*
Black, non-Hispanic	**12.1***	9.6*	21.7	16.2*	14.7*	**8.4***	5.7*	17.2	8.0*	10.0*
Other races and multiple races	**7.7**	8.1	8.2	5.4*	6.6	**5.0***	3.5*	9.8	4.7*	15.7
Health Status (%)										
Excellent or very good	**63.9***	71.8*	42.4	16.4*	55.0*	**44.8***	51.5*	23.0	44.8*	29.8
Good	**25.4***	22.2*	30.6	28.4	32.2	**32.6**	31.7	32.8	32.8	30.1
Fair or poor	**10.7***	6.0*	27.0	55.2*	12.8*	**22.6***	16.8*	44.2	22.4*	40.1
Place of Residence (%)[3]										
Large MSA	**54.7**	56.4	51.9	44.5*	52.4	**49.3**	45.8*	54.5	48.4	61.0
Small MSA	**30.4**	30.2	29.4	32.5	29.8	**30.1***	31.2*	24.3	30.4*	24.4
Not in MSA	**15.0***	13.4*	18.7	23.0	17.8	**20.6**	23.1	21.2	21.2	14.6

TABLE 18, Continued

Notes:

1 Sum of health insurance coverage types may not add to total for each age group because individuals may have multiple sources of coverage and because not all types of coverage (e.g., military) are displayed. Insurance coverage is measured at the time of the interview. Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care. Medicaid/CHIP also includes persons covered by other public programs, excluding Medicare (e.g., other state-sponsored health plans); nevertheless, as discussed in Table 1, survey data tend to report lower Medicaid/CHIP enrollment than administrative data. Individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid/CHIP, state-sponsored or other government-sponsored health plans, or a 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.

2 For numerous reasons, poverty status shown here may differ from levels calculated by state Medicaid and CHIP programs. While these survey results show coverage as of the time of the survey in 2013, family income is for the prior year, 2012. In 2012, 100 percent of poverty using the U.S. Census Bureau's poverty threshold was $18,284 for a family of three. The poverty threshold differs from the federal poverty guidelines used for Medicaid and CHIP eligibility determinations. (The family income results shown here exclude the 9.9 percent of respondents with unknown poverty status.) In addition, data from surveys such as the National Health Interview Survey tend to include more income and more relatives as part of the family unit, compared to how income is counted for Medicaid and CHIP.

3 MSA is a metropolitan statistical area with a population size of 50,000 or more persons. Large MSAs have a population size of 1,000,000 or more; small MSAs have a population size between 50,000 and 1,000,000.

† Sample size is not sufficient to support published estimates.

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

Source: National Center for Health Statistics (NCHS) analysis for MACPAC of National Health Interview Survey (NHIS) data, January 2014; the estimates for 2013 are based on data collected from January through June, based on household interviews of a sample of the civilian non-institutionalized population.

TABLE 19. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2014

States		Annual Family size 1	2	3	4	Amount for each additional family member	States		Monthly Family size 1	2	3	4	Amount for each additional family member
Lower 48 states and DC	100% FPL	$11,670	$15,730	$19,790	$23,850	$4,060	Lower 48 states and DC	100% FPL	$973	$1,311	$1,649	$1,988	$338
	133% FPL	15,521	20,921	26,321	31,721	5,400		133% FPL	1,293	1,743	2,193	2,643	450
	138% FPL	16,105	21,707	27,310	32,913	5,603		138% FPL	1,342	1,809	2,276	2,743	467
	150% FPL	17,505	23,595	29,685	35,775	6,090		150% FPL	1,459	1,966	2,474	2,981	508
	185% FPL	21,590	29,101	36,612	44,123	7,511		185% FPL	1,799	2,425	3,051	3,677	626
	200% FPL	23,340	31,460	39,580	47,700	8,120		200% FPL	1,945	2,622	3,298	3,975	677
	250% FPL	29,175	39,325	49,475	59,625	10,150		250% FPL	2,431	3,277	4,123	4,969	846
	300% FPL	35,010	47,190	59,370	71,550	12,180		300% FPL	2,918	3,933	4,948	5,963	1,015
	400% FPL	46,680	62,920	79,160	95,400	16,240		400% FPL	3,890	5,243	6,597	7,950	1,353
Alaska	100% FPL	$14,580	$19,660	$24,740	$29,820	$5,080	Alaska	100% FPL	$1,215	$1,638	$2,062	$2,485	$423
	133% FPL	19,391	26,148	32,904	39,661	6,756		133% FPL	1,616	2,179	2,742	3,305	563
	138% FPL	20,120	27,131	34,141	41,152	7,010		138% FPL	1,677	2,261	2,845	3,429	584
	150% FPL	21,870	29,490	37,110	44,730	7,620		150% FPL	1,823	2,458	3,093	3,728	635
	185% FPL	26,973	36,371	45,769	55,167	9,398		185% FPL	2,248	3,031	3,814	4,597	783
	200% FPL	29,160	39,320	49,480	59,640	10,160		200% FPL	2,430	3,277	4,123	4,970	847
	250% FPL	36,450	49,150	61,850	74,550	12,700		250% FPL	3,038	4,096	5,154	6,213	1,058
	300% FPL	43,740	58,980	74,220	89,460	15,240		300% FPL	3,645	4,915	6,185	7,455	1,270
	400% FPL	58,320	78,640	98,960	119,280	20,320		400% FPL	4,860	6,553	8,247	9,940	1,693
Hawaii	100% FPL	$13,420	$18,090	$22,760	$27,430	$4,670	Hawaii	100% FPL	$1,118	$1,508	$1,897	$2,286	$389
	133% FPL	17,849	24,060	30,271	36,482	6,211		133% FPL	1,487	2,005	2,523	3,040	518
	138% FPL	18,520	24,964	31,409	37,853	6,445		138% FPL	1,543	2,080	2,617	3,154	537
	150% FPL	20,130	27,135	34,140	41,145	7,005		150% FPL	1,678	2,261	2,845	3,429	584
	185% FPL	24,827	33,467	42,106	50,746	8,640		185% FPL	2,069	2,789	3,509	4,229	720
	200% FPL	26,840	36,180	45,520	54,860	9,340		200% FPL	2,237	3,015	3,793	4,572	778
	250% FPL	33,550	45,225	56,900	68,575	11,675		250% FPL	2,796	3,769	4,742	5,715	973
	300% FPL	40,260	54,270	68,280	82,290	14,010		300% FPL	3,355	4,523	5,690	6,858	1,168
	400% FPL	53,680	72,360	91,040	109,720	18,680		400% FPL	4,473	6,030	7,587	9,143	1,557

Notes: The FPLs shown here are based on the U.S. Department of Health and Human Services 2014 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: U.S. Department of Health and Human Services (HHS), Annual update of the HHS poverty guidelines, *Federal Register* 78 (January 22): 3593, 2014.

TABLE 20. Supplemental Payments by State and Category, FY 2013 (millions)

State	Inpatient and Outpatient Hospitals[1]				Mental Health Facilities[2]		
	DSH payments	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	DSH payments	Total Medicaid payments	Supplemental payments as % of total
All states	**$13,427.8**	**$20,598.8**	**$89,465.4**	**38.0%**	**$2,949.5**	**$6,524.0**	**45.2%**
Alabama	470.9	343.2	1,891.5	43.0	–	67.5	–
Alaska	7.6	–	302.6	2.5	14.1	32.3	43.7
Arizona	145.1	846.3	1,466.7	67.6	28.0	30.2	92.6
Arkansas	61.0	314.8	990.0	38.0	–	159.9	–
California	2,119.5	5,641.3	16,290.6	47.6	0.2	531.5	0.0
Colorado	194.2	787.1	1,712.8	57.3	–	6.2	–
Connecticut	167.3	95.7	1,721.2	15.3	105.6	179.6	58.8
Delaware	5.2	–	50.8	10.3	5.6	6.5	87.1
District of Columbia	49.9	–	359.3	13.9	6.5	14.0	46.3
Florida	241.9	993.9	5,104.2	24.2	93.1	141.9	65.7
Georgia	430.0	125.2	2,198.9	25.2	–	24.3	–
Hawaii	25.0	81.7	117.9	90.4	–	–	–
Idaho	23.7	35.0	505.7	11.6	–	1.6	–
Illinois	371.6	1,881.9	6,498.3	34.7	75.5	226.7	33.3
Indiana	333.5	201.8	1,858.0	28.8	4.0	50.1	8.0
Iowa	54.6	32.5	792.8	11.0	–	20.5	–
Kansas	51.3	21.8	328.0	22.3	25.3	43.9	57.5
Kentucky	178.9	17.8	456.6	43.1	37.3	44.9	83.2
Louisiana	652.0	918.9	2,202.1	71.3	114.8	117.2	98.0
Maine	–	4.7	997.1	0.5	37.5	99.8	37.6
Maryland	41.9	47.7	993.3	9.0	92.4	184.9	50.0
Massachusetts	–	591.9	2,120.2	27.9	–	109.3	–
Michigan	388.0	622.9	1,722.1	58.7	–	22.6	–
Minnesota	46.1	70.0	603.1	19.3	0.2	86.9	0.2
Mississippi	218.0	490.5	1,660.4	42.7	–	74.2	–
Missouri	496.2	121.6	2,980.5	20.7	207.2	230.4	90.0
Montana	17.7	1.5	268.2	7.2	–	18.1	–
Nebraska	43.7	–	216.1	20.2	1.6	18.9	8.4
Nevada	81.4	120.0	539.1	37.4	–	45.4	–

TABLE 20, Continued

State	Inpatient and Outpatient Hospitals[1]				Mental Health Facilities[2]		
	DSH payments	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as % of total	DSH payments	Total Medicaid payments	Supplemental payments as % of total
New Hampshire	$18.6	–	$156.3	11.9%	$22.4	$30.0	74.6%
New Jersey	940.7	$259.1	1,739.5	69.0	357.4	452.5	79.0
New Mexico	25.2	123.1	365.8	40.5	–	2.7	–
New York[5]	2,766.9	-854.7	8,760.0	21.8	656.5	1,129.9	58.1
North Carolina	308.9	1,374.5	3,460.8	48.6	308.5	350.1	88.1
North Dakota	0.5	2.0	138.5	1.8	0.7	7.6	9.8
Ohio[6]	555.7	568.4	2,493.6	45.1	93.4	721.0	13.0
Oklahoma	41.2	442.1	1,544.0	31.3	0.5	72.8	0.7
Oregon	56.6	93.3	348.3	43.0	20.0	23.0	87.0
Pennsylvania	534.5	350.0	1,726.1	51.2	312.6	401.3	77.9
Rhode Island	129.8	11.6	350.7	40.3	–	5.6	–
South Carolina	405.0	108.3	1,156.1	44.4	52.2	102.0	51.1
South Dakota	0.7	2.8	187.7	1.9	0.8	4.0	18.9
Tennessee	80.3	969.5	1,171.3	89.6	–	33.9	–
Texas	106.3	2,014.1	4,918.2	43.1	120.5	141.3	85.3
Utah	27.9	183.4	457.6	46.2	0.9	13.3	7.0
Vermont[5]	37.4	-0.0	44.3	84.5	–	0.0	–
Virginia	179.3	270.6	1,011.0	44.5	7.2	141.9	5.1
Washington	238.6	–	1,033.4	23.1	128.2	153.3	83.6
West Virginia	56.5	229.7	588.2	48.7	18.9	106.9	17.7
Wisconsin	0.6	24.9	743.2	3.4	–	27.9	–
Wyoming	0.5	16.7	122.5	14.0	–	13.4	–

TABLE 20, Continued. Supplemental Payments by State and Category, FY 2013 (millions)

State	Nursing Facilities and ICFs-ID[3]			Physician and Other Practitioners[4]		
	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total
All states	**$2,393.8**	**$62,953.8**	**3.8%**	**$846.3**	**$13,163.5**	**6.4%**
Alabama	–	904.7	–	–	382.3	–
Alaska	–	128.2	–	–	125.7	–
Arizona	2.8	37.3	7.5	–	34.8	–
Arkansas	–	804.6	–	33.3	316.1	10.5
California	290.1	5,353.6	5.4	–	916.5	–
Colorado	91.1	688.3	13.2	14.2	357.7	4.0
Connecticut	–	1,557.9	–	–	414.8	–
Delaware	–	31.6	–	–	12.6	–
District of Columbia	–	312.6	–	–	46.9	–
Florida	11.0	3,156.7	0.3	79.0	1,265.3	6.2
Georgia	144.3	1,395.9	10.3	33.5	409.3	8.2
Hawaii	–	8.8	–	–	1.2	–
Idaho	81.5	288.4	28.3	–	89.9	–
Illinois	–	2,745.0	–	–	894.7	–
Indiana	461.6	1,946.3	23.7	109.9	286.8	38.3
Iowa	–	889.6	–	–	210.0	–
Kansas	2.3	198.6	1.2	15.6	49.9	31.3
Kentucky	0.4	1,010.0	0.0	6.2	50.7	12.3
Louisiana	–	1,336.3	–	42.5	316.7	13.4
Maine	–	339.1	–	–	131.9	–
Maryland	–	1,137.5	–	–	107.6	–
Massachusetts	1.4	1,640.2	0.1	28.0	355.6	7.9
Michigan	339.6	1,775.0	19.1	125.0	283.3	44.1
Minnesota	–	910.6	–	21.7	332.0	6.5
Mississippi	62.5	1,049.0	6.0	–	218.5	–
Missouri	–	1,089.1	–	–	47.9	–
Montana	–	173.1	–	–	65.2	–
Nebraska	–	414.9	–	–	42.3	–
Nevada	–	208.3	–	3.4	109.1	3.1
New Hampshire	–	302.0	–	–	63.2	–
New Jersey	–	2,508.5	–	–	48.2	–
New Mexico	–	28.1	–	14.1	91.1	15.5
New York[5]	172.5	9,540.3	1.8	32.6	585.5	5.6

TABLE 20, Continued

State	Nursing Facilities and ICFs-ID[3]			Physician and Other Practitioners[4]		
	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total	Non-DSH supplemental payments	Total Medicaid payments	Supplemental payments as of total
North Carolina	–	$1,309.9	–	$67.3	$912.6	7.4%
North Dakota	$1.7	304.6	0.6%	–	55.2	–
Ohio[6]	-82.1	3,153.6	-2.6	–	365.1	–
Oklahoma	–	673.4	–	0.0	513.9	0.0
Oregon	–	331.3	–	–	45.3	–
Pennsylvania	713.6	4,448.9	16.0	–	153.9	–
Rhode Island	–	339.9	–	–	11.6	–
South Carolina	22.2	671.8	3.3	32.8	237.4	13.8
South Dakota	–	163.1	–	–	64.2	–
Tennessee	–	250.3	–	–	27.7	–
Texas	–	3,424.2	–	83.1	1,358.2	6.1
Utah	5.0	233.7	2.2	27.9	102.0	27.3
Vermont[5]	0.1	116.2	0.1	–	1.9	–
Virginia	4.1	1,149.6	0.4	24.1	213.4	11.3
Washington	–	729.2	–	24.2	138.6	17.5
West Virginia	–	608.7	–	28.0	158.0	17.7
Wisconsin	39.6	1,013.7	3.9	–	78.4	–
Wyoming	28.6	121.4	23.6	–	62.7	–

Notes: 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; they 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. The Centers for Medicare & Medicaid Services (CMS) only began to require separate reporting of non-disproportionate share hospital (DSH) supplemental payments in fiscal year (FY) 2010 and is continuing to work with states to standardize this reporting. As a result, the information presented may not reflect a consistent classification of supplemental payment spending across states. Reporting is expected to improve over time. All states had certified their CMS-64 Finanical Management Report (FMR) submissions as of February 12, 2014. Figures presented in this table may change if states revise their expenditure data after this date. Zeroes indicate amounts less than 0.05 million that round to zero. Dashes indicate amounts that are true zeroes.

1 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 Social Security 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.

2 Includes inpatient psychiatric services for individuals under age 21 and inpatient hospital or nursing facility services for individuals age 65 or older in an institution for mental diseases. The CMS-64 instructions to states note that DSH payments are those made in accordance with Section 1923 of the Social Security Act. States are not instructed to break out non-DSH supplemental payments for mental health facilities.

3 Includes nursing facility and intermediate care facility for persons with intellectual disabilities (ICF-ID). Non-DSH supplemental payments are described in the CMS-64 instructions to states as payments that are made in addition to the standard fee schedule or other standard payment for a given service, including payments made under institutional upper payment limit rules.

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. The CMS-64 instructions to states describe supplemental payments as those that are made in addition to the standard fee schedule payment. Unlike for institutional providers, there is not a regulatory upper payment limit for physicians and other practitioners.

5 New York and Vermont reported negative non-DSH supplemental payments for inpatient hospitals.

6 Ohio reported negative non-DSH supplemental payments for ICFs-ID, creating a negative percentage.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2014.

TABLE 21. Federal CHIP Allotments, FY 2013 and FY 2014 (millions)

State	FY 2013 CHIP Allotments	FY 2014 Allotment Increase Factor	FY 2014 Federal CHIP Allotments
	A	B	C = A x B
Alabama	$162.8	1.0627	$173.1
Alaska	20.6	1.0627	21.8
Arizona	25.4	1.0650	27.0
Arkansas	103.1	1.0636	109.7
California	1,296.0	1.0627	1,377.3
Colorado	131.8	1.0658	140.5
Connecticut	41.3	1.0627	43.9
Delaware	15.7	1.0637	16.7
District of Columbia	14.9	1.0969	16.3
Florida	359.0	1.0647	382.3
Georgia	282.7	1.0642	300.9
Hawaii	25.8	1.0641	27.5
Idaho	36.0	1.0627	38.2
Illinois	275.6	1.0627	292.8
Indiana	144.9	1.0627	153.9
Iowa	92.5	1.0627	98.3
Kansas	55.4	1.0627	58.9
Kentucky	147.9	1.0627	157.2
Louisiana	171.9	1.0643	182.9
Maine	31.5	1.0627	33.5
Maryland	160.5	1.0627	170.5
Massachusetts	330.9	1.0627	351.6
Michigan	54.8	1.0627	58.2
Minnesota	32.1	1.0627	34.1
Mississippi	176.9	1.0627	188.0
Missouri	122.9	1.0627	130.7
Montana	59.4	1.0627	63.1
Nebraska	42.5	1.0666	45.3
Nevada	31.5	1.0650	33.5
New Hampshire	18.2	1.0627	19.3
New Jersey	640.2	1.0627	680.3
New Mexico	124.2	1.0627	132.0
New York	579.8	1.0627	616.1
North Carolina	304.2	1.0642	323.7
North Dakota	17.3	1.0853	18.8
Ohio	336.1	1.0627	357.1

TABLE 21, Continued

State	FY 2013 CHIP Allotments	FY 2014 Allotment Increase Factor	FY 2014 Federal CHIP Allotments
	A	B	C = A x B
Oklahoma	$114.2	1.0678	$121.9
Oregon	143.9	1.0627	152.9
Pennsylvania	305.7	1.0627	324.9
Rhode Island	39.5	1.0627	42.0
South Carolina	98.3	1.0658	104.7
South Dakota	19.4	1.0681	20.8
Tennessee	200.2	1.0635	212.9
Texas	891.5	1.0721	955.8
Utah	62.5	1.0696	66.8
Vermont	13.0	1.0627	13.9
Virginia	186.6	1.0630	198.3
Washington	96.9	1.0654	103.3
West Virginia	48.3	1.0627	51.3
Wisconsin	103.0	1.0627	109.5
Wyoming	10.8	1.0705	11.5
Subtotal	**$8,799.9**		**$9,365.7**
American Samoa	1.3	1.0627	1.4
Guam	4.5	1.0627	4.8
N. Mariana Islands	0.9	1.0627	1.0
Puerto Rico	132.7	1.0627	141.0
Virgin Islands	–	1.0627	–
Total	**$8,939.4**		**$9,513.9**

Notes: For even-numbered years (e.g., fiscal year (FY) 2014), federal CHIP allotments are calculated as the sum of last year's allotment and any shortfall payments (e.g., contingency funds), increased by a state-specific growth factor. In FY 2013, there were no contingency fund payments. For even-numbered years, a state can also have its allotment increased to reflect a CHIP eligibility or benefits expansion; some states have applied for these allotment increases, but the Centers for Medicare & Medicaid Services (CMS) has not named them nor finalized their additional allotment amounts, if any.

Source: MACPAC communication with the Centers for Medicare & Medicaid Services (CMS), February 2014.

TABLE 22. Federal CHIPRA Bonus Payments (millions)

State	FY 2009 CHIPRA bonus payments	FY 2010 CHIPRA bonus payments	FY 2011 CHIPRA bonus payments	FY 2012 CHIPRA bonus payments	Preliminary FY 2013 CHIPRA bonus payments	FY 2013 Outreach and Enrollment Efforts Among 23 States Receiving CHIPRA Bonus Payments							
						12 months of continuous eligibility	Liberalization of asset requirements	Elimination of in-person interview	Joint application and renewal form	Automatic, administrative renewal	Presumptive eligibility	Express Lane	Premium assistance
Total	**$37.1**	**$167.2**	**$303.5**	**$318.3**	**$307.3**	**15**	**22**	**23**	**23**	**17**	**13**	**5**	**5**
AL[1]	1.5	5.7	20.4	15.8	11.5	✓	✓	✓	✓	✓	–	–	–
AK	0.7	4.9	5.7	4.1	2.6	✓	✓	✓	✓	✓	–	–	–
CO	–	18.2	32.9	47.5	58.5	–	✓	✓	✓	✓	✓	✓	✓
CT	–	–	5.2	3.0	1.7	–	✓	✓	✓	✓	✓	–	–
GA	–	–	4.9	2.2	–								
ID	–	0.9	0.5	1.4	5.4	✓	✓	✓	✓	✓	–	–	✓
IL	9.5	15.3	15.3	13.3	6.3	✓	✓	✓	✓	✓	✓	–	–
IA	–	7.7	10.0	11.4	10.6	✓	✓	✓	✓	–	✓	✓	–
KS	1.2	5.5	6.0	12.8	10.9	✓	✓	✓	✓	✓	✓	–	–
LA	1.5	3.7	1.9	–	–								
MD	–	11.4	28.0	37.5	43.5	–	✓	✓	✓	✓	–	✓	–
MI	4.7	8.4	6.9	4.4	1.6	✓	✓	✓	✓	–	✓	–	–
MT	–	–	5.0	7.2	7.0	–	✓	✓	✓	✓	✓	–	–
NJ	3.1	8.8	17.6	24.4	22.4	–	–	✓	✓	✓	✓	✓	–
NM	5.4	9.0	5.2	2.7	1.7	✓	✓	✓	✓	✓	✓	–	–
NC	–	–	11.6	18.6	11.6	✓	✓	✓	✓	✓	–	–	–
ND	–	–	3.2	2.7	1.1	✓	✓	✓	✓	✓	–	–	–
NY[2]	–	–	–	0.6	13.1	✓	✓	✓	✓	–	✓	–	
OH	–	13.1	20.9	19.0	10.8	✓	✓	✓	✓	–	✓	–	–
OK	–	–	0.5	–	–								
OR	1.6	10.6	22.3	25.9	24.4	✓	✓	✓	✓	✓	–	–	–
SC	–	–	2.7	2.9	17.5	✓	✓	✓	✓	–	✓	✓	–
UT	–	–	–	9.9	5.3	–	✓	✓	✓	✓	✓	–	–
VA	–	–	24.6	20.0	18.0	–	✓	✓	✓	✓	–	–	✓
WA	7.9	20.7	19.0	13.8	7.8	✓	✓	✓	✓	–	–	–	✓
WI	–	23.4	33.3	17.1	13.9	–	✓	✓	✓	✓	–	–	✓
WV	–	–	0.1	–	–								

Notes: CHIPRA is the Children's Health Insurance Program Reauthorization Act. Each of these outreach and enrollment efforts is described in MACPAC's March 2011 report (pp. 68–69). Some fiscal year (FY) 2012 bonus payments have been revised based on final enrollment figures.

1 Originally, Alabama's bonus payments were $40 million for FY 2009 and $55 million for FY 2010. A preliminary audit conducted by CMS and the state revealed an error in the state's calculation of qualifying children. For some states, preliminary bonus payments may be revised to reflect final figures showing growth in children's enrollment in Medicaid.

2 New York qualified for FY 2012 bonus payment after reconciliation of final enrollment figures.

Sources: U.S. Department of Health and Human Services (HHS), *CHIPRA performance bonuses: A history (FY 2009 – FY 2013)*, December 2013. http://www.insurekidsnow.gov/professionals/eligibility/pb-2013-chart.pdf; and HHS, *FY 2013 CHIPRA performance bonus awards*. http://www.insurekidsnow.gov/professionals/eligibility/fy2013-pb-table.pdf.

TABLE 23. Provider Availability Measures of Access to Care for Medicaid/CHIP Beneficiaries, 2012

	Measure Number[1]	All Primary Care Physicians[2]	Physicians in Primary Care Specialties	
			General pediatrics	General, family or internal medicine
Provider Availability				
Primary care physician (PCP) is accepting new patients by source of payment[3]	P1			
New Medicaid/CHIP patients		**67.4%**	79.5%^	62.6%^†
New Medicare patients		**75.1***	–[4]	87.5*^
New privately insured patients		**85.2***	94.7*^	81.8*^†
Percentage of the PCP's patient care revenue that comes from Medicaid/CHIP (categories sum to 100%)[5]	P2			
None		**27.3**	19.2^	30.6^†
1 to 9 percent of revenue		**18.5**	10.0^	22.0^†
10 to 25 percent of revenue		**27.5**	20.9^	30.2^†
26 to 50 percent of revenue		**17.9**	27.5^	14.0^†
More than 50 percent of revenue		**8.8**	22.4^	3.2^†

Notes: Data in this table are drawn from the 2012 National Electronic Health Records Survey, a component of the National Ambulatory Medical Care Survey (NAMCS-NEHRS). The 2012 NAMCS-NEHRS draws on a national multistage probability sample of practicing physicians in office-based settings, defined as a physician office where non-federally employed physicians provide direct patient care. This includes community health centers, HMOs, and faculty practices that refer patients to academic health centers and excludes outpatient hospital departments. Physicians in the specialties of anesthesiology, pathology, and radiology are excluded.

* Difference from percentage accepting new Medicaid patients is statistically significant at the 0.01 level.

^ Difference from all primary care physicians (PCPs) is statistically significant at the 0.01 level.

† Difference from PCPs in general pediatrics is statistically significant at the 0.01 level.

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 PCPs include physicians in general pediatrics, general medicine, family medicine, and internal medicine. Obstetrician-gynecologists are not included in the table.

3 Physicians who do not accept any new patients are considered not to be accepting any new Medicaid, Medicare, or privately insured patients.

4 The percentage of pediatricians accepting new Medicare patients is omitted due to very low Medicare participation by this group.

Source: National Center for Health Statistics analysis for MACPAC of the 2012 National Electronic Health Records Survey, a component of the 2012 National Ambulatory Medical Care Survey (NAMCS-NEHRS).

TABLE 24. Parent-Reported Measures of Access to Care for Non-Institutionalized Children by Source of Health Insurance, 2011–2012

	Measure Number[1]	All Children[2]	Children with Selected Sources of Insurance[2,3]		
			Medicaid/ CHIP[4]	Private/ Other[5]	Uninsured[6]
Connection to the health care system (past 12 months)					
Has a usual source of care[8]	S1	**95.4%**	96.8%	98.0%*	65.9%*
Had same usual source of medical care 12 months ago (all children)[8]	S2	**88.8**	90.0	91.9*	64.3*
Has a personal doctor or nurse[7]	S3	**90.3**	87.8	94.5*	64.5*
Access barrier is reason for having no usual source of care[8,9]	S4	**1.4**	0.4	0.2	18.1*
Had trouble finding a doctor[8,10]	S5	**3.7**	4.8	2.2*	4.5
Had usual source of care barrier or trouble finding a doctor[8,11]	S6	**4.9**	5.1	2.4*	20.8*
Receipt of effective care coordination[7,12]	S7				
Parent did not receive all care coordination needed		**14.3**	16.4	12.9	14.6
Parent received all care coordination needed		**27.8**	27.1	29.9*	12.2*
Did not need care coordination		**57.9**	56.5	57.3	73.1*
Contact with health care professionals (past 12 months)					
Had at least one office visit[8,13]	C1	**90.7**	91.6	92.7	63.1*
Saw a general doctor[8]	C2	**81.8**	82.4	84.6*	50.3*
Saw a general doctor, nurse practitioner, PA, midwife, or Ob-Gyn[8,14]	C3	**83.6**	83.7	86.3*	54.5*
Had at least one preventive dental visit (age 2–17)[7]	C4	**80.7**	76.9	86.3*	49.5*
Timeliness of care (past 12 months)					
Delayed medical care due to an access barrier[8,15]	T1	**11.5**	13.4	7.3*	23.6*
Any time when needed health care was delayed or not received[7]	T2				
Medical care		**3.4**	4.4	1.8*	13.2*
Mental health care		**0.8**	1.0	0.7*	1.4
Dental care		**2.6**	3.0	1.7*	10.7*
Vision		**0.9**	1.0	0.5*	4.4*

TABLE 24, Continued

	Measure Number[1]	All Children[2]	Children with Selected Sources of Insurance[2,3]		
			Medicaid/ CHIP[4]	Private/ Other[5]	Uninsured[6]
Unmet need for selected types of care due to cost[8]	T3				
Medical care		**1.8%**	0.9%	0.8%	10.5%*
Mental health care or counseling, age 2–18		**1.0**	0.8	0.7	2.7*
Dental care		**5.6**	4.2	3.2*	21.7*
Prescription drugs		**2.2**	1.9	1.3*	7.2*
Eyeglasses		**2.0**	2.0	1.1*	7.2*
Had problem getting referrals (of children needing referrals)[7]	T4	**20.8**	24.9	15.9*	43.5*
Receipt of appropriate care (past 12 months)					
Doctors and other providers spend enough time with child[7,16]	A1	**77.5**	68.8	85.6*	47.4*
Received at least one preventive medical visit (age 0–17)[8]	A2	**80.2**	82.7	82.1	46.1*
Children age 0–5		**89.7**	88.4	92.8*	62.5*
Children age 6–11		**77.9**	81.2	79.5	45.1*
Children age 12–17		**73.0**	76.2	75.8	40.8*
Received selected EPSDT services (of children needing service)[7,17]	A3				
Vision screening in last 2 years (age 5–17) or ever (age 0–4)		**67.6**	63.4	71.5*	57.6*
Mental health care (children needing mental health care, age 2–17)		**61.1**	59.2	66.1*	41.9*
Therapy services (children with autism or developmental delays)		**87.9**	86.7	90.0	77.7
Received coordinated, ongoing, comprehensive care within a medical home[7]	A4	**54.4**	43.9	64.0*	27.8*
Had at least one hospital emergency room (ER) visit[8]	A5	**18.0**	24.9	13.3*	12.9*
ER visit was related to a serious health problem[18]		**10.0**	13.1	7.9*	5.4*
ER visit was related to an access barrier, not a serious problem[18]		**6.6**	9.8	4.2*	5.5*
Had two or more ER visits[8]	A6	**5.9**	9.9	3.2*	3.8*

TABLE 24, Continued

Notes: Data in this table are drawn from national samples of children based on two different surveys, the 2012 National Health Interview Survey (NHIS) and the 2010–2011 National Survey of Children's Health (NSCH). The NHIS and NSCH apply different sampling methodologies, and data are collected from different time periods. In addition, the surveys have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared. The table is intended to compare populations with different coverage sources within each measure. Responses to access and use questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. As a result, experiences with access barriers and service use in part may be due to periods with other coverage or no coverage in the past year.

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

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 For NHIS measures, the population is children age 0–18 who were insured or uninsured for the entire year. For NSCH measures, the population is all children age 0–17.

3 The population in each column differs somewhat based on the data source, as described in the footnotes on individual columns. Children covered by Medicare (generally children with end-stage renal disease) are not separately shown.

4 For NHIS measures, the Medicaid/CHIP population consists of children age 0–18 with Medicaid/CHIP at the time of interview and is limited to children insured for the entire year, including children who switched coverage sources during the year. For NSCH measures, the Medicaid/CHIP population consists of children age 0–17 with Medicaid/CHIP at the time of interview, including children who were uninsured during the past year. NHIS measures exclude a small number of children with Medicaid/CHIP who are also covered by private, Medicare, or other state-sponsored and government-sponsored insurance at the time of interview, while NSCH measures include any children with Medicaid/CHIP and additional sources of public or private coverage.

5 For NHIS measures, the private/other population is limited to children age 0–18 insured for the entire year and includes children who switched coverage sources during the year, while NSCH measures include children age 0–17 who were uninsured during the past year. The private/other population for NHIS measures consists of children with employer-sponsored insurance, other private plans, and military health plans at the time of the interview and includes children with both private insurance and Medicaid/CHIP or other coverage. For NSCH measures, the privately insured/other population consists of children who were covered by any insurance other than Medicaid/CHIP at the time of the interview. These children primarily have employer-sponsored insurance, other private plans, and military health plans, but this population also includes a small number of children with other state-sponsored or other government-sponsored insurance.

6 For NHIS measures, the uninsured population is children age 0–18 who did not have any health insurance coverage at the time of interview and who were uninsured for the entire year. Children with Indian Health Service coverage only or a private plan that paid for one type of service, such as accidents or dental care, were classified as uninsured. For NSCH measures, the uninsured population is children age 0–17 who did not have any type of health insurance coverage at the time of interview and includes children who had a source of coverage sometime in the past year.

7 Measure is constructed from the 2011–2012 NSCH.

8 Measure is constructed from the 2012 NHIS.

9 Reasons given by those who reported no usual place of care that were classified as access barriers include: too expensive/cost, previous doctor not available, parent does not know where to go, and speaks a different language.

10 Parent reported one of these barriers in the past 12 months: trouble finding a doctor or provider, doctor's office/clinic did not accept child's insurance coverage, or office/clinic did not accept child as a new patient.

11 Reported any experiences captured in measure S4 and S5.

12 Children are classified as needing care coordination if they received two or more services or the parent reported needing care coordination. The criteria for receipt of effective care coordination were that the family received some type of help with care coordination, and the family was very satisfied with doctors' communication with other health care providers, school, and other programs, if those services were needed. The denominator for each statistic is all children.

13 Parents may report encounters with a broad range of health professionals (e.g., speech therapist or social worker) but the question is limited to visits in a doctor's office or clinic.

14 PA is physician assistant. Ob-Gyn is obstetrician-gynecologist, and these visits were limited to females age 15–18.

15 Reasons given for delayed care classified as access barriers include cost, transportation, and provider-related reasons (parent couldn't get an appointment, had to wait too long to see doctor, couldn't go when open, couldn't get through on phone, and parent speaks a different language).

16 Defined as the percentage of children whose parents reported the providers usually or always spend enough time with child.

17 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are a mandatory Medicaid benefit. The denominator for vision screening is all children. The denominator for mental health care is children whose parents report the child needed mental health care. The denominator for therapy services is children with autism or a developmental delay. These measures do not capture children with an undiagnosed need or whose parents are not aware the child needs services.

18 Based on questions about the most recent emergency room (ER) visit. The most recent ER visit is classified as related to a serious health problem if the parent reported that the visit resulted in a hospital admission or reason for the visit was taken by ambulance, advised by doctor to go, or problem too serious for doctor's office/clinic. The ER visit is classified as related to an access barrier if the parent reported that the visit occurred at night or on a weekend, or the reason for the visit was that doctor's office/clinic was closed, excluding visits for a serious health problem. These categories do not capture all visits.

Source: MACPAC analysis of the 2012 National Health Interview Survey (NHIS) and the 2011–2012 National Survey of Children's Health (NSCH).

TABLE 25. Parent-Reported Measures of Access to Care for Non-Institutionalized Children with Special Health Care Needs (CSHCN) by Source of Health Insurance, 2009–2012

	Measure Number[1]	All CSHCN[2]	CSHCN[2] with Selected Sources of Insurance[3]		
			Medicaid/ CHIP[4]	Private/ Other[5]	Uninsured[6]
Connection to the health care system (past 12 months)					
Has a personal doctor or nurse[7]	S3	**92.8%**	90.3%	95.8%*	75.3%*
Receipt of effective care coordination[7,8]	S7				
Parent did not receive all care coordination needed		**33.1**	34.3	32.1	38.2*
Parent received all care coordination needed		**42.9**	41.8	45.5	18.9*
Did not need care coordination		**23.9**	24.0	22.4	42.8*
Family had one or more unmet needs for support services[9,10]	S8	**7.2**	8.8	4.6*	18.1*
Contact with health professionals (past 12 months)					
Had at least one preventive dental visit (age 2–17)[7]	C4	**84.4**	80.1	90.1*	49.7*
Received care from a specialist doctor[9]	C5	**45.6**	40.4	50.0*	31.9*
Timeliness of care (past 12 months)					
Had unmet need for selected types of care[9]	T5				
Specialist care		**4.4**	6.2	2.5*	15.3*
Prescription drugs		**2.6**	3.4	1.4*	15.9*
Mental health care and counseling		**5.6**	7.3	4.0*	14.9*
Non-preventive dental		**5.4**	7.1	3.7*	20.8*
Physical, occupational, or speech therapy		**4.7**	5.1	3.8*	8.0*
Vision care or eyeglasses		**2.1**	2.8	1.3*	8.2*
Had 2 or more unmet needs for 14 specific services[9,11]	T6	**8.8**	11.9	5.3*	33.6*
Receipt of appropriate care (past 12 months)					
Doctors and other providers spend enough time with child[7,12]	A1	**79.7**	74.2	85.8*	54.3*
Had at least one preventive medical visit[9]	A2	**90.4**	91.5	91.1	70.3*
Children less than age 2		**97.8**	97.5	98.3*	–[13]
Children age 2–4		**94.6**	92.9	96.6*	93.5
Children age 5–11		**89.3**	88.1	93.1*	52.6*
Children age 12–17		**90.4**	90.2	90.2	64.5*
Received coordinated, ongoing, comprehensive care within a medical home[9]	A4	**46.8**	40.6	53.2*	25.8*
Had two or more ER visits[9]	A6	**21.6**	33.0	12.8*	23.5*

TABLE 25, Continued

Notes: Data in this table are drawn from national samples of children based on two different surveys, the 2010–2011 National Survey of Children's Health (NSCH) and the 2009–2010 National Survey of Children with Special Health Care Needs (NS-CSHCN). Measures are for children age 0–17, unless otherwise noted. The NSCH and NS-CSHCN apply different methods to sample children, and data are collected from different time periods. In addition, the surveys have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared. The table is intended to compare populations with different coverage sources within each measure. Responses to access and use questions are based on the previous 12 months, during which time the individual may have had different coverage than that shown in the table. As a result, experiences with access barriers and service use may be due partly to periods with other coverage or no coverage in the past year. Not separately shown are children covered by Medicare (generally children with end-stage renal disease). See additional notes.

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

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 CSHCN is children with special health care needs. In both the NSCH and NS-CSHCN, CSHCN are identified using a five-item, parent-reported tool that identifies children across the range and diversity of childhood chronic conditions and special needs and who currently experience one or more of five common health consequences due to a physical, mental, behavioral, or other type of health condition lasting or expected to last at least 12 months. See Child and Adolescent Health Measurement Initiative (CAHMI), Fast facts: *Children with special health care needs screener* (Portland, OR: CAHMI, 2007). http://childhealthdata.org/docs/cshcn/cshcn-screener-cahmi-quickguide-pdf.pdf.

3 The population in each column differs somewhat based on the data source. See additional notes for the selected populations.

4 CHIP is State Children's Health Insurance Program. For all measures, the Medicaid/CHIP population is children with Medicaid or CHIP at the time of interview and includes children who were uninsured during the past year or who switched coverage sources during the year. For NSCH measures, Medicaid/CHIP includes a small number of children with additional sources of public or private coverage. For NS-CSHCN measures, Medicaid/CHIP is limited to children with Medicaid or CHIP only at the time of interview and excludes children with additional sources of public or private coverage.

5 For NSCH measures, the private/other population consists of children who were covered by any insurance other than Medicaid/CHIP at the time of the interview. These children primarily have employer-sponsored insurance, other private plans, and military health plans, but this population also includes a small number of children with other state-sponsored or other government-sponsored insurance. For the NS-CHSCN measures, the private/other population is limited to children with private health insurance only, defined as insurance through an employer, purchased directly from an insurance company, or any military health plan. For both NSCH and NS-CSHCN measures, the private/other population includes children insured at the time of interview who were uninsured during the year or who switched coverage sources during the year.

6 For both NSCH and NS-CHSCN measures, the uninsured population consists of children who did not have any health insurance coverage at the time of interview and includes children who had a source of coverage sometime in the past year. For NS-CHSCN measures, parents who indicated the child was insured by a source other than Medicaid/CHIP were asked a follow-up question of whether the insurance covered doctor visits and hospital stays. If not, these children also were classified as uninsured. In addition, the NS-CSHCN instructed parents not to count dental, vision, school, or accident insurance as coverage.

7 Measure is constructed from the 2011–2012 NSCH (see source noted below).

8 Children are defined as needing care coordination if they received two or more services or the parent reported needing care coordination. The criteria for receipt of effective care coordination were that the family received some type of help with care coordination, and the family was very satisfied with doctors' communication with other health care providers, school, and other programs, if those services were needed. The denominator for each statistic is all children.

9 Measure is constructed from the 2009–2010 NS-CSHCN (see source noted below).

10 The family needed one or more family supports (respite care, genetic counseling, or family mental health care or counseling) but did not receive all the help they needed.

11 In addition to the services listed in the table, this includes unmet need for dental, home health care, substance abuse treatment or counseling, durable medical equipment, genetic counseling, and respite care.

12 The percentage of children whose parents reported the providers usually or always spend enough time with child.

13 Data not shown due to small sample size.

Source: MACPAC analysis of the 2011–2012 National Survey of Children's Health (NSCH) and the 2009–2010 National Survey of Children with Special Health Care Needs (NS-CSHCN).

TABLE 26. Measures of Access to Care for Non-Institutionalized Individuals Age 19 to 64 by Source of Health Insurance, 2012

	Measure Number[1]	All Adults[2]	Adults with Selected Sources of Insurance		
			Medicaid[3]	Private[4]	Uninsured[5]
Connection to the health care system (past 12 months)					
Has a usual source of care when sick or needs advice	S9	**79.6%**	87.1%	89.9%*	41.7%*
Access barrier is reason for having no usual source of care[6]	S11	**8.4**	3.1	1.4*	34.5*
Had trouble finding a doctor[7]	S12	**3.1**	4.5	1.5*	6.3*
Had usual source of care barrier or trouble finding a doctor[8]	S13	**13.3**	11.6	5.1*	38.4*
Contact with health professionals (past 12 months)					
Had at least one office visit[9]	C6	**77.5**	84.9	84.7	46.6*
Saw a selected health professional (any setting)[10]					
Saw a nurse practitioner, physician assistant (PA), or midwife	C7	**19.1**	22.3	20.7	9.0*
Saw a medical doctor, nurse practitioner, PA, or midwife[11]	C8	**76.7**	81.7	84.2*	45.7*
Saw a mental health professional (adults with SMI only)[12]	C9	**39.5**	45.9	38.9	24.2*
Saw a dental professional	C10	**61.3**	50.7	74.2*	28.1*
Saw any health professional, excluding dental[13]	C11	**82.4**	88.6	89.1	53.4*
Saw any health professional, including dental[13]	C12	**88.8**	92.8	94.9*	62.3*
Timeliness of care (past 12 months)					
Delayed medical care due to an access barrier (any below)[14]	T7	**21.8**	22.9	14.7*	37.9*
Because of costs		**13.0**	7.9	6.0*	32.4*
Provider-related reasons[14]		**10.3**	14.6	9.5*	8.4*
Did not have transportation		**1.9**	6.0	0.6*	2.5*
Unmet need for selected types of care due to cost	T8				
Medical care		**9.9**	6.1	3.4*	28.1*
Mental health care or counseling		**3.0**	2.2	1.2*	7.1*
Did not take medication as prescribed to save money[15]	T9	**14.3**	12.8	8.0*	28.6*
Had any barriers to finding a doctor, delayed care, or unmet need[16]	T10	**34.1**	33.5	21.8*	65.3*

TABLE 26, Continued

	Measure Number[1]	All Adults[2]	Adults with Selected Sources of Insurance		
			Medicaid[3]	Private[4]	Uninsured[5]
Receipt of appropriate care (past 12 months)					
Received any preventive visit or counseling, all individuals[17]	A7	**84.1%**	89.1%	90.3%	57.3%*
Individuals age 19 to 49		**80.7**	87.8	87.8	54.2*
Individuals age 50 to 64		**91.2**	93.3	94.6	68.0*
Individuals with a chronic condition or pregnant, all ages		**92.7**	96.3	96.0	73.9*
Had cholesterol checked by health professional, all individuals	A8	**57.3**	60.9	64.9*	27.2*
Men age 35 to 64		**65.4**	67.4	73.8*	28.6*
Individuals with health-related risk of heart disease (CHD)[18]		**65.6**	69.2	75.6*	33.3*
All individuals at increased risk of CHD		**63.5**	66.8	72.6*	30.0*
Had a flu shot, all individuals	A9	**31.6**	31.3	37.3*	13.0*
Individuals age 50 to 64		**42.8**	42.6	46.4	19.3*
Individuals with a chronic condition or pregnant		**40.5**	38.8	46.5*	18.5*
All individuals at high-risk of influenza complications[19]		**39.1**	38.1	44.2*	17.4*
Had professional counseling about smoking (current smokers)	A10	**49.2**	59.0	55.0	28.8*
Had any test for colorectal cancer (age 50 to 64)	A11	**22.8**	24.7	25.1	6.3*
Men age 50 to 64		**24.9**	22.1	27.5	5.9*
Women age 50 to 64		**20.9**	26.4	22.8	6.7*
Had Pap smear or test for cervical cancer (women age 21 to 60)	A12	**59.3**	61.6	65.8*	33.6*
Had more than 15 office visits	A13	**5.3**	9.6	5.0*	1.9*
Had at least one hospital emergency room (ER) visit	A14	**18.8**	35.9	14.9*	17.1*
ER visit was related to a serious health problem[20]		**12.1**	23.8	9.7*	8.9*
ER visit was related to an access barrier, not a serious problem[20]		**4.9**	8.7	4.0*	5.0*
Four or more ER visits	A15	**2.0**	7.2	0.8*	2.0*

TABLE 26, Continued

Notes: Measures in this table are based on national samples of adults from the 2012 National Health Interview Survey (NHIS). Measures are for adults age 19–64, unless otherwise noted. The population in this table is limited to individuals insured for the entire year or uninsured for the entire year and excludes individuals insured for only part of the year and uninsured part of the year. Responses to access and use questions are based on the previous 12 months, during which time the individual may have had a different source of coverage than that shown in the table. Not separately shown are individuals covered by Medicare.

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

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 In addition to individuals in the Medicaid, private, and uninsured columns, includes individuals dually covered by Medicare and Medicaid and covered by Medicare only.

3 Medicaid includes a small number of individuals covered by other state-sponsored health plans. Individuals with both Medicaid and Medicare or other public coverage at the time of interview were excluded.

4 Private health insurance coverage includes individuals with employer-sponsored coverage, other private plans, and military health plans at the time of interview and includes individuals with both private insurance and Medicaid/CHIP, Medicare, or other public coverage.

5 Uninsured includes individuals who did not have any health insurance coverage at the time of interview (individuals were also classified 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).

6 Reasons given by those who reported no usual place of care that were classified as access barriers include: too expensive/cost, previous doctor not available, respondent does not know where to go, and respondent speaks a different language.

7 Individual reported one of these barriers in the past 12 months: trouble finding a doctor or provider, doctor's office/clinic did not accept the individual's insurance coverage, or office/clinic did not accept individual as a new patient.

8 Reported any experiences captured in measures S11 and S12.

9 Respondents may report encounters with a broad range of health professionals (e.g., a chiropractor or physical therapist) but the question is limited to visits in a doctor's office or clinic.

10 Respondents may not limit encounters with health professionals to visits in a doctor's office or clinic.

11 Medical doctor includes general doctor, obstetrician-gynecologist, medical specialist, and eye doctor, but excludes other health professionals (e.g., a chiropractor, podiatrist or foot doctor, or physical therapist).

12 SMI is serious mental illness. Individuals were defined as having SMI if they reported a limitation due to a mental health or behavioral problem or received a score over 30 (out of 40) on the Kessler Psychological Distress Scale (K10) in the NHIS. For more information on the Kessler Psychological Distress Scale, see R. Kessler, P. Barker, L. Colpe, et al., Screening for serious mental illness in the general population, *Archives of General Psychiatry* 60, no. 2 (2003): 184–189.

13 C11 is a global measure of professional contact and includes all encounters in C8, all encounters with a mental health professional (not just those in C9 by individuals with SMI), and encounters with other health professionals not counted elsewhere (e.g. chiropractor, podiatrist or foot doctor, or physical therapist). C12 adds to C11 all dental professional visits. Responses to questions about specific types of health professionals may not align with reported office visits in C6 due to differences in question wording, respondent interpretation, and recall.

14 Reasons given for delayed care classified as access barriers include: cost, transportation, and provider-related reasons (respondent couldn't get an appointment, had to wait too long to see doctor, couldn't go when open, couldn't get through on phone, and speaks a different language).

15 Individuals reporting unmet need because of cost for prescription drugs, and individuals who took specific actions to save money on medications (skipped doses, took less medicine, and delayed filling a prescription).

16 Measure T10 is all individuals with an access problem reported in S13 and T7–T9.

17 Includes all preventive services in measures A8–A12 and other services reported in the NHIS: health professional talked to you about diet, blood pressure checked by health professional, and screening for breast cancer. Includes individuals who reported receiving the service, but who are not in a high-risk group or of a recommended age for the service.

18 Individuals of any age or sex reporting hypertension, diabetes, and who currently smoke. See details in MACStats Appendix.

19 Based on common risk factors that can be measured in the NHIS. See details in MACStats Appendix.

20 Based on responses to questions about the most recent emergency room (ER) visit. Most recent ER visit is classified as related to a serious health problem if the individual reported that the visit resulted in a hospital admission, or reason for the visit was either taken by ambulance, advised by doctor to go, or problem too serious for doctor's office/clinic. Visit is classified as related to an access barrier if the individual reported the visit occurred at night or on weekend, or reason for the visit was doctor's office/clinic was closed, and excludes individuals reporting a serious health problem.

Source: MACPAC analysis of the 2012 National Health Interview Survey (NHIS).

TABLE 27. Measures of Access to Care for Non-Institutionalized Medicaid Beneficiaries Age 19 to 64 by Receipt of Supplemental Security Income (SSI), 2009–2011

	Measure Number[1]	Adult Medicaid Enrollees by Receipt of SSI	
		Received SSI	Did not receive SSI
Connection to the health care system (past 12 months)			
Has a usual source of care when sick or needs advice	S9	91.0%	87.3%*
Had same usual source of care 12 months ago (all adults)	S10	83.8	81.0
Contact with health care professionals (past 12 months)			
Had at least one office visit[2]	C6	87.9	82.2*
Saw a selected health professional (any setting)[3]			
Saw a nurse practitioner, physician assistant (PA), or midwife	C7	22.8	17.1*
Saw a medical doctor, nurse practitioner, PA, or midwife[4]	C8	86.4	81.1*
Saw a mental health professional	C9	32.9	12.5*
Saw an obstetrician-gynecologist (women)	C13	32.5	49.9*
Saw other specialist, not an obstetrician-gynecologist	C14	36.5	22.0*
Timeliness of care (past 12 months)			
Delayed medical care due to an access barrier (any below)[5]	T7	29.4	21.8*
Because of costs		8.2	7.2
Provider-related reasons[5]		16.6	14.7
Did not have transportation		14.9	5.5*
Unmet need for selected types of care due to cost	T8		
Medical care		6.3	5.7
Mental health care or counseling		4.8	2.8*
Prescription drugs		12.2	9.1*
Dental care		20.0	18.3
Eyeglasses		12.5	9.9*
Receipt of appropriate care (past 12 months)			
Had more than 15 office visits	A13	17.0	8.8*
Four or more hospital emergency room (ER) visits	A15	11.6	5.7*

TABLE 27, Continued

Notes: Measures in this table are based on national samples of adults from the National Health Interview Survey (NHIS) using 2009–2011 data. Measures are for adults age 19–64, unless otherwise noted. All individuals in this table were covered by Medicaid at the time of interview. The population is limited to individuals who were insured for the entire year and includes individuals who switched coverage sources during the year. Medicaid includes a small number of persons covered by other state-sponsored health plans at the time of interview. Individuals with both Medicaid and other coverage (private, Medicare, or other public insurance) at the time of interview were excluded from the table. SSI is Supplemental Security Income. Adults with SSI are individuals with little or no income and assets whose ability to work is limited by a physical or mental disability that can be expected to result in death or last for at least 12 months. The SSI group does not capture all persons with a disability. Responses to recent-care questions are based on the previous 12 months, during which time the individual may have had different insurance than that shown in the table.

* Difference from adults who received SSI is statistically significant at the 0.05 level.

1 Measure number corresponds to the index of access measures in the MACStats Appendix. See the appendix for additional details on each measure.

2 Respondents may report encounters with a broad range of health professionals (e.g., a chiropractor or physical therapist) but the question is limited to visits in a doctor's office or clinic.

3 Respondents may not limit encounters with health professionals to visits in a doctor's office or clinic.

4 Medical doctor includes general doctor, obstetrician-gynecologist, medical specialist, and eye doctor, but excludes other health professionals (e.g., a chiropractor, podiatrist or foot doctor, or physical therapist).

5 Reasons given for delayed care classified as access barriers include cost, transportation, and provider-related reasons (respondent couldn't get an appointment, had to wait too long to see doctor, couldn't go when open, couldn't get through on phone).

Source: MACPAC analysis of three years of pooled 2009–2011 data from the National Health Interview Survey (NHIS).

MACStats Appendix

MACStats Appendix

Five new tables (Tables 23–27) presenting measures of access to care have been added to the March 2014 edition of MACStats. Measures reflect the conceptual framework for access to care that MACPAC first presented in its March 2011 report to Congress, which stresses timely receipt of care in an appropriate setting.[1] Each measure in Tables 23–27 is assigned a measure number that corresponds to a detailed description in the table (MACStats Appendix Table) contained in this appendix.

Access Domains. A total of 54 measures were selected to represent 5 access domains: provider availability, connection to the health care system, contact with health care professionals, timeliness of care, and receipt of appropriate care.

Populations. Table 23 presents data on provider availability for Medicaid/CHIP beneficiaries. Tables 24 and 26 present data for children and adults under age 65, respectively, and compare access measures for these individuals based on insurance status. Table 25 presents data on children with special health care needs (CSHCN) and compares access measures for these children based on insurance status. Table 27 presents data for adult Medicaid beneficiaries under age 65 and compares access measures for these individuals based on receipt of Supplemental Security Income (SSI). The SSI population is comprised of individuals with little or no income and assets whose ability to work is limited by a physical or mental disability that can be expected to result in death or last for at least 12 months. Although this definition does not capture all individuals with disabilities, receipt of SSI is used as a proxy to identify individuals with a diverse range of severe disabilities and complex needs.

Data Sources. Measures are drawn from four federal surveys with the broadest available scope of access measures. The surveys and years of data presented in this report are:

- National Ambulatory Medical Care Survey-National Electronic Health Records Survey (2012 NAMCS-NEHRS);[2]
- National Health Interview Survey (2012 NHIS, and pooled 2009–2011 NHIS data);[3]
- National Survey of Children's Health (2011–2012 NSCH);[4] and
- National Survey of Children with Special Health Care Needs (2009–2010 NS-CSHCN).[5]

Measurement Approach. All measures represent national estimates. The data are drawn from surveys that apply different sampling methods, are collected from different time periods, and have different questions on health insurance coverage. For these reasons, measures from different surveys should not be directly compared.

Limitations. Interpretation of measures should consider the limitations of survey data. Particular weaknesses associated with household survey data include:

- Survey data are based on a respondent's recall of events, which tend to omit some health care encounters documented by other sources such as medical records or administrative data.

- Parents reporting experiences for their children may feel pressure to provide answers that are socially desirable rather than factually accurate.
- Survey data are based on subjective perceptions that might not align with objective criteria (for example, individuals may not be aware of services they or their children need).

Moreover, interpretation of measures should consider the definition of each population and its characteristics:

- Responses about recent experiences with access to care and service use are based on the previous 12 months, during which some individuals had a different source of coverage than that shown in the table.
- Comparison of measures are unadjusted for differences between populations in age, health, income, ethnicity, race, family and household characteristics known to explain much but not all differences in access and use observed between individuals with different insurance experience.[6]
- Finally, measures might be interpreted differently based on the needs of each population. For example, people with severe disabilities need more help with transportation than other individuals, so one might expect that Medicaid beneficiaries receiving SSI would report more problems getting timely care because they did not have transportation.

Endnotes

[1] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP,* March 2011 (Washington, DC: MACPAC, 2011). http://www.macpac.gov/reports.

[2] National Center for Health Statistics, *Ambulatory health care data* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/ahcd/new_ahcd.htm.

[3] National Center for Health Statistics, *National Health Interview Survey: About the National Health Interview Survey* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/nhis/about_nhis.htm.

[4] National Center for Health Statistics, *State and Local Area Telephone Integrated Survey: 2011–2012 National Survey of Children's Health quick facts* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/slaits/nsch.htm.

[5] National Center for Health Statistics, *State and Local Area Telephone Integrated Survey: 2009–2010 National Survey of Children with Special Health Care Needs quick facts and additions* (Atlanta, GA: U.S. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2013). http://www.cdc.gov/nchs/slaits/cshcn.htm.

[6] Kenney, G.M., and Coyer, C., *National findings on access to health care and service use for children enrolled in Medicaid or CHIP* (MACPAC Contractor Report No. 1) (Washington, DC: MACPAC, 2012). http://www.macpac.gov/publications; Long, S.K., Stockley, K., Grimm, E., and C. Coyer. *National findings on access to health care and service use for non-elderly adults enrolled in Medicaid* (MACPAC Contractor Report No.2) (Washington, DC: MACPAC, 2012). http://www.macpac.gov/publications.

MACStats APPENDIX TABLE. Index of Access Measures in March 2014 MACStats Tables 23–27

Provider Availability

Measures	Population Subgroups	Data Source	Rationale for Measure Selection
P1. Primary care physician acceptance of new patients by source of payment Percentage of office-based physicians who reported currently accepting new patients into their practice with a type of payment of Medicaid/CHIP, Medicare, and private insurance, respectively.	Pediatricians and other primary care physicians	NAMCS-NEHRS 2012	This measure is one method of identifying physicians participating in Medicaid or CHIP. Change in the proportion accepting new Medicaid/CHIP patients could indicate a change in Medicaid workforce capacity.
P2. Percentage of the primary care physician's patient care revenue that comes from Medicaid/CHIP This measure shows the distribution of responses for Medicaid/CHIP by office-based physicians to the question: "Roughly, what percent of your patient care revenue at the reporting location comes from the following: Medicare? Medicaid/CHIP? Private insurance? All other sources?"	Pediatricians and other primary care physicians	NAMCS-NEHRS 2012	Because many physicians see only a small number of Medicaid or CHIP patients, this alternative measure of physician participation in Medicaid/CHIP is based on the amount of revenue they receive from Medicaid/CHIP. A change in this revenue distribution could indicate a change in Medicaid/CHIP workforce capacity.

Connection to the Health Care System — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
S1. Has a usual source of care when sick or needs advice Percentage of children whose parents report that child had a usual place to go when sick or needs health advice (not the emergency department).	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Having a usual source of care is a common measure of potential access to health care and represents the interim step between provider availability and utilization with potential for timely access.
S2. Had same usual source of medical care 12 months ago Percentage of children whose parents report that child had the same usual place of care 12 months ago. Denominator is all children.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	The foundation of a medical home is having an ongoing source of care. Having an ongoing source of care is Objective AHS-5.2 of Healthy People 2020 (HP2020). The HP2020 target is 100 percent of all children ages 17 and under.[1]
S3. Has a personal doctor or nurse Percentage of children whose parents reported having one or more persons they think of as the child's personal doctor or nurse.	Children and CSHCN[2] with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure is a higher bar for potential access than having a usual source of care. Having a personal doctor or nurse is one of the criteria for receiving care in a medical home. See measure A4.
S4. Access barrier is reason for having no usual source of care Percentage of children whose parents reported child had no usual source of medical care for reasons: too expensive, no insurance, or cost; doesn't know where to go; previous doctor not available/moved; or speaks a different language.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	When children have no usual source of care, primary and preventive care may be missed. Measure is limited to reasons for having no usual source of care that can be affected by health plan supports or other program features. This percentage is expected to be small, but reflects a gap in outreach for children enrolled the full year.
S5. Had trouble finding a doctor Percentage of children whose parents reported one of three barriers during the past 12 months: trouble finding general doctor/provider who would see them; doctor's office/clinic would not accept child as new patient; doctor's office/clinic did not accept child's health care coverage.	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	This is an alternative measure for barriers to access. Problems finding a doctor can be affected by provider behavior, plan recruitment of providers, payment, and other factors.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Connection to the Health Care System — Children, Continued

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
S6. Had usual source of care barrier or trouble finding a doctor Composite of children facing barriers in S4 or S5.	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	This measure captures the extent to which children experience barriers to connecting to the health system across measures.
S7. Receipt of effective care coordination[3] Children were classified as needing care coordination if the child received two or more services or the parent reported they needed help coordinating care.[3] The criteria for "received all care coordination needed" were that the family has some type of help with care coordination and was very satisfied with doctors' communication with other health care providers, school or other programs, if those services were needed. Otherwise children were classified as "did not receive all care coordination needed."	Children and CSHCN with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	Effective care coordination is one component of the medical home summary measure reported as A4. CSHCN often require care coordination among multiple providers. Lack of coordination may result in duplication of services and missed opportunities for better care.
S8. Family had one or more unmet needs for support services Percentage of children whose parents reported that their family needed one or more family supports (respite care, genetic counseling, or family mental health care or counseling) but did not receive them.	CSHCN with Medicaid/CHIP, children with private insurance, uninsured children	NS-CSHCN 2009–2010	These three specific family support services are services a family member of CSHCN might need because of the child's medical, behavioral, or other conditions.

Connection to the Health Care System — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
S9. Has a usual source of care when sick or needs advice Percentage of adults who reported currently having a place they usually go when they are sick or need advice about their health (not the emergency department).	Adults with Medicaid, private insurance, uninsured; Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Having a usual source of care is a common measure of potential access to health care and represents the interim step between provider availability and utilization with potential for timely access.
S10. Had same usual source of medical care 12 months ago Percentage of adults who reported having the same usual place of care 12 months ago.	Medicaid SSI-related and non-SSI-related adults	NHIS 2009–2011	A higher bar for potential access than having a usual source of care, this measure indicates an established relationship with a provider important for patient-centered, quality care.
S11. Access barrier is reason for having no usual source of care Percentage of adults who reported one of the access-related reasons for having no usual place of medical care as listed in S4.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	Problems navigating the provider network, lack of consumer information, language barriers, cost and distance all are barriers to providers with factors that can be addressed by health plan outreach, payment, and other factors.
S12. Had trouble finding a doctor Percentage of adults who reported facing one of three barriers during the past 12 months as listed in S5.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	This is an alternative measure of barriers to access. Trouble finding a doctor can be addressed by provider behavior, health plan recruitment of providers, payment, and other factors.
S13. Had usual source of care barrier or trouble finding doctor Composite of adults who reported barriers in S11 or S12.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	Captures extent to which adults experienced barriers to connecting to the health system across measures.

MACStats APPENDIX TABLE, Continued

Contact with Health Professionals — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
C1. Had at least one office visit Percentage of children whose parent reported they had seen a doctor or other health care professional at a doctor's office, clinic, or other place (not including hospitalization, ER visits, dental visits, or telephone calls) during the past 12 months.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	This measure is commonly used to ascertain a minimal threshold of contact in an office or clinic setting and allows comparison between populations and data sources.
C2. Saw a general doctor Percentage of children whose parent reported they had seen or talked to a general doctor who treats a variety of illnesses (a doctor in general practice, pediatrics, family medicine, or internal medicine) during the past 12 months.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	Contact with a general doctor is commonly used to ascertain a minimal threshold of contact with a physician and allows comparison between populations.
C3. Saw a general doctor, nurse practitioner, PA, midwife, or Ob-Gyn Percentage of children whose parent reported the child had seen a general doctor, nurse practitioner, physician assistant (PA), midwife, or obstetrician-gynecologist (Ob-Gyn) during the past 12 months. Ob-Gyn encounters are limited to females age 15–18.	Children with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012	This measure contributes to the interpretation of C2 by including mid-level clinicians and obstetrician-gynecologists. C3 more accurately gauges primary care contact that Medicaid enrollees may have at community clinics and through reproductive health care for adolescents.
C4. Received at least one preventive dental visit Percentage of children whose parent reported that child had seen a dentist for preventive care, such as check-ups and dental cleanings, during the past 12 months.	Children and CSHCN with Medicaid/CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure monitors contact with the oral health care system and also is a measure of receipt of appropriate care. This question is not asked of children in the NHIS.
C5. Received care from a specialist doctor Percentage of CSHCN whose parent reported that child received care from a specialist doctor during the past 12 months.	CSHCN with Medicaid/CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	Specialists can play a critical role in the care of CSHCN.

Contact with Health Professionals — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
C6. Had at least one office visit Percentage of adults who reported seeing a doctor or other health care professional at a doctor's office, clinic, or other place (not including hospitalization, ER visits, dental visits, or telephone calls) during the past 12 months.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure is commonly used to ascertain a minimal threshold of contact in an office or clinic setting and allows comparison between populations and data sources. Survey respondents may recall having an office visit but not know or recall which type of professional they saw.
C7. Saw a nurse practitioner (NP), physician assistant (PA), or midwife Percentage of adults who reported seeing a nurse practitioner, physician assistant, or midwife in any setting during the past 12 months.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	Mid-level clinicians are expected to play a role in expanding access to health care for Medicaid enrollees, yet little is known about the degree to which adults encounter these clinicians.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Contact with Health Professionals — Adults, Continued

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
C8. Saw a medical doctor, nurse practitioner, PA, or midwife Percentage of adults who reported seeing or talking to any of these selected practitioners during the past 12 months: medical doctor, nurse practitioner, physician assistant (PA), midwife, and includes obstetrician-gynecologist, specialist, or eye doctor. For Medicaid adults with and without SSI, obstetrician-gynecologists and other specialists are presented separately in C13 and C14.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure emphasizes contact with a medical doctor or advanced practice clinician in any setting. Counting mid-level clinicians may increase contact levels observed in shortage areas.
C9. Saw a mental health professional (individuals with SMI)[4] Percentage of adults with serious mental illness (SMI) who reported seeing or talking to a mental health professional (psychiatrist, psychologist, psychiatric nurse, or clinical social worker) during the past 12 months.	Adults with Medicaid, private insurance, and uninsured, Medicaid adults with and without SSI	NHIS 2012	This measure monitors contact with the mental health system. The denominator for this measure is based partly on active symptoms and will miss some adults who no longer have symptoms because they are receiving successful treatment.
C10. Saw a dental professional Percentage of adults who reported at least one visit to a dentist, dental specialist, or dental hygienist during the past 12 months.	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	This measure monitors contact with the oral health care system.
C11. Saw any health professional, excluding dental Percentage of adults who reported at least one visit in C8 or reported seeing a mental health professional (not limited to just those with SMI as in C9). The measure also includes encounters with health professionals not captured elsewhere (e.g. chiropractor, podiatrist or foot doctor, or physical therapist).	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Expands C8 to include mental health professionals, a major source of care for adults, and other health professionals to provide a global measure of contact. This percentage may not align with reported office visits in C6 due to differences in question wording, respondent interpretation, and recall.
C12. Saw any health professional, including dental Composite measure of adults with at least one visit in C11 or C10, including visits to a dental professional.	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Much of the difference in contact between Medicaid and private patients is due to dental visits, so the summary measure is reported with and without visits to dental professionals in C12 and C11, respectively. Dental services are an optional Medicaid benefit.
C13. Saw an obstetrician-gynecologist Percentage of Medicaid adults who reported seeing or talking with an obstetrician-gynecologist during the past 12 months. Limited to women.	Medicaid adults with and without SSI	NHIS 2012	This measure is a subset of C8 that highlights specialists, who can play a critical role in the care of individuals with disabilities.
C14. Saw other specialist, not an obstetrician-gynecologist Percentage of Medicaid adults who reported seeing or talking with a specialist other than an obstetrician-gynecologist during the past 12 months.	Medicaid adults with and without SSI	NHIS 2012	This measure is a subset of C8 that highlights specialists, who can play a critical role in the care of individuals with disabilities.

MACStats APPENDIX TABLE, Continued

Timeliness of Care — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
T1. Delayed medical care due to an access barrier Percentage of all children whose parents reported the child needed health care during the past 12 months that was delayed due to a cost barrier, transportation, or provider-related reasons (couldn't get appointment, had to wait too long to see doctor, couldn't go when open or get through on phone, and speaks a different language). Each barrier is separately reported.	Children with Medicaid/ CHIP, private insurance, and uninsured	NHIS 2012	Delayed care is a common measure, but this measure limits the definition to delays for reasons that could reasonably be influenced by providers, health plans, and program services and supports. Delays for reasons that primarily reflect parents' motivation (i.e.,"put it off") are excluded.
T2. Selected types of care were delayed or not received Percentage of all children whose parents reported child needed but delayed or did not receive a service during the past 12 months. Medical care, mental health care, dental care, and vision are separately reported.	Children with Medicaid/ CHIP, private insurance, and uninsured	NSCH 2011–2012	This measure provides information on specific services for which parents are reporting delayed or unmet needs. The measure does not capture reasons for delay or unmet need. Question wording is not comparable to NHIS measure of delayed care (T1).
T3. Unmet need for selected types of care due to cost Percentage of all children whose parents reported a time in the past 12 months when their child needed a service but didn't get it because they couldn't afford it: medical care, mental health care or counseling, dental care, prescription drugs, eyeglasses. Services are separately reported.	Children with Medicaid/ CHIP, private insurance, and uninsured	NHIS 2012	These measures track access to service domains in the mandatory Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit for children, but not unmet need due to barriers other than cost that can impact Medicaid disproportionately. Other barriers are presumably captured in measure T2.
T4. Had a problem getting referrals (children needing referrals)[3] Percentage of children whose parents reported that getting referrals was a big or small problem. The denominator of this measure is children whose parents reported that the child needed a referral to see a doctor or receive services during the past 12 months.	Children with Medicaid/ CHIP, private insurance, and uninsured	NSCH 2011–2012	Difficulty getting referrals from primary care providers or health plans can lead to delays obtaining timely diagnosis and treatment critical to child development.
T5. Unmet need for selected types of care Percentage of children whose parents reported needing the service and did not receive all the care needed or received no care. The six types of care are: specialist; prescription drugs; mental health care; non-preventive dental; physical, occupational or speech therapy; vision care or eyeglasses.	CSHCN with Medicaid/ CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	The NS-CSHCN provides measures of unmet need for a wide array of services that are needed by children with severe mobility, cognitive, and sensory disabilities. All of these services fall under the EPSDT benefit. Unmet need for many of these services is not collected in the NHIS or the NSCH.
T6. Had 2 or more unmet needs for 14 specific services In addition to types of care in T5, this measure captures unmet need for dental, mobility aids or devices, communication aids or devices, home health care, substance abuse treatment or counseling, durable medical equipment, genetic counseling, and respite care.	CSHCN with Medicaid/ CHIP, private insurance, and uninsured	NS-CSHCN 2009–2010	By measuring unmet need for particular services, this measure helps determine if unmet need is a significant problem for a small proportion of CSHCN with particular service needs.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Timeliness of Care — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
T7. Delayed medical care due to an access barrier Percentage of adults who reported they needed medical care during the past 12 months and that it was delayed because of selected reasons as listed in T1.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Medicaid beneficiaries primarily report barriers to care other than cost. Reasons for these delays are segmented to help identify where in the health care system the barriers exist.
T8. Unmet need for selected types of care due to cost Percentage of adults who reported a time in the past 12 months when they needed a type of care but didn't get it because they couldn't afford it. For all adults, this measure reports on unmet need for medical care and mental health care or counseling. Other services reported for Medicaid adults with and without SSI are dental care, prescription drugs, and eyeglasses.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	These measures track access to two mandatory service groups for adult beneficiaries, but do not capture barriers to service unrelated to cost.
T9. Did not take medication as prescribed to save money Percentage of adults who reported one of the following in past 12 months: unmet need for prescription medicines because of cost; skipped medication doses to save money; took less medicine to save money; or delayed filling a prescription to save money.	Adults with Medicaid, private insurance, uninsured	NHIS 2012	This measure expands the well-known definition of "unmet need for prescriptions due to cost" to include individuals who took specific actions to save money. Some actions, such as "asked for a generic drug" were not included.
T10. Reported any barriers to care, delayed care, or unmet need Composite of adults who reported any barriers in measures in measure S13 (had usual source of care barrier or trouble finding doctor), T7–T9 (delayed care due to an access barrier, unmet need due to cost, reported not taking medication as prescribed to save money).	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	Provides a gauge for the overall reach and potential impact of all barriers to timely care in the population. Unmet need for dental care and eyeglasses are excluded due to the very limited Medicaid benefit available.

MACStats APPENDIX TABLE, Continued

Receipt of Appropriate Care — Children

Measures for Children	Population Subgroups	Data Source	Rationale for Measure Selection
A1. Doctors and other providers spend enough time with child Percentage of children whose parents reported doctors or other health care providers usually or always spend enough time with the child.	Children with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	This measure is one of the criteria for receiving care in a medical home.
A2. Received at least one preventive medical visit Percentage of children whose parents reported that child saw a doctor, nurse, or other provider for preventive medical care such as a physical exam or well-child checkup during the past 12 months. Presented for selected age ranges.	Children and CSHCN with Medicaid/CHIP, private insurance, uninsured	NHIS 2012 NSCH 2011–2012	The EPSDT benefit in Medicaid states that children should receive one or more preventive or well-child visits, dependent on the age group. This measure sets a low bar well below the number of preventive visits recommended for 0–3 year olds.
A3. Received selected EPSDT services (children needing services) Among children whose parents reported that their child needed a specific type of EPSDT service, the percentage who received it: mental health services (children age 2–17 with a problem needing treatment), therapy services (children with autism or developmental delay), and vision screening (age 2–17).	Children with Medicaid/CHIP, private insurance, uninsured	NSCH 2011–2012	These measures capture receipt of appropriate care for common EPSDT services. The denominator for each measure is limited to children needing the service based on parent-reported condition and/or eligible for screening based on age.
A4. Received coordinated, ongoing, comprehensive care within a medical home[3, 5] Percentage of children who have met all criteria for receiving care in a medical home based on a series of questions.	CSHCN with Medicaid/CHIP, private insurance, uninsured	NS-CSHCN 2009–2010	This measure reflects a core outcome chosen by the Maternal and Child Health Bureau for the community-based system of services required for all CSHCN under Title V of the Social Security Act.[6] Increasing the proportion of CSHCN receiving care in a medical home is an HP2020 objective. The HP2020 target is 51.8 percent.[7]
A5. Had an ER visit in past 12 months and most recent ER visit was related to a serious health problem or an access barrier Percentage of children whose parents reported the child had an ER visit in the past 12 months, and the most recent ER visit is related to either serious health problem[8] (e.g., admitted to hospital) or an access barrier, excluding serious health problems.	Children with Medicaid/CHIP, private insurance, uninsured	NHIS 2012	ER visits due to access barriers (e.g. doctor's office wasn't open) may reflect poor access to primary care or a need for more education about the importance of using primary care providers when possible, rather than the ER.
A6. Had 2 or more ER visits during the past 12 months Percentage of children whose parents reported that the child went to a hospital ER 2 or more times in past 12 months.	Children and CSHCN with Medicaid/CHIP, private insurance, and uninsured	NHIS 2012 NS-CSHCN 2009–2010	High use of ER services may signify complex health needs, poor access to primary care, or a need for parent education.

MACStats APPENDIX TABLE, Continued. Index of Access Measures in March 2014 MACStats Tables 23–27

Receipt of Appropriate Care — Adults

Measures for Adults	Population Subgroups	Data Source	Rationale for Measure Selection
A7. Received any preventive visit or counseling Percentage of adult beneficiaries who reported receipt of prevention services, including any service in measures A8–A12, talking with a health professional about diet, having blood pressure checked by health professional, or screening for breast cancer. Includes individuals not in a high-risk group or of a recommended age who received the preventive service.	Adults age 19–49, 50–64, pregnant or have chronic condition with Medicaid, private insurance, and uninsured	NHIS 2012	This measure is a global indicator that adults received some aspect of recommended prevention services. Physicians and patients may prioritize preventive services based on a patient's risk of complications or a patient's health goals and care preferences.
A8. Had cholesterol checked by health professional (at-risk groups) Percentage of adults at high-risk for coronary heart disease who reported having their blood cholesterol checked by a doctor, nurse, or other professional during the past 12 months.	Selected at-risk groups with Medicaid, private insurance, and uninsured	NHIS 2012	The U.S. Preventive Services Task Force (USPSTF) recommends routine screening for men ages 35 and over for lipid disorders, and others at increased risk of coronary heart disease.[9] The HP2020 target for the proportion of adults who have their blood cholesterol checked within preceding 5 years is 82.1 percent.[10]
A9. Had an influenza vaccine or flu shot Percentage of adults who reported having an influenza shot in the past 12 months is presented for all individuals and for three vaccination priority groups whose percentages should be higher as the result of flu shot campaigns.	Selected high-risk groups with Medicaid, private insurance, and uninsured	NHIS 2012	The Centers for Disease Control and Prevention (CDC) recommends annual vaccination of persons at risk of severe complications from influenza. Priority is given to these high-risk groups when supply is short. Vaccination rates of wider populations will fluctuate with supply.[11]
A10. Had professional counseling about smoking (current smokers) Percentage of currently smoking adults who reported that a doctor or other health professional talked to them about their smoking during the past 12 months.	Current smokers with Medicaid, private insurance, and uninsured	NHIS 2012	This measure captures preventive counseling for smoking for a targeted population but will miss persons who reported using tobacco products other than cigarettes or who quit during the past 12 months, possibly as the result of counseling.
A11. Had any test for colorectal cancer (CRC) Percentage of adults who reported having any test done for colon cancer during the past 12 months using a single item. Limited to individuals in the recommended age group 50–64.	Men and women age 50 to 64 with Medicaid, private insurance, and uninsured	NHIS 2012	The HP2020 target for the proportion of adults age 50 to 75 receiving regular CRC screening is 70.5 percent.[12] Because the periodicity of screening recommended by USPSTF has been increased to 5 years,[13] the proportion in annual surveys will be lower than the HP2020 target.
A12. Had Pap smear or test for cervical cancer (women age 21 to 60)[14] Percentage of women who reported having a Pap smear or Pap test during the past 12 months. This measure omits women over age 60 who are least likely to be eligible for screening.	Women age 21–60 with Medicaid, private insurance, and uninsured	NHIS 2012	Because screening is recommended every 3 or 5 years, the proportion in annual surveys will be lower than the HP2020 target (93 percent for women age 21 to 64).[15]
A13. Had more than 15 office visits Percentage of adults who reported more than 15 office visits as defined in C6.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	Individuals with over 15 office visits may have very high needs or high use may be a sign of opportunities for improved clinical management.
A14. Had an ER visit in past 12 months and most recent ER visit was related to a serious health problem or an access barrier[8] Percentage of adults as defined in A5.	Adults with Medicaid, private insurance, and uninsured	NHIS 2012	See A5. If physicians are unable to meet demand from the new Medicaid expansion population, ER use related to access problems could increase.
A15. Reported 4 or more ER visits Percentage of adults who reported having gone to a hospital ER 4 or more times in the past 12 months.	Adults with Medicaid, private insurance, uninsured, Medicaid adults with and without SSI	NHIS 2012 NHIS 2009–2011	High use of the ER relative to others may signify complex health needs, poor access to primary care, or a need for patient education.

MACStats APPENDIX TABLE, Continued

Notes: NAMCS-NEHRS is the 2012 National Ambulatory Medical Care Survey-National Electronic Health Records Survey. NSCH is the National Survey of Children's Health. NHIS is the National Health Interview Survey. NS-CSHCN is the National Survey of Children with Special Health Care Needs.

HP2020 is Healthy People 2020. SSI is Supplemental Security Income. EPSDT is the Medicaid early and periodic screening, diagnostic, and treatment benefit. USPSTF is the U.S. Preventive Services Task Force. CDC is the Centers for Disease Control and Prevention. ER is hospital emergency room or emergency department.

CSHCN is children with special health care needs.

Recommendations by the USPSTF are based on a rigorous review of existing peer-reviewed evidence; see U.S. Preventive Services Task Force (USPSTF), *About the USPSTF* (Washington, DC: USPSTF). http://www.uspreventiveservicestaskforce.org/about.htm.

Surveys from which the measures are drawn use different methods to sample individuals, and data are collected from different time periods. In addition, the surveys have different questions about health insurance and different reference periods. As a result, the population sampled and subsequently classified as Medicaid, privately insured, or uninsured differs based on the data source. See additional notes in MACStats Tables 23–27 for detailed definitions of populations and insurance coverage.

1 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=AHS-5.2.

2 CSHCN is children with special health care needs. CSHCN are identified in the NSCH and NS-CSHCN using a 5-item, parent-reported tool that identifies children across the range and diversity of childhood chronic conditions and special needs who currently experience 1 or more of 5 common health consequences due to a physical, mental, behavioral, or other type of health condition lasting or expected to last at least 12 months. For more on how children are categorized as CSHCN, see Child and Adolescent Health Measurement Initiative (CAHMI), *Fast facts: Children with special health care needs screener* (Portland, OR: CAHMI, 2007). http://childhealthdata.org/docs/cshcn/cshcn-screener-cahmi-quickguide-pdf.pdf.

3 Measures S7, T4, and A4 are child quality measures developed by the Maternal and Child Health Bureau, Health Resources and Services Administration through the Child & Adolescent Health Measurement Initiative (CAHMI). For details on these measure definitions, see Data Resource Center for Child & Adolescent Health (DRC), CAHMI, *Indicator 4.9d: Medical home component: Effective care coordination.* http://www.nschdata.org/browse/survey/results?q=2512&r=1 [for S7]; DRC, CAMHI, *Problems getting referrals, only children who needed referrals.* http://www.nschdata.org/browse/survey/results?q=2549&r=1 [for T4]; DRC, CAHMI, *Indicator 4.8: Children who receive coordinated, ongoing, comprehensive care within a medical home.* http://www.nschdata.org/browse/survey/results?q=2507&r=1 [for A4].

4 Individuals were defined as having serious mental illness if they reported an activity limitation due to depression, anxiety, or emotional problem; feelings interfered with life a lot in the past 30 days; or received a score of 13 or over (out of 24) on the Kessler Psychological Distress Scale (K6) in the NHIS. See R.C. Kessler, P.R. Barker, L.J. Colpe, et al., Screening for serious mental illness in the general population, *Archives of General Psychiatry* 60, no. 2 (2003): 184–189.

5 NS-CSHCN survey questions from which this measure is constructed are whether the child has a personal doctor or nurse, has a usual source of sick and well-child care, or has no problems obtaining needed referrals; family is satisfied with doctors' communication, or gets help coordinating the child's care if needed; doctor spends enough time with the child, listens carefully to the parent, is sensitive to the family's customs, or provides enough information; and the parent feels like a partner in care.

6 Maternal and Child Health Bureau, *The national survey of children with special health care needs chartbook 2009–2010* (Rockville, MD: Health Resources and Services Administration, U.S. Department of Health and Human Services, 2013). http://mchb.hrsa.gov/cshcn0910/.

7 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=MICH-30.2.

8 The ER visit is classified as a serious health problem if it resulted in a hospital admission, a health provider advised the person to go, the problem was too serious for a doctor's office, or they arrived by ambulance. The ER visit is classified as an access-related problem if it happened either at night or on the weekend, or when their doctor's office or clinic was not open, and excludes individuals reporting a serious health problem.

9 M. Helfand, and S. Carson, Screening for lipid disorders in adults: Selective update of 2001 U.S. Preventive Services Task Force review, *Evidence Syntheses* 49 (Rockville, MD: Agency for Healthcare Research and Quality, 2008). http://www.ncbi.nlm.nih.gov/books/NBK33500/.

10 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=HDS-6.

11 Over time and geographically, vaccination rates fluctuate based on supply of the vaccine and flu activity, reducing the utility of monitoring changes for the entire population. When vaccine supply is limited, health professionals are instructed to focus vaccination efforts on older adults and people with conditions that place them at high risk of developing complications from influenza. See L.A. Krosskopf, et al., Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices–United States, 2013–2014, *Morbidity and Mortality Weekly Review* 62, no. RR07 (2013): 1–43. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm?s_cid=rr6207a1_w#PersonsAtRiskMedicalComplicationsAttributableSevereInfluenza.

12 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC, 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=C-16.

13 The USPSTF recommends screening adults beginning at age 50 and continuing until age 75 for colorectal cancer using fecal occult blood testing every year, sigmoidoscopy in the past 5 years and blood test in the past 3 years, or colonoscopy in the past 10 years. See U.S. Preventive Services Task Force (USPSTF), *USPSTF A and B Recommendations* (Washington, DC: USPSTF). http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

14 The USPSTF recommends against cervical cancer screening for women who have had a hysterectomy with removal of the cervix and who do not have a history of cervical abnormalities or cancer, but the 2012 NHIS removed the survey item capturing this history. Women over age 60 are not included in measure A12 to minimize overcounting of older women not eligible for screening. The USPSTF recommends screening for cervical cancer in women age 21 to 65 with cytology (Pap smear) every 3 years, and provides an alternative recommendation of screening every 5 years for women age 30 to 65 who want to lengthen the screening interval. See U.S. Preventive Services Task Force (USPSTF), *USPSTF A and B Recommendations* (Washington, DC: USPSTF). http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

15 U.S. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, *Healthy People 2020: Topics and national data-technical specifications* (Atlanta, GA: CDC 2013). http://healthypeople.gov/2020/topicsobjectives2020/TechSpecs.aspx?hp2020id=C-15.

Source: MACPAC analysis.

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