Program Information on Medicaid & State Children's Health Insurance Program (SCHIP)

Centers for Medicare & Medicaid Services

Office of Research, Development, and Information

CMS Centers for Medicare & Medicaid Services

2004 Edition

Medicaid Chartbook 2004 Table of Contents

Medicaid Chartbook 2004 Table of Contents (Continued)

Medicaid Chartbook 2004 Table of Contents (Continued)

Section I

Medicaid Benefits

Chart 1
Mandatory[1] Medicaid Benefits

- **Inpatient hospital (excluding inpatient hospital services for mental illness)**
- **Outpatient hospital including Federally Qualified Health Centers (FQHC), and if state law permits, Rural Health Clinics**
- **Physician**
- **Nurse Midwife**
- **Laboratory and x-ray**
- **Certified Pediatric and Family Nurse Practitioner, if state law permits**
- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for individuals under age 21**
- **Family planning services and supplies**
- **Pregnancy-related services**
- **Postpartum pregnancy related services (60 days)**
- **Nursing facility services for those 21 and older**
- **Home health for those entitled to Medicaid Skilled Nursing Facility (SNF) services under state plan: intermittent or part-time nursing services by home health agency or registered nurse when there is no home health agency, home health aides, medical supplies and appliances for use in the home.**
- **Medical supplies and surgical services of a dentist**

Note: (1) Under the Social Security Act (Section 1905(a)), the above services are required to be provided by states. (2) Medicaid eligibility groups classified as "categorically needy" are entitled to the above services unless waived under Section 1115 of the Medicaid law. (3) When the "medically needy" are included in a state's Medicaid plan, states must provide at least the following services: prenatal and delivery, postpartum pregnancy for persons under age 18 who are entitled to institutional and ambulatory services, home health for those entitled to nursing facility services, and specific services for persons in institutions for mental disease and or ICF/MR (if included as medically needy). (4) The service list above does not apply to the SCHIP program.
Source: CMS/Center for Medicaid and State Operations publication, "Medicaid At-a-Glance 2002: A Medicaid Information Source".

Chart 2
Optional[1] Medicaid Benefits

Number of States[2] Providing Optional Benefits in Parentheses

- **Mental health rehabilitation/stabilization (44)**
- **Diagnostic (35), screening (32), and preventive (35) services**
- **Private duty nursing (29)**
- **Therapy: e.g., physical (44), speech, hearing, and language disorder (43) or occupational (38)**
- **Inpatient psychiatric for under age 21 (44)**
- **Medical equipment and supplies: e.g., dentures (38), eyeglasses (47), prosthetic devices (51)**
- **Prescribed drugs (51)**
- **Intermediate Care Facility for people who are developmentally disabled (ICF/MR) (51)**
- **Personal care (36)**
- **Nursing facility for those under age 21 (50) or over 65 in Institutions for Mental Disease (IMDs) (43)**
- **Primary Care (22)/Targeted Case Management (50)**
- **Other licensed practitioners: e.g., chiropractors (32), psychologists (32), podiatrists (47), optometrists (51), nurse anesthetist (28)**
- **Dental services (47)**
- **Physician-directed clinic services (50)**
- **Home Health services: audiology services (45), physical therapy (50), occupational therapy (49), speech/language therapy (49)**
- **Critical access hospital (21)/emergency hospital care in non-Medicare participating (37)/inpatient hospital for 65 and older in IMD (43)**
- **Transportation (48)**
- **Care at a religious, non-medical health care institution (13)**
- **All Inclusive Care for the Elderly (PACE) (18)[3]**
- **Respiratory care for ventilator dependent (15)**
- **Hospice care (45)**

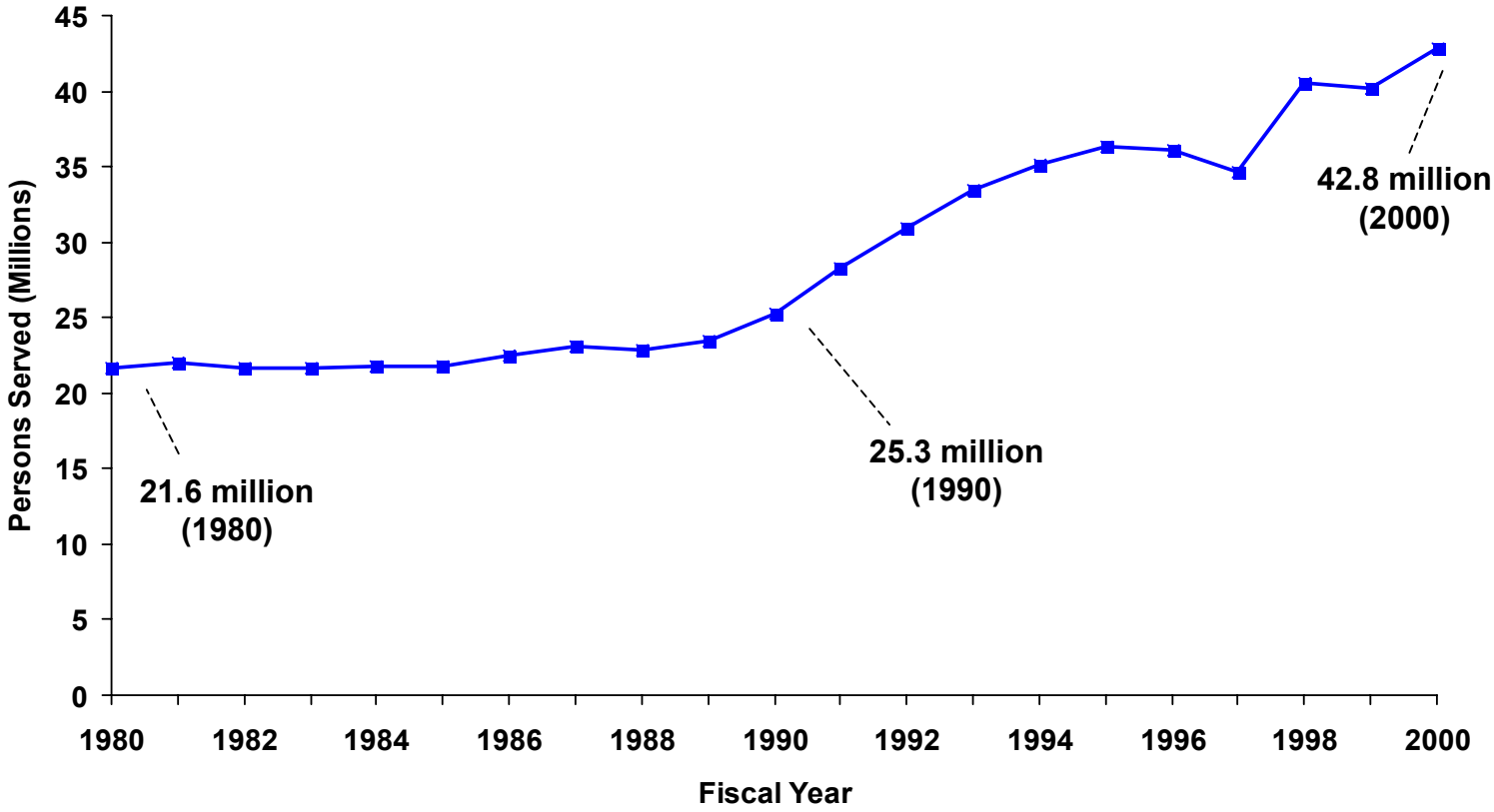
Note: (1) The above are optional services states have elected to include under state plans and managed care waivers as of November 2002. (2) The 50 states and the District of Columbia are included. (3) Updated figure as of March 2003. (4) No SCHIP program services or additional non-plan services through waivers or managed care entities are included.
Source: CMS/Center for Medicaid and State Operations publication, "Medicaid At-a-Glance 2002: A Medicaid Information Source".

Section II

Medicaid Populations

Chart 3
Persons Served Through Medicaid, Fiscal Years 1980-2000

Mandatory eligibility expansions enacted in the late 1980s led to an increase in the number of persons served.

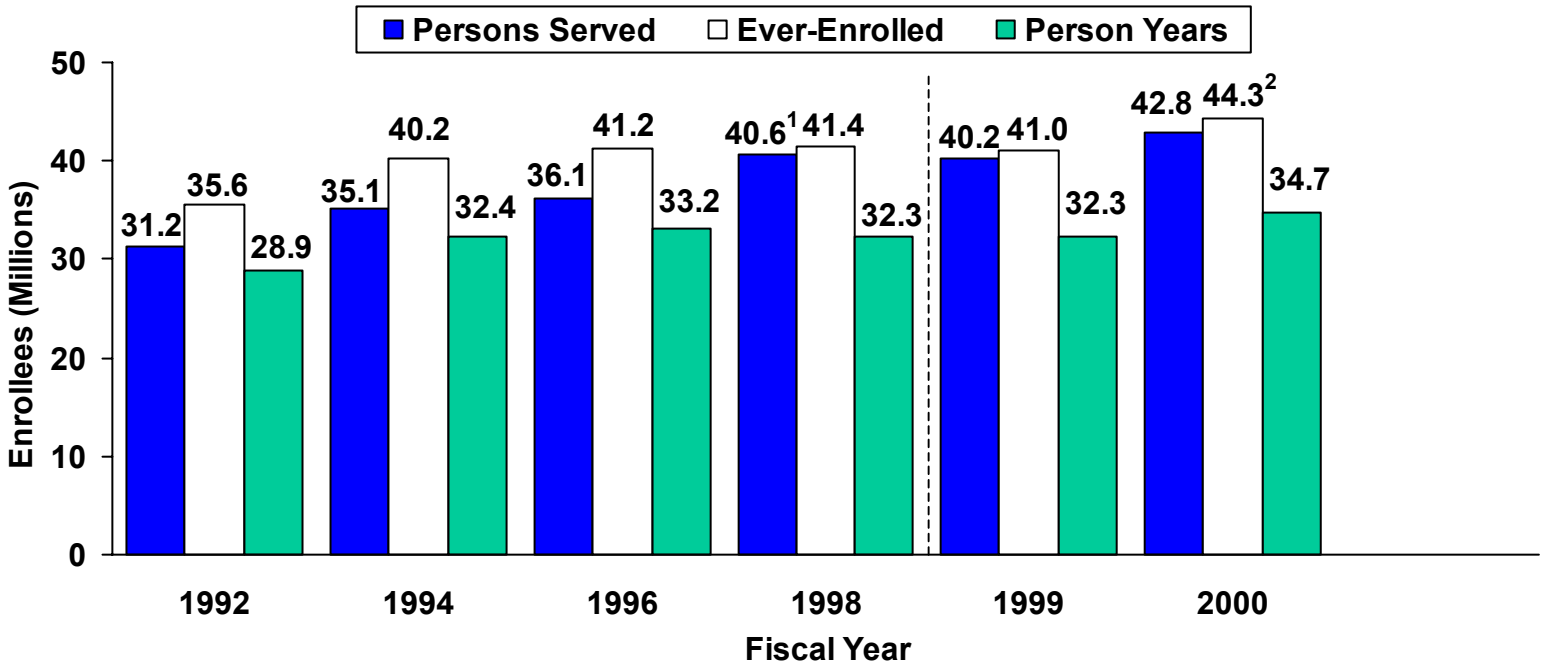


Note: (1) In FY 1998, a large increase appears to have occurred in the number of persons served through Medicaid, primarily as the result of a new reporting methodology that included persons on whose behalf payments were made to managed care entities; this new methodology probably has the greatest effect on the reported number of children. (2) Beginning in 1998, figures include enrollees covered by Medicaid expansion SCHIP.

Source: CMS, HCFA-2082 and MSIS.

Chart 4
Medicaid Participation

See the Glossary of Terms to understand the different ways to count Medicaid enrollees.

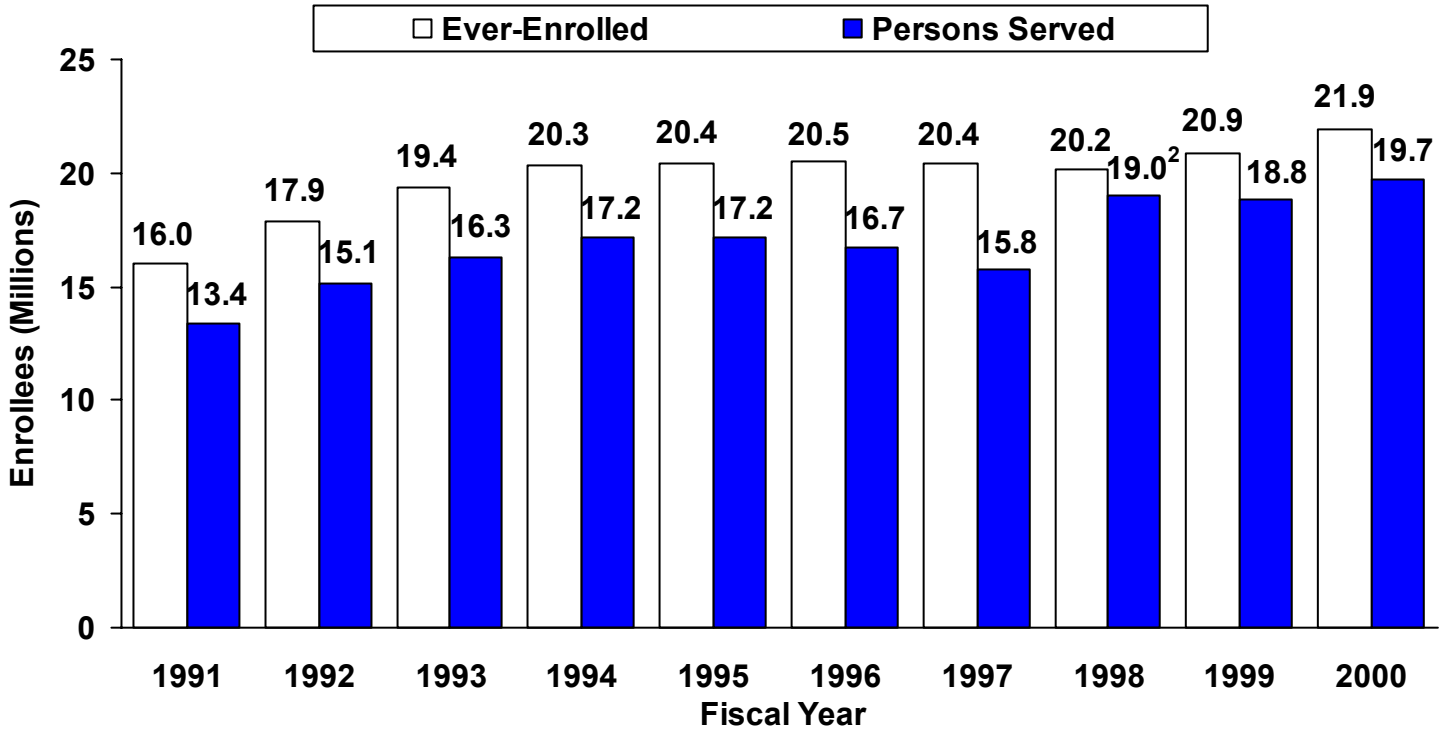


Note: (1) In FY 1998, a large increase appears to have occurred in the number of persons served through Medicaid, primarily as the result of a new reporting methodology that included persons on whose behalf payments were made to managed care entities; this new methodology probably has the greatest effect on the reported number of children. (2) The large increase in ever-enrolled in 2000 is largely due to the enrollment of over 1.8 million adults in California in FY 2000 as part of a new family planning waiver. (3) Beginning in 1998, figures include enrollees covered by Medicaid through expansions in SCHIP. (4) Beginning in 1999, person-year figures exclude territory data and include data on Medicaid expansions in SCHIP.

Source: CMS, HCFA-2082/MSIS, person years data supplied by CMS/Office of the Actuary.

Chart 5
Child Medicaid Population

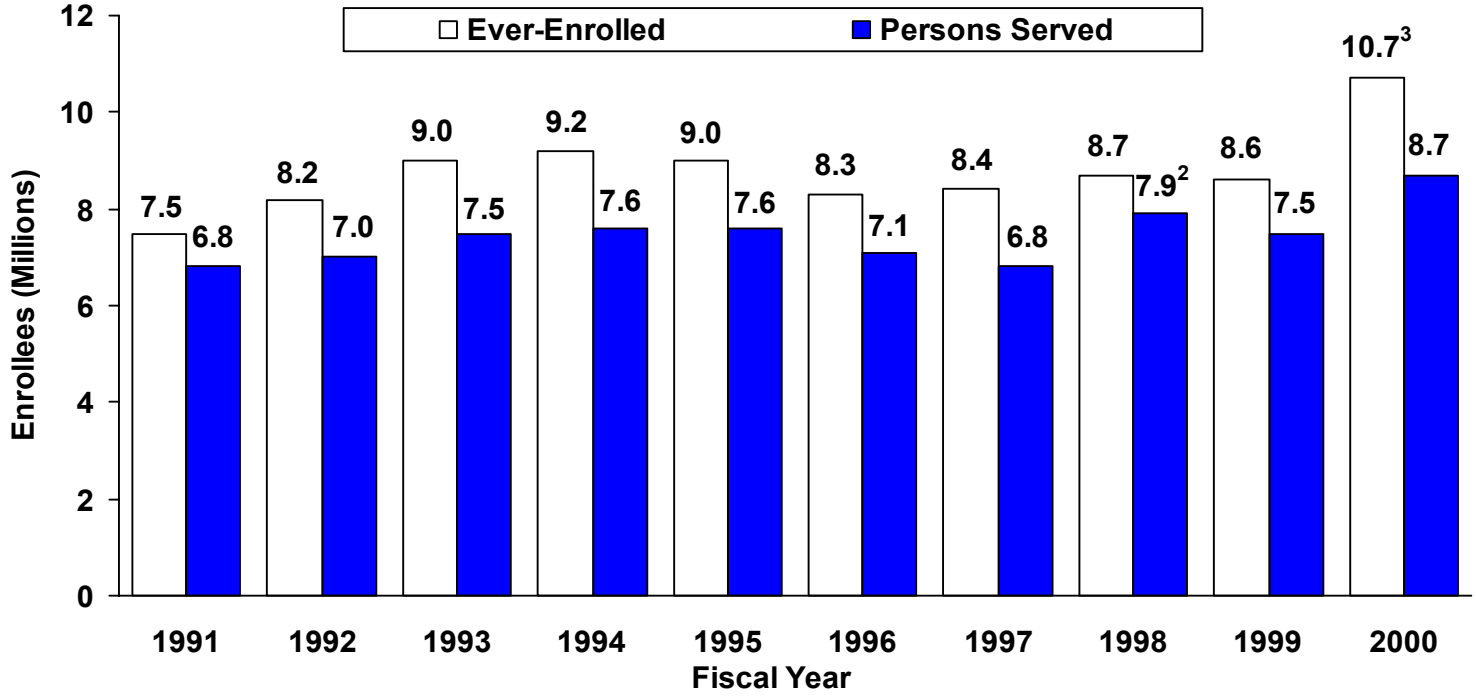
Medicaid enrollment of children[1] reached nearly 22 million in Fiscal Year 2000.



Note: (1) Children are defined as under age 21 and neither blind nor disabled. This category includes foster care children. (2) In FY 1998, a large increase appears to have occurred in the number of persons served through Medicaid, primarily as the result of a new reporting methodology that included persons on whose behalf payments were made to managed care entities; this new methodology probably has the greatest effect on the reported number of children. (3) Beginning in 1998, figures include enrollees covered by Medicaid through expansions in SCHIP.
Source: CMS, HCFA-2082 and MSIS.

Chart 6
Adult Medicaid Population

Medicaid adult[1] enrollment rose in Fiscal Year 2000 due largely to implementation of a California family planning waiver.

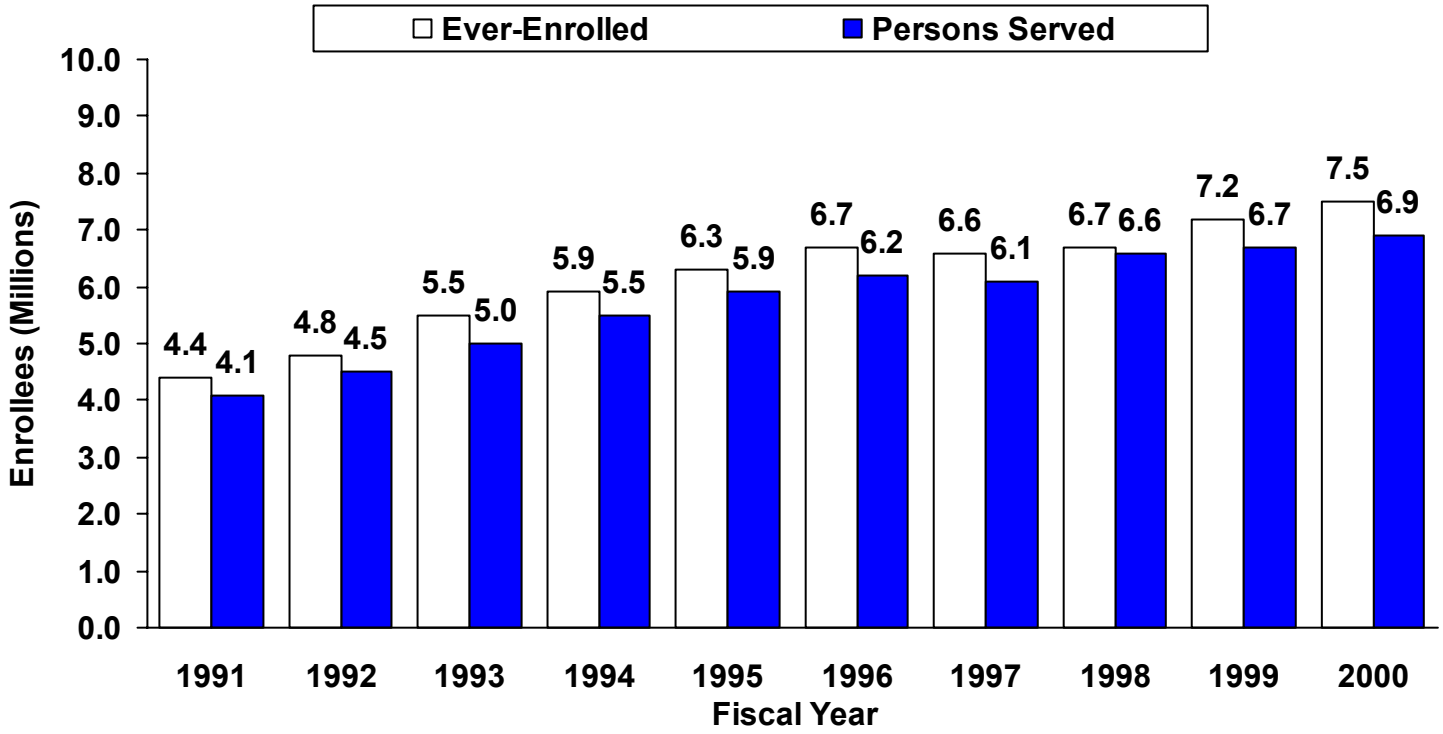


Note: (1) Adults are defined as between ages 21 and 65 and neither blind nor disabled. A small number of individuals under age 21 may be counted as adults based on other eligibility criteria. (2) In FY 1998, a large increase appears to have occurred in the number of persons served through Medicaid, primarily as the result of a new reporting methodology that included persons on whose behalf payments were made to managed care entities; this new methodology probably has the greatest effect on the reported number of children. (3) The large increase in enrollees in 2000 is largely due to an increase of over 1.8 million adults in California in FY2000 due to a new family planning waiver.

Source: CMS, HCFA-2082 and MSIS.

Chart 7
Disabled and Blind Medicaid Population

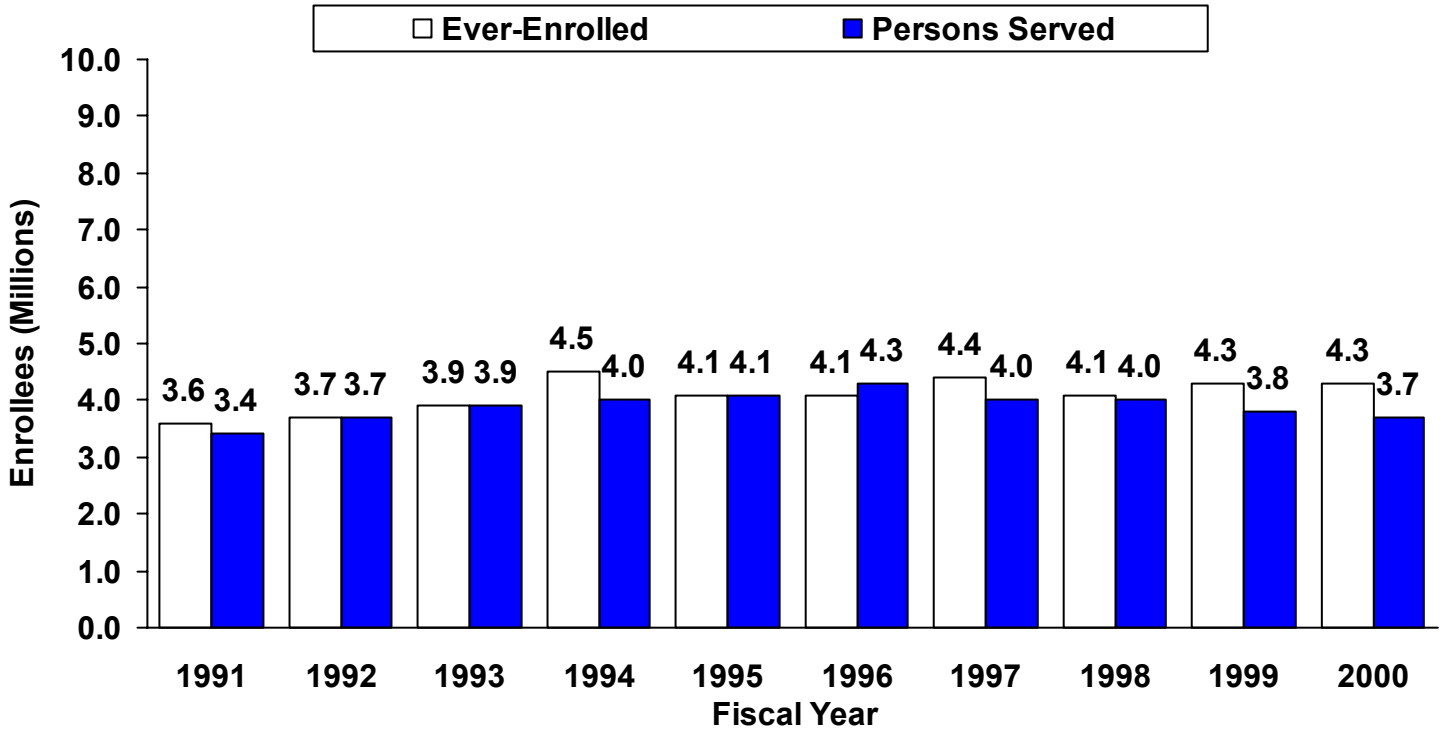
The Medicaid disabled and blind population grew over 50 percent during the 1990s.



Note: (1) Children, adults and the aged who are blind or disabled are included in the data presented above.
Source: CMS, HCFA-2082 and MSIS.

Chart 8
Aged Medicaid Population

The Medicaid aged population was relatively stable throughout the 1990s.



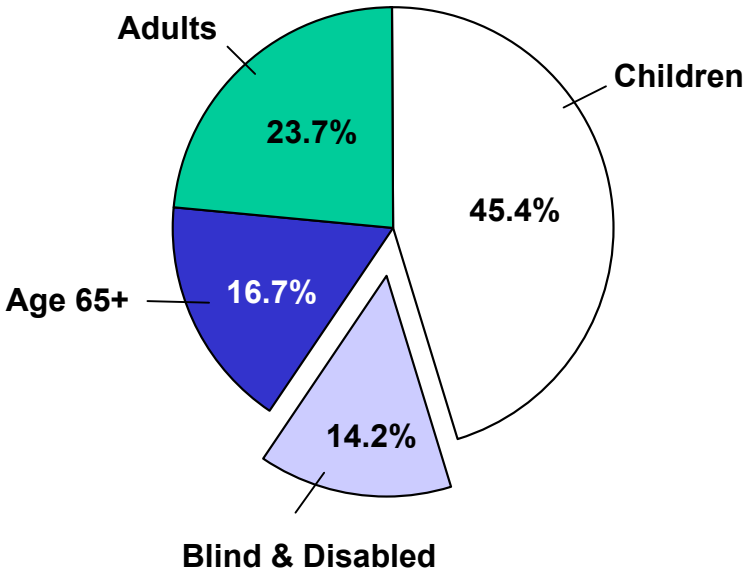
Note: The aged population consists of those who are age 65 and older.
Source: CMS, HCFA-2082 and MSIS.

Chart 9
Persons Served Through Medicaid, by Basis of Eligibility, Fiscal Years 1973 and 2000

The proportion of persons with disabilities served through Medicaid has increased while the proportion of individuals aged 65 and older has decreased.

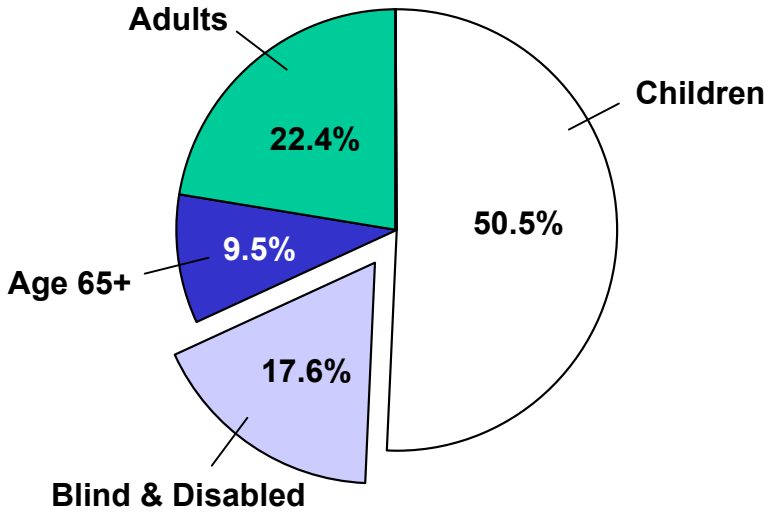
1973

20.6 Million Persons Served[1]



2000

42.8 Million Persons Served[1]

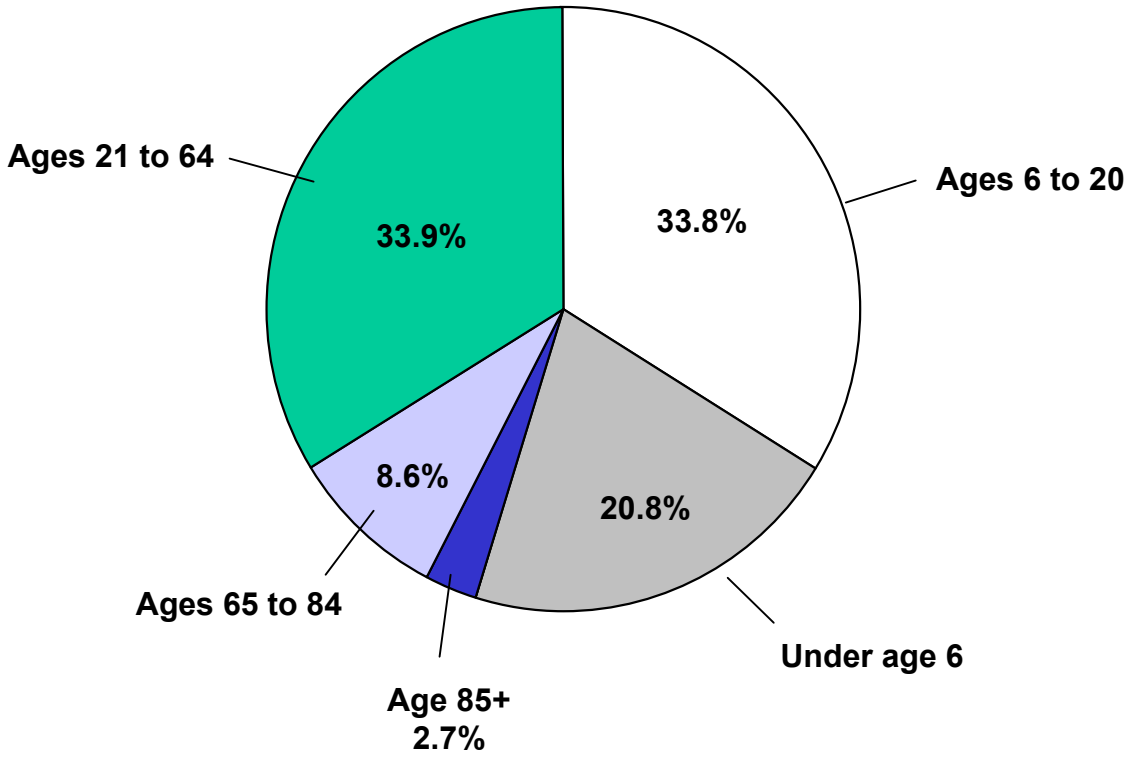


Note: (1) The percentage distribution for 1973 does not include 1.5 million persons served by Medicaid whose basis of eligibility is reported as "other"; the percentage distribution for 2000 does not include 3.7 million persons served whose basis of eligibility is "unknown". (2) The term "adults," refers to non-elderly, non-disabled adults. (3) Children with disabilities are included in the blind & disabled category shown above. (4) Percentages may not sum to 100 due to rounding.

Source: CMS, HCFA-2082 and MSIS.

Chart 10
Medicaid Enrollees by Age, Fiscal Year 2000

Children (individuals under age 21) represent over half of the Medicaid ever-enrolled population.

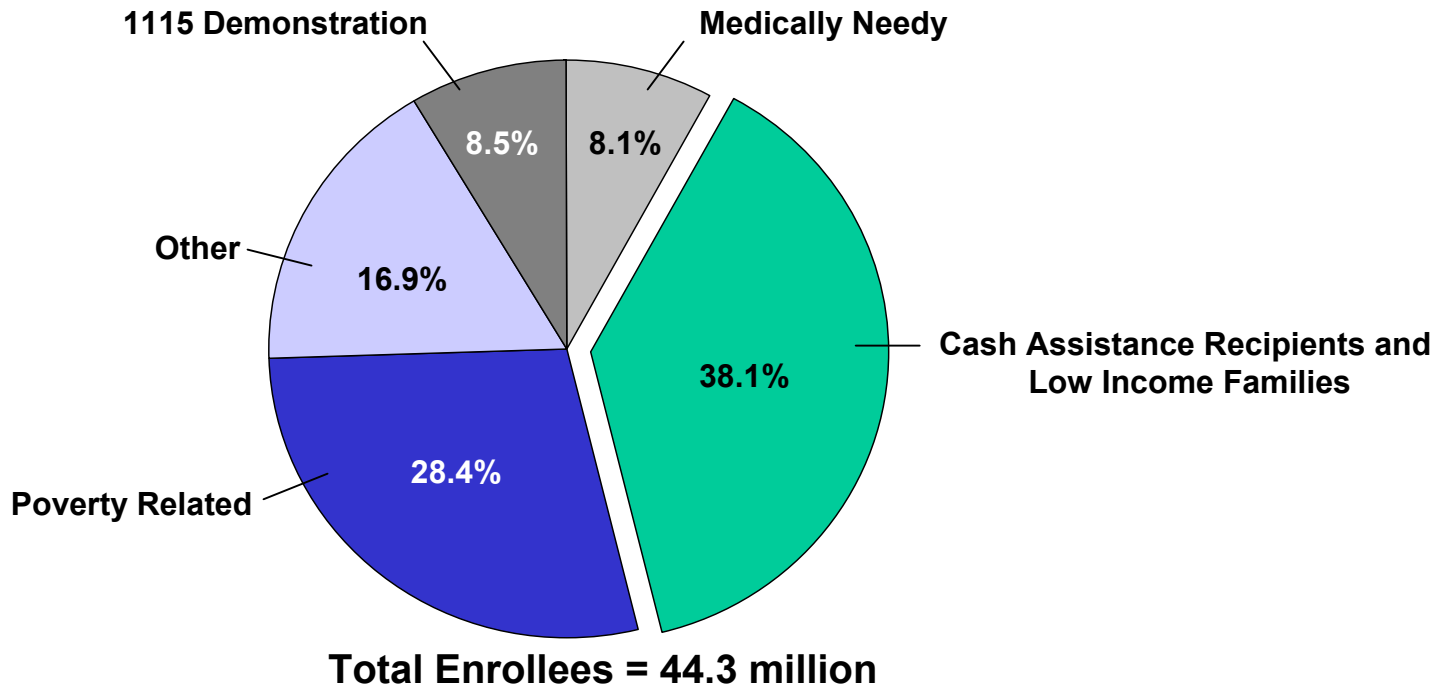


Total Enrollees = 44.3 million

Note: There were 89,060 individuals with unknown age, making up 0.2 percent of total Medicaid enrollees.
Source: CMS, MSIS.

Chart 11
Medicaid Enrollees by Maintenance Assistance Status, Fiscal Year 2000

Less than half of Medicaid enrollees receive cash assistance.

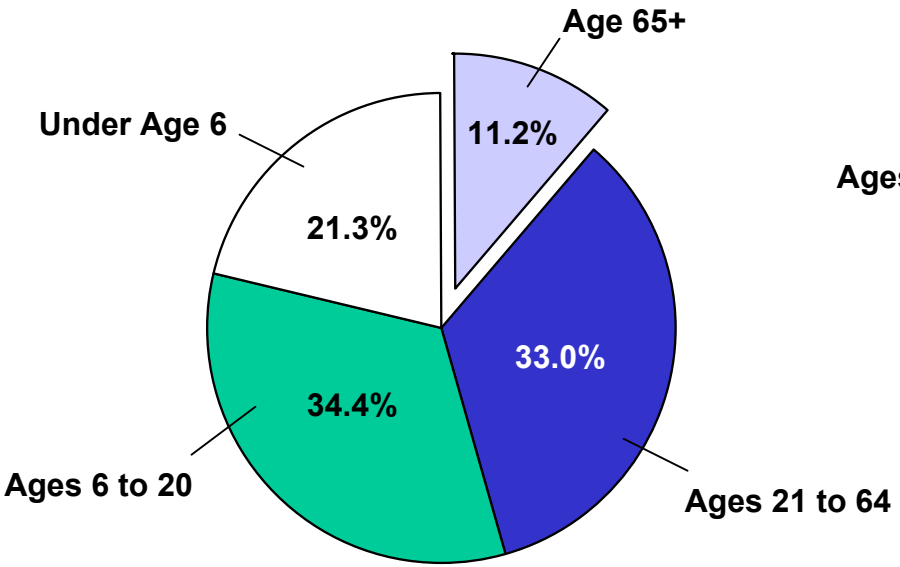


Note: (1) There are 1,324 Medicaid enrollees with "unknown" maintenance assistance status who are not included in the percent distribution above but are included in the total enrollees. (2) "Cash Assistance Recipients and Low Income Families" includes all SSI recipients, any recipients of state supplementary payment based on need (other than SSI), and families with children who meet the eligibility criteria that states had in effect under their Aid to Families with Dependent Children (AFDC) programs as of July 16, 1996, who may or may not receive cash assistance in addition to Medicaid benefits. (3) For explanation of individual eligibility categories, see the attached glossary and/or notes on data sources.
Source: CMS, MSIS.

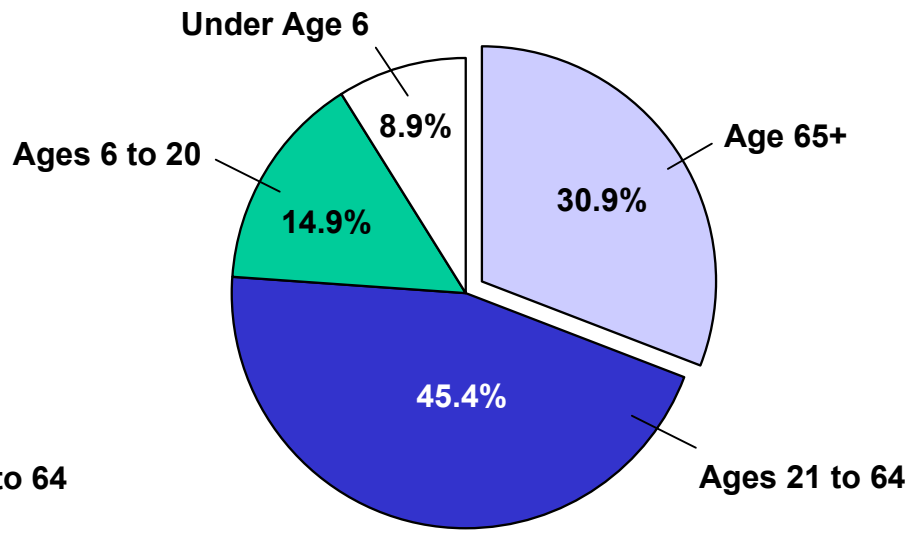
Chart 12
Persons Served Through Medicaid and Payments by Age, Fiscal Year 2000

While individuals age 65 and older comprise about 11 percent of persons served by Medicaid, they account for nearly 31 percent of expenditures.

Persons Served = 42.8 million[1]



Expenditures = $168.3 billion[1]



Note: (1) While the total persons served and total expenditures figures include $6.7 billion in expenditures on behalf of 3.7 million persons served with "unknown" age, these figures have been excluded from calculation of the percents in the pie charts. If included, figures for persons served with "unknown" age would make up about 9 percent of persons served and about 4 percent of expenditures. (2) This presentation of data is based on ages of persons served rather than basis of eligibility. All individuals certified eligible for Medicaid must be classified under a basis of eligibility (BOE) for medical care (e.g. aged, blind/disabled, children, adults, etc.). The BOE status is separate from age categorization. (3) Percentages do not sum to 100 due to rounding.
Source: CMS, MSIS.

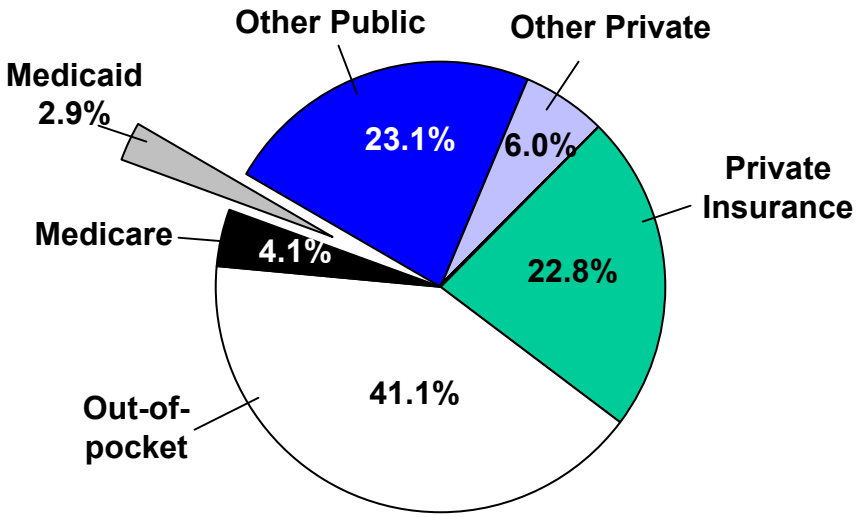
Section III

Medicaid Expenditures

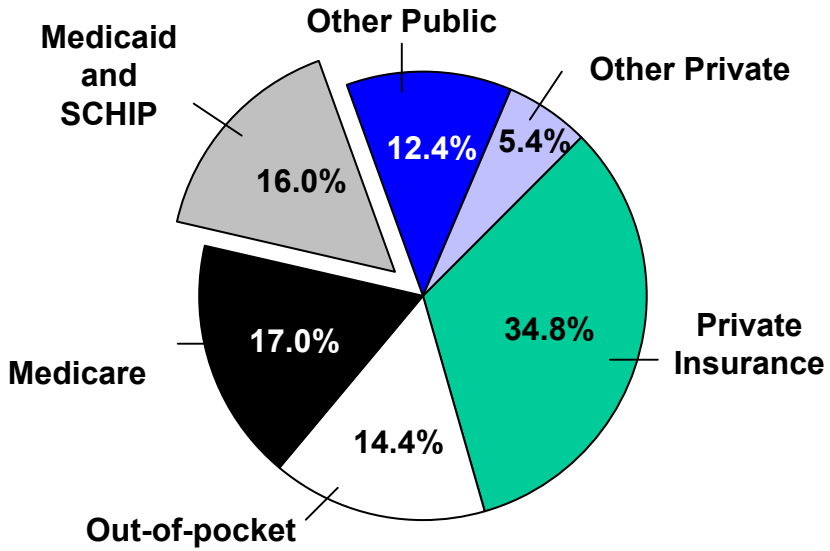
Chart 13
Medicaid and SCHIP Expenditures as a Percent of All National Health Expenditures, Calendar Years 1966 and 2001

By 2001, Medicaid and SCHIP made up 16 percent of total national health expenditures.

CY 1966 Total Expenditures = $45.1 Billion



CY 2001 Total Expenditures = $1.4 Trillion

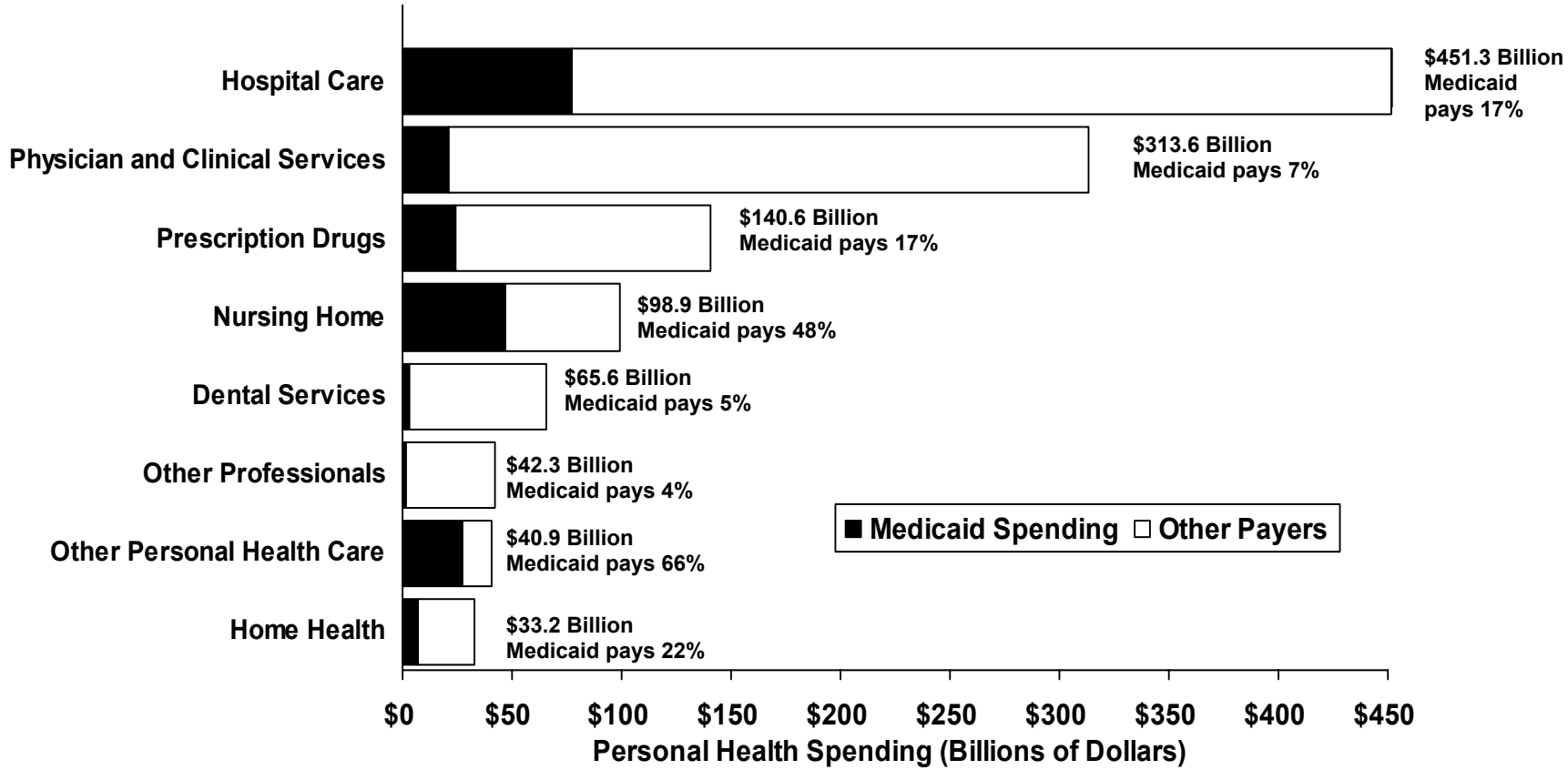


Note: (1) Health insurance premiums are included in the relevant payer source category, i.e. private health insurance premiums are included within "Private Insurance" and Medicare premiums are included within "Medicare". (2) "Out-of-pocket" does not include premium expenditures. The State Children's Health Insurance Program (SCHIP) is included within the "Medicaid & SCHIP" category and was 0.27 percent of National Health Expenditures during 2001. (3) The "Other Public" category includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health. (4) "Other Private" includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

Source: CMS/Office of the Actuary, National Health Statistics Group, National Health Accounts.

Chart 14
Total U.S. Personal Health Expenditures[1] by Type of Service and Percent Paid by Medicaid[2], Calendar Year 2001

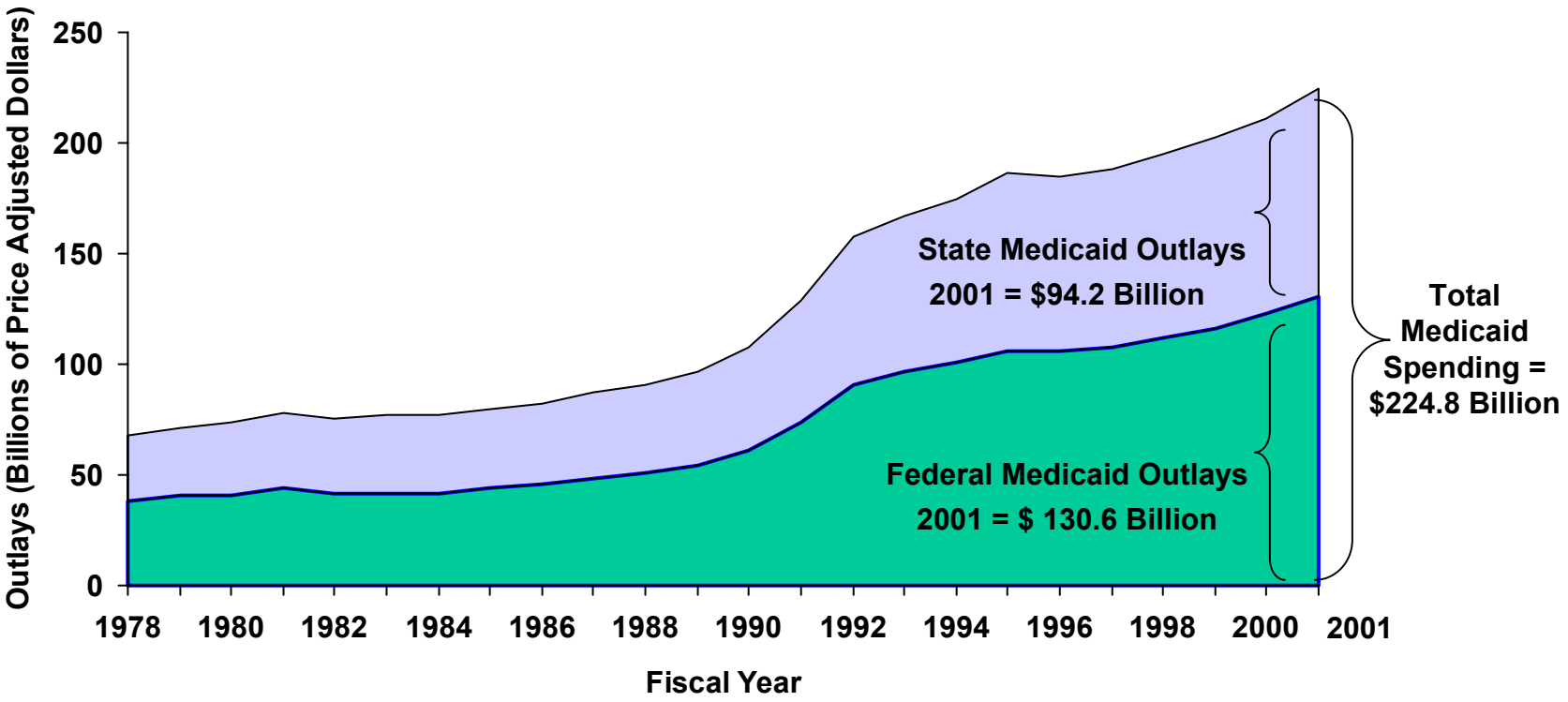
Medicaid's share of spending varies by type of service.



Note: (1) Personal Health Spending refers to provision of therapeutic goods or services rendered to treat or prevent a specific disease or condition in a specific person. (2) Medicaid excludes SCHIP expansion programs. (3) "Other Personal Health Care" includes Medicaid Home and Community Based waivers services, direct services provided by employers for the health care needs of their employees, offered either onsite or offsite, government expenditures for care not specified by kind (e.g. for medical care delivered in unconventional provider's sites such as schools, military field stations, and community centers).
Source: CMS/Office of the Actuary, National Health Statistics Group, National Health Accounts.

Chart 15
Medicaid Expenditure Trends, in Price Adjusted Terms, Fiscal Years 1978-2001

Federal Medicaid spending grew at an average annual rate of 3.2 percent in the 1980s. In the early 1990s, outlay growth increased to 13.5 percent on average, tapering off to about 3 percent in the second half of the decade.

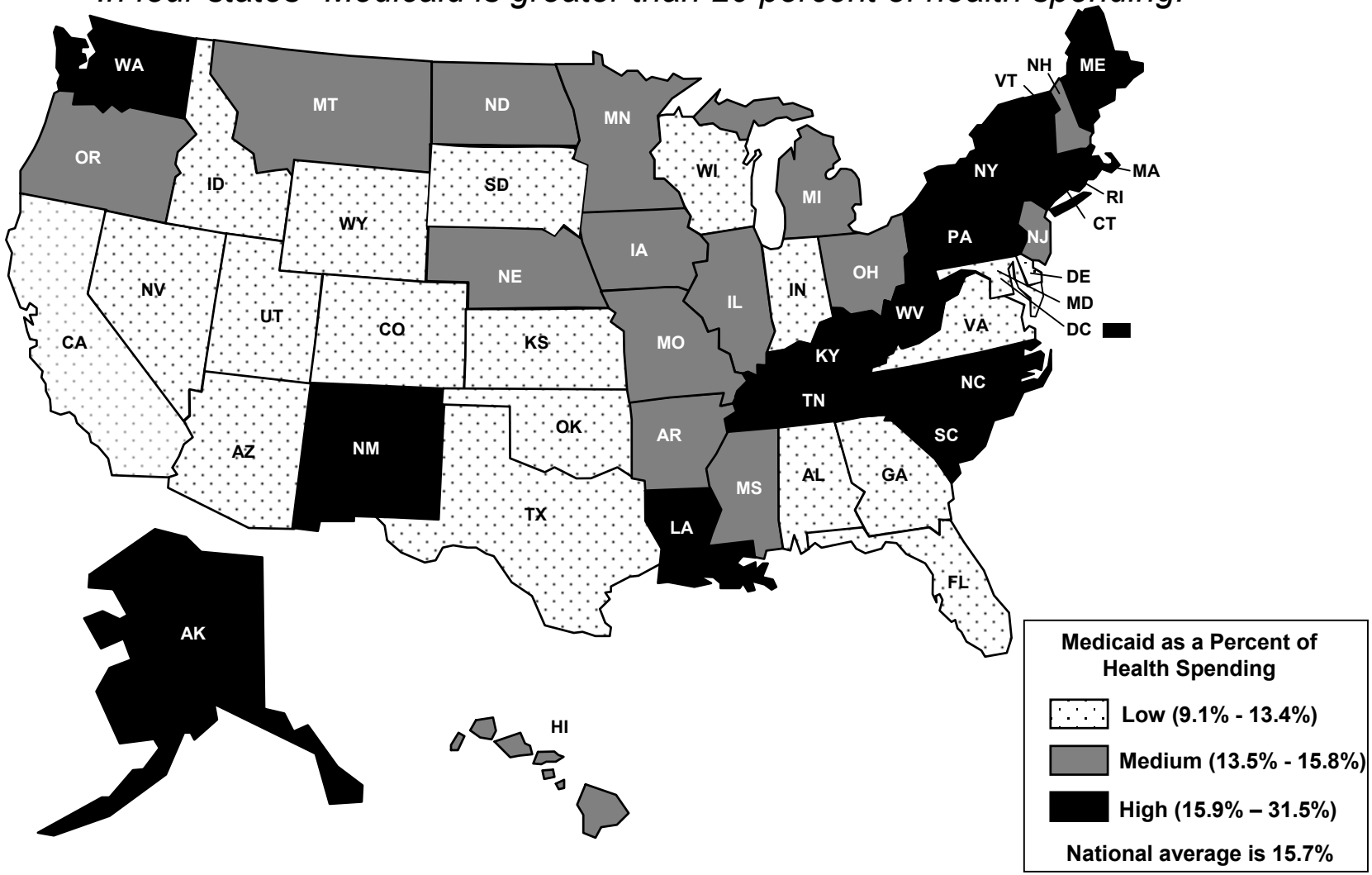


Note: (1) The data shown above are expressed in 2001 dollars calculated by removing medical price inflation specific to the services paid by Medicaid. A Medicaid Personal Health Care Chain-Weighted Price Index was created by the CMS Office of the Actuary/National Health Statistics Group for this purpose. (2) Total Medicaid spending does not include SCHIP or SCHIP expansion programs.

Source: CMS/Office of the Actuary, Medicare and Medicaid Cost Estimates Group. Index supplied by Office of the Actuary, National Health Statistics Group, National Health Accounts.

Chart 16
Medicaid as a Percentage of State Health-Specific Spending[1], 1998

In four states[2] Medicaid is greater than 20 percent of health spending.



Note: (1) Health spending is both public and private spending. (2) Maine, Rhode Island, New York and the District of Columbia.
Source: CMS/Office of the Actuary, National Health Statistics Group, National Health Accounts.

Chart 17
Medicaid Fiscal Year 2004 Federal Medical Assistance Percentage (FMAP) Rates

50% ----------60.22% ----------77.08%[1]

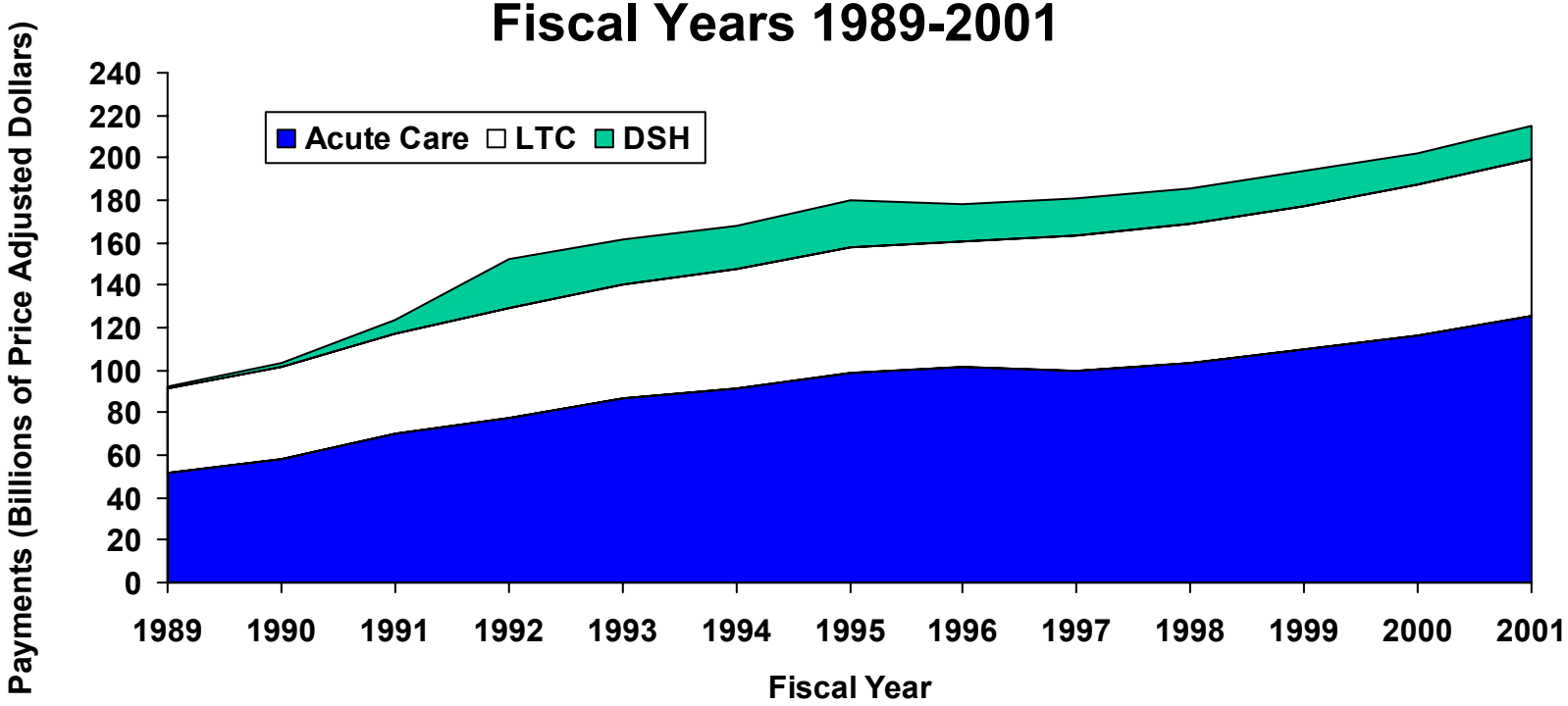
Lowest FMAP Rate ***Median FMAP Rate*** ***Highest FMAP Rate***

50%	51%-59%	60%-69%	70% and Greater
13 States	12 States	14 States	12 States
California Colorado Connecticut Delaware Illinois Maryland Massachusetts Minnesota New Hampshire New Jersey New York Virginia Washington	Alaska Florida Georgia Hawaii Michigan Nebraska Nevada Ohio Pennsylvania Rhode Island Wisconsin Wyoming	Arizona Indiana Iowa Kansas Maine Missouri North Carolina North Dakota Oregon South Carolina South Dakota Tennessee Texas Vermont	Alabama Arkansas Dist. of Columbia Kentucky Idaho Louisiana Mississippi Montana New Mexico Oklahoma Utah West Virginia

Note: (1) Mississippi has the highest FMAP rate. (2) Under Section 1905(b) of the Social Security Act a State's Federal Medical Assistance Percentage (FMAP) is calculated based on a state's per capita income and cannot be less than 50 percent nor exceed 83 percent. All U.S. Territories (e.g., Puerto Rico, Virgin Islands, American Samoa, Guam, Northern Mariana Islands) have a 50 percent FMAP.

Source: Federal Register: November 15, 2002 (Volume 67, Number 221).

Chart 18
Total (Federal and State) Medical Assistance Payments by Category, Fiscal Years 1989-2001



FY ($ in Billions)	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Acute Care	$51.3	$58.2	$69.9	$77.4	$86.5	$91.2	$98.7	$101.4	$99.8	$103.7	$110.1	$116.7	$125.5
LTC	$40.3	$43.7	$47.3	$51.8	$53.8	$56.3	$58.9	$59.2	$63.3	$65.2	$67.1	$70.6	$73.9
DSH	$0.9	$1.3	$6.6	$23.2	$21.2	$20.8	$22.6	$17.4	$18.0	$16.5	$16.7	$15.0	$15.5

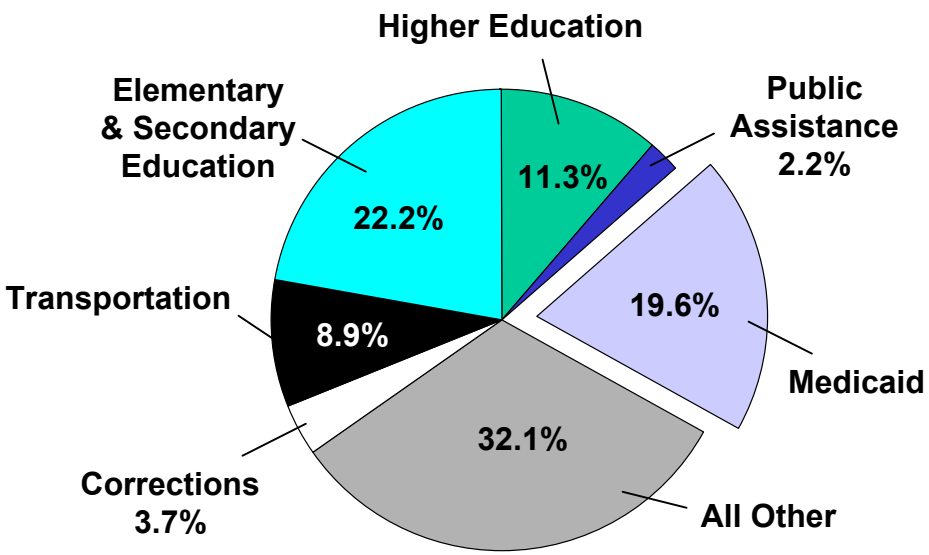
Note: (1) LTC refers to Medicaid Long-Term Care spending. (2) DSH refers to Disproportionate Share Hospitals. (3) Data shown above are expressed in 2001 dollars calculated by removing medical price inflation specific to the services paid by Medicaid. A Medicaid Personal Health Care Chain-Weighted Price Index was created by the CMS Office of the Actuary/National Health Statistics Group for this purpose.

Source: CMS/Office of the Actuary, Medicare and Medicaid Cost Estimates Group.

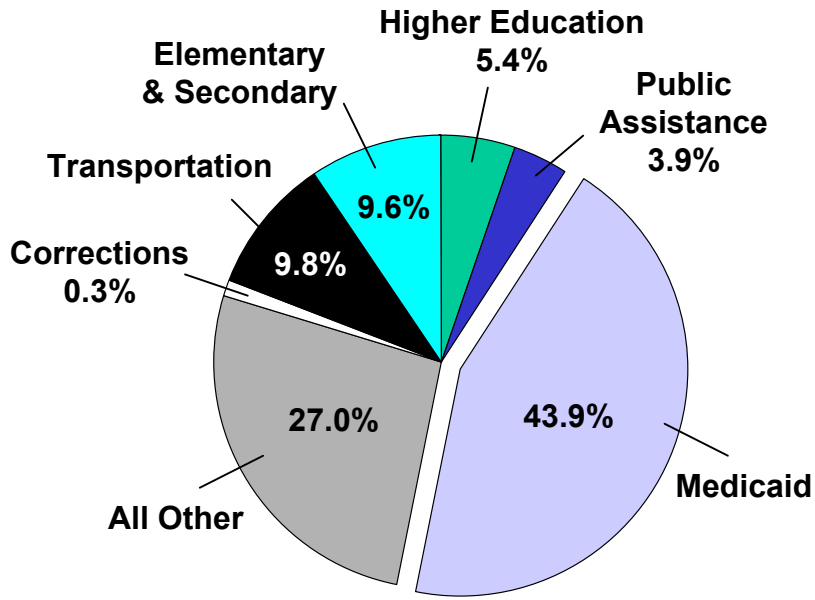
Chart 19
Total State Spending and Federal Funds Provided to States, Fiscal Year 2001

Medicaid accounts for about one-fifth of total state spending and more than 43 percent of Federal funds provided to states.

Total State Spending[1] = $760.4 Billion



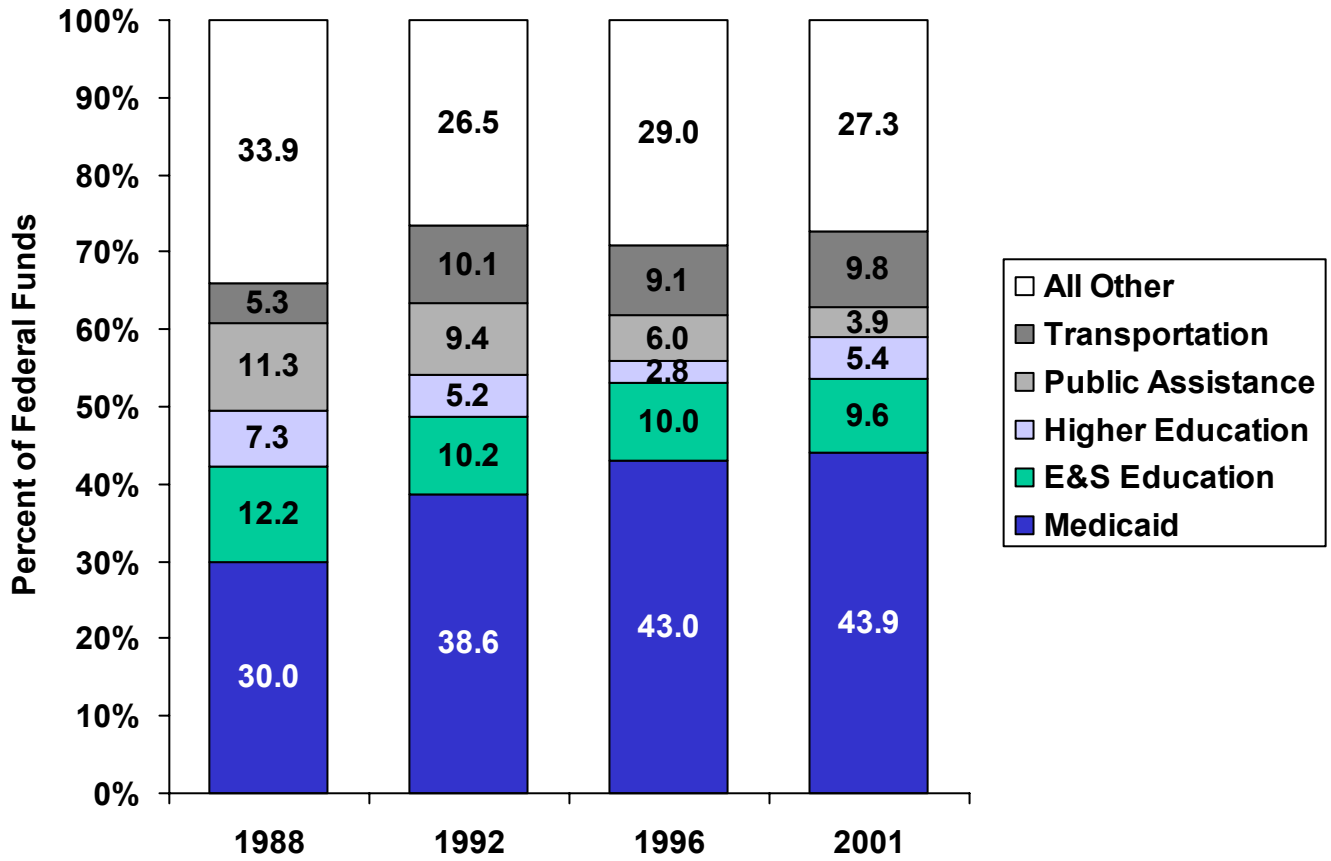
Federal Funds Provided to States = $264.0 Billion



Note: (1) Total state spending is made up of general funds (revenues received from broad-based state taxes) plus other state funds (revenue sources restricted by law for particular governmental functions or activities such as provider taxes in the case of Medicaid). (2) The "All Other" category of state spending includes state functions such as hospitals, economic development, housing, environmental programs, health programs (including SCHIP), parks and recreation, natural resources, air transportation, and water transport and terminals. (3) The "All Other" category of federal funds to states includes but is not limited to public health programs; community and institutional services for the mentally ill/developmentally disabled; environmental programs; parks and recreation; housing; and general aid to local governments. (4) Percentages may not sum to 100 due to rounding.
Source: National Association of State Budget Officers, 2001 State Expenditure Report.

Chart 20
Trends in Distribution of Federal Funds to States, Selected Fiscal Years

Medicaid accounts for the largest, and growing, share of Federal funds to states.

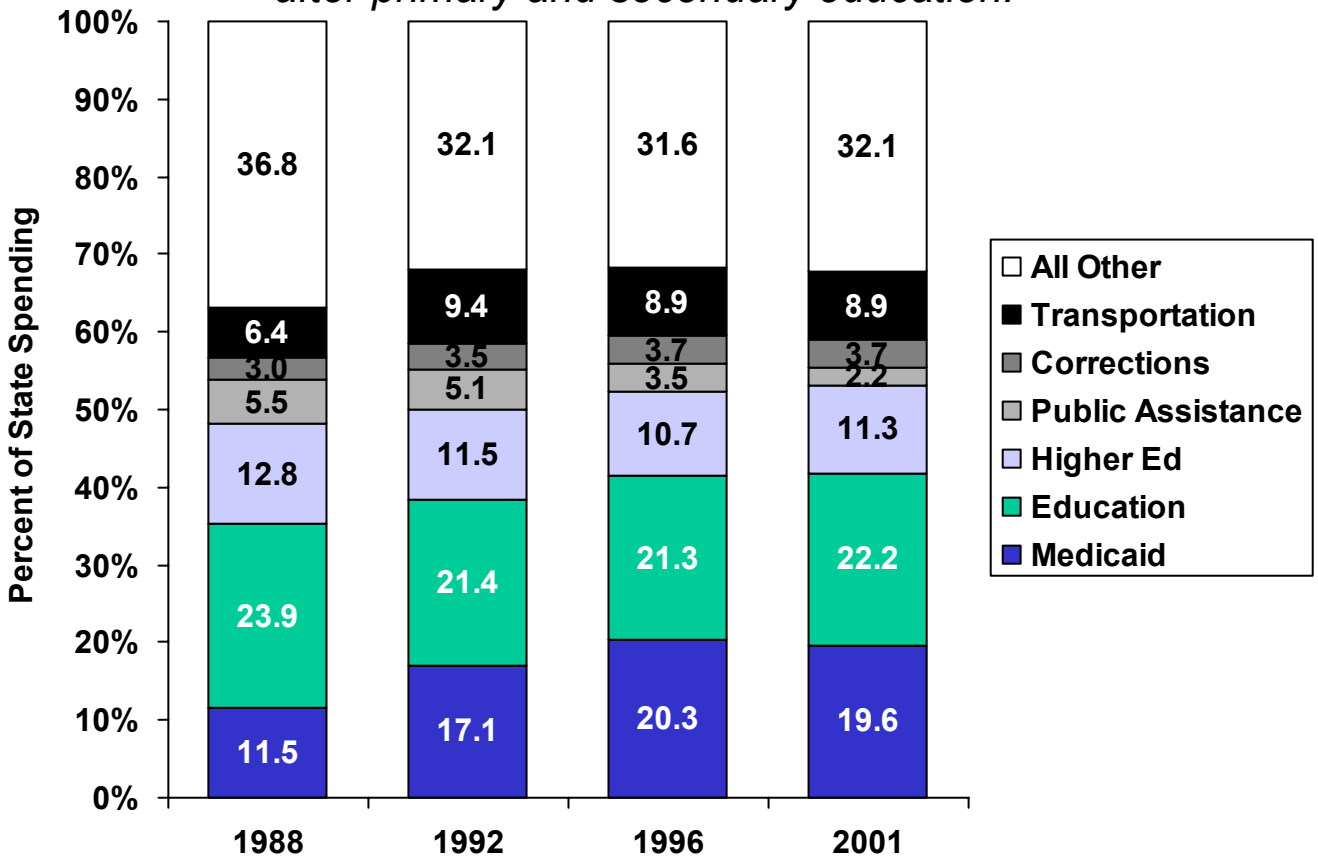


Note: (1) The "All Other" category of federal funds to states includes but is not limited to corrections; public health programs; community and institutional services for the mentally ill/developmentally disabled; environmental programs; parks and recreation; housing; and general aid to local governments. (2) Percentages may not sum to 100 due to rounding.

Source: National Association of State Budget Officers, 2001 State Expenditure Report.

Chart 21
Trends in Distribution of State Spending, Selected Fiscal Years

Historically, Medicaid has been the second largest specific category of state expenditure after primary and secondary education.

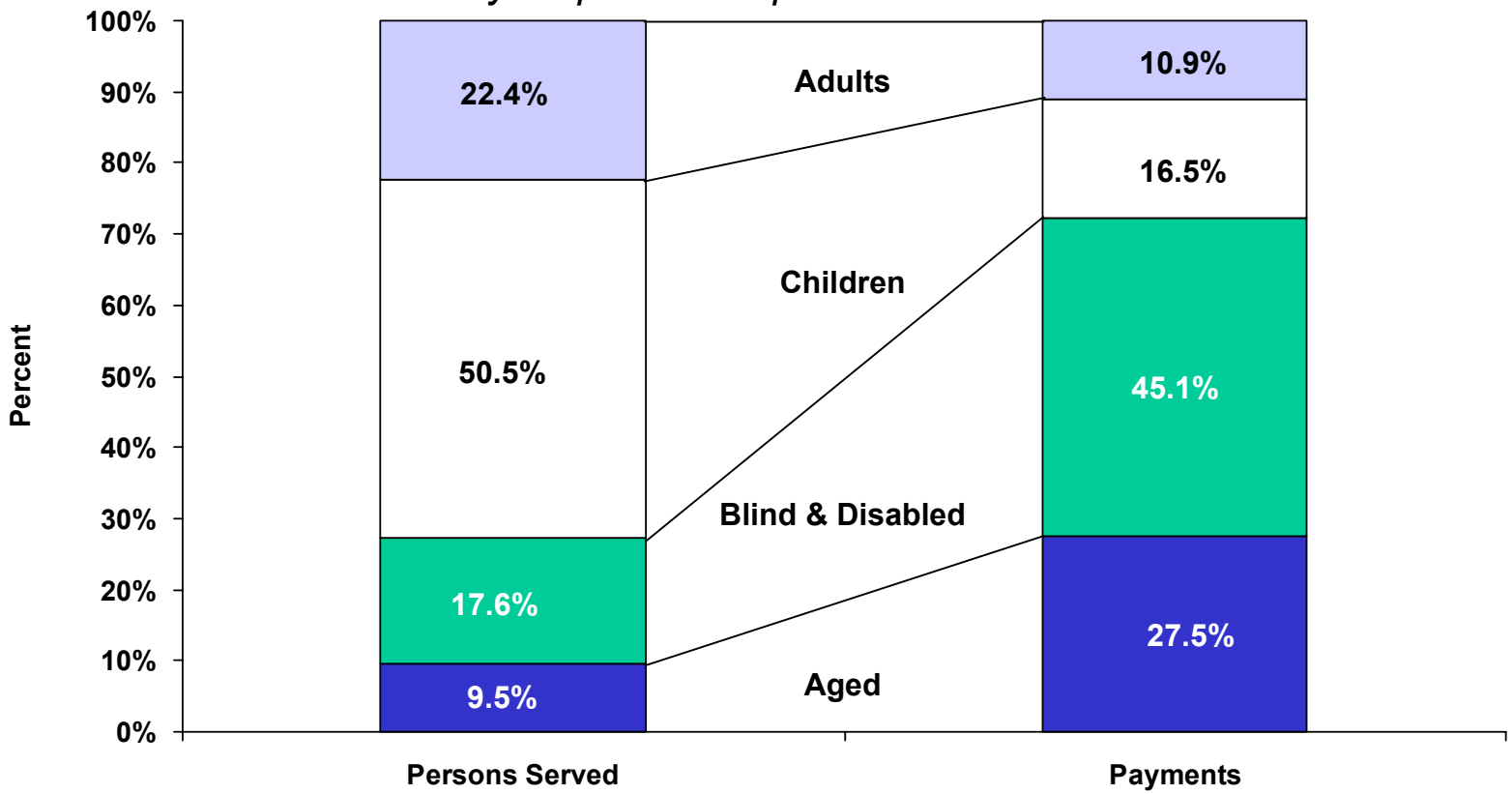


Note: (1) Total state spending is made up of general funds (expenditures from revenues received from broad-based state taxes, this is the largest source of state funding) plus other state funds (expenditures from revenue sources restricted by law for particular governmental functions or activities such as, in the case of Medicaid, provider taxes, fees, donations, assessments, and local funds). (2) The "All Other" category of state spending includes state functions such as hospitals, economic development, housing, environmental programs, health programs (including SCHIP), parks and recreation, natural resources, air transportation, and water transport and terminals. (3) Percentages may not sum to 100 due to rounding.

Source: National Association of State Budget Officers, 2001 State Expenditure Report.

Chart 22
Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 2000

Payments for the elderly, blind and disabled account for 73 percent of total payments and only 27 percent of persons served.

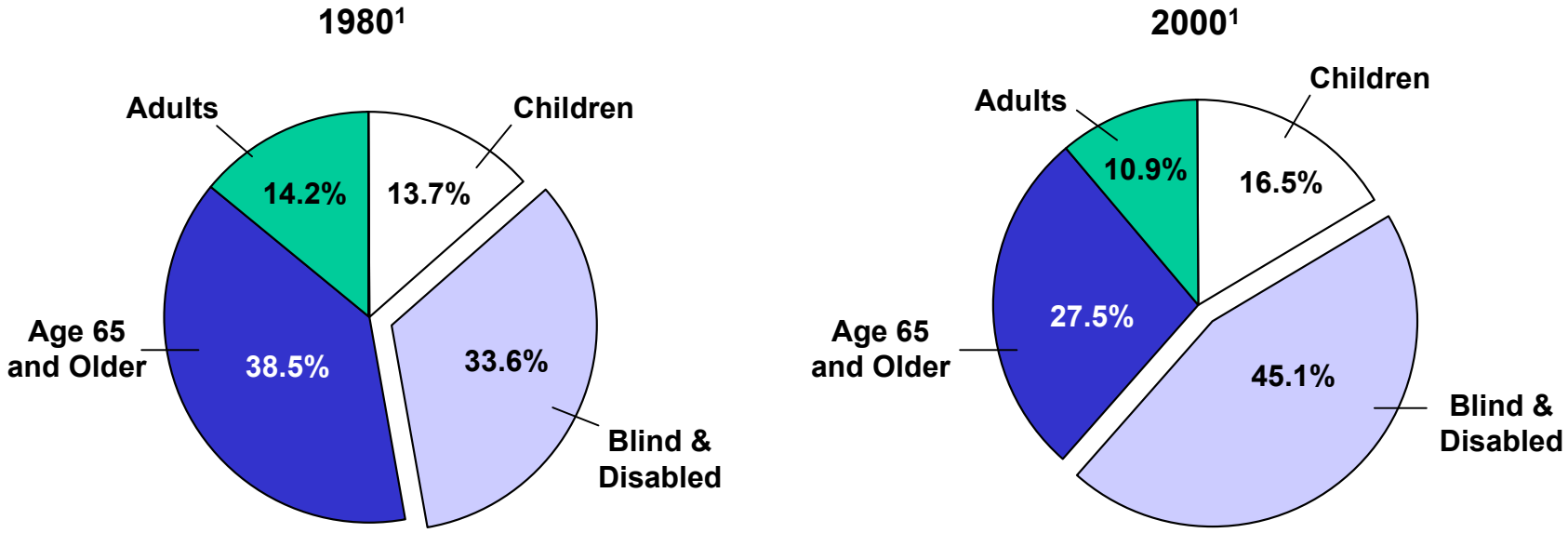


Note: (1) "Payments" describe direct Medicaid provider payments and Medicaid program expenditures for premium payments to third parties for managed care, as well as cost sharing on behalf of persons served who are dually enrolled in Medicaid and Medicare, but exclude DSH payments and Medicare premiums. (2) This chart excludes 3.7 million persons served with "unknown" basis of eligibility and 6.5 billion expenditures on behalf of persons served with "unknown" basis of eligibility in FY 2000. If included in the total above, "unknown" Medicaid persons served would have comprised about 9 percent of total persons served and about 4 percent of total expenditures.

Source: CMS, MSIS.

Chart 23
Medicaid Payments by Basis of Eligibility, Fiscal Years 1980 and 2000

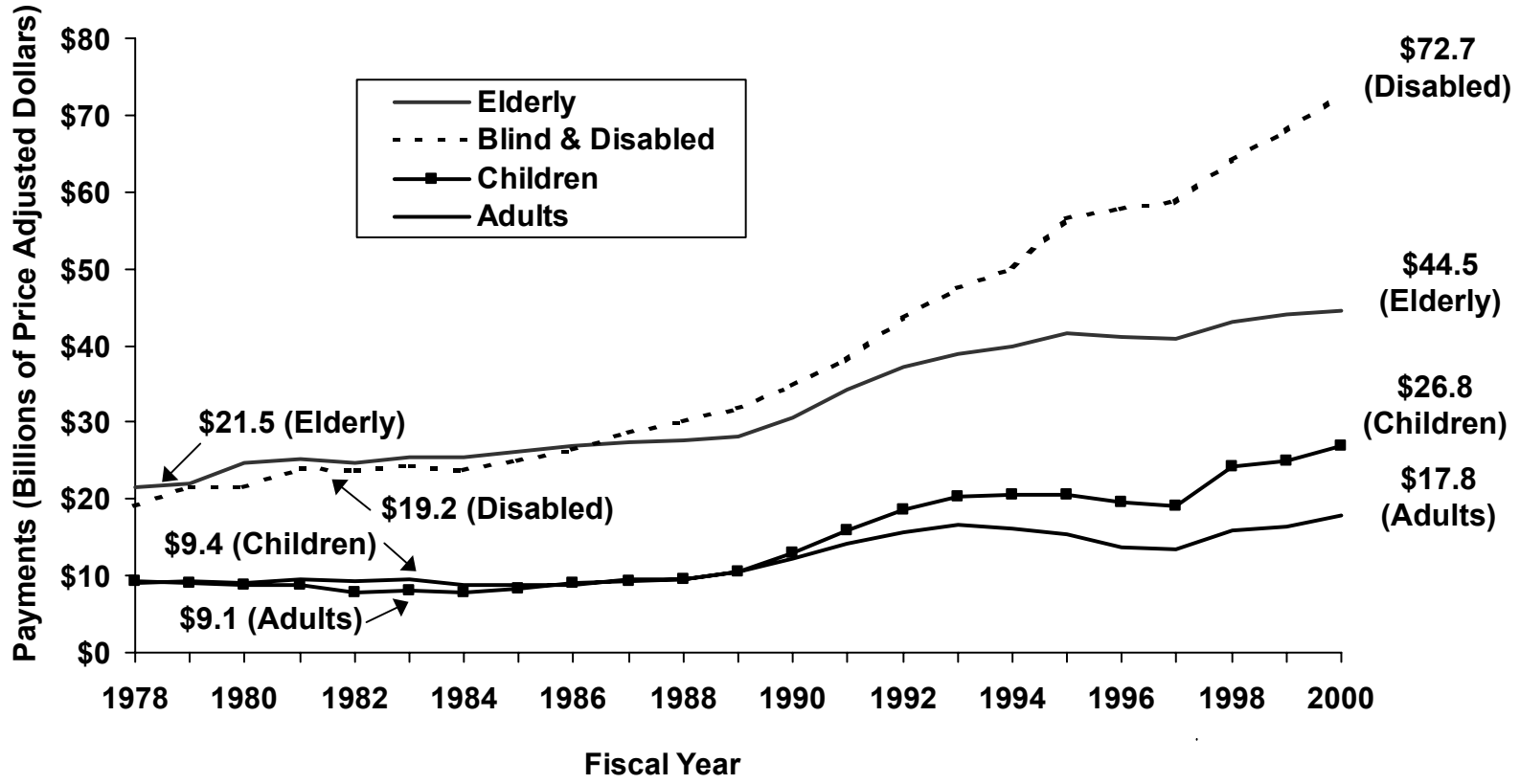
The proportion of Medicaid provider payments attributed to blind and disabled individuals has increased greatly since 1980.



Note: (1) These pie charts exclude payments of $596 million and $6.5 billion for 1980 and 2000, respectively, on behalf of 1.5 million persons served by Medicaid in 1980 and 3.7 million for 2000 whose basis of eligibility is reported as “other” in 1980 or “unknown” in 2000. If these payments had been included, they would make up 2.6% of payments by basis of eligibility in 1980 and 3.9% in 2000. (2) "Payments" describe direct Medicaid provider payments and Medicaid program expenditures for premium payments to third parties for managed care, as well as cost sharing on behalf of persons dually enrolled in Medicaid and Medicare, but exclude DSH payments and Medicare premiums. (3) The term “adults” as used here refers to non-elderly, non-disabled adults. (4) Disabled children are included in the blind and disabled categories. (5) Percentages may not sum to 100 due to rounding.
Source: CMS, HCFA-2082 and MSIS.

Chart 24
Total Medicaid Payments in Price Adjusted Dollars by Basis of Eligibility, Fiscal Years 1978-2000

Since 1990, Medicaid spending for individuals with disabilities has grown dramatically compared to other eligibility groups.

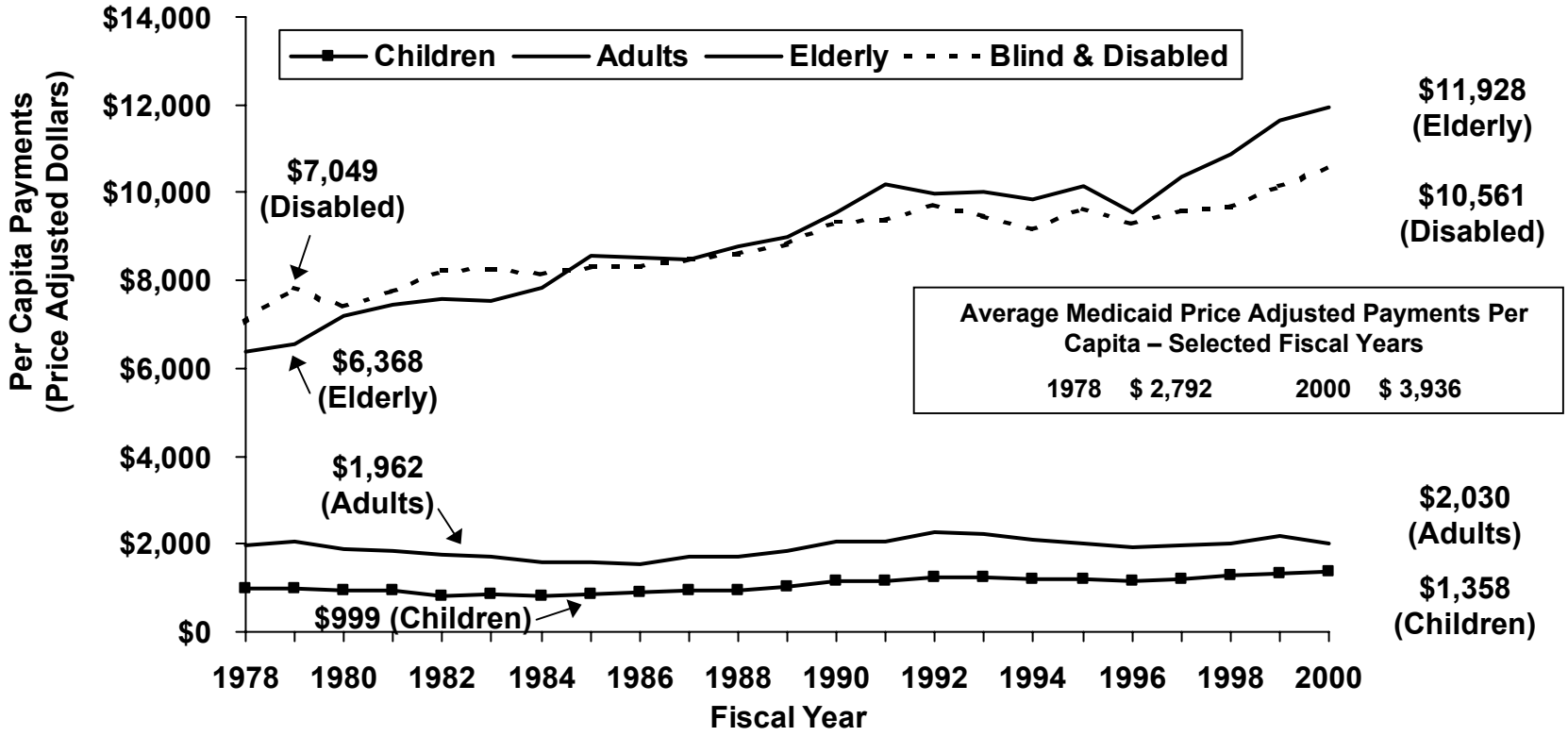


Note: (1) Data labels refer to FY1978 and FY 2000, respectively. (2) Data shown above are expressed in 2000 dollars calculated by removing medical price inflation specific to the services paid by Medicaid. A Medicaid Personal Health Care Chain-Weighted Price Index was created by the CMS Office of the Actuary/National Health Statistics Group for this purpose. (3) The term "adults" as used above refers to non-elderly, non-disabled adults. (4) Children are persons under age 21. Disabled children are included in the blind & disabled category.

Source: CMS/Center for Medicaid and State Operations and Office of the Actuary: HCFA-2082 and MSIS.

Chart 25
Average Medicaid Payments per Person Served in Price Adjusted Dollars, Fiscal Years 1978-2000

Per capita payments for the elderly and individuals with disabilities experienced larger growth between 1978 and 2000 than per capita expenditures for children and adults.

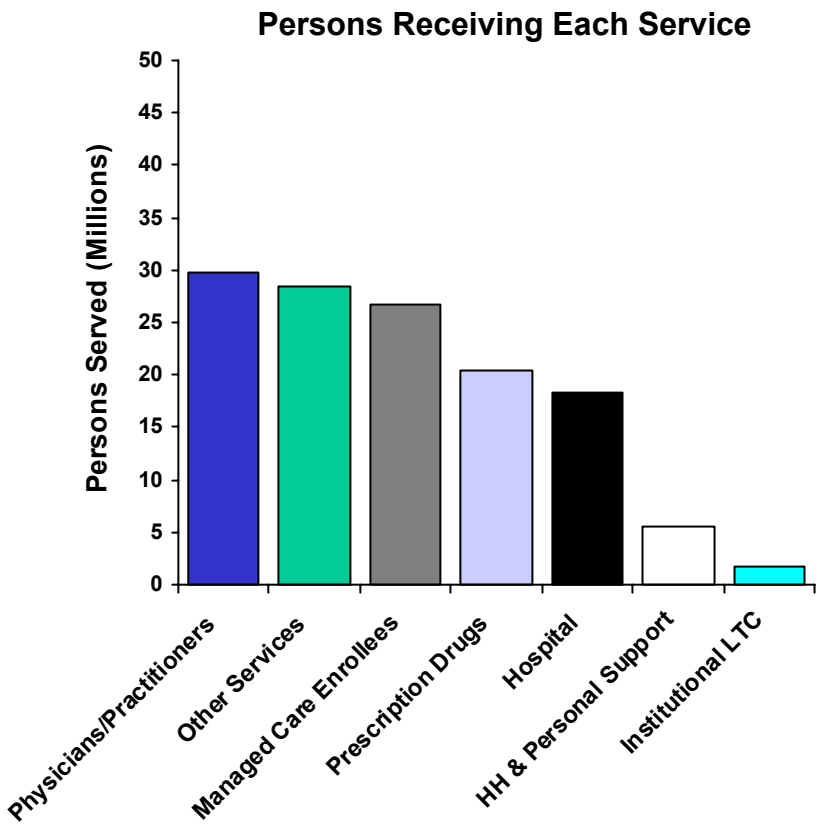


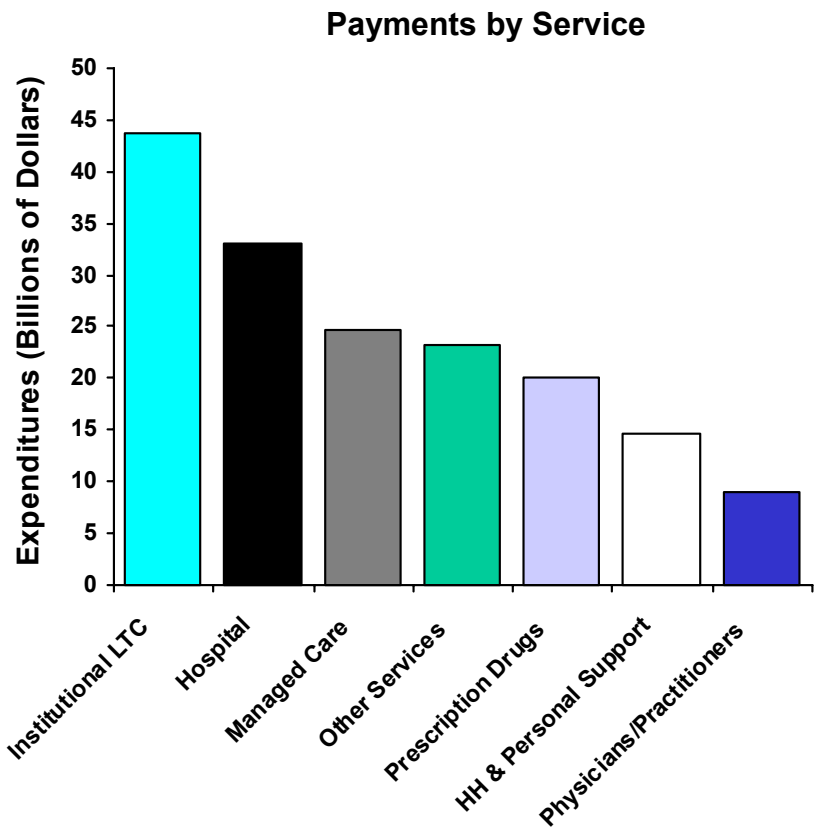
Note: (1) Data labels refer to FY1978 and FY 2000, respectively. (2) Data shown above are expressed in 2000 dollars calculated by removing medical price inflation specific to the services paid by Medicaid. A Medicaid Personal Health Care Chain-Weighted Price Index was created by the CMS Office of the Actuary/National Health Statistics Group for this purpose. (3) The term "adults" as used above refers to non-elderly, non-disabled adults. (4) Children are persons under age 21. Disabled children are included in the blind & disabled category.

Source: CMS, HCFA-2082/MSIS, and Office of the Actuary.

Chart 26
Medicaid Persons Served and Payments by Service, Fiscal Year 2000

While under five percent of Medicaid persons served utilize institutional long-term care services, these services account for over one-quarter of Medicaid expenditures.



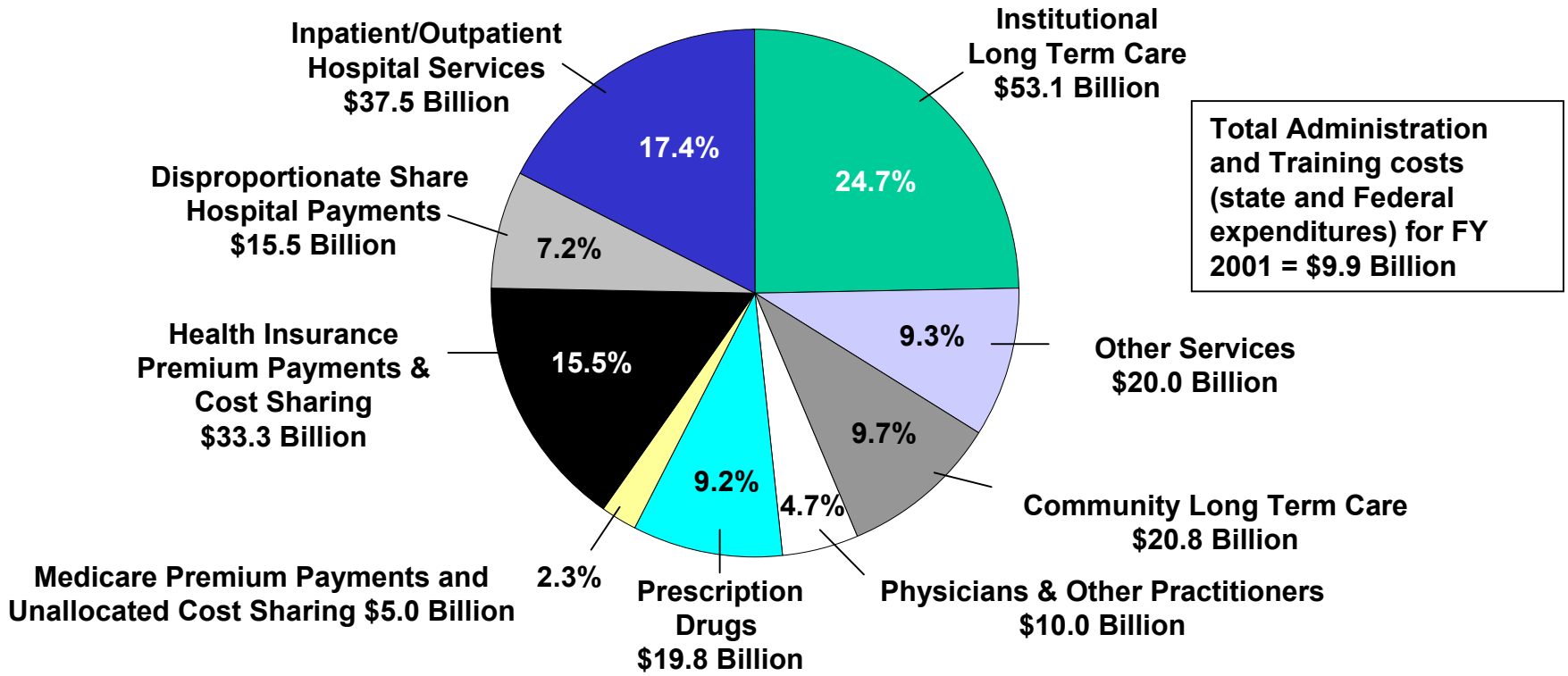


Note: (1) Hospital expenditures include inpatient, outpatient and mental health facility expenditures and do not include DSH. (2) "Physicians/Practitioners" includes non-physician providers and dental services. (3) "Institutional LTC" includes ICF/MR and nursing facility services. (4) Major categories of service in "Other Services" are clinic services, laboratory and x-ray services, transportation, prosthetic devices and eyeglasses. (5) Persons receiving services may be counted in more than one service category.
Source: CMS, MSIS.

Chart 27
Medicaid Expenditures by Category, Fiscal Year 2001

Nearly half of Medicaid expenditures go to hospitals and long-term care facilities.

Total Medical Assistance Payments= $214.9 Billion



Note: (1) Administrative costs are not included in the pie chart above. (2) All categories refer to fee-for-service (FFS) payments except "Health Insurance Premium Payments & Cost Sharing" and "Medicare Premium Payments and Unallocated Cost Sharing". (3) No SCHIP or SCHIP expansion program dollars are included. (4) "Community Long Term Care" includes the following expenditure categories; home health services, personal care, home and community-based (H&CB) waiver services, H&CB services for disabled elderly and PACE. (5) "Health Insurance Premium Payments" includes Medicaid premium payments to Managed Care Organizations (MCOs), Prepaid Health Plans (PHPs), Group Health Plans (GHPs), Primary Care Case Management (PCCM), as well as premiums, coinsurance and deductibles for employer group health and other private insurance. (6) "Medicare Premium Payments and Unallocated Cost Sharing" are program payments on behalf of dual enrollees. Unallocated Cost Sharing can not be allocated to a category of service. (7) Mental Health hospital expenditures are included in "Inpatient/Outpatient Hospital Services". (8) "DSH Payments" include mental health hospitals.
Source: CMS, CMS-64, Total Current Expenditures, Federal and State Shares.

Chart 28
Total (State and Federal) Medicaid Expenditures,[1] Fiscal Year 2001

	Total Reported Medicaid Expenditures[2] (CMS Form 64)	FY 2001 Federal Medical Assistance Percentage (FMAP)	Medicaid DSH Payments
All Jurisdictions (56)[3]	**$224,793,823,752**	**59.82%**	**$15,516,244,937**
Alabama	$3,000,282,109	69.99%	$366,737,888
Alaska	$627,983,804	56.04%	$13,826,606
American Samoa	$11,107,674	50.00%	0
Arizona	$2,799,737,340	65.77%	$102,773,900
Arkansas	$1,932,891,128	73.02%	$22,728,184
California	$21,754,531,941	51.25%	$1,924,248,250
Colorado	$2,253,874,846	50.00%	$186,055,130
Connecticut	$3,509,332,996	50.00%	$299,388,509
Delaware	$634,006,286	50.00%	$4,140,000
District of Columbia	$1,011,607,372	70.00%	$55,700,453
Florida	$9,168,395,221	56.62%	$338,809,359
Georgia	$5,461,387,669	59.67%	$418,024,133
Guam	$13,047,746	50.00%	0
Hawaii	$675,073,374	53.85%	0
Idaho	$758,863,548	70.76%	$10,047,333
Illinois	$8,611,415,776	50.00%	$380,939,064
Indiana	$4,180,411,041	62.04%	$712,157,782
Iowa	$1,811,213,103	62.67%	$14,273,308

Note: (1) Expenditures shown on CMS-64 differ from those derived from MSIS. CMS-64 shows actual Medicaid payments while MSIS shows expenditures from adjudicated claims and excludes items such as disproportionate share hospital payments. (2) Total Reported Medicaid Expenditures includes Disproportionate Share Hospital (DSH) payments (noted separately above) and administrative costs of the program. (3) CMS-64 data include the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico and Virgin Islands.

Source: CMS, CMS-64, Total Current Expenditures, Federal and State Shares; FMAP data: Federal Register: February 23, 2000 (Volume 65, Number 36), pp.8979-8980.

Chart 28 (Continued)
Total (State and Federal) Medicaid Expenditures,[1] Fiscal Year 2001

	Total Reported Medicaid Expenditures (CMS Form 64)	FY 2001 Federal Medical Assistance Percentage (FMAP)	Medicaid DSH Payments
Kansas	$1,766,781,422	59.85%	$46,990,903
Kentucky	$3,479,314,198	70.39%	$191,149,308
Louisiana	$4,488,321,117	70.53%	$872,303,142
Maine	$1,420,271,658	66.12%	$49,160,020
Maryland	$3,528,315,531	50.00%	$62,525,396
Massachusetts	$7,468,953,886	50.00%	$455,591,643
Michigan	$7,844,128,064	56.18%	$435,347,236
Minnesota	$4,145,167,323	51.11%	$63,742,066
Mississippi	$2,582,166,299	76.82%	$178,733,044
Missouri	$4,901,503,084	61.03%	$455,068,472
Montana	$546,454,340	73.04%	$244,000
N. Mariana Islands	$8,143,613	50.00%	0
Nebraska	$1,272,413,854	60.38%	$1,260,920
Nevada	$730,910,037	50.36%	$76,042,494
New Hampshire	$927,127,934	50.00%	$158,369,610
New Jersey	$7,312,668,520	50.00%	$1,121,582,243
New Mexico	$1,501,664,243	73.80%	$9,165,167
New York	$32,284,690,177	50.00%	$2,347,049,523
North Carolina	$6,515,714,163	62.47%	$434,444,149

See note on previous page.

Source: CMS, CMS-64, Total Current Expenditures, Federal and State Shares; FMAP data: Federal Register: February 23, 2000 (Volume 65, Number 36), pp.8979-8980.

Chart 28 (Continued)
Total (State and Federal) Medicaid Expenditures,[1] Fiscal Year 2001

	Total Reported Medicaid Expenditures (CMS Form 64)	FY 2001 Federal Medical Assistance Percentage (FMAP)	Medicaid DSH Payments
North Dakota	$437,968,172	69.99%	$1,061,172
Ohio	$8,748,879,395	59.03%	$636,464,510
Oklahoma	$2,205,027,185	71.24%	$23,081,693
Oregon	$2,879,361,679	60.00%	$29,637,191
Pennsylvania	$11,335,598,808	53.62%	$628,509,273
Puerto Rico	$368,800,000	50.00%	0
Rhode Island	$1,282,874,463	53.79%	$81,058,126
South Carolina	$3,198,796,844	70.44%	$371,947,763
South Dakota	$485,367,182	68.31%	$1,074,602
Tennessee	$5,595,077,456	63.79%	0
Texas	$12,088,811,059	60.57%	$1,238,327,955
Utah	$917,323,389	71.44%	$3,766,083
Vermont	$649,768,799	62.40%	$26,500,000
Virgin Islands	$11,517,758	50.00%	0
Virginia	$3,257,787,060	51.85%	$233,726,260
Washington	$4,855,860,245	50.70%	$328,896,481
West Virginia	$1,630,801,303	75.34%	$91,719,689
Wisconsin	$3,636,118,082	59.29%	$11,854,904
Wyoming	$268,212,436	64.60%	0

See note on first page of Chart 28.

Source: CMS, CMS-64, Total Current Expenditures, Federal and State Shares; FMAP data: Federal Register: February 23, 2000 (Volume 65, Number 36), pp.8979-8980.

Chart 29
Per Capita State Medicaid Payments,[1] Fiscal Year 2000

	Average Payment per Person Served[2]	Persons Served (MSIS)	Payments (MSIS)
51 Jurisdictions	**$3,936**	**42,763,233**	**$168,307,231,429**
Alabama	**$3,860**	**619,480**	**$2,391,194,897**
Alaska	**$4,876**	**96,432**	**$470,249,823**
Arizona	**$3,100**	**681,258**	**$2,111,769,849**
Arkansas	**$3,086**	**489,325**	**$1,510,079,842**
California	**$2,155**	**7,915,450**	**$17,060,494,184**
Colorado	**$4,747**	**380,964**	**$1,808,569,210**
Connecticut	**$6,762**	**419,890**	**$2,839,310,317**
Delaware	**$4,584**	**115,267**	**$528,339,689**
District of Columbia	**$5,715**	**138,677**	**$792,584,432**
Florida	**$3,114**	**2,360,417**	**$7,350,363,024**
Georgia	**$2,774**	**1,289,795**	**$3,577,903,288**
Hawaii[3]	**$2,626**	**203,763**	**$535,162,729**
Idaho	**$4,530**	**131,077**	**$593,750,993**
Illinois	**$5,150**	**1,516,082**	**$7,807,447,335**
Indiana	**$4,224**	**704,624**	**$2,976,177,145**
Iowa	**$4,707**	**313,648**	**$1,476,340,040**

Note: (1) Expenditures shown on MSIS differ from those derived from CMS-64. CMS-64 shows actual Medicaid payments while MSIS shows expenditures from adjudicated claims and excludes items such as disproportionate share hospital payments (DSH). (2) Average payments per person served do not include DSH payments because MSIS does not include DSH. (3) FY2000 data were not available for Hawaii; FY1999 data were used. (4) Data do not include territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico and Virgin Islands.
Source: CMS, MSIS.

Chart 29 (Continued)
Per Capita State Medicaid Payments,[1] Fiscal Year 2000

	Average Payment per Person Served	Persons Served (MSIS)	Payments (MSIS)
Kansas	$4,670	262,557	$1,226,210,559
Kentucky	$3,780	770,536	$2,912,792,289
Louisiana	$3,456	761,248	$2,630,563,430
Maine	$6,820	191,624	$1,306,809,473
Maryland	$5,396	664,576	$3,585,781,047
Massachusetts	$5,153	1,047,440	$5,397,153,356
Michigan	$3,611	1,351,650	$4,880,769,009
Minnesota	$5,857	559,463	$3,277,014,103
Mississippi	$2,987	605,077	$1,807,391,891
Missouri	$3,673	890,318	$3,270,152,458
Montana	$4,173	103,821	$433,207,577
Nebraska	$4,185	229,038	$958,490,235
Nevada	$3,733	138,069	$515,444,377
New Hampshire	$6,712	96,935	$650,594,289
New Jersey	$5,724	822,369	$4,706,928,703
New Mexico	$3,325	375,585	$1,248,764,305
New York	$7,646	3,419,893	$26,147,613,087

See note on previous page.

Source: CMS, MSIS.

Chart 29 (Continued)
Per Capita State Medicaid Payments,[1] Fiscal Year 2000

	Average Payment per Person Served	Persons Served (MSIS)	Payments (MSIS)
North Carolina	$3,996	1,208,789	$4,830,025,832
North Dakota	$5,852	60,864	$356,184,829
Ohio	$5,434	1,304,886	$7,090,395,763
Oklahoma	$3,163	507,059	$1,603,788,998
Oregon	$3,135	542,392	$1,700,408,573
Pennsylvania	$4,266	1,492,352	$6,365,806,031
Rhode Island	$5,982	178,859	$1,069,994,225
South Carolina	$3,900	685,104	$2,672,145,530
South Dakota	$3,935	101,951	$401,175,221
Tennessee	$2,226	1,568,318	$3,490,956,581
Texas	$3,487	2,602,616	$9,075,305,589
Utah	$4,277	224,268	$959,100,396
Vermont	$3,451	138,862	$479,258,616
Virginia	$3,960	627,214	$2,483,930,711
Washington	$2,717	895,279	$2,432,050,117
West Virginia	$4,154	335,014	$1,391,731,163
Wisconsin	$5,039	576,636	$2,905,598,526
Wyoming	$4,609	46,422	$213,957,743

See note on first page of Chart 29.

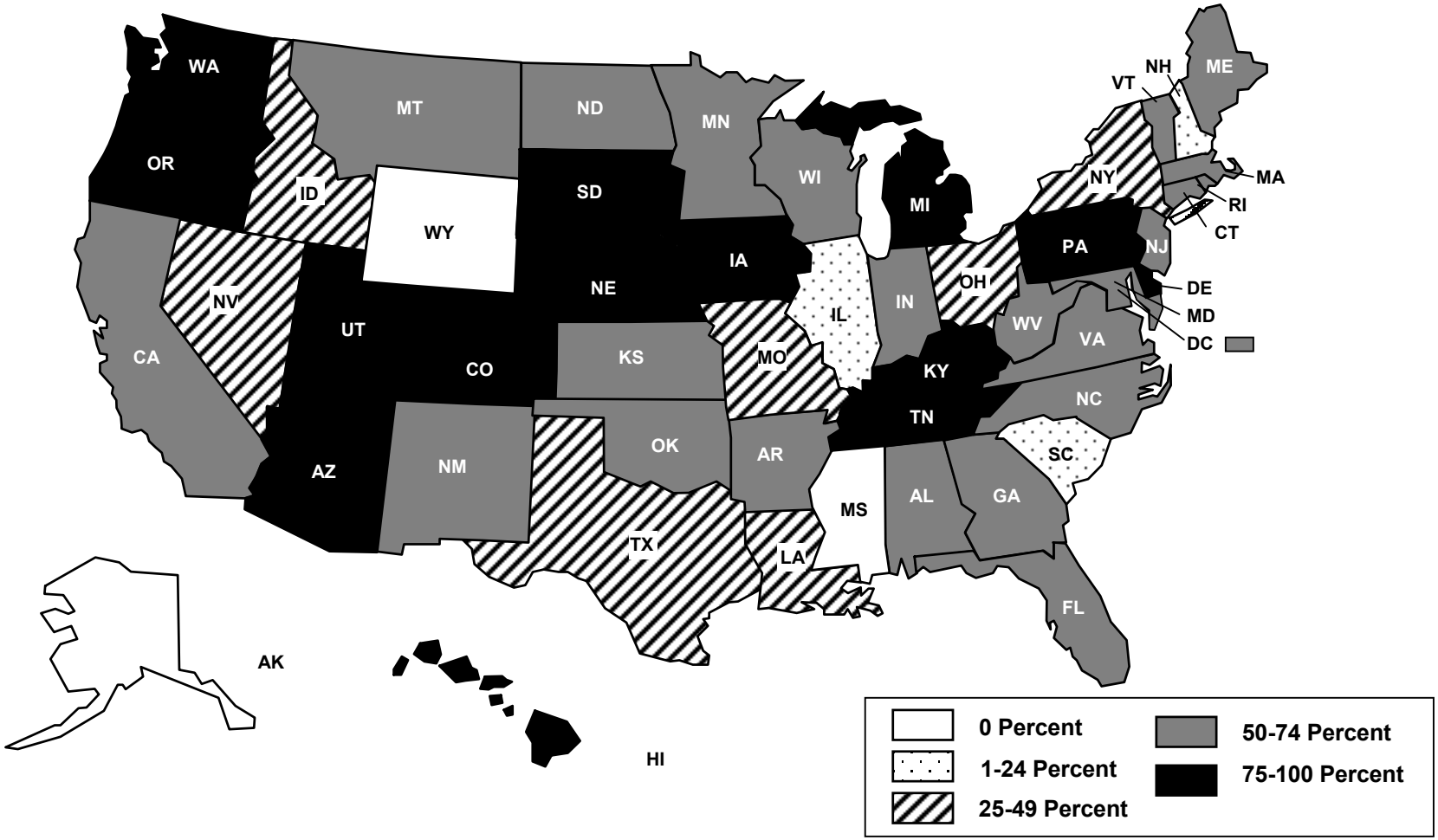
Source: CMS, MSIS.

Section IV

Medicaid Managed Care

Chart 30
Medicaid Managed Care Penetration, 2002

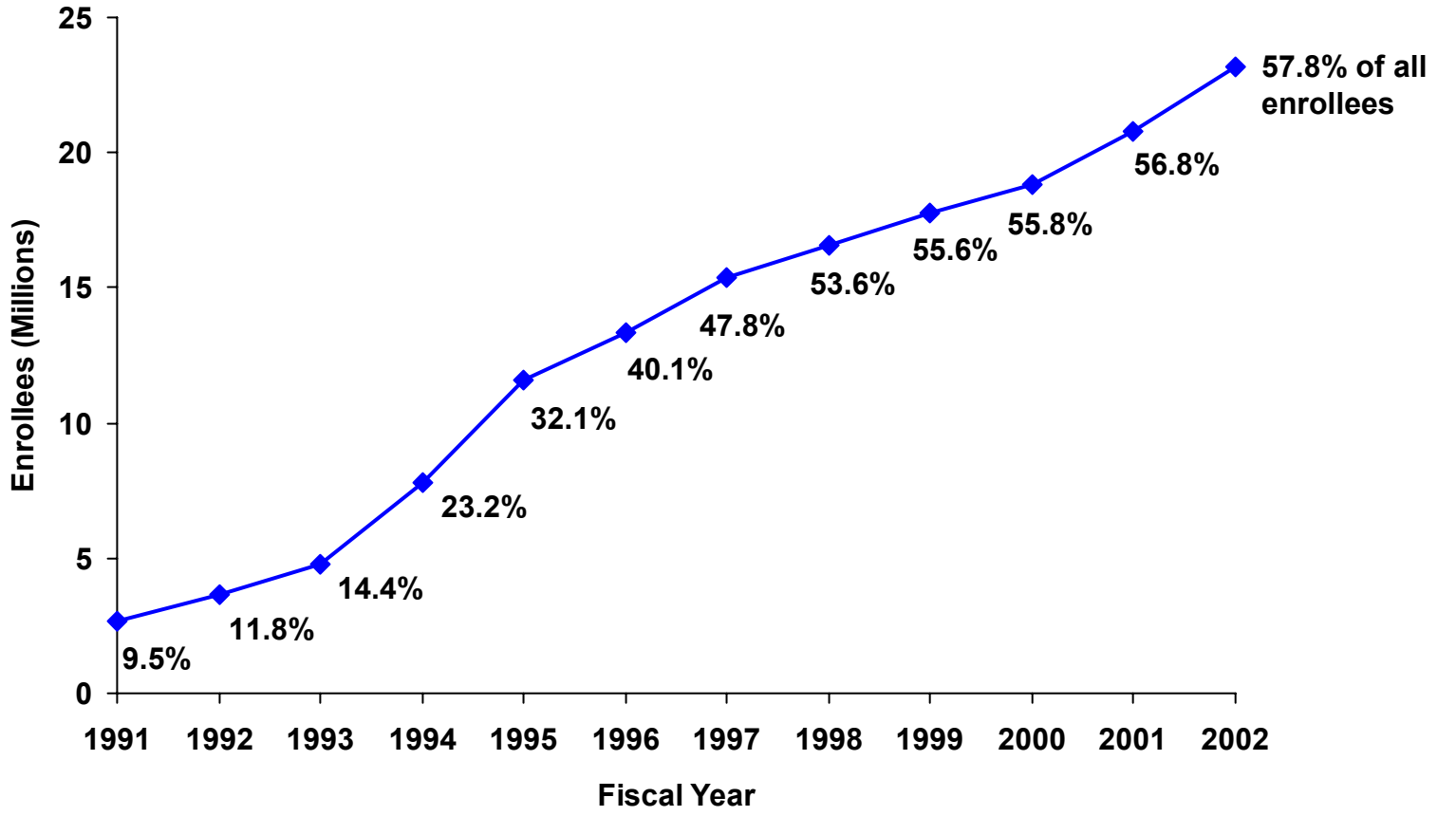
Thirty-eight states[1] have over 50 percent of the Medicaid population in managed care.



Note: (1) Thirty-eight states including the District of Columbia. (2) Medicaid managed care population derived using unduplicated enrollment figures of enrollees including Primary Care Case Management and Prepaid Health Plan enrollees.
Source: CMS/Center for Medicaid and State Operations, Medicaid Managed Care Enrollment Report.

Chart 31
Medicaid Managed Care Enrollment Trends

Managed care enrollment has made up over 50 percent of Medicaid enrollees since 1998.

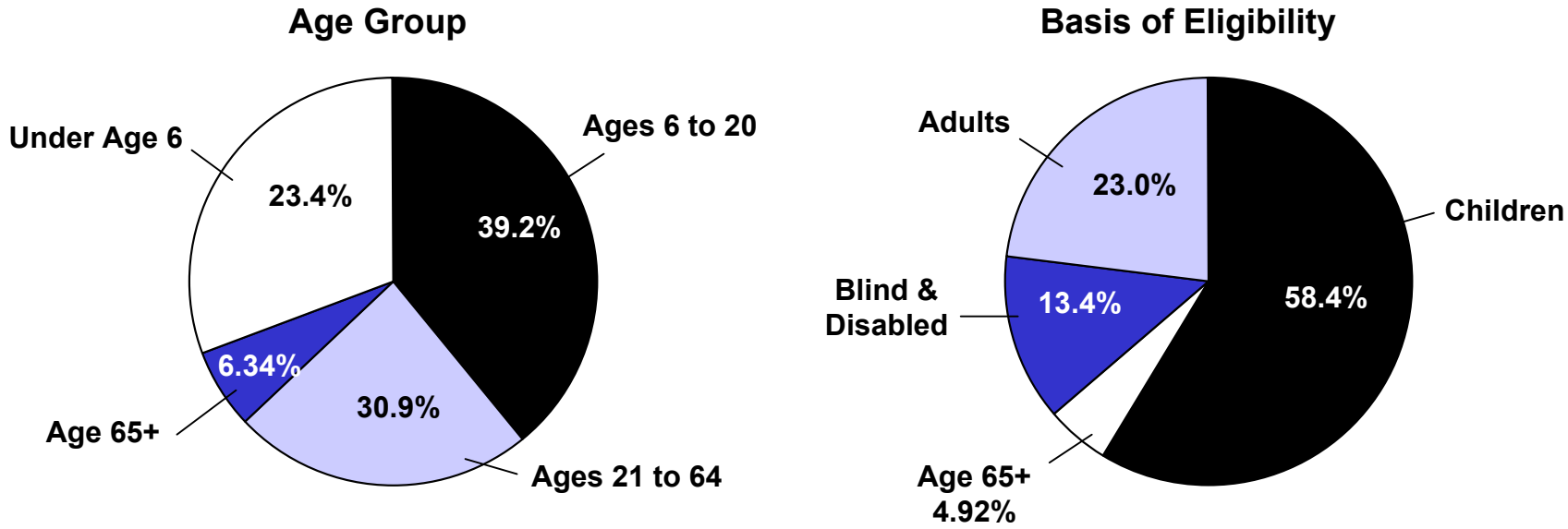


Note: Enrollees are individuals enrolled in Medicaid managed care at least one month during the year. These figures include enrollees in comprehensive Managed Care Organizations (MCOs), Primary Care Case Management (PCCM) plans, Prepaid Health Plans (PHPs) and other types of managed care entities.

Source: CMS/Center for Medicaid and State Operations, Medicaid Managed Care Enrollment Report.

Chart 32
Medicaid Managed Care Enrollment by Age and Basis of Eligibility, Fiscal Year 2000

Children and non-disabled, non-elderly adults are an overwhelming majority of Medicaid managed care enrollees.



Total Enrolled Managed Care Population: 21.3 million

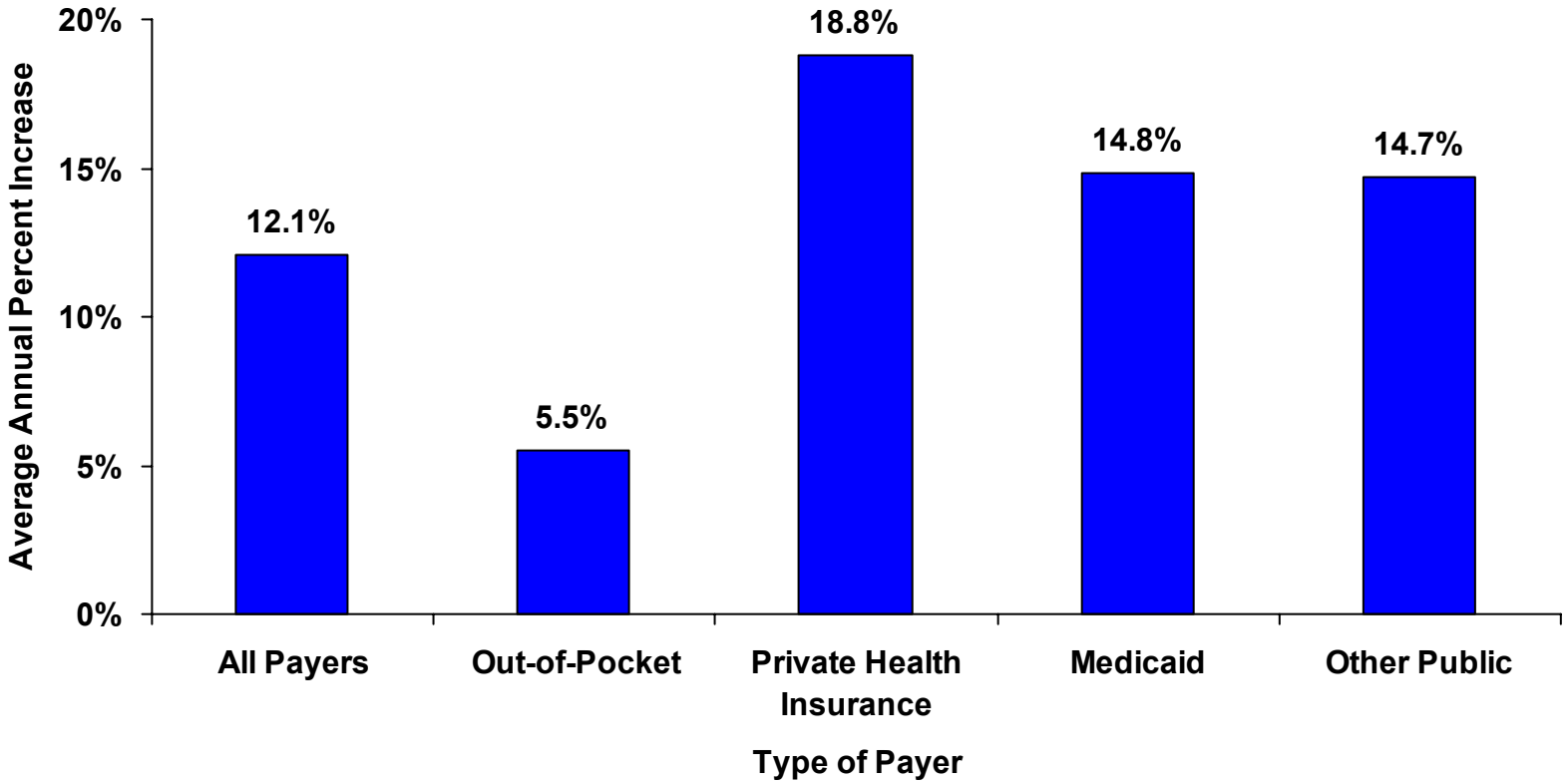
Note: (1) Data include only enrollees with capitation payments in HMOs, Health Insurance Organizations (HIOs) and pre-paid health plans; it does not include primary care case management (PCCM) enrollees. (2) Disabled children and adults are included in the blind and disabled eligibility category. Total Medicaid enrollment in Fiscal Year 2000 was 44.3 million. (3) Percentages may not sum to 100 due to rounding.
Source: CMS, MSIS.

Section V

Prescription Drugs

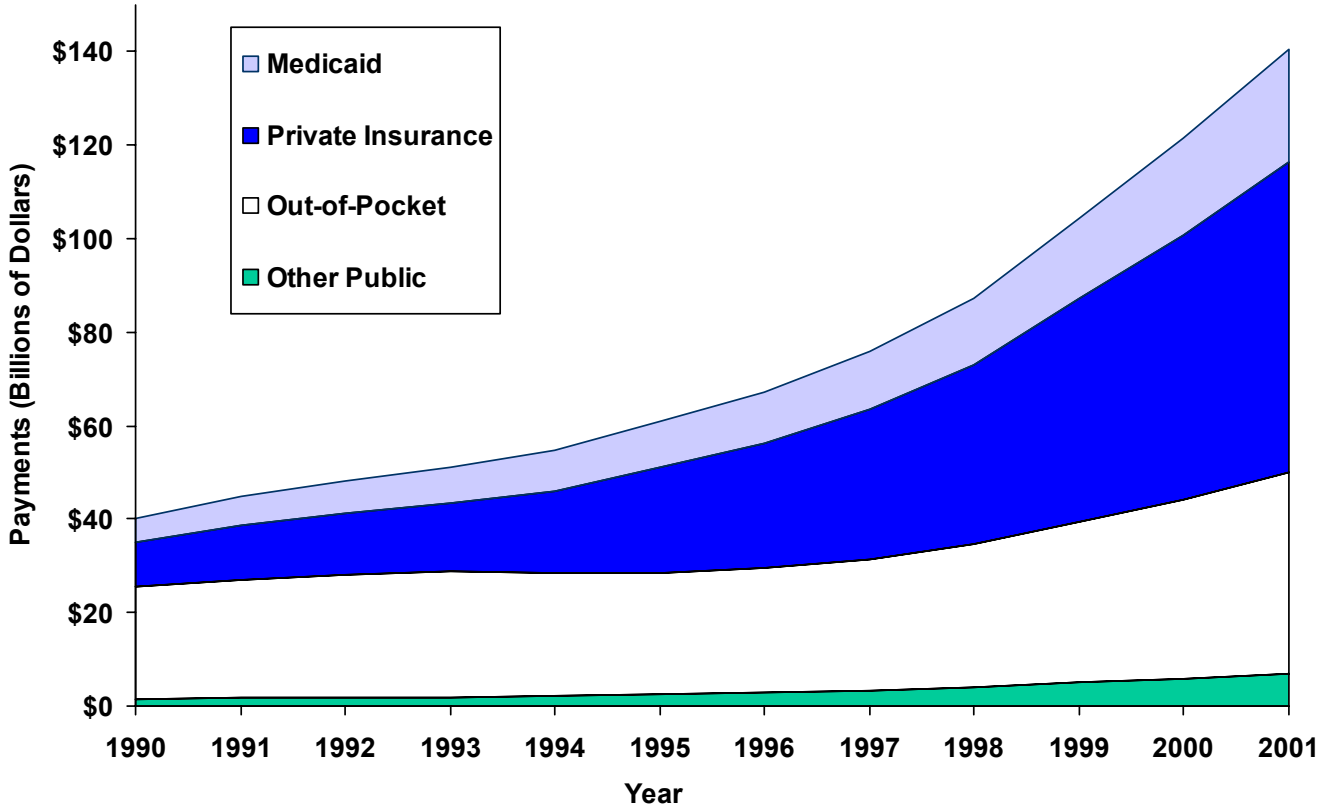
Chart 33
Prescription Drug Payments by Payer
Average Annual Growth: Calendar Years 1991 - 2001

The average annual growth rate for prescription drugs in Medicaid was slower than for private health insurance.



Note: (1) "All Payers" category equals sum of out-of-pocket, private health insurance, Medicaid and other public payments. (2) The data presented here is prescription drug transactions at the retail level, such as community pharmacies, grocery store pharmacies, mail-order establishments, and mass-merchandising establishments. (3) "Other Public" includes SCHIP expansion and SCHIP data.
Source: CMS/Office of the Actuary, National Health Statistics Group, National Health Accounts.

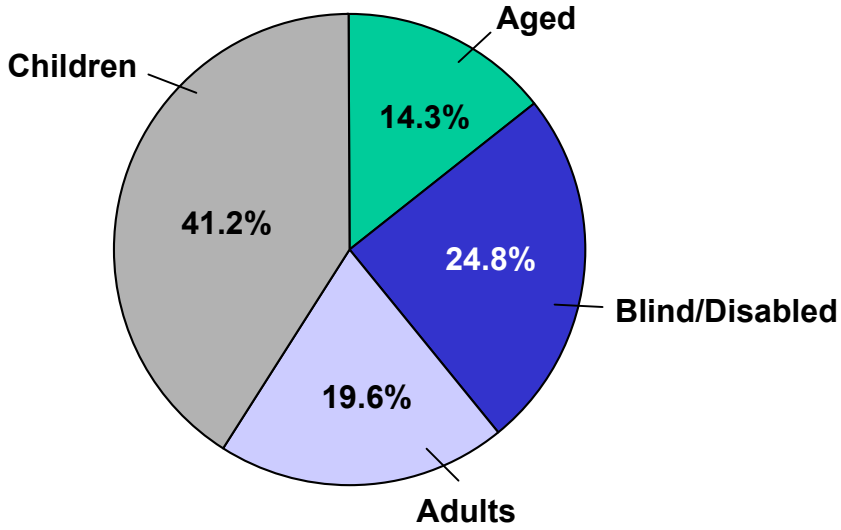
Chart 34
All-Payer Prescription Drug Payments by Payer, Calendar Years 1990 - 2001



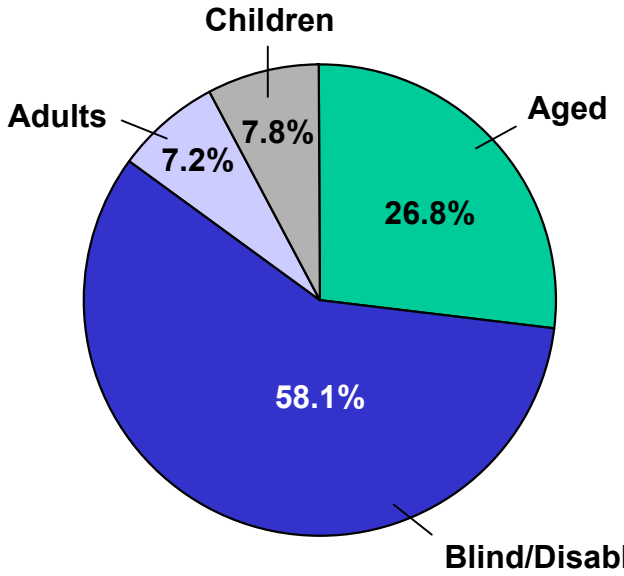
Fiscal Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001[1]
Medicaid (Dollars in Billions)	$5,077	$6,043	$6,883	$7,726	$8,652	$9,742	$10,899	$12,367	$14,414	$17,260	$20,815	$24,084

Note: (1) See the Data Sources: Information and Caveats guide (under National Health Accounts) for differences between National Health Accounts and CMS-64 2001 prescription drug estimates. (2) "Other Public" includes SCHIP and SCHIP expansion data.
Source: CMS/Office of the Actuary, National Health Statistics Group, National Health Accounts.

Chart 35
Percent of Total Medicaid Prescription Drug Recipients and Payments by Basis of Eligibility, Fiscal Year 2000



Prescription Drug Recipients[1] = 20.5 Million



Prescription Drug Payments[2] = $20.0 Billion

Note: (1) A prescription drug recipient is a Medicaid enrollee who received at least one Medicaid payment for a prescription drug under fee-for-service during the fiscal year. Medicaid prescription drug payments include all payments for prescription drugs provided under a fee-for-service setting (i.e. prescription drugs for which Medicaid paid a pharmacy claim). Since Medicaid pays a single premium to a prepaid plan for all covered services, it is not possible to identify prescription drug payments when they are covered by a prepaid plan. To this extent, Medicaid prescription drug payments presented here understate total Medicaid payments for prescription drugs. (2) Medicaid prescription drug payments are gross amounts prior to the receipt of rebates by prescription drug manufacturers. (3) The Medicaid eligibility group is the basis by which ability to enroll in Medicaid was determined, regardless of cash assistance status. (4) The Blind/Disabled group includes individuals of any age who were determined to be eligible because of disability. A small number of individuals (361,663) that are not reported in these four groups have been excluded. Expenditures ($61.6 million) on behalf of these Medicaid persons served with “unknown” basis of eligibility have also been excluded. (5) Percentages may not sum to 100 due to rounding.

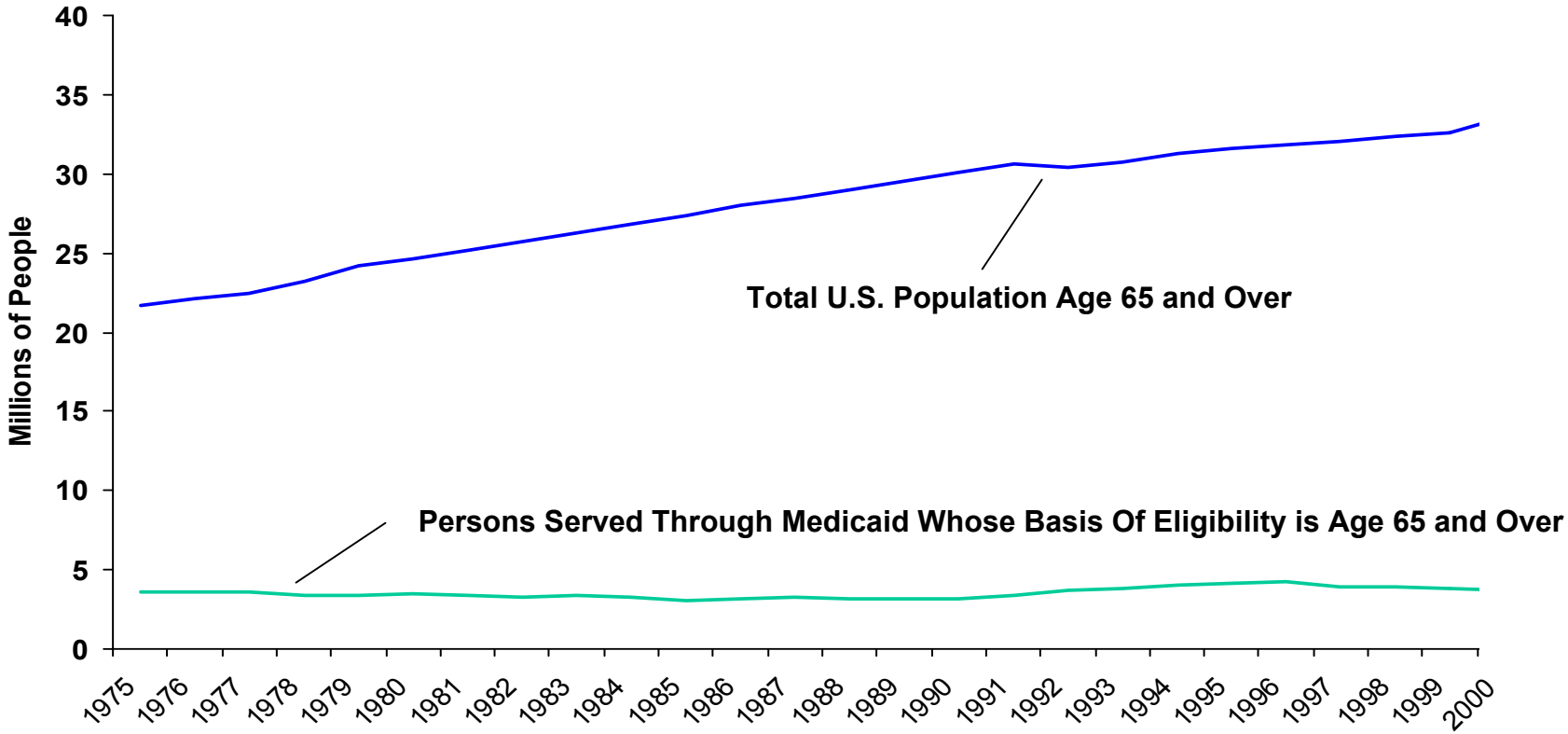
Source: CMS, MSIS.

Section VI

The Elderly and Individuals with Disabilities

Chart 36
Individuals Age 65 and Over: U.S. Population and Persons Served Through Medicaid[1], Fiscal Years 1975-2000

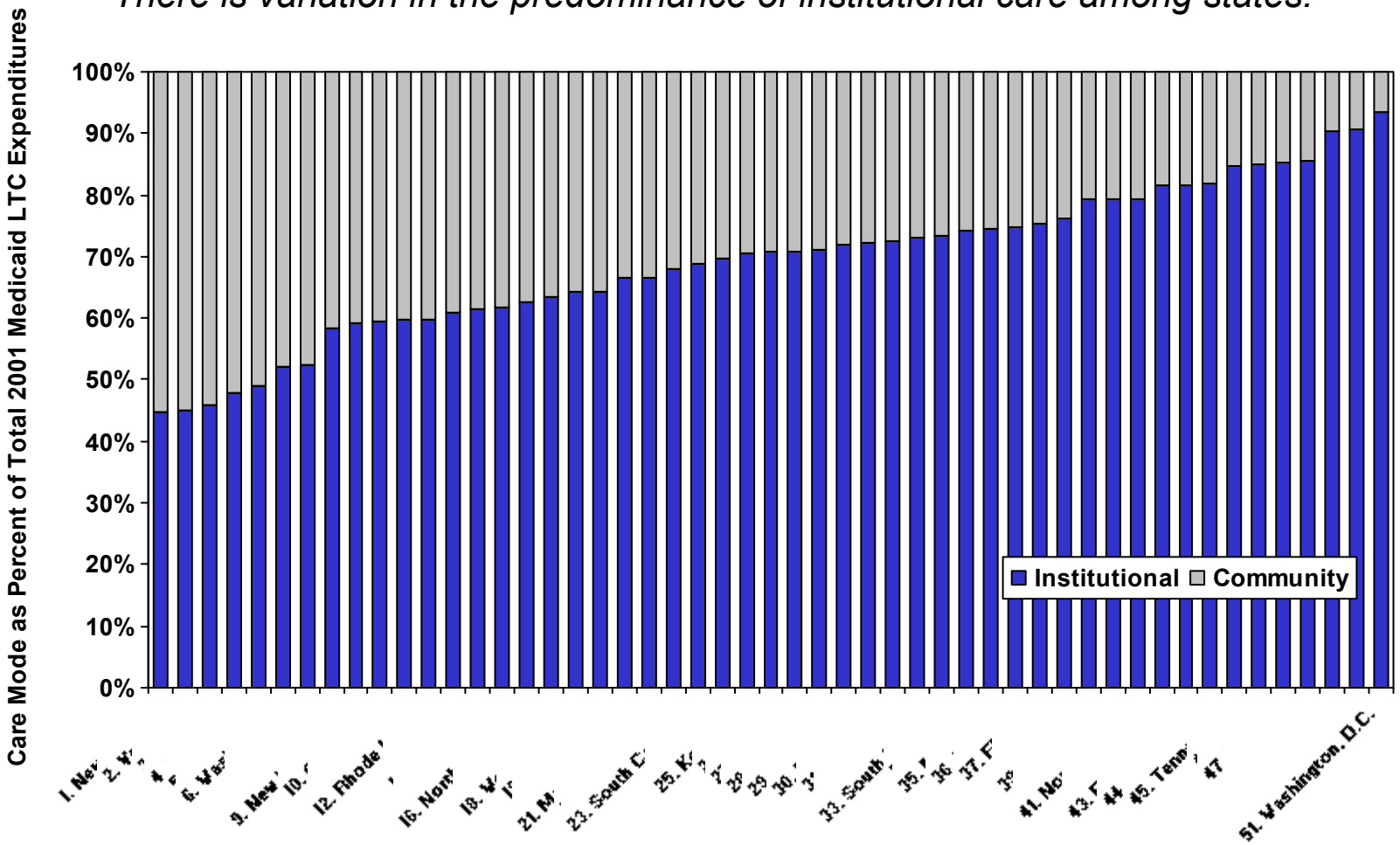
While the total U.S. population aged 65 and over has grown over 54 percent during the last 25 years, the number of elderly Medicaid persons served has only risen about 3 percent.



Note: (1) Data are for persons served in the age 65 and older eligibility group. Data do not include individuals age 65 and older who are counted as disabled. (2) One explanation for why the Medicaid over age 65 population has been stable over time while the total U.S. population over age 65 has grown is that the percent of those over age 65 with income below the poverty level has been decreasing over time. In 1975, 13.8 percent of the U.S. over 65 population lived below the poverty level while 8.2 percent did in 2000.
Source: U.S. Census Bureau 2001 Poverty in the U.S.; CMS, HCFA-2082/MSIS.

Chart 37
Share of Medicaid Long Term Care Expenditures Provided in Institutional Versus Community-Based Settings, Fiscal Year 2001

There is variation in the predominance of institutional care among states.

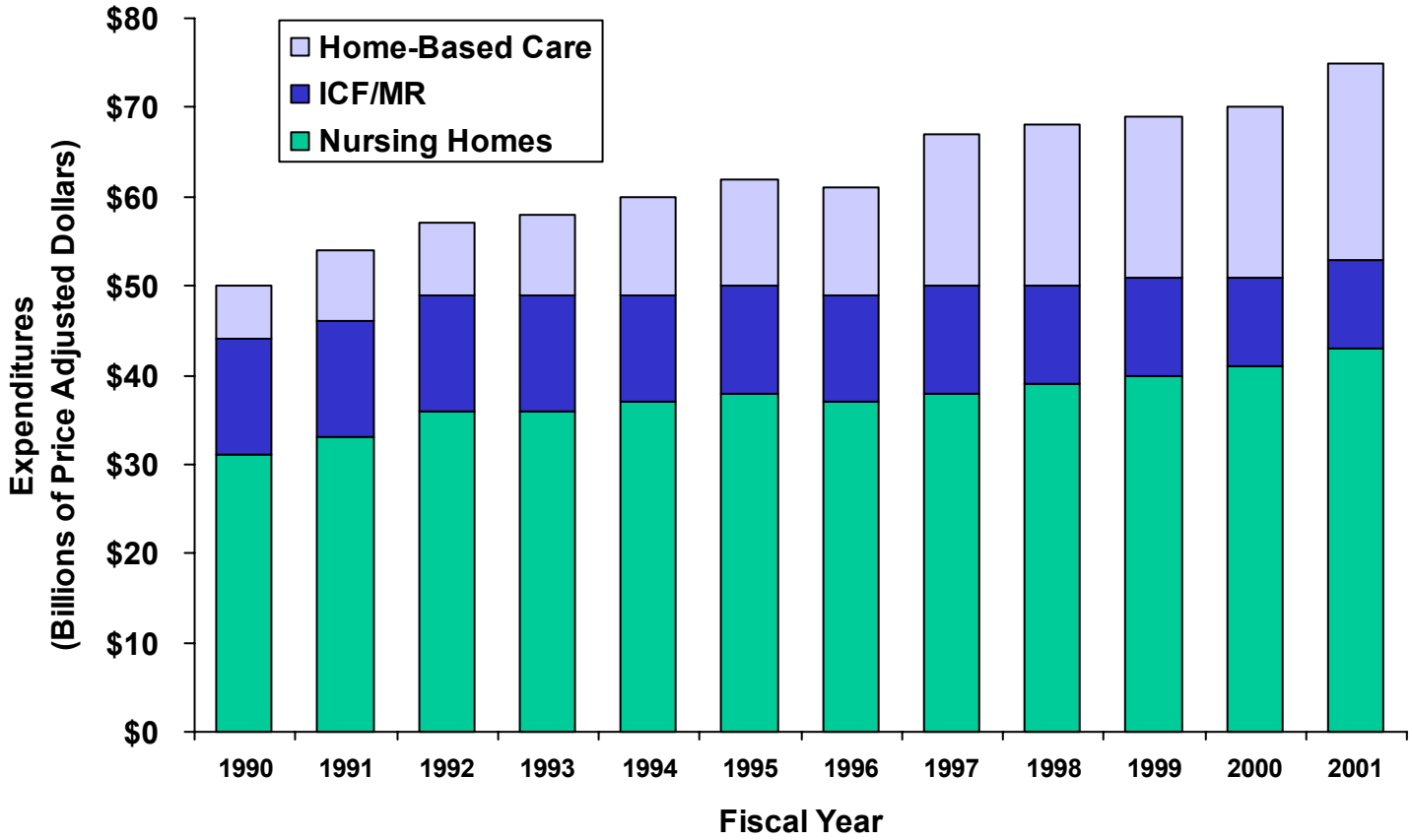


Note: (1) The institutional category includes nursing facility and ICF/MR expenditures. (2) The Community category includes home health, personal care and HCBW services expenditures.

Source: CMS, CMS-64 Total Current Expenditures.

Chart 38
Medicaid Long Term Care Expenditures in Price Adjusted Terms, Fiscal Years 1990-2001

Expenditures for home and community-based care have been growing more rapidly than those for institutional care.

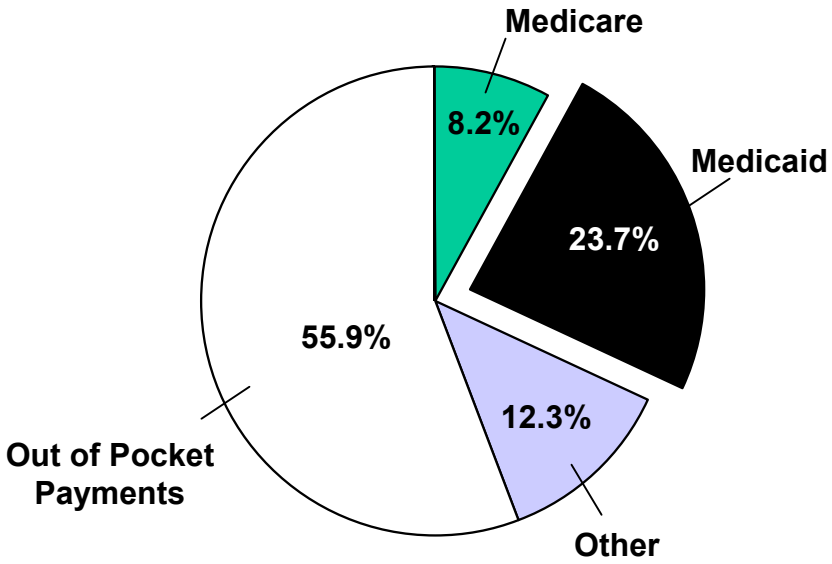


Note: (1) The "Home-Based Care" category includes home health, personal care and HCBW services expenditures. (2) Dollars are expressed in 2001 terms using Bureau of Labor Statistics Consumer Price Index Medical Care Services Index.
Source: CMS, CMS-64 Total Current Expenditures.

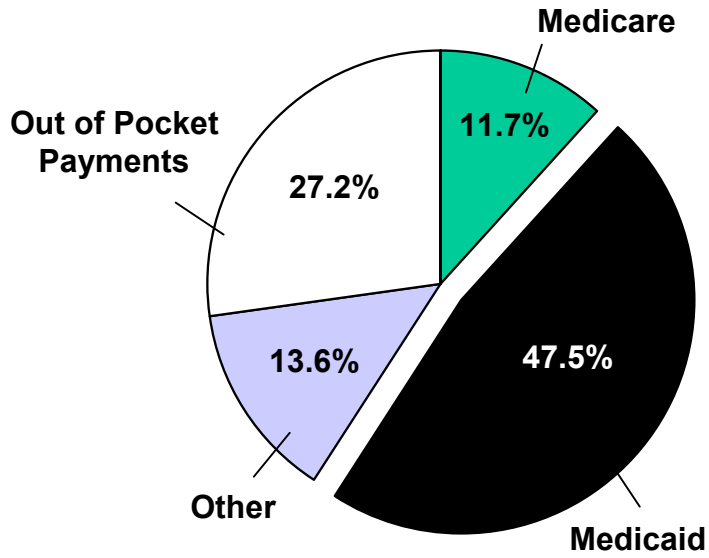
Chart 39
Medicaid Nursing Home Expenditures as a Percent of Total U.S. Nursing Home Care Expenditures, Calendar Years 1968 and 2001

By 2001, Medicaid accounted for nearly half of all U.S. spending on nursing home care.

1968 Total Nursing Home Spending = $2.9 Billion



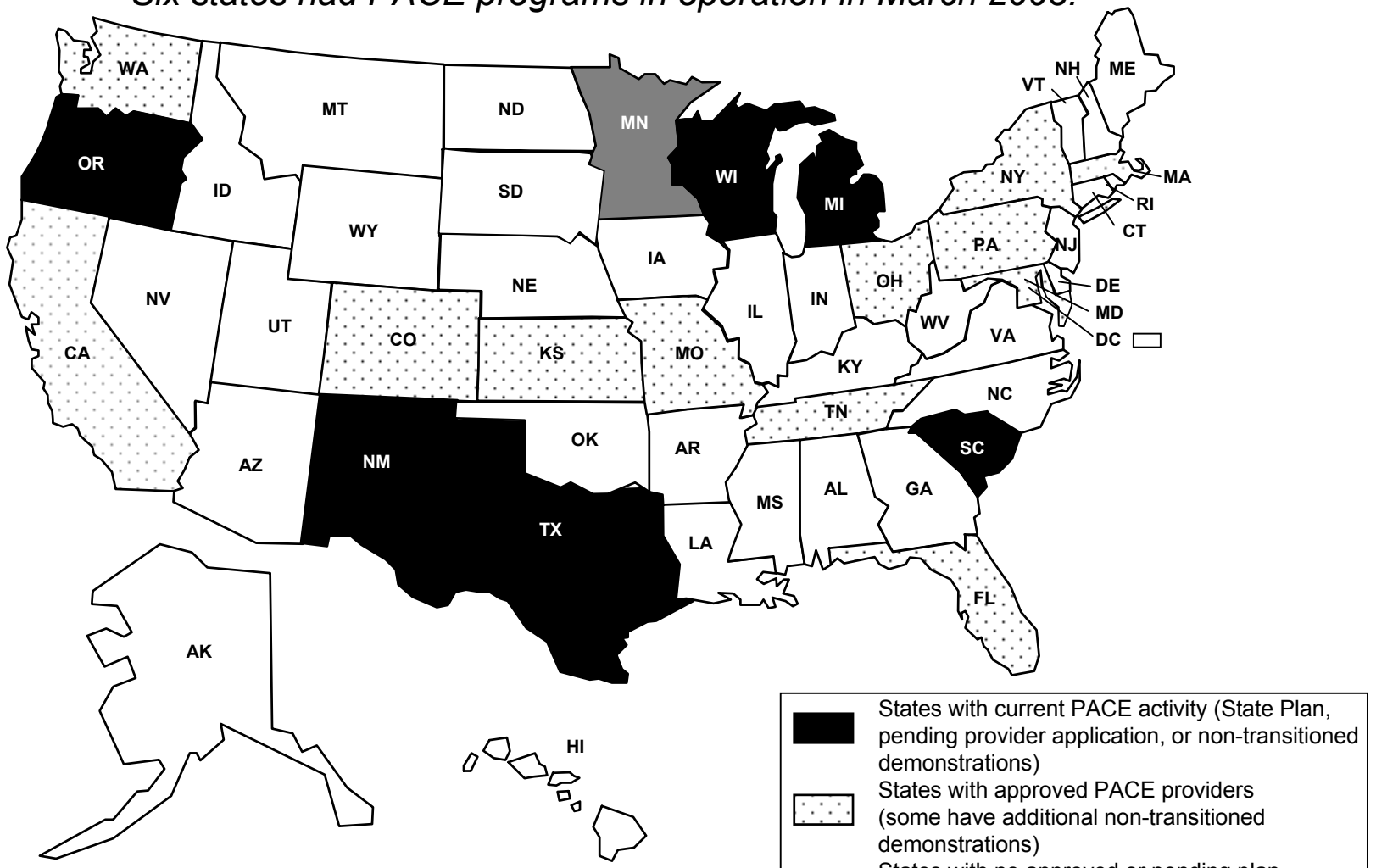
2001 Total Nursing Home Spending = $98.9 Billion



Note: (1) Medicaid spending includes the state and Federal shares. (2) The 2001 "other" expenditures primarily consists of private health insurance and Veteran's Administration spending. The 2001 "Medicaid" expenditures includes SCHIP and Medicaid SCHIP expansion. (3) The 1968 "other" consists largely of non-Medicaid general funds from state/local and Federal governments.
Source: CMS/Office of the Actuary, National Health Statistics Group, National Health Accounts.

Chart 40
Nationwide Activity on Program of All-Inclusive Care for the Elderly (PACE) as of March 2003

Six states had PACE programs in operation in March 2003.



Note: See explanation of PACE program in Glossary.

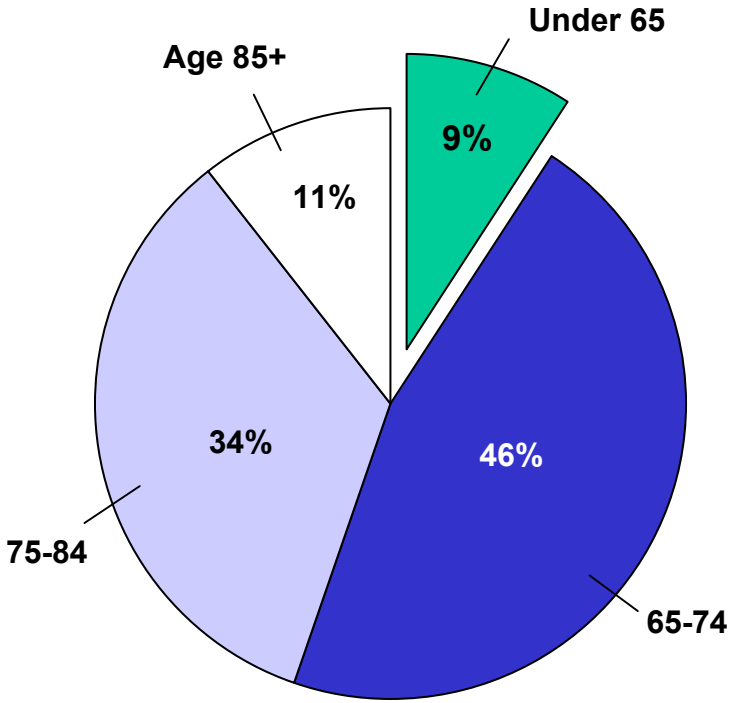
Source: CMS/Center for Medicaid and State Operations.

Section VII

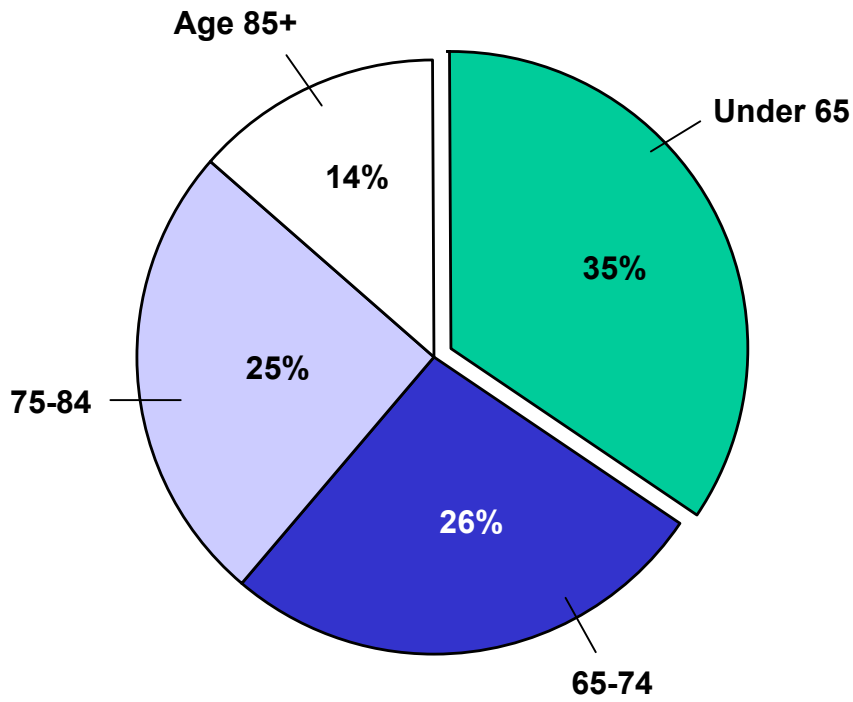
Dually Enrolled Population

Chart 41
Age Distribution of Dual and Medicare Enrollees, Calendar Year 2001

Thirty-five percent of the dually enrolled population are under age 65 compared to nine percent of Medicare enrollees.



Medicare Enrollees

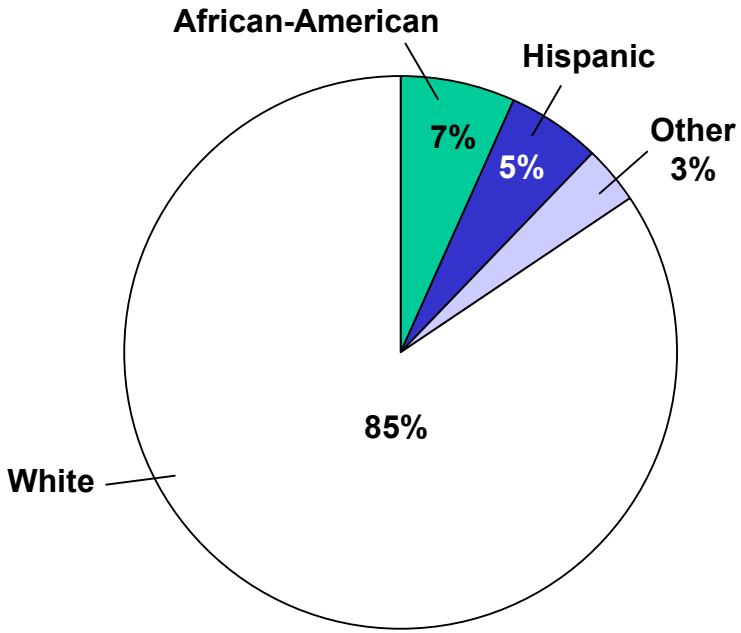


Dual Enrollees

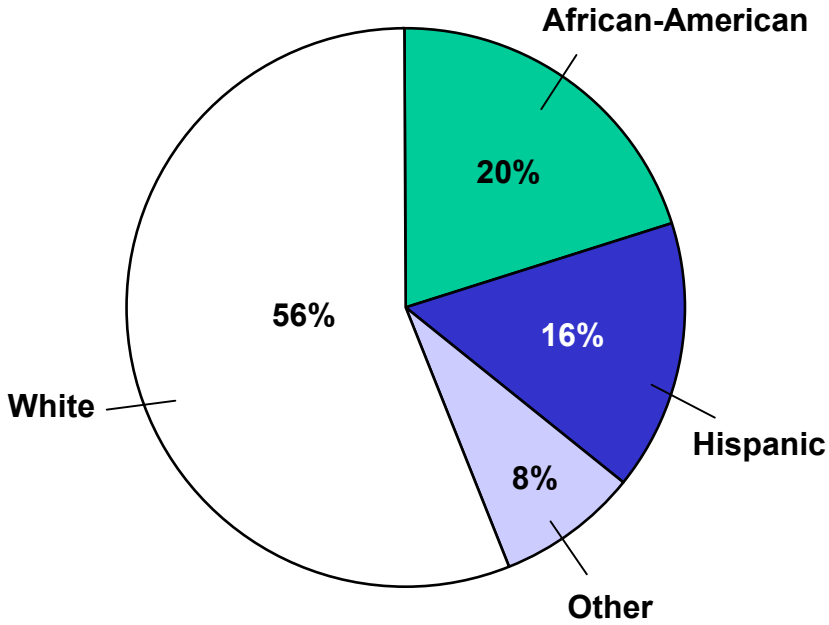
Note: Medicare enrollees do not include dual enrollees.
Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 42
Proportion of Dual and Medicare Enrollees by Race/Ethnicity, Calendar Year 2001

Forty-four percent of the dually enrolled population are members of minority groups.



Medicare Enrollees

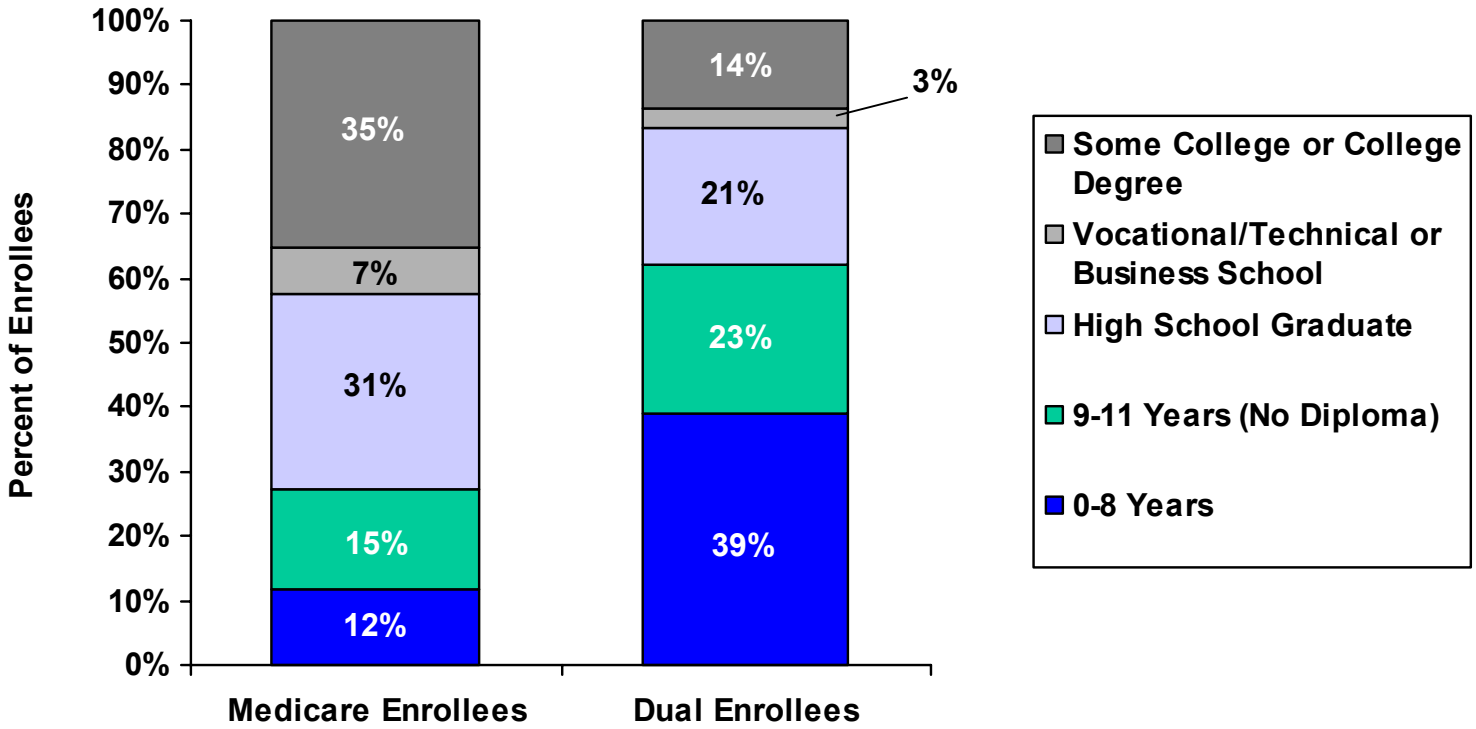


Dual Enrollees

Note: Medicare enrollees do not include dual enrollees.
Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 43
Level of Education Among Dual and Medicare Enrollees, Calendar Year 2001

Over half of the dually enrolled population have less than a high school education compared to 27 percent of the Medicare population.

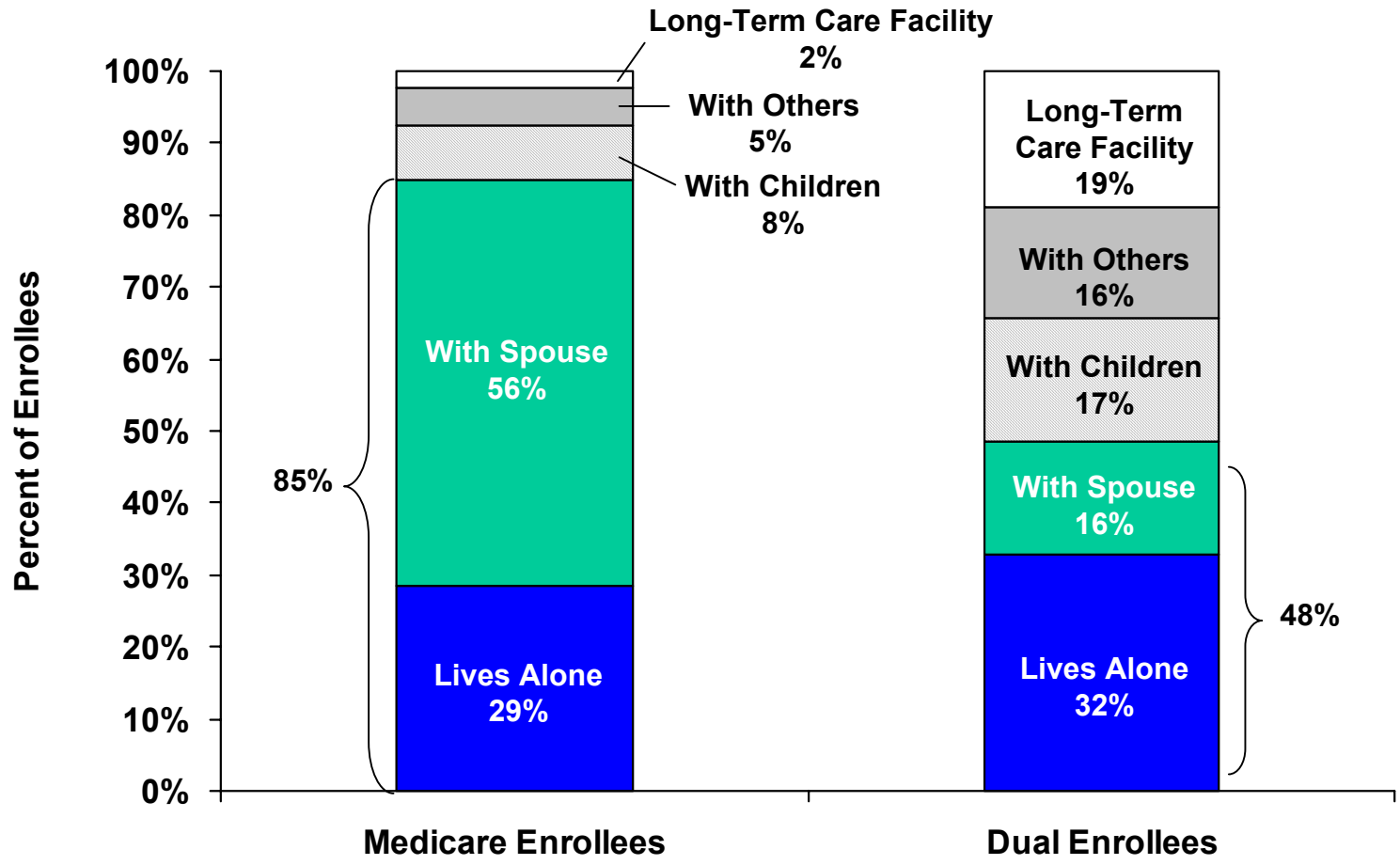


Note: Medicare enrollees do not include dual enrollees.

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 44
Living Arrangements of Dual and Medicare Enrollees, Calendar Year 2001

Only 48 percent of the dually enrolled population lives alone or with a spouse compared to 85 percent of the Medicare population.

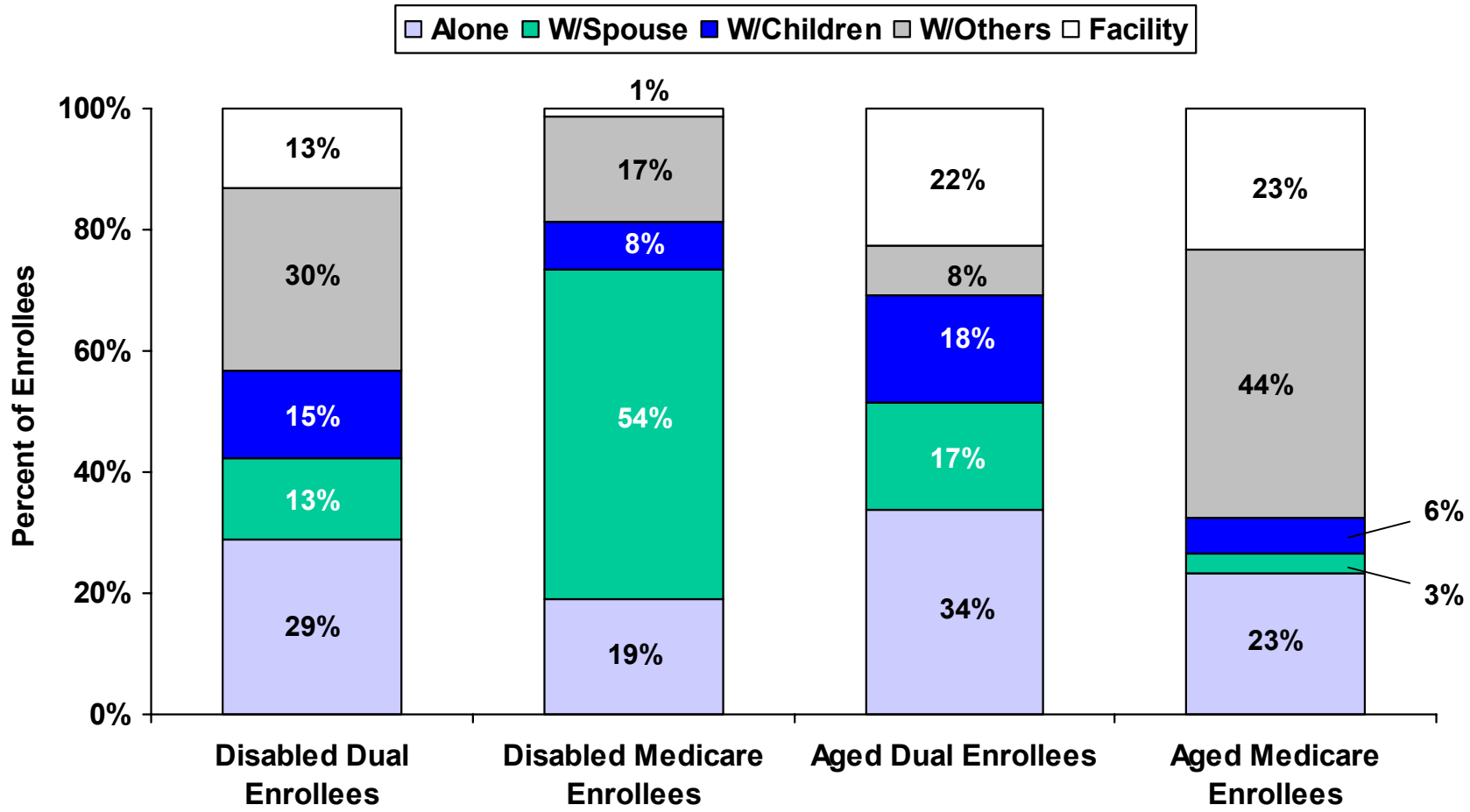


Note: Medicare enrollees do not include dual enrollees.

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 45
Living Arrangements of Medicare Enrollees by Medicaid Status and Age, Calendar Year 2001

Over 20 percent of aged dual enrollees live in institutional facilities.

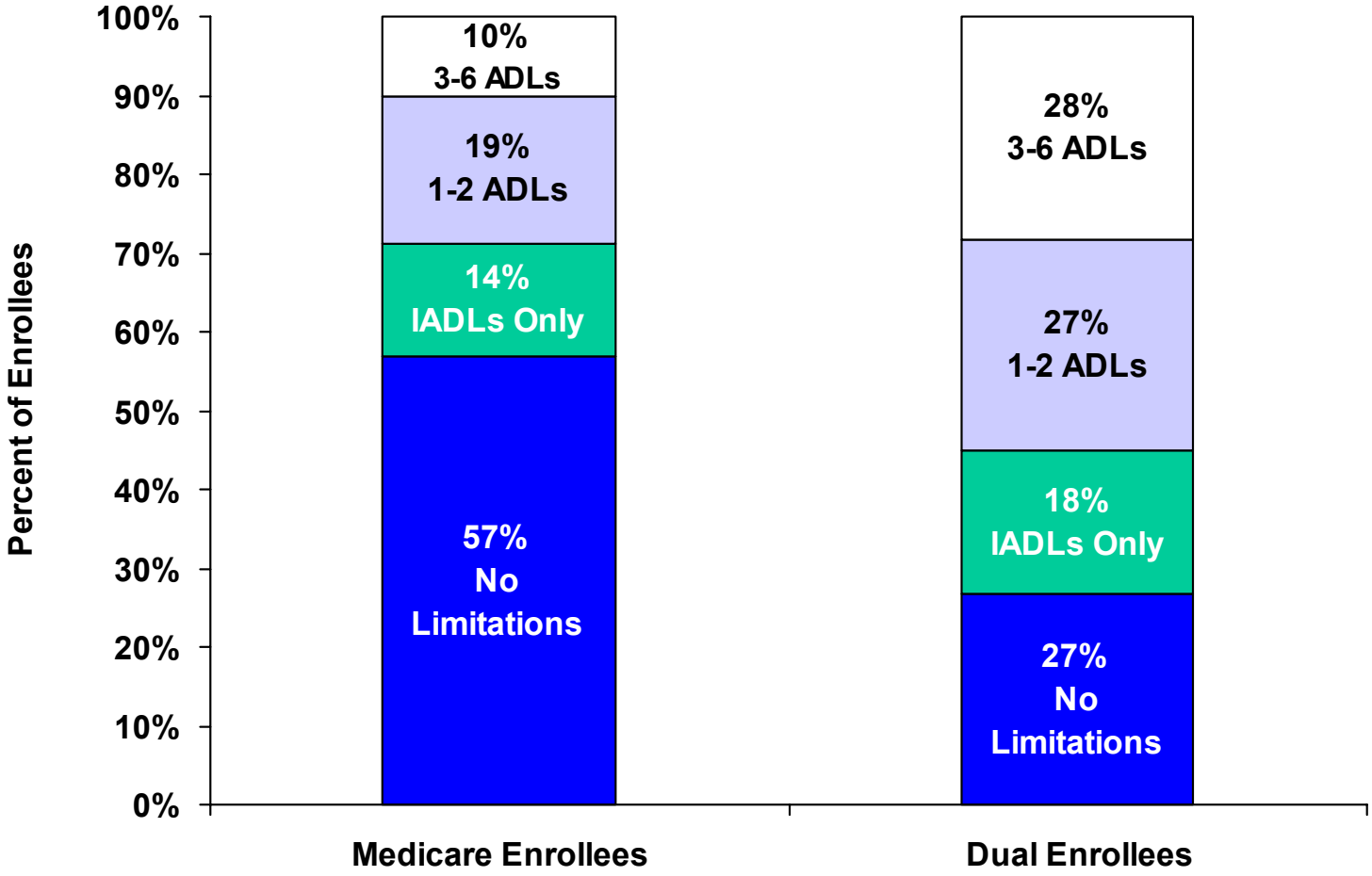


Note: Medicare enrollees do not include dual enrollees.

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 46
Functional Status of Dual and Medicare Enrollees, Calendar Year 2001

Nearly three-quarters of the dually enrolled population report some functional limitation.

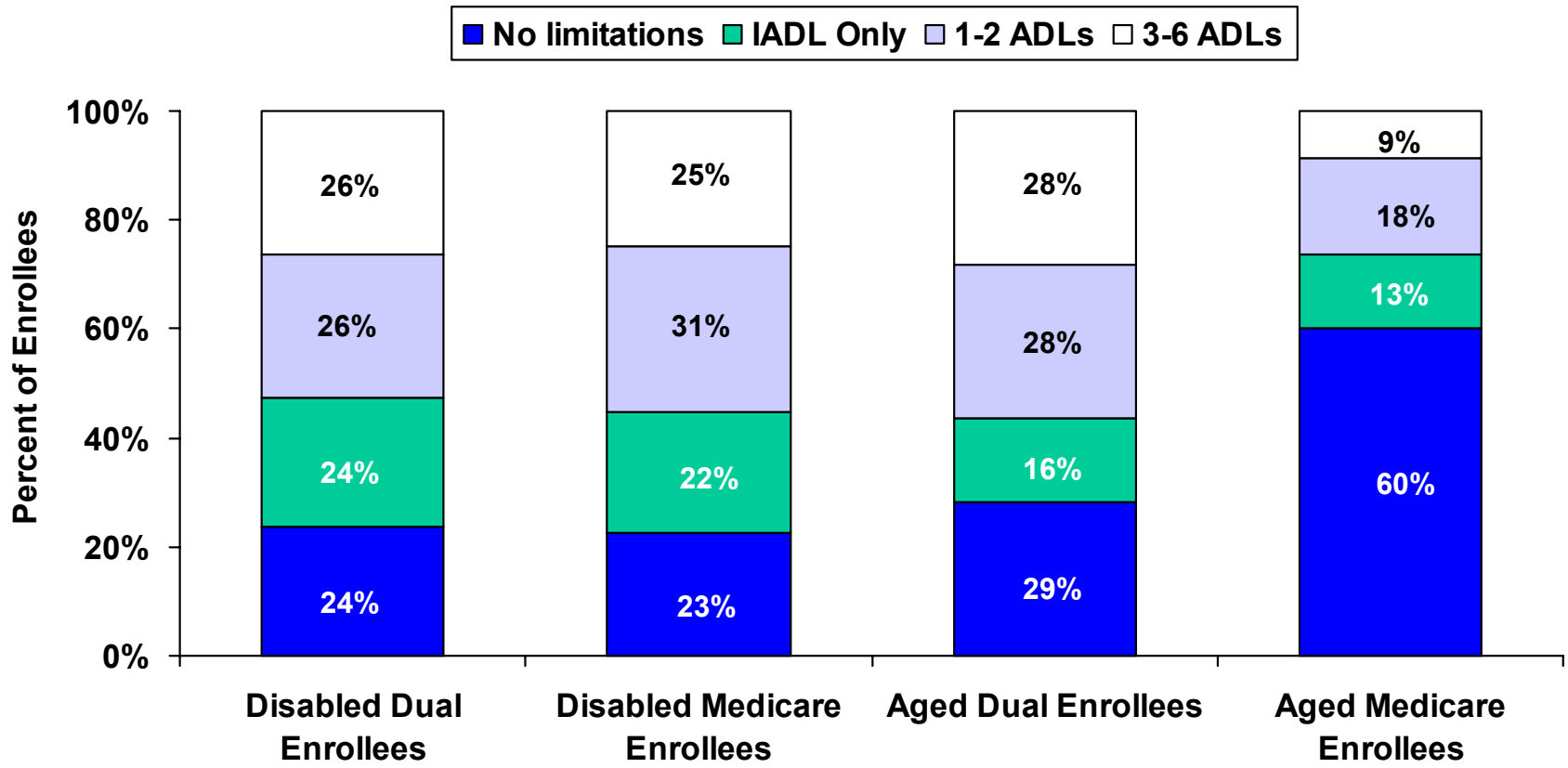


Note: (1) Medicare enrollees do not include dual enrollees. (2) ADLs are activities of daily living (e.g., eating, bathing). (3) IADLs are instrumental activities of daily living (e.g., shopping, use of phone, cleaning). (4) Enrollees limited in at least one ADL(s) may also be limited in one or more IADLs.

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 47
Percentage of Medicare Enrollees with Functional Limitations by Medicaid Status and Age, Calendar Year 2001

The ADL limitation levels of aged dual enrollees are more similar to those of disabled Medicare and disabled dual enrollees than to those of aged Medicare enrollees.

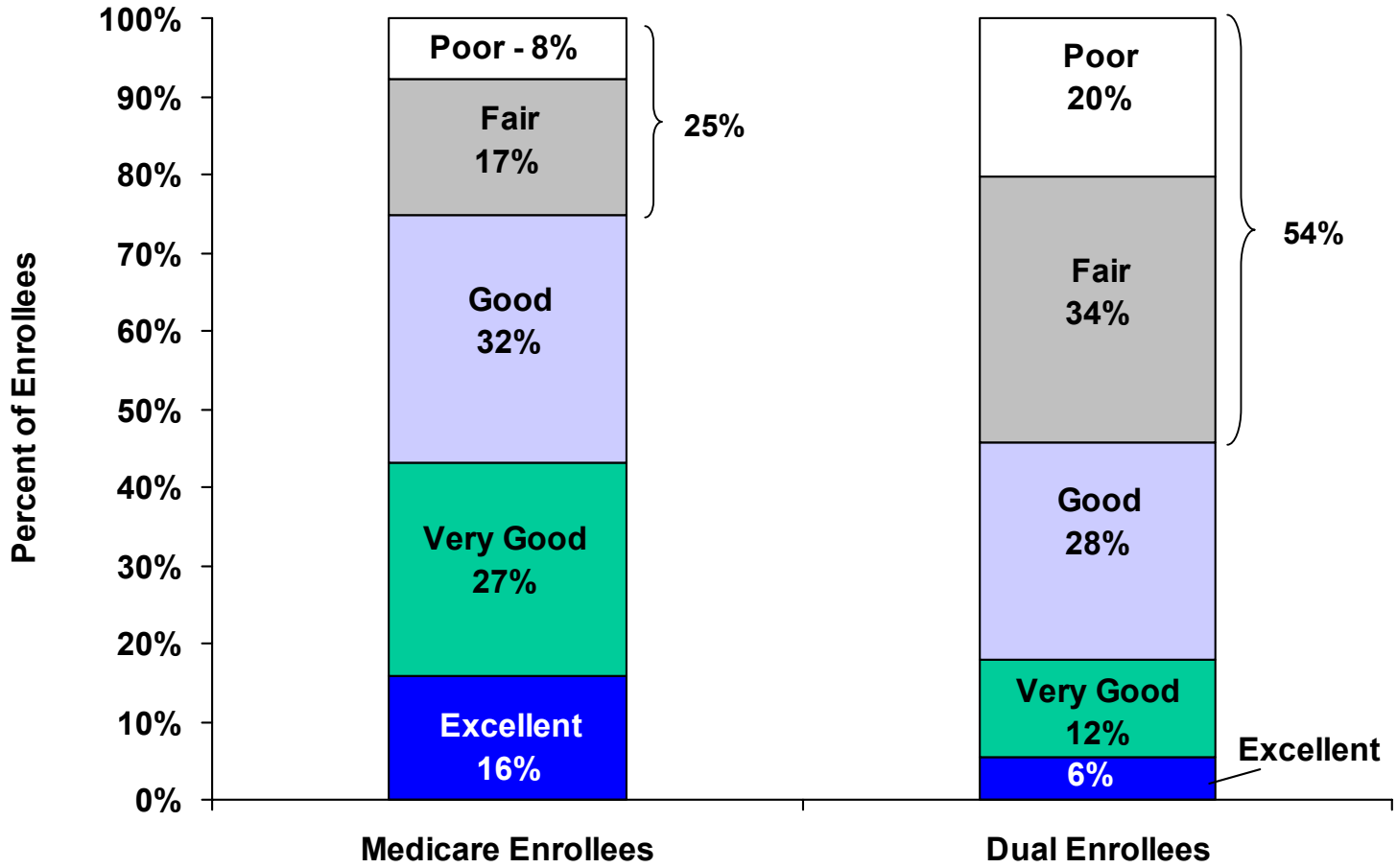


Note: (1) Medicare enrollees do not include dual enrollees. (2) ADLs are activities of daily living (e.g., eating, bathing). (3) IADLs are instrumental activities of daily living (e.g., shopping, use of phone, cleaning).

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 48
Self-Reported Health Status of Dual and Medicare Enrollees, Calendar Year 2001

Over half of the dually enrolled population reports poor or fair health status compared to one quarter of the non-dually enrolled population.

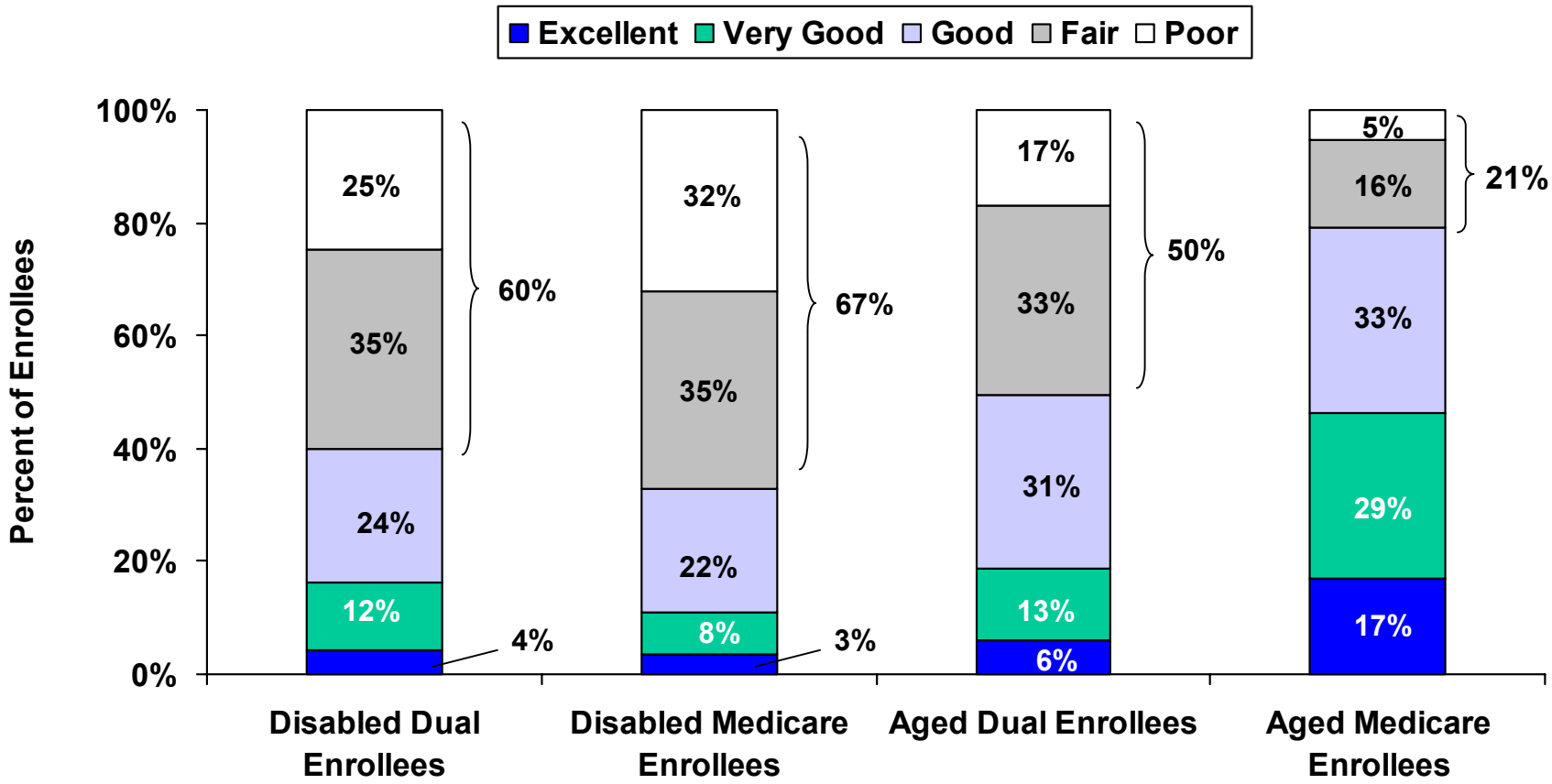


Note: Medicare enrollees do not include dual enrollees.

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 49
Health Status of Medicare Enrollees by Medicaid Status and Age, Calendar Year 2001

Aged dual enrollees report more similar health status to disabled enrollees, regardless of Medicaid status, than aged Medicare enrollees.

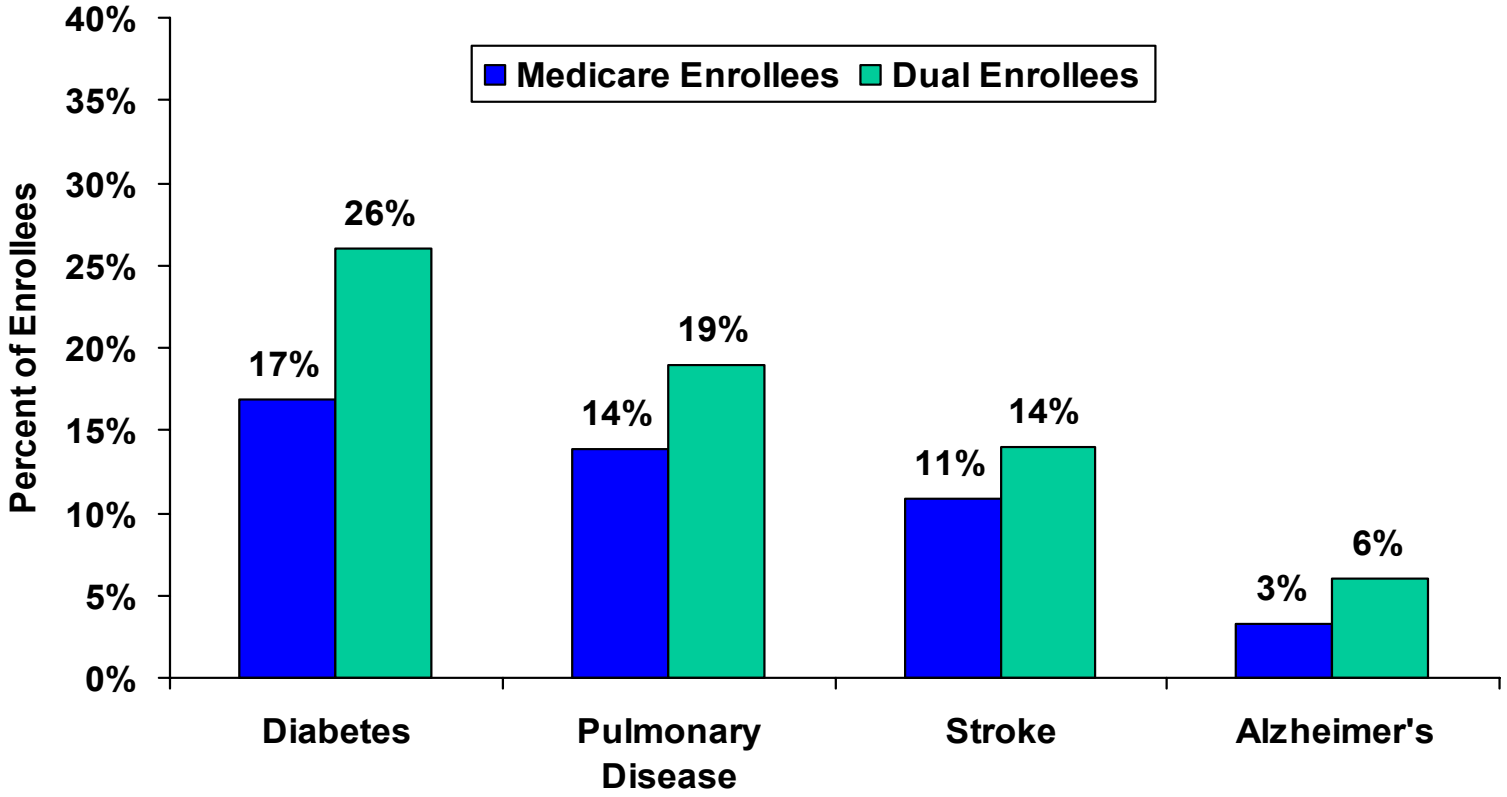


Note: (1) Medicare enrollees do not include dual enrollees. (2) Health status is self-reported. (3) Disabled dual enrollees report slightly higher health status when compared to disabled Medicare enrollees because the disabled dual population is younger overall. About 40 percent of disabled dual enrollees are under age 45 compared with 17.7 percent of disabled Medicare enrollees.

Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

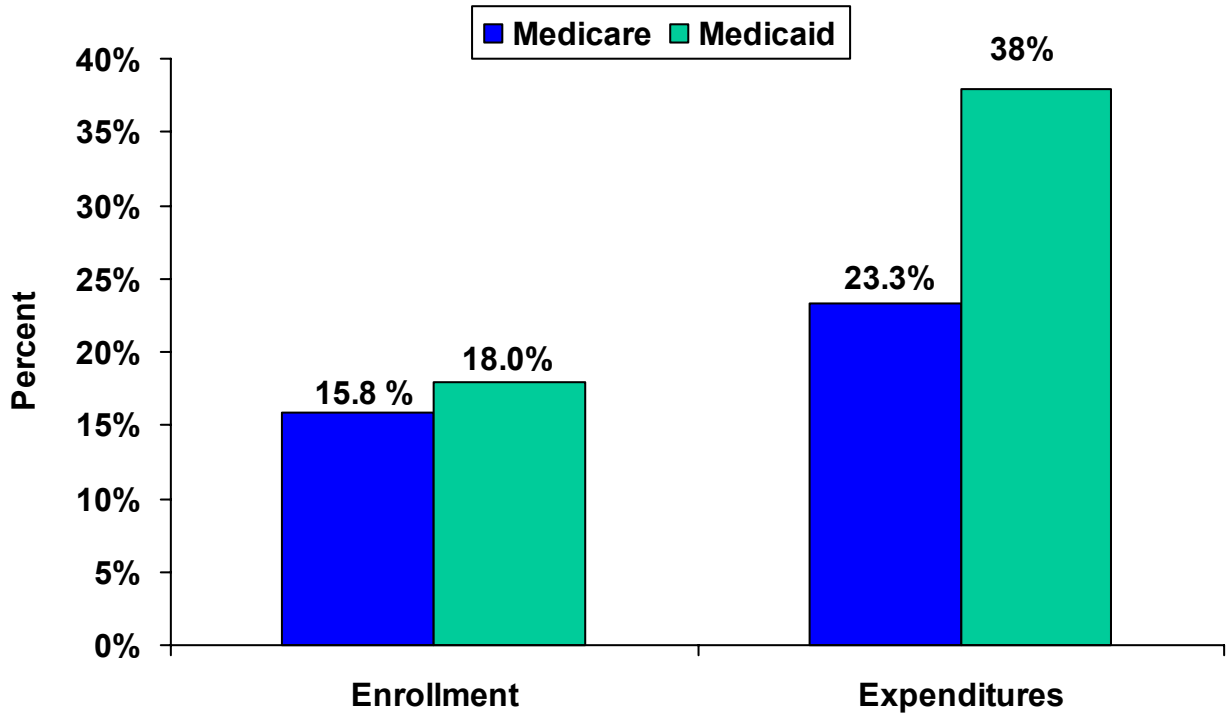
Chart 50
Selected Diseases and Chronic Conditions Among Dual and Medicare Enrollees, Calendar Year 2001

The dually enrolled population has higher rates of debilitating diseases and conditions such as pulmonary disorders and Alzheimer's disease than the Medicare population.



Note: (1) Medicare enrollees do not include dual enrollees. (2) Diseases and conditions of community residents were self-reported or reported by a proxy. Diseases and conditions of facility residents were reported by the facility staff.
Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Chart 51
Dual Enrollees as Percentages of Medicare and Medicaid Enrollment and Expenditures, Calendar Year 2000



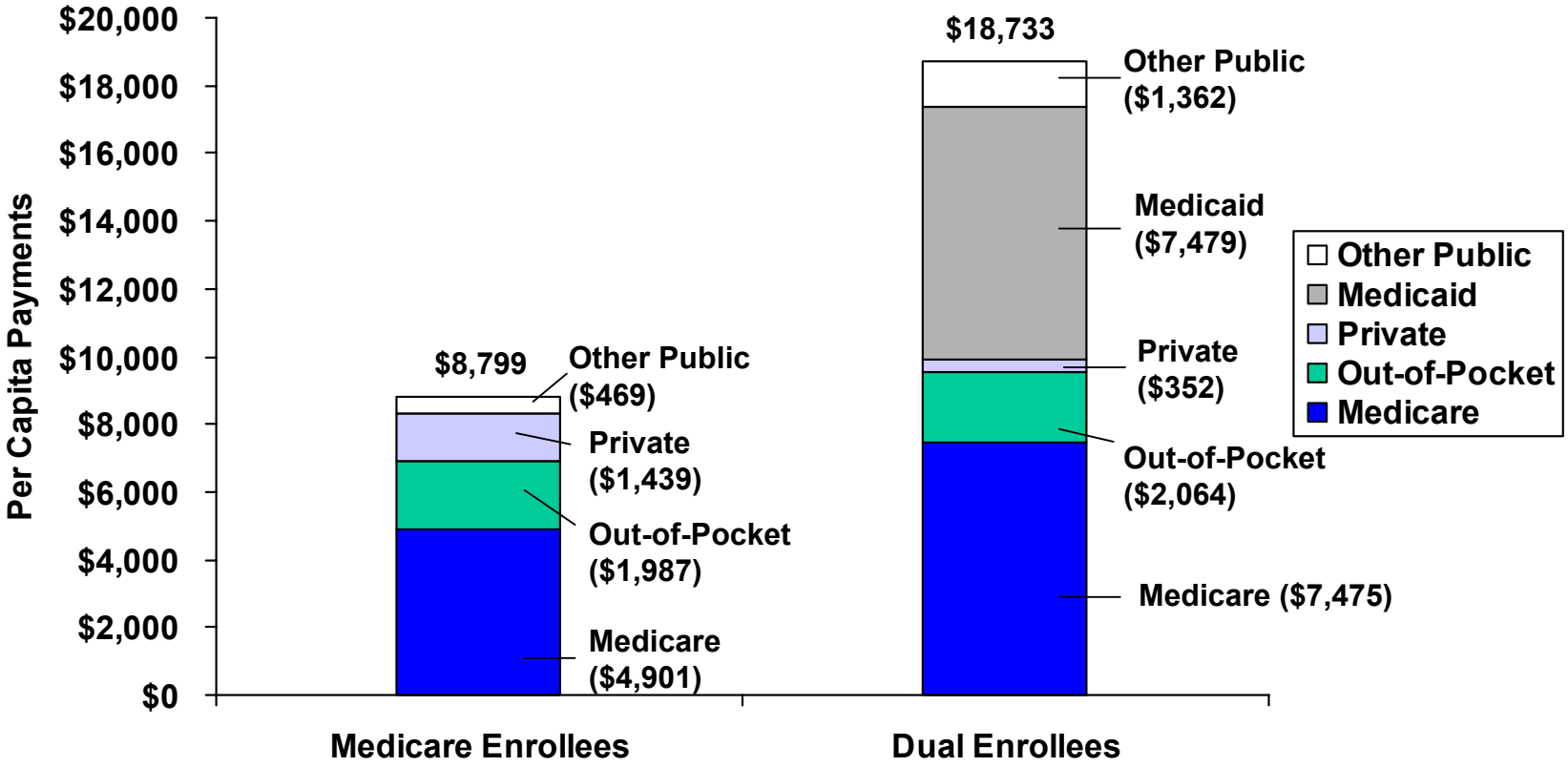
- **The average number of dual enrollees during the year was 6.4 million**
- **Medicare spent an estimated $51 billion (23% of total Medicare spending)**
- **Medicaid spent an estimated $76 billion (38% of total Medicaid spending)[1]**
- **Total Dually Enrolled Expenditures: $127 billion**
- **Total Federal Expenditures on Dual Enrollees: $94 billion**
- **Total State Expenditures on Dual Enrollees: $33 billion**

Note: (1) Federal and state shares.

Source: CMS/Office of Research, Development, and Information and Office of the Actuary: 2001 MCBS, MSIS and CMS-64 data.

Chart 52
Per Capita Health Expenditures by Payer for Dual and Medicare Enrollees, Calendar Year 2000

Health expenditures for the dually enrolled population were more than double that of the non-dually enrolled.



Note: (1) Medicare enrollees do not include dual enrollees. (2) "Out-of-Pocket" does not include premium payments. (3) Amounts will not sum to total due to some small categories being omitted. (4) "Other Public" includes VA, DOD, and state-based pharmaceutical assistance programs.

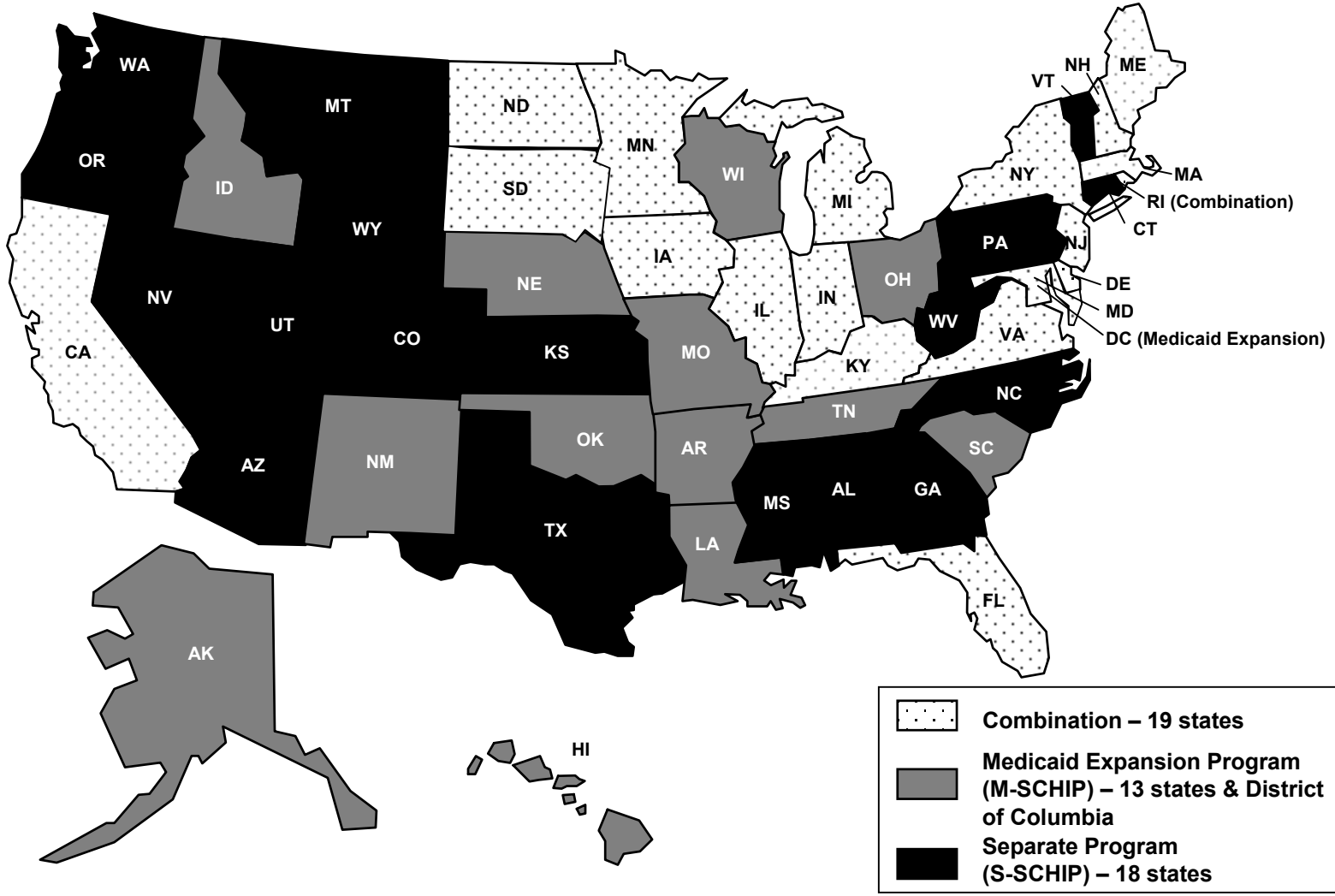
Source: CMS/Office of Research, Development, and Information: MCBS 2001 Access to Care File.

Section VIII

The State Children's Health Insurance Program

Chart 53
Types of SCHIP Programs: Separate, Medicaid Expansion and Combination

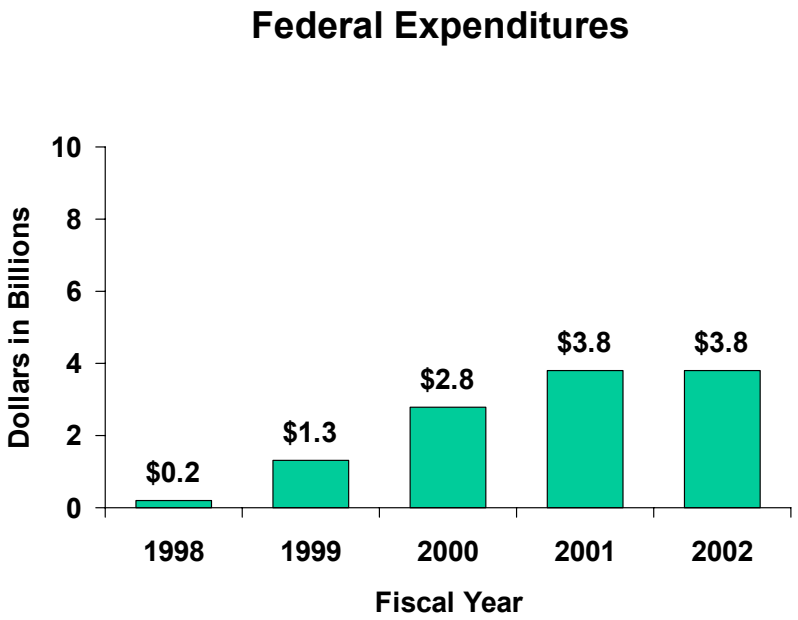
Seventeen states have combination[1] SCHIP programs as of March 2004.

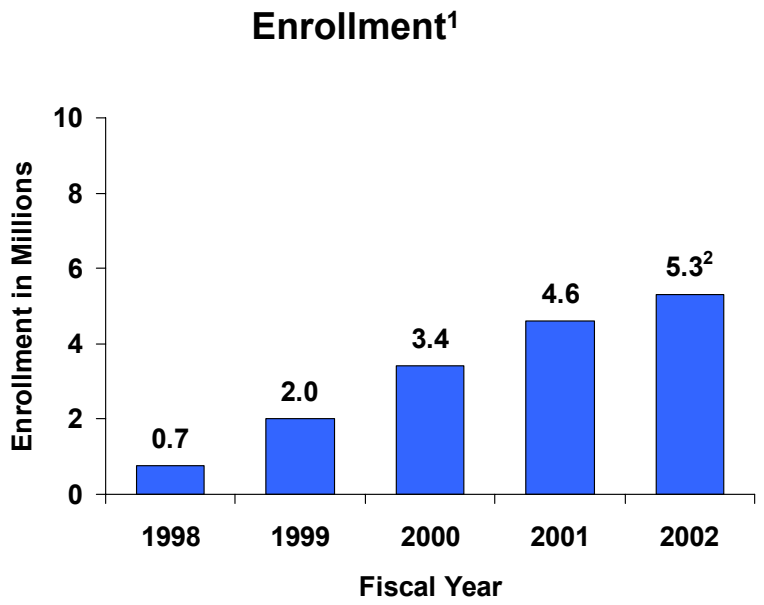


Note: (1) Combination SCHIP programs refer to states with both Medicaid expansion SCHIP and separate SCHIP.
Source: www.cms.hhs.gov.

Chart 54
Total State Children's Health Insurance Program Spending and Enrollment, Fiscal Years 1998 - 2002

The SCHIP program covers a growing number of children.

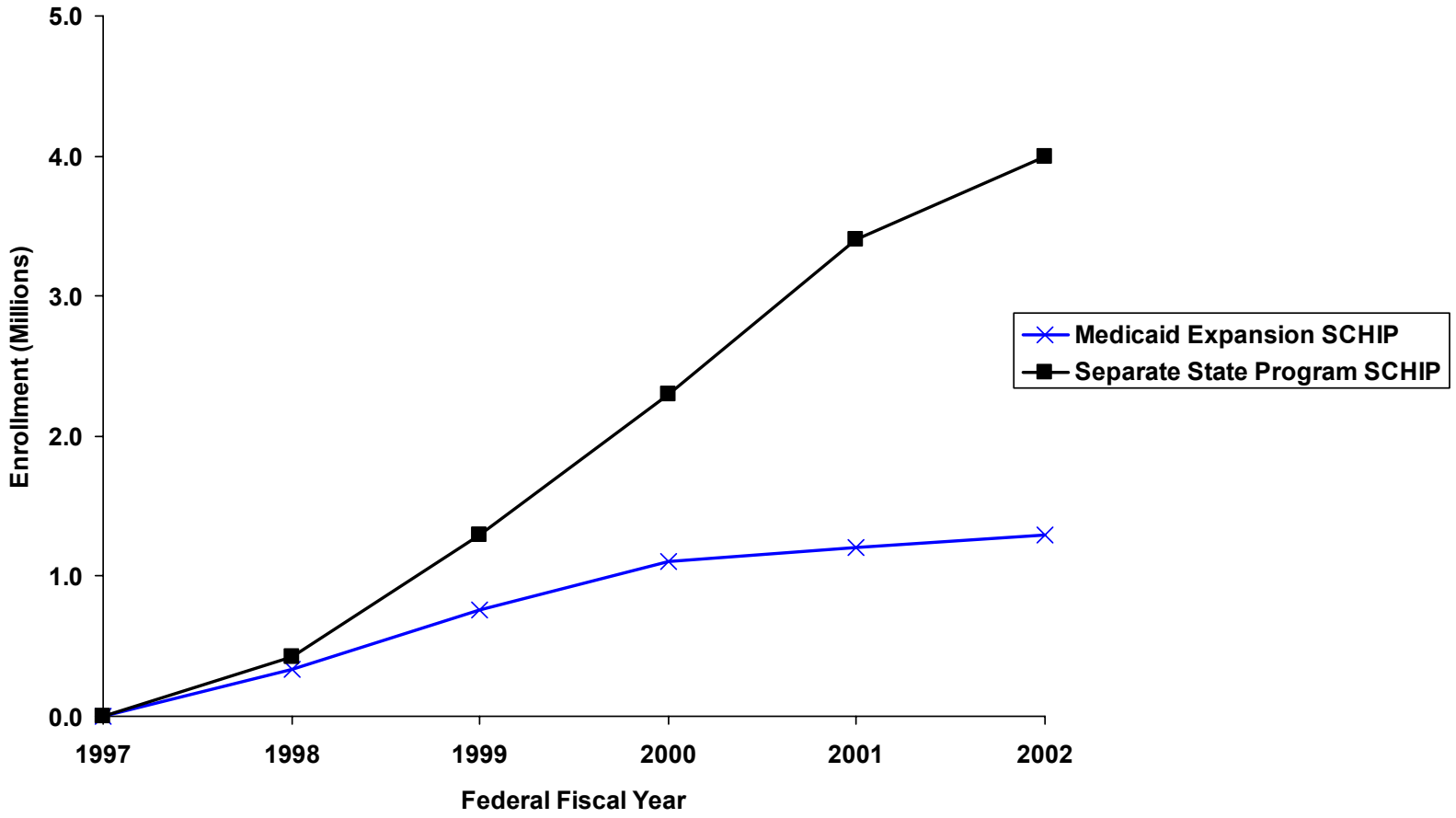




Note: (1) Ever-enrolled in SCHIP during the year, not a point in time estimate. Enrollment figures displayed here are slightly higher than those reported in CMS' enrollment reports which use the SCHIP Enrollment Data System (SEDS) because subsequent corrections to data reports increased the enrollment levels and enrollment figures were imputed for states that did not report to the SEDS. (2) The 2002 enrollment figure is from CMS's enrollment report because Mathematica Policy Research validated data was not available.
Source: CMS/Center for Medicaid and State Operations Medicaid Budget and Expenditure System; Mathematica Policy Research "SCHIP's Steady Enrollment Growth Continues: Final Report", May 2003.

Chart 55
SCHIP Enrollment by Type of Program

The majority of children are enrolled in separate SCHIP programs.



Note: The 2002 ever-enrolled figure is from CMS's enrollment report because Mathematica Policy Research validated data was not available. All other figures are from Mathematica Policy Research validated data report cited below.

Source: CMS/Center for Medicaid and State Operations report, "SCHIP's Steady Enrollment Growth Continues", as prepared by Mathematica Policy Research, Inc., May 2003.

Chart 56
Fiscal Year 2002 State Children's Health Insurance Program Statistics

State	Program Type	Child M-SCHIP[1]	Child S-SCHIP[2]	Total Child Enrollment	Adult SCHIP[3]	Federal Expenditures
Alabama	Combination	17,332	66,027	83,359	-	$ 54,993,821
Alaska	M-SCHIP	22,291	-	22,291	-	$ 21,011,515
Arizona	S-SCHIP	-	92,705	92,705	30,382	$ 126,775,764
Arkansas	M-SCHIP	1,912	-	1,912	-	$ 1,543,980
California	Combination	81,089	775,905	856,994	-	$ 454,189,935
Colorado	S-SCHIP	-	51,826	51,826	-	$ 31,181,315
Connecticut	Combination	3,216	18,130	21,346	-	$ 16,168,059
Delaware	S-SCHIP	-	9,691	9,691	-	$ 2,610,230
Dist. of Columbia	M-SCHIP	5,060	-	5,060	-	$ 5,469,696
Florida	Combination	4,706	363,474	368,180	-	$ 269,996,093
Georgia	S-SCHIP	-	221,005	221,005	-	$ 105,881,100
Hawaii	M-SCHIP	8,474	-	8,474	-	$ 3,900,427
Idaho	M-SCHIP	16,895	-	16,895	-	$ 14,349,960
Illinois	Combination	42,992	25,040	68,032	-	$ 36,311,644
Indiana	Combination	50,423	15,802	66,225	-	$ 60,404,483
Iowa	Combination	13,373	21,133	34,506	-	$ 28,724,907
Kansas	S-SCHIP	-	40,783	40,783	-	$ 35,933,510
Kentucky	Combination	59,642	34,299	93,941	-	$ 71,921,223
Louisiana	M-SCHIP	87,675	-	87,675	-	$ 65,082,370
Maine	Combination	15,033	7,553	22,586	-	$ 17,799,771
Maryland	Combination	121,305	3,875	125,180	-	$ 119,198,140

Note: See note on last page of Chart 56.

Source: CMS/Center for Medicaid and State Operations SCHIP Preliminary Annual Enrollment Report for FY 2002.

Chart 56 (Continued)
Fiscal Year 2002 State Children's Health Insurance Program Statistics

State	Program Type	Child M-SCHIP[1]	Child S-SCHIP[2]	Total Child Enrollment	Adult SCHIP[3]	Federal Expenditures
Massachusetts	Combination	77,788	38,911	116,699	-	$ 59,909,653
Michigan	Combination	26,777	45,105	71,882	-	$ 39,568,929
Minnesota	M-SCHIP	NR[4]	-	NR[4]	40,008	$ 64,715,779
Mississippi	Combination	1,180	63,625	64,805	-	$ 69,735,044
Missouri	M-SCHIP	112,004	-	112,004	-	$ 62,187,478
Montana	S-SCHIP	-	13,875	13,875	-	$ 12,095,451
Nebraska	M-SCHIP	16,227	-	16,227	-	$ 11,807,964
Nevada	S-SCHIP	-	37,878	37,878	-	$ 20,432,048
New Hampshire	Combination	438	7,700	8,138	-	$ 3,916,626
New Jersey	Combination	42,017	75,036	117,053	142,427	$ 252,507,470
New Mexico	M-SCHIP	19,940	-	19,940	-	$ 13,893,959
New York	Combination	NR[4]	807,145	807,145	-	$ 371,562,639
North Carolina	S-SCHIP	-	120,090	120,090	-	$ 86,032,756
North Dakota	Combination	892	3,571	4,463	-	$ 3,825,164
Ohio	M-SCHIP	183,034	-	183,034	-	$ 129,032,772
Oklahoma	M-SCHIP	84,490	-	84,490	-	$ 30,156,974
Oregon	S-SCHIP	-	42,976	42,976	-	$ 16,285,960
Pennsylvania	S-SCHIP	-	148,689	148,689	-	$ 104,009,578
Rhode Island	M-SCHIP	19,515	-	19,515	22,459	$ 34,506,325
South Carolina	M-SCHIP	68,928	-	68,928	-	$ 41,550,241

Note: See note on last page of Chart 56.

Source: CMS/Center for Medicaid and State Operations SCHIP Preliminary Annual Enrollment Report for FY 2002.

Chart 56 (Continued)
Fiscal Year 2002 State Children's Health Insurance Program Statistics

State	Program Type	Child M-SCHIP[1]	Child S-SCHIP[2]	Total Child Enrollment	Adult SCHIP[3]	Federal Expenditures
South Dakota	Combination	8,893	2,290	11,183	-	$ 8,657,394
Tennessee	M-SCHIP	NR[4]	-	NR[4]	-	$ 3,994,469
Texas	Combination	10,491	716,961	727,452	-	$ 535,735,402
Utah	S-SCHIP	-	33,808	33,808	-	$ 25,838,081
Vermont	S-SCHIP	-	6,162	6,162	-	$ 2,553,015
Virginia	Combination	11,484	56,490	67,974	-	$ 39,733,144
Washington	S-SCHIP	-	8,754	8,754	-	$ 8,041,411
West Virginia	S-SCHIP	-	35,949	35,949	-	$ 26,891,620
Wisconsin	M-SCHIP	62,391	-	62,391	113,842	$ 80,272,444
Wyoming	S-SCHIP	-	5,059	5,059	-	$ 3,158,772
Totals		1,297,907	4,017,322	5,315,229	349,118	$ 3,706,056,505

Note: (1) M-SCHIP is a Medicaid expansion SCHIP program. (2) S-SCHIP is a separate SCHIP program. (3) States can use SCHIP funds to cover parents of SCHIP and Medicaid children, pregnant women, and other adults through demonstration authority under Section 1115 of the Social Security Act. (4) "NR" indicates that a state has not reported data via the Statistical Enrollment Data System (SEDS).

Source: CMS/Center for Medicaid and State Operations SCHIP Preliminary Annual Enrollment Report for FY 2002.

Chart 57
SCHIP Fiscal Year 2004 Enhanced[1] Federal Medical Assistance Percentage Rates

65% ----------72.15% ----------83.96%[2]

Lowest EFMAP Rate Median EFMAP Rate Highest EFMAP Rate

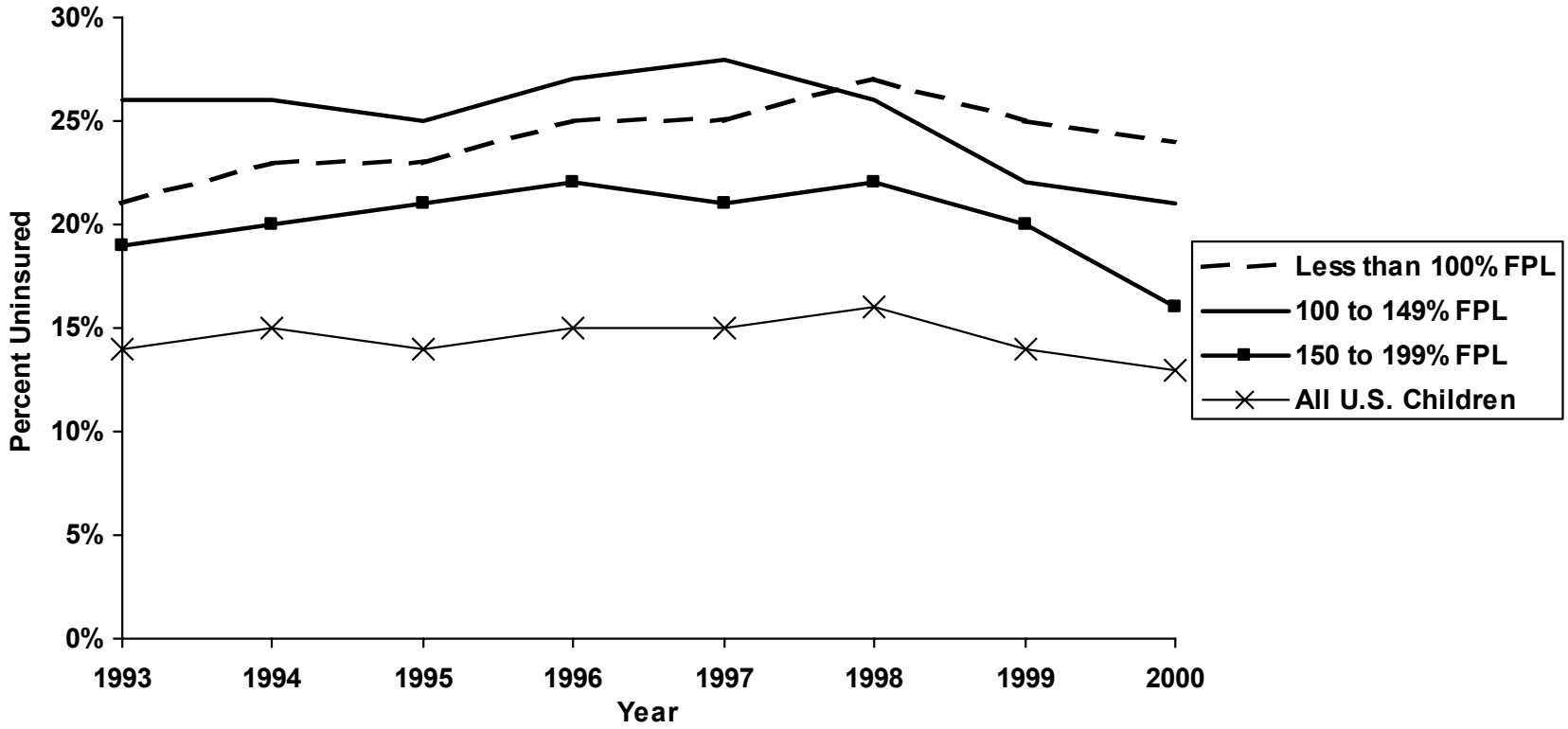
65%-70%	71%-75%	76%-80	81% and Greater
19 States	**16 States**	**11 States**	**5 States**
Alaska	**Florida**	**Alabama**	**Arkansas**
California	**Georgia**	**Arizona**	**Mississippi**
Colorado	**Hawaii**	**District of Columbia**	**Montana**
Connecticut	**Indiana**	**Idaho**	**New Mexico**
Delaware	**Iowa**	**Kentucky**	**West Virginia**
Illinois	**Kansas**	**Louisiana**	
Maryland	**Missouri**	**Maine**	
Massachusetts	**Nebraska**	**North Dakota**	
Michigan	**North Carolina**	**Oklahoma**	
Minnesota	**Ohio**	**South Carolina**	
Nevada	**Oregon**	**Utah**	
New Hampshire	**South Dakota**		
New Jersey	**Tennessee**		
New York	**Texas**		
Pennsylvania	**Vermont**		
Rhode Island	**Wyoming**		
Virginia			
Washington			
Wisconsin			

Note: (1) Enhanced Federal Medicaid Assistance Percentage rates are for everyone covered through SCHIP such as parents of SCHIP and Medicaid children, pregnant women, and other adults through demonstration authority under Section 1115 of the Social Security Act. (2) Mississippi has the highest EFMAP rate. (3) All U.S. Territories (e.g., Puerto Rico, Virgin Islands, American Samoa, Guam, Northern Mariana Islands) have a 65 percent EFMAP.

Source: Federal Register: November 15, 2002 (Volume 67, Number 221).

Chart 58
Percentage of Uninsured Children by Federal Poverty Level, Calendar Years 1993-2000

Since SCHIP was enacted in 1997, the proportion of uninsured children in the U.S. has declined.

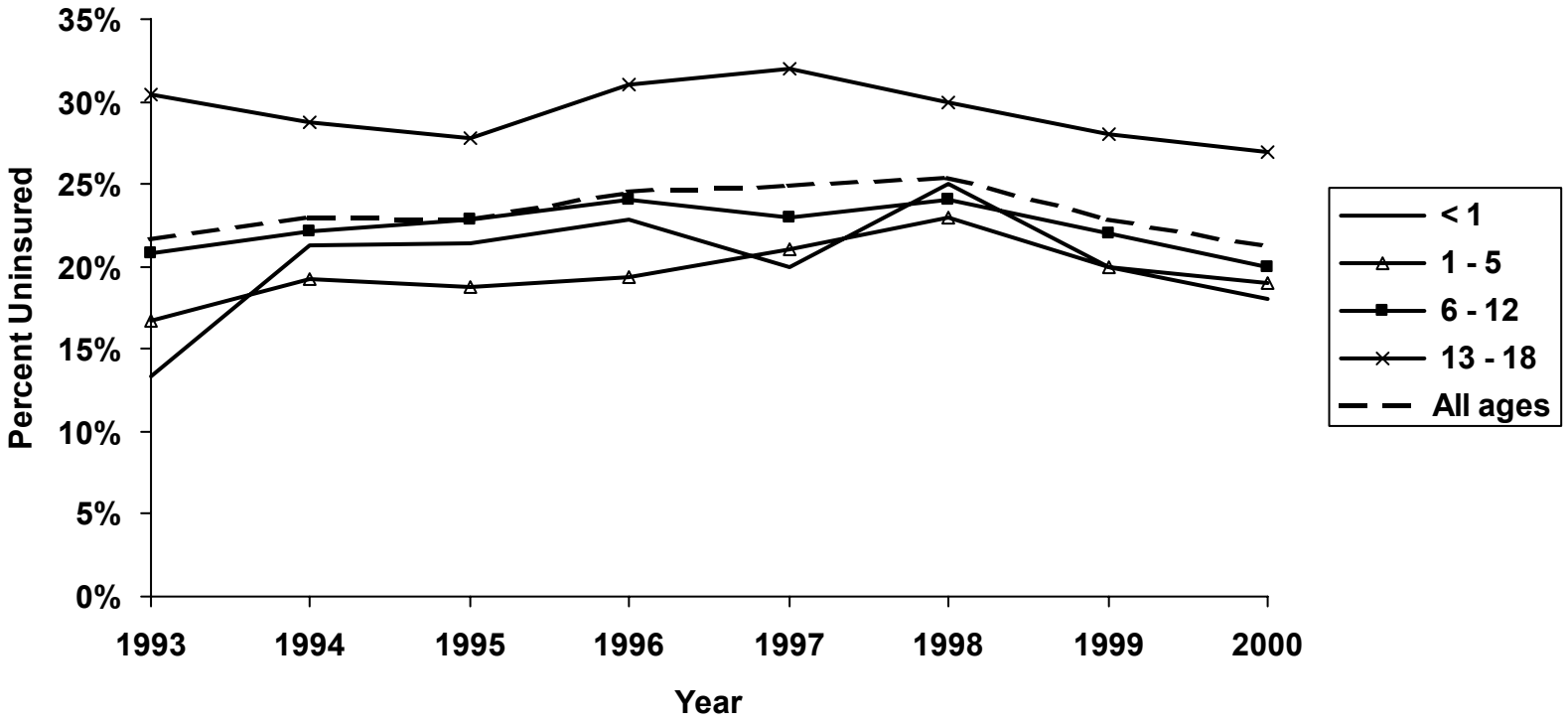


Note: Data above reflects reporting year as opposed to the year the survey was conducted. See discussion of CPS methodological changes during the 1990's in the Data Sources section.

Source: Mathematica Policy Research analysis of Current Population Survey, March 1994 to March 2001.

Chart 59
Percentage of Uninsured Children With Household Incomes < 200% of Federal Poverty Level by Age, Calendar Years 1993-2000

The enactment of SCHIP has helped to decrease the numbers of uninsured children across all ages, especially among adolescents.

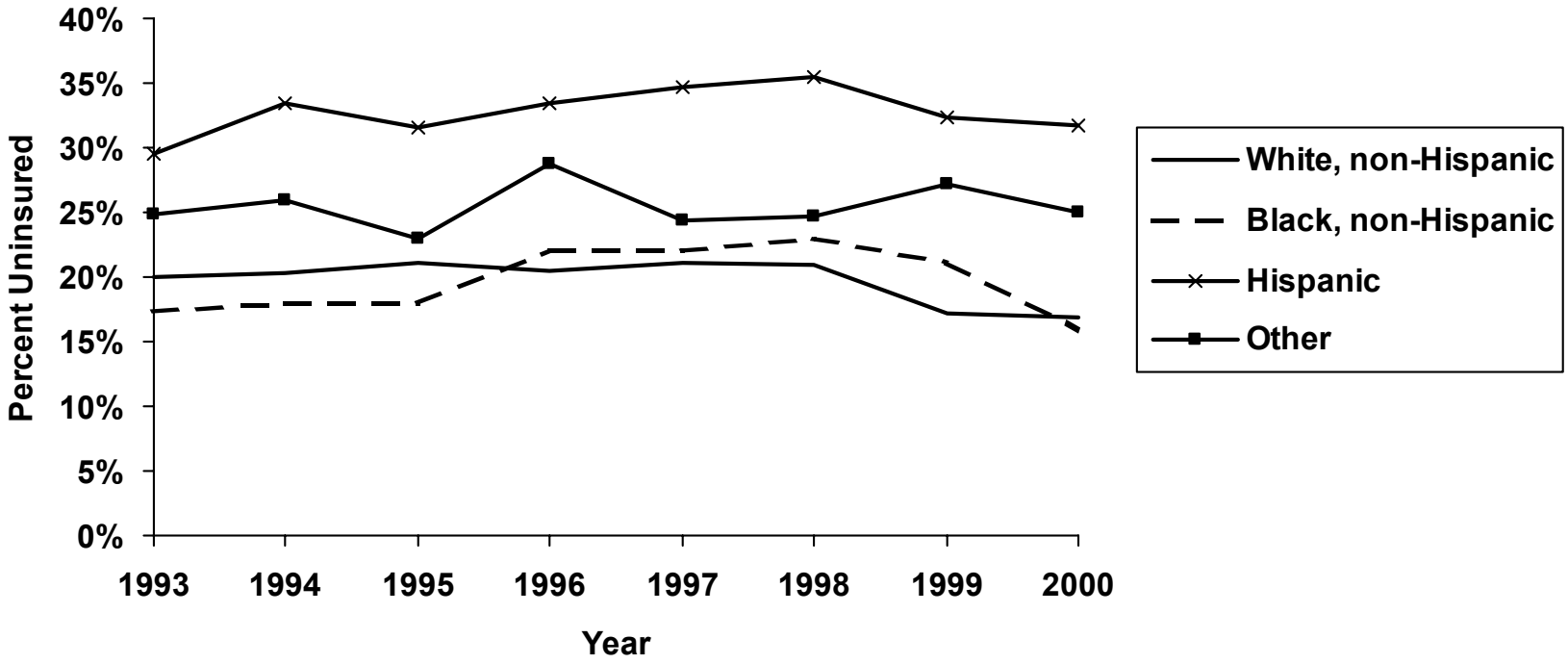


Note: Data above reflects reporting year as opposed to the year the survey was conducted. See discussion of CPS methodological changes during the 1990's in the Data Sources section.

Source: Mathematica Policy Research analysis of Current Population Survey, March 1994 to March 2001.

Chart 60
Percentage of Uninsured Children with Household Incomes < 200% of Federal Poverty Level by Race, Calendar Years 1993-2000

Since the enactment of SCHIP the numbers of uninsured children across different ethnic groups has declined. However, racial and ethnic disparities remain.



Note: Data above reflects reporting year as opposed to the year the survey was conducted. See discussion of CPS methodological changes during the 1990's in the Data Sources section.

Source: Mathematica Policy Research analysis of Current Population Survey, March 1994 to March 2001.

Chart 61
Upper Income Thresholds for Medicaid Prior to Enactment of the State Children's Health Insurance Program (SCHIP) and SCHIP Thresholds in October 2002

Percent of the Federal Poverty Level

	Medicaid Thresholds as of March 31, 1997				Thresholds as of October 2002[1]	
State	Ages 0-1	Ages 1-5	Ages 6-13	Ages 14-18	M-SCHIP	S-SCHIP
Alabama	133%	133%	100%	15%	-	200%
Alaska	133%	133%	100%	100%	200%	-
Arizona	140%	133%	100%	30%	-	200%
Arkansas[2]	133%	133%	100%	18%	200%	-
California	200%	133%	100%	82%	-	250%
Colorado	133%	133%	100%	37%	-	185%
Connecticut	185%	185%	185%	100%	185%	300%
Delaware	133%	133%	100%	100%	-	200%
District of Columbia	185%	133%	100%	50%	200%	-
Florida	185%	133%	100%	28%	200%	200%
Georgia	185%	133%	100%	100%	-	235%
Hawaii[3]	185%	133%	100%	100%	200%	-
Idaho	133%	133%	100%	100%	150%	-
Illinois[4]	133%	133%	100%	46%	133%	185%
Indiana	150%	133%	100%	100%	150%	200%
Iowa	185%	133%	100%	37%	133%	200%
Kansas	150%	133%	100%	100%	-	200%
Kentucky	185%	133%	100%	33%	150%	200%
Louisiana	133%	133%	100%	10%	200%	-

Chart 61 (Continued)
Upper Income Thresholds for Medicaid Prior to Enactment of the State Children's Health Insurance Program (SCHIP) and SCHIP Thresholds in October 2002

Percent of the Federal Poverty Level

	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of October 2002	
State	Ages 0-1	Ages 1-5	Ages 6-13	Ages 14-18	M-SCHIP	S-SCHIP
Maine	185%	133%	125%	125%	150%	200%
Maryland	185%	185%	185%	100%	200%	300%
Massachusetts	185%	133%	114%	86%	150%[5]	200%
Michigan	185%	133%	100%	100%	150%	200%
Minnesota	275%	275%	275%	275%	280%[6]	-
Mississippi	185%	133%	100%	34%	-	200%
Missouri	185%	133%	100%	100%	300%	-
Montana	133%	133%	100%	40.5%	-	150%
Nebraska	150%	133%	100%	33%	185%	-
Nevada	133%	133%	100%	31%	-	200%
New Hampshire	185%	185%	185%	185%	300%[7]	300%
New Jersey	185%	133%	100%	41%	133%	350%
New Mexico	185%	185%	185%	185%	235%	-
New York	185%	133%	100%	51%	133%	250%
North Carolina	185%	133%	100%	100%	-	200%
North Dakota	133%	133%	100%	100%[8]	100%[9]	140%
Ohio	133%	133%	100%	33%	200%	-
Oklahoma	150%	133%	100%	48%	185%	-
Oregon	133%	133%	100%	100%	-	185%

Chart 61 (Continued)
Upper Income Thresholds for Medicaid Prior to Enactment of the State Children's Health Insurance Program (SCHIP) and SCHIP Thresholds in October 2002

Percent of the Federal Poverty Level

	Traditional Medicaid Thresholds as of March 31, 1997				Thresholds as of October 2002	
State	Ages 0-1	Ages 1-5	Ages 6-13	Ages 14-18	M-SCHIP	S-SCHIP
Pennsylvania	185%	133%	100%	41%	-	200%
Rhode Island	250%	250%[10]	100%[11]	100%	250%[12]	-
South Carolina	185%	133%	100%	48%	150%	-
South Dakota	133%	133%	100%	100%	140%	200%
Tennessee[13]	-	-	-	16%	-	-
Texas	185%	133%	100%	17%	-	200%
Utah	133%	133%	100%	100%[14]	-	200%
Vermont[15]	225%	225%	225%	225%	-	300%
Virginia	133%	133%	100%	100%	-	200%
Washington	200%	200%	200%	200%	-	250%
West Virginia	150%	133%	100%	100%	-	200%
Wisconsin	185%	185%	100%	45%	185%[16]	-
Wyoming	133%	133%	100%	55%	-	133%[17]

See Note on last page of Chart 61.

Source: CMS/Center for Medicaid and State Operations, information from SCHIP state plans.

Chart 61 (Continued)

Note: (1) Some numbers may differ in practice because of the operation of an income disregard that has not been taken into account.
(2) Arkansas increased Medicaid eligibility to 200 percent of the FPL, effective September 1997, through section 1115 demonstration authority. This expansion was effective September 1997, which is after the SCHIP maintenance effort date.
(3) Hawaii covered 17 and 18 year olds under a section 1115 demonstration. However, the demonstration is subject to an enrollment cap and, when in effect, only people with income below the cash assistance standard are eligible to enroll. When the enrollment cap is in effect, the income level of 17 and 18 year olds covered is approximately 54 percent of the FPL.
(4) The SCHIP Medicaid expansion covers infants up to 200% of the FPL when the child is born to a woman in the Moms and Babies program. The separate child health program, KidCare Share covers children up to 150 percent of the FPL.
(5) The SCHIP Medicaid expansion program covers infants in families with income up to 200 percent of the FPL.
(6) Only children ages birth through two are eligible for the SCHIP Medicaid expansion.
(7) Infants are covered through the SCHIP Medicaid expansion and children ages one through 18 are covered through the separate child health program.
(8) Ages 14-17
(9) The SCHIP Medicaid expansion consists of children who became eligible for Medicaid when the state eliminated the Medicaid asset tests on January 1, 2002.
(10) Ages 1-7
(11) Ages 8-13
(12) An amendment to increase the SCHIP Medicaid expansion income threshold to 300 percent of the FPL has been approved, but has not been implemented.
(13) Tennessee provides coverage to children above the Medicaid state plan levels under a section 1115 demonstration. The demonstration covers: (1) Children without access to group health insurance up to 200 percent of the FPL; (2) Children enrolled as of 12/31/01 who have access to group health insurance up to 200 percent of the FPL; and (3) Children who are medically uninsurable with no upper income limit. Therefore, TennCare has no upper limit. TennCare recipients with incomes above the poverty level are charged a monthly premium based on a sliding scale. There are no premium subsidies for families with incomes > 400 percent of the FPL. The SCHIP Medicaid expansion covered children born before October 1, 1983 who enrolled in TennCare on or after April 1, 1997.
(14) Ages 14-17
(15) Vermont's SCHIP covers uninsured children between 225 and 300 percent of the FPL. Other children in this income range that are ineligible for SCHIP are covered under the state's Medicaid Section 1115 waiver, which was implemented October 1998.
(16) Once a child is enrolled, eligibility is maintained as long as income stays below 200 percent of the FPL.
(17) Wyoming is approved to cover up to 150 percent of the FPL through coordination with the private market but has postponed implementation of this program.

Glossary of Terms

Basis of Eligibility (BOE): BOE is the classification of individuals after they are certified enrolled in Medicaid. Enrollees are grouped by those who are aged, blind or disabled, children, or adults, usually either pregnant women or caregivers of children enrolled in Medicaid, as well as 1115 waiver expansion enrollees.

Calendar Year (CY): The twelve-month period running from January 1 through December 31 that is used as the basis for data collection and reporting of MCBS and National Health Accounts data.

Centers for Medicare & Medicaid Services (CMS): The agency within the Department of Health and Human Services responsible for administering and financing the Medicare Medicaid and State Children's Health Insurance (SCHIP) programs at the federal level. Prior to July 1, 2002, CMS was named Health Care Financing Administration (HCFA).

Disproportionate Share Hospital (DSH) Payments: Payments made by a state's Medicaid program to hospitals designated as serving a disproportionate share of low-income or uninsured patients. DSH payments are in addition to regular Medicaid payments for providing care to Medicaid beneficiaries. The maximum amount of federal matching funds available annually to individual states for DSH payments is specified in the federal Medicaid statute. Territories are not eligible for DSH funding.

Dual Enrollee (or Dually Enrolled): Medicare enrollees who receive Medicaid coverage for the payment of Medicare premiums and/or cost sharing or are entitled to full Medicaid benefits. See definition of Enrollee.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): EPSDT services are required for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and includes periodic screening, vision, dental, and hearing services. Also, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan.

Enhanced Federal Medical Assistance Percentage (EFMAP) Rate: The rate, determined through a statutory formula, at which state SCHIP spending is matched by the federal government.

Enrollee: A person who is eligible for coverage and is enrolled in the Medicare, Medicaid, or SCHIP programs. Some enrollees are "persons served" (see definition) because they received a covered service during a specified amount of time. See definition of Ever-Enrolled.

Ever-Enrolled: Individuals enrolled in Medicaid at least one month during the year. See definition of Enrollee.

Glossary of Terms (Continued)

Expenditure: a term generally used in reference to financial management data reported by states to CMS on form CMS-64. These expenditures are eligible for federal matching funds (according to a state's particular FMAP). The CMS-64 provides a method of accounting for states' use federal matching funds.

Federal Medical Assistance Percentage (FMAP) Payments: Also known as federal financial participation (FFP). Federal government payments states are entitled to for purchasing covered services on behalf of Medicaid eligible individuals.

Federal Medical Assistance Percentage (FMAP) Rate: The rate, determined through a statutory formula, at which state Medicaid spending is matched by the federal government.

Federal Poverty Level: The FPL for a family of four in FY 2000 was $17,050 in the 48 contiguous states and Washington, D.C. (*Federal Register*, Vol. 65, No. 31, February 15, 2000, pp. 7555-7557). They are issued each year in the *Federal Register* by the Department of Health and Human Services (HHS). The guidelines are a simplification of the poverty thresholds for use for administrative purposes — for instance, determining financial eligibility for certain federal programs.

Fiscal Year or Federal Fiscal Year (FY/FFY): The 12-month period under which the federal government operates. Until 1976, the fiscal year extended from July 1 of each year through June 30 of the following year. Beginning in 1976, the fiscal year was changed to October 1 through September 30. (The three-month period July-September 1976—the so-called transition quarter—does not belong to any fiscal year.) Fiscal years are labeled by the year in which they end, e.g., October 1, 2000 through September 30, 2001 is called fiscal year 2001.

Group Health Plan (GHP): A health maintenance organization that contracts with a medical group for the provision of health care services.

Maintenance Assistance Status (MAS): To receive Federal funds under Medicaid, states are required to provide Medicaid coverage to certain individuals who receive Federally assisted income-maintenance payments and for related groups not receiving cash payments. The MAS code is used to categorize how an enrollee met the Federal requirements for purposes of having his or her state payments reimbursable under Medicaid (e.g., cash assistance recipients and low income families, medically needy, poverty related, 1115 demonstration enrollees).

Managed Care Organization (MCO): A health insurance plan that uses primary care providers and a network of designated health care providers whose services are covered under the plan.

Glossary of Terms (Continued)

Medically Needy: The Medically Needy program allows an individual to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible for Medicaid. The Medically Needy or "spend down" category is the one Medicaid eligibility group that has no absolute income limit. Children, persons with disabilities, pregnant women, the elderly and some other adults as specified who have medical bills large enough to meet their deductible - the amount by which their income exceeds the Medically Needy Income limit – qualify for Medicaid under this provision. The resource limits for Medically Needy eligibility are also higher than those for other categories of eligibility.

Payment: the term used to refer to state spending for vendor, provider, and/or health plan services for which there is a fee-for-service claim or capitated payment made on behalf of a Medicaid enrollee. These payments do not capture lump sum payments (such as DSH), and Medicare premiums.

Persons Served: Generally, persons served are enrollees in Medicare, Medicaid or SCHIP who received a covered service. In Medicaid, a person served is an individual for whom a Medicaid claim was paid during the year as well as all managed care enrollees (including primary care case management). In 1998, CMS began using capitated payments as a proxy for service use by managed care enrollees. This may produce an over-count of persons actually receiving a service paid for through Medicaid (i.e. persons served). Persons served are a subset of enrollees (variously referred to as ever-enrolled).

Person Years: The total number of months individuals were enrolled in Medicaid divided by 12. Otherwise known as full-year equivalents.

Poverty-Related: The Poverty Related eligibility category in Medicaid
Originally, financial eligibility for Medicaid was linked to receipt of federally assisted income maintenance payments such as Aid to Families with Dependent Children (AFDC) and starting in 1972, Supplemental Security Income (SSI). The Personal Responsibility and Work Opportunity Act of 1996 changed the Medicaid program and the AFDC welfare program by creating certain Medicaid groups where financial eligibility is based solely on income and resources, not receipt of cash assistance. Some of these "non-cash" groups are referred to as the "poverty-related" groups. This eligibility category was created to expand Medicaid coverage of pregnant women and children by delinking Medicaid eligibility from receipt of AFDC.

Prepaid Health Plan (PHP): A managed care entity which makes contracts with health care providers on a case-managed, prepaid, capitated basis.

Price-Adjusted: A dollar amount re-assigned value based on a particular base year's dollar amount, i.e. that account for inflation. This allows for accurate historical comparison between years of financial data.

Glossary of Terms (Continued)

Primary Care Case Management (PCCM) Plan or Provider: PCCM is a type of managed care in that a PCCM provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) contracts directly with the State to locate, coordinate, and monitor covered primary care (and sometimes additional services such as specialty care). A PCCM provider is paid a monthly management fee for each enrollee in addition to regular fee-for-service payments.

Program of All-Inclusive Care for the Elderly (PACE): PACE is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The BBA established the PACE model of care as a permanent entity within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a State option.

Title XIX: refers to the Social Security Act title statutory authority under which the Medicaid program was enacted and is operated.

Title XXI: refers to the Social Security Act title statutory authority under which the SCHIP program was enacted and is operated.

Data Sources: Information and Caveats

A majority of the information presented in this chartbook is based on state reported program data collected by the Centers for Medicare & Medicaid Services (CMS). Each chart cites reference sources as well as notes to clarify the data. The descriptions below further supplement the notes. The names of two major data sources have changed since last publication of this chart series in 2000. These are **HCFA-2082** (replaced by **MSIS**) and **HCFA-64** (now named **CMS-64** since the agency which collects the data changed names).

CMS-64: This data report (formerly named **HCFA-64**) is a product of the financial budget and grants system which states submit quarterly. It is an accounting statement of only those expenditures made by states for which they are entitled to receive federal reimbursement under Title XIX. The amount claimed on the **CMS-64** is a summary of expenditures derived from invoices and cost reports. The **CMS-64** data presented show total current expenditures, both federal and state shares, that exclude adjustments to data reported more than one month after the original expenditure. See discussion on **MSIS** below regarding differences between **CMS-64** and **MSIS**. For more on **CMS-64**, see http://www.cms.hhs.gov/medicaid/mbes/ofs-64.asp.

Current Population Survey (CPS): The **CPS** is a monthly survey (reporting on a calendar year basis) of approximately 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The Annual Demographic Survey, or March **CPS** supplement, is the primary source of detailed information on income and work experience, including health insurance coverage, in the United States. The **CPS** sample, which surveys information from the previous calendar year, is scientifically selected to represent the civilian, non-institutional population.

Over the years for which **CPS** data are presented in this chartbook, the **CPS** survey underwent methodological changes. The charts presented here were designed to minimize and/or eliminate the impact of changes in questions and weighting: (1) all data in this chartbook employ weights based on the 1990 Census; (2) any child whose sole coverage is from Indian Health Service (IHS) is counted as uninsured; (3) March 2000 and March 2001 data from new **CPS** questions designed to more accurately capture information on insured status, especially of children and ethnic minorities, were left out of the analyses in order to maintain consistency; and (4) analysis of the effect of revisions to health insurance questions in March 1995 showed negligible impact on counts of the uninsured therefore no adjustments have been proposed. For more on **CPS**, see http://www.bls.census.gov/cps/cpsmain.htm.

HCFA-2082 refers to a Medicaid data collection form completed by states and submitted to the federal government for collection of aggregate eligibility, utilization and payment information about the Medicaid population. This form (both electronic and paper versions) has been replaced by **MSIS** data collection.

Managed Care Enrollment Report is a report provided by states to CMS of the percent of the Medicaid population enrolled in managed care entities. The Medicaid managed care population is derived using unduplicated enrollment figures of enrollees including Primary Care Case Management and Prepaid Health Plan enrollees. For more on managed care data, see http://www.cms.hhs.gov/medicaid/managedcare/default.asp.

Data Sources: Information and Caveats (Continued)

Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a nationally representative sample of aged, disabled, and institutionalized Medicare beneficiaries. **MCBS**, which is sponsored by CMS, is the only comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of the entire spectrum of Medicare beneficiaries. While the MCBS is useful in examining these variables in the dually enrolled population (those enrolled in both the Medicare and Medicaid programs), this type of information is not available for Medicaid-only beneficiaries. Data is collected and reported according to a calendar year cycle (January 1 – December 31). MCBS data is self-reported, therefore, answers such as "good" are subjective and based on how the respondent (or proxy) compares him/herself with peers.

In 2000, the **MCBS** conducted personal interviews with over 3,300 dually eligible Medicare beneficiaries. In the charts presented here, a beneficiary was considered a dual eligible if Medicare data showed that they were a Medicaid program buy-in or if they reported being in Medicaid during the interview. Therefore, anyone receiving any kind of Medicaid benefits in addition to their Medicare benefits was counted as a dual eligible beneficiary. For more on MCBS, see http://cms.hhs.gov/mcbs/default.asp.

MSIS: Having replaced the data collection system known as **HCFA-2082**, the **Medicaid Statistical Information System** (**MSIS**) is a reporting system by which states submit eligibility and demographic data on each Medicaid enrollee and every service claim or capitation payment that was adjudicated during the four quarters of the federal fiscal year. Each person covered by Medicaid for at least one day during the reporting cycle (including those in institutions) is included in the data regardless of managed care status (enrollees in PCCM plans are included). Persons are counted once for each type of covered service used but are not double counted in aggregate totals. **MSIS** excludes data from the territories; data are reported for the 50 states and the District of Columbia.

The following are **MSIS** data caveats: (1) Hawaii data were not available at time of publication therefore 1999 figures were included in place of 2000 for that state throughout MSIS reported data. (2) Trends are not comparable. Changes have been made to eligibility categories and services in 1997, 1998 and 1999. Some shifts also occurred in the categories in 1999 and 2000. (3) Beginning in 1998, Medicaid expansion SCHIP (funded through Title XIX) information is included but data on separate SCHIP programs are not. (4) Unless otherwise noted and where applicable, counts of enrolled children or enrollees overall include foster care children. (5) Puerto Rico data have been included where available: persons served for FY 1991 through FY 1998 as well as total enrollees for FY 1997 and FY 1998. No maintenance assistance status/basis of eligibility or demographic information were provided. PR has not reported any data to CMS after FY 1998. (6) Apparent inconsistencies in financial data are due to differences in the information captured through **MSIS** and **CMS-64** reporting (two separate systems). Adjudicated claims data are used in **MSIS**; actual payments are reported in the **CMS-64**. States claim the federal match for payments to disproportionate share hospitals on the **CMS-64**; payments to disproportionate share hospitals do not appear on the **MSIS** because states reimburse these hospitals directly. Finally, **CMS-64** data includes data from the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico and Virgin Islands. For more on maintenance assistance/basis of eligibility categories, see Attachment 3 of the MSIS Tape Specifications and Data Dictionary Attachments http://www.cms.hhs.gov/medicaid/msis/default.asp. For more on MSIS, see http://www.cms.hhs.gov/medicaid/msis/mstats.asp.

Data Sources: Information and Caveats (Continued)

National Health Accounts: Since 1964, the United States Department of Health and Human Services has published an annual series of statistics presenting total national health expenditures. The basic aim of these statistics, termed National Health Accounts (NHA), is to identify all goods and services that can be characterized as relating to health care in the nation, and determine the amount of money used for the purchase of these goods and services. Data is collected and reported according to a calendar year cycle (January 1 – December 31).

There are two reasons for the differences between National Health Account and CMS-64 total prescription drug estimates. First, as explained above, National Health Accounts presents data on a calendar year basis whereas CMS-64 is based on the fiscal year. The second reason for the difference is NHA data contains allocations for premiums and the CMS-64 data does not. State programs with drug "carveout" plans do not have premiums allocated to them. For more on NHA, see http://www.cms.hhs.gov/statistics/nhe.