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Beta-MAX Pilot Implementation Results

Final Report

July 30, 2010

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ACRONYMS

BPSF	Base Person Summary File
CHIP	Children's Health Insurance Program
CLTC	Community long-term care
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DME	Durable medical equipment
EDB	Medicare Enrollment Database
FFS	Fee-for-service
FFY	Federal fiscal year
HCBS	Home- and community-based services
HMO	Health Maintenance Organization
ICN	Internal control number
ID	Identification number
ILTC	Institutional long-term care
IP	MAX inpatient claims file
LT	MAX institutional long-term care claims file
MAX	Medicaid Analytic eXtract
MAX-PDQ	MAX Production, Enhancement, and Data Quality
M-CHIP	Medicaid expansion Children's Health Insurance Program
MSIS	Medicaid Statistical Information System
OT	MAX other service claims file
PHP	Prepaid health plan
PS	MAX person summary file
QA	Quality assurance

RX	MAX prescription drug claims file
S-CHIP	Separate Children's Health Insurance Program
SSA	Social Security Administration
SSN	Social Security number
TOS	Type of service
UB	Uniform billing
UEG	Uniform eligibility group
v1	Beta-MAX version 1 file (contains four quarters of input data)
v2	Beta-MAX version 2 file (contains five quarters of input data)
v3	Beta-MAX version 3 file (contains six quarters of input data)
v4	Beta-MAX version 4 file (contains seven quarters of input data)

I. INTRODUCTION

A. Background

Beginning in 1999, all states and the District of Columbia were required to report Medicaid enrollee eligibility and claims data in a standard format into the Medicaid Statistical Information System (MSIS). Mathematica Policy Research, on behalf of the Centers for Medicare & Medicaid Services (CMS), has produced research files derived from these data for each state, by calendar year; the research files are known as the Medicaid Analytic eXtract (MAX) files. The MAX files are described in detail in the MAX and Beta-MAX Design Report and Work Plan,[1] hereafter referred to as "the design report." Much of the text in this chapter and in the introductory sections of the following chapters summarizes information in the design report.

Several structural elements and data enhancements make the MAX files better suited for policy research than the MSIS files upon which MAX is built. The calendar year (CY) structure, the collapsing of claim adjustments into final-action claims, and the additional variables gained through linking to external sources (for example, the Medicare Enrollment Database (EDB)) make the MAX files easier for researchers to use than the raw MSIS files. Often, however, MAX files are not available until more than two years after the end of the CY data period. In the past, researchers who have needed more current Medicaid data have had to rely on other less convenient or less complete sources.

By far the most significant reason for the delay in MAX production is the need to wait for additional data from MSIS submissions. Twenty-eight states submit retroactive and correction

[1] Hourihan, Kerianne, and Julie Sykes. "MAX and Beta-MAX Design Report and Work Plan." Final report submitted to the Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, June 2010.

records to their eligibility files, which can modify enrollment numbers for previous quarters. All states also experience some lag in claims submissions, especially in inpatient and long-term care adjustment claims, so that claims for a service provided in CY 2008 may not be submitted by the state until halfway through CY 2009. To get the most complete and accurate information regarding service use and expenditures during a particular calendar year, MAX must wait for both eligibility and claims data for three quarters beyond the CY data period.

These additional quarters provide more complete information about enrollment and services performed in the MAX CY; they do not extend the enrollment or services beyond the MAX CY. For some research purposes, the extra quarters of retroactive, correction, and adjustment records might be unnecessary, or might not be sufficiently necessary to warrant the long delay in the release of the MAX data. For example, a research project focused on prescription drug claims, which have considerably less lag than other claims files, might be unaffected by incomplete records for long-term care claims. Another researcher might feel that it is more important to get an immediate rough estimate of the number of Medicaid enrollees for the CY than to wait many additional months for a more precise count. To alleviate the need for a quicker release of MAX data, CMS has decided to create a new set of early files called Beta-MAX files.

Three key elements of the Beta-MAX design will help CMS to achieve an earlier release date for Beta-MAX than for a full MAX file for the same data period. First, the Beta-MAX file may be constructed using fewer than seven quarters of each MSIS file type. Second, Beta-MAX files will be produced using software from the previous round of full MAX production, including eligibility and claims "business rules"—changes designed to correct coding errors and other data quality problems. Third, Beta-MAX will be subject to an abbreviated and highly automated data quality review rather than a more time-consuming manual data quality review.

B. Beta-MAX Pilot Design

Although it is possible to make informed guesses about the range of data quality differences that may occur between Beta-MAX and full MAX files, the most reliable way to learn about the potential differences is to actually build and analyze Beta-MAX files. During summer 2010, Mathematica tested Beta-MAX production by creating Beta-MAX 2008 files for six states. The results of the pilot, presented in this report, provide some clues about the nature of Beta-MAX files. However, because MSIS data patterns vary across states and years, the conclusions in this report cannot be generalized to Beta-MAX files for other states or years.

The six states chosen for the pilot—Alaska, Delaware, Idaho, Iowa, Maryland, and New York—were chosen because they had at least three quarters of approved MSIS data beyond the 2008 calendar year and because they represent a wide range of characteristics often seen in Medicaid data. All of the states except Iowa submit retroactive or correction records in their MSIS eligibility files; many of the states also submit a significant number of adjustment claims. More information regarding the selection of the pilot states is available in the design report.

The Beta-MAX 2008 pilot coincided with the production of the full MAX 2008 files, enabling Mathematica to observe the differences between Beta-MAX and full MAX files produced from the same input data. The ability to compare the files side by side provides an invaluable opportunity to learn as much as possible about the effects of key Beta-MAX design decisions, such as the use of the prior MAX year's software and business rules.

To best study the effects of using additional quarters of MSIS data, Mathematica produced four Beta-MAX files for each of the pilot states. The first pilot Beta-MAX file for each state, known as version 1 (v1), includes data only through the end of CY 2008. The second pilot file, version 2 (v2), contains the CY data plus one additional quarter of claims and eligibility. Version 3 (v3) contains the CY data plus two additional quarters of each file type, and version 4 (v4)

contains the CY data plus three additional quarters. The v4 files contain exactly the same input data as the full MAX file, allowing Mathematica to study the importance of software differences and business rule changes between Beta-MAX and MAX. Table I.1 describes the file specifications for each Beta-MAX pilot version and for MAX 2008.

Table I.1. File Specifications for Beta-MAX Pilot and MAX 2008

File	Number of Quarters[1]	MSIS Federal Fiscal Year Quarters	Version of Software and Business Rules
Beta-MAX v1	Four	FFY 2008 Q2–FFY 2009 Q1	MAX 2007
Beta-MAX v2	Five	FFY 2008 Q2–FFY 2009 Q2	MAX 2007
Beta-MAX v3	Six	FFY 2008 Q2–FFY 2009 Q3	MAX 2007
Beta-MAX v4	Seven	FFY 2008 Q2–FFY 2009 Q4	MAX 2007
MAX 2008	Seven	FFY 2008 Q2–FFY 2009 Q4	MAX 2008

[1]Because Iowa does not submit retroactive or correction records with its eligibility files, it will have only four quarters of eligibility data in all four pilot versions and in MAX.

For each state and each Beta-MAX version, Mathematica produced a set of tables known as the MAX Validation Tables. These tables, which consist of over 1,500 data quality measures, were developed as part of the manual review process for full MAX files. For the Beta-MAX pilot, Mathematica analyzed every measure in the MAX validation tables, comparing each state's Beta-MAX v1, v2, v3, and v4 values to the value in the full MAX 2008 file. The tables, which are presented in Appendix A, should prove very helpful to researchers who wish to determine the suitability of Beta-MAX files for their research needs.

In analyzing the validation tables for each of the Beta-MAX files, Mathematica paid special attention to any measures for which the Beta-MAX value was less than 80 percent (or greater than 120 percent) of the corresponding value in the full MAX 2008 file. Based on past experience assessing the quality and completeness of MAX data, Mathematica believes that differences greater than 20 percentage points are a good indication of potential quality problems.

In contrast, values between 80 percent and 90 percent of the full MAX value, while an indication that the two files are not equivalent, may be a good enough approximation for some types of research. For some measures, even large percentage differences would be unlikely to cause problems because the absolute magnitude of the difference is quite small.

Chapter II of this report describes Mathematica's analysis of the Beta-MAX person summary (PS) files, which contain demographic and enrollment information. It illustrates the effects of using fewer than seven quarters of MSIS eligibility data, as well as the effects of using the eligibility business rules from the prior MAX year. Finally, it makes a recommendation for the minimum number of quarters of MSIS eligibility files required in order to make a Beta-MAX PS file suitable for at least some research purposes.

Chapter III describes Mathematica's analysis of the Beta-MAX claims files. In a separate analysis for each claim type, it illustrates the effects of using fewer than seven quarters of MSIS data. It also describes the effects of using the adjustment rules and type of service (TOS) mapping rules from the prior MAX year. Finally, it makes a recommendation for the minimum number of quarters of each MSIS claim type required to make a Beta-MAX file suitable for research using those claims.

Chapter IV describes the automated data quality review system that will be used to check for extreme data quality problems in Beta-MAX files. It presents the data quality measures and the thresholds that will be used to determine when a Beta-MAX file should be withheld due to egregious problems.

Finally, Chapter V concludes the report with a summary of the Beta-MAX pilot results. It also presents the proposed Beta-MAX production schedule for Beta-MAX files for CY 2009 through CY 2012.

The full validation tables for each Beta-MAX version in each pilot state are presented in Appendix A. These tables include columns indicating when a Beta-MAX value is less than the recommended 80 percent (or more than 120 percent) of the full MAX value. Mathematica recommends that researchers interested in specific subpopulations or types of service examine the tables in Appendix A to determine whether Beta-MAX files made with a given number of quarters of MSIS data are suitable for their research projects.

II. ELIGIBILITY FILES

MAX and Beta-MAX person summary (PS) files contain data from the MSIS eligibility files as well as summary information from the MSIS claims files. In this chapter, we focus on the eligibility information only. Twenty-eight states submit retroactive and correction records with their eligibility files, which can modify enrollment numbers for previous quarters. Retroactive and correction records may have a large effect (for example, enrolling or disenrolling individuals), or a very small one (for example, updating Social Security numbers (SSNs)). To be certain that all eligibility records for a CY are included, MAX production is usually delayed until there are at least three additional quarters of eligibility records (beyond the CY) for states that submit retroactive and correction records. States sometimes submit these records several years after the end of the calendar year. However, in most cases, only those records received in the three quarters following the end of a CY are included in MAX. A number of factors, including retroactive and correction records, created discrepancies between Beta-MAX and MAX 2008 data in the pilot study.

The following sections describe the effects of different software and business rules used to generate Beta-MAX and MAX files, then compares the effects of using additional quarters of data on the quality of various eligibility measures.

A. Effects of Software Changes

By design, the production system for Beta-MAX uses the software from the preceding MAX year. Therefore, any software changes implemented in MAX 2008 are not reflected in any of the versions of Beta-MAX. One MAX 2008 change remedied a bug that had existed since 1999 in the program that merges the MAX PS file to the Medicare Enrollment Database (EDB). Previously, the software code overwrote the EDB sex value in order to make the values more similar to the values in the MAX PS file. However, this recoding meant that when there were

multiple PS records with different MSIS identification numbers (IDs) but the same MAX SSN, date of birth (DOB) and sex, only one of those records could be linked to the EDB. This software bug was fixed in MAX 2008, allowing multiple records per person to link to the EDB. The effect of this change can be seen in the total count of records that linked to the EDB. New York is the only state for which this change is evident in the final PS file validation tables. In New York, the total count of records that linked to the EDB is slightly higher in MAX 2008 than it is in the v4 Beta-MAX file (754,597 vs. 754,470). The Beta-MAX v4 value is equal to 99.98 percent of the MAX 2008 value, indicating that this discrepancy between MAX and Beta-MAX is very small.

One additional software change relates to the use of the SSA Death Master File (DMF), from which the SSA date of death is copied onto the MAX PS file. This change was made due to an unavoidable technical delay in CMS's receipt of an updated copy of the DMF. All four Beta-MAX versions used a copy of the DMF that was created in September 2008. Without having access to a more updated DMF, the MAX 2008 systems team determined that it was better to set the value of the SSA date of death to missing than to provide reliable date of death information for only part of the year. This software change is evident in a number of the Beta-MAX validation tables in Appendix A, where the counts of individuals with an SSA date of death in the v4 Beta-MAX files are substantially different from the same counts in MAX 2008.

B. Effects of Eligibility Business Rules

Eligibility business rules are designed to correct coding errors and other data quality problems in data submitted to MSIS by states. Because the goal of Beta-MAX is to produce files as quickly as possible, Mathematica recommends using the prior year's MAX business rules, rather than writing new rules for Beta-MAX.

In MAX, the eligibility business rules for a new calendar year file are drafted using the prior year's rules as a starting point. Updating the rules for a new MAX year requires intensive manual

review of data quality tables, as well as time to write and test changes to the software. The final eligibility rules are determined in an iterative cycle in which the Base Person Summary File (BPSF) tables are produced and reviewed after each set of changes to the rules. During MAX 2007, more than 30 states went through multiple rounds of eligibility rule revision. These additions and modifications to eligibility rules are important, but adding them can cause significant delays in processing. On the other hand, rules that are subsequently deleted are unlikely to do any harm if left in the software. For example, an eligibility business rule might change the restricted benefits code for a small group of records from an incorrect value to a correct one. If the state fixes the error in its next submission, the rule is no longer necessary. If it is left in the software it will act on zero records, because there are zero records with the incorrect restricted benefits code, thus the outdated rule has no effect.

For this analysis, the effect of using the prior year's business rules was assessed by comparing the v4 Beta-MAX data with the MAX 2008 data. There were no new business rules for Iowa in MAX 2008. Among the other states, the impact of using outdated business rules is quite small.

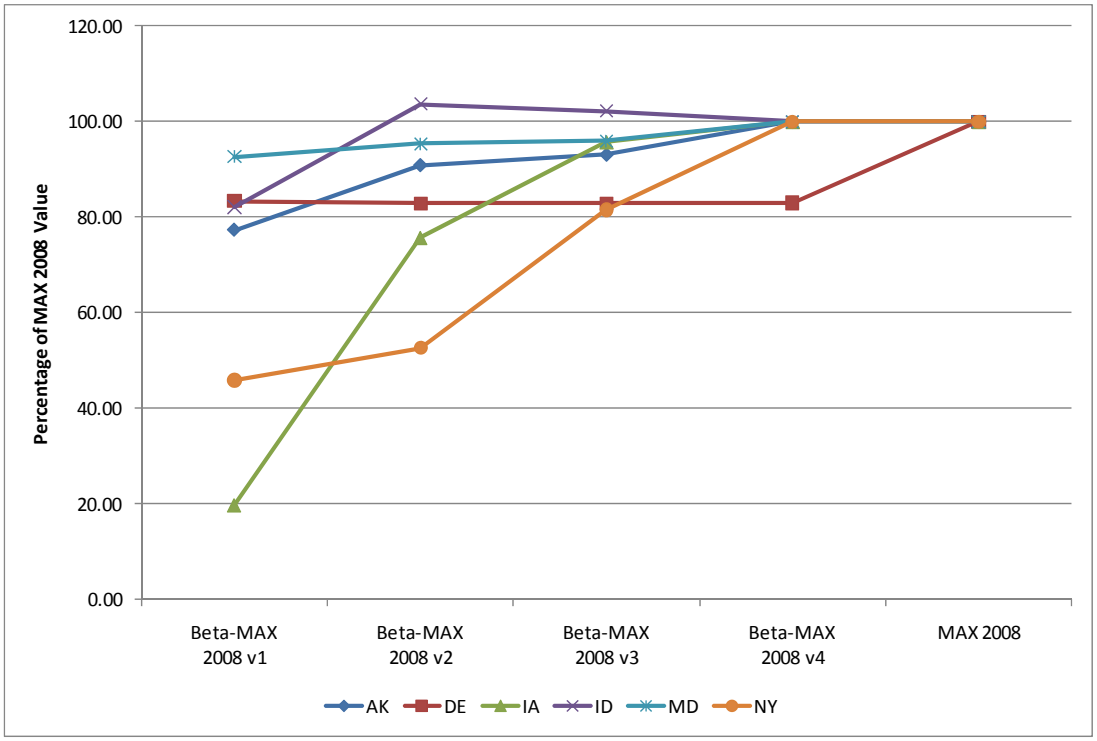
1. Alaska

In Alaska, the use of the previous year's business rules caused a discrepancy in MASBOE codes for several thousand enrollees. A business rule created for MAX 2008 moved 3,856 people from the MAX uniform eligibility group (UEG) 54 (child, Section 1115 demonstration) and 75 people from UEG 55 (adult, Section 1115 demonstration) into UEG 34 (child, poverty). Because this rule was not in place in 2007, all Beta-MAX files report these individuals in UEG 54 or UEG 55 rather than in UEG 34. Therefore, the v4 Beta-MAX value for the number of individuals in UEG 34 (46,915) represents only 92.27 percent of the value of that measure in MAX 2008 (50,846).

2. Delaware

In Delaware, a business rule implemented in 2008 eliminated all retroactive and correction records from MAX 2008. This was done because these records were inadvertently miscoding enrollment for thousands of enrollees. This difference in business rules results in discrepancies between Beta-MAX 2008 values and MAX 2008 values on a variety of measures. It is especially notable in the number of claims with missing Medicaid eligibility information, most likely because retroactive records would have provided eligibility information for some of these claims had the retroactive records not been excluded from MAX 2008. As shown in Figure II.1, the v4 Beta-MAX value for missing Medicaid eligibility information is equal to only 83 percent of the MAX 2008 value for Delaware, while it is 100 percent of the MAX 2008 value in all other states. However, the overall percentage of claims that do not link to eligibility records in Delaware is quite small. This is not indicative of a severe data quality problem in the Beta-MAX files for Delaware.

Figure II.1. Number of Records with Claims but Missing Medicaid Eligibility, as a Percentage of MAX 2008 Values



3. Idaho

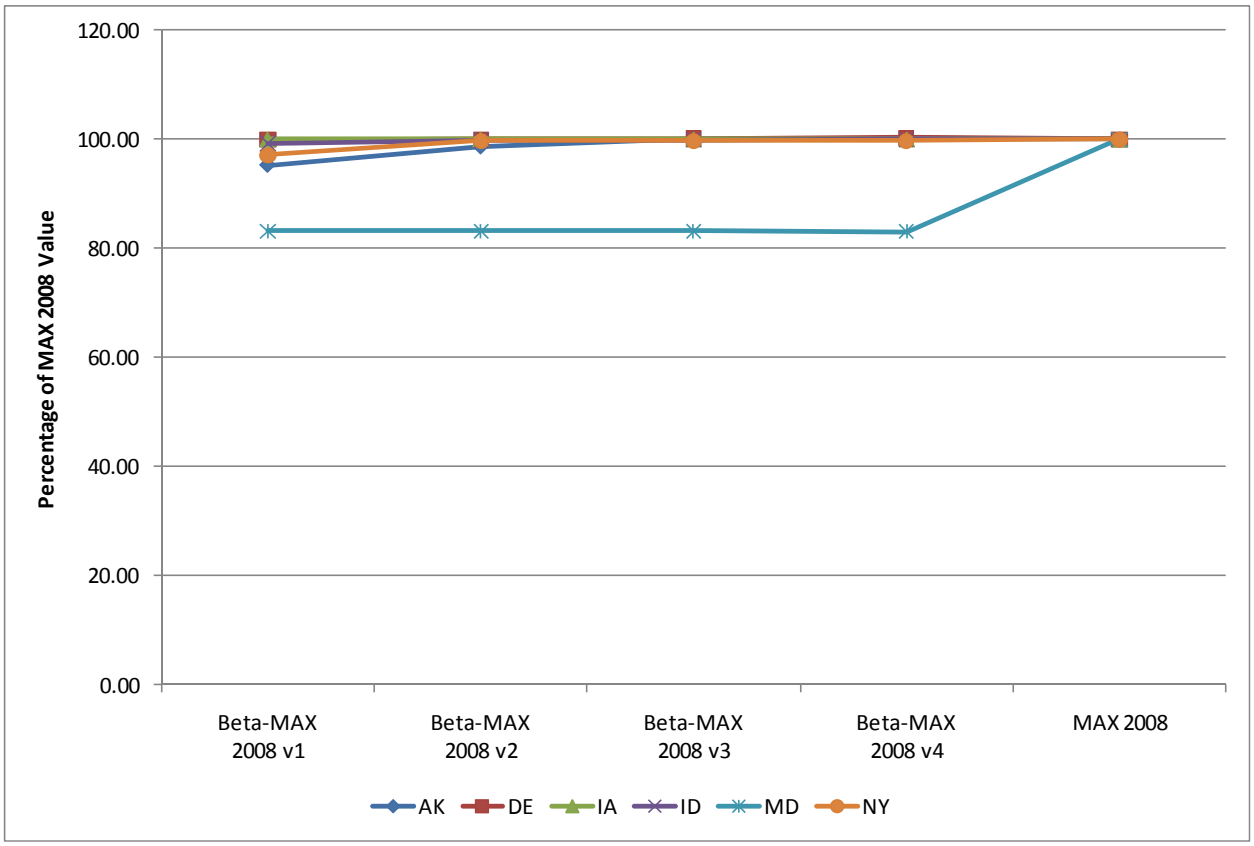
In Idaho, 218 people were incorrectly reported as enrolled in health maintenance organizations (HMOs) in April of 2008. MAX 2008 included a business rule that changed the enrollment category for these records to fee-for-service (FFS). However, because Beta-MAX did not apply this business rule, there were several very small discrepancies between Beta-MAX and MAX 2008 values. For example, the total count of FFS enrollees in the v4 Beta-MAX file (220,326) is 99.90 percent of the MAX 2008 value (220,544) for this measure. Additionally, this new business rule caused small discrepancies between Beta-MAX and MAX 2008 values for all measures that exclude people who were ever enrolled in an HMO or health insuring organization (HIO). For example, the v4 Beta-MAX value for total Medicaid amount paid for FFS enrollees ($1,220,667,172) is slightly below the MAX 2008 value ($1,225,955,947).

4. New 1915 (c) Waivers in Maryland, Delaware and New York

Enrollment in a 1915 (c) waiver program is underestimated in the Beta-MAX files for Maryland because the state received a new 1915 (c) waiver for medical day care services in 2008 that is not reflected in the 2007 business rules. This affects nearly all of the 1915 (c) waiver-related measures in Maryland. For example, in the v4 Beta-MAX file, 3,408 fewer individuals are counted as "ever enrolled in a 1915(c) waiver" than are counted in that category in MAX 2008. Figure II.2 illustrates that this Beta-MAX v4 value represents only 83.14 percent of the MAX 2008 value for that measure. Notably, the percentage difference between Beta-MAX and MAX 2008 is greater in many subcategories of this measure than it is in the overall category. For example, in the v4 Beta-MAX file, the number of enrollees with a section 1915 (c) waiver for

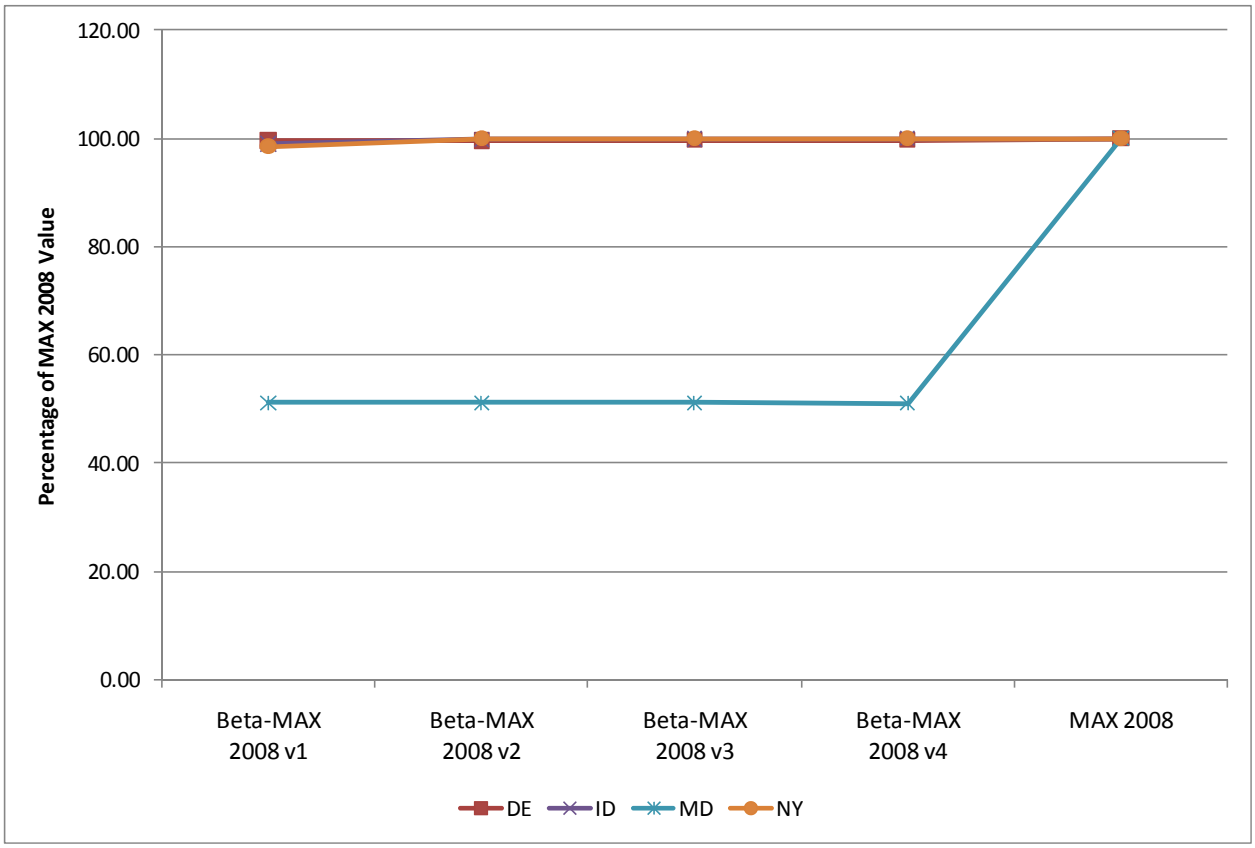
aged and disabled individuals (reported in MAX as waiver type 'G')[2] is only 51.07 percent of the MAX 2008 value for this measure (Figure II.3). Alaska and Iowa are not shown in Figure II.3 because they do not offer MAX type 'G' 1915 (c) waivers. While new 1915 (c) waivers had the largest effects on Beta-MAX values in Maryland, they were also responsible for small differences between Beta-MAX and MAX 2008 data in Delaware and New York.

Figure II.2. Number Ever Enrolled in Any Section 1915 (c) Waiver, as a Percentage of MAX 2008 Values



[2] To help MAX data users better understand Section 1915(c) waiver types, MSIS Waiver Type code 3, which identifies enrollment in a Section 1915(c) waiver in MSIS, is recoded to values 'G' through 'O' in MAX person summary files. MAX Waiver Type 'G' identifies a Section 1915(c) waiver that is targeted for the aged and disabled.

Figure II.3. Number of Enrollees with Section 1915 (c) Waivers for Aged and Disabled (MAX Waiver Type G), as a Percentage of MAX 2008 Values



C. Effects of Additional Quarters of Data

This section explores the effects of using different numbers of quarters of retroactive and correction records on the data quality of Beta-MAX person summary files.[3] In many ways, retroactive and correction records are similar to eligibility business rules. Their purpose is to correct the information on the eligibility record. The impact of these records on the eligibility record (and therefore on the PS file) could be large or small, depending on what information the state is modifying through those records.[4] Surprisingly, the use of fewer quarters of data did not

[3] Iowa does not submit retroactive or correction records, so all eligibility measures for Iowa have equal values throughout the different versions of Beta-MAX.

[4] The distinction between retroactive and correction records is blurred, as states often submit retroactive records as if they were correction records. In other words, a retroactive record does not purely indicate previously unreported enrollment; instead it may modify information on an existing eligibility record; thus it may or may not

have a substantial impact on total enrollment or enrollment by group in any of the pilot states. The only measure that was consistently affected across all states was the linkage between claims and eligibility. In a few states, the number of people assigned more than one MSIS ID and the number of people with an invalid SSN was different. For a few other measures the effects of additional quarters of data are apparent in only one state, likely reflecting state-specific data issues that will fluctuate from year to year. None of the differences presented in this section were substantial enough to suggest that more than four quarters of data are necessary.

1. Individuals with Claims but No Eligibility Record

In all but one state, there were discrepancies between Beta-MAX and MAX 2008 values in the number of individuals with claims but no eligibility record. Figure II.1 demonstrates that Beta-MAX files made with fewer quarters of data typically have fewer individuals with claims but no eligibility record. In Alaska, for example, the v1 Beta-MAX value for this measure represents only 77.3 percent of the MAX 2008 value. In Iowa, the v1 Beta-MAX value is only 19.8 percent of the MAX 2008 value. Finally, in New York, the v1 Beta-MAX value is only 45.9 percent of the MAX 2008 value.[5] Even though each additional quarter of data increases the non-linkage rate and brings it closer to the MAX 2008 amount, the non-linkage amount in MAX 2008 is not very high and would not be considered problematic.

The difference in claims without eligibility records between Beta-MAX and MAX may be caused by a variety of factors. One theory is that retroactive or correction records may disenroll individuals and cause claims that previously linked to eligibility to stop linking. Another

(continued)
affect the monthly enrollment information. Consequently, we have not made a conceptual distinction between retroactive and correction records.

[5] The discrepancy between the v4 Beta-MAX value and the full MAX value in Delaware was caused by a change in the eligibility business rule and has been discussed previously.

possibility could be that claims arriving in the sixth or seventh quarter (two or three quarters after the end of the CY) have arrived ahead of the eligibility record. Their dates of service may precede the person's enrollment.

2. MSIS ID and SSN Issues

In two states, the number of people assigned more than one MSIS ID was the lowest in the v1 data but became progressively similar to the MAX 2008 data as more quarters were added. In Alaska, for example, there were 31 people with more than one MSIS ID in the v1 Beta-MAX file and 59 people in the MAX 2008 file. In Idaho there were seven people in Beta-MAX v1 and 20 people in MAX 2008. The increase over time indicates that the retroactive and correction records in the later quarters have introduced a second PS record for the same person.

Similarly, in two states, the percentage of people whose SSN was invalid is lowest in the v1 Beta-MAX file but increases and becomes progressively similar to the MAX 2008 version as more quarters are added. In Alaska, for example, 0.08 percent of persons with an SSN are invalid in Beta-MAX v1 whereas 0.24 percent are invalid in MAX 2008. In New York, 0.06 percent of persons with an SSN are invalid in Beta-MAX v1 whereas 0.12 percent are invalid in MAX 2008. Again, the increase over time indicates that the retroactive and correction records in the later quarters have introduced an error.

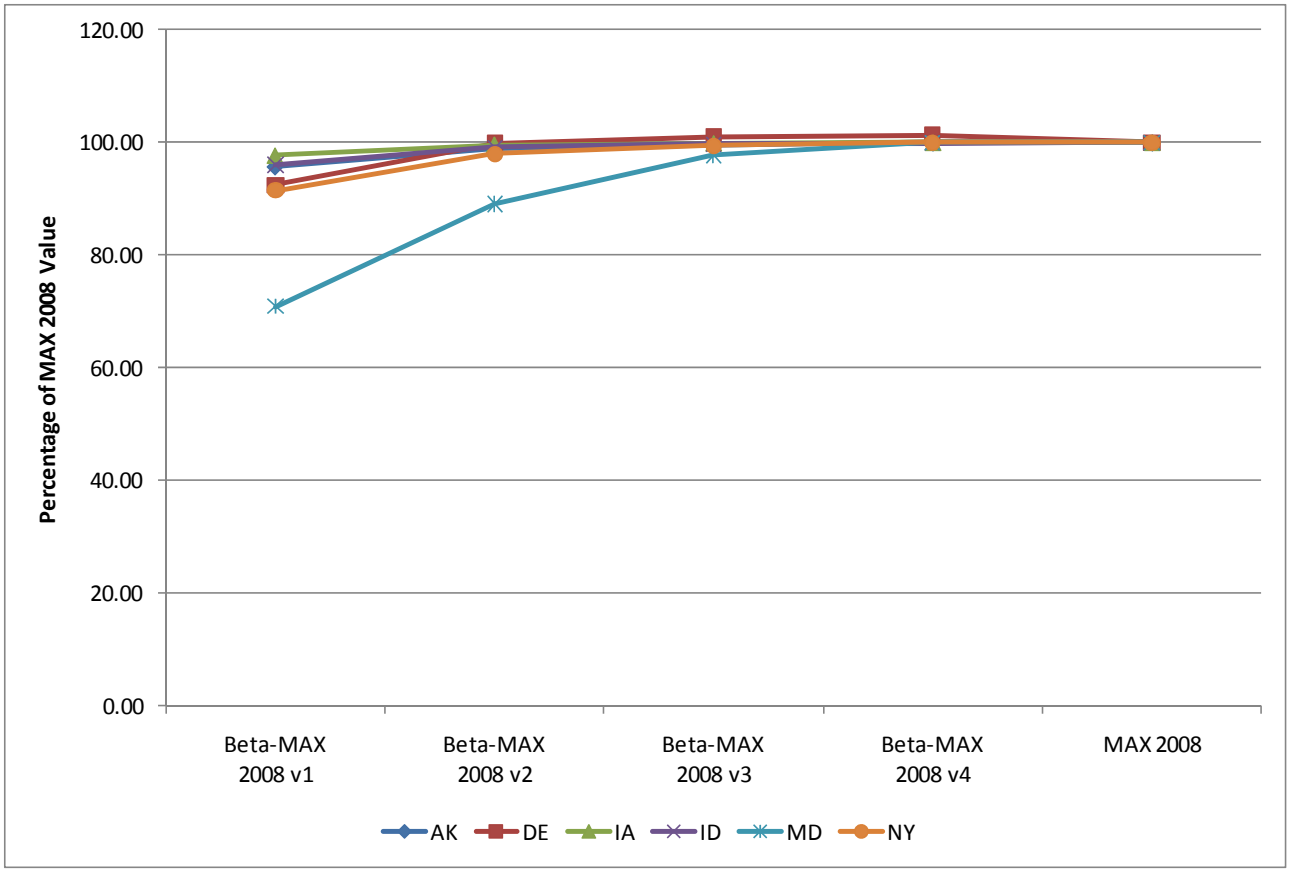
In both of these examples, while the percent differences were large, the nominal differences were very small. Moreover, while we want the Beta-MAX version to be similar to MAX 2008, these differences suggest that the number of invalid MSIS ID and SSN's may increase as additional quarters of data are incorporated into the Beta-MAX file.

3. State-Specific Issues

One of the most significant discrepancies between Beta-MAX and MAX appears to be a state-specific issue. In Maryland, the number of non-dual FFS recipients (individuals with at

least one FFS claim) was strikingly low in the v1 Beta-MAX file (Figure II.4). While the v1 Beta-MAX value for this measure is only 70.91 percent of the MAX 2008 value, the v2 Beta-MAX value is 89.06 percent of the MAX 2008 value and the v4 Beta-MAX value for this measure is identical to that found in MAX 2008. This discrepancy is due not to enrollment records but instead to the late submission of OT claims for the CY, especially for children and adults. This issue is discussed in more detail in Chapter III.

Figure II.4. Number of Non-Dual FFS Recipients, as a Percentage of MAX 2008 Values

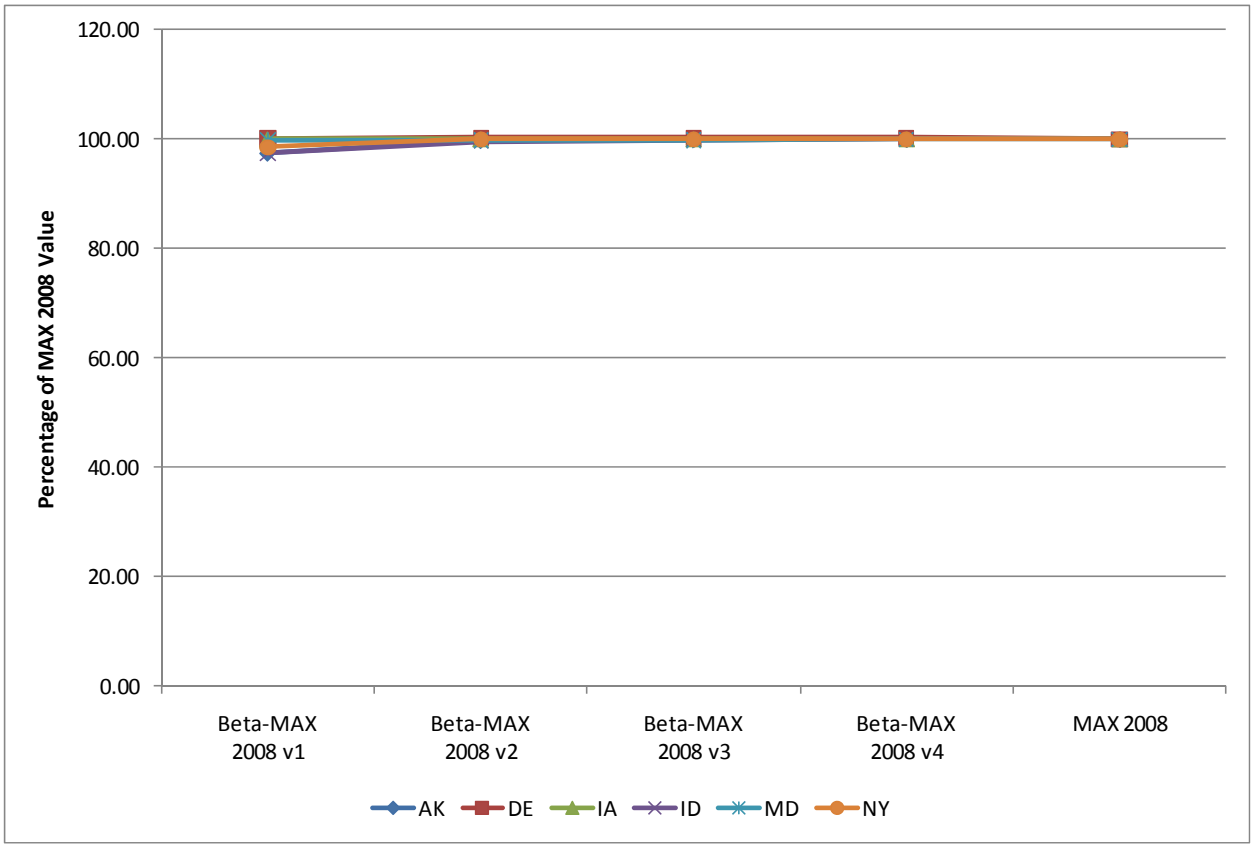


4. Enrollment and Eligibility Subgroups

For most enrollment measures, there is an extremely high degree of similarity between the data in the v1 Beta-MAX data and the MAX 2008 data. The examples below illustrate the extent to which the Beta-MAX value is an excellent approximation of the full MAX value.[6]

As shown in Figure II.5, the total number of Medicaid enrollees in the v1 Beta-MAX files ranges from 97.41 percent of the full MAX value in Idaho to 100.10 percent of the full MAX value in Delaware.

Figure II.5. Number of Medicaid Enrollees, as a Percentage of MAX 2008 Values



[6] Because Iowa does not submit retroactive or correction records, the values in each Beta-MAX file for the measures below are identical to the value in MAX.

Figure II.6 shows that the total Medicaid person-years of enrollment in the v1 Beta-MAX files ranges from 98.76 percent of the full MAX value in Alaska to 99.88 percent of the full MAX value in Maryland.

As shown in Figure II.7, the number of dual enrollees confirmed by the EDB in the v1 Beta-MAX files ranges from 98.31 percent of the full MAX value in Idaho to 100.10 percent of the full MAX value in Delaware. Very similar ranges are seen for more specific categories of dual enrollees, including those with full or restricted benefits and those represented by each of the Medicare dual codes.

Figure II.6. Total Person Years of Enrollment in Medicaid, as a Percentage of MAX 2008 Values

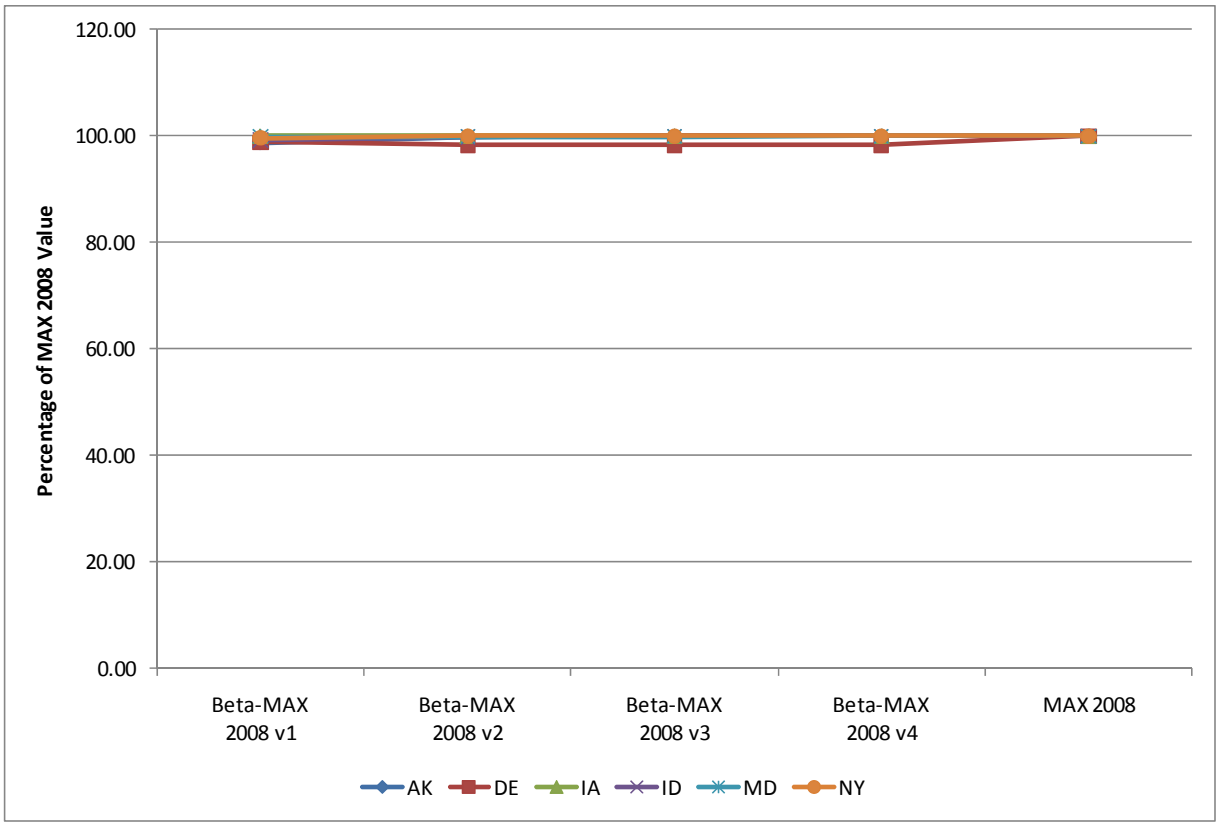


Figure II.7 Number of EDB-Confirmed Dual Enrollees, as a Percentage of MAX 2008 Values

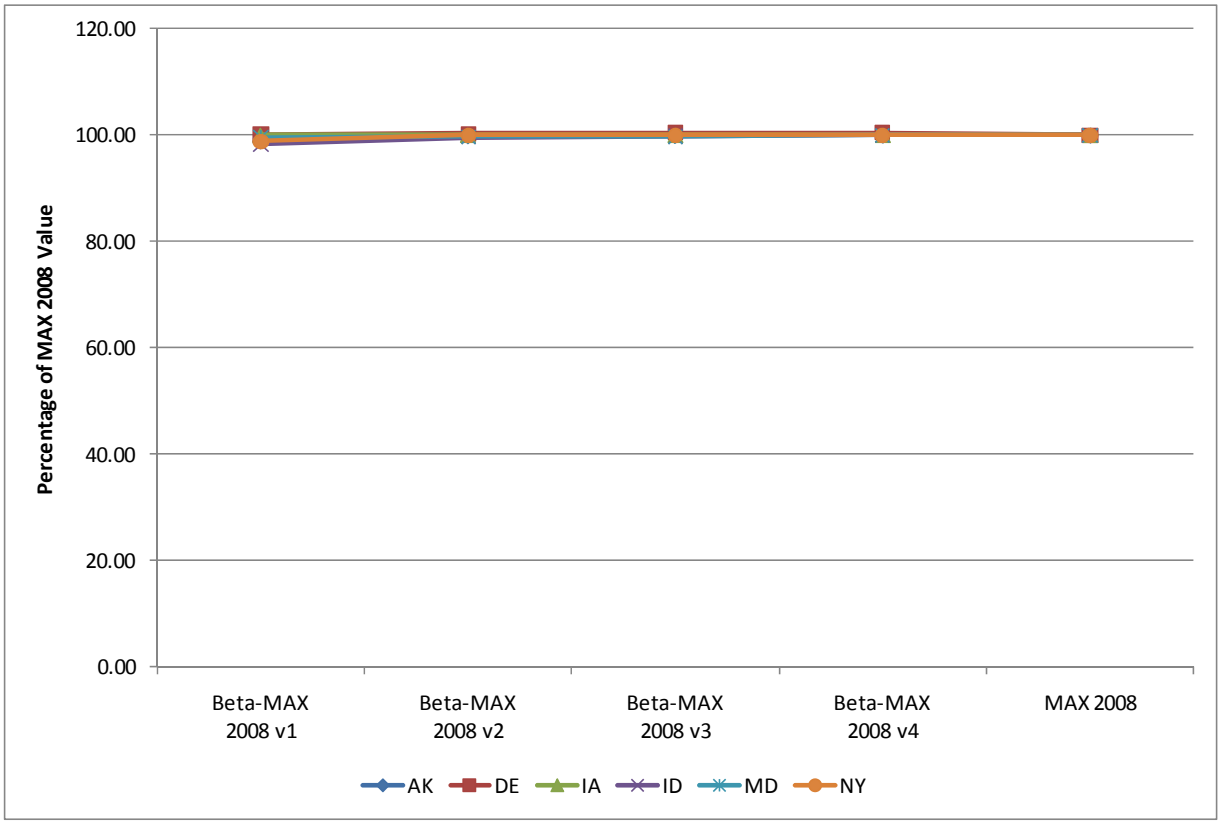


Figure II.8 shows that the number of aged enrollees in the v1 Beta-MAX files ranges from 97.96 percent in Idaho to 99.70 percent in Delaware. Similarly, as shown in Figure II.9, the number of enrollees who are children in the v1 Beta-MAX files ranges from 97.58 percent in Alaska to 100.20 percent in Delaware. The v1 Beta-MAX files look similarly complete in the count of disabled enrollees and the count of nondisabled, non-aged adults. In general, counts of enrollees in each of the more finely tuned UEG groups also appear relatively complete in the v1 Beta-MAX files.

Figure II.8. Number of Aged Enrollees, as a Percentage of MAX 2008 Values

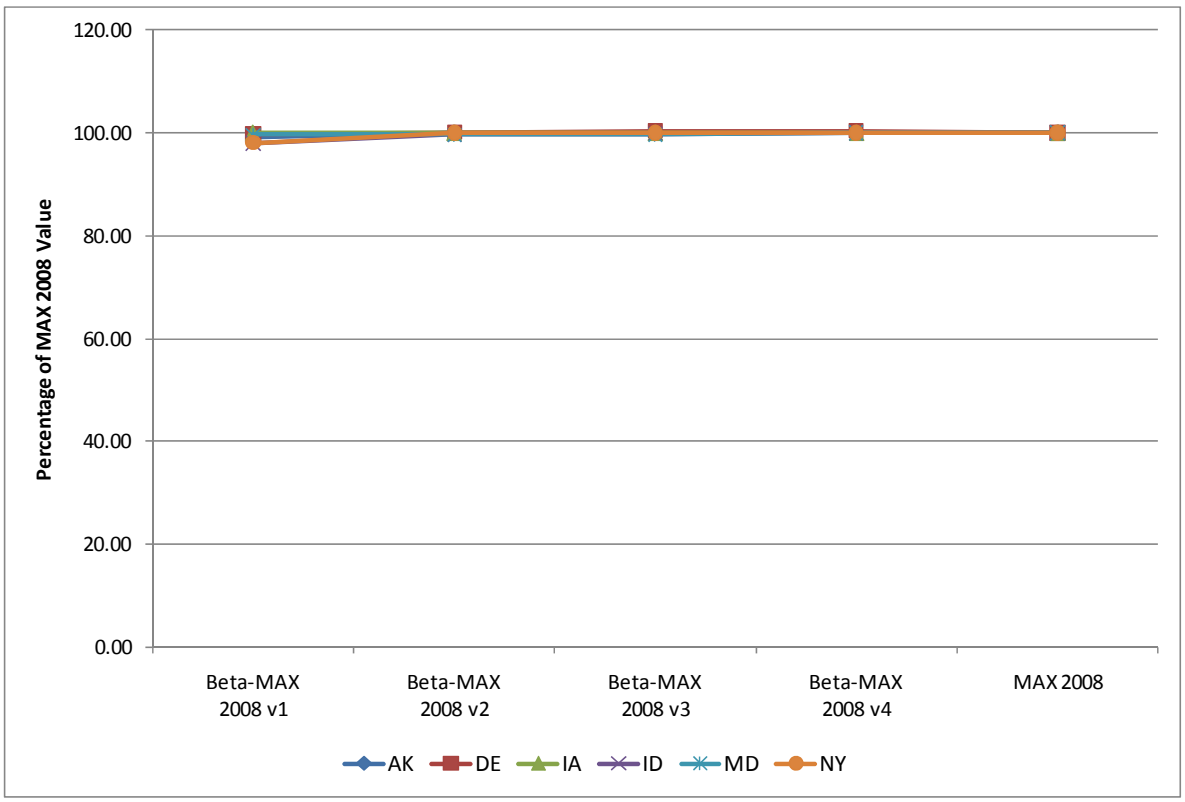
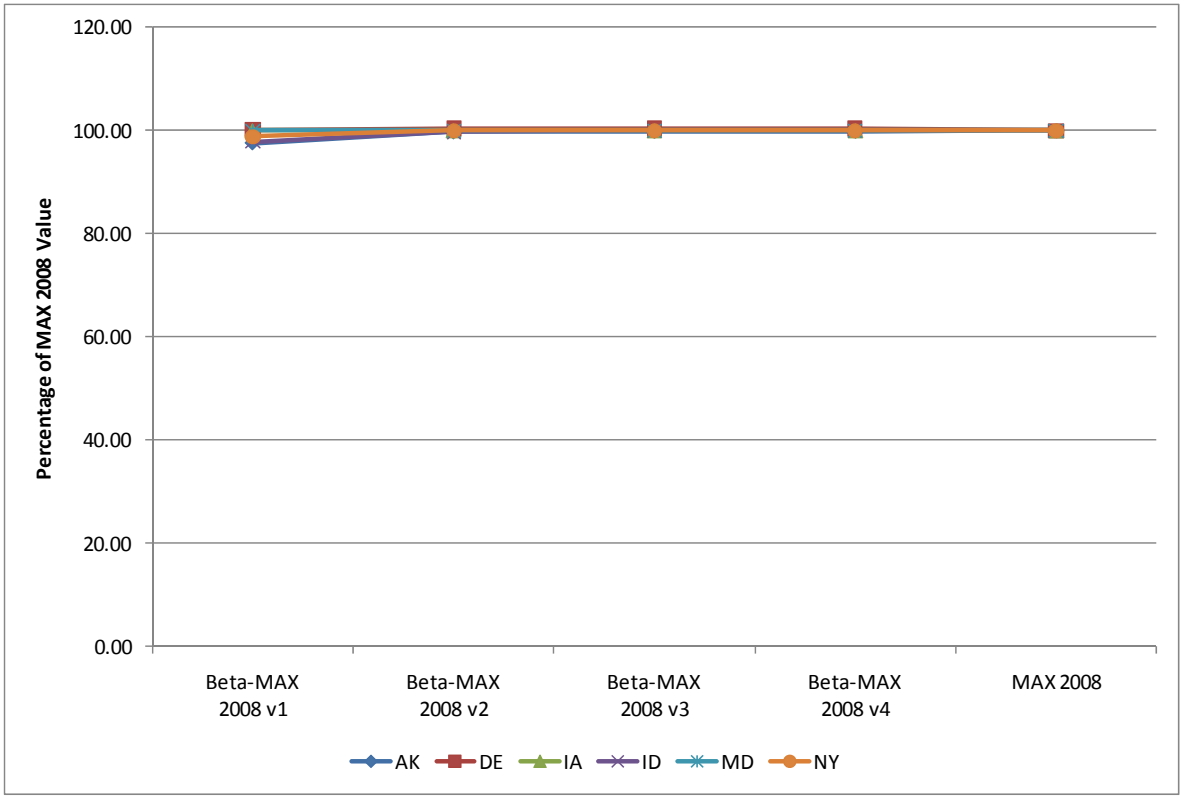
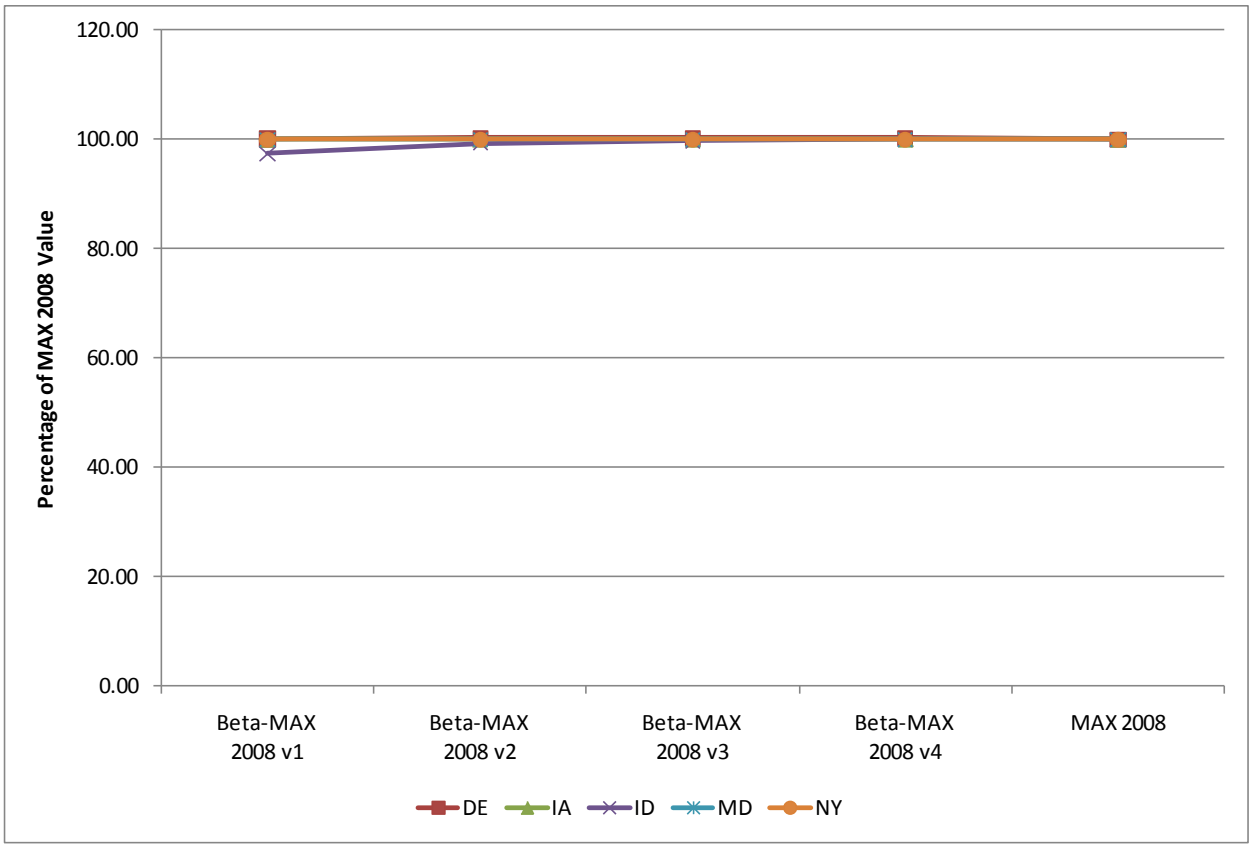


Figure II.9. Number of Child Enrollees, as a Percentage of MAX 2008 Values



Finally, as shown in Figure II.10, the number of enrollees in managed care in the v1 Beta-MAX files ranges from 97.37 percent in Idaho to 100 percent in Maryland. Alaska is not shown in Figure II.10 because it has no Medicaid managed care programs. The counts of managed care enrollees in each of the four major eligibility groups (aged, disabled, child, and adult) and the counts of those in particular types of managed care plans also appear to be very close to the full MAX value in v1 of Beta-MAX.

Figure II.10. Number of Enrollees in Managed Care, as a Percentage of MAX 2008 Values



D. Summary

The production software and eligibility business rules changed slightly between MAX 2007 and MAX 2008. In most cases, however, the effect of these changes on the differences between MAX (using the new software and rules) and Beta-MAX (using the 2007 software and rules) was minimal. Similarly, the effect of using fewer quarters of retroactive and eligibility records

four quarters of MSIS eligibility are sufficient for making high-quality Beta-MAX files, even for states that regularly submit retroactive and correction records. While it is possible to produce slightly more accurate eligibility counts by including additional quarters of retroactive and correction records, the improvement is not sufficiently large to justify the additional time needed to wait for these data to be submitted by the states.

III. CLAIMS

In both MAX and Beta-MAX, there are four types of claims files. The inpatient hospital (IP) file contains claims for inpatient hospital services. The long-term care (LT) file contains claims for long-term care received in institutions such as nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric hospitals. The other services (OT) file contains claims for services provided in the community, in hospitals, and in long-term care facilities, as well as per-person capitation claims for services provided by managed care organizations. The prescription drug (RX) file contains claims for prescription drugs and durable medical equipment prescribed by a pharmacist. Each claim file contains original and adjustment claims (voids, resubmits, credits, and debits). Mathematica uses adjustment rules to define how adjustment claims should be combined with an original claim to generate a single "final action" claim, which is easier for researchers to use than the raw claims.

Adjustment records can have effects of varying size. Some adjustments could change the payment amount by only a few dollars. Others could change payment amounts by hundreds or even thousands of dollars. Some original claims might have only one adjustment claim (for example, a credit) while others might have many adjustment claims (for example, a void-resubmit-void-resubmit or a credit-debit). The number of adjustment records in a file does not predict the magnitude of their impact.

To further complicate the adjustment process, many claims are not submitted immediately after a service is provided. Instead, claims go through an adjudication process that can delay their submission to MSIS. As shown in the design report, this lag is especially true for adjustment claims, but also affects original claims. IP and OT original claims lag more than LT and RX claims. Adjustment claims lag behind original claims and are more likely than original claims to

arrive in the calendar year following the one in which the service was performed. RX adjustment claims have the shortest lag compared to the other files.

The lag can have a profound impact on the payment amount on the final action claim shown in MAX or Beta-MAX. For example, assume the adjustment set includes an original $100 claim, a $100 void, a $100 resubmit, and a $50 credit, and each claim arrives in the subsequent quarter. Table III.1 shows four scenarios with different lag times. In scenario 1, all adjustments arrive within four quarters. In scenario 2 there is a one-quarter lag between the original claim and the adjustments, in scenario 3 there is a two-quarter lag, and scenario 4 has a three-quarter lag. In all four scenarios, the final action claim would be $50 if we used seven quarters of data. If we used fewer than seven quarters, however, the final action claim would vary between $0, $50, and $100 depending on the lag in the adjustments and the number of quarters of data included. This is the reason why, historically, MAX files have included at least three quarters of data beyond the calendar year.

Table III.1. How Lags Can Affect the Final Action Claim

	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Quarter with the Claim				
FY 2008 Q2	Original $100	Original $100	Original $100	Original $100
FY 2008 Q3	Void $100	Lag	Lag	Lag
FY 2008 Q4	Resubmit $100	Void $100	Lag	Lag
FY 2009 Q1	Credit $50	Resubmit $100	Void $100	Lag
FY 2009 Q2	No adjustment	Credit $50	Resubmit $100	Void $100
FY 2009 Q3	No adjustment	No adjustment	Credit $50	Resubmit $100
FY 2009 Q4	No adjustment	No adjustment	No adjustment	Credit $50
Final Action Claim				
Beta-MAX v1	$50	$100	$0	$100
Beta-MAX v2	$50	$50	$100	$0
Beta-MAX v3	$50	$50	$50	$100
Beta-MAX v4	$50	$50	$50	$50

In contrast to the eligibility analysis, which showed little difference in the level of impact caused by changes to the MAX software and business rules and by the inclusion of retroactive and correction records, the claims analysis is more directly affected by the number of quarters of data. The primary purpose, therefore, of the Beta-MAX pilot claims analysis was to measure the impact of using fewer than seven quarters to produce the final action claims belonging to CY 2008. We first evaluated the impact of the quarters by examining all of the measures in the validation tables (Appendix A). As with the eligibility data, we examined closely any Beta-MAX measure that differed from the MAX 2008 value by more than 20 percent (higher or lower). We paid special attention to three measures that provide the best indication of the overall quality of the data: total expenditures, average expenditures, and total number of users. We then examined the impact of using the claims business rules from the preceding MAX year. We conclude this chapter with our recommendations.

A. Impact on IP Claims

To assess the impact on IP claims, we examined the IP validation tables and the IP measures in the PS validation tables. Specifically, we compared each validation measure in each Beta-MAX version (v1, v2, v3, and v4) to the values in MAX 2008 for each of the six Beta-MAX states (see Appendix A). We also compared the total expenditures, average expenditures, and number of users of inpatient hospital services in the PS validation tables.

As shown in Figure III.1, the Beta-MAX values for total IP expenditures among FFS non-dual enrollees are near or below the 80 percent mark for all states in v1. This is especially true in Maryland, where the Beta-MAX v1 total expenditure is only 67 percent of the value in the MAX 2008 file. The measure improves substantially in the Beta-MAX v2 file—all states are above the 80 percent mark and Maryland's value is now 83 percent of the MAX 2008 file.

The average Medicaid amount paid for inpatient claims among FFS non-dual enrollees is also low relative to the MAX 2008 value for most states in Beta-MAX v1, as shown in Figure III.2. The average amount paid for Maryland in v1 is 69 percent of the MAX 2008 value; the average amount paid for Delaware in v1 is 79 percent of the MAX 2008 value. In v2, including just one additional quarter of data brings all of the states above 85 percent of the MAX 2008 value.

Figure III.1. Total FFS Medicaid Amount Paid for Non-Dual Enrollees in Inpatient Hospitals, as a Percentage of MAX 2008 Values

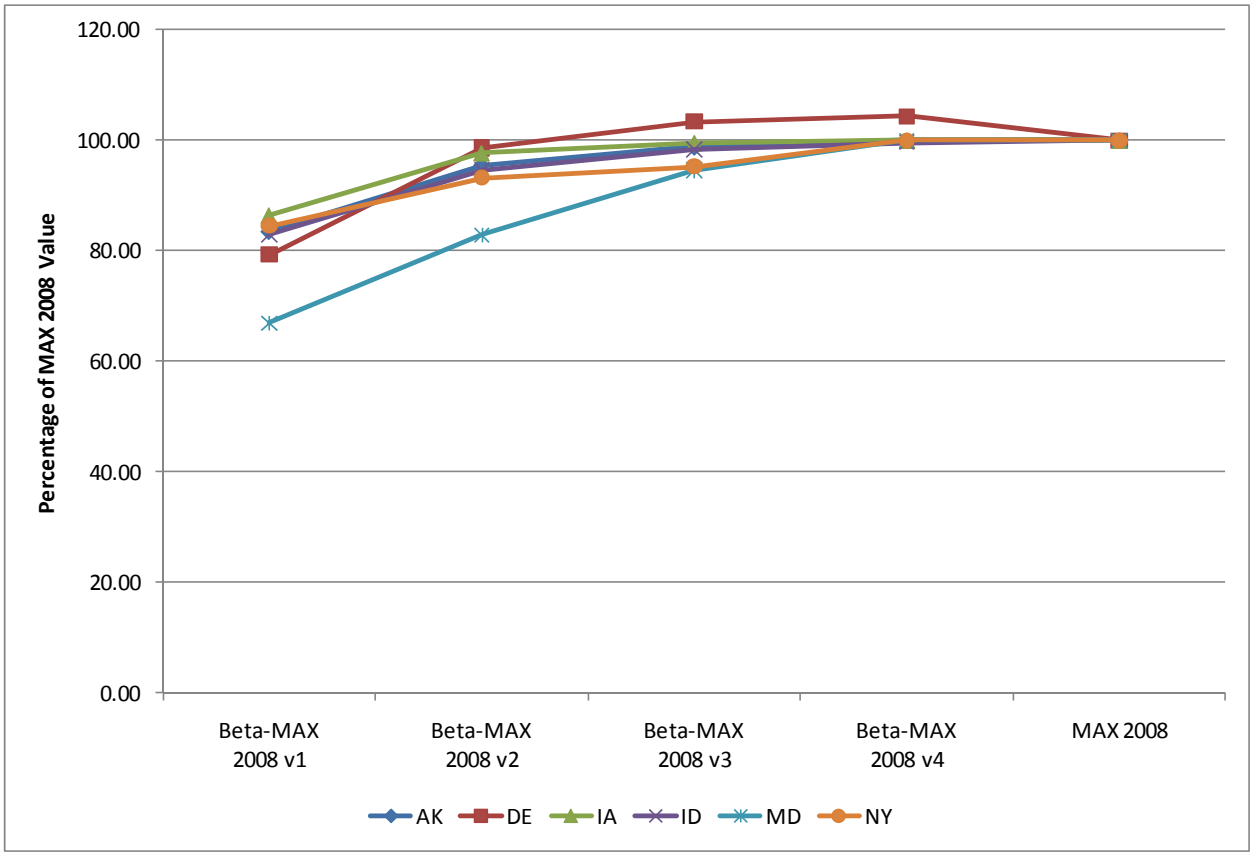
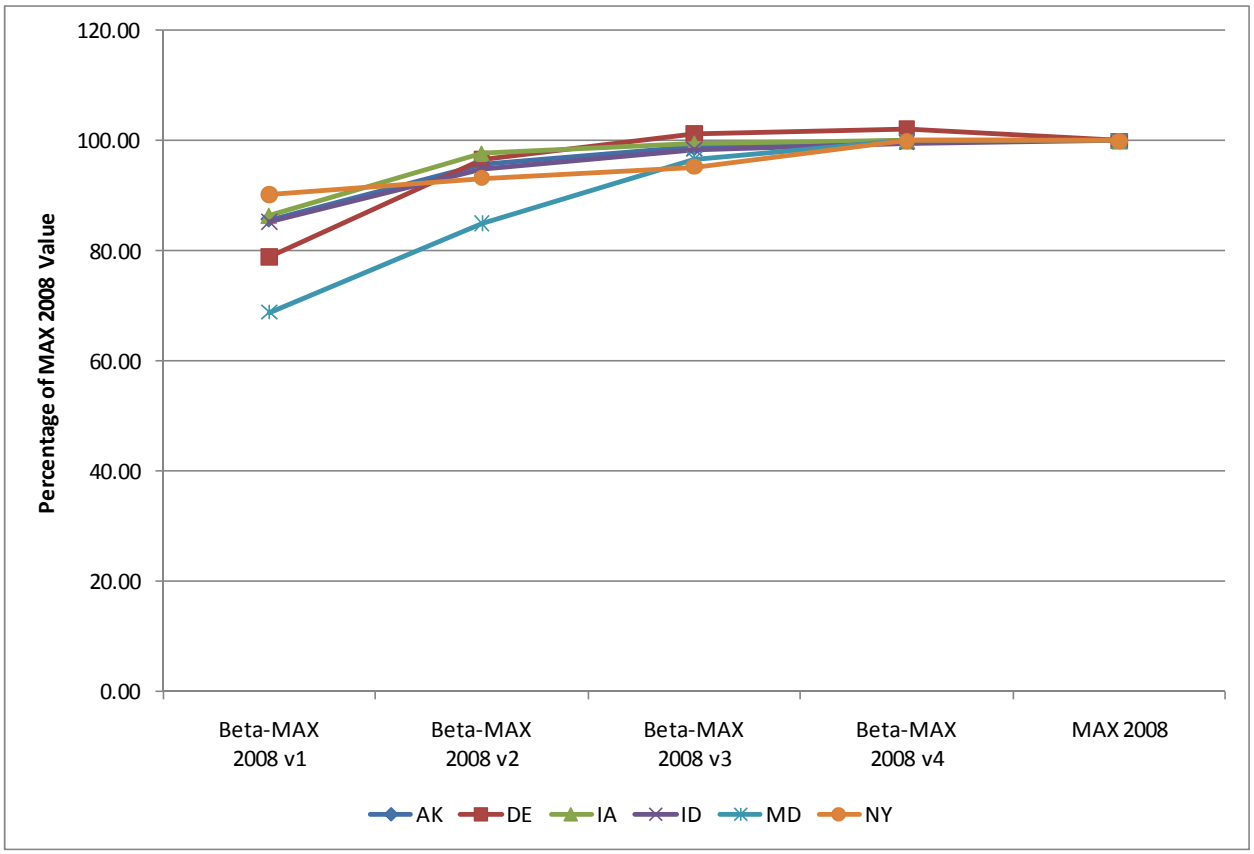
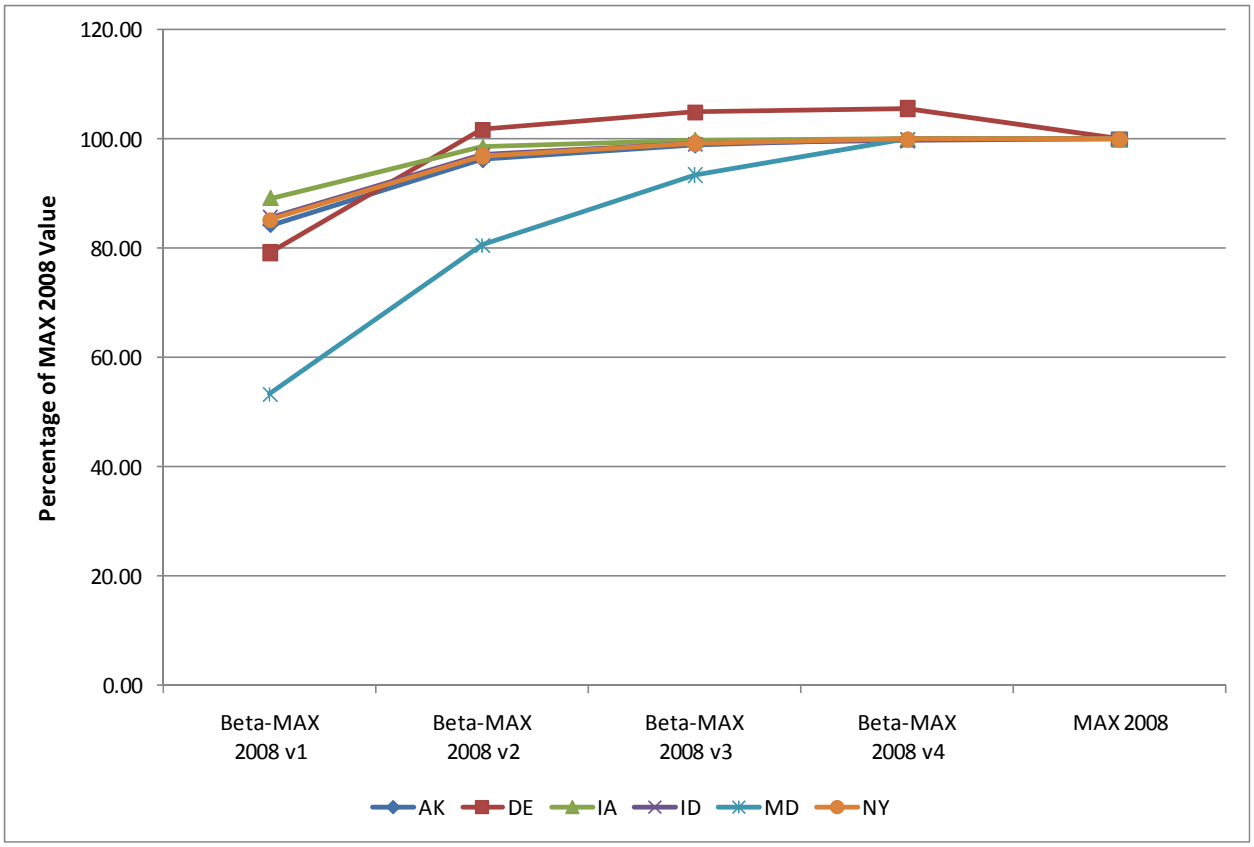


Figure III.2. Average FFS Medicaid Amount Paid per Non-Dual Enrollee in an Inpatient Hospital, as a Percentage of MAX 2008 Values



The number of FFS non-dual enrollees with at least one inpatient hospital claim is shown in Figure III.3. Again, Maryland and Delaware fall below the 80 percent mark in Beta-MAX v1. The value in Maryland is quite low, capturing only 53 percent of the number of IP users reflected in MAX 2008, whereas Delaware is just below the 80 percent mark. In the Beta-MAX v2 file, Maryland's measure moves above the 80 percent mark and values in the other states are close to 100 percent of the MAX 2008 value.

Figure III.3. Number of FFS Non-Dual Users of Inpatient Hospital Services, as a Percentage of MAX 2008 Values



There is a substantial difference between v1 and the MAX 2008 version in a few other Beta-MAX measures as well. The percent of claims that are adjusted tends to vary with the number of quarters of input data. As might be expected, this value is often lower in v1 and generally increases as additional quarters of data are added. For example, in the IP file for Maryland in Beta-MAX v1, 1.94 percent of the claims were adjusted. In the Beta-MAX v2, v3, and v4 files, respectively, 2.02 percent, 4.50 percent, and 4.65 percent of the IP claims were adjusted. This compares with 4.65 percent of claims adjusted in the MAX 2008 file. Related measures, such as average Medicaid amount paid among adjusted claims, are affected in the same way. For example, the Beta-MAX v1 values for average amount paid (among adjusted claims) in the IP files in Delaware and Maryland are less than 70 percent of the value in the MAX 2008 file. This could be the result of original claims or debits adding to the average amount, or could be due to

adjustments applied to more expensive, previously unadjusted claims. In contrast, Iowa's Beta-MAX v1 value is over 130 percent of the MAX 2008 value, indicating that voids or credits are reducing the amount paid per user, or that less expensive previously unadjusted claims are being adjusted later files. As additional quarters of data are added to each file, the percent of adjusted claims and the average amount paid among those claims become closer to the value in MAX 2008.

Another measure that is often lowest in Beta-MAX v1 and typically increases as additional quarters of data are added is the number of claims that do not link to an eligibility record, as discussed in Chapter II. This pattern is seen across all states and all claim types, indicating that it is most likely related either to the submission of retroactive or correction records that are disenrolling people or to people receiving Medicaid services before they are enrolled.

One final measure that is often substantially lower in Beta-MAX v1 is the percentage of claims with third-party liability. For example, in Alaska in v1, this measure is only 65 percent of the MAX 2008 value. The measure increases as additional quarters of data are added, most likely because it takes more time for third-party liability to be established and for adjudication procedures to show up in the data. The impact of differences in third-party liability is likely to be minor, however, because only a small percentage of claims are affected.

In summary, the four-quarter v1 Beta-MAX file is not sufficient for research on inpatient claims. Adjustments can affect a large portion of inpatient claims and they tend to lag longer than in other types of claim files. At least one state repeatedly did not achieve the benchmark of 80 percent of the MAX 2008 value. Consequently, Mathematica recommends that a minimum of five quarters of IP claims files should be used to produce Beta-MAX files.

B. Impact on LT Claims

To assess the impact of fewer quarters of data on LT claims, we examined the LT validation tables and the LT measures in the PS validation tables (Appendix A). Overall, the Beta-MAX v1 measures compare well to the MAX 2008 value for almost all measures. In the few instances in which there is a difference, it affects only a small group of records or a very low payment amount.

As shown in Figure III.4, total long-term care expenditures among FFS non-dual enrollees are above the 80 percent mark in each version of Beta-MAX in all six states, reaching close to 100 percent of the MAX 2008 value in v2, v3, and v4. Likewise, the average amount paid for long-term care claims among FFS non-dual enrollees (Figure III.5) and the number of FFS non-dual users of long-term care services (Figure III.6) are well above the 80 percent mark in all versions and close to 100 percent in Beta-MAX v2, v3, and v4.

Figure III.4. Total FFS Medicaid Amount Paid for Non-Dual Enrollees for Long-Term Care, as a Percentage of MAX 2008 Values

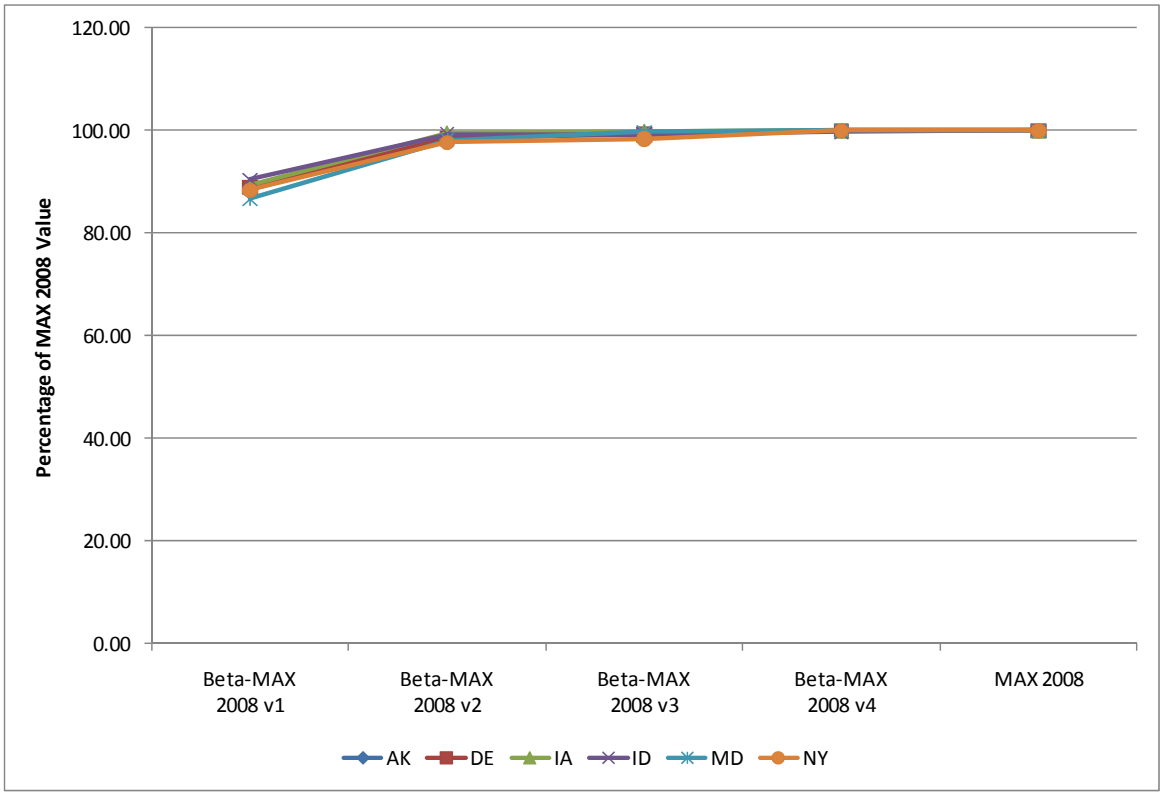


Figure III.5. Average FFS Medicaid Amount Paid per Non-Dual Enrollee for Long-Term Care, as a Percentage of MAX 2008 Values

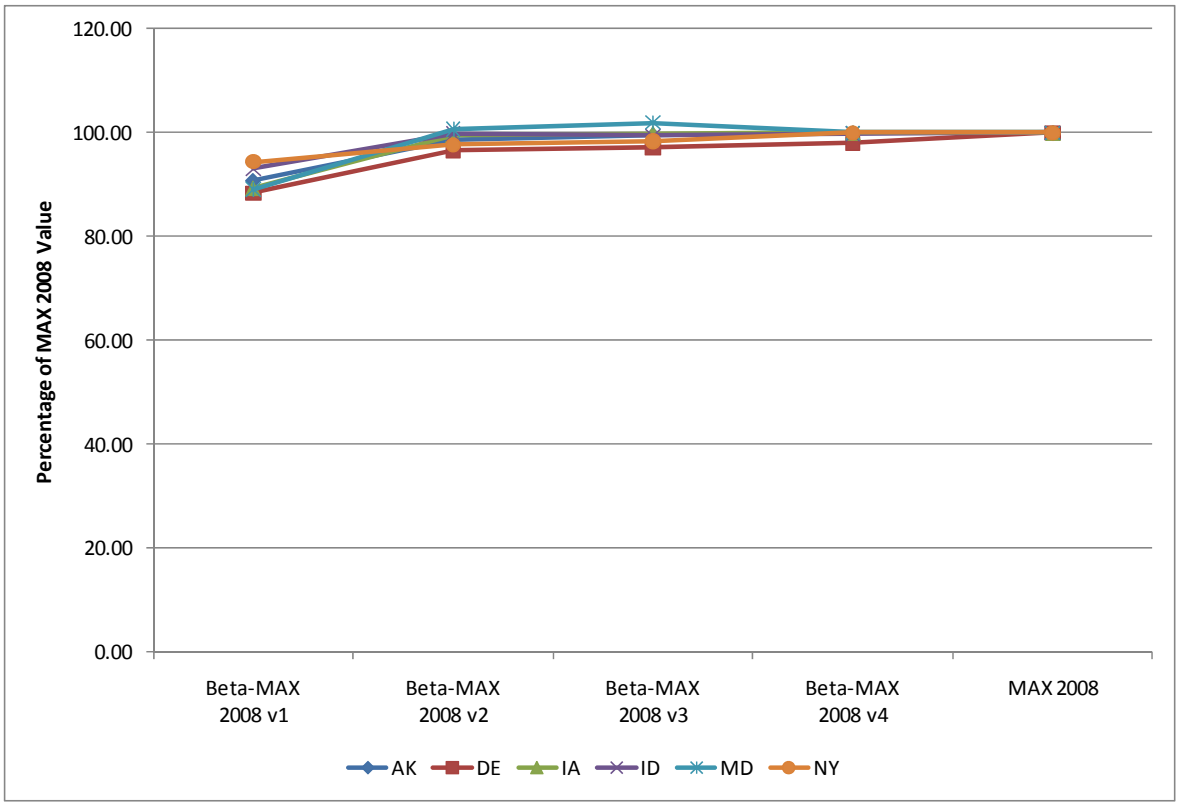
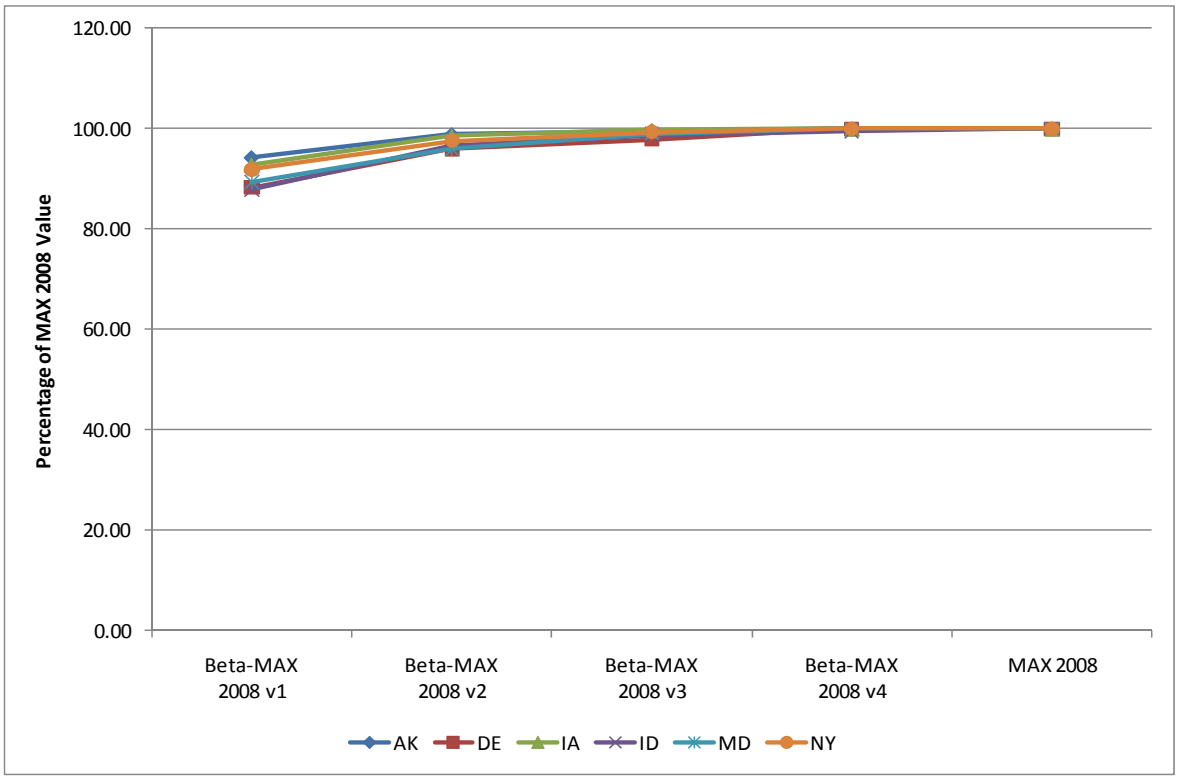


Figure III.6. Number of FFS Non-Dual Users of Long-Term Care Services, as a Percentage of MAX 2008 Values



There are two other groups of Beta-MAX measures worthy of mention. First, the percent of claims reporting a particular patient status (returned home, still a patient, died) tend to fluctuate a bit as additional quarters are added. This fluctuation was especially strong in categories representing the smallest percentages of claims. For example, the Beta-MAX v1 files in Alaska and Iowa show 1.21 percent and 1.25 percent, respectively, of FFS crossover claims reporting the death of the patient. This represents 78 percent of the MAX 2008 value in Alaska and 71 percent of the MAX 2008 value in Iowa. Second, the percentage of long-term care claims by type of facility (such as nursing facilities, inpatient psychiatric facilities, or mental hospitals) also varied across Beta-MAX versions. For example, the percentage of FFS non-crossover claims for inpatient psychiatric services for enrollees under the age of 21 in the v1 file for Delaware is only 30 percent of the MAX 2008 value. Although the percentage differences between the Beta-MAX v1 and MAX 2008 values for these measures are large, they apply to a small number of claims and have minimal impact on overall data quality in the long-term care file.

In New York, there is one additional measure to note. The Beta-MAX v2 file has a 4.4 million *reduction* in the total number of claims compared to the v1 file. This is caused by the inclusion of roughly 4.4 million originals and debits in the Beta-MAX v1 file that are completely offset by credits contained in the fifth quarter of data. The dollar amount of these claims must have been small, as there was no significant downward effect on the total or average long-term care expenditures.

Beta-MAX v1 values compare well to the MAX 2008 value for almost all measures. In the few instances where there is a difference, it affects a very small group of records or a low payment amount. Consequently, Mathematica considers four quarters of data sufficient for Beta-MAX long-term care claims files.

C. Impact on OT Claims

As with the IP and LT files, to assess the impact on OT claims we examined the OT validation tables and the OT measures in the PS validation tables (Appendix A). As shown in Figures III.7 and III.8, the total Medicaid amount paid among FFS non-dual enrollees and the average Medicaid amount paid per FFS non-dual enrollee in Beta-MAX v1 compare well to the MAX 2008 value. For all states except Maryland, as shown in Figure III.9, the number of users reported in Beta-MAX v1 is at least 90 percent of the MAX 2008 value. Maryland, however, is a clear outlier in this measure, reporting only 69 percent of the MAX 2008 value.

Figure III.7. Total FFS Medicaid Amount Paid for Non-Dual Enrollees Using Other Services, as a Percentage of MAX 2008 Values

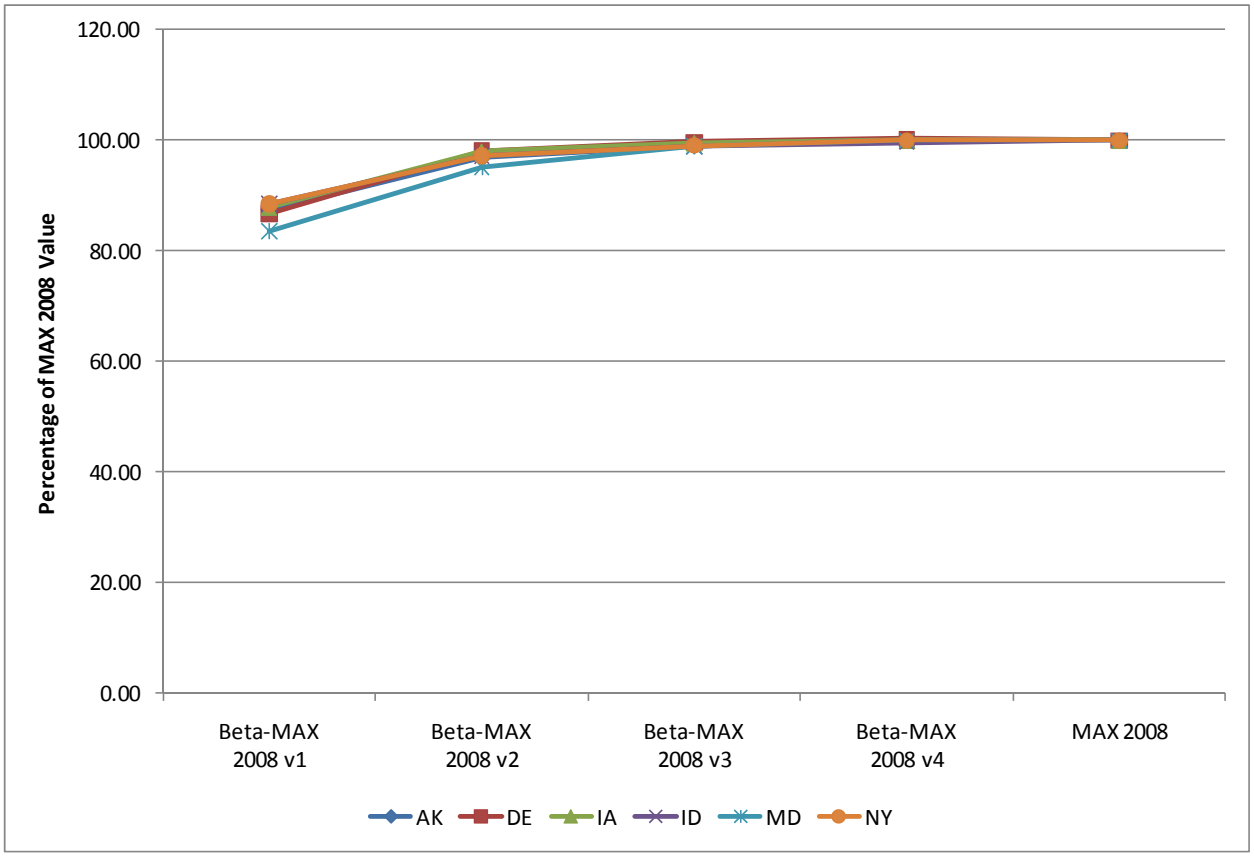


Figure III.8. Average FFS Medicaid Amount Paid per Non-Dual Enrollee for Other Services, as a Percentage of MAX 2008 Values

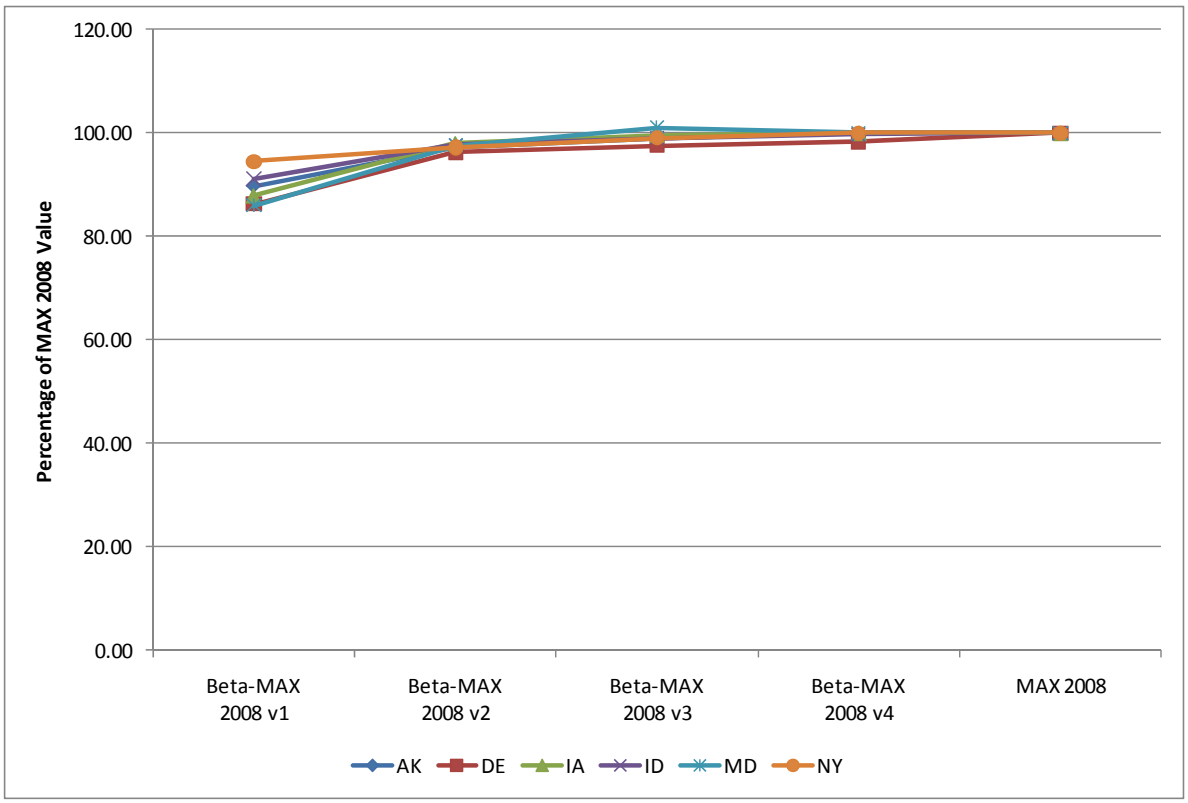
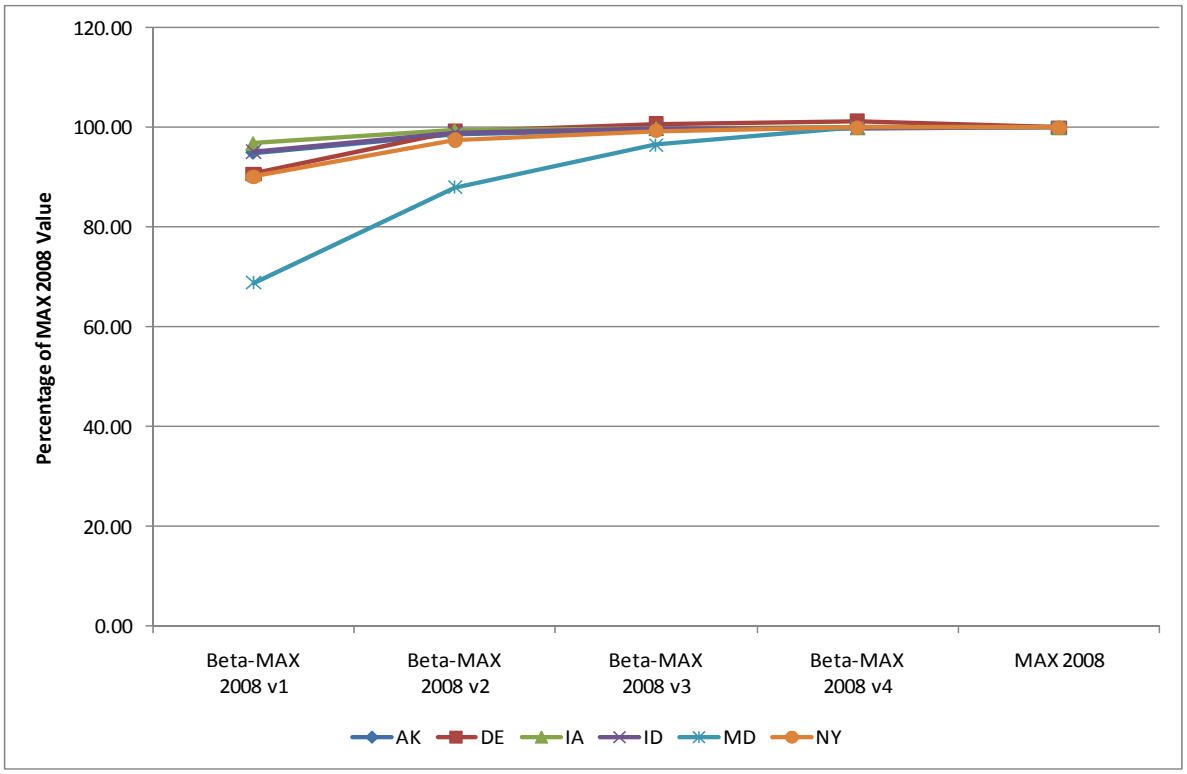


Figure III.9. Number of FFS Non-Dual Users of Other Services, as a Percentage of MAX 2008 Values



A closer look at other measures in Maryland's Beta-MAX v1 file reveals that the "missing" users (that is, the enrollees who have zero claims in the first four quarters of data, but who have claims in the sixth or seventh quarters) are primarily children and non-aged, non-disabled adults. The validation tables demonstrate that these individuals are primarily using clinic and physician services. Since the total Medicaid amount paid in Maryland's Beta-MAX v1 file is in line with other states' v1 files, it is clear that these late-arriving claims are not among the more expensive OT claims. However, researchers interested in studying physician or clinic services among these two eligibility groups may find that four quarters of OT data are inadequate for Maryland in 2008.

The different versions of the Beta-MAX files demonstrate some fluctuations in type of service (TOS), place of service, and categorizations of community long-term care (CLTC) claims. The fluctuation is especially strong in the categories representing very small numbers of

claims, which vary somewhat from state to state. In particular, the total Medicaid amounts paid for TOS 34 (PT/OT/Speech/Hearing) and TOS 35 (Hospice) seem low in v1 for many states. Researchers who are interested in studying claims for more narrow types of service categories should carefully examine Appendix A before using a Beta-MAX files constructed with fewer than seven quarters of OT files.

There are a few other measures for which the v1 Beta-MAX file looks incomplete, although they are usually measuring only a small number of claims. A closer look at Idaho reveals that the percentage of FFS crossover outpatient claims with a span bill (that is, a bill that covers more than one day of service) is 35 percent of the MAX 2008 value. Additionally, as with IP claims, the percentage of OT claims with third-party liability is often substantially lower in Beta-MAX v1 across almost every state. Because this measure is based on a very small percentage of claims, however, it does not represent a significant data quality problem with the Beta-MAX v1 file.

Despite the lag in adjustment claims and the concern regarding the number of users of specific types of services in Maryland, Mathematica believes that four quarters of OT claims are generally sufficient for research on larger populations and for types of services that are broadly defined. More specific or finely tuned research questions may require additional quarters of OT claims to achieve similar results to those that could be achieved with a MAX 2008 file.

D. Impact on RX Claims

To assess the impact on RX claims, we examined the RX validation tables and the RX measures in the PS validation tables (Appendix A). In Beta-MAX v1, the total Medicaid amount paid among FFS non-dual enrollees (Figure III.10), the average Medicaid amount paid per FFS non-dual enrollee (Figure III.11), and the number of users receiving prescription drugs (Figure III.12) compare well to the MAX 2008 value. In every state, these measures are at least 92 percent of the MAX value. For most other measures in the RX validation tables, the values in

Beta-MAX v1 are extremely close to the MAX 2008 values. Consequently, Mathematica considers four quarters of RX claims to be sufficient for Beta-MAX.

Figure III.10. Total FFS Medicaid Amount Paid for Non-Dual Enrollees for Prescription Drugs, as a Percentage of MAX 2008 Values

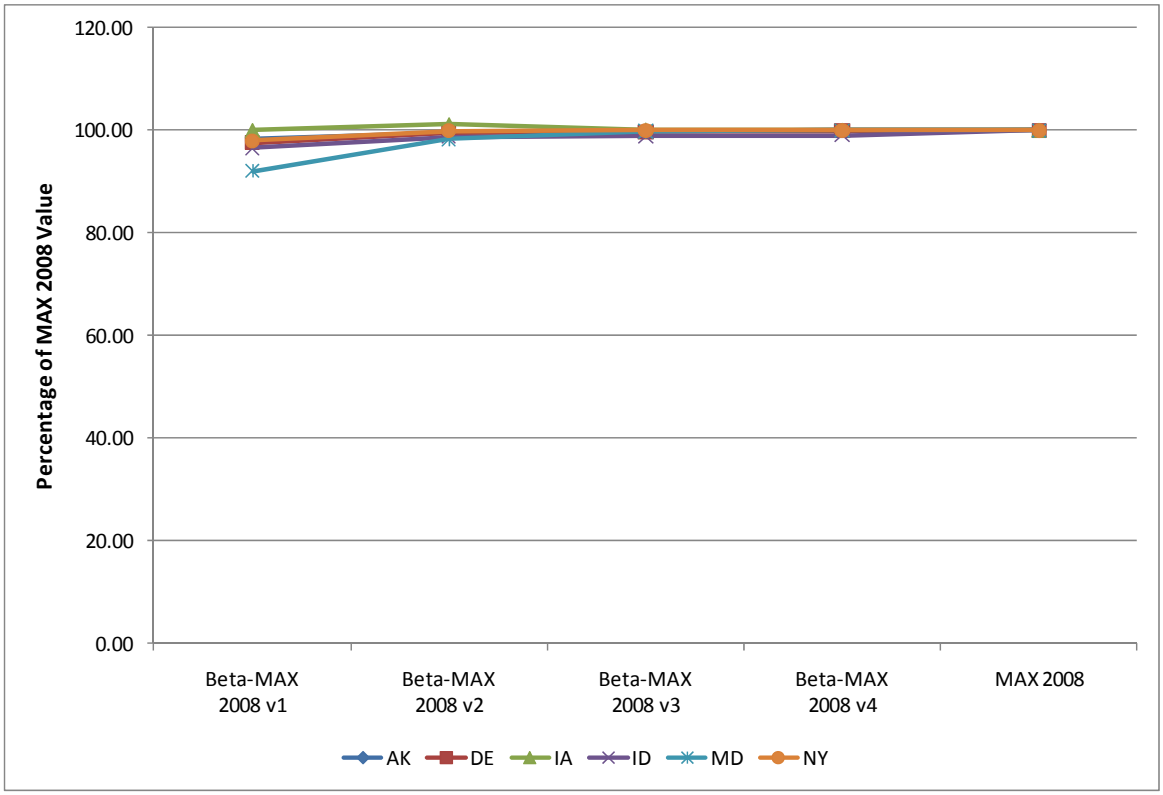


Figure III.11. Average FFS Medicaid Amount Paid per Non-Dual Enrollee for Prescription Drugs, as a Percentage of MAX 2008 Values

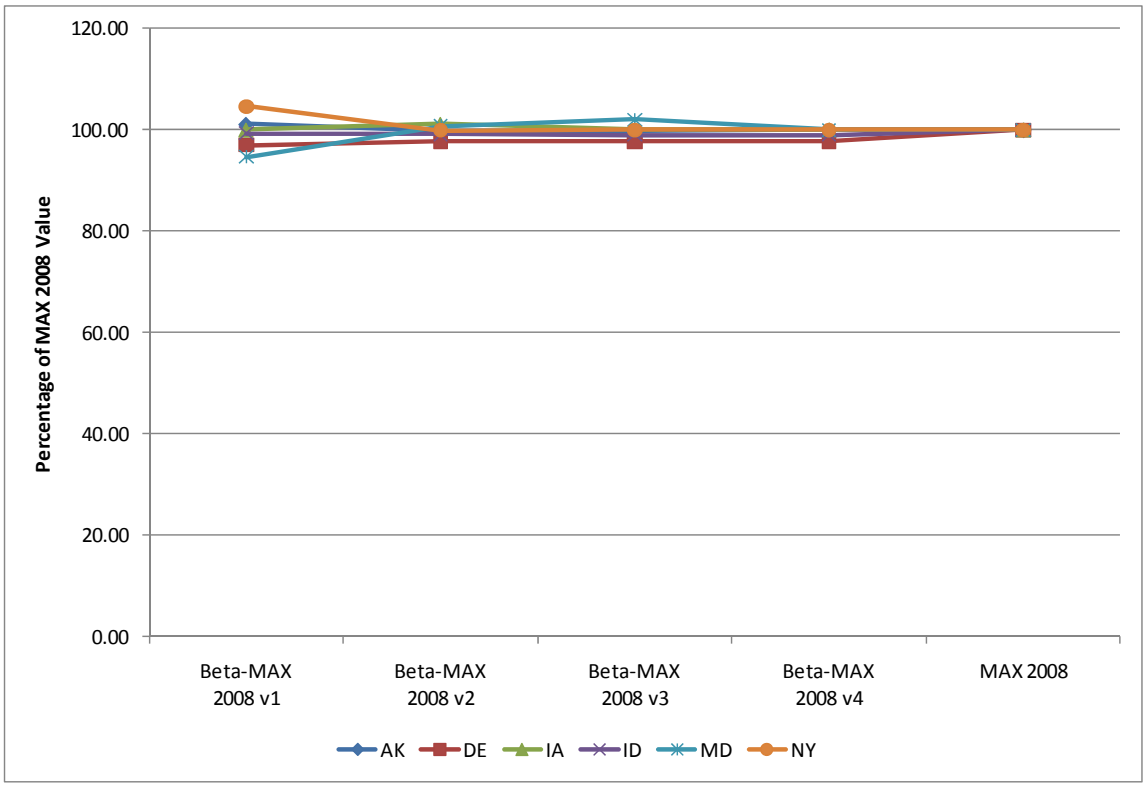
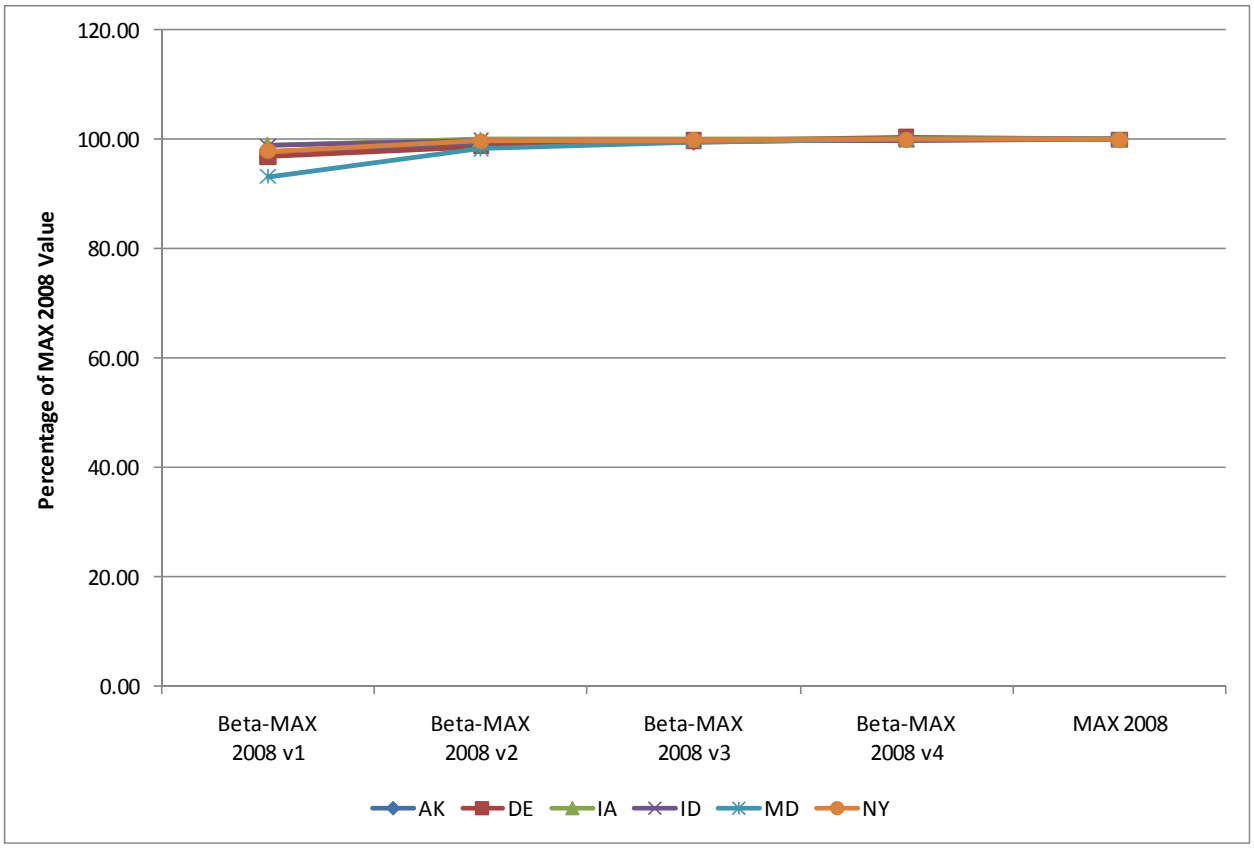


Figure III.12. Number of FFS Non-Dual Users of Prescription Drugs, as a Percentage of MAX 2008 Values



E. Impact of Claims Business Rules

In addition to changing the number of quarters of input data, using the previous year's business rules can also have a substantial impact. There are three types of business rules: (1) adjustment rules, (2) type of service (TOS) mapping rules, and (3) other business rules. We discuss each one below and describe their impacts on Beta-MAX files.

1. Adjustment Rules

Adjustment rules ensure that MSIS adjustment claims (voids, resubmits, credits, and debits) are properly applied to the original claim. In MAX, the creation of adjustment rules currently involves inferring the adjustment set by assembling all claims for the same person, provider, and date of service, then manually inspecting several types of adjustment sets (for example, original-void-resubmit or original-credit-debit). Rules are written based on the inspection and

conversations with the state. When an adjustment set does not conform to the standard set of adjustment rules, it is reclassified as nonstandard and monitored closely from year to year. If the number of nonstandard adjustments grows substantially, new adjustment rules are developed accordingly. The adjustment rules focus primarily on FFS and encounter claims. Capitation and supplemental claims are not adjusted, although they are part of MAX (and Beta-MAX) files.

When a state submits many unexpected adjustment combinations, new adjustment rules are written. There were no new rules for Beta-MAX pilot states in MAX 2008. Because the rules did not change, the use of the 2007 adjustment rules in Beta-MAX did not affect any of the Beta-MAX files. Although adjustment rules can change (for example, there was a new adjustment rule for Colorado in MAX 2007), such changes are rare and not likely to have a huge impact. During the past few years, the claims adjustment rules have been relatively stable, with very few changes.

However, one change on the horizon will influence future Beta-MAX files in a more significant way: the use of the Internal Control Number (ICN) on MSIS claims. The ICN is intended to specify the adjustment claims belonging to each original claim. States began submitting ICNs in MSIS in the first quarter of FFY2009. Although CMS currently requests, rather than requires, this data element, we anticipate that the ICN will drive the adjustment rules in MAX 2009 production in states that are using the ICN properly in at least 98 percent of their claims. Because Beta-MAX 2009 will be using the adjustment rules from MAX 2008 (and not the new rules developed for MAX 2009 using the ICN), Beta-MAX 2009 could be substantially different from MAX 2009.

We are currently evaluating the impact of the ICN on the adjustment rules. If the new rules have a profound impact on the results, Mathematica will communicate that message to the research community in our documentation about Beta-MAX.

2. TOS Mapping Rules

In MAX, we use TOS mapping rules to recode procedure (service) codes from the vague "other" services MSIS TOS "19" category into four more detailed MAX TOS categories:

- Durable medical equipment (DME) and supplies (MAX TOS = 51)
- Residential care services (MAX TOS = 52)
- Psychiatric services (MAX TOS = 53)
- Adult day care services (MAX TOS = 54)

We also recode laboratory and imaging services into the proper "lab and X-ray" MAX TOS "15" category, because not all states properly code such services. Among undefined services, we use the uniform billing (UB) revenue codes to classify them into the appropriate MAX TOS category. The TOS mapping rules include both national procedure codes and state-defined codes. Claims not affected by the remapping rules have a MAX TOS equal to the MSIS TOS.

Similar to the adjustment rules, the TOS mapping rules have also stayed fairly consistent from one MAX year to the next. Mathematica plans to use the previous MAX year's TOS mapping rules in Beta-MAX. Consequently, as part of the Beta-MAX pilot, we assessed the effect of using the previous year's (2007) TOS mapping rules by comparing the Beta-MAX v4 file to the MAX 2008 file. The two files contain precisely the same input data, so discrepancies in TOS codes between Beta-MAX v4 and MAX 2008 can be attributed to changes in the TOS mapping rules.

The use of the 2007 TOS mapping rules in Beta-MAX caused changes in several states, but in all cases the effects are quite small. For example, in Alaska, two new TOS mapping rules in MAX 2008 affected services mapped into TOS 53 (Psychiatric services). In Beta-MAX, the claims were not remapped and continued to be assigned to TOS 19 (other services) instead. These services account for only about $2,820 out of over $70 million, and therefore have a very small effect on the data. In New York, a new TOS mapping rule in MAX 2008 also affected services

mapped into TOS 53 (Psychiatric services). In Beta-MAX, these claims were mapped to TOS 12 (clinic services) instead. These services account for $18,942 out of more than $1.2 billion—also a very small effect. Changes due to new TOS mapping rules in the other Beta-MAX states are of equal or smaller magnitude.

Although the impact of TOS rule differences was minor in the Beta-MAX states, there could be rules in some states in the future that might have major impact. It is difficult to predict if or when a state will start using a new TOS that needs to be remapped into the four special services. Consequently, we recommend using the previous year's TOS remapping rules in Beta-MAX, but remaining vigilant to detect changes. If it is determined during a given MAX year that new rules are needed and that they will have a substantial impact on future results, we will communicate that message to the research community in our documentation about Beta-MAX.

3. Other Business Rules

As with the eligibility business rules, claims business rules are periodically revised to improve the quality of the MAX data. Examples include times when a state has erroneously submitted capitation claims for people who are not in a full risk-bearing managed care plan, or when the plan ID on the claims is in a different format (such as with leading zeroes or extra digits at the end) than the plan ID on the eligibility record. Since claims are classified by type of managed care plan (which can only be obtained from the eligibility record), data cleaning rules are necessary to ensure these plan IDs link across the file types. Because these rules are fairly consistent from one MAX year to the next, we plan to use the previous year's rules in Beta-MAX.

New data cleaning rules were implemented in MAX 2008 in two states included in the Beta-MAX pilot—Idaho and New York. In both cases the rules fixed a formatting difference between

the plan IDs on the eligibility record and those on the claims. The rules improve the plan type assigned to the managed care claim, but have no effect on expenditures or service utilization.

Although the impact of these data cleaning rules was minor in the Beta-MAX states, there could be some rules in some states in the future where such rules might have a major impact. It is difficult to predict when a state will need a data cleaning rule. Consequently, we recommend using the previous year's data cleaning rules in Beta-MAX but remaining vigilant for changes. If it is determined during a given MAX year that new rules are needed and that they will have a substantial impact on future results, we will communicate that message to the research community in our documentation about Beta-MAX.

F. Summary and Recommendations

The results of the Beta-MAX pilot present a clear picture of the potential effects of the Beta-MAX design decisions on the claims files. The use of the adjustment rules, TOS mapping rules, and other business rules from the previous MAX year generally had very little effect. Although adjustment claims tend to lag behind original claims, in most of the Beta-MAX pilot files this lag had little overall effect on the total Medicaid amount paid, average Medicaid amount paid, or number of users. The claims categories that seemed most incomplete in the v1 Beta-MAX files represent only a small percentage of the total claims in each file. For many types of research projects, especially those looking at large populations or coarsely defined statistics, the pilot results suggest that Beta-MAX files based on **four** quarters of MSIS data could be sufficient for LT, OT, and RX claims files. In the IP file, however, Mathematica recommends including at least **five** quarters.

IV. AUTOMATED VALIDATION SYSTEM

A. Introduction

In addition to differences in data content and production software, one important way that Beta-MAX files differ from full MAX files is the purpose and design of the data quality review process. Full MAX files typically undergo multiple rounds of careful manual review, including a review of all 1,500 measures in the MAX validation tables (Appendix A). The reviews uncover data quality problems that were not apparent during MSIS reviews, often because they are the result of retroactive, correction, or adjustment records, or because they are noticeable only when claims are combined with eligibility information. These new data quality problems can frequently be fixed (or at least mitigated) by instituting new business rules in MAX. The manual reviews also inform the MAX anomaly notes that are made available to researchers on the MAX website.

The intention of Beta-MAX, however, is to create an early release version of MAX. The time required to manually review the validation tables would delay the release of the Beta-MAX files. Therefore, the Beta-MAX data quality review process will differ from the MAX review process in a number of ways. First, the process will be highly automated, and second, only a small subset of the measures in the validation tables will be reviewed. The preliminary list of measures selected for the Beta-MAX data quality review are shown in Table IV.1. The measures were chosen to represent the "big picture" measures, the most critical indicators of the suitability of the file for general Medicaid research.

For each Beta-MAX file, we will generate a table containing the measures listed Table IV.1. We will compare each measure in Beta-MAX to the value of the same measure in the full MAX file for the *preceding* calendar year. For example, the Beta-MAX 2009 values will be compared to MAX 2008. These tables, known as the Beta-MAX Quality Assurance (QA) tables, will be

used to catch severe data quality problems, as well as to ensure that the Beta-MAX production software is running correctly.

Table IV.1 Preliminary Beta-MAX QA Measures

Measure Name
All Records
Total number of PS records
Percentage with FFS claims and missing Medicaid eligibility (excludes S-CHIP only)
Number with any S-CHIP enrollment
Number with any M-CHIP enrollment
Percentage with duplicated SSNs (excludes missing eligibility and S-CHIP only)
Types of Claims
Percentage with no services
Percentage with FFS-only claims
Percentage with only capitation claims
Percentage with only encounter claims
Percentage with FFS and capitation claims
Percentage with capitation and encounter claims only
Percentage with FFS and encounter claims only
Percentage with FFS, capitation, and encounter claims
Long-Term Care
Number with any institutional long-term care (ILTC) claims
Average Medicaid amount paid per enrollee with ILTC claims
Number with any HCBS enrollment or claims
Number ever enrolled in 1915(c) waiver
Percentage of Section 1915(c) waiver enrollees with no waiver claims
Percentage of Section 1915(c) claim recipients with no waiver enrollment
Section 1915(c) waiver: number of non-dual FFS users
Full-Benefit Enrollees
Number of Medicaid enrollees—aged
Number of Medicaid enrollees—disabled
Number of Medicaid enrollees—child
Number of Medicaid enrollees—adult
Total Medicaid amount paid
Average Medicaid amount paid per enrollee—aged
Average Medicaid amount paid per enrollee—disabled
Average Medicaid amount paid per enrollee—child
Average Medicaid amount paid per enrollee—adult
EDB Duals
Number of EDB duals with restricted benefits
Number of EDB full-dual enrollees—aged
Number of EDB full-dual enrollees—disabled
Average Medicaid amount paid per EDB full-dual enrollee—aged
Average Medicaid amount paid per EDB full-dual enrollee—disabled
Number of non-dual FFS enrollees with MSIS dual code but no EDB confirmation
Number of EDB dual FFS enrollees
Managed Care
Ratio of HMO capitation claims to person months of enrollment
Ratio of PHP capitation claims to person months of enrollment
Number ever enrolled in an HMO during year—aged
Number ever enrolled in an HMO during year—disabled

Measure Name
Number ever enrolled in an HMO during year—child
Number ever enrolled in an HMO during year—adult
Types of Service
Total non-dual FFS Medicaid amount paid for IP services
Total non-dual FFS Medicaid amount paid for LT services
Total non-dual FFS Medicaid amount paid for drugs
Total non-dual FFS Medicaid amount paid for other services
Average Medicaid amount paid per non-dual FFS enrollee for IP services
Average Medicaid amount paid per non-dual FFS enrollee for LT services
Average Medicaid amount paid per non-dual FFS enrollee for drugs
Average Medicaid amount paid per non-dual FFS enrollee for other services
Percentage of non-dual FFS enrollees with IP claims
Percentage of non-dual FFS enrollees with ILTC claims
Percentage of non-dual FFS enrollees with drug claims
Percentage of non-dual FFS Enrollees with all other claims

The automated QA review system will monitor both the absolute change and the percent change in each measure in the Beta-MAX QA tables and compare those changes to predetermined thresholds. If the change surpasses both thresholds, the automated system will flag the measure. When a measure is flagged, Mathematica will examine the discrepancy to determine whether the data quality problem is the result of a software error, an expected change in the data (for example, due to a recent change in state Medicaid policy), or an unexpected change in the data. If it is the result of a software error, the software will be modified to address the problem and the Beta-MAX file will be produced using the revised software. If it is the result of an expected change in the data, the Beta-MAX file will be released according to the usual schedule. If the discrepancy is caused by an unexpected change in the data (for example, if total enrollment doubles and there have been no significant changes in the state's Medicaid and CHIP programs), the Beta-MAX file for that state will not be released unless the problem can be resolved in a timely manner. Most likely, in these situations, researchers will need to wait for the MAX version to resolve the problem.

B. Threshold Selection

One goal of the Beta-MAX pilot was to determine the appropriate thresholds beyond which a measure in the Beta-MAX QA tables should be flagged. At the start of the pilot, Mathematica developed software to compare these measures for each Beta-MAX pilot version to the corresponding measures from MAX 2007. Using these comparisons, Mathematica has developed a set of thresholds for each of the measures in the Beta-MAX QA tables. The thresholds are shown in Table IV.2.

Some measures presented in Table IV.1 are not shown in Table IV.2. Table IV.1 includes all measure that we think might be of interest to users. However, we learned during the pilot that some measures vary so widely among states and from year to year that it would not be helpful to include them as part of the Beta-MAX data quality review. For example, Table IV.2 does not include the percent of enrollees with only FFS claims, the percent with only capitation claims, the percent with only encounter claims, or the percent with any combination of FFS and managed care claims. Likewise, the measures pertaining to long-term care and 1915(c) waiver enrollment vary widely and affect only a small number of people in each state. Although such measures provide valuable data quality signals to researchers interested in those special populations, they are not the best measures for determining the overall data quality of a Beta-MAX file. Therefore, they have been eliminated from the Beta-MAX data quality review.

The second column of Table IV.2 lists the proposed threshold for the absolute change between a Beta-MAX file and the previous year's MAX file, calculated as the absolute value of the difference between the two files. The third column offers the proposed threshold for the relative or percentage change between Beta-MAX and the previous year's MAX file. This statistic is calculated as the Beta-MAX value minus the MAX value, divided by the MAX value.

Table IV.2. Proposed Thresholds for Beta-MAX QA Measures

Measure Name	Absolute Change Threshold	Relative Change Threshold
All Records		
Total number of PS records	n.a	-50%,+50%
Percentage with FFS claims and missing Medicaid eligibility (excludes S-CHIP only)	3.0	+300%
Number with any S-CHIP enrollment	500	-150%,+150%
Number with any M-CHIP enrollment	500	-150%,+150%
Percentage with duplicated SSNs (excludes missing eligibility and S-CHIP only)	5.0	+150%
Percentage with no services	10.0	+100%
Full-Benefit Enrollees		
Number of Medicaid enrollees—aged	1,000	-50%, +100%
Number of Medicaid enrollees—disabled	1,000	-50%, +100%
Number of Medicaid enrollees—child	1,000	-50%, +100%
Number of Medicaid enrollees—adult	1,000	-50%, +100%
Total Medicaid Amount Paid	n.a	-50%, +100%
Average Medicaid amount paid per enrollee—aged	$2,500	-50%, +100%
Average Medicaid amount paid per enrollee—disabled	$2,500	-50%, +100%
Average Medicaid amount paid per enrollee—child	$2,500	-50%, +100%
Average Medicaid amount paid per enrollee—adult	$2,500	-50%, +100%
EDB Duals		
Number of EDB duals with restricted benefits	1,000	-50%, +100%
Number of EDB full-dual enrollees—aged	1,000	-50%, +100%
Number of EDB full-dual enrollees—disabled	1,000	-50%, +100%
Average Medicaid amount paid per EDB full-dual enrollee—aged	$2,500	-50%, +100%
Average Medicaid amount paid per EDB full-dual enrollee—disabled	$2,500	-50%, +100%
Number of non-dual FFS enrollees with MSIS dual code but no EDB confirmation	1,000	+100%
Number of EDB dual FFS enrollees	1,000	-50%, +100%
Managed Care		
Ratio of HMO capitation claims to person months of enrollment	1.0	+100%
Ratio of PHP capitation claims to person months of enrollment	1.0	+100%
Number ever enrolled in an HMO during year—aged	1,000	-100%,+100%
Number ever enrolled in an HMO during year—disabled	1,000	-100%,+100%
Number ever enrolled in an HMO during year—child	1,000	-100%,+100%
Number ever enrolled in an HMO during year—adult	1,000	-100%,+100%
Types of Service		
Total non-dual FFS Medicaid amount paid for IP services	n.a	-50%, +100%
Total non-dual FFS Medicaid amount paid for LT services	n.a	-50%, +100%
Total non-dual FFS Medicaid amount paid for drugs	n.a	-50%, +100%
Total non-dual FFS Medicaid amount paid for other services	n.a	-50%, +100%
Average FFS Medicaid amount paid per non-dual FFS enrollee for IP services	$2,500	-50%, +100%
Average FFS Medicaid amount paid per non-dual FFS enrollee for LT services	$2,500	-50%, +100%
Average FFS Medicaid amount paid per non-dual FFS enrollee for drugs	$2,500	-50%, +100%

Measure Name	Absolute Change Threshold	Relative Change Threshold
Average FFS Medicaid amount paid per non-dual FFS enrollee for other services	$2,500	-50%, +100%
Percentage of non-dual FFS enrollees with IP claims	5.0	-50%, +100%
Percentage of non-dual FFS enrollees with ILTC claims	5.0	-50%, +100%
Percentage of non-dual FFS enrollees with drug claims	5.0	-50%, +100%
Percentage of non-dual FFS enrollees with all other claims	5.0	-50%, +100%

Both the absolute threshold and the relative threshold must be exceeded in order for a measure to be flagged. This rule helps to ensure that changes in the data are of significant magnitude to warrant a data quality flag. For example, if the percent of claims with missing Medicaid eligibility quadruples (a 300 percent increase) between MAX 2008 and Beta-MAX 2009, but the value only changes from 0.1 percent of claims to 0.4 percent of claims, that measure should not be flagged. Similarly, if the number of disabled Medicaid enrollees increases by 1,500, but the state usually has tens of thousands of such enrollees, the increase is not indicative of a major data quality problem and should not be flagged.

For some of the measures in Table IV.2, there is no appropriate threshold for absolute change, although the relative (percent) change should still be checked. For example, if the total Medicaid amount paid doubles (a 100 percent increase) between MAX 2008 and Beta-MAX 2009, it is a cause for concern regardless of the value of that measure. Because meaningful changes in the absolute numbers for measures such as total expenditures and total number of PS records will vary widely across states, the absolute change threshold is listed in Table IV.2 as "n.a." or not applicable.

The thresholds for the relative (percent) change are set intentionally wide. This decision is based on an examination of the Beta-MAX pilot files, as well as experience in manually reviewing the full MAX files. For many states, the values of the measures listed in the Beta-MAX QA tables can vary significantly from one year to the next without being an indication of

poor data quality. Wider thresholds will ensure that we are not withholding a Beta-MAX file because of meaningless differences. As the relative thresholds show, we believe it is appropriate to release a Beta-MAX file on schedule unless a critical data quality measure has increased by more than 100 percent or decreased by more than 50 percent. Based on our findings in the pilot test, we expect the number of states that trigger these flags during any given Beta-MAX cycle to be very small.

C. Testing

To test the thresholds, especially for measures for which there is a lot of cross-state variation that may not be adequately represented in the six Beta-MAX pilot states, Mathematica also examined the same measures using MAX 2007 files for all 50 states and the District of Columbia. For this test, the MAX 2007 measures were compared to the corresponding measures from MAX 2006 for each state. This test allowed us to determine which states and measures would have been flagged during 2007 production if the MAX 2007 files had been reviewed using the highly automated Beta-MAX QA process. Since both MAX 2006 and MAX 2007 files underwent careful manual review by Mathematica staff, this test should provide a good indication of the strength of the thresholds. As shown in Table IV.3, only six states would have been flagged by the automated QA system.

In Arizona, three of the measures on the Beta-MAX QA tables would have been flagged in MAX 2007. The average Medicaid amount paid for aged enrollees increased by $11,551, a 595 percent increase over the same measure in MAX 2006. The average Medicaid amount paid for aged enrollees dually enrolled in Medicaid and Medicare increased by a similar amount. The average Medicaid amount paid for disabled enrollees increased by $4,497, a 178 percent increase. Investigation of validation tables from previous years would prove that these increases were the result of extremely low values in Arizona's MAX 2006 file. In fact, the 2007 values

were quite similar to the 2004 and 2005 values, indicating that the 2007 file is probably fine. If the Arizona MAX 2007 file had been tested using the Beta-MAX QA review system, it would have been flagged but ultimately released.

Table IV.3. MAX 2007 Values That Exceed the Beta-MAX QA Thresholds

State	Measure	MAX 2006 Value	MAX 2007 Value	Absolute Change	Percent Change
AZ	Average Medicaid amount paid per EDB full-dual enrollee—aged	$1,639	$13,394	$11,755	717.17
AZ	Average Medicaid amount paid per EDB full-dual enrollee—disabled	$2,799	$7,746	$4,947	176.75
AZ	Average Medicaid amount paid per enrollee—aged	$1,940	$13,491	$11,551	595.30
ID	Number with any S-CHIP enrollment	5,918	19,735	13,817	233.47
MA	Number ever enrolled in an HMO or HIO during year—aged	435	12,416	11,981	2,754.25
MD	Total FFS non-dual Medicaid amount paid for other services	$123,806,236	$257,511,411	$133,705,175	108.00
OH	Number ever enrolled in an HMO or HIO during year—aged	27	7,301	7,274	26,940.74
OH	Number ever enrolled in an HMO or HIO during year—disabled	13,941	147,454	133,513	957.70
OH	Total FFS non-dual Medicaid amount paid for drugs	$846,804,001	$353,936,762	-$492,867,239	-58.20
TX	Number ever enrolled in an HMO or HIO during year—aged	26,090	61,418	35,328	135.41

In Idaho, the number of S-CHIP enrollees increased from 5,918 in MAX 2006 to 19,735 in MAX 2007. This represents a 233 percent increase, and would have been flagged by the Beta-MAX QA review system. The Beta-MAX systems team would have consulted with Mathematica's Idaho state liaison, who would know whether or not the state had expanded their S-CHIP program. This would likely be considered an expected change, and the file would probably have been released.

In Maryland, the total Medicaid amount paid for "other services" for non-dual FFS enrollees increased by 108 percent, an increase of more than $133 million. Although some increase in

expenditures from year to year is expected, this is an abnormally large increase and would have been flagged by the Beta-MAX QA system. Most likely, had the MAX 2007 file for Maryland been a Beta-MAX file, it would not have been released. Instead, it would have been held for further investigation during the next regular MAX production cycle.

In Ohio, the total Medicaid amount paid for prescription drug services for non-dual FFS enrollees dropped by 58 percent, a decrease of more than $492 million. If the 2007 file had been a Beta-MAX file, and had thus been constructed with fewer than seven quarters, it might have been a reasonable assumption that the fewer quarters of input data were the cause of the drop in total expenditures. Had the MAX 2007 file for Ohio been a Beta-MAX file, it likely would not have been released. Instead, it would have been held for further investigation during the next regular MAX production cycle.

A few states would also have been flagged due to large increases in HMO enrollment between 2006 and 2007. In Texas, the number of aged enrollees ever enrolled in an HMO during the year increased by 35,328, a 135 percent increase between MAX 2006 and MAX 2007. In Ohio, the number of disabled enrollees ever enrolled in an HMO increased by 133,513, a 988 percent increase between MAX 2006 and MAX 2007. A similar increase in Massachusetts would also have been flagged. In reviewing this measure, the Beta-MAX team would consult the Mathematica state liaisons to confirm that they expected an increase in the HMO enrollment in each of these states. Since state liaisons are generally aware of HMO expansions, it is likely that these changes would have a simple explanation and the files would be released as usual.

D. Conclusion

Rather than the intensive, manual data quality review employed in full MAX, Beta-MAX files will be evaluated using a simple, highly automated review system. This system employs a series of thresholds beyond which a change in the data is considered anomalous and indicative of

a potential data quality problem. The thresholds are intentionally set to catch only very large changes in the data. One important implication of this design is that even when a Beta-MAX file is released, researchers should still proceed with some caution. The files will not have been manually reviewed and many of the finer data quality measures will not have been examined. Beta-MAX files may contain data quality errors, or the data quality may suffer from a lack of complete claims or eligibility data. Severe data quality problems, which Mathematica expects to be very rare, will trigger a warning and the Beta-MAX files will be withheld. In those cases, the data quality issues will not be addressed in Beta-MAX but will be addressed during the next full MAX production cycle.

V. CONCLUSION

While MAX files will continue to be high-quality research files, Beta-MAX files are designed to be available to researchers at a much faster pace. Several elements of Beta-MAX design, including the use of fewer quarters of input data, the use of the software and business rules from the prior MAX year, and a highly automated data quality review system, help to make Beta-MAX files an early release version of MAX.

The Beta-MAX pilot study, conducted using data for the 2008 calendar year, provides an opportunity to evaluate the effects of the key Beta-MAX design elements on the overall data quality of Beta-MAX files. The pilot centered around six states, with four Beta-MAX pilot versions produced for each state. The first version (v1) contained four quarters of input data, v2 contained five quarters of input data, v3 contained six, and v4 contained seven. MAX 2008, which also used seven quarters of input data, differed from Beta-MAX v4 only in the use of different production software and business rules.

A. Summary of Results

During the Beta-MAX pilot, the effects of using the prior year's production software were minimal. Likewise, there were very few changes in the TOS mapping rules and no changes in the adjustment rules, and the use of the 2007 rules for Beta-MAX did not cause the Beta-MAX files to differ significantly from the MAX 2008 files. This may change in the future, however, as new data elements, such as the ICN, are introduced into MAX. The eligibility business rules changed somewhat for a few states, but the changes caused only small discrepancies between Beta-MAX and MAX.

Table V.1 summarizes our findings in the pilot study. In general, the results of using fewer quarters of data are surprisingly consistent across the six pilot states. Many measures of Beta-MAX data quality in the first pilot version are very close in value to the full MAX value. This is

especially the case with eligibility measures, where it seems that four quarters of MSIS eligibility files may be sufficient for most research projects, even in states that submit many retroactive and correction records. Four quarters may also be sufficient for some research projects examining long-term care claims, outpatient and "other services" claims, and prescription drug claims. Of the four MAX claim types, only the IP file seems insufficient for any type of research when constructed with four quarters of data.

Table V.1. Summary of Beta-MAX Pilot Conclusions

Description	Conclusion
Number of Quarters	
Eligibility files	Four quarters may be sufficient
IP files	Four quarters are not sufficient; use at least five quarters
LT files	Four quarters may be sufficient
OT files	Four quarters may be sufficient
RX files	Four quarters may be sufficient
Software and Business Rules	
Eligibility business rules	Using previous year's rules has little or no impact for most populations
Claims adjustment rules	Using previous year's rules has little or no impact for most populations
TOS mapping rules	Using previous year's rules has little or no impact for most populations
Other claims adjustment rules	Using previous year's rules has little or no impact for most populations

Of the six pilot states, Maryland's Beta-MAX v1 files seemed the least complete. This was especially true for both inpatient hospital services and "other services," where the numbers of Medicaid recipients were strikingly low when observing only four quarters of data. This raises the question of how many other Beta-MAX files might be like Maryland's. Unfortunately, it is nearly impossible to answer this question using available data. There is very little correlation between the lag in adjustment claims and the values of important measures such as total expenditures and counts of enrollees, and an examination of the lag in original claims shows a similar result—there is little or no correlation between the submission date of a particular claim and the contribution of that claim to the overall file quality. It is not possible to predict the effect

of claims without grouping them by date of service and combining them with eligibility claims; this grouping and combination are precisely what make MAX files so valuable to researchers. MSIS, which is built around submission dates and which keeps claims separate from eligibility, cannot be used to answer questions like the one posed above. In the end, then, the production of a Beta-MAX file with only four or five quarters of data requires a small leap of faith. Once the file has been produced, the automated quality review system will weed out the files that are so incomplete as to be a hindrance to research.

While the pilot results provide some clues about the potential data quality in Beta-MAX, the results of the pilot cannot necessarily be generalized to other states or years. MSIS data patterns vary greatly over time and across states. When Beta-MAX files are released to researchers, full validation tables comparing the Beta-MAX files to the previous MAX year will also be made available. Researchers who are interested in using Beta-MAX files, especially those interested in smaller subpopulations or less common types of service, should carefully examine the validation tables before making a final decision regarding the use of Beta-MAX. In many cases, the smaller the number of claims or enrollees under consideration, the more likely it is that the research will be affected by using fewer quarters of data. Ultimately, the decision to use Beta-MAX files or to wait for full MAX files must be left to the researcher.

B. Beta-MAX Production Schedule

Under the MAX-PDQ contract, Mathematica plans to produce four calendar years of Beta-MAX files. However, the exact schedule depends on the availability and quality of each state's MSIS submissions, as well as on decisions from CMS regarding the number of Beta-MAX files to be produced. As shown in Table V.2, Beta-MAX 2009 is currently scheduled to begin in September 2010 and finish in April 2011. A group of production reports corresponding to the

first year of full Beta-MAX production will be delivered to CMS in May 2011. These reports include:

- Beta-MAX production specifications
- Record counts by file and state
- Beta-MAX QA tables, including state-specific and cross-state tables
- Full validation tables, including state-specific and cross-state tables

The validation tables delivered at the end of Beta-MAX production will compare Beta-MAX 2009 to MAX 2008 only, because MAX 2009 will not yet be finished. When MAX 2009 is finished in January 2012, we will provide two additional deliverables:

- Validation tables comparing Beta-MAX 2009 to MAX 2009
- List of critical business rule updates that affected MAX 2009

In May 2011, we will archive the Beta-MAX 2009 software in the CMS Endevor configuration management system. Beta-MAX files will only be archived for five years.

Beta-MAX 2010 will begin in June 2011 and finish in January 2012. The production reports will be delivered and production files will be archived in February 2012. The comparison reports will be delivered when MAX 2010 is completed in October 2012.

Beta-MAX 2011 will begin in March and finish in October 2012. The production reports will be delivered and production files will be archived in November 2012. The comparison reports will be delivered when MAX 2011 is completed in July 2013.

Beta-MAX 2012 is scheduled to begin in December 2012 and finish in July 2013.[7] The production reports will be delivered and production files will be archived in August 2013.

[7] The dates presented here reflect the schedules in the contract. Given the current rate of MSIS file submissions and approvals, however, it seems unlikely that Beta-MAX 2012 will begin in December 2012 and finish by July 2013.

Because MAX 2012 will not be produced under this contract, creation of comparison reports is not currently planned.

Table V.2. Beta-MAX Schedule and Deliverables

Deliverables	Schedule
2009 Beta-MAX Production	
Production of files	September 2010–April 2011
Production reports	May 2011
Beta-MAX production specifications	
Record counts by file and state	
Beta-MAX QA tables	
Validation tables	
Archive files	May 2011
MAX 2009 comparison reports	January 2012
Comparison of validation tables	
Critical business-rule updates	
2010 Beta-MAX Production	
Production of files	June 2011–January 2012
Production reports	February 2012
Beta-MAX production specifications	
Record counts by file and state	
Beta-MAX QA tables	
Validation tables	
Archive files	February 2012
MAX 2010 comparison reports	October 2012
Comparison of validation tables	
Critical business-rule updates	
2011 Beta-MAX Production	
Production of files	March 2012–October 2012
Production reports	November 2012
Beta-MAX production specifications	
Record counts by file and state	
Beta-MAX QA tables	
Validation tables	
Archive files	November 2012
MAX 2011 comparison reports	July 2013
Comparison of validation tables	
Critical business-rule updates	
2012 Beta-MAX Production	
Production of files	December 2012–July 2013
Production reports	August 2013
Beta-MAX production specifications	
Record counts by file and state	
Beta-MAX QA tables	
Validation tables	
Archive files	August 2013

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APPENDIX A

BETA-MAX COMPARISON VALIDATION TABLES

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2008 BETA-MAX Comparison IP Validation Table
State: AK

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All IP Claims									
Total Number of Claims	15,730		18,224		18,387		18,599		18,599
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	15,730		18,224		18,387		18,599		18,599
% Crossover	12.17		12.76		10.90		10.89		10.89
% Adjusted Claims	12.72		11.76		12.53		12.75		12.75
% Standard Adjustments	99.80		99.81		99.78		99.70		99.70
Avg Medicaid Paid, Adjusted Claims (Include $0)	$9,922		$10,536		$10,361		$10,414		$10,414
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	96	X	127		126		133		133
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$8,063		$7,402		$8,529		$8,764		$8,764
# Claims with > $1 Million Paid	1		1		1		1		1
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	13,816		15,898		16,382		16,573		16,573
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$9,051		$9,002		$9,045		$9,051		$9,051
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	$2,334		$2,338		$2,338		$2,336		$2,336
% Claims with TPL	1.98	X	2.51		2.85		3.02		3.02
Avg TPL Paid for Claims with TPL	$4,371		$4,188		$4,429		$4,370		$4,370
% Claims with UB-92 Accommodation Codes	100.00		100.00		100.00		100.00		100.00
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.13		1.14		1.14		1.15		1.15
% Claims with UB-92 Ancillary Codes	78.50		79.22		79.64		79.74		79.74
Avg # of UB-92 Ancillary Codes (> 0 Codes)	6.80		6.75		6.77		6.77		6.77
Avg Length of Stay	4.01		3.98		4.01		4.01		4.01
Avg Covered Days (> 0 Days)	3.90		3.87		3.89		3.90		3.90
% Begin Date = Admission Date	99.64		99.64		99.65		99.64		99.64
% IP Claims (MAX TOS = 01)	98.99		98.88		98.85		98.83		98.83
% Family Planning Claims (PGM TYPE = 2)	1.01		1.12		1.15		1.17		1.17
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	1.91		1.91		1.91		1.91		1.91
% Primary Diagnosis Code Claims with Length = 3	4.69		4.62		4.57		4.57		4.57
% Primary Diagnosis Code Claims with Length = 4	17.49		17.03		17.02		17.07		17.07
% Primary Diagnosis Code Claims with Length = 5	77.82		78.36		78.41		78.36		78.36
% Claims with a Procedure Code	61.31		61.03		61.07		61.14		61.14
Avg # of Procedure Codes (> 0 Codes)	1.55		1.55		1.55		1.55		1.55
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	98.88		98.93		98.91		98.91		98.91
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

2008 BETA-MAX Comparison IP Validation Table
State: AK

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
% Claims Maternal Delivery Indicator	27.95		27.26		27.04		27.00		27.00
% Claims Newborn Delivery Indicator (Only for Separate Infant Delivery Claims Using Mother's ID)	27.03		28.65		28.90		28.90		28.90
PATIENT STATUS									
% Home	93.11		92.92		92.90		92.88		92.88
% Transferred	5.17		5.11		5.12		5.09		5.09
% Still a Patient	0.51	X	0.70		0.70		0.72		0.72
% Died	0.51		0.51		0.51		0.51		0.51
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	1,914		2,326		2,005		2,026		2,026
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$994		$1,010		$1,012		$1,016		$1,016
% Claims with TPL	0.10	X	0.13		0.20	X	0.15		0.15
Avg TPL Paid for Claims with TPL	$206	X	$400		$469	X	$376		$376
% Claims with UB-92 Accommodation Codes	85.68		84.09		82.89		82.87		82.87
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.29		1.32		1.32		1.32		1.32
% Claims with UB-92 Ancillary Codes	77.95		78.16		76.06		75.67		75.67
Avg # of UB-92 Ancillary Codes (> 0 Codes)	9.50		9.31		9.08		9.05		9.05
Avg Length of Stay	5.78		5.75		6.28		6.31		6.31
% Begin Date = Admission Date	99.58		99.57		99.50		99.51		99.51
% IP Claims (MAX TOS = 01)	100.00		100.00		100.00		100.00		100.00
% Claims with Primary Diagnosis Code	99.69		99.74		99.70		99.70		99.70
Avg # of Diagnosis Codes (> 0 Codes)	1.98		1.98		1.97		1.97		1.97
% Primary Diagnosis Code Claims with Length = 3	8.65		8.36		9.00		8.96		8.96
% Primary Diagnosis Code Claims with Length = 4	36.48		36.68		36.72		36.44		36.44
% Primary Diagnosis Code Claims with Length = 5	54.87		54.96		54.28		54.60		54.60
% Claims with a Procedure Code	47.54		47.55		43.74		44.08		44.08
Avg # of Procedure Codes (> 0 Codes)	1.61		1.60		1.58		1.58		1.58
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	99.12		98.55		98.75		97.65		97.65
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison LT Validation Table
State: AK

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All LT Claims									
Total Number of Claims	15,216		16,978		17,128		17,177		17,177
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	15,216		16,978		17,128		17,177		17,177
% Crossover	3.26	X	4.32		4.11		4.14		4.14
% Adjusted Claims	5.39		5.65		5.80		5.91		5.91
% Standard Adjustments	87.20		87.71		87.32		87.29		87.29
Avg Medicaid Paid, Adjusted Claims (Include $0)	$9,448		$9,188		$9,129		$9,099		$9,099
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	2	X	8	X	13		13		13
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$1,216	X	$4,527	X	$7,085		$7,085		$7,085
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	14,720		16,245		16,424		16,466		16,466
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
NF (MAX TOS = 07)	$419		$420		$419		$419		$419
ICF/MR (MAX TOS = 05)	$526		$527		$527		$527		$527
MH Aged (MAX TOS = 02)	$1,080		$1,080		$1,080		$1,080		$1,080
IP Psych, Age < 21 (MAX TOS = 04)	$384		$383		$383		$383		$383
TYPE OF SERVICE									
% NF (MAX TOS = 07)	38.51		39.20		39.50		39.49		39.49
% NF claims with NF Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for NF claims with Covered Days	28.09		28.01		27.93		27.89		27.89
% ICF/MR (MAX TOS = 05)	0.41		0.42		0.42		0.42		0.42
% ICF/MR claims with ICF/MR Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for ICF/MR claims with Covered Days	28.97		28.96		28.96		28.96		28.96
% MH Aged (MAX TOS = 02)	0.03		0.02		0.02		0.02		0.02
% MH Aged claims with MH Aged Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for MH Aged claims with Covered Days	11.00		11.00		11.00		11.00		11.00
% IP Psych, Age < 21 (MAX TOS = 04)	61.06		60.35		60.06		60.07		60.07
% IP Psych, Age < 21 Claims with IP Psych Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for IP Psych, Age < 21 Claims with Covered Days	15.74		16.06		16.07		16.08		16.08
LEAVE DAYS									
% Claims with Leave Days	1.60		1.65		1.73		1.72		1.72
ADMISSION DATE									
% Claims with Admission Date	100.00		100.00		100.00		100.00		100.00
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Primary Diagnosis Code Claims with Length = 3	5.25		5.21		5.18		5.18		5.18

2008 BETA MAX Comparison LT Validation Table
State: AK

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% Primary Diagnosis Code Claims with Length = 4	20.20		20.39		20.52		20.51		20.51
% Primary Diagnosis Code Claims with Length = 5	74.54		74.40		74.29		74.31		74.31
PATIENT STATUS									
% Claims with Patient Status	100.00		100.00		100.00		100.00		100.00
% Home	6.56		6.43		6.48		6.48		6.48
% Still a Patient	89.53		89.56		89.47		89.43		89.43
% Died	0.84		0.87		0.90		0.92		0.92
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	496	X	733		704		711		711
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$779		$743		$760		$776		$776
TYPE OF SERVICE									
% NF (MAX TOS = 07)	98.19		98.64		98.58		98.45		98.45
% ICF/MR (MAX TOS = 05)	0.00		0.00		0.00		0.00		0.00
% MH Aged (MAX TOS = 02)	1.81		1.36		1.42		1.55		1.55
% IP Psych, Age < 21 (MAX TOS = 04)	0.00		0.00		0.00		0.00		0.00
ADMISSION DATE									
% Claims with Admission Date	99.40		99.59		99.57		99.58		99.58
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	97.38		98.09		98.01		98.03		98.03
% Primary Diagnosis Code Claims with Length = 3	8.28		8.48		8.99		8.90		8.90
% Primary Diagnosis Code Claims with Length = 4	29.19		33.52		32.32		32.28		32.28
% Primary Diagnosis Code Claims with Length = 5	62.53		58.00		58.70		58.82		58.82
PATIENT STATUS									
% Claims with Patient Status	97.38		98.23		98.15		98.17		98.17
% Home	8.27	X	15.14	X	11.51		11.39		11.39
% Still a Patient	80.44		74.62		77.84		77.92		77.92
% Died	1.21	X	1.50		1.56		1.55		1.55

2008 BETA MAX Comparison OT Validation Table
State: AK

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All OT Claims									
Total Number of Claims	4,119,086		4,496,203		4,562,544		4,598,367		4,598,367
% Encounter Claims	0.02		0.02		0.02		0.02		0.02
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
% Capitation Claims **	0.00		0.00		0.00		0.00		0.00
Total FFS Claims Excluding Capitation Payments	4,118,158		4,495,275		4,561,616		4,597,325		4,597,325
% Crossover	7.02		7.39		7.42		7.45		7.45
% Adjusted Claims	1.75	X	2.19		2.32		2.40		2.40
% Standard Adjustments	90.69		88.33		88.64		88.58		88.58
Avg Medicaid Paid, Adjusted Claims (Include $0)	$319		$299		$306		$307		$307
% Claims with HMO Capitation Payment	0.00		0.00		0.00		0.00		0.00
% Claims with PHP Capitation Payment	0.00		0.00		0.00		0.00		0.00
% Claims with PCCM Capitation Payment	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid per HMO Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per PHP Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per PCCM Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	34,086		36,855		37,331		38,014		38,014
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$115		$114		$114		$116		$116
# Claims with > $200,000 Paid	0		0		0		0		0
# Encounter Claims	928		928		928		1,042		1,042
% Encounter Claims for HMO or PACE	0.00		0.00		0.00		0.00		0.00
% Encounter Claims for PHP	0.00		0.00		0.00		0.00		0.00
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	3,828,866		4,163,156		4,223,182		4,254,684		4,254,684
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
% Claims with Span Bill	5.53		5.47		5.43		5.41		5.41
% Outpatient Claims with Span Bill	7.67		7.81		7.76		7.71		7.71
% Home Health Claims with Span Bill	58.49		60.85		59.29		58.35		58.35
% Other Claims with Span Bill	5.48		5.41		5.37		5.35		5.35
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	12.52		12.09		12.09		12.09		12.09
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	5.02		5.07		5.11		5.12		5.12
% Claims with Servicing Provider ID = Billing Provider ID	9.22		8.99		8.87		8.81		8.81
PLACE OF SERVICE									
% Claims with Place of Service	92.20		91.92		91.76		91.50		91.50
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	25.65		25.62		25.65		25.62		25.62
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	41.35		41.08		40.90		40.73		40.73
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	3.00		3.12		3.16		3.16		3.16
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	0.02		0.02		0.02		0.02		0.02
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	2.32		2.30		2.33		2.33		2.33

2008 BETA MAX Comparison OT Validation Table
State: AK

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% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	5.83		6.02		6.08		6.10		6.10
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	7.69		7.95		8.11		8.37		8.37
THIRD-PARTY LIABILITY									
% Claims with TPL	0.34	X	0.40		0.43		0.45		0.45
Avg TPL Paid for Claims with TPL	$116		$122		$123		$125		$125
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE									
Physician Services (MAX TOS = 08)	10.90		11.17		11.36		11.55		11.55
Dental Services (MAX TOS = 09)	7.92		7.75		7.72		7.70		7.70
Other Practitioner Services (MAX TOS = 10)	1.14		1.13		1.13		1.12		1.12
Outpatient Services (MAX TOS = 11)	1.92		1.96		1.98		1.99		1.99
Clinic Services (MAX TOS = 12)	3.37		3.43		3.47		3.49		3.49
Home Health Services (MAX TOS = 13)	0.02	X	0.02		0.03		0.03		0.03
Lab/Xray Services (MAX TOS = 15)	7.05		7.06		7.12		7.19		7.19
Drugs (MAX TOS = 16)	0.02		0.02		0.03		0.03		0.03
Other Services (MAX TOS = 19)	5.05		5.35		5.38		5.39		5.39
Durable Medical Equipment (MAX TOS = 51)	5.20		5.13		5.14		5.13		5.13
Transportation Services (MAX TOS = 26)	9.07		8.95		8.84		8.79		8.79
Sterilizations (MAX TOS = 24)	0.01		0.01		0.01		0.01		0.01
Abortions (MAX TOS = 25)	0.00		0.00		0.00		0.00		0.00
Personal Care Services (MAX TOS = 30)	26.48		25.71		25.47		25.30		25.30
Targeted Case Management (MAX TOS = 31)	1.08		1.12		1.12		1.12		1.12
Rehabilitation Services (MAX TOS = 33)	0.01		0.01		0.01		0.01		0.01
PT/OT/Hearing/Speech Services (MAX TOS = 34)	2.16		2.15		2.15		2.15		2.15
Hospice Services (MAX TOS = 35)	0.00	X	0.00		0.00		0.00		0.00
Nurse Midwife Services (MAX TOS = 36)	0.19		0.20		0.20		0.20		0.20
Nurse Practitioner Services (MAX TOS = 37)	0.83		0.83		0.84		0.84		0.84
Private Nursing Services (MAX TOS = 38)	0.03	X	0.04		0.04		0.04		0.04
Religious Non-Medical Services (MAX TOS = 39)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	3.25		3.45		3.46		3.45		3.45
Psychiatric Services (MAX TOS = 53)	14.01		14.23		14.23		14.19		14.19
Adult Day Care (MAX TOS = 54)	0.28		0.27		0.28		0.27		0.27
Unknown Services (MAX TOS = 99)	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
Total	$139		$141		$141		$141		$141
Physician Services (MAX TOS = 08)	$130		$131		$130		$129		$129
Dental Services (MAX TOS = 09)	$84		$85		$85		$85		$85
Other Practitioner Services (MAX TOS = 10)	$86		$87		$87		$87		$87
Outpatient Services (MAX TOS = 11)	$551		$554		$552		$551		$551
Clinic Services (MAX TOS = 12)	$267		$271		$273		$276		$276
Home Health Services (MAX TOS = 13)	$735		$784		$795		$790		$790
Lab/Xray Services (MAX TOS = 15)	$106		$109		$109		$109		$109
Drugs (MAX TOS = 16)	$83		$82		$82		$85		$85
Other Services (MAX TOS = 19)	$303		$294		$292		$291		$291
Durable Medical Equipment (MAX TOS = 51)	$82		$85		$86		$86		$86

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Transportation Services (MAX TOS = 26)	$139		$138		$138		$139		$139
Personal Care Services (MAX TOS = 30)	$79		$80		$80		$80		$80
Targeted Case Management (MAX TOS = 31)	$214		$215		$215		$216		$216
Rehabilitation Services (MAX TOS = 33)	$595		$581		$577		$577		$577
PT/OT/Hearing/Speech Services (MAX TOS = 34)	$85		$85		$85		$85		$85
Hospice Services (MAX TOS = 35)	$2,736		$2,692		$2,604		$2,614		$2,614
Residential Care Services (MAX TOS = 52)	$379		$378		$379		$380		$380
Psychiatric Services (MAX TOS = 53)	$131		$131		$131		$131		$131
Adult Day Care (MAX TOS = 54)	$177		$182		$180		$180		$180
PERCENT OF CLAIMS BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	0.14		0.14		0.15		0.15		0.15
Rural Health Clinic (PGM TYPE = 3)	0.00		0.00		0.00		0.00		0.00
Federally Qualified Health Center (PGM TYPE = 4)	0.36		0.37		0.38		0.38		0.38
Indian Health Services (PGM TYPE = 5)	3.55		3.62		3.63		3.64		3.64
Home and Community Based Waiver (PGM TYPE = 6,7)	14.89		15.39		15.42		15.39		15.39
AVERAGE EXPENDITURES BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	$144		$147		$150		$151		$151
Rural Health Clinic (PGM TYPE = 3)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Federally Qualified Health Center (PGM TYPE = 4)	$223		$222		$221		$221		$221
Indian Health Services (PGM TYPE = 5)	$83		$84		$84		$83		$83
Home and Community Based Waiver (PGM TYPE = 6,7)	$232		$233		$234		$234		$234
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	55.23		56.10		56.43		56.66		56.66
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.82		99.82		99.82		99.82		99.82
% Primary Diagnosis Claims with Secondary Diagnosis Code	26.45		26.59		26.56		26.46		26.46
% Primary Diagnosis Code Claims with Length = 3	5.90		6.14		6.20		6.28		6.28
% Primary Diagnosis Code Claims with Length = 4	38.08		37.85		37.91		37.98		37.98
% Primary Diagnosis Code Claims with Length = 5	56.01		56.01		55.89		55.74		55.74
% Claims with Procedure Code	96.77		96.70		96.66		96.64		96.64
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	100.00		100.00		100.00		100.00		100.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	99.95		99.94		99.93		99.92		99.92
% Other Claims with Procedure Code	98.32		98.29		98.27		98.26		98.26
% Claims with Procedure Code with CPT-4 Indicator	26.20		26.62		26.96		27.25		27.25
% Claims with Procedure Code with HCPCS (II & III) Indicator	73.24		72.81		72.47		72.17		72.17
% with Procedure Code with Other National Indicator	0.50		0.52		0.52		0.52		0.52
% with Procedure Code with State-Specific Indicator	0.05		0.06		0.06		0.06		0.06
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	100.00		100.00		100.00		100.00		100.00
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	89.62		89.27		89.22		89.22		89.22
PHYSICIAN SPECIALTY									
% Physician Claims with Physician Specialty	100.00		100.00		100.00		100.00		100.00
PERCENT OF CLAIMS BY CLTC CODE									

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Not a CLTC Claim (CLTC FLAG = 00)	57.25		57.54		57.79		57.99		57.99
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	28.05		27.24		26.97		26.80		26.80
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	21.94		21.20		20.94		20.79		20.79
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	0.02	X	0.03		0.03		0.03		0.03
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	0.02	X	0.02		0.03		0.03		0.03
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	0.01		0.01		0.01		0.01		0.01
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	2.49		2.45		2.42		2.40		2.40
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	0.00	X	0.00		0.00		0.00		0.00
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	3.56		3.53		3.54		3.54		3.54
CLTC Waiver Claims (CLTC FLAG = 30-40)	14.70		15.22		15.24		15.20		15.20
CLTC Other Waiver (CLTC FLAG = 30)	4.80		5.06		5.08		5.07		5.07
CLTC Waiver Personal Care (CLTC FLAG = 31)	4.15		4.17		4.15		4.13		4.13
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	0.02		0.02		0.02		0.02		0.02
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	0.27		0.27		0.27		0.27		0.27
CLTC Waiver Home Health (CLTC FLAG = 34)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Residential Care (CLTC FLAG = 35)	3.25		3.45		3.46		3.45		3.45
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	0.98		1.01		1.01		1.01		1.01
CLTC Waiver Transportation (CLTC FLAG = 38)	1.01		1.04		1.05		1.04		1.04
CLTC Waiver Hospice (CLTC FLAG = 39)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	0.22		0.21		0.21		0.21		0.21
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	289,292		332,119		338,434		342,641		342,641
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$41		$42		$42		$41		$41
% Claims with Span Bill	2.98		3.03		3.05		3.05		3.05
% Outpatient Claims with Span Bill	9.17		9.64		10.02		10.01		10.01
% Home Health Claims with Span Bill	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Span Bill	2.37		2.35		2.36		2.36		2.36
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)									
Physician Services (MAX TOS = 08)	38.47		38.68		38.78		38.74		38.74
Other Practitioner Services (MAX TOS = 10)	2.43		2.42		2.40		2.46		2.46
Outpatient Services (MAX TOS = 11)	9.07		9.33		9.07		9.04		9.04
Clinic Services (MAX TOS = 12)	6.55		6.56		6.66		6.70		6.70
Home Health Services (MAX TOS = 13)	0.00		0.00		0.00		0.00		0.00
Lab/Xray Services (MAX TOS = 15)	17.91		17.71		17.53		17.44		17.44
Other Services (MAX TOS = 19)	1.22		1.29		1.30		1.30		1.30
Durable Medical Equipment (MAX TOS = 51)	12.35		12.15		12.29		12.40		12.40
Transportation Services (MAX TOS = 26)	2.99		3.01		3.01		2.99		2.99
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00

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Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	0.17		0.15		0.14		0.14		0.14
PT/OT/Hearing/Speech Services (MAX TOS = 34)	2.91		2.91		2.90		2.88		2.88
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.00		0.00		0.00		0.00		0.00
Psychiatric Services (MAX TOS = 53)	3.69		3.77		3.88		3.89		3.89
Adult Day Care (MAX TOS = 54)	0.00		0.00		0.00		0.00		0.00
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	99.30		99.33		99.33		99.34		99.34
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.18		99.22		99.23		99.23		99.23
% Primary Diagnosis Claims with Secondary Diagnosis Code	43.27		43.16		43.05		43.02		43.02
% Primary Diagnosis Code Claims with Length = 3	6.10		6.11		6.09		6.14		6.14
% Primary Diagnosis Code Claims with Length = 4	40.93		41.04		41.02		40.94		40.94
% Primary Diagnosis Code Claims with Length = 5	52.96		52.85		52.89		52.93		52.93
% Claims with Procedure Code	84.62		84.15		84.47		84.51		84.51
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	95.23		95.48		95.27		95.21		95.21
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Procedure Code	92.59		92.38		92.48		92.50		92.50
% Claims with Procedure Code with CPT-4 Indicator	78.63		78.65		78.51		78.39		78.39
% Claims with Procedure Code with HCPCS (II & III) Indicator	21.31		21.28		21.43		21.55		21.55
% with Procedure Code with Other Code Indicator	0.06		0.07		0.06		0.06		0.06
PERCENT OF CLAIMS BY CLTC CODE									
Not a CLTC Claim (CLTC FLAG = 00)	84.79		85.00		84.86		84.78		84.78
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	15.21		15.00		15.14		15.22		15.22
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Claims (CLTC FLAG = 30-40)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison RX Validation Table
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All RX Claims									
Total Number of Claims	945,015		955,930		958,089		960,031		960,031
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	945,015		955,930		958,089		960,031		960,031
% Adjusted Claims	0.56		0.61		0.62		0.63		0.63
% Standard Adjustments	99.42		99.44		99.45		99.45		99.45
Avg Medicaid Paid, Adjusted Claims (Include $0)	$116		$112		$112		$111		$111
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	4,058		4,067		4,056		4,243		4,243
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	42.23		40.11		39.95		42.71		42.71
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Claims (Type of Claim = 1)									
Total Number of Claims	945,015		955,930		958,089		960,031		960,031
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$80		$80		$80		$80		$80
% Claims with TPL	2.57		2.58		2.58		2.60		2.60
Avg TPL Paid for Claims with TPL	$102		$101		$101		$101		$101
% Family Planning Claims (PGM TYPE = 2)	0.90		0.89		0.89		0.89		0.89
% Drug Claims (MAX TOS = 16)	100.00		100.00		100.00		100.00		100.00
% Durable Medical Equipment Claims (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Prescribing Physician	59.19		59.23		59.24		59.27		59.27
% Drug Claims with Date Prescribed	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Quantity	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Days Supply	100.00		100.00		100.00		100.00		100.00
DRUG CLASSIFICATION									
% Claims with Medispan	99.54		99.50		99.50		99.50		99.50
% Claims with Generic Therapeutic Class	99.66		99.63		99.63		99.63		99.63
% Claims with Specific Therapeutic Class	99.66		99.63		99.63		99.63		99.63
NDC CONFIGURATION INDICATOR									
% Prescription (NDC FMT IND = 0-3)	65.26		65.20		65.20		65.20		65.20
% Products (NDC FMT IND = 4-6)	34.40		34.42		34.43		34.43		34.43
% Health Related Item (NDC FMT IND = 7)	0.00		0.00		0.00		0.00		0.00
% Claims with Clinical Formulation Identifier	99.66		99.63		99.63		99.63		99.63
% Claims with Ingredient List Identifier	99.66		99.63		99.63		99.63		99.63
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	99.66		99.63		99.63		99.63		99.63
% Claims with Over-the-Counter Drug Class	3.57		3.58		3.58		3.59		3.59
% Claims with Prescription Drug Class	96.09		96.05		96.05		96.04		96.04
% Claims with Multiple Sources	62.74		62.81		62.84		62.86		62.86
% Claims with Single Source (No Generic)	30.31		30.23		30.19		30.18		30.18

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All Records									
Total Number of Records	125,092		128,097		128,344		128,385		128,385
Total Medicaid Paid	$868,289,661		$958,923,618		$975,870,709		$983,192,417		$983,192,417
% with No Services (RCPNT IND = 0)	15.86		15.29		14.90		14.58		14.58
% with FFS Only Claims (RCPNT IND = 1)	83.55		84.14		84.53		84.79		84.79
% with Only Capitation Claims (RCPNT IND = 2)	0.00		0.00		0.00		0.00		0.00
% with Only Encounter Claims (RCPNT IND = 3)	0.07		0.06		0.06		0.06		0.06
% with FFS and Capitation Claims (RCPNT IND = 4)	0.00		0.00		0.00		0.00		0.00
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	0.00		0.00		0.00		0.00		0.00
% with FFS and Encounter Claims Only (RCPNT IND = 6)	0.52		0.51		0.51		0.56		0.56
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	0.00		0.00		0.00		0.00		0.00
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	460	X	541		554		595		595
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.37	X	0.42		0.43		0.46		0.46
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$4,855,855		$5,330,353		$5,591,075		$5,830,499		$5,830,499
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$10,556		$9,853		$10,092		$9,799		$9,799
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	460	X	541		554		595		595
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.37	X	0.42		0.43		0.46		0.46
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$4,855,855		$5,330,353		$5,591,075		$5,830,499		$5,830,499
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$10,556		$9,853		$10,092		$9,799		$9,799
S-CHIP ENROLLMENT									
# with ONLY S-CHIP Enrollment	0		0		0		0		0
% with ONLY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
# with ANY S-CHIP Enrollment	0		0		0		0		0
% with ANY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	0		0		0		0		0
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)									
Total Medicaid Enrollees	124,632		127,556		127,790		127,790		127,790
Total Medicaid Person-Years of Enrollment	95,121		96,215		96,316		96,316		96,316
# with Any M-CHIP Enrollment	15,624		16,200		16,253		16,253		16,253
Total Person-Years of Enrollment Any M-CHIP	8,509		8,673		8,685		8,685		8,685
Demographic Characteristics									
% Records with Valid SSN Format	95.91		96.64		97.33		97.33		97.33
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	95.83		96.48		97.08		97.08		97.08
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	0.01		0.02		0.01		0.01		0.01
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	0.07	X	0.14	X	0.23		0.23		0.23

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	0.00		0.00		0.00		0.00		0.00
# Records Without Valid SSN	5,203	X	4,484	X	3,726		3,726		3,726
% Records Without Valid SSN	4.17	X	3.52	X	2.92		2.92		2.92
% for Children Under Age 21	99.14		99.04		99.06		99.06		99.06
% for Infants Under Age 1	66.29		67.40		63.90		63.90		63.90
% Ever Aliens Eligible for Only Emergency Services	0.04	X	0.04	X	0.08		0.08		0.08
# SSNs with More Than One MSIS ID	31	X	44	X	59		59		59
% Records with Duplicated SSNs	0.05	X	0.07	X	0.09		0.09		0.09
% for Children Under Age 21	96.77		97.73		98.31		98.31		98.31
% for Infants Under Age 1	3.23	X	4.55	X	8.47		8.47		8.47
% Ever Aliens Eligible for Only Emergency Services	0.00		0.00		0.00		0.00		0.00
% with External SSN from EDB (EXT SSN SRCE = 1)	12.10		11.97		11.97		11.97		11.97
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	0.00		0.00		0.00		0.00		0.00
% with County Code	99.66		99.66		99.65		99.65		99.65
% with Valid 5 Digit Zip Code Format	100.00		100.00		100.00		100.00		100.00
% White	39.51		39.49		39.51		39.51		39.51
% Black	5.53		5.54		5.55		5.55		5.55
% Native American/Alaskan Native	39.02		38.89		38.90		38.90		38.90
% Asian	6.57		6.68		6.70		6.70		6.70
% Native Hawaiian or Other Pacific Islander	3.18		3.20		3.20		3.20		3.20
% More Than One Race	0.00		0.00		0.00		0.00		0.00
% Unknown Race	6.19		6.19		6.14		6.14		6.14
% Hispanic/Latino (Included with Race Categories Prior to 2005)	3.60		3.65		3.67		3.67		3.67
% of Hispanic/Latino with Unknown Race	100.00		100.00		100.00		100.00		100.00
% Age 0	4.34		4.67		4.69		4.69		4.69
% Age 0-20 Years	65.78		65.77		65.73		65.73		N/A
% Age > 64 Years	6.73		6.63		6.62		6.62		N/A
% with Century of Birth '18' , '19', '20'	100.00		100.00		100.00		100.00		100.00
% with Gender Code 'M' or 'F'	100.00		100.00		100.00		100.00		100.00
% Enrollees with 12 Months Enrollment	47.15		48.17		48.27		48.27		48.27
% Aged Enrollees with 12 Months Enrollment	76.83		76.46		76.43		76.43		76.43
% Disabled Enrollees with 12 Months Enrollment	78.26		77.41		76.94		76.94		76.94
% Child Enrollees with 12 Months Enrollment	44.76		46.91		47.15		47.15		47.11
% Adult Enrollees with 12 Months Enrollment	26.76		26.56		26.54		26.54		26.59
% Enrollees with MSIS Date of Death During Year	0.60		0.62		0.62		0.62		0.62
% Enrollees with SSA Date of Death During Year	0.44		0.43		0.43		0.43		0.00
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	0.80		0.78		0.78		0.78		0.74
# with MSIS Date of Death ≠ SSA Date of Death	631	X	675		678		678		841
# with MSIS Date of Death Prior to 2007	49		50		49		49		49
# with SSA Date of Death Prior to 2007	51		51		51		51		0
EDB Dual Eligibles									
Total EDB Duals (Duals Confirmed by EDB)	13,927		14,061		14,080		14,080		14,080

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Total EDB Dual Person-Years of Enrollment	12,615		12,656		12,660		12,660		12,660
% Age > 64 Years Who Are EDB Duals	89.35		89.42		89.42		89.42		89.42
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	89.74		89.84		89.83		89.83		89.83
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	45.16		44.78		44.60		44.60		44.60
% EDB Only (EDB DUAL = 50)	7.30		6.53		6.33		6.33		6.33
% EDB QMB Only (EDB DUAL = 51)	0.02		0.02		0.02		0.02		0.02
% EDB QMB Plus (EDB DUAL = 52)	68.84		68.59		68.49		68.49		68.49
% EDB SLMB Only (EDB DUAL = 53)	1.33		1.34		1.34		1.34		1.34
% EDB SLMB Plus (EDB DUAL = 54)	0.00		0.00		0.00		0.00		0.00
% EDB QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% EDB QI-1 (EDB DUAL = 56)	0.80		0.81		0.81		0.81		0.81
% EDB QI-2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% EDB Other (EDB DUAL = 58)	21.70		22.70		23.01		23.01		23.01
% EDB Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Dual Status Unknown (EDB DUAL = 98)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	97.85		97.82		97.83		97.83		97.83
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	2.15		2.18		2.17		2.17		2.17
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	130		126		127		127		127
% Non-EDB Duals Without Valid SSN	0.00		0.00		0.00		0.00		0.00
% Non-EDB Duals Who Are Children/Adults	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Spanish Language	0.78		0.79		0.79		0.79		0.79
% EDB Duals with EDB Date of Death During Year	5.26		5.23		5.22		5.22		5.22
% EDB Duals with MSIS Date of Death During Year	3.93		4.19		4.21		4.21		4.21
% EDB Duals with SSA Date of Death During Year	2.84		2.81		2.81		2.81		0.00
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	5.30		5.27		5.26		5.26		5.26
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	304		275		272		272		272
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	364	X	366	X	366	X	366	X	735
% EDB Duals with Medicaid Reported HIC	90.24		88.61		86.83		86.83		86.83
% EDB Duals with Medicaid Reported HIC = Medicare HIC	98.84		98.82		98.81		98.81		98.81
Total EDB Dual Enrollees in June	13,265		13,378		13,394		13,394		13,394
JUNE MEDICARE ELIGIBILITY GROUP									
June % with Part A Medicare only	1.01		1.17		1.19		1.19		1.19
June % with Part B Medicare only	0.35		0.34		0.34		0.34		0.34
June % Part A/B Medicare	98.64		98.48		98.46		98.46		98.46
ORIGINAL REASON FOR MEDICARE ENTITLEMENT									
% Aged (MDCR ORIG REAS CD = 0)	43.42		43.49		43.47		43.47		43.47
% Disabled (MDCR ORIG REAS CD = 1)	55.20		55.13		55.16		55.16		55.16
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	0.61		0.61		0.61		0.61		0.61
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	0.77		0.77		0.77		0.77		0.77
Other Eligibility Characteristics (All Enrollees)									
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	99.63		99.63		99.64		99.64		99.64
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	7.03		6.95		6.92		6.92		6.92
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	99.67		99.69		99.69		99.69		99.69
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	81.10		81.14		81.17		81.17		81.39

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% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	100.00		100.00		100.00		100.00		Div by 0
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	100.00		100.00		100.00		100.00		Div by 0
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	64.34		63.43		63.51		63.51		0.00
Aged Total	7,234		7,302		7,305		7,305		7,305
Aged, Cash (MAX ELIG CD = 11)	6,079		6,131		6,131		6,131		6,131
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	198		197		196		196		196
Other Aged (MAX ELIG CD = 41)	957		974		978		978		978
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	16,141		16,426		16,530		16,530		16,530
Disabled, Cash (MAX ELIG CD = 12)	14,330		14,558		14,643		14,643		14,643
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	287		289		289		289		289
Other Disabled (MAX ELIG CD = 42)	1,524		1,579		1,598		1,598		1,598
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	74,852		76,538		76,635		76,635		76,710
AFDC Child, Cash (MAX ELIG CD = 14)	17,593		18,012		18,104		18,104		18,104
AFDC-U Child, Cash (MAX ELIG CD = 16)	353		384	X	311		311		311
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	45,725		46,858		46,915		46,915		50,846
Other Child (MAX ELIG CD = 44)	4,222		4,220		4,225		4,225		4,225
Foster Care Child (MAX ELIG CD = 48)	3,231		3,222		3,224		3,224		3,224
1115 Child (MAX ELIG CD = 54)	3,728		3,842		3,856		3,856		0
Adult Total	26,405		27,290		27,320		27,320		27,245
AFDC Adult, Cash (MAX ELIG CD = 15)	14,464		14,857		14,932		14,932		14,932
AFDC-U Adult, Cash (MAX ELIG CD = 17)	644		681		610		610		610
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	9,227		9,671		9,695		9,695		9,695
Other Adult (MAX ELIG CD = 45)	1,994		2,006		2,008		2,008		2,008
1115 Adult (MAX ELIG CD = 55)	76		75		75		75		0
Long-Term Care Enrollees									
INSTITUTIONAL STATUS									
# Enrollees with Any ILTC Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	2,030		2,205		2,202		2,208		2,208
% Enrollees with Any ILTC Claims	1.63		1.73		1.72		1.73		1.73
% Aged Enrollees with Any ILTC Claims	7.44		8.27		8.24		8.24		8.24
% Disabled Enrollees with Any ILTC Claims	2.64		2.95		2.92		2.95		2.95
% Child Enrollees with Any ILTC Claims	1.35		1.38		1.38		1.38		1.38
% Adult Enrollees with Any ILTC Claims	0.22		0.21		0.22		0.22		0.22
COMMUNITY LONG-TERM CARE STATUS									
# Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	6,242		6,545		6,630		6,679		6,679

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% Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	5.01		5.13		5.19		5.23		5.23
% Aged Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	33.23		34.16		34.28		34.35		34.35
% Disabled Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	23.12		23.80		23.93		24.18		24.18
% Child Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.09	X	0.12	X	0.15		0.16		0.16
% Adult Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.15	X	0.17		0.19		0.20		0.20
# Enrollees with ILTC Claims and CLTC Claims (Excludes CLTC FLAG = 16-20)	214	X	276		280		283		283
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	6,385		6,679		6,763		6,809		6,809
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT									
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	3,885		4,026		4,078		4,078		4,078
% Enrolled in Any Section 1915(c) Waiver	3.12		3.16		3.19		3.19		3.19
% Aged Enrollees in Section 1915(c) Waiver	20.21		20.88		21.11		21.11		21.11
% Disabled Enrollees in Section 1915(c) Waiver	14.88		15.06		15.15		15.15		15.15
% Child Enrollees in Section 1915(c) Waiver	0.03	X	0.04		0.04		0.04		0.04
% Adult Enrollees in Section 1915(c) Waiver	0.00		0.00		0.00		0.00		0.00
# Aged, EDB Dual	1,365		1,426		1,439		1,439		1,439
# Aged, Non-Dual	97		99		103		103		103
# Disabled, EDB Dual	1,192		1,217		1,225		1,225		1,225
# Disabled, Non-Dual	1,210		1,256		1,280		1,280		1,280
# Other (Child or Adult)	21	X	28		31		31		31
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	1,451		1,513		1,530		1,530		1,530
# Aged, EDB Dual	1,355		1,416		1,429		1,429		1,429
# Aged, Non-Dual	96		97		101		101		101
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	1,089		1,130		1,140		1,140		1,140
# Aged, EDB Dual	1		1		1		1		1
# Aged, Non-Dual	1		1		1		1		1
# Disabled, EDB Dual	659		676		680		680		680
# Disabled, Non-Dual	428		452		458		458		458
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0

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# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	1,131		1,164		1,186		1,186		1,186
# Aged, EDB Dual	9		9		9		9		9
# Aged, Non-Dual	0	X	1		1		1		1
# Disabled, EDB Dual	528		536		540		540		540
# Disabled, Non-Dual	584		603		618		618		618
# Other (Child or Adult)	10	X	15		18		18		18
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	214		219		222		222		222
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	5		5		5		5		5
# Disabled, Non-Dual	198		201		204		204		204
# Other (Child or Adult)	11		13		13		13		13
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	4.12		3.87		3.75		3.58		3.58
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	16.33		17.69		17.56		18.20		18.20
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	0.00		0.00		0.00		0.00		0.00
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/HIOs with No Waiver claim (PGM TYPE = 6 or 7)	4.12		3.87		3.75		3.58		3.58

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# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	22		23		23		23		23
Other Waiver Enrollment (Enrolled Any Time During the Year)									
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	5,912		6,175		6,190		6,190		6,190
% Aged Enrollees with Any 1115 Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1115 Waiver	0.06	X	0.07		0.07		0.07		0.07
% Child Enrollees with Any 1115 Waiver	7.67		7.84		7.85		7.85		7.94
% Adult Enrollees with Any 1115 Waiver	0.61	X	0.59	X	0.59	X	0.59	X	0.31
% with Any HMO/HIO Enrollment	0.00		0.00		0.00		0.00		0.00
# with Any 1915(b) Waiver (WVR TYPE = 2)	0		0		0		0		0
% Aged Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	0		0		0		0		0
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with 1115 HIFA Waiver (WVR TYPE = 5)	0		0		0		0		0
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	0		0		0		0		0
% Aged Enrollees with Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Other Type of Waiver (WVR TYPE = 7)	0		0		0		0		0
# with Unknown Type of Waiver (WVR TYPE = 9)	0		0		0		0		0
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	0		0		0		0		0
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	0		0		0		0		0
# of Waiver IDs with More than One Waiver Type	0		0		0		0		0
# of Waiver IDs with Reporting in January but Not December	0		0		0		0		0
# of Waiver IDs with Reporting in December but Not January	0		0		0		0		0
Enrollees with Restricted Benefits									
Family Planning enrollees with Restricted Benefits (RBF = 6)									
# with ONLY Family Planning Only Enrollment	0		0		0		0		0
# with ANY Family Planning Only Enrollment	0		0		0		0		0
# Person-Years of Enrollment ANY Family Planning Only Enrollment	0		0		0		0		0
Aliens with Restricted Benefits (RBF = 2)									
# Aliens with ONLY Restricted Benefits	6.00	X	9.00		10.00		10.00		10.00
# Aliens with ANY Restricted Benefits	6.00	X	10.00		11.00		11.00		11.00
# Person-Years of Enrollment Aliens with ANY Restricted Benefits	0.50	X	0.83		0.92		0.92		0.92

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EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
# EDB Duals with ONLY Restricted Benefits Enrollment	295		295		293		293		293
# EDB Duals with ANY Restricted Benefits Enrollment	355		359		360		360		360
# Person-Years of Enrollment EDB Duals with ANY Restricted Benefits	259		260		260		260		260
% EDB Duals with ONLY Restricted Benefits Enrollment	2.12		2.10		2.08		2.08		2.08
Prescription Drug Enrollees (RBF = X, Y, or Z)									
# with ONLY Prescription Drug Enrollment (May Have a Month or More of RBF = 3)	0		0		0		0		0
# with ANY Prescription Drug Enrollment	0		0		0		0		0
# Person-Years of ANY Prescription Drug Enrollment	0		0		0		0		0
Dual Prescription Drug Enrollees									
# with ONLY Prescription Drugs Who Are EDB Duals	0		0		0		0		0
June Eligibility Profile									
Total Enrollees in June	97,003		97,003		97,003		97,003		97,003
June % Full Scope Benefits (RBF = 1)	99.73		99.73		99.73		99.73		99.73
June % Restricted Benefits Alien (RBF = 2)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Dual (RBF = 3)	0.27		0.27		0.27		0.27		0.27
June % Restricted Benefits Pregnant (RBF = 4)	0.01		0.01		0.01		0.01		0.01
June % Restricted Benefits Other (RBF = 5)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Family Planning (RBF = 6)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Benchmark-Equivalent (RBF = 7)	0.00		0.00		0.00		0.00		0.00
June % Money Follows the Person Enrollee (RBF = 8)	0.00		0.00		0.00		0.00		0.00
June % Unknown Benefits (RBF = 9)	0.00		0.00		0.00		0.00		0.00
June % PRTF Enrollee (RBF = A)	0.00		0.00		0.00		0.00		0.00
June % Health Opportunity Account (RBF = B)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Non-Dual Enrollee (RBF = X)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Receiving Medicare Cost Sharing (RBF = Y)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Not Receiving Medicare Cost Sharing (RBF = Z)	0.00		0.00		0.00		0.00		0.00
June % Private Health Insurance (PVT INS CD = 2-4)	62.87		62.87		62.87		62.87		62.87
June Total Enrollees with TANF Flag (TANF FLAG = 2)	0.00		0.00		0.00		0.00		0.00
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	8,363		8,363		8,363		8,363		8,363
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	208		208		208		208		208
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	0		0		0		0		0
Medicaid Expenditures									
Total Medicaid Paid	$863,433,806		$953,593,265		$970,279,634		$977,361,918		$977,361,918
Avg Medicaid Paid per Enrollee	$6,928		$7,476		$7,593		$7,648		$7,648
25th Percentile	$192		$215		$226		$235		$235
50th Percentile (Median)	$1,007		$1,105		$1,138		$1,162		$1,162
75th Percentile	$4,375		$4,772		$4,881		$4,933		$4,933
95th Percentile	$33,505		$35,828		$36,273		$36,457		$36,457
99th Percentile	$107,699		$117,336		$118,363		$118,686		$118,686
Maximum Medicaid Paid	$1,311,975		$1,526,623		$1,556,650		$1,556,665		$1,556,665

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PERCENT OF ENROLLEES WITH ZERO EXPENDITURES									
% of Enrollees with Total Medicaid Paid = $0	15.99		15.41		15.02		14.71		14.71
Aged	9.97		9.52		9.30		9.09		9.09
Disabled	7.92		7.77		7.72		7.49		7.49
Child	18.10		17.35		16.92		16.61		16.63
Adult	16.61		16.15		15.66		15.25		15.20
NUMBER OF HIGH-COST ENROLLEES									
# of Enrollees with Total Medicaid Paid > $1,000,000	1.00		1.00		1.00		1.00		1.00
# of Enrollees with Total Medicaid Paid > $500,000	13.00	X	15.00		17.00		17.00		17.00
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$6,928		$7,476		$7,593		$7,648		$7,648
Aged	$18,545		$20,044		$20,176		$20,221		$20,221
Disabled	$20,876		$22,687		$22,946		$23,090		$23,090
Child	$3,558		$3,867		$3,936		$3,973		$3,971
Adult	$4,772		$5,078		$5,196		$5,251		$5,262
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$16,472		$17,951		$18,113		$18,160		$18,160
Aged	$18,311		$19,822		$19,953		$19,991		$19,991
Disabled	$14,945		$16,412		$16,606		$16,660		$16,660
EDB Only (EDB DUAL = 50)	$11,205		$12,330		$11,296		$11,282		$11,282
EDB QMB Only (EDB DUAL = 51)	$132	X	$167		$194		$194		$194
EDB QMB Plus (EDB DUAL = 52)	$14,638		$16,001		$16,179		$16,239		$16,239
EDB SLMB Only (EDB DUAL = 53)	$89	X	$124		$124		$124		$124
EDB SLMB Plus (EDB DUAL = 54)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QDWI (EDB DUAL = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QI-1 (EDB DUAL = 56)	$45		$45		$46	X	$38		$38
EDB QI-2 (EDB DUAL = 57)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Other (EDB DUAL = 58)	$25,692		$27,172		$27,441		$27,469		$27,469
EDB Dual Type Unknown (EDB DUAL = 59)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Dual Status Unknown (EDB DUAL = 98)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	$16,833		$18,348		$18,512		$18,560		$18,560
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	$73	X	$95		$96		$93		$93
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE									
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	$76,861		$80,082		$81,166		$81,428		$81,428
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	$44,297		$47,682		$48,188		$48,202		$48,202
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	$72,230		$78,303		$78,213		$79,273		$79,273
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT									
Avg Medicaid Paid per Section 1915(c) Enrollee	$55,788		$60,768		$61,305		$61,657		$61,657
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Aged (WVR TYPE = H)	$38,571		$40,490		$40,480		$40,602		$40,602
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$56,097		$59,825		$60,352		$60,613		$60,613
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0

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Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$71,702		$80,889		$81,779		$82,398		$82,398
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	$86,846		$98,781		$100,335		$101,307		$101,307
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT									
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	$33,492		$36,473		$36,673		$36,880		$36,880
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Aged (WVR TYPE = H)	$22,003		$22,795		$22,734		$22,816		$22,816
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$19,858		$20,760		$20,795		$20,877		$20,877
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$60,627		$68,321		$68,713		$69,210		$69,210
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	$37,366		$42,782		$43,095		$43,264		$43,264
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EXPENDITURES FOR RESTRICTED BENEFIT ENROLLEES									
Expenditures for Family Planning Enrollees with Restricted Benefits (RBF = 6)									
Total Medicaid Paid for ONLY Family Planning Only Enrollees	$0		$0		$0		$0		$0
Avg Medicaid Paid per ONLY Family Planning Only Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Aliens with Restricted Benefits (RBF = 2)									
Total Medicaid Paid for Aliens with Restricted Benefits ONLY Enrollment	$53,459	X	$72,323		$80,987		$87,462		$87,462
Avg Medicaid Paid per Alien Enrollee with Restricted Benefits ONLY	$8,910		$8,036		$8,099		$8,746		$8,746
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
Total Medicaid Paid for EDB Duals with Only Restricted Benefits Enrollment	$545	X	$1,069		$1,151		$1,151		$1,151
Avg Medicaid Paid per EDB Dual with Only Restricted Benefits Enrollment	$2	X	$4		$4		$4		$4
Expenditures for Prescription Drug Enrollees (RBF = X, Y, or Z)									
Total Medicaid Paid for Prescription Drug ONLY Enrollees (May Have a Month or More of RBF = 3)	$0		$0		$0		$0		$0
Avg Medicaid Paid per Prescription Drug ONLY Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Dual Prescription Drug Enrollees									
Total Medicaid Paid for Prescription Drug ONLY Enrollees Who Are EDB Duals	$0		$0		$0		$0		$0
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.									
Total Medicaid Enrollees	124,331		127,252		127,487		127,487		127,487
Aged Total	7,051		7,118		7,122		7,122		7,122
Disabled Total	16,026		16,311		16,416		16,416		16,416
Child Total	74,852		76,538		76,635		76,635		76,710
Adult Total	26,402		27,285		27,314		27,314		27,239
Total Medicaid Person-Years of Enrollment	94,885		95,981		96,083		96,083		96,083
Total EDB Duals	13,632		13,766		13,787		13,787		13,787

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Aged	6,310		6,378		6,381		6,381		6,381
Disabled	7,177		7,242		7,260		7,260		7,260
TOTAL MEDICAID AMOUNT PAID									
Total Medicaid Paid	$863,379,802		$953,519,873		$970,197,496		$977,273,305		$977,273,305
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$6,944		$7,493		$7,610		$7,666		$7,666
Aged	$19,023		$20,559		$20,691		$20,736		$20,736
Disabled	$21,025		$22,846		$23,104		$23,250		$23,250
Child	$3,558		$3,867		$3,936		$3,973		$3,971
Adult	$4,772		$5,078		$5,195		$5,251		$5,262
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$16,828		$18,336		$18,498		$18,545		$18,545
Aged	$18,839		$20,387		$20,519		$20,558		$20,558
Disabled	$15,180		$16,668		$16,863		$16,917		$16,917
Managed CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.									
% Total Enrollees in MC Anytime During Year	0.00		0.00		0.00		0.00		0.00
Total MC Enrollees	0		0		0		0		0
Aged	0		0		0		0		0
Disabled	0		0		0		0		0
Child	0		0		0		0		0
Adult	0		0		0		0		0
% of MC Enrollees in HMO/HIO (MC TYPE = 1)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% of MC Enrollees in Dental (MC TYPE = 2)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% of MC Enrollees in BHO (MC TYPE = 3)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% of MC Enrollees in Prenatal (MC TYPE = 4)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% of MC Enrollees in LTC (MC TYPE = 5)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% of MC Enrollees in PACE (MC TYPE = 6)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% of MC Enrollees in PCCM (MC TYPE = 7)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% of MC Enrollees in Other MC (MC TYPE = 8)	Div by 0		Div by 0		Div by 0		Div by 0		N/A
% EDB Duals Ever Enrolled in HMO/HIOs	0.00		0.00		0.00		0.00		0.00
% EDB Duals in PHP Only or PHP/PCCM Only	0.00		0.00		0.00		0.00		0.00
% EDB Duals in PCCM Only	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees in PCCM Only	0.00		0.00		0.00		0.00		0.00
Total Enrollees in June	96,769		96,773		96,775		96,775		96,775
June % HMO/HIO Only (MC COMBO = 01)	0.00		0.00		0.00		0.00		0.00
June % Dental Plan Only (MC COMBO = 02)	0.00		0.00		0.00		0.00		0.00
June % BHO Only (MC COMBO = 03)	0.00		0.00		0.00		0.00		0.00
June % PCCM Only (MC COMBO = 04)	0.00		0.00		0.00		0.00		0.00
June % Other MC Only (MC COMBO = 05)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental (MC COMBO = 06)	0.00		0.00		0.00		0.00		0.00

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June % HMO/HIO & BHO (MC COMBO = 07)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Other MC (MC COMBO = 08)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	0.00		0.00		0.00		0.00		0.00
June % Dental & PCCM (MC COMBO = 10)	0.00		0.00		0.00		0.00		0.00
June % BHO & PCCM (MC COMBO = 11)	0.00		0.00		0.00		0.00		0.00
June % Other MC & PCCM (MC COMBO = 12)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO & PCCM (MC COMBO = 13)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO (MC COMBO = 14)	0.00		0.00		0.00		0.00		0.00
June % Other Combinations (MC COMBO = 15)	0.00		0.00		0.00		0.00		0.00
June % FFS Only (MC COMBO = 16)	100.00		100.00		100.00		100.00		100.00
June % MC Status Unknown (MC COMBO = 99)	0.00		0.00		0.00		0.00		0.00
CAPITATION CLAIMS									
Total Capitation Payments	$0		$0		$0		$0		$0
HMO/HIO	$0		$0		$0		$0		$0
PHP	$0		$0		$0		$0		$0
PCCM	$0		$0		$0		$0		$0
Ratio of Capitation Claims to Person-Month Enrollment in MC	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
HMO/HIO	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PHP	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PCCM	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Capitation Payment per Person-Month Enrollment in MC	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
HMO/HIO	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PHP	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PCCM	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY									
Total Capitation Payments	$0		$0		$0		$0		$0
Total Medicaid Paid	$0		$0		$0		$0		$0
Count of Enrollees	0		0		0		0		0
PERSONS ENROLLED IN PCCM ONLY									
Total Capitation Payments	$0		$0		$0		$0		$0
Count of Enrollees	0		0		0		0		0
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR									
Count of Enrollees	0		0		0		0		0
Aged	0		0		0		0		0
Disabled	0		0		0		0		0
Child	0		0		0		0		0
Adult	0		0		0		0		0
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	0		0		0		0		0
Total Capitation Payments	$0		$0		$0		$0		$0
Avg Capitation Payments	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0

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Total FFS Payments	$0		$0		$0		$0		$0
Avg FFS Payments per Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Total FFS Payments by Type of Service									
IP (MAX TOS = 01)	$0		$0		$0		$0		$0
ILTC (MAX TOS = 02, 04, 05, 07)	$0		$0		$0		$0		$0
Drug (MAX TOS = 16)	$0		$0		$0		$0		$0
All Other (Excluding Capitation Payments)	$0		$0		$0		$0		$0
Average FFS Payments by Type of Service									
IP (MAX TOS = 01)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
ILTC (MAX TOS = 02, 04, 05, 07)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Drug (MAX TOS = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
All Other (Excluding Capitation Payments)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total Non-Dual FFS Enrollees	110,699		113,486		113,700		113,700		113,700
Total Non-Dual FFS Recipients	92,057		95,052		95,704		96,078		96,078
Total Non-Dual FFS Person-Years of Enrollment	82,506		83,559		83,655		83,655		83,655
Aged Total	741		740		741		741		741
Aged, Cash (MAX ELIG CD = 11)	700		702		703		703		703
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	2		2		2		2		2
Other Aged (MAX ELIG CD = 41)	39		36		36		36		36
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	8,849		9,069		9,156		9,156		9,156
Disabled, Cash (MAX ELIG CD = 12)	7,779		7,950		8,020		8,020		8,020
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	161		164		164		164		164
Other Disabled (MAX ELIG CD = 42)	909		955		972		972		972
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	74,851		76,537		76,634		76,634		76,709
AFDC Child, Cash (MAX ELIG CD = 14)	17,593		18,012		18,104		18,104		18,104
AFDC-U Child, Cash (MAX ELIG CD = 16)	353		384	X	311		311		311
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	45,725		46,858		46,915		46,915		50,846
Other Child (MAX ELIG CD = 44)	4,221		4,219		4,224		4,224		4,224
Foster Care Child (MAX ELIG CD = 48)	3,231		3,222		3,224		3,224		3,224
1115 Child (MAX ELIG CD = 54)	3,728		3,842		3,856		3,856		0
Adult Total	26,258		27,140		27,169		27,169		27,094
AFDC Adult, Cash (MAX ELIG CD = 15)	14,351		14,743		14,818		14,818		14,818

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AFDC-U Adult, Cash (MAX ELIG CD = 17)	643		681		610		610		610
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	9,215		9,659		9,683		9,683		9,683
Other Adult (MAX ELIG CD = 45)	1,973		1,982		1,983		1,983		1,983
1115 Adult (MAX ELIG CD = 55)	76		75		75		75		0
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	130		126		127		127		127
Total FFS Medicaid Paid	$633,977,543		$701,110,235		$715,161,113		$721,588,010		$721,588,010
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	$5,727		$6,178		$6,290		$6,346		$6,346
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	$6,887		$7,376		$7,473		$7,510		$7,510
Total Capitation Payments	$0		$0		$0		$0		$0
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	0		0		0		0		0
Total HMO/HIO Payments (Among People not Enrolled)	$0		$0		$0		$0		$0
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$20,593		$22,045		$22,174		$22,277		$22,277
Aged, Cash (MAX ELIG CD = 11)	$18,827		$20,280		$20,419		$20,526		$20,526
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$0		$0		$0		$0		$0
Other Aged (MAX ELIG CD = 41)	$53,341		$57,675		$57,693		$57,705		$57,705
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$25,766		$27,780		$28,053		$28,271		$28,271
Disabled, Cash (MAX ELIG CD = 12)	$26,160		$28,136		$28,409		$28,635		$28,635
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$13,091		$14,957		$15,119		$15,246		$15,246
Other Disabled (MAX ELIG CD = 42)	$24,641		$27,018		$27,298		$27,463		$27,463
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$3,558		$3,867		$3,936		$3,973		$3,971
AFDC Child, Cash (MAX ELIG CD = 14)	$2,367		$2,562		$2,589		$2,614		$2,614
AFDC-U Child, Cash (MAX ELIG CD = 16)	$1,468	X	$1,461	X	$1,789		$1,847		$1,847
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child Poverty (MAX ELIG CD = 34)	$3,395		$3,721		$3,805		$3,848		$3,722
Other Child (MAX ELIG CD = 44)	$7,070		$7,687		$7,780		$7,843		$7,843
Foster Care Child (MAX ELIG CD = 48)	$9,726		$10,544		$10,622		$10,648		$10,648
1115 Child (MAX ELIG CD = 54)	$2,049		$2,214		$2,224		$2,238		Div by 0
Adult	$4,739		$5,044		$5,161		$5,217		$5,228
AFDC Adult, Cash (MAX ELIG CD = 15)	$4,731		$5,051		$5,146		$5,200		$5,200
AFDC-U Adult, Cash (MAX ELIG CD = 17)	$3,403		$3,506		$3,807		$3,858		$3,858
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult, Poverty (MAX ELIG CD = 35)	$5,029		$5,331		$5,469		$5,529		$5,529
Other Adult (MAX ELIG CD = 45)	$4,012		$4,263		$4,340		$4,391		$4,391
1115 Adult (MAX ELIG CD = 55)	$1,170		$1,141		$1,146		$1,146		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$122,154,462		$139,788,078		$144,580,645		$146,323,748		$146,323,748
IP: Number of Users	11,048		12,620		12,975		13,114		13,114
IP: Avg Medicaid Paid per User	$11,057		$11,077		$11,143		$11,158		$11,158

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IP: Avg Medicaid Covered Days Per User	4.75		4.75		4.78		4.79		4.79
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$8,386		$8,386		$8,386		$8,386		$8,386
MH Aged: Number of Users	1		1		1		1		1
MH Aged: Avg Medicaid Paid per User	$8,386		$8,386		$8,386		$8,386		$8,386
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$54,275,332		$60,283,137		$60,636,258		$60,848,770		$60,848,770
IP Psych, Age < 21: Number of Users	1,203		1,258		1,259		1,261		1,261
IP Psych, Age < 21: Avg Medicaid Paid per User	$45,117		$47,920		$48,162		$48,254		$48,254
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$907,272		$1,035,412		$1,035,412		$1,035,412		$1,035,412
ICF/MR: Number of Users	7		7		7		7		7
ICF/MR: Avg Medicaid Paid per User	$129,610		$147,916		$147,916		$147,916		$147,916
NF: Total Medicaid Paid (MAX TOS = 07)	$11,079,339		$12,536,154		$12,939,600		$13,004,296		$13,004,296
NF: Number of Users	163		175		185		188		188
NF:Avg Medicaid Paid per User	$67,971		$71,635		$69,944		$69,172		$69,172
Physician: Total Medicaid Paid (MAX TOS = 08)	$52,878,374		$59,529,729		$61,238,476		$62,178,422		$62,178,422
Physician: Number of Users	62,654		67,033		68,266		69,308		69,308
Physician: Avg Medicaid Paid per User	$844		$888		$897		$897		$897
Dental: Total Medicaid Paid (MAX TOS = 09)	$22,537,777		$24,169,490		$24,415,701		$24,548,625		$24,548,625
Dental: Number of Users	36,692		38,352		38,681		38,921		38,921
Dental: Avg Medicaid Paid per User	$614		$630		$631		$631		$631
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$3,424,036		$3,712,061		$3,747,149		$3,757,784		$3,757,784
Other Practitioner: Number of Users	14,469		15,395		15,502		15,542		15,542
Other Practitioner: Avg Medicaid Paid per User	$237		$241		$242		$242		$242
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$39,678,306		$44,437,352		$45,353,440		$45,824,163		$45,824,163
Outpatient: Number of Users	30,934		33,193		33,811		34,082		34,082
Outpatient: Avg Medicaid Paid per User	$1,283		$1,339		$1,341		$1,345		$1,345
Clinic: Total Medicaid Paid (MAX TOS = 12)	$32,151,764		$36,490,847		$37,899,297		$38,789,336		$38,789,336
Clinic: Number of Users	25,730		28,151		28,906		29,239		29,239
Clinic: Avg Medicaid Paid per User	$1,250		$1,296		$1,311		$1,327		$1,327
Home Health: Total Medicaid Paid (MAX TOS = 13)	$530,005	X	$729,815		$826,858		$846,903		$846,903
Home Health: Number of Users	176	X	227		268		275		275
Home Health: Avg Medicaid Paid per User	$3,011		$3,215		$3,085		$3,080		$3,080
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$28,080,327		$31,177,116		$32,030,715		$32,498,564		$32,498,564
Lab/Xray: Number of Users	46,333		49,562		50,518		51,357		51,357
Lab/Xray:Avg Medicaid Paid per User	$606		$629		$634		$633		$633
Drugs: Total Medicaid Paid (MAX TOS = 16)	$72,696,437		$73,566,443		$73,707,024		$73,823,652		$73,823,652
Drugs: Number of Users	58,833		59,620		59,911		60,138		60,138
Drugs: Avg Medicaid Paid per User	$1,236		$1,234		$1,230		$1,228		$1,228
Other Services: Total Medicaid Paid (MAX TOS = 19)	$17,374,351		$20,000,318		$20,440,278		$20,635,257		$20,632,437
Other Services: Number of Users	5,069		5,354		5,449		5,475		5,474
Other Services: Avg Medicaid Paid per User	$3,428		$3,736		$3,751		$3,769		$3,769
Transportation: Total Medicaid Paid (MAX TOS = 26)	$39,565,578		$42,173,901		$42,456,128		$42,600,606		$42,600,606
Transportation: Number of Users	17,265		17,730		17,786		17,815		17,815
Transportation: Avg Medicaid Paid per User	$2,292		$2,379		$2,387		$2,391		$2,391
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$24,350,807		$25,925,736		$26,075,303		$26,126,357		$26,126,357

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Personal Care Services: Number of Users	1,327		1,383		1,396		1,398		1,398
Personal Care Services: Avg Medicaid Paid per User	$18,350		$18,746		$18,679		$18,688		$18,688
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$3,383,527		$3,934,014		$4,053,654		$4,105,167		$4,105,167
Targeted Case Management: Number of Users	2,451		2,671		2,763		2,811		2,811
Targeted Case Management: Avg Medicaid Paid per User	$1,380		$1,473		$1,467		$1,460		$1,460
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$174,306		$202,040		$204,045		$204,045		$204,045
Rehabilitation Services: Number of Users	122		134		136		136		136
Rehabilitation Services: Avg Medicaid Paid per User	$1,429		$1,508		$1,500		$1,500		$1,500
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$6,945,648		$7,469,109		$7,611,407		$7,671,998		$7,671,998
PT/OT/Speech/Hearing: Number of Users	3,643		3,852		3,890		3,924		3,924
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,907		$1,939		$1,957		$1,955		$1,955
Hospice: Total Medicaid Paid (MAX TOS = 35)	$133,261	X	$180,184		$196,177		$199,569		$199,569
Hospice: Number of Users	20	X	24		27		27		27
Hospice: Avg Medicaid Paid per User	$6,663		$7,508		$7,266		$7,391		$7,391
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$11,545,781		$12,984,992		$13,374,924		$13,497,290		$13,497,290
Durable Medical Equipment: Number of Users	22,789		23,820		24,020		24,148		24,148
Durable Medical Equipment: Avg Medicaid Paid per User	$507		$545		$557		$559		$559
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$21,407,068		$24,765,326		$25,264,978		$25,502,064		$25,502,064
Residential Care: Number of Users	456		486		494		497		497
Residential Care: Avg Medicaid Paid per User	$46,945		$50,957		$51,144		$51,312		$51,312
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$63,144,737		$69,476,323		$70,404,491		$70,810,451		$70,813,271
Psych Services: Number of Users	12,153		12,824		13,010		13,108		13,117
Psych Services: Avg Medicaid Paid per User	$5,196		$5,418		$5,412		$5,402		$5,399
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$256,321		$267,925		$258,996		$258,996		$258,996
Adult Day Care: Number of Users	82		84		84		84		84
Adult Day Care: Avg Medicaid Paid per User	$3,126		$3,190		$3,083		$3,083		$3,083
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$1,103		$1,232		$1,272		$1,287		$1,287
Aged	$2,119		$2,362		$2,396		$2,410		$2,410
Disabled	$3,992		$4,392		$4,475		$4,530		$4,530
Child	$732		$837		$868		$878		$878
Adult	$1,159		$1,258		$1,301		$1,315		$1,319
ILTC (MAX TOS = 02,04,05,07)	$599		$651		$656		$659		$659
Aged	$3,638		$4,012		$3,908		$3,908		$3,908
Disabled	$1,925		$2,134		$2,182		$2,192		$2,192
Child	$595		$647		$647		$649		$649
Adult	$76		$74		$78		$79		$80
Drugs (MAX TOS = 16)	$657		$648		$648		$649		$649
Aged	$2,448		$2,467		$2,458		$2,458		$2,458
Disabled	$4,568		$4,500		$4,466		$4,470		$4,470
Child	$226		$225		$226		$227		$227
Adult	$517		$504		$504		$504		$505
All Other Services	$3,368		$3,647		$3,714		$3,751		$3,751
Aged	$12,388		$13,204		$13,412		$13,500		$13,500

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Disabled	$15,281		$16,755		$16,931		$17,078		$17,078
Child	$2,004		$2,157		$2,195		$2,219		$2,218
Adult	$2,987		$3,208		$3,278		$3,317		$3,324
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	9.98		11.12		11.41		11.53		11.53
Aged	14.84		16.35		16.87		16.87		16.87
Disabled	14.27		15.37		15.60		15.76		15.76
Child	6.94		7.98		8.26		8.35		8.34
Adult	17.06		18.40		18.75		18.94		18.99
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	1.24		1.27		1.28		1.28		1.28
Aged	3.64		3.65		3.51		3.51		3.51
Disabled	3.15		3.25		3.35		3.39		3.39
Child	1.35		1.38		1.38		1.38		1.38
Adult	0.22		0.21		0.22		0.22		0.22
% with Ratio of ILTC Days/Enrollment Days > 1	0.22	X	0.14	X	0.28		0.27		0.27
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	53.15		52.54		52.69		52.89		52.89
Aged	70.58		70.81		70.85		70.99		70.99
Disabled	81.29		79.92		79.46		79.62		79.62
Child	45.88		45.55		45.74		45.95		45.94
Adult	63.89		62.59		62.80		62.97		63.04
% Non-Dual FFS Enrollees with All Other Claims	81.04		82.12		82.65		83.08		83.08
Aged	87.04		87.03		87.04		87.18		87.18
Disabled	91.32		91.42		91.48		91.82		91.82
Child	79.96		81.17		81.72		82.13		82.11
Adult	80.50		81.58		82.20		82.69		82.75
Avg # IP Days per Non-Dual FFS User	5		5		5		5		5
Aged	6		6		6		6		6
Disabled	12		12		12		12		12
Child	4		4		4		4		4
Adult	3		3		3		3		3
Avg # ILTC Days per Non-Dual FFS User	124		132		132		132		132
Aged	241		263		265		265		265
Disabled	149		159		158		157		157
Child	116		123		123		124		124
Adult	96		98		100		101		101
% Non-Dual FFS Enrollees with Maternal Delivery	3.48		3.80		3.87		3.91		3.91
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	1		1		1		1		1
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	13	X	15		17		17		17
Inpatient Hospital (MAX TOS = 01) > $500,000	7		7		8		8		8
ILTC (MAX TOS = 02,04,05,07) > $200,000	10		12		12		12		12
Drugs (MAX TOS = 16) > $200,000	3		3		3		3		3
All Other Services > $200,000	24	X	43		44		44		44
Maximum FFS Medicaid Paid	$1,311,975		$1,526,623		$1,556,650		$1,556,665		$1,556,665

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Inpatient Hospital (MAX TOS = 01)	$1,140,999		$1,231,040		$1,231,040		$1,231,040		$1,231,040
ILTC (MAX TOS = 02,04,05,07)	$273,914		$299,261		$299,261		$299,261		$299,261
Drugs (MAX TOS = 16)	$803,154		$803,154		$803,154		$803,154		$803,154
All Other Services	$432,418	X	$541,447		$599,938		$600,622		$600,622
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$2,138,753	X	$2,508,279		$2,642,418		$2,684,999		$2,684,999
FP: Number of Users	4,584		4,817		4,900		4,908		4,908
FP: Avg Medicaid Paid per User	$467		$521		$539		$547		$547
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$2,987,399		$3,254,145		$3,441,494		$3,466,221		$3,466,221
FQHC: Number of Users	4,412		4,802		4,979		5,022		5,022
FQHC: Avg Medicaid Paid per User	$677		$678		$691		$690		$690
IHS: Total Medicaid Paid (PGM TYPE = 5)	$42,749,235		$47,874,379		$48,706,921		$49,033,980		$49,033,980
IHS: Number of Users	15,552		16,755		17,065		17,305		17,305
IHS: Avg Medicaid Paid per User	$2,749		$2,857		$2,854		$2,834		$2,834
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$47,931,123		$55,158,045		$56,366,582		$56,896,989		$56,896,989
Section 1915(c) Waiver: Number of Users	1,759		1,898		1,933		1,976		1,976
Section 1915(c) Waiver: Avg Medicaid Paid per User	$27,249		$29,061		$29,160		$28,794		$28,794
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$69,502,137		$78,268,688		$79,620,935		$80,191,687		$80,191,687
Number of Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	2,394		2,572		2,635		2,678		2,678
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	$29,032		$30,431		$30,217		$29,945		$29,945
Aged	$24,392		$25,586		$25,747		$25,904		$25,904
Disabled	$30,588		$32,391		$32,440		$32,096		$32,096
Child	$9,758	X	$8,323		$7,210		$7,218		$7,218
Adult	$8,162	X	$7,046		$6,710		$6,518		$6,518
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	2.16		2.27		2.32		2.36		2.36
Aged	33.20		33.51		33.74		33.74		33.74
Disabled	23.11		24.12		24.25		24.68		24.68
Child	0.09	X	0.12	X	0.15		0.16		0.16
Adult	0.13	X	0.16		0.17		0.18		0.18
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$47,931,123		$55,158,045		$56,366,582		$56,896,989		$56,896,989
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	1,759		1,898		1,933		1,976		1,976
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$27,249		$29,061		$29,160		$28,794		$28,794
Aged	$16,718		$17,533		$18,246		$18,236		$18,236
Disabled	$28,199		$30,280		$30,365		$29,967		$29,967
Child	$15,598	X	$12,670		$12,892		$12,731		$12,731
Adult	$1,004		$1,039		$1,033		$1,033		$1,033
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	1.59		1.67		1.70		1.74		1.74
Aged	11.88		12.16		12.28		12.55		12.55

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Disabled	18.41		19.29		19.44		19.88		19.88
Child	0.04	X	0.06		0.07		0.07		0.07
Adult	0.03	X	0.04		0.04		0.04		0.04
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total EDB Dual FFS Enrollees	13,632		13,766		13,787		13,787		13,787
Number of EDB Dual FFS Recipients	12,634		12,831		12,874		12,899		12,899
Total EDB Dual FFS Person-Years of Enrollment	12,379		12,422		12,428		12,428		12,428
% EDB Only Dual (EDB DUAL = 50)	7.31		6.57		6.37		6.37		6.37
% QMB Only (EDB DUAL = 51)	0.00		0.00		0.00		0.00		0.00
% QMB Plus (EDB DUAL = 52)	70.33		70.06		69.95		69.95		69.95
% SLMB Only (EDB DUAL = 53)	0.13		0.12		0.13		0.13		0.13
% SLMB Plus (EDB DUAL = 54)	0.00		0.00		0.00		0.00		0.00
% QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% QI 1 (EDB DUAL = 56)	0.05		0.05		0.05		0.05		0.05
% QI 2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% Other Type Dual (EDB DUAL = 58)	22.17		23.19		23.50		23.50		23.50
% Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	99.82		99.83		99.82		99.82		99.82
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	0.18		0.17		0.18		0.18		0.18
Aged EDB Dual FFS Total	6,310		6,378		6,381		6,381		6,381
Aged, Cash (MAX ELIG CD = 11)	5,379		5,429		5,428		5,428		5,428
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	14		13		13		13		13
Other Aged (MAX ELIG CD = 41)	917		936		940		940		940
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled EDB Dual FFS Total	7,177		7,242		7,260		7,260		7,260
Disabled, Cash (MAX ELIG CD = 12)	6,551		6,608		6,623		6,623		6,623
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	13		12		13		13		13
Other Disabled (MAX ELIG CD = 42)	613		622		624		624		624
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Total FFS Medicaid Paid	$229,402,259		$252,409,638		$255,036,383		$255,685,295		$255,685,295
Avg FFS Medicaid Paid per FFS Dual	$16,828		$18,336		$18,498		$18,545		$18,545
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	$18,158		$19,672		$19,810		$19,822		$19,822
Total Capitation Payments	$0		$0		$0		$0		$0
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	0		0		0		0		0
Total HMO/HIO Payments (Among People not Enrolled)	$0		$0		$0		$0		$0
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP									
Aged	$18,839		$20,387		$20,519		$20,558		$20,558
Aged, Cash (MAX ELIG CD = 11)	$11,182		$11,988		$12,048		$12,086		$12,086
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$818		$744		$763		$763		$763

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Other Aged (MAX ELIG CD = 41)	$64,031		$69,375		$69,705		$69,751		$69,751
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$15,180		$16,668		$16,863		$16,917		$16,917
Disabled, Cash (MAX ELIG CD = 12)	$13,258		$14,575		$14,760		$14,815		$14,815
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$771	X	$444		$473		$406		$406
Other Disabled (MAX ELIG CD = 42)	$36,027		$39,213		$39,523		$39,576		$39,576
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$3,115,304		$3,547,377		$3,295,879		$3,287,766		$3,287,766
IP: Number of Users	1,684		1,972		1,723		1,736		1,736
IP: Avg Medicaid Paid per User	$1,850		$1,799		$1,913		$1,894		$1,894
IP: Avg Medicaid Covered Days Per User	0.33		0.28		0.33		0.32		0.32
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$44,107		$44,198		$44,198		$52,902		$52,902
MH Aged: Number of Users	5		5		5		6		6
MH Aged: Avg Medicaid Paid per User	$8,821		$8,840		$8,840		$8,817		$8,817
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$42,977		$42,977		$42,977		$42,977		$42,977
IP Psych, Age < 21: Number of Users	2		2		2		2		2
IP Psych, Age < 21: Avg Medicaid Paid per User	$21,489		$21,489		$21,489		$21,489		$21,489
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$6,842	X	$16,843		$16,843		$16,843		$16,843
ICF/MR: Number of Users	1		1		1		1		1
ICF/MR: Avg Medicaid Paid per User	$6,842	X	$16,843		$16,843		$16,843		$16,843
NF: Total Medicaid Paid (MAX TOS = 07)	$55,938,359		$62,826,335		$63,487,642		$63,518,333		$63,518,333
NF: Number of Users	651		759		745		745		745
NF:Avg Medicaid Paid per User	$85,927		$82,775		$85,218		$85,260		$85,260
Physician: Total Medicaid Paid (MAX TOS = 08)	$3,677,056		$4,129,840		$4,252,026		$4,307,315		$4,307,315
Physician: Number of Users	9,798		10,218		10,334		10,415		10,415
Physician: Avg Medicaid Paid per User	$375		$404		$411		$414		$414
Dental: Total Medicaid Paid (MAX TOS = 09)	$2,939,961		$3,152,132		$3,189,849		$3,207,809		$3,207,809
Dental: Number of Users	3,275		3,433		3,453		3,468		3,468
Dental: Avg Medicaid Paid per User	$898		$918		$924		$925		$925
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$456,715		$503,130		$506,467		$508,554		$508,554
Other Practitioner: Number of Users	3,603		3,867		3,856		3,923		3,923
Other Practitioner: Avg Medicaid Paid per User	$127		$130		$131		$130		$130
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$3,716,368		$4,424,375		$4,405,104		$4,424,001		$4,424,001
Outpatient: Number of Users	6,602		7,084		7,002		7,018		7,018
Outpatient: Avg Medicaid Paid per User	$563		$625		$629		$630		$630
Clinic: Total Medicaid Paid (MAX TOS = 12)	$3,789,720		$3,888,096		$3,904,890		$3,912,385		$3,912,385
Clinic: Number of Users	4,719		5,009		5,083		5,151		5,151
Clinic: Avg Medicaid Paid per User	$803		$776		$768		$760		$760
Home Health: Total Medicaid Paid (MAX TOS = 13)	$19,502	X	$21,102	X	$67,199		$69,839		$69,839
Home Health: Number of Users	12	X	12	X	19		19		19
Home Health: Avg Medicaid Paid per User	$1,625	X	$1,759	X	$3,537		$3,676		$3,676
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$1,993,849		$2,313,925		$2,325,906		$2,348,657		$2,348,657

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Lab/Xray: Number of Users	8,037		8,494		8,550		8,608		8,608
Lab/Xray:Avg Medicaid Paid per User	$248		$272		$272		$273		$273
Drugs: Total Medicaid Paid (MAX TOS = 16)	$2,951,379		$2,971,551		$2,976,638		$2,976,996		$2,976,996
Drugs: Number of Users	3,968		3,987		3,989		3,989		3,989
Drugs: Avg Medicaid Paid per User	$744		$745		$746		$746		$746
Other Services: Total Medicaid Paid (MAX TOS = 19)	$40,649,702		$44,882,402		$45,374,940		$45,506,595		$45,506,595
Other Services: Number of Users	2,597		2,733		2,764		2,782		2,782
Other Services: Avg Medicaid Paid per User	$15,653		$16,422		$16,416		$16,358		$16,358
Transportation: Total Medicaid Paid (MAX TOS = 26)	$9,447,118		$10,051,105		$10,132,568		$10,140,954		$10,140,954
Transportation: Number of Users	4,585		4,773		4,800		4,809		4,809
Transportation: Avg Medicaid Paid per User	$2,060		$2,106		$2,111		$2,109		$2,109
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$54,350,145		$57,514,962		$57,804,643		$57,872,875		$57,872,875
Personal Care Services: Number of Users	2,634		2,714		2,726		2,732		2,732
Personal Care Services: Avg Medicaid Paid per User	$20,634		$21,192		$21,205		$21,183		$21,183
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$5,264,953		$5,818,815		$5,878,366		$5,903,750		$5,903,750
Targeted Case Management: Number of Users	2,646		2,762		2,789		2,793		2,793
Targeted Case Management: Avg Medicaid Paid per User	$1,990		$2,107		$2,108		$2,114		$2,114
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$9,759		$9,759		$9,759		$9,759		$9,759
Rehabilitation Services: Number of Users	199		199		199		199		199
Rehabilitation Services: Avg Medicaid Paid per User	$49		$49		$49		$49		$49
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$243,020		$286,375		$296,203		$301,769		$301,769
PT/OT/Speech/Hearing: Number of Users	986		1,111		1,128		1,137		1,137
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$246		$258		$263		$265		$265
Hospice: Total Medicaid Paid (MAX TOS = 35)	$3,231	X	$3,231	X	$4,527		$4,527		$4,527
Hospice: Number of Users	1	X	1	X	2		2		2
Hospice: Avg Medicaid Paid per User	$3,231	X	$3,231	X	$2,264		$2,264		$2,264
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$5,662,960		$6,133,823		$6,212,334		$6,264,002		$6,264,002
Durable Medical Equipment: Number of Users	7,225		7,440		7,479		7,514		7,514
Durable Medical Equipment: Avg Medicaid Paid per User	$784		$824		$831		$834		$834
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$25,833,006		$29,465,000		$30,175,637		$30,293,954		$30,293,954
Residential Care: Number of Users	403		420		425		425		425
Residential Care: Avg Medicaid Paid per User	$64,102		$70,155		$71,001		$71,280		$71,280
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$7,478,934		$8,395,407		$8,619,089		$8,691,007		$8,691,007
Psych Services: Number of Users	2,982		3,153		3,194		3,225		3,225
Psych Services: Avg Medicaid Paid per User	$2,508		$2,663		$2,699		$2,695		$2,695
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$1,563,241		$1,745,218		$1,781,631		$1,791,760		$1,791,760
Adult Day Care: Number of Users	333		341		349		352		352
Adult Day Care: Avg Medicaid Paid per User	$4,694		$5,118		$5,105		$5,090		$5,090
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$229		$258		$239		$238		$238
Aged	$173		$206		$189		$190		$190
Disabled	$248		$274		$254		$251		$251
ILTC (MAX TOS = 02,04,05,07)	$4,110		$4,571		$4,612		$4,615		$4,615
Aged	$7,120		$7,910		$7,990		$7,995		$7,995

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Disabled	$1,547		$1,723		$1,737		$1,738		$1,738
Drugs (MAX TOS = 16)	$217		$216		$216		$216		$216
Aged	$67		$68		$68		$68		$68
Disabled	$289		$288		$288		$288		$288
All Other Services	$12,273		$13,291		$13,431		$13,476		$13,476
Aged	$11,479		$12,203		$12,272		$12,305		$12,305
Disabled	$13,096		$14,383		$14,584		$14,641		$14,641
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Duals with IP Claims (MAX TOS = 01)	12.35		14.33		12.50		12.59		12.59
Aged	13.20		15.49		13.71		13.81		13.81
Disabled	11.58		13.27		11.38		11.46		11.46
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	4.83		5.56		5.45		5.46		5.46
Aged	8.10		9.05		9.03		9.03		9.03
Disabled	2.05		2.61		2.42		2.44		2.44
% FFS Duals with Drug Claims (MAX TOS = 16)	29.11		28.96		28.93		28.93		28.93
Aged	22.95		22.89		22.85		22.85		22.85
Disabled	34.01		33.82		33.79		33.79		33.79
% FFS Duals with All Other Claims	91.77		92.45		92.64		92.83		92.83
Aged	91.52		92.10		92.34		92.57		92.57
Disabled	92.11		92.87		92.99		93.15		93.15
Avg # IP Days per FFS Dual User (MAX TOS = 01)	0		0		0		0		0
Aged	0		0		0		0		0
Disabled	1		0		1		1		1
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	201		193		199		199		199
Aged	206		204		207		207		207
Disabled	182		159		173		172		172
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Duals with FFS Medicaid Paid > $500,000	0		0		0		0		0
Inpatient Hospital (MAX TOS = 01) > $500,000	0		0		0		0		0
ILTC (MAX TOS = 02,04,05,07) > $200,000	30	X	44		45		45		45
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	15	X	28		31		31		31
Maximum FFS Medicaid Paid	$337,128		$302,442		$302,442		$302,442		$302,442
Inpatient Hospital (MAX TOS = 01)	$186,705		$186,705		$186,705		$186,705		$186,705
ILTC (MAX TOS = 02,04,05,07)	$272,538		$298,122		$298,122		$298,122		$298,122
Drugs (MAX TOS = 16)	$75,370		$75,370		$75,370		$75,370		$75,370
All Other Services	$277,537		$285,707		$285,707		$285,707		$285,707
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$9,323	X	$12,415	X	$14,461		$15,523		$15,523
FP: Number of Users	54	X	65		71		73		73
FP: Avg Medicaid Paid per User	$173		$191		$204		$213		$213
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0

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RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$284,766		$323,722		$337,363		$345,102		$345,102
FQHC: Number of Users	1,590		1,734		1,779		1,834		1,834
FQHC: Avg Medicaid Paid per User	$179		$187		$190		$188		$188
IHS: Total Medicaid Paid (PGM TYPE = 5)	$1,239,329		$1,457,433		$1,507,862		$1,525,769		$1,525,769
IHS: Number of Users	1,082		1,188		1,187		1,197		1,197
IHS: Avg Medicaid Paid per User	$1,145		$1,227		$1,270		$1,275		$1,275
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$82,760,422		$92,376,947		$93,880,567		$94,222,097		$94,222,097
Section 1915(c) Waiver: Number of Users	2,691		2,801		2,825		2,828		2,828
Section 1915(c) Waiver: Avg Medicaid Paid per User	$30,755		$32,980		$33,232		$33,318		$33,318
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$130,104,902		$142,069,818		$143,765,272		$144,120,645		$144,120,645
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	3,846		3,970		3,992		3,998		3,998
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	$33,829		$35,786		$36,013		$36,048		$36,048
Aged	$27,699		$28,443		$28,487		$28,466		$28,466
Disabled	$41,721		$45,404		$45,850		$45,973		$45,973
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	28.21		28.84		28.95		29.00		29.00
Aged	34.18		35.18		35.29		35.37		35.37
Disabled	23.48		23.78		23.90		23.91		23.91
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$82,760,422		$92,376,947		$93,880,567		$94,222,097		$94,222,097
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	2,691		2,801		2,825		2,828		2,828
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$30,755		$32,980		$33,232		$33,318		$33,318
Aged	$21,986		$22,668		$22,644		$22,658		$22,658
Disabled	$40,746		$45,007		$45,547		$45,740		$45,740
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	19.74		20.35		20.49		20.51		20.51
Aged	22.68		23.61		23.77		23.82		23.82
Disabled	17.54		17.87		18.00		18.00		18.00
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total FFS Enrollees	124,331		127,252		127,487		127,487		127,487
# FFS Recipients	104,691		107,883		108,578		108,977		108,977
% FFS Enrollees Who Are Recipients	84.20		84.78		85.17		85.48		85.48
% Aged Who Are Recipients	92.33		92.75		92.95		93.16		93.16
% Disabled Who Are Recipients	92.72		92.86		92.90		93.13		93.13
% Child Who Are Recipients	81.90		82.65		83.08		83.39		83.37
% Adults Who Are Recipients	83.39		83.85		84.33		84.74		84.79
Total FFS Person-Years of Enrollment	94,885		95,981		96,083		96,083		96,083
Aged Total	7,051		7,118		7,122		7,122		7,122
Aged, Cash (MAX ELIG CD = 11)	6,079		6,131		6,131		6,131		6,131
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	16		15		15		15		15

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Other Aged (MAX ELIG CD = 41)	956		972		976		976		976
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	16,026		16,311		16,416		16,416		16,416
Disabled, Cash (MAX ELIG CD = 12)	14,330		14,558		14,643		14,643		14,643
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	174		176		177		177		177
Other Disabled (MAX ELIG CD = 42)	1,522		1,577		1,596		1,596		1,596
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	74,852		76,538		76,635		76,635		76,710
AFDC Child, Cash (MAX ELIG CD = 14)	17,593		18,012		18,104		18,104		18,104
AFDC-U Child, Cash (MAX ELIG CD = 16)	353		384	X	311		311		311
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	45,725		46,858		46,915		46,915		50,846
Other Child (MAX ELIG CD = 44)	4,222		4,220		4,225		4,225		4,225
Foster Care Child (MAX ELIG CD = 48)	3,231		3,222		3,224		3,224		3,224
1115 Child (MAX ELIG CD = 54)	3,728		3,842		3,856		3,856		0
Adult Total	26,402		27,285		27,314		27,314		27,239
AFDC Adult, Cash (MAX ELIG CD = 15)	14,464		14,857		14,932		14,932		14,932
AFDC-U Adult, Cash (MAX ELIG CD = 17)	644		681		610		610		610
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	9,227		9,671		9,695		9,695		9,695
Other Adult (MAX ELIG CD = 45)	1,991		2,001		2,002		2,002		2,002
1115 Adult (MAX ELIG CD = 55)	76		75		75		75		0
Total FFS Medicaid Paid	$863,379,802		$953,519,873		$970,197,496		$977,273,305		$977,273,305
Avg FFS Medicaid Paid per FFS Enrollee	$6,944		$7,493		$7,610		$7,666		$7,666
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	$8,247		$8,838		$8,935		$8,968		$8,968
Total Capitation Payments	$0		$0		$0		$0		$0
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	0		0		0		0		0
Total HMO/HIO Payments (Among People not Enrolled)	$0		$0		$0		$0		$0
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$19,023		$20,559		$20,691		$20,736		$20,736
Aged, Cash (MAX ELIG CD = 11)	$12,062		$12,938		$13,008		$13,054		$13,054
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$716		$645		$661		$661		$661
Other Aged (MAX ELIG CD = 41)	$63,595		$68,942		$69,262		$69,306		$69,306
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$21,025		$22,846		$23,104		$23,250		$23,250
Disabled, Cash (MAX ELIG CD = 12)	$20,262		$21,981		$22,236		$22,384		$22,384
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$12,170		$13,967		$14,044		$14,156		$14,156
Other Disabled (MAX ELIG CD = 42)	$29,227		$31,828		$32,078		$32,199		$32,199
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$3,558		$3,867		$3,936		$3,973		$3,971
AFDC Child, Cash (MAX ELIG CD = 14)	$2,367		$2,562		$2,589		$2,614		$2,614

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AFDC-U Child, Cash (MAX ELIG CD = 16)	$1,468	X	$1,461	X	$1,789		$1,847		$1,847
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child Poverty (MAX ELIG CD = 34)	$3,395		$3,721		$3,805		$3,848		$3,722
Other Child (MAX ELIG CD = 44)	$7,069		$7,687		$7,779		$7,842		$7,842
Foster Care Child (MAX ELIG CD = 48)	$9,726		$10,544		$10,622		$10,648		$10,648
1115 Child (MAX ELIG CD = 54)	$2,049		$2,214		$2,224		$2,238		Div by 0
Adult	$4,772		$5,078		$5,195		$5,251		$5,262
AFDC Adult, Cash (MAX ELIG CD = 15)	$4,796		$5,117		$5,212		$5,266		$5,266
AFDC-U Adult, Cash (MAX ELIG CD = 17)	$3,398		$3,506		$3,807		$3,858		$3,858
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult, Poverty (MAX ELIG CD = 35)	$5,024		$5,327		$5,464		$5,524		$5,524
Other Adult (MAX ELIG CD = 45)	$4,019		$4,270		$4,346		$4,395		$4,395
1115 Adult (MAX ELIG CD = 55)	$1,170		$1,141		$1,146		$1,146		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$125,269,766		$143,335,455		$147,876,524		$149,611,514		$149,611,514
IP: Number of Users	12,732		14,592		14,698		14,850		14,850
IP: Avg Medicaid Paid per User	$9,839		$9,823		$10,061		$10,075		$10,075
IP: Avg Medicaid Covered Days Per User	4.16		4.15		4.26		4.27		4.27
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$52,493		$52,584		$52,584		$61,288		$61,288
MH Aged: Number of Users	6		6		6		7		7
MH Aged: Avg Medicaid Paid per User	$8,749		$8,764		$8,764		$8,755		$8,755
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$54,318,309		$60,326,114		$60,679,235		$60,891,747		$60,891,747
IP Psych, Age < 21: Number of Users	1,205		1,260		1,261		1,263		1,263
IP Psych, Age < 21: Avg Medicaid Paid per User	$45,077		$47,878		$48,120		$48,212		$48,212
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$914,114		$1,052,255		$1,052,255		$1,052,255		$1,052,255
ICF/MR: Number of Users	8		8		8		8		8
ICF/MR: Avg Medicaid Paid per User	$114,264		$131,532		$131,532		$131,532		$131,532
NF: Total Medicaid Paid (MAX TOS = 07)	$67,017,698		$75,362,489		$76,427,242		$76,522,629		$76,522,629
NF: Number of Users	814		934		930		933		933
NF:Avg Medicaid Paid per User	$82,331		$80,688		$82,180		$82,018		$82,018
Physician: Total Medicaid Paid (MAX TOS = 08)	$56,555,430		$63,659,569		$65,490,502		$66,485,737		$66,485,737
Physician: Number of Users	72,452		77,251		78,600		79,723		79,723
Physician: Avg Medicaid Paid per User	$781		$824		$833		$834		$834
Dental: Total Medicaid Paid (MAX TOS = 09)	$25,477,738		$27,321,622		$27,605,550		$27,756,434		$27,756,434
Dental: Number of Users	39,967		41,785		42,134		42,389		42,389
Dental: Avg Medicaid Paid per User	$637		$654		$655		$655		$655
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$3,880,751		$4,215,191		$4,253,616		$4,266,338		$4,266,338
Other Practitioner: Number of Users	18,072		19,262		19,358		19,465		19,465
Other Practitioner: Avg Medicaid Paid per User	$215		$219		$220		$219		$219
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$43,394,674		$48,861,727		$49,758,544		$50,248,164		$50,248,164
Outpatient: Number of Users	37,536		40,277		40,813		41,100		41,100
Outpatient: Avg Medicaid Paid per User	$1,156		$1,213		$1,219		$1,223		$1,223
Clinic: Total Medicaid Paid (MAX TOS = 12)	$35,941,484		$40,378,943		$41,804,187		$42,701,721		$42,701,721
Clinic: Number of Users	30,449		33,160		33,989		34,390		34,390

2008 BETA MAX Comparison PS Validation Table
State: AK

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Clinic: Avg Medicaid Paid per User	$1,180		$1,218		$1,230		$1,242		$1,242
Home Health: Total Medicaid Paid (MAX TOS = 13)	$549,507	X	$750,917		$894,057		$916,742		$916,742
Home Health: Number of Users	188	X	239		287		294		294
Home Health: Avg Medicaid Paid per User	$2,923		$3,142		$3,115		$3,118		$3,118
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$30,074,176		$33,491,041		$34,356,621		$34,847,221		$34,847,221
Lab/Xray: Number of Users	54,370		58,056		59,068		59,965		59,965
Lab/Xray:Avg Medicaid Paid per User	$553		$577		$582		$581		$581
Drugs: Total Medicaid Paid (MAX TOS = 16)	$75,647,816		$76,537,994		$76,683,662		$76,800,648		$76,800,648
Drugs: Number of Users	62,801		63,607		63,900		64,127		64,127
Drugs: Avg Medicaid Paid per User	$1,205		$1,203		$1,200		$1,198		$1,198
Other Services: Total Medicaid Paid (MAX TOS = 19)	$58,024,053		$64,882,720		$65,815,218		$66,141,852		$66,139,032
Other Services: Number of Users	7,666		8,087		8,213		8,257		8,256
Other Services: Avg Medicaid Paid per User	$7,569		$8,023		$8,014		$8,010		$8,011
Transportation: Total Medicaid Paid (MAX TOS = 26)	$49,012,696		$52,225,006		$52,588,696		$52,741,560		$52,741,560
Transportation: Number of Users	21,850		22,503		22,586		22,624		22,624
Transportation: Avg Medicaid Paid per User	$2,243		$2,321		$2,328		$2,331		$2,331
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$78,700,952		$83,440,698		$83,879,946		$83,999,232		$83,999,232
Personal Care Services: Number of Users	3,961		4,097		4,122		4,130		4,130
Personal Care Services: Avg Medicaid Paid per User	$19,869		$20,366		$20,349		$20,339		$20,339
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$8,648,480		$9,752,829		$9,932,020		$10,008,917		$10,008,917
Targeted Case Management: Number of Users	5,097		5,433		5,552		5,604		5,604
Targeted Case Management: Avg Medicaid Paid per User	$1,697		$1,795		$1,789		$1,786		$1,786
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$184,065		$211,799		$213,804		$213,804		$213,804
Rehabilitation Services: Number of Users	321		333		335		335		335
Rehabilitation Services: Avg Medicaid Paid per User	$573		$636		$638		$638		$638
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$7,188,668		$7,755,484		$7,907,610		$7,973,767		$7,973,767
PT/OT/Speech/Hearing: Number of Users	4,629		4,963		5,018		5,061		5,061
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,553		$1,563		$1,576		$1,576		$1,576
Hospice: Total Medicaid Paid (MAX TOS = 35)	$136,492	X	$183,415		$200,704		$204,096		$204,096
Hospice: Number of Users	21	X	25		29		29		29
Hospice: Avg Medicaid Paid per User	$6,500		$7,337		$6,921		$7,038		$7,038
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$17,208,741		$19,118,815		$19,587,258		$19,761,292		$19,761,292
Durable Medical Equipment: Number of Users	30,014		31,260		31,499		31,662		31,662
Durable Medical Equipment: Avg Medicaid Paid per User	$573		$612		$622		$624		$624
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$47,240,074		$54,230,326		$55,440,615		$55,796,018		$55,796,018
Residential Care: Number of Users	859		906		919		922		922
Residential Care: Avg Medicaid Paid per User	$54,994		$59,857		$60,327		$60,516		$60,516
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$70,623,671		$77,871,730		$79,023,580		$79,501,458		$79,504,278
Psych Services: Number of Users	15,135		15,977		16,204		16,333		16,342
Psych Services: Avg Medicaid Paid per User	$4,666		$4,874		$4,877		$4,868		$4,865
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$1,819,562		$2,013,143		$2,040,627		$2,050,756		$2,050,756
Adult Day Care: Number of Users	415		425		433		436		436
Adult Day Care: Avg Medicaid Paid per User	$4,384		$4,737		$4,713		$4,704		$4,704
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE									

2008 BETA MAX Comparison PS Validation Table
State: AK

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Inpatient Hospital (MAX TOS = 01)	$1,008		$1,126		$1,160		$1,174		$1,174
Aged	$377		$430		$419		$421		$421
Disabled	$2,316		$2,563		$2,608		$2,637		$2,637
Child	$732		$837		$868		$878		$878
Adult	$1,162		$1,260		$1,303		$1,318		$1,321
ILTC (MAX TOS = 02,04,05,07)	$984		$1,075		$1,084		$1,087		$1,087
Aged	$6,754		$7,505		$7,565		$7,569		$7,569
Disabled	$1,756		$1,951		$1,985		$1,991		$1,991
Child	$595		$647		$647		$649		$649
Adult	$75		$74		$78		$79		$79
Drugs (MAX TOS = 16)	$608		$601		$602		$602		$602
Aged	$317		$317		$317		$317		$317
Disabled	$2,652		$2,630		$2,618		$2,621		$2,621
Child	$226		$225		$226		$227		$227
Adult	$531		$518		$518		$518		$519
All Other Services	$4,345		$4,690		$4,765		$4,803		$4,803
Aged	$11,575		$12,307		$12,391		$12,429		$12,429
Disabled	$14,302		$15,702		$15,893		$16,000		$16,000
Child	$2,004		$2,157		$2,195		$2,219		$2,218
Adult	$3,004		$3,226		$3,296		$3,336		$3,342
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Enrollees with IP Claims (MAX TOS = 01)	10.24		11.47		11.53		11.65		11.65
Aged	13.37		15.58		14.04		14.13		14.13
Disabled	13.07		14.44		13.73		13.86		13.86
Child	6.94		7.98		8.26		8.35		8.34
Adult	17.04		18.39		18.73		18.93		18.98
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	1.63		1.73		1.73		1.73		1.73
Aged	7.63		8.49		8.45		8.45		8.45
Disabled	2.66		2.97		2.94		2.97		2.97
Child	1.35		1.38		1.38		1.38		1.38
Adult	0.22		0.21		0.22		0.22		0.22
% FFS Enrollees with Drug Claims (MAX TOS = 16)	50.51		49.99		50.12		50.30		50.30
Aged	27.95		27.87		27.84		27.86		27.86
Disabled	60.11		59.45		59.26		59.35		59.35
Child	45.88		45.55		45.74		45.95		45.94
Adult	63.84		62.54		62.75		62.92		62.98
% FFS Enrollees with All Other Claims	82.22		83.24		83.73		84.13		84.13
Aged	91.05		91.57		91.79		92.01		92.01
Disabled	91.68		92.07		92.15		92.41		92.41
Child	79.96		81.17		81.72		82.13		82.11
Adult	80.52		81.61		82.23		82.72		82.78
Avg # IP Days per FFS User	4		4		4		4		4
Aged	1		1		1		1		1
Disabled	7		7		8		8		8

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Child	4		4		4		4		4
Adult	3		3		3		3		3
Avg # ILTC Days per FFS User	149		153		155		155		155
Aged	208		207		209		209		209
Disabled	160		159		164		163		163
Child	116		123		123		124		124
Adult	96		98		100		101		101
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	1		1		1		1		1
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	13	X	15		17		17		17
Inpatient Hospital (MAX TOS = 01) > $500,000	7		7		8		8		8
ILTC (MAX TOS = 02,04,05,07) > $200,000	40	X	56		57		57		57
Drugs (MAX TOS = 16) > $200,000	3		3		3		3		3
All Other Services > $200,000	39	X	71		75		75		75
Maximum FFS Medicaid Paid	$1,311,975		$1,526,623		$1,556,650		$1,556,665		$1,556,665
Inpatient Hospital (MAX TOS = 01)	$1,140,999		$1,231,040		$1,231,040		$1,231,040		$1,231,040
ILTC (MAX TOS = 02,04,05,07)	$273,914		$299,261		$299,261		$299,261		$299,261
Drugs (MAX TOS = 16)	$803,154		$803,154		$803,154		$803,154		$803,154
All Other Services	$432,418	X	$541,447		$599,938		$600,622		$600,622
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$2,148,076	X	$2,520,694		$2,656,879		$2,700,522		$2,700,522
FP: Number of Users	4,638		4,882		4,971		4,981		4,981
FP: Avg Medicaid Paid per User	$463		$516		$534		$542		$542
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$3,272,165		$3,577,867		$3,778,857		$3,811,323		$3,811,323
FQHC: Number of Users	6,002		6,536		6,758		6,856		6,856
FQHC: Avg Medicaid Paid per User	$545		$547		$559		$556		$556
IHS: Total Medicaid Paid (PGM TYPE = 5)	$43,988,564		$49,331,812		$50,214,783		$50,559,749		$50,559,749
IHS: Number of Users	16,634		17,943		18,252		18,502		18,502
IHS: Avg Medicaid Paid per User	$2,644		$2,749		$2,751		$2,733		$2,733
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$130,691,545		$147,534,992		$150,247,149		$151,119,086		$151,119,086
Section 1915(c) Waiver: Number of Users	4,450		4,699		4,758		4,804		4,804
Section 1915(c) Waiver: Avg Medicaid Paid per User	$29,369		$31,397		$31,578		$31,457		$31,457
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$199,607,039		$220,338,506		$223,386,207		$224,312,332		$224,312,332
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	6,240		6,542		6,627		6,676		6,676
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	$31,988		$33,681		$33,708		$33,600		$33,600
Aged	$27,361		$28,158		$28,213		$28,210		$28,210
Disabled	$35,617		$38,123		$38,323		$38,125		$38,125
Child	$9,758	X	$8,323		$7,210		$7,218		$7,218
Adult	$8,781	X	$7,706		$7,286		$7,097		$7,097
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	5.02		5.14		5.20		5.24		5.24

2008 BETA MAX Comparison PS Validation Table
State: AK

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Aged	34.08		35.01		35.13		35.20		35.20
Disabled	23.27		23.97		24.09		24.34		24.34
Child	0.09	X	0.12	X	0.15		0.16		0.16
Adult	0.15	X	0.17		0.19		0.20		0.20
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$130,691,545		$147,534,992		$150,247,149		$151,119,086		$151,119,086
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	4,450		4,699		4,758		4,804		4,804
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$29,369		$31,397		$31,578		$31,457		$31,457
Aged	$21,680		$22,378		$22,395		$22,403		$22,403
Disabled	$33,669		$36,543		$36,793		$36,560		$36,560
Child	$15,598	X	$12,670		$12,892		$12,731		$12,731
Adult	$912		$959		$960		$960		$960
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	3.58		3.69		3.73		3.77		3.77
Aged	21.54		22.42		22.58		22.65		22.65
Disabled	18.02		18.66		18.80		19.05		19.05
Child	0.04	X	0.06		0.07		0.07		0.07
Adult	0.04	X	0.04		0.05		0.05		0.05

2008 BETA-MAX Comparison IP Validation Table
State: DE

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All IP Claims									
Total Number of Claims	10,953		12,770		13,074		13,127		13,127
% Encounter Claims	16.71		16.95		16.67		16.61		16.61
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	9,123		10,605		10,894		10,946		10,946
% Crossover	37.42		37.50		37.67		37.71		37.71
% Adjusted Claims	1.07	X	1.36	X	1.84		2.00		2.00
% Standard Adjustments	100.00		99.31		99.50		99.09		99.09
Avg Medicaid Paid, Adjusted Claims (Include $0)	$3,996	X	$6,285		$5,340		$5,746		$5,746
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	13	X	14	X	15	X	16	X	121
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$5,944	X	$5,593	X	$5,352	X	$5,101	X	$8,372
# Claims with > $1 Million Paid	1		1		1		1		1
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	5,709		6,628		6,790		6,818		6,818
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$7,927		$8,178		$8,295		$8,315		$8,315
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	$1,816		$1,825		$1,821		$1,824		$1,824
% Claims with TPL	2.77	X	3.23		3.45		3.61		3.61
Avg TPL Paid for Claims with TPL	$2,818	X	$2,973	X	$4,022		$3,866		$3,866
% Claims with UB-92 Accommodation Codes	100.00		100.00		100.00		100.00		100.00
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.17		1.18		1.18		1.18		1.18
% Claims with UB-92 Ancillary Codes	99.96		99.95		99.96		99.96		99.96
Avg # of UB-92 Ancillary Codes (> 0 Codes)	9.13		9.13		9.13		9.13		9.13
Avg Length of Stay	4.36		4.48		4.54		4.55		4.55
Avg Covered Days (> 0 Days)	4.36		4.48		4.55		4.56		4.56
% Begin Date = Admission Date	99.89		99.80		99.76		99.77		99.77
% IP Claims (MAX TOS = 01)	100.00		99.98		99.99		99.99		99.99
% Family Planning Claims (PGM TYPE = 2)	0.00		0.00		0.00		0.00		0.00
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	4.51		4.50		4.51		4.51		4.51
% Primary Diagnosis Code Claims with Length = 3	5.80		5.58		5.52		5.54		5.54
% Primary Diagnosis Code Claims with Length = 4	16.43		16.07		16.11		16.10		16.10
% Primary Diagnosis Code Claims with Length = 5	77.77		78.35		78.37		78.35		78.35
% Claims with a Procedure Code	58.45		59.64		59.79		59.90		59.90
Avg # of Procedure Codes (> 0 Codes)	2.25		2.24		2.24		2.24		2.24
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	100.00		100.00		100.00		100.00		100.00
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		99.97		99.98		99.98		99.98
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

2008 BETA-MAX Comparison IP Validation Table
State: DE

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
% Claims Maternal Delivery Indicator	28.27		26.87		26.60		26.55		26.55
% Claims Newborn Delivery Indicator (Only for Separate Infant Delivery Claims Using Mother's ID)	28.15		29.51		29.54		29.55		29.55
PATIENT STATUS									
% Home	72.11		72.16		71.83		71.88		71.88
% Transferred	11.75		11.99		12.06		12.00		12.00
% Still a Patient	0.05		0.05		0.04		0.04		0.04
% Died	1.96		1.92		1.93		1.94		1.94
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	3,414		3,977		4,104		4,128		4,128
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,114		$1,111		$1,138		$1,192		$1,192
% Claims with TPL	0.70		0.78		0.88		0.87		0.87
Avg TPL Paid for Claims with TPL	$924		$902		$974		$1,029		$1,029
% Claims with UB-92 Accommodation Codes	99.71		99.72		99.76		99.73		99.73
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.31		1.31		1.31		1.31		1.31
% Claims with UB-92 Ancillary Codes	99.97		99.97		99.98		99.98		99.98
Avg # of UB-92 Ancillary Codes (> 0 Codes)	13.94		13.94		14.00		14.00		14.00
Avg Length of Stay	6.64		6.63		6.69		6.70		6.70
% Begin Date = Admission Date	99.74		99.57		99.59		99.59		99.59
% IP Claims (MAX TOS = 01)	99.97		99.97		99.98		99.98		99.98
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	7.84		7.85		7.86		7.86		7.86
% Primary Diagnosis Code Claims with Length = 3	6.12		6.06		5.99		5.96		5.96
% Primary Diagnosis Code Claims with Length = 4	37.73		38.07		38.11		38.15		38.15
% Primary Diagnosis Code Claims with Length = 5	56.15		55.87		55.90		55.89		55.89
% Claims with a Procedure Code	57.23		57.00		56.99		57.15		57.15
Avg # of Procedure Codes (> 0 Codes)	2.69		2.64		2.61		2.61		2.61
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	0.05	X	0.04	X	0.04	X	0.17		0.17
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison LT Validation Table
State: DE

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All LT Claims									
Total Number of Claims	35,727		40,217		40,733		40,961		40,961
% Encounter Claims	1.32		1.40		1.40		1.39		1.39
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	35,254		39,655		40,164		40,390		40,390
% Crossover	8.74		9.46		9.93		10.17		10.17
% Adjusted Claims	0.26	X	0.31	X	3.35		3.34		3.34
% Standard Adjustments	83.70		71.90		76.75		76.39		76.39
Avg Medicaid Paid, Adjusted Claims (Include $0)	$14,715	X	$12,001	X	$7,915		$7,955		$7,955
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	28	X	25	X	25	X	25	X	123
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$3,171	X	$3,268		$3,268		$3,268		$4,044
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	32,172		35,902		36,177		36,281		36,281
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
NF (MAX TOS = 07)	$207		$207		$207		$207		$207
ICF/MR (MAX TOS = 05)	$614		$614		$614		$614		$614
MH Aged (MAX TOS = 02)	$505		$503		$502		$502		$502
IP Psych, Age < 21 (MAX TOS = 04)	$300		$338		$321		$290		$290
TYPE OF SERVICE									
% NF (MAX TOS = 07)	93.44		93.41		93.40		93.32		93.32
% NF claims with NF Covered Days	99.90		99.90		99.89		99.89		99.89
Avg days for NF claims with Covered Days	25.82		25.67		25.62		25.60		25.60
% ICF/MR (MAX TOS = 05)	5.38		5.29		5.25		5.24		5.24
% ICF/MR claims with ICF/MR Covered Days	99.71		99.74		99.74		99.74		99.74
Avg days for ICF/MR claims with Covered Days	25.62		25.48		25.48		25.48		25.48
% MH Aged (MAX TOS = 02)	1.08		1.09		1.10		1.10		1.10
% MH Aged claims with MH Aged Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for MH Aged claims with Covered Days	12.56		12.38		12.30		12.26		12.26
% IP Psych, Age < 21 (MAX TOS = 04)	0.11	X	0.20	X	0.25	X	0.34		0.34
% IP Psych, Age < 21 Claims with IP Psych Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for IP Psych, Age < 21 Claims with Covered Days	27.24		27.75		27.25		27.84		27.84
LEAVE DAYS									
% Claims with Leave Days	8.00		8.28		8.33		8.35		8.35
ADMISSION DATE									
% Claims with Admission Date	100.00		100.00		100.00		100.00		100.00
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	99.99		99.98		99.98		99.98		99.98
% Primary Diagnosis Code Claims with Length = 3	14.22		14.34		14.39		14.37		14.37

2008 BETA MAX Comparison LT Validation Table
State: DE

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% Primary Diagnosis Code Claims with Length = 4	55.13		54.95		54.88		54.85		54.85
% Primary Diagnosis Code Claims with Length = 5	30.64		30.71		30.74		30.78		30.78
PATIENT STATUS									
% Claims with Patient Status	91.48		91.49		91.53		91.54		91.54
% Home	0.99		1.01		1.02		1.03		1.03
% Still a Patient	85.03		84.99		84.99		85.01		85.01
% Died	1.92		1.94		1.93		1.93		1.93
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	3,082	X	3,753		3,987		4,109		4,109
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,006		$1,009		$1,001		$991		$991
TYPE OF SERVICE									
% NF (MAX TOS = 07)	99.94		99.89		99.90		99.90		99.90
% ICF/MR (MAX TOS = 05)	0.00		0.00		0.00		0.00		0.00
% MH Aged (MAX TOS = 02)	0.06	X	0.11		0.10		0.10		0.10
% IP Psych, Age < 21 (MAX TOS = 04)	0.00		0.00		0.00		0.00		0.00
ADMISSION DATE									
% Claims with Admission Date	100.00		100.00		100.00		100.00		100.00
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Primary Diagnosis Code Claims with Length = 3	10.45		10.15		10.28		10.29		10.29
% Primary Diagnosis Code Claims with Length = 4	64.50		62.75		62.45		62.33		62.33
% Primary Diagnosis Code Claims with Length = 5	25.05		27.10		27.26		27.38		27.38
PATIENT STATUS									
% Claims with Patient Status	99.64		99.65		99.67		99.68		99.68
% Home	2.82		3.14		3.01		2.94		2.94
% Still a Patient	93.54		92.89		92.60		92.70		92.70
% Died	0.62		0.56		0.60		0.63		0.63

2008 BETA MAX Comparison OT Validation Table
State: DE

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All OT Claims									
Total Number of Claims	7,405,275		8,059,667		8,180,557		8,215,175		8,215,175
% Encounter Claims	37.71		38.96		39.16		39.08		39.08
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
% Capitation Claims **	37.46		34.46		33.95		33.81		33.81
Total FFS Claims Excluding Capitation Payments	1,838,868		2,141,914		2,199,832		2,226,941		2,226,941
% Crossover	17.55		17.46		17.37		17.27		17.27
% Adjusted Claims	0.46	X	0.61		0.67		0.71		0.71
% Standard Adjustments	97.24		97.79		97.82		97.72		97.72
Avg Medicaid Paid, Adjusted Claims (Include $0)	$207	X	$207	X	$282		$282		$282
% Claims with HMO Capitation Payment	27.30		25.67		25.37		25.23		25.23
% Claims with PHP Capitation Payment	32.84		30.79		30.43		30.27		30.27
% Claims with PCCM Capitation Payment	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid per HMO Capitation Claim	$351		$358		$357		$357		$357
Avg Medicaid Paid per PHP Capitation Claim	$6		$6		$6		$6		$6
Avg Medicaid Paid per PCCM Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	1,863	X	1,860	X	1,861	X	1,866	X	3,297
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$85	X	$88	X	$88	X	$89	X	$116
# Claims with > $200,000 Paid	0		0		0		0		0
# Encounter Claims	2,792,657		3,140,339		3,203,245		3,210,749		3,210,749
% Encounter Claims for HMO or PACE	74.60		72.81		72.83		72.84		74.64
% Encounter Claims for PHP	11.82		13.10		12.93		12.92		13.20
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	1,516,171		1,768,037		1,817,673		1,842,323		1,842,323
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
% Claims with Span Bill	6.95		6.63		6.47		6.39		6.39
% Outpatient Claims with Span Bill	0.03	X	0.02		0.02		0.02		0.02
% Home Health Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Other Claims with Span Bill	7.33		6.99		6.81		6.73		6.73
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	22.33		22.34		22.20		22.18		22.18
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	19.52		19.39		19.26		19.24		19.24
% Claims with Servicing Provider ID = Billing Provider ID	33.55		31.62		31.02		30.69		30.69
PLACE OF SERVICE									
% Claims with Place of Service	66.99		62.76		61.79		61.30		61.30
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	32.45		29.55		29.01		28.73		28.73
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	13.62		12.84		12.59		12.45		12.45
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	2.90		2.94		2.97		2.98		2.98
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	0.34		0.41		0.41		0.40		0.40
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	0.02		0.02		0.02		0.02		0.02
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	0.20		0.19		0.19		0.19		0.19
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	0.08		0.09		0.09		0.09		0.09
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	1.45		1.39		1.37		1.36		1.36

2008 BETA MAX Comparison OT Validation Table
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% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	9.39		9.02		8.94		8.88		8.88
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	33.00		37.24		38.21		38.70		38.70
THIRD-PARTY LIABILITY									
% Claims with TPL	0.21		0.22		0.23		0.23		0.23
Avg TPL Paid for Claims with TPL	$78		$79		$82		$82		$82
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE									
Physician Services (MAX TOS = 08)	9.49		9.11		9.05		9.01		9.01
Dental Services (MAX TOS = 09)	18.55		16.49		16.08		15.87		15.87
Other Practitioner Services (MAX TOS = 10)	18.44		21.92		22.48		22.61		22.61
Outpatient Services (MAX TOS = 11)	2.38		2.31		2.30		2.29		2.29
Clinic Services (MAX TOS = 12)	0.92		1.00		0.99		0.98		0.98
Home Health Services (MAX TOS = 13)	2.81		2.79		2.75		2.72		2.72
Lab/Xray Services (MAX TOS = 15)	10.97		10.40		10.26		10.20		10.20
Drugs (MAX TOS = 16)	0.75		0.75		0.85		0.89		0.89
Other Services (MAX TOS = 19)	18.87		17.88		17.54		17.34		17.34
Durable Medical Equipment (MAX TOS = 51)	2.04		1.91		1.89		1.89		1.89
Transportation Services (MAX TOS = 26)	2.22		2.35		2.52		2.63		2.63
Sterilizations (MAX TOS = 24)	0.01	X	0.02		0.02		0.02		0.02
Abortions (MAX TOS = 25)	0.00	X	0.00		0.00		0.00		0.00
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00
Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	3.56		3.42		3.33		3.29		3.29
PT/OT/Hearing/Speech Services (MAX TOS = 34)	4.48	X	5.18		5.54		5.89		5.89
Hospice Services (MAX TOS = 35)	0.24		0.22		0.22		0.22		0.22
Nurse Midwife Services (MAX TOS = 36)	0.01		0.01		0.01		0.01		0.01
Nurse Practitioner Services (MAX TOS = 37)	0.00	X	0.00		0.00		0.00		0.00
Private Nursing Services (MAX TOS = 38)	0.41		0.40		0.39		0.38		0.38
Religious Non-Medical Services (MAX TOS = 39)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.58		0.57		0.57		0.56		0.56
Psychiatric Services (MAX TOS = 53)	2.44		2.49		2.48		2.47		2.47
Adult Day Care (MAX TOS = 54)	0.82		0.77		0.75		0.74		0.74
Unknown Services (MAX TOS = 99)	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
Total	$167		$163		$161		$160		$160
Physician Services (MAX TOS = 08)	$95		$96		$96		$96		$96
Dental Services (MAX TOS = 09)	$83		$84		$84		$84		$84
Other Practitioner Services (MAX TOS = 10)	$44		$44		$44		$44		$44
Outpatient Services (MAX TOS = 11)	$214		$218		$218		$218		$218
Clinic Services (MAX TOS = 12)	$240		$257		$255		$257		$257
Home Health Services (MAX TOS = 13)	$99		$101		$101		$101		$101
Lab/Xray Services (MAX TOS = 15)	$37		$37		$38		$37		$37
Drugs (MAX TOS = 16)	$13		$12		$12		$12		$12
Other Services (MAX TOS = 19)	$280		$279		$278		$278		$278
Durable Medical Equipment (MAX TOS = 51)	$89		$92		$93		$93		$93

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Transportation Services (MAX TOS = 26)	$71		$73		$71		$70		$70
Personal Care Services (MAX TOS = 30)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management (MAX TOS = 31)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Rehabilitation Services (MAX TOS = 33)	$150		$148		$148		$148		$148
PT/OT/Hearing/Speech Services (MAX TOS = 34)	$57		$58		$58		$58		$58
Hospice Services (MAX TOS = 35)	$3,018		$3,214		$3,272		$3,298		$3,298
Residential Care Services (MAX TOS = 52)	$2,384		$2,344		$2,319		$2,323		$2,323
Psychiatric Services (MAX TOS = 53)	$1,233		$1,205		$1,190		$1,183		$1,183
Adult Day Care (MAX TOS = 54)	$168		$171		$171		$171		$171
PERCENT OF CLAIMS BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	0.16		0.15		0.15		0.14		0.14
Rural Health Clinic (PGM TYPE = 3)	0.00		0.00		0.00		0.00		0.00
Federally Qualified Health Center (PGM TYPE = 4)	0.23		0.22		0.22		0.21		0.21
Indian Health Services (PGM TYPE = 5)	0.00		0.00		0.00		0.00		0.00
Home and Community Based Waiver (PGM TYPE = 6,7)	18.76		17.74		17.40		17.19		17.19
AVERAGE EXPENDITURES BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	$58		$61		$61		$62		$62
Rural Health Clinic (PGM TYPE = 3)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Federally Qualified Health Center (PGM TYPE = 4)	$140		$141		$141		$141		$141
Indian Health Services (PGM TYPE = 5)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Home and Community Based Waiver (PGM TYPE = 6,7)	$341		$343		$343		$343		$343
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	94.04		94.25		94.17		94.15		94.15
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.99		99.99		99.99		99.99		99.99
% Primary Diagnosis Claims with Secondary Diagnosis Code	7.40		7.15		7.09		7.06		7.06
% Primary Diagnosis Code Claims with Length = 3	24.04		23.46		23.19		23.04		23.04
% Primary Diagnosis Code Claims with Length = 4	57.77		58.94		59.37		59.62		59.62
% Primary Diagnosis Code Claims with Length = 5	18.19		17.60		17.43		17.34		17.34
% Claims with Procedure Code	98.23		98.26		98.28		98.26		98.26
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	99.38		99.36		99.36		99.35		99.35
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	99.47		99.46		99.45		99.45		99.45
% Other Claims with Procedure Code	98.42		98.44		98.46		98.44		98.44
% Claims with Procedure Code with CPT-4 Indicator	30.69		30.34		30.63		30.90		30.90
% Claims with Procedure Code with HCPCS (II & III) Indicator	69.31		69.66		69.37		69.10		69.10
% with Procedure Code with Other National Indicator	0.00		0.00		0.00		0.00		0.00
% with Procedure Code with State-Specific Indicator	0.00		0.00		0.00		0.00		0.00
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	100.00		100.00		100.00		100.00		100.00
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	100.00		100.00		100.00		100.00		100.00
PHYSICIAN SPECIALTY									
% Physician Claims with Physician Specialty	100.00		100.00		100.00		100.00		100.00
PERCENT OF CLAIMS BY CLTC CODE									

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Not a CLTC Claim (CLTC FLAG = 00)	71.20		72.34		72.70		72.88		72.88
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	10.04		9.92		9.90		9.93		9.93
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	0.41		0.40		0.39		0.38		0.38
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	2.81		2.79		2.75		2.72		2.72
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	0.01		0.01		0.01		0.01		0.01
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	3.55		3.41		3.32		3.28		3.28
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	1.86		1.99		2.13		2.23		2.23
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	0.23		0.22		0.21		0.21		0.22
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	1.17		1.10		1.09		1.09		1.09
CLTC Waiver Claims (CLTC FLAG = 30-40)	18.76		17.74		17.40		17.19		17.19
CLTC Other Waiver (CLTC FLAG = 30)	16.93		16.01		15.71		15.52		15.52
CLTC Waiver Personal Care (CLTC FLAG = 31)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	0.82		0.77		0.75		0.74		0.74
CLTC Waiver Home Health (CLTC FLAG = 34)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Residential Care (CLTC FLAG = 35)	0.57		0.56		0.56		0.55		0.55
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Transportation (CLTC FLAG = 38)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Hospice (CLTC FLAG = 39)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	0.43		0.40		0.39		0.38		0.38
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	322,697		373,877		382,159		384,618		384,618
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$32		$33		$34		$34		$34
% Claims with Span Bill	1.38		1.38		1.42		1.43		1.43
% Outpatient Claims with Span Bill	0.72	X	0.58		0.55		0.54		0.54
% Home Health Claims with Span Bill	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Span Bill	1.43		1.45		1.50		1.51		1.51
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)									
Physician Services (MAX TOS = 08)	63.80		62.52		61.96		61.85		61.85
Other Practitioner Services (MAX TOS = 10)	3.93		3.95		4.02		4.03		4.03
Outpatient Services (MAX TOS = 11)	7.40		8.15		8.39		8.46		8.46
Clinic Services (MAX TOS = 12)	1.83		1.83		1.91		1.91		1.91
Home Health Services (MAX TOS = 13)	0.00		0.00		0.00		0.00		0.00
Lab/Xray Services (MAX TOS = 15)	14.04		14.05		13.88		13.82		13.82
Other Services (MAX TOS = 19)	5.69		6.12		6.37		6.46		6.46
Durable Medical Equipment (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
Transportation Services (MAX TOS = 26)	1.82		1.79		1.76		1.75		1.75
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00

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Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	0.00		0.00		0.00		0.00		0.00
PT/OT/Hearing/Speech Services (MAX TOS = 34)	0.13	X	0.16		0.19		0.19		0.19
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.00		0.00		0.00		0.00		0.00
Psychiatric Services (MAX TOS = 53)	0.00		0.00		0.00		0.00		0.00
Adult Day Care (MAX TOS = 54)	0.00		0.00		0.00		0.00		0.00
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	99.98		99.98		99.98		99.98		99.98
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.99		99.99		99.99		99.99		99.99
% Primary Diagnosis Claims with Secondary Diagnosis Code	5.66		6.13		6.38		6.44		6.44
% Primary Diagnosis Code Claims with Length = 3	6.42		6.44		6.47		6.49		6.49
% Primary Diagnosis Code Claims with Length = 4	45.04		44.84		44.75		44.72		44.72
% Primary Diagnosis Code Claims with Length = 5	48.54		48.72		48.78		48.79		48.79
% Claims with Procedure Code	0.00		0.00		0.00		0.00		0.00
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	0.00		0.00		0.00		0.00		0.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Procedure Code	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with CPT-4 Indicator	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Claims with Procedure Code with HCPCS (II & III) Indicator	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% with Procedure Code with Other Code Indicator	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PERCENT OF CLAIMS BY CLTC CODE									
Not a CLTC Claim (CLTC FLAG = 00)	98.22		98.24		98.26		98.27		98.27
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	1.78		1.76		1.74		1.73		1.73
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Claims (CLTC FLAG = 30-40)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison RX Validation Table
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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All RX Claims									
Total Number of Claims	1,628,219		1,653,582		1,653,626		1,653,620		1,653,620
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	1,628,219		1,653,582		1,653,626		1,653,620		1,653,620
% Adjusted Claims	0.00	X	0.00	X	0.00		0.00		0.00
% Standard Adjustments	100.00		90.48		94.44		94.59		94.59
Avg Medicaid Paid, Adjusted Claims (Include $0)	$3,523	X	$1,902	X	$1,394		$1,259		$1,259
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	938		949		949		949		971
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	77.95		77.83		77.83		77.83		77.22
# Claims with > $200,000 Paid	3		3		3		3		3
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Claims (Type of Claim = 1)									
Total Number of Claims	1,628,219		1,653,582		1,653,626		1,653,620		1,653,620
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$72		$72		$72		$72		$72
% Claims with TPL	2.47		2.47		2.47		2.47		2.47
Avg TPL Paid for Claims with TPL	$101		$101		$101		$101		$101
% Family Planning Claims (PGM TYPE = 2)	2.45		2.45		2.45		2.45		2.45
% Drug Claims (MAX TOS = 16)	100.00		100.00		100.00		100.00		100.00
% Durable Medical Equipment Claims (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Prescribing Physician	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Date Prescribed	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Quantity	99.95		99.95		99.95		99.95		99.95
% Drug Claims with Days Supply	100.00		100.00		100.00		100.00		100.00
DRUG CLASSIFICATION									
% Claims with Medispan	99.73		99.73		99.73		99.73		99.73
% Claims with Generic Therapeutic Class	99.78		99.78		99.78		99.78		99.78
% Claims with Specific Therapeutic Class	99.78		99.78		99.78		99.78		99.78
NDC CONFIGURATION INDICATOR									
% Prescription (NDC FMT IND = 0-3)	68.17		68.14		68.14		68.14		68.14
% Products (NDC FMT IND = 4-6)	30.60		30.63		30.63		30.63		30.63
% Health Related Item (NDC FMT IND = 7)	0.00		0.00		0.00		0.00		0.00
% Claims with Clinical Formulation Identifier	99.78		99.78		99.78		99.78		99.78
% Claims with Ingredient List Identifier	99.78		99.78		99.78		99.78		99.78
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	99.78		99.78		99.78		99.78		99.78
% Claims with Over-the-Counter Drug Class	7.02		7.01		7.01		7.01		7.01
% Claims with Prescription Drug Class	92.76		92.77		92.77		92.77		92.77
% Claims with Multiple Sources	64.02		64.08		64.08		64.08		64.08
% Claims with Single Source (No Generic)	31.00		30.98		30.98		30.98		30.98

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All Records									
Total Number of Records	198,924		199,287		199,364		199,381		199,084
Total Medicaid Paid	$1,074,132,587		$1,153,123,012		$1,161,259,654		$1,164,800,319		$1,164,800,319
% with No Services (RCPNT IND = 0)	9.18		8.79		8.75		8.74		8.61
% with FFS Only Claims (RCPNT IND = 1)	3.65		4.00		4.06		4.08		4.08
% with Only Capitation Claims (RCPNT IND = 2)	12.13		10.75		10.57		10.52		10.53
% with Only Encounter Claims (RCPNT IND = 3)	0.02		0.02		0.02		0.02		0.02
% with FFS and Capitation Claims (RCPNT IND = 4)	16.84		16.00		15.95		15.97		16.00
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	5.14		5.41		5.43		5.41		5.42
% with FFS and Encounter Claims Only (RCPNT IND = 6)	0.05		0.05		0.05		0.05		0.05
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	53.00		54.97		55.17		55.21		55.29
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	1,495		1,487		1,487		1,488		1,793
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.75		0.75		0.75		0.75		0.90
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$396,661	X	$397,484	X	$400,125	X	$402,378	X	$1,968,783
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$265	X	$267	X	$269	X	$270	X	$1,098
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	121	X	125	X	126	X	127	X	323
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.06	X	0.06	X	0.06	X	0.06	X	0.16
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$348,397	X	$348,927	X	$351,938	X	$353,582	X	$1,839,220
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$2,879	X	$2,791	X	$2,793	X	$2,784	X	$5,694
S-CHIP ENROLLMENT									
# with ONLY S-CHIP Enrollment	0		0		0		0		0
% with ONLY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
# with ANY S-CHIP Enrollment	0		0		0		0		0
% with ANY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	0		0		0		0		0
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)									
Total Medicaid Enrollees	197,429		197,800		197,877		197,893		197,291
Total Medicaid Person-Years of Enrollment	153,177		152,414		152,311		152,330		154,974
# with Any M-CHIP Enrollment	143		143		143		143		142
Total Person-Years of Enrollment Any M-CHIP	46		45		45		45		45
Demographic Characteristics									
% Records with Valid SSN Format	92.59		92.61		92.65		92.69		92.61
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	92.36		92.38		92.41		92.45		92.37
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	0.01		0.01		0.01		0.01		0.01
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	0.23		0.23		0.23		0.23		0.23

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% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	0.00		0.00		0.00		0.00		0.00
# Records Without Valid SSN	15,088		15,081		15,010		14,939		15,047
% Records Without Valid SSN	7.64		7.62		7.59		7.55		7.63
% for Children Under Age 21	68.96		68.89		68.79		68.75		68.93
% for Infants Under Age 1	24.73		24.97		24.97		24.89		24.53
% Ever Aliens Eligible for Only Emergency Services	37.84		38.03		38.23		38.41		37.94
# SSNs with More Than One MSIS ID	62		65		72		72		61
% Records with Duplicated SSNs	0.06		0.07		0.07		0.07		0.06
% for Children Under Age 21	75.81		74.62		77.08		77.08		75.41
% for Infants Under Age 1	1.61		3.08	X	4.17	X	4.17	X	1.64
% Ever Aliens Eligible for Only Emergency Services	8.87		10.77		11.11	X	11.11	X	9.02
% with External SSN from EDB (EXT SSN SRCE = 1)	13.98		13.99		14.00		14.00		13.98
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	0.00		0.00		0.00		0.00		0.00
% with County Code	98.89		98.87		98.89		98.90		98.90
% with Valid 5 Digit Zip Code Format	100.00		100.00		100.00		100.00		100.00
% White	42.66		42.66		42.66		42.66		42.66
% Black	39.98		39.95		39.95		39.95		39.98
% Native American/Alaskan Native	0.22		0.22		0.22		0.22		0.22
% Asian	1.75		1.75		1.75		1.75		1.75
% Native Hawaiian or Other Pacific Islander	0.00		0.00		0.00		0.00		0.00
% More Than One Race	0.00		0.00		0.00		0.00		0.00
% Unknown Race	15.40		15.42		15.42		15.42		15.40
% Hispanic/Latino (Included with Race Categories Prior to 2005)	15.40		15.42		15.42		15.42		15.40
% of Hispanic/Latino with Unknown Race	100.00		100.00		100.00		100.00		100.00
% Age 0	3.43		3.49		3.49		3.49		3.41
% Age 0-20 Years	48.74		48.76		48.76		48.76		N/A
% Age > 64 Years	7.14		7.15		7.16		7.16		N/A
% with Century of Birth '18' , '19', '20'	100.00		100.00		100.00		100.00		100.00
% with Gender Code 'M' or 'F'	100.00		100.00		100.00		100.00		100.00
% Enrollees with 12 Months Enrollment	47.65		46.11		45.84		45.86		52.28
% Aged Enrollees with 12 Months Enrollment	79.40		78.97		78.78		78.76		79.66
% Disabled Enrollees with 12 Months Enrollment	80.26		79.60		79.51		79.48		82.21
% Child Enrollees with 12 Months Enrollment	44.04		41.97		41.63		41.66		50.28
% Adult Enrollees with 12 Months Enrollment	36.21		34.78		34.49		34.52		40.63
% Enrollees with MSIS Date of Death During Year	0.88	X	0.88	X	0.89	X	0.90	X	0.70
% Enrollees with SSA Date of Death During Year	0.62		0.62		0.62		0.61		0.00
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	1.06		1.06		1.06		1.06		0.96
# with MSIS Date of Death ≠ SSA Date of Death	1,205		1,195		1,206		1,219		1,380
# with MSIS Date of Death Prior to 2007	0		0		0		0		0
# with SSA Date of Death Prior to 2007	48		48		48		48		0
EDB Dual Eligibles									
Total EDB Duals (Duals Confirmed by EDB)	24,718		24,770		24,801		24,805		24,689

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Total EDB Dual Person-Years of Enrollment	22,292		22,291		22,294		22,295		22,298
% Age > 64 Years Who Are EDB Duals	94.95		94.99		95.00		95.00		94.93
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	97.83		97.83		97.81		97.78		97.86
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	45.28		45.22		45.20		45.20		45.34
% EDB Only (EDB DUAL = 50)	4.20		3.94		3.89		3.89		3.93
% EDB QMB Only (EDB DUAL = 51)	26.44		26.39		26.36		26.36		26.51
% EDB QMB Plus (EDB DUAL = 52)	26.60		26.62		26.63		26.65		26.64
% EDB SLMB Only (EDB DUAL = 53)	17.57		17.59		17.60		17.59		17.62
% EDB SLMB Plus (EDB DUAL = 54)	0.00		0.00		0.00		0.00		0.00
% EDB QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% EDB QI-1 (EDB DUAL = 56)	7.16		7.21		7.23		7.22		7.19
% EDB QI-2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% EDB Other (EDB DUAL = 58)	18.03		18.24		18.29		18.29		18.11
% EDB Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Dual Status Unknown (EDB DUAL = 98)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	48.83		48.81		48.81		48.82		48.68
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	51.17		51.19		51.19		51.18		51.32
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	221		227		232		238		208
% Non-EDB Duals Without Valid SSN	0.45		0.44		0.43		0.42		0.00
% Non-EDB Duals Who Are Children/Adults	8.14		10.57	X	9.91	X	10.50	X	8.17
% EDB Duals with Spanish Language	1.60		1.59		1.59		1.60		1.60
% EDB Duals with EDB Date of Death During Year	6.52		6.52		6.51		6.51		6.47
% EDB Duals with MSIS Date of Death During Year	5.49	X	5.46	X	5.48	X	5.51	X	4.48
% EDB Duals with SSA Date of Death During Year	3.77		3.77		3.76		3.76		0.00
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	6.53		6.53		6.52		6.52		6.48
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	706	X	704	X	694	X	684	X	966
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	704	X	705	X	706	X	706	X	1,597
% EDB Duals with Medicaid Reported HIC	95.54		95.77		95.81		95.82		95.87
% EDB Duals with Medicaid Reported HIC = Medicare HIC	99.01		99.01		99.01		99.02		99.06
Total EDB Dual Enrollees in June	23,379		23,426		23,456		23,460		23,356
JUNE MEDICARE ELIGIBILITY GROUP									
June % with Part A Medicare only	1.94		1.93		1.94		1.94		1.92
June % with Part B Medicare only	1.90		1.90		1.89		1.89		1.90
June % Part A/B Medicare	96.16		96.17		96.16		96.16		96.18
ORIGINAL REASON FOR MEDICARE ENTITLEMENT									
% Aged (MDCR ORIG REAS CD = 0)	43.32		43.39		43.42		43.42		43.29
% Disabled (MDCR ORIG REAS CD = 1)	55.08		55.01		54.99		54.98		55.11
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	0.53		0.53		0.53		0.53		0.53
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	1.06		1.06		1.06		1.06		1.07
Other Eligibility Characteristics (All Enrollees)									
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	99.92		99.89		99.87		99.84		100.00
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	1.20		1.21		1.21		1.21		1.19
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	99.91		99.91		99.90		99.89		100.00
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	92.05		92.05		92.05		92.05		92.06

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% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	99.98		99.98		99.98		99.98		99.98
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	99.99		99.99		99.99		99.99		99.99
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	22.52		22.51		22.49		22.49		22.55
Aged Total	13,211		13,259		13,288		13,294		13,241
Aged, Cash (MAX ELIG CD = 11)	2,753		2,753		2,756		2,758		2,752
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	7,185		7,195		7,203		7,204		7,198
Other Aged (MAX ELIG CD = 41)	3,273		3,311		3,329		3,332		3,291
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	23,324		23,378		23,403		23,412		23,302
Disabled, Cash (MAX ELIG CD = 12)	14,457		14,469		14,476		14,480		14,442
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	5,756		5,762		5,767		5,768		5,755
Other Disabled (MAX ELIG CD = 42)	3,111		3,147		3,160		3,164		3,105
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	84,352		84,564		84,589		84,600		84,222
AFDC Child, Cash (MAX ELIG CD = 14)	62,637		62,806		62,830		62,841		62,532
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	7,624		7,658		7,661		7,661		7,620
Other Child (MAX ELIG CD = 44)	11,799		11,805		11,805		11,807		11,780
Foster Care Child (MAX ELIG CD = 48)	2,208		2,211		2,209		2,207		2,206
1115 Child (MAX ELIG CD = 54)	84		84		84		84		84
Adult Total	76,542		76,599		76,597		76,587		76,526
AFDC Adult, Cash (MAX ELIG CD = 15)	29,571		29,620		29,628		29,630		29,542
AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	421		426		426		428		421
Other Adult (MAX ELIG CD = 45)	10,587		10,606		10,610		10,608		10,581
1115 Adult (MAX ELIG CD = 55)	35,963		35,947		35,933		35,921		35,982
Long-Term Care Enrollees									
INSTITUTIONAL STATUS									
# Enrollees with Any ILTC Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	3,681		3,942		4,010		4,027		3,985
% Enrollees with Any ILTC Claims	1.86		1.99		2.03		2.03		2.02
% Aged Enrollees with Any ILTC Claims	21.01		22.36		22.64		22.69		22.65
% Disabled Enrollees with Any ILTC Claims	3.22		3.44		3.50		3.52		3.48
% Child Enrollees with Any ILTC Claims	0.03	X	0.03	X	0.04	X	0.04	X	0.02
% Adult Enrollees with Any ILTC Claims	0.17		0.19		0.20		0.20		0.20
COMMUNITY LONG-TERM CARE STATUS									
# Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	3,303		3,433		3,458		3,463		3,461

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% Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	1.67		1.74		1.75		1.75		1.75
% Aged Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	7.13		7.30		7.31		7.31		7.35
% Disabled Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	9.01		9.22		9.25		9.26		9.29
% Child Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.15	X	0.19		0.20		0.20		0.19
% Adult Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.17		0.20		0.20		0.21		0.21
# Enrollees with ILTC Claims and CLTC Claims (Excludes CLTC FLAG = 16-20)	202	X	251		261		263		263
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	3,477		3,567		3,592		3,596		3,582
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT									
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	2,900		2,903		2,910		2,912		2,903
% Enrolled in Any Section 1915(c) Waiver	1.47		1.47		1.47		1.47		1.47
% Aged Enrollees in Section 1915(c) Waiver	6.81		6.80		6.80		6.80		6.86
% Disabled Enrollees in Section 1915(c) Waiver	8.54		8.52		8.54		8.54		8.54
% Child Enrollees in Section 1915(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees in Section 1915(c) Waiver	0.01		0.01		0.01		0.01		0.01
# Aged, EDB Dual	890		892		894		894		898
# Aged, Non-Dual	10		10		10		10		10
# Disabled, EDB Dual	1,295		1,294		1,296		1,297		1,296
# Disabled, Non-Dual	697		698		702		703		693
# Other (Child or Adult)	8	X	9	X	8	X	8	X	6
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	1,282		1,282		1,283		1,283		1,287
# Aged, EDB Dual	787		788		790		790		794
# Aged, Non-Dual	7		7		7		7		7
# Disabled, EDB Dual	377		376		376		376		379
# Disabled, Non-Dual	107		107		107		107		105
# Other (Child or Adult)	4	X	4	X	3	X	3	X	2
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	26		26		27		27		26
# Aged, EDB Dual	1		1		1		1		1
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	19		19		20		20		19
# Disabled, Non-Dual	6		6		6		6		6
# Other (Child or Adult)	0		0		0		0		0

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# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	724		724		724		725		723
# Aged, EDB Dual	21		21		21		21		21
# Aged, Non-Dual	1		1		1		1		1
# Disabled, EDB Dual	358		358		358		359		359
# Disabled, Non-Dual	340		339		339		339		338
# Other (Child or Adult)	4		5	X	5	X	5	X	4
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	868		871		876		877		867
# Aged, EDB Dual	81		82		82		82		82
# Aged, Non-Dual	2		2		2		2		2
# Disabled, EDB Dual	541		541		542		542		539
# Disabled, Non-Dual	244		246		250		251		244
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	6.21	X	4.75		4.74		4.70		4.31
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	0.84		1.00		1.04		1.00		0.89
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	3.62		3.69		3.78		3.81		3.58
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/HIOs with No Waiver claim (PGM TYPE = 6 or 7)	5.48	X	4.31		4.30		4.22		3.96

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# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	17		18		18		18		16
Other Waiver Enrollment (Enrolled Any Time During the Year)									
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	160,018		160,070		160,086		160,095		159,929
% Aged Enrollees with Any 1115 Waiver	2.63		2.69		2.72		2.75		2.61
% Disabled Enrollees with Any 1115 Waiver	53.09		53.05		53.02		53.01		53.12
% Child Enrollees with Any 1115 Waiver	93.67		93.49		93.47		93.48		93.71
% Adult Enrollees with Any 1115 Waiver	89.20		89.11		89.10		89.10		89.23
% with Any HMO/HIO Enrollment	90.85		90.85		90.85		90.85		90.87
# with Any 1915(b) Waiver (WVR TYPE = 2)	0		0		0		0		0
% Aged Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	0		0		0		0		0
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with 1115 HIFA Waiver (WVR TYPE = 5)	0		0		0		0		0
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	0		0		0		0		0
% Aged Enrollees with Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Other Type of Waiver (WVR TYPE = 7)	0		0		0		0		0
# with Unknown Type of Waiver (WVR TYPE = 9)	0		0		0		0		0
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	0		0		0		0		0
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	8,437		8,433		8,434		8,435		8,470
# of Waiver IDs with More than One Waiver Type	1		1		1		1		1
# of Waiver IDs with Reporting in January but Not December	0		0		0		0		0
# of Waiver IDs with Reporting in December but Not January	0		0		0		0		0
Enrollees with Restricted Benefits									
Family Planning enrollees with Restricted Benefits (RBF = 6)									
# with ONLY Family Planning Only Enrollment	2,979		2,976		2,974		2,973		2,969
# with ANY Family Planning Only Enrollment	8,437		8,433		8,434		8,435		8,470
# Person-Years of Enrollment ANY Family Planning Only Enrollment	3,740		3,725		3,719		3,718		3,791
Aliens with Restricted Benefits (RBF = 2)									
# Aliens with ONLY Restricted Benefits	8,328.00		8,365.00		8,370.00		8,368.00		8,325.00
# Aliens with ANY Restricted Benefits	8,539.00		8,580.00		8,588.00		8,591.00		8,538.00
# Person-Years of Enrollment Aliens with ANY Restricted Benefits	5,807.83		5,770.83		5,760.92		5,762.75		5,870.58

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EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
# EDB Duals with ONLY Restricted Benefits Enrollment	11,900		11,910		11,917		11,915		11,921
# EDB Duals with ANY Restricted Benefits Enrollment	13,275		13,299		13,318		13,319		13,295
# Person-Years of Enrollment EDB Duals with ANY Restricted Benefits	11,515		11,516		11,516		11,516		11,539
% EDB Duals with ONLY Restricted Benefits Enrollment	48.14		48.08		48.05		48.03		48.28
Prescription Drug Enrollees (RBF = X, Y, or Z)									
# with ONLY Prescription Drug Enrollment (May Have a Month or More of RBF = 3)	0		0		0		0		0
# with ANY Prescription Drug Enrollment	0		0		0		0		0
# Person-Years of ANY Prescription Drug Enrollment	0		0		0		0		0
Dual Prescription Drug Enrollees									
# with ONLY Prescription Drugs Who Are EDB Duals	0		0		0		0		0
June Eligibility Profile									
Total Enrollees in June	155,486		155,500		155,500		155,500		153,064
June % Full Scope Benefits (RBF = 1)	86.23		86.23		86.23		86.23		86.19
June % Restricted Benefits Alien (RBF = 2)	3.83		3.83		3.83		3.83		3.76
June % Restricted Benefits Dual (RBF = 3)	7.49		7.49		7.49		7.49		7.60
June % Restricted Benefits Pregnant (RBF = 4)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Other (RBF = 5)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Family Planning (RBF = 6)	2.45		2.45		2.45		2.45		2.45
June % Restricted Benefits Benchmark-Equivalent (RBF = 7)	0.00		0.00		0.00		0.00		0.00
June % Money Follows the Person Enrollee (RBF = 8)	0.00		0.00		0.00		0.00		0.00
June % Unknown Benefits (RBF = 9)	0.00		0.00		0.00		0.00		0.00
June % PRTF Enrollee (RBF = A)	0.00		0.00		0.00		0.00		0.00
June % Health Opportunity Account (RBF = B)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Non-Dual Enrollee (RBF = X)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Receiving Medicare Cost Sharing (RBF = Y)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Not Receiving Medicare Cost Sharing (RBF = Z)	0.00		0.00		0.00		0.00		0.00
June % Private Health Insurance (PVT INS CD = 2-4)	4.42		4.44		4.44		4.44		4.33
June Total Enrollees with TANF Flag (TANF FLAG = 2)	0.00		0.00		0.00		0.00		0.00
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	51	X	51	X	51	X	51	X	41
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	0		0		0		0		0
Medicaid Expenditures									
Total Medicaid Paid	$1,073,735,926		$1,152,725,528		$1,160,859,529		$1,164,397,941		$1,162,831,536
Avg Medicaid Paid per Enrollee	$5,439		$5,828		$5,867		$5,884		$5,894
25th Percentile	$782		$860		$870		$873		$882
50th Percentile (Median)	$2,017		$2,130		$2,140		$2,147		$2,153
75th Percentile	$4,952		$5,143		$5,141		$5,147		$5,156
95th Percentile	$16,400		$17,277		$17,385		$17,456		$17,489
99th Percentile	$63,577		$70,018		$70,460		$70,660		$70,680
Maximum Medicaid Paid	$1,534,357		$1,536,558		$1,536,558		$1,536,558		$1,536,558

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PERCENT OF ENROLLEES WITH ZERO EXPENDITURES									
% of Enrollees with Total Medicaid Paid = $0	9.26		8.88		8.83		8.82		8.70
Aged	32.11		31.35		31.24		31.19		31.14
Disabled	11.78		11.55		11.53		11.53		11.37
Child	3.83	X	3.27		3.20		3.20		3.02
Adult	10.54		10.36		10.32		10.32		10.24
NUMBER OF HIGH-COST ENROLLEES									
# of Enrollees with Total Medicaid Paid > $1,000,000	2.00		2.00		2.00		2.00		2.00
# of Enrollees with Total Medicaid Paid > $500,000	6.00	X	9.00		9.00		9.00		9.00
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$5,439		$5,828		$5,867		$5,884		$5,894
Aged	$12,637		$14,073		$14,207		$14,271		$14,325
Disabled	$16,079		$17,378		$17,516		$17,572		$17,603
Child	$2,353		$2,518		$2,540		$2,554		$2,552
Adult	$4,354		$4,530		$4,534		$4,533		$4,547
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$11,797		$13,096		$13,212		$13,249		$13,292
Aged	$12,575		$14,011		$14,135		$14,175		$14,263
Disabled	$11,509		$12,775		$12,889		$12,923		$12,923
EDB Only (EDB DUAL = 50)	$10,784		$11,559		$11,735		$11,745		$11,610
EDB QMB Only (EDB DUAL = 51)	$1,116		$1,255		$1,303		$1,313		$1,334
EDB QMB Plus (EDB DUAL = 52)	$16,139		$17,921		$18,098		$18,141		$18,220
EDB SLMB Only (EDB DUAL = 53)	$287		$354		$353		$354		$298
EDB SLMB Plus (EDB DUAL = 54)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QDWI (EDB DUAL = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QI-1 (EDB DUAL = 56)	$304		$303		$302		$302		$313
EDB QI-2 (EDB DUAL = 57)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Other (EDB DUAL = 58)	$37,071		$40,855		$41,053		$41,156		$41,704
EDB Dual Type Unknown (EDB DUAL = 59)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Dual Status Unknown (EDB DUAL = 98)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	$23,409		$25,979		$26,192		$26,254		$26,424
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	$717		$811		$835		$841		$835
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE									
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	$58,320		$61,350		$61,178		$61,238		$61,777
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	$42,749		$46,926		$47,235		$47,310		$47,334
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	$41,299	X	$50,102		$51,938		$51,899		$51,899
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT									
Avg Medicaid Paid per Section 1915(c) Enrollee	$42,652		$47,304		$47,659		$47,747		$47,977
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$20,513		$22,938		$23,262		$23,336		$23,641
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$22,448		$25,646		$25,161		$25,161		$25,854

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Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	$16,520		$17,748		$17,935		$17,962		$18,004
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$97,751		$108,383		$108,649		$108,776		$109,760
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT									
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	$33,408		$37,003		$37,200		$37,246		$37,371
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$12,047		$13,400		$13,485		$13,513		$13,527
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$18,600		$21,642		$21,208		$21,208		$21,846
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	$4,028		$4,469		$4,475		$4,477		$4,494
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$89,906		$99,247		$99,475		$99,552		$100,649
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EXPENDITURES FOR RESTRICTED BENEFIT ENROLLEES									
Expenditures for Family Planning Enrollees with Restricted Benefits (RBF = 6)									
Total Medicaid Paid for ONLY Family Planning Only Enrollees	$123,587		$128,023		$124,342		$124,418		$112,930
Avg Medicaid Paid per ONLY Family Planning Only Enrollee	$41		$43		$42		$42		$38
Expenditures for Aliens with Restricted Benefits (RBF = 2)									
Total Medicaid Paid for Aliens with Restricted Benefits ONLY Enrollment	$7,331,243		$8,426,701		$8,576,306		$8,919,674		$8,868,810
Avg Medicaid Paid per Alien Enrollee with Restricted Benefits ONLY	$880		$1,007		$1,025		$1,066		$1,065
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
Total Medicaid Paid for EDB Duals with Only Restricted Benefits Enrollment	$4,745,217	X	$5,573,654		$5,795,812		$5,858,142		$6,106,891
Avg Medicaid Paid per EDB Dual with Only Restricted Benefits Enrollment	$399	X	$468		$486		$492		$512
Expenditures for Prescription Drug Enrollees (RBF = X, Y, or Z)									
Total Medicaid Paid for Prescription Drug ONLY Enrollees (May Have a Month or More of RBF = 3)	$0		$0		$0		$0		$0
Avg Medicaid Paid per Prescription Drug ONLY Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Dual Prescription Drug Enrollees									
Total Medicaid Paid for Prescription Drug ONLY Enrollees Who Are EDB Duals	$0		$0		$0		$0		$0
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.									
Total Medicaid Enrollees	174,222		174,549		174,616		174,637		174,076
Aged Total	6,298		6,337		6,360		6,368		6,308
Disabled Total	18,336		18,389		18,413		18,422		18,313
Child Total	82,291		82,490		82,513		82,524		82,163
Adult Total	67,297		67,333		67,330		67,323		67,292
Total Medicaid Person-Years of Enrollment	134,727		134,014		133,932		133,955		136,427
Total EDB Duals	12,785		12,827		12,852		12,858		12,739

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Aged	6,011		6,049		6,069		6,073		6,024
Disabled	5,575		5,583		5,590		5,593		5,576
TOTAL MEDICAID AMOUNT PAID									
Total Medicaid Paid	$1,061,535,879		$1,138,597,150		$1,146,363,069		$1,149,495,707		$1,147,742,905
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$6,093		$6,523		$6,565		$6,582		$6,593
Aged	$26,109		$28,980		$29,206		$29,311		$29,555
Disabled	$20,331		$21,949		$22,113		$22,180		$22,243
Child	$2,405		$2,572		$2,594		$2,605		$2,603
Adult	$4,850		$5,038		$5,041		$5,040		$5,055
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$22,435		$24,852		$25,043		$25,101		$25,281
Aged	$26,620		$29,558		$29,772		$29,837		$30,139
Disabled	$21,403		$23,718		$23,898		$23,950		$23,970
Managed CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.									
% Total Enrollees in MC Anytime During Year	99.93		99.93		99.93		99.93		99.93
Total MC Enrollees	174,092		174,421		174,487		174,508		173,956
Aged	6,222		6,264		6,288		6,296		6,236
Disabled	18,286		18,338		18,361		18,370		18,267
Child	82,291		82,490		82,513		82,524		82,163
Adult	67,293		67,329		67,325		67,318		67,290
% of MC Enrollees in HMO/HIO (MC TYPE = 1)	83.47		83.33		83.31		83.31		N/A
% of MC Enrollees in Dental (MC TYPE = 2)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in BHO (MC TYPE = 3)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in Prenatal (MC TYPE = 4)	0.00		0.00		0.00		0.00		Div by 0
% of MC Enrollees in LTC (MC TYPE = 5)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PACE (MC TYPE = 6)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PCCM (MC TYPE = 7)	7.76		7.75		7.74		7.74		N/A
% of MC Enrollees in Other MC (MC TYPE = 8)	100.00		100.00		100.00		100.00		N/A
% EDB Duals Ever Enrolled in HMO/HIOs	13.34		13.32		13.30		13.30		13.02
% EDB Duals in PHP Only or PHP/PCCM Only	86.55		86.58		86.59		86.59		86.89
% EDB Duals in PCCM Only	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	3.62		3.69		3.78		3.81		3.58
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	96.38		96.31		96.22		96.19		96.42
% Section 1915(c) Waiver Enrollees in PCCM Only	0.00		0.00		0.00		0.00		0.00
Total Enrollees in June	136,750		136,777		136,789		136,794		134,595
June % HMO/HIO Only (MC COMBO = 01)	0.03	X	0.03	X	0.03	X	0.03	X	0.02
June % Dental Plan Only (MC COMBO = 02)	0.00		0.00		0.00		0.00		0.00
June % BHO Only (MC COMBO = 03)	0.00		0.00		0.00		0.00		0.00
June % PCCM Only (MC COMBO = 04)	0.00		0.00		0.00		0.00		0.00
June % Other MC Only (MC COMBO = 05)	13.83		13.84		13.84		13.84		12.80
June % HMO/HIO & Dental (MC COMBO = 06)	0.00		0.00		0.00		0.00		0.00

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June % HMO/HIO & BHO (MC COMBO = 07)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Other MC (MC COMBO = 08)	77.01		76.99		76.98		76.98		77.93
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	0.00		0.00		0.00		0.00		0.00
June % Dental & PCCM (MC COMBO = 10)	0.00		0.00		0.00		0.00		0.00
June % BHO & PCCM (MC COMBO = 11)	0.00		0.00		0.00		0.00		0.00
June % Other MC & PCCM (MC COMBO = 12)	7.26		7.26		7.26		7.26		7.35
June % Dental & BHO & PCCM (MC COMBO = 13)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO (MC COMBO = 14)	0.00		0.00		0.00		0.00		0.00
June % Other Combinations (MC COMBO = 15)	0.00		0.00		0.00		0.00		0.00
June % FFS Only (MC COMBO = 16)	1.87		1.88		1.89		1.89		1.90
June % MC Status Unknown (MC COMBO = 99)	0.00		0.00		0.00		0.00		0.00
CAPITATION CLAIMS									
Total Capitation Payments	$451,442,778		$460,524,508		$459,541,569		$459,537,086		$459,477,304
HMO/HIO	$442,364,076		$451,445,722		$450,462,777		$450,458,294		$450,398,128
PHP	$9,078,702		$9,078,786		$9,078,792		$9,078,792		$9,079,176
PCCM	$0		$0		$0		$0		$0
Ratio of Capitation Claims to Person-Month Enrollment in MC	1.75		1.76		1.76		1.76		1.73
HMO/HIO	1.02		1.02		1.03		1.03		1.00
PHP	0.95		0.96		0.96		0.96		0.94
PCCM	0.00		0.00		0.00		0.00		0.00
Avg Capitation Payment per Person-Month Enrollment in MC	$285		$292		$292		$292		$286
HMO/HIO	$357		$367		$366		$366		$357
PHP	$6		$6		$6		$6		$6
PCCM	$0		$0		$0		$0		$0
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY									
Total Capitation Payments	$1,500,695		$1,565,071		$1,572,045		$1,570,310		$1,463,299
Total Medicaid Paid	$398,569,585		$446,151,467		$451,755,755		$453,573,957		$452,465,704
Count of Enrollees	28,784		29,068		29,121		29,129		28,695
PERSONS ENROLLED IN PCCM ONLY									
Total Capitation Payments	$0		$0		$0		$0		$0
Count of Enrollees	0		0		0		0		0
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR									
Count of Enrollees	145,308		145,353		145,366		145,379		145,261
Aged	321		328		333		336		319
Disabled	11,270		11,285		11,289		11,291		11,270
Child	72,938		72,978		72,990		73,001		72,861
Adult	60,779		60,762		60,754		60,751		60,811
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	103,307		102,667		102,581		102,592		105,133
Total Capitation Payments	$449,942,083		$458,959,437		$457,969,524		$457,966,776		$458,014,005
Avg Capitation Payments	$3,096		$3,158		$3,150		$3,150		$3,153
Aged	$5,118		$4,980		$4,882		$4,860		$5,047
Disabled	$8,997		$8,971		$8,918		$8,916		$8,931
Child	$1,476		$1,505		$1,506		$1,506		$1,507
Adult	$3,936		$4,053		$4,045		$4,045		$4,045

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Total FFS Payments	$213,003,181		$233,460,900		$236,612,040		$237,929,047		$237,219,840
Avg FFS Payments per Enrollee	$1,466		$1,606		$1,628		$1,637		$1,633
Aged	$2,845		$3,722		$3,807		$3,796		$3,320
Disabled	$6,546		$7,294		$7,441		$7,491		$7,480
Child	$1,024		$1,142		$1,158		$1,167		$1,162
Adult	$1,047		$1,095		$1,100		$1,101		$1,105
Total FFS Payments by Type of Service									
IP (MAX TOS = 01)	$16,944,813		$19,418,941		$20,116,248		$20,129,296		$20,364,449
ILTC (MAX TOS = 02, 04, 05, 07)	$4,760,083		$5,960,878		$6,213,044		$6,255,571		$5,536,321
Drug (MAX TOS = 16)	$99,136,472		$100,730,734		$100,745,251		$100,746,823		$100,732,107
All Other (Excluding Capitation Payments)	$92,161,813		$107,350,347		$109,537,497		$110,797,357		$110,586,963
Average FFS Payments by Type of Service									
IP (MAX TOS = 01)	$117		$134		$138		$138		$140
ILTC (MAX TOS = 02, 04, 05, 07)	$33		$41		$43		$43		$38
Drug (MAX TOS = 16)	$682		$693		$693		$693		$693
All Other (Excluding Capitation Payments)	$634		$739		$754		$762		$761
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total Non-Dual FFS Enrollees	17,835		18,077		18,107		18,110		17,735
Total Non-Dual FFS Recipients	12,686		13,706		13,879		13,914		13,723
Total Non-Dual FFS Person-Years of Enrollment	11,456		11,419		11,420		11,419		11,525
Aged Total	190		190		190		191		188
Aged, Cash (MAX ELIG CD = 11)	66		66		66		66		65
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	76		73		72		73		72
Other Aged (MAX ELIG CD = 41)	48		51		52		52		51
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	2,245		2,274		2,288		2,293		2,227
Disabled, Cash (MAX ELIG CD = 12)	1,636		1,645		1,654		1,656		1,629
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	105		106		106		106		101
Other Disabled (MAX ELIG CD = 42)	504		523		528		531		497
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	9,347		9,507		9,518		9,518		9,301
AFDC Child, Cash (MAX ELIG CD = 14)	6,836		6,951		6,957		6,959		6,810
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	970		1,000		1,006		1,004		968
Other Child (MAX ELIG CD = 44)	1,166		1,178		1,178		1,179		1,151
Foster Care Child (MAX ELIG CD = 48)	373		376		375		374		371
1115 Child (MAX ELIG CD = 54)	2	X	2	X	2	X	2	X	1
Adult Total	6,053		6,106		6,111		6,108		6,019
AFDC Adult, Cash (MAX ELIG CD = 15)	2,969		3,007		3,008		3,005		2,957

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AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	91		99		100		101		91
Other Adult (MAX ELIG CD = 45)	510		518		523		524		505
1115 Adult (MAX ELIG CD = 55)	2,483		2,482		2,480		2,478		2,466
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	201		197		199		201		189
Total FFS Medicaid Paid	$125,342,180		$141,584,500		$144,112,634		$145,058,673		$143,725,924
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	$7,028		$7,832		$7,959		$8,010		$8,104
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	$9,880		$10,330		$10,384		$10,425		$10,473
Total Capitation Payments	$825,324		$885,317		$892,426		$890,691		$786,554
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	90	X	139	X	144	X	143	X	51
Total HMO/HIO Payments (Among People not Enrolled)	$78,816	X	$137,969	X	$144,982	X	$143,625	X	$40,946
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$16,792		$18,940		$19,978		$21,845		$19,365
Aged, Cash (MAX ELIG CD = 11)	$22,379		$24,908		$25,077		$25,077		$25,463
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$191	X	$291	X	$241	X	$5,174	X	$587
Other Aged (MAX ELIG CD = 41)	$35,396		$37,911		$40,834		$41,146		$38,103
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$37,898		$41,727		$42,012		$42,139		$43,079
Disabled, Cash (MAX ELIG CD = 12)	$42,716		$47,081		$47,396		$47,485		$48,254
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$8,489		$9,768		$9,870		$10,043		$10,540
Other Disabled (MAX ELIG CD = 42)	$28,388		$31,366		$31,598		$31,873		$32,731
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$1,608	X	$1,940		$2,002		$2,032		$2,042
AFDC Child, Cash (MAX ELIG CD = 14)	$1,431		$1,712		$1,769		$1,780		$1,786
AFDC-U Child, Cash (MAX ELIG CD = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child Poverty (MAX ELIG CD = 34)	$1,384		$1,652		$1,675		$1,689		$1,702
Other Child (MAX ELIG CD = 44)	$1,187		$1,363		$1,431		$1,437		$1,427
Foster Care Child (MAX ELIG CD = 48)	$6,753	X	$8,729		$9,014		$9,547		$9,532
1115 Child (MAX ELIG CD = 54)	$0		$0		$0		$0		$0
Adult	$3,641		$4,038		$4,113		$4,079		$4,180
AFDC Adult, Cash (MAX ELIG CD = 15)	$2,492		$2,732		$2,809		$2,828		$2,863
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult, Poverty (MAX ELIG CD = 35)	$772	X	$1,468		$1,776		$1,782		$1,739
Other Adult (MAX ELIG CD = 45)	$1,668	X	$1,975		$2,039		$2,053		$2,100
1115 Adult (MAX ELIG CD = 55)	$5,526		$6,153		$6,227		$6,119		$6,275
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$20,223,173	X	$25,136,832		$26,361,073		$26,593,285		$25,484,141
IP: Number of Users	1,611	X	2,068		2,133		2,147		2,032
IP: Avg Medicaid Paid per User	$12,553		$12,155		$12,359		$12,386		$12,541

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IP: Avg Medicaid Covered Days Per User	7.11		6.93		7.04		7.07		7.12
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$541,575		$620,450		$627,100		$629,200		$629,200
MH Aged: Number of Users	121		138		141		143		143
MH Aged: Avg Medicaid Paid per User	$4,476		$4,496		$4,448		$4,400		$4,400
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$145,612	X	$274,068	X	$320,078	X	$484,732		$487,431
IP Psych, Age < 21: Number of Users	5	X	7	X	7	X	11		12
IP Psych, Age < 21: Avg Medicaid Paid per User	$29,122	X	$39,153		$45,725		$44,067		$40,619
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$7,972,058		$8,693,073		$8,693,073		$8,693,073		$8,693,073
ICF/MR: Number of Users	40		40		40		40		40
ICF/MR: Avg Medicaid Paid per User	$199,301		$217,327		$217,327		$217,327		$217,327
NF: Total Medicaid Paid (MAX TOS = 07)	$18,006,168		$19,945,676		$20,105,291		$20,182,337		$20,162,199
NF: Number of Users	204		217		223		226		225
NF:Avg Medicaid Paid per User	$88,266		$91,916		$90,158		$89,302		$89,610
Physician: Total Medicaid Paid (MAX TOS = 08)	$8,404,979		$9,541,326		$9,742,836		$9,826,808		$9,735,450
Physician: Number of Users	10,279		11,125		11,280		11,315		11,193
Physician: Avg Medicaid Paid per User	$818		$858		$864		$868		$870
Dental: Total Medicaid Paid (MAX TOS = 09)	$1,977,590		$2,080,039		$2,089,299		$2,090,061		$2,086,639
Dental: Number of Users	2,795		2,883		2,894		2,895		2,886
Dental: Avg Medicaid Paid per User	$708		$721		$722		$722		$723
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$1,364,371	X	$1,867,639		$1,980,794		$2,016,880		$2,015,153
Other Practitioner: Number of Users	3,572	X	4,244		4,435		4,489		4,476
Other Practitioner: Avg Medicaid Paid per User	$382		$440		$447		$449		$450
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$4,831,963		$5,660,798		$5,750,363		$5,780,529		$5,754,594
Outpatient: Number of Users	4,666		5,118		5,199		5,212		5,186
Outpatient: Avg Medicaid Paid per User	$1,036		$1,106		$1,106		$1,109		$1,110
Clinic: Total Medicaid Paid (MAX TOS = 12)	$1,330,553	X	$1,698,465		$1,727,556		$1,748,568		$1,736,209
Clinic: Number of Users	1,396	X	1,844		1,884		1,891		1,855
Clinic: Avg Medicaid Paid per User	$953		$921		$917		$925		$936
Home Health: Total Medicaid Paid (MAX TOS = 13)	$820,212		$979,232		$1,007,884		$1,019,669		$1,016,060
Home Health: Number of Users	264		316		323		323		321
Home Health: Avg Medicaid Paid per User	$3,107		$3,099		$3,120		$3,157		$3,165
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$3,968,739		$4,392,942		$4,459,633		$4,487,511		$4,473,633
Lab/Xray: Number of Users	7,716		8,245		8,329		8,358		8,291
Lab/Xray:Avg Medicaid Paid per User	$514		$533		$535		$537		$540
Drugs: Total Medicaid Paid (MAX TOS = 16)	$16,576,613		$16,932,299		$16,944,506		$16,965,802		$16,987,526
Drugs: Number of Users	10,068		10,269		10,383		10,442		10,403
Drugs: Avg Medicaid Paid per User	$1,646		$1,649		$1,632		$1,625		$1,633
Other Services: Total Medicaid Paid (MAX TOS = 19)	$19,393,803		$21,064,770		$21,225,192		$21,249,822		$21,246,783
Other Services: Number of Users	1,324		1,415		1,427		1,430		1,428
Other Services: Avg Medicaid Paid per User	$14,648		$14,887		$14,874		$14,860		$14,879
Transportation: Total Medicaid Paid (MAX TOS = 26)	$554,428	X	$686,464		$713,336		$729,709		$729,922
Transportation: Number of Users	978		1,048		1,073		1,081		1,083
Transportation: Avg Medicaid Paid per User	$567		$655		$665		$675		$674
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$0		$0		$0		$0		$0

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Personal Care Services: Number of Users	0		0		0		0		0
Personal Care Services: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$0		$0		$0		$0		$0
Targeted Case Management: Number of Users	0		0		0		0		0
Targeted Case Management: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$623,566		$680,462		$680,833		$680,833		$680,833
Rehabilitation Services: Number of Users	49		51		51		51		51
Rehabilitation Services: Avg Medicaid Paid per User	$12,726		$13,342		$13,350		$13,350		$13,350
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$574,645	X	$764,128		$824,133		$875,511		$868,967
PT/OT/Speech/Hearing: Number of Users	374		412		439		445		444
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,536	X	$1,855		$1,877		$1,967		$1,957
Hospice: Total Medicaid Paid (MAX TOS = 35)	$735,384		$799,620		$811,004		$867,389		$871,091
Hospice: Number of Users	40		45		45		45		46
Hospice: Avg Medicaid Paid per User	$18,385		$17,769		$18,022		$19,275		$18,937
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$1,511,493		$1,719,693		$1,783,040		$1,820,393		$1,819,762
Durable Medical Equipment: Number of Users	1,935		2,150		2,215		2,253		2,249
Durable Medical Equipment: Avg Medicaid Paid per User	$781		$800		$805		$808		$809
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$7,254,603		$8,085,470		$8,157,602		$8,175,209		$8,175,209
Residential Care: Number of Users	88		89		89		89		89
Residential Care: Avg Medicaid Paid per User	$82,439		$90,848		$91,658		$91,856		$91,856
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$5,621,973		$6,767,427		$6,883,094		$6,907,938		$6,852,649
Psych Services: Number of Users	2,241		2,423		2,476		2,495		2,490
Psych Services: Avg Medicaid Paid per User	$2,509		$2,793		$2,780		$2,769		$2,752
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$223,322		$246,076		$246,076		$246,076		$246,076
Adult Day Care: Number of Users	22		22		22		22		22
Adult Day Care: Avg Medicaid Paid per User	$10,151		$11,185		$11,185		$11,185		$11,185
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$1,134	X	$1,391		$1,456		$1,468		$1,437
Aged	$482	X	$988		$1,723	X	$3,405	X	$858
Disabled	$4,114	X	$5,068		$5,265		$5,318		$5,239
Child	$350	X	$482		$513		$516		$501
Adult	$1,259		$1,448		$1,490		$1,446		$1,495
ILTC (MAX TOS = 02,04,05,07)	$1,495		$1,634		$1,643		$1,656		$1,690
Aged	$13,244		$14,600		$14,769		$14,713		$15,074
Disabled	$10,500		$11,431		$11,413		$11,420		$11,737
Child	$16	X	$29	X	$34	X	$51		$52
Adult	$71		$81		$83		$83		$85
Drugs (MAX TOS = 16)	$929		$937		$936		$937		$958
Aged	$763		$798		$798		$794		$805
Disabled	$4,443		$4,476		$4,449		$4,448		$4,577
Child	$193		$194		$195		$196		$200
Adult	$769		$779		$778		$778		$795
All Other Services	$3,469		$3,871		$3,925		$3,949		$4,019
Aged	$2,304		$2,554		$2,689		$2,933		$2,628

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Disabled	$18,841		$20,752		$20,884		$20,953		$21,527
Child	$1,049		$1,235		$1,260		$1,270		$1,288
Adult	$1,542		$1,731		$1,763		$1,772		$1,805
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	9.03	X	11.44		11.78		11.86		11.46
Aged	12.11	X	15.26		16.32		16.75		15.43
Disabled	16.26		17.50		17.61		17.66		17.87
Child	6.16	X	9.57		10.01		10.12		9.42
Adult	10.69		11.97		12.21		12.23		12.11
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	2.07		2.22		2.26		2.31		2.36
Aged	22.11		23.68		24.21		24.61		27.13
Disabled	10.11		10.51		10.58		10.64		10.69
Child	0.05	X	0.07	X	0.07	X	0.12		0.13
Adult	1.59		1.82		1.88		1.92		1.96
% with Ratio of ILTC Days/Enrollment Days > 1	1.89	X	4.23		4.39	X	4.53	X	3.58
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	56.45		56.81		57.34		57.66		58.66
Aged	28.42		30.00		30.00		29.84		30.85
Disabled	78.84		78.32		78.10		77.98		79.79
Child	49.56		50.19		51.24		51.86		52.81
Adult	59.67		59.92		59.92		59.94		60.74
% Non-Dual FFS Enrollees with All Other Claims	67.59		72.93		73.96		74.24		74.89
Aged	52.63		55.79		57.37		58.12		56.91
Disabled	84.90		86.85		87.11		87.05		88.64
Child	66.50		73.83		75.38		75.85		76.51
Adult	63.32		66.87		67.34		67.44		67.87
Avg # IP Days per Non-Dual FFS User	7		7		7		7		7
Aged	2	X	4	X	6	X	11	X	3
Disabled	15		17		17		18		17
Child	4		4		4		4		4
Adult	6		6		6		6		6
Avg # ILTC Days per Non-Dual FFS User	184		188		185		184		184
Aged	244		250		247		243		227
Disabled	249		261		258		256		262
Child	107	X	129	X	162		180		166
Adult	9		9		10		10		9
% Non-Dual FFS Enrollees with Maternal Delivery	1.58		1.79		1.82		1.83		1.85
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	1	X	4		4		4		4
Inpatient Hospital (MAX TOS = 01) > $500,000	0	X	1		1		1		1
ILTC (MAX TOS = 02,04,05,07) > $200,000	35		37		37		37		37
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	25	X	33		33		33		33
Maximum FFS Medicaid Paid	$512,092	X	$731,615		$783,140		$800,176		$800,176

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Inpatient Hospital (MAX TOS = 01)	$473,006	X	$626,013		$626,013		$626,013		$626,013
ILTC (MAX TOS = 02,04,05,07)	$366,670		$400,418		$400,418		$400,418		$400,418
Drugs (MAX TOS = 16)	$71,168		$73,369		$73,369		$73,369		$73,369
All Other Services	$388,606		$479,284		$479,729		$479,729		$479,729
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$243,834		$257,720		$260,100		$261,185		$261,056
FP: Number of Users	1,013		1,034		1,036		1,036		1,034
FP: Avg Medicaid Paid per User	$241		$249		$251		$252		$252
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$229,557		$261,868		$266,138		$268,002		$263,537
FQHC: Number of Users	574		652		666		671		656
FQHC: Avg Medicaid Paid per User	$400		$402		$400		$399		$402
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$25,269,495		$27,679,515		$27,883,180		$27,910,131		$27,907,202
Section 1915(c) Waiver: Number of Users	568		572		573		574		573
Section 1915(c) Waiver: Avg Medicaid Paid per User	$44,489		$48,391		$48,662		$48,624		$48,704
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$28,683,978		$31,496,682		$31,751,907		$31,793,448		$31,772,896
Number of Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	771		823		832		833		829
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	$37,204		$38,271		$38,163		$38,167		$38,327
Aged	$23,682		$22,799		$22,799		$20,813		$20,813
Disabled	$43,802		$46,966		$47,195		$47,255		$47,510
Child	$1,261		$1,182		$1,144		$1,149		$1,164
Adult	$1,068		$1,165		$1,211		$1,211		$1,203
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	4.32		4.55		4.59		4.60		4.67
Aged	4.74		5.26		5.26		5.76		5.85
Disabled	28.82		29.11		29.02		28.96		29.64
Child	0.45	X	0.67		0.72		0.72		0.73
Adult	1.21		1.42		1.46		1.46		1.50
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$25,269,495		$27,679,515		$27,883,180		$27,910,131		$27,907,202
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	568		572		573		574		573
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$44,489		$48,391		$48,662		$48,624		$48,704
Aged	$25,879		$27,692		$27,692		$24,721		$24,721
Disabled	$44,754		$48,684		$48,959		$49,005		$49,086
Child	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	3.18		3.16		3.16		3.17		3.23
Aged	4.21		4.21		4.21		4.71		4.79

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Disabled	24.94		24.80		24.69		24.64		25.33
Child	0.00		0.00		0.00		0.00		0.00
Adult	0.00		0.00		0.00		0.00		0.00
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total EDB Dual FFS Enrollees	11,079		11,119		11,143		11,148		11,080
Number of EDB Dual FFS Recipients	10,293		10,477		10,523		10,531		10,488
Total EDB Dual FFS Person-Years of Enrollment	9,916		9,923		9,931		9,933		9,933
% EDB Only Dual (EDB DUAL = 50)	2.05		1.80		1.76		1.76		1.97
% QMB Only (EDB DUAL = 51)	2.27		2.25		2.26		2.26		2.26
% QMB Plus (EDB DUAL = 52)	54.92		54.81		54.78		54.79		54.88
% SLMB Only (EDB DUAL = 53)	0.81		0.85		0.84		0.84		0.79
% SLMB Plus (EDB DUAL = 54)	0.00		0.00		0.00		0.00		0.00
% QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% QI 1 (EDB DUAL = 56)	0.37		0.38		0.38		0.38		0.37
% QI 2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% Other Type Dual (EDB DUAL = 58)	39.58		39.92		39.98		39.97		39.74
% Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	96.55		96.53		96.52		96.52		96.59
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	3.45		3.47		3.48		3.48		3.41
Aged EDB Dual FFS Total	5,787		5,819		5,837		5,841		5,801
Aged, Cash (MAX ELIG CD = 11)	2,487		2,487		2,488		2,489		2,488
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	78		80		81		81		76
Other Aged (MAX ELIG CD = 41)	3,222		3,252		3,268		3,271		3,237
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled EDB Dual FFS Total	4,821		4,830		4,836		4,838		4,816
Disabled, Cash (MAX ELIG CD = 12)	3,158		3,163		3,164		3,165		3,154
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	306		308		309		309		305
Other Disabled (MAX ELIG CD = 42)	1,357		1,359		1,363		1,364		1,357
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Total FFS Medicaid Paid	$271,741,913		$303,024,264		$306,093,848		$306,967,923		$307,319,837
Avg FFS Medicaid Paid per FFS Dual	$24,528		$27,253		$27,470		$27,536		$27,736
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	$26,401		$28,923		$29,088		$29,149		$29,302
Total Capitation Payments	$681,198		$682,732		$682,597		$682,597		$676,745
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	8	X	9	X	9	X	9	X	3
Total HMO/HIO Payments (Among People not Enrolled)	$8,388	X	$9,946	X	$9,811	X	$9,811	X	$2,519
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP									
Aged	$27,360		$30,391		$30,617		$30,683		$30,990
Aged, Cash (MAX ELIG CD = 11)	$12,082		$13,516		$13,668		$13,702		$13,752
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$5,898		$7,864	X	$8,636	X	$8,639	X	$5,883

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Other Aged (MAX ELIG CD = 41)	$39,673		$43,850		$44,065		$44,150		$44,828
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$23,245		$25,821		$26,031		$26,093		$26,162
Disabled, Cash (MAX ELIG CD = 12)	$16,698		$18,562		$18,750		$18,789		$18,821
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$3,292		$3,812		$3,866		$3,882		$3,663
Other Disabled (MAX ELIG CD = 42)	$42,981		$47,704		$47,958		$48,072		$48,281
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$4,401,073	X	$5,431,692		$5,706,816		$5,746,799		$5,703,250
IP: Number of Users	1,967		2,192		2,253		2,252		2,251
IP: Avg Medicaid Paid per User	$2,237		$2,478		$2,533		$2,552		$2,534
IP: Avg Medicaid Covered Days Per User	0.64		0.76		0.77		0.73		0.72
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$1,601,775		$1,753,482		$1,753,482		$1,753,482		$1,753,482
MH Aged: Number of Users	16		17		17		17		17
MH Aged: Avg Medicaid Paid per User	$100,111		$103,146		$103,146		$103,146		$103,146
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$0		$0		$0		$0		$0
IP Psych, Age < 21: Number of Users	0		0		0		0		0
IP Psych, Age < 21: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$19,240,661		$20,970,876		$20,970,876		$20,970,876		$20,970,876
ICF/MR: Number of Users	94		95		95		95		95
ICF/MR: Avg Medicaid Paid per User	$204,688		$220,746		$220,746		$220,746		$220,746
NF: Total Medicaid Paid (MAX TOS = 07)	$140,492,938		$155,923,512		$157,240,958		$157,490,063		$157,595,757
NF: Number of Users	3,011		3,201		3,247		3,254		3,214
NF:Avg Medicaid Paid per User	$46,660		$48,711		$48,427		$48,399		$49,034
Physician: Total Medicaid Paid (MAX TOS = 08)	$3,500,635		$3,911,483		$3,965,898		$3,986,827		$3,987,237
Physician: Number of Users	9,176		9,384		9,441		9,459		9,454
Physician: Avg Medicaid Paid per User	$381		$417		$420		$421		$422
Dental: Total Medicaid Paid (MAX TOS = 09)	$13,885		$14,007		$14,007		$14,007		$13,246
Dental: Number of Users	8		8		8		8		7
Dental: Avg Medicaid Paid per User	$1,736		$1,751		$1,751		$1,751		$1,892
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$162,317		$180,815		$186,371		$187,755		$187,901
Other Practitioner: Number of Users	3,351		3,578		3,632		3,643		3,648
Other Practitioner: Avg Medicaid Paid per User	$48		$51		$51		$52		$52
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$1,704,418	X	$2,032,321		$2,196,641		$2,270,510		$2,270,037
Outpatient: Number of Users	4,853		5,324		5,436		5,464		5,467
Outpatient: Avg Medicaid Paid per User	$351		$382		$404		$416		$415
Clinic: Total Medicaid Paid (MAX TOS = 12)	$1,405,136	X	$1,750,175		$1,853,792		$1,904,466		$1,902,014
Clinic: Number of Users	1,093		1,177		1,203		1,212		1,210
Clinic: Avg Medicaid Paid per User	$1,286		$1,487		$1,541		$1,571		$1,572
Home Health: Total Medicaid Paid (MAX TOS = 13)	$3,175,227		$3,704,739		$3,751,630		$3,763,707		$3,776,413
Home Health: Number of Users	520		542		549		551		553
Home Health: Avg Medicaid Paid per User	$6,106		$6,835		$6,834		$6,831		$6,829
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$547,110		$608,205		$617,350		$618,109		$617,278

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Lab/Xray: Number of Users	6,581		6,941		6,988		6,999		7,005
Lab/Xray:Avg Medicaid Paid per User	$83		$88		$88		$88		$88
Drugs: Total Medicaid Paid (MAX TOS = 16)	$1,583,607		$1,607,696		$1,608,044		$1,608,044		$1,604,033
Drugs: Number of Users	4,752		4,826		4,830		4,830		4,840
Drugs: Avg Medicaid Paid per User	$333		$333		$333		$333		$331
Other Services: Total Medicaid Paid (MAX TOS = 19)	$56,304,432		$62,370,988		$62,886,607		$63,036,398		$63,086,156
Other Services: Number of Users	3,736		3,948		4,011		4,042		4,048
Other Services: Avg Medicaid Paid per User	$15,071		$15,798		$15,679		$15,595		$15,585
Transportation: Total Medicaid Paid (MAX TOS = 26)	$814,141	X	$1,062,346		$1,063,394		$1,063,489		$1,063,077
Transportation: Number of Users	2,773		2,968		2,989		2,990		2,995
Transportation: Avg Medicaid Paid per User	$294		$358		$356		$356		$355
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$0		$0		$0		$0		$0
Personal Care Services: Number of Users	0		0		0		0		0
Personal Care Services: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$0		$0		$0		$0		$0
Targeted Case Management: Number of Users	0		0		0		0		0
Targeted Case Management: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$3,234,406		$3,532,770		$3,532,770		$3,532,770		$3,532,770
Rehabilitation Services: Number of Users	240		240		240		240		240
Rehabilitation Services: Avg Medicaid Paid per User	$13,477		$14,720		$14,720		$14,720		$14,720
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$87,366	X	$110,137	X	$127,377		$142,019		$138,172
PT/OT/Speech/Hearing: Number of Users	225	X	293		331		337		336
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$388		$376		$385		$421		$411
Hospice: Total Medicaid Paid (MAX TOS = 35)	$9,792,565		$11,364,825		$11,730,690		$11,941,164		$12,178,964
Hospice: Number of Users	474		521		529		534		550
Hospice: Avg Medicaid Paid per User	$20,659		$21,813		$22,175		$22,362		$22,144
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$939,867		$994,585		$1,015,974		$1,014,959		$1,016,347
Durable Medical Equipment: Number of Users	1,256		1,308		1,316		1,338		1,340
Durable Medical Equipment: Avg Medicaid Paid per User	$748		$760		$772		$759		$758
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$13,467,503		$15,253,889		$15,301,182		$15,350,924		$15,350,924
Residential Care: Number of Users	200		208		208		208		208
Residential Care: Avg Medicaid Paid per User	$67,338		$73,336		$73,563		$73,803		$73,803
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$6,000,523		$6,852,525		$6,949,272		$6,950,094		$6,950,442
Psych Services: Number of Users	678		709		716		718		719
Psych Services: Avg Medicaid Paid per User	$8,850		$9,665		$9,706		$9,680		$9,667
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$1,848,735		$2,046,776		$2,049,324		$2,049,324		$2,049,324
Adult Day Care: Number of Users	213		219		220		220		220
Adult Day Care: Avg Medicaid Paid per User	$8,680		$9,346		$9,315		$9,315		$9,315
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$397	X	$489		$512		$516		$515
Aged	$376	X	$474		$494		$493		$494
Disabled	$364		$436		$464		$472		$449
ILTC (MAX TOS = 02,04,05,07)	$14,562		$16,067		$16,151		$16,166		$16,274
Aged	$21,545		$23,780		$23,895		$23,910		$24,122

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Disabled	$7,579		$8,322		$8,357		$8,368		$8,384
Drugs (MAX TOS = 16)	$143		$145		$144		$144		$145
Aged	$50		$51		$51		$51		$51
Disabled	$231		$235		$234		$234		$233
All Other Services	$9,425		$10,553		$10,663		$10,710		$10,803
Aged	$5,389		$6,086		$6,176		$6,229		$6,323
Disabled	$15,072		$16,828		$16,976		$17,019		$17,097
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Duals with IP Claims (MAX TOS = 01)	17.75		19.71		20.22		20.20		20.32
Aged	18.49		20.67		21.35		21.25		21.50
Disabled	17.03		18.61		18.92		18.97		18.94
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	28.16		29.78		30.13		30.18		30.00
Aged	46.03		48.67		49.20		49.29		49.08
Disabled	9.29		9.77		9.88		9.90		9.80
% FFS Duals with Drug Claims (MAX TOS = 16)	42.89		43.40		43.35		43.33		43.68
Aged	39.78		40.52		40.45		40.42		40.84
Disabled	46.77		47.12		47.06		47.04		47.26
% FFS Duals with All Other Claims	89.31		90.79		91.03		91.17		91.65
Aged	88.28		90.17		90.53		90.74		91.38
Disabled	91.39		92.30		92.39		92.46		92.69
Avg # IP Days per FFS Dual User (MAX TOS = 01)	1		1		1		1		1
Aged	1		1		1		1		1
Disabled	0		0		0	X	0		0
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	238		248		246		246		249
Aged	237		247		245		244		248
Disabled	247		258		256		256		259
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Duals with FFS Medicaid Paid > $500,000	0		0		0		0		0
Inpatient Hospital (MAX TOS = 01) > $500,000	0		0		0		0		0
ILTC (MAX TOS = 02,04,05,07) > $200,000	59		62		62		62		62
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	22	X	42		43		44		44
Maximum FFS Medicaid Paid	$383,895		$416,785		$416,785		$416,785		$416,785
Inpatient Hospital (MAX TOS = 01)	$152,190		$152,190		$152,190		$153,816		$153,816
ILTC (MAX TOS = 02,04,05,07)	$355,592		$388,465		$388,465		$388,465		$388,465
Drugs (MAX TOS = 16)	$64,530		$69,009		$69,009		$69,009		$69,009
All Other Services	$291,277		$327,112		$327,151		$327,184		$327,184
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$2,265	X	$2,419	X	$2,544		$3,113		$3,113
FP: Number of Users	51		52		53		53		53
FP: Avg Medicaid Paid per User	$44	X	$47	X	$48		$59		$59
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0

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RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$41,866		$46,366		$49,105		$49,735		$49,685
FQHC: Number of Users	346		365		374		377		378
FQHC: Avg Medicaid Paid per User	$121		$127		$131		$132		$131
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$70,928,591		$78,806,690		$79,348,592		$79,518,939		$79,569,501
Section 1915(c) Waiver: Number of Users	2,088		2,122		2,126		2,127		2,131
Section 1915(c) Waiver: Avg Medicaid Paid per User	$33,970		$37,138		$37,323		$37,385		$37,339
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$75,459,404		$83,982,553		$84,571,425		$84,753,849		$84,817,117
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	2,267		2,310		2,317		2,318		2,322
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	$33,286		$36,356		$36,500		$36,563		$36,528
Aged	$17,973		$19,573		$19,676		$19,723		$19,723
Disabled	$44,032		$48,265		$48,440		$48,504		$48,450
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	20.46		20.78		20.79		20.79		20.96
Aged	16.00		16.33		16.33		16.32		16.46
Disabled	27.69		28.03		28.08		28.09		28.26
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$70,928,591		$78,806,690		$79,348,592		$79,518,939		$79,569,501
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	2,088		2,122		2,126		2,127		2,131
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$33,970		$37,138		$37,323		$37,385		$37,339
Aged	$17,984		$19,581		$19,678		$19,721		$19,714
Disabled	$44,901		$49,267		$49,545		$49,611		$49,546
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	18.85		19.08		19.08		19.08		19.23
Aged	14.65		14.90		14.90		14.89		15.03
Disabled	25.72		25.98		25.97		25.98		26.14
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total FFS Enrollees	28,914		29,196		29,250		29,258		28,815
# FFS Recipients	22,979		24,183		24,402		24,445		24,211
% FFS Enrollees Who Are Recipients	79.47		82.83		83.43		83.55		84.02
% Aged Who Are Recipients	92.82		94.72		95.04		95.09		95.21
% Disabled Who Are Recipients	90.76		91.69		91.79		91.78		92.38
% Child Who Are Recipients	69.16		76.02		77.24		77.57		78.09
% Adults Who Are Recipients	69.79		72.23		72.67		72.69		73.12
Total FFS Person-Years of Enrollment	21,372		21,342		21,351		21,352		21,458
Aged Total	5,977		6,009		6,027		6,032		5,989
Aged, Cash (MAX ELIG CD = 11)	2,553		2,553		2,554		2,555		2,553
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	154		153		153		154		148

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Other Aged (MAX ELIG CD = 41)	3,270		3,303		3,320		3,323		3,288
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	7,066		7,104		7,124		7,131		7,043
Disabled, Cash (MAX ELIG CD = 12)	4,794		4,808		4,818		4,821		4,783
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	411		414		415		415		406
Other Disabled (MAX ELIG CD = 42)	1,861		1,882		1,891		1,895		1,854
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	9,353		9,512		9,523		9,523		9,302
AFDC Child, Cash (MAX ELIG CD = 14)	6,840		6,955		6,961		6,963		6,811
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	970		1,000		1,006		1,004		968
Other Child (MAX ELIG CD = 44)	1,168		1,179		1,179		1,180		1,151
Foster Care Child (MAX ELIG CD = 48)	373		376		375		374		371
1115 Child (MAX ELIG CD = 54)	2	X	2	X	2	X	2	X	1
Adult Total	6,518		6,571		6,576		6,572		6,481
AFDC Adult, Cash (MAX ELIG CD = 15)	3,331		3,370		3,371		3,367		3,318
AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	93		101		102		103		93
Other Adult (MAX ELIG CD = 45)	551		559		564		565		544
1115 Adult (MAX ELIG CD = 55)	2,543		2,541		2,539		2,537		2,526
Total FFS Medicaid Paid	$397,084,093		$444,608,764		$450,206,482		$452,026,596		$451,045,761
Avg FFS Medicaid Paid per FFS Enrollee	$13,733		$15,228		$15,392		$15,450		$15,653
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	$17,280		$18,385		$18,450		$18,492		$18,630
Total Capitation Payments	$1,506,522		$1,568,049		$1,575,023		$1,573,288		$1,463,299
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	98	X	148	X	153	X	152	X	54
Total HMO/HIO Payments (Among People not Enrolled)	$87,204	X	$147,915	X	$154,793	X	$153,436	X	$43,465
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$27,024		$30,029		$30,281		$30,403		$30,625
Aged, Cash (MAX ELIG CD = 11)	$12,348		$13,811		$13,963		$13,996		$14,051
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$3,082		$4,251	X	$4,685	X	$6,996	X	$3,306
Other Aged (MAX ELIG CD = 41)	$39,610		$43,758		$44,015		$44,103		$44,724
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$27,901		$30,913		$31,163		$31,253		$31,511
Disabled, Cash (MAX ELIG CD = 12)	$25,577		$28,319		$28,584		$28,646		$28,846
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$4,620		$5,337		$5,399		$5,456		$5,374
Other Disabled (MAX ELIG CD = 42)	$39,029		$43,164		$43,390		$43,533		$44,112
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$1,619	X	$1,946		$2,009		$2,039		$2,042
AFDC Child, Cash (MAX ELIG CD = 14)	$1,441		$1,721		$1,778		$1,789		$1,786

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AFDC-U Child, Cash (MAX ELIG CD = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child Poverty (MAX ELIG CD = 34)	$1,384		$1,652		$1,675		$1,689		$1,702
Other Child (MAX ELIG CD = 44)	$1,224		$1,364		$1,432		$1,438		$1,427
Foster Care Child (MAX ELIG CD = 48)	$6,753	X	$8,729		$9,014		$9,547		$9,532
1115 Child (MAX ELIG CD = 54)	$0		$0		$0		$0		$0
Adult	$3,570		$3,965		$4,040		$4,010		$4,121
AFDC Adult, Cash (MAX ELIG CD = 15)	$2,395		$2,643		$2,718		$2,738		$2,768
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult, Poverty (MAX ELIG CD = 35)	$764	X	$1,451		$1,753		$1,760		$1,716
Other Adult (MAX ELIG CD = 45)	$1,615	X	$1,910		$1,971		$1,985		$2,034
1115 Adult (MAX ELIG CD = 55)	$5,636		$6,270		$6,345		$6,241		$6,435
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$24,624,246	X	$30,568,524		$32,067,889		$32,340,084		$31,187,391
IP: Number of Users	3,578		4,260		4,386		4,399		4,283
IP: Avg Medicaid Paid per User	$6,882		$7,176		$7,311		$7,352		$7,282
IP: Avg Medicaid Covered Days Per User	3.55		3.76		3.82		3.82		3.75
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$2,143,350		$2,373,932		$2,380,582		$2,382,682		$2,382,682
MH Aged: Number of Users	137		155		158		160		160
MH Aged: Avg Medicaid Paid per User	$15,645		$15,316		$15,067		$14,892		$14,892
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$145,612	X	$274,068	X	$320,078	X	$484,732		$487,431
IP Psych, Age < 21: Number of Users	5	X	7	X	7	X	11		12
IP Psych, Age < 21: Avg Medicaid Paid per User	$29,122	X	$39,153		$45,725		$44,067		$40,619
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$27,212,719		$29,663,949		$29,663,949		$29,663,949		$29,663,949
ICF/MR: Number of Users	134		135		135		135		135
ICF/MR: Avg Medicaid Paid per User	$203,080		$219,733		$219,733		$219,733		$219,733
NF: Total Medicaid Paid (MAX TOS = 07)	$158,499,106		$175,869,188		$177,346,249		$177,672,400		$177,757,956
NF: Number of Users	3,215		3,418		3,470		3,480		3,439
NF:Avg Medicaid Paid per User	$49,300		$51,454		$51,108		$51,055		$51,689
Physician: Total Medicaid Paid (MAX TOS = 08)	$11,905,614		$13,452,809		$13,708,734		$13,813,635		$13,722,687
Physician: Number of Users	19,455		20,509		20,721		20,774		20,647
Physician: Avg Medicaid Paid per User	$612		$656		$662		$665		$665
Dental: Total Medicaid Paid (MAX TOS = 09)	$1,991,475		$2,094,046		$2,103,306		$2,104,068		$2,099,885
Dental: Number of Users	2,803		2,891		2,902		2,903		2,893
Dental: Avg Medicaid Paid per User	$710		$724		$725		$725		$726
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$1,526,688	X	$2,048,454		$2,167,165		$2,204,635		$2,203,054
Other Practitioner: Number of Users	6,923		7,822		8,067		8,132		8,124
Other Practitioner: Avg Medicaid Paid per User	$221		$262		$269		$271		$271
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$6,536,381		$7,693,119		$7,947,004		$8,051,039		$8,024,631
Outpatient: Number of Users	9,519		10,442		10,635		10,676		10,653
Outpatient: Avg Medicaid Paid per User	$687		$737		$747		$754		$753
Clinic: Total Medicaid Paid (MAX TOS = 12)	$2,735,689	X	$3,448,640		$3,581,348		$3,653,034		$3,638,223
Clinic: Number of Users	2,489		3,021		3,087		3,103		3,065

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Clinic: Avg Medicaid Paid per User	$1,099		$1,142		$1,160		$1,177		$1,187
Home Health: Total Medicaid Paid (MAX TOS = 13)	$3,995,439		$4,683,971		$4,759,514		$4,783,376		$4,792,473
Home Health: Number of Users	784		858		872		874		874
Home Health: Avg Medicaid Paid per User	$5,096		$5,459		$5,458		$5,473		$5,483
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$4,515,849		$5,001,147		$5,076,983		$5,105,620		$5,090,911
Lab/Xray: Number of Users	14,297		15,186		15,317		15,357		15,296
Lab/Xray:Avg Medicaid Paid per User	$316		$329		$331		$332		$333
Drugs: Total Medicaid Paid (MAX TOS = 16)	$18,160,220		$18,539,995		$18,552,550		$18,573,846		$18,591,559
Drugs: Number of Users	14,820		15,095		15,213		15,272		15,243
Drugs: Avg Medicaid Paid per User	$1,225		$1,228		$1,220		$1,216		$1,220
Other Services: Total Medicaid Paid (MAX TOS = 19)	$75,698,235		$83,435,758		$84,111,799		$84,286,220		$84,332,939
Other Services: Number of Users	5,060		5,363		5,438		5,472		5,476
Other Services: Avg Medicaid Paid per User	$14,960		$15,558		$15,467		$15,403		$15,400
Transportation: Total Medicaid Paid (MAX TOS = 26)	$1,368,569	X	$1,748,810		$1,776,730		$1,793,198		$1,792,999
Transportation: Number of Users	3,751		4,016		4,062		4,071		4,078
Transportation: Avg Medicaid Paid per User	$365		$435		$437		$440		$440
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$0		$0		$0		$0		$0
Personal Care Services: Number of Users	0		0		0		0		0
Personal Care Services: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$0		$0		$0		$0		$0
Targeted Case Management: Number of Users	0		0		0		0		0
Targeted Case Management: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$3,857,972		$4,213,232		$4,213,603		$4,213,603		$4,213,603
Rehabilitation Services: Number of Users	289		291		291		291		291
Rehabilitation Services: Avg Medicaid Paid per User	$13,349		$14,478		$14,480		$14,480		$14,480
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$662,011	X	$874,265		$951,510		$1,017,530		$1,007,139
PT/OT/Speech/Hearing: Number of Users	599	X	705		770		782		780
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,105		$1,240		$1,236		$1,301		$1,291
Hospice: Total Medicaid Paid (MAX TOS = 35)	$10,527,949		$12,164,445		$12,541,694		$12,808,553		$13,050,055
Hospice: Number of Users	514		566		574		579		596
Hospice: Avg Medicaid Paid per User	$20,482		$21,492		$21,850		$22,122		$21,896
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$2,451,360		$2,714,278		$2,799,014		$2,835,352		$2,836,109
Durable Medical Equipment: Number of Users	3,191		3,458		3,531		3,591		3,589
Durable Medical Equipment: Avg Medicaid Paid per User	$768		$785		$793		$790		$790
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$20,722,106		$23,339,359		$23,458,784		$23,526,133		$23,526,133
Residential Care: Number of Users	288		297		297		297		297
Residential Care: Avg Medicaid Paid per User	$71,952		$78,584		$78,986		$79,213		$79,213
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$11,622,496		$13,619,952		$13,832,366		$13,858,032		$13,803,091
Psych Services: Number of Users	2,919		3,132		3,192		3,213		3,209
Psych Services: Avg Medicaid Paid per User	$3,982		$4,349		$4,333		$4,313		$4,301
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$2,072,057		$2,292,852		$2,295,400		$2,295,400		$2,295,400
Adult Day Care: Number of Users	235		241		242		242		242
Adult Day Care: Avg Medicaid Paid per User	$8,817		$9,514		$9,485		$9,485		$9,485
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE									

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Inpatient Hospital (MAX TOS = 01)	$852	X	$1,047		$1,096		$1,105		$1,082
Aged	$379	X	$490		$533		$585		$506
Disabled	$1,555	X	$1,919		$2,006		$2,030		$1,963
Child	$350	X	$482		$513		$516		$501
Adult	$1,241		$1,431		$1,472		$1,433		$1,493
ILTC (MAX TOS = 02,04,05,07)	$6,502		$7,130		$7,170		$7,184		$7,298
Aged	$21,281		$23,490		$23,607		$23,619		$23,838
Disabled	$8,507		$9,317		$9,338		$9,349		$9,444
Child	$27	X	$36	X	$40	X	$58		$52
Adult	$68		$77		$79		$79		$81
Drugs (MAX TOS = 16)	$628		$635		$634		$635		$645
Aged	$73		$74		$74		$74		$75
Disabled	$1,569		$1,593		$1,588		$1,589		$1,607
Child	$193		$194		$195		$196		$200
Adult	$742		$751		$750		$750		$766
All Other Services	$5,751		$6,416		$6,491		$6,525		$6,628
Aged	$5,291		$5,974		$6,066		$6,125		$6,207
Disabled	$16,270		$18,084		$18,231		$18,284		$18,497
Child	$1,049		$1,234		$1,260		$1,270		$1,289
Adult	$1,519		$1,706		$1,739		$1,748		$1,781
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Enrollees with IP Claims (MAX TOS = 01)	12.37		14.59		14.99		15.04		14.86
Aged	18.29		20.50		21.19		21.10		21.31
Disabled	16.78		18.26		18.50		18.55		18.60
Child	6.18	X	9.59		10.03		10.13		9.42
Adult	11.06		12.46		12.71		12.75		12.67
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	12.07		12.72		12.88		12.93		12.99
Aged	45.27		47.88		48.42		48.51		48.39
Disabled	9.55		10.01		10.11		10.14		10.08
Child	0.09	X	0.09	X	0.09	X	0.14		0.13
Adult	1.55		1.77		1.82		1.84		1.90
% FFS Enrollees with Drug Claims (MAX TOS = 16)	51.26		51.70		52.01		52.20		52.90
Aged	39.42		40.19		40.12		40.09		40.52
Disabled	56.96		57.11		57.03		56.99		57.55
Child	49.56		50.18		51.22		51.84		52.81
Adult	58.36		58.59		58.61		58.63		59.42
% FFS Enrollees with All Other Claims	75.91		79.73		80.46		80.69		81.34
Aged	87.15		89.08		89.48		89.70		90.30
Disabled	89.33		90.55		90.69		90.72		91.41
Child	66.51		73.83		75.39		75.85		76.51
Adult	64.56		68.01		68.48		68.56		69.03
Avg # IP Days per FFS User	4		4		4		4		4
Aged	1	X	1		1		1	X	1
Disabled	5		6		6		6		6

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Child	4		4		4		4		4
Adult	6		6		6		5		6
Avg # ILTC Days per FFS User	232		242		239		239		242
Aged	237		247		245		244		248
Disabled	248		259		257		256		260
Child	142		156		182		191		166
Adult	9		9		9		9		9
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	1	X	4		4		4		4
Inpatient Hospital (MAX TOS = 01) > $500,000	0	X	1		1		1		1
ILTC (MAX TOS = 02,04,05,07) > $200,000	94		99		99		99		99
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	47	X	75		76		77		77
Maximum FFS Medicaid Paid	$512,092	X	$731,615		$783,140		$800,176		$800,176
Inpatient Hospital (MAX TOS = 01)	$473,006	X	$626,013		$626,013		$626,013		$626,013
ILTC (MAX TOS = 02,04,05,07)	$366,670		$400,418		$400,418		$400,418		$400,418
Drugs (MAX TOS = 16)	$71,168		$73,369		$73,369		$73,369		$73,369
All Other Services	$388,606		$479,284		$479,729		$479,729		$479,729
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$246,099		$260,139		$262,644		$264,298		$264,169
FP: Number of Users	1,064		1,086		1,089		1,089		1,087
FP: Avg Medicaid Paid per User	$231		$240		$241		$243		$243
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$271,423		$308,234		$315,243		$317,737		$313,222
FQHC: Number of Users	920		1,017		1,040		1,048		1,034
FQHC: Avg Medicaid Paid per User	$295		$303		$303		$303		$303
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$96,198,086		$106,486,205		$107,231,772		$107,429,070		$107,476,703
Section 1915(c) Waiver: Number of Users	2,656		2,694		2,699		2,701		2,704
Section 1915(c) Waiver: Avg Medicaid Paid per User	$36,219		$39,527		$39,730		$39,774		$39,747
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$104,143,382		$115,479,235		$116,323,332		$116,547,297		$116,590,013
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	3,038		3,133		3,149		3,151		3,151
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	$34,280		$36,859		$36,940		$36,987		$37,001
Aged	$18,028		$19,606		$19,709		$19,735		$19,735
Disabled	$43,957		$47,838		$48,031		$48,094		$48,143
Child	$1,261		$1,182		$1,144		$1,149		$1,164
Adult	$1,409		$1,500		$1,536		$1,565		$1,554
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	10.51		10.73		10.77		10.77		10.94

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Aged	15.64		15.98		15.98		15.98		16.13
Disabled	28.05		28.38		28.38		28.37		28.70
Child	0.45	X	0.67		0.72		0.72		0.73
Adult	1.21		1.42		1.44		1.45		1.48
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$96,198,086		$106,486,205		$107,231,772		$107,429,070		$107,476,703
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	2,656		2,694		2,699		2,701		2,704
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$36,219		$39,527		$39,730		$39,774		$39,747
Aged	$18,058		$19,655		$19,751		$19,773		$19,765
Disabled	$44,856		$49,086		$49,363		$49,423		$49,404
Child	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	9.19		9.23		9.23		9.23		9.38
Aged	14.32		14.56		14.57		14.57		14.71
Disabled	25.47		25.61		25.56		25.55		25.88
Child	0.00		0.00		0.00		0.00		0.00
Adult	0.00		0.00		0.00		0.00		0.00

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All IP Claims									
Total Number of Claims	25,468		29,147		29,783		30,020		30,020
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	25,468		29,147		29,783		30,020		30,020
% Crossover	19.68		20.02		19.99		20.10		20.10
% Adjusted Claims	0.34	X	0.46	X	0.75		0.88		0.88
% Standard Adjustments	87.36		83.70		85.59		85.93		85.93
Avg Medicaid Paid, Adjusted Claims (Include $0)	$12,097		$16,334		$14,711		$14,746		$14,746
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	33	X	67		66		66		66
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$7,454	X	$5,721		$5,844		$5,830		$5,830
# Claims with > $1 Million Paid	1		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	20,456		23,312		23,829		23,987		23,987
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$7,446		$7,441		$7,570		$7,607		$7,607
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	$1,895		$1,887		$1,895		$1,898		$1,898
% Claims with TPL	3.34	X	4.15		4.39		4.52		4.52
Avg TPL Paid for Claims with TPL	$3,109		$3,518		$3,752		$3,765		$3,765
% Claims with UB-92 Accommodation Codes	99.11		99.15		99.27		99.28		99.28
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.30		1.29		1.29		1.29		1.29
% Claims with UB-92 Ancillary Codes	99.85		99.83		99.83		99.83		99.83
Avg # of UB-92 Ancillary Codes (> 0 Codes)	8.38		8.39		8.41		8.41		8.41
Avg Length of Stay	3.21		3.23		3.27		3.28		3.28
Avg Covered Days (> 0 Days)	3.95		3.96		4.01		4.02		4.02
% Begin Date = Admission Date	99.35		99.28		99.24		99.23		99.23
% IP Claims (MAX TOS = 01)	100.00		100.00		100.00		100.00		100.00
% Family Planning Claims (PGM TYPE = 2)	0.00		0.00		0.00		0.00		0.00
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	4.35		4.35		4.36		4.36		4.36
% Primary Diagnosis Code Claims with Length = 3	5.55		5.40		5.37		5.35		5.35
% Primary Diagnosis Code Claims with Length = 4	14.54		14.31		14.39		14.38		14.38
% Primary Diagnosis Code Claims with Length = 5	79.91		80.29		80.24		80.27		80.27
% Claims with a Procedure Code	62.19		61.98		61.73		61.66		61.66
Avg # of Procedure Codes (> 0 Codes)	2.34		2.35		2.35		2.35		2.35
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	100.00		100.00		100.00		100.00		100.00
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

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% Claims Maternal Delivery Indicator	40.97		40.38		39.97		39.90		39.90
% Claims Newborn Delivery Indicator (Only for Separate Infant Delivery Claims Using Mother's ID)	20.09		21.30		21.63		21.68		21.68
PATIENT STATUS									
% Home	91.15		90.94		90.78		90.71		90.71
% Transferred	6.24		6.22		6.26		6.29		6.29
% Still a Patient	1.96		2.19		2.30		2.34		2.34
% Died	0.54		0.54		0.55		0.55		0.55
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	5,012		5,835		5,954		6,033		6,033
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,372		$1,350		$1,476		$1,487		$1,487
% Claims with TPL	0.22	X	0.31		0.34		0.33		0.33
Avg TPL Paid for Claims with TPL	$8,674	X	$5,707		$5,211		$5,211		$5,211
% Claims with UB-92 Accommodation Codes	85.55		85.16		84.28		83.54		83.54
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.18		1.18		1.18		1.18		1.18
% Claims with UB-92 Ancillary Codes	85.45		85.07		84.20		83.47		83.47
Avg # of UB-92 Ancillary Codes (> 0 Codes)	11.26		11.32		11.31		11.32		11.32
Avg Length of Stay	5.33		5.37		5.39		5.39		5.39
% Begin Date = Admission Date	98.56		98.59		98.52		98.51		98.51
% IP Claims (MAX TOS = 01)	100.00		100.00		100.00		100.00		100.00
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	7.44		7.49		7.48		7.49		7.49
% Primary Diagnosis Code Claims with Length = 3	7.42		7.35		7.34		7.31		7.31
% Primary Diagnosis Code Claims with Length = 4	34.02		33.86		33.76		33.68		33.68
% Primary Diagnosis Code Claims with Length = 5	58.56		58.78		58.90		59.01		59.01
% Claims with a Procedure Code	51.24		51.55		51.66		51.91		51.91
Avg # of Procedure Codes (> 0 Codes)	2.61		2.60		2.60		2.59		2.59
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	83.64		83.24		82.25		81.16		81.16
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

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All LT Claims									
Total Number of Claims	113,276		119,410		120,222		120,616		120,616
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	113,276		119,410		120,222		120,616		120,616
% Crossover	0.45		0.51		0.54		0.55		0.55
% Adjusted Claims	22.07	X	26.85	X	33.09		36.76		36.76
% Standard Adjustments	92.55		89.96		90.30		89.59		89.59
Avg Medicaid Paid, Adjusted Claims (Include $0)	$1,516		$1,513		$1,782		$1,846		$1,846
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	0		0		0		0		0
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$0		$0		$0		$0		$0
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)		#VALUE!		#VALUE!		#VALUE!		#VALUE!	
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)		#VALUE!		#VALUE!		#VALUE!		#VALUE!	
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	112,769		118,800		119,571		119,948		119,948
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
NF (MAX TOS = 07)	$158		$159		$159		$158		$158
ICF/MR (MAX TOS = 05)	$320		$322		$315		$315		$315
MH Aged (MAX TOS = 02)	$971		$984		$986		$991		$991
IP Psych, Age < 21 (MAX TOS = 04)	$757		$757		$755		$754		$754
TYPE OF SERVICE									
% NF (MAX TOS = 07)	82.53		82.30		82.32		82.32		82.32
% NF claims with NF Covered Days	99.99		99.99		99.99		99.99		99.99
Avg days for NF claims with Covered Days	10.29		10.49		10.53		10.53		10.53
% ICF/MR (MAX TOS = 05)	15.33		15.32		15.25		15.22		15.22
% ICF/MR claims with ICF/MR Covered Days	94.75		94.19		94.14		94.11		94.11
Avg days for ICF/MR claims with Covered Days	11.20		11.36		11.36		11.36		11.36
% MH Aged (MAX TOS = 02)	0.83		0.93		0.95		0.96		0.96
% MH Aged claims with MH Aged Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for MH Aged claims with Covered Days	6.52		6.38		6.33		6.36		6.36
% IP Psych, Age < 21 (MAX TOS = 04)	1.31		1.45		1.47		1.50		1.50
% IP Psych, Age < 21 Claims with IP Psych Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for IP Psych, Age < 21 Claims with Covered Days	8.28		8.21		8.22		8.11		8.11
LEAVE DAYS									
% Claims with Leave Days	0.81		0.90		0.90		0.90		0.90
ADMISSION DATE									
% Claims with Admission Date	99.93		99.92		99.92		99.90		99.90
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Primary Diagnosis Code Claims with Length = 3	19.85		19.80		19.78		19.81		19.81

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% Primary Diagnosis Code Claims with Length = 4	45.81		45.76		45.72		45.72		45.72
% Primary Diagnosis Code Claims with Length = 5	34.33		34.44		34.49		34.47		34.47
PATIENT STATUS									
% Claims with Patient Status	99.94		99.94		99.94		99.94		99.94
% Home	3.23		3.35		3.37		3.40		3.40
% Still a Patient	95.09		94.86		94.78		94.74		94.74
% Died	0.31		0.34		0.37		0.37		0.37
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	507	X	610		651		668		668
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,051		$1,071		$1,049		$1,060		$1,060
TYPE OF SERVICE									
% NF (MAX TOS = 07)	100.00		100.00		100.00		100.00		100.00
% ICF/MR (MAX TOS = 05)	0.00		0.00		0.00		0.00		0.00
% MH Aged (MAX TOS = 02)	0.00		0.00		0.00		0.00		0.00
% IP Psych, Age < 21 (MAX TOS = 04)	0.00		0.00		0.00		0.00		0.00
ADMISSION DATE									
% Claims with Admission Date	100.00		100.00		100.00		100.00		100.00
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	99.80		99.84		99.85		99.85		99.85
% Primary Diagnosis Code Claims with Length = 3	9.09		9.36		9.38		9.15		9.15
% Primary Diagnosis Code Claims with Length = 4	36.96		37.60		38.31		38.53		38.53
% Primary Diagnosis Code Claims with Length = 5	53.95		53.04		52.31		52.32		52.32
PATIENT STATUS									
% Claims with Patient Status	70.22		70.16		69.89		69.91		69.91
% Home	7.30		8.20		7.83		7.63		7.63
% Still a Patient	43.98		43.28		43.01		42.96		42.96
% Died	1.97		1.97		2.30		2.40		2.40

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All OT Claims									
Total Number of Claims	11,070,261		11,830,143		11,964,209		12,017,868		12,017,868
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.04		0.03		0.03		0.03		0.03
% Capitation Claims **	28.39		26.78		26.51		26.40		26.40
Total FFS Claims Excluding Capitation Payments	7,923,547		8,657,770		8,788,459		8,841,503		8,841,503
% Crossover	6.73		7.24		7.30		7.36		7.36
% Adjusted Claims	0.23	X	0.28	X	0.35		0.38		0.38
% Standard Adjustments	79.18		78.62		74.35		74.18		74.18
Avg Medicaid Paid, Adjusted Claims (Include $0)	$102	X	$107	X	$102	X	$141		$141
% Claims with HMO Capitation Payment	0.00		0.00		0.00		0.00		0.00
% Claims with PHP Capitation Payment	13.32		12.68		12.57		12.51		12.51
% Claims with PCCM Capitation Payment	15.08		14.11		13.95		13.89		13.89
Avg Medicaid Paid per HMO Capitation Claim	$50		$50		$50		$50		$50
Avg Medicaid Paid per PHP Capitation Claim	$18		$18		$18		$18		$18
Avg Medicaid Paid per PCCM Capitation Claim	$4		$4		$4		$4		$4
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	11,519	X	14,953		15,939		15,923		15,923
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$47		$46		$45		$45		$45
# Claims with > $200,000 Paid	3		3		3		3		3
# Encounter Claims	0		0		0		0		0
% Encounter Claims for HMO or PACE	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Encounter Claims for PHP	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	7,390,289		8,031,142		8,146,622		8,191,112		8,191,112
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
% Claims with Span Bill	12.41		12.11		11.99		11.96		11.96
% Outpatient Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Home Health Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Other Claims with Span Bill	13.00		12.70		12.58		12.54		12.54
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	48.90		49.16		49.18		49.18		49.18
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	44.67		44.63		44.54		44.51		44.51
% Claims with Servicing Provider ID = Billing Provider ID	65.58		65.40		65.27		65.26		65.26
PLACE OF SERVICE									
% Claims with Place of Service	80.05		80.65		80.75		80.76		80.76
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	30.59		29.95		29.83		29.78		29.78
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	20.82		20.40		20.23		20.17		20.17
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	1.73		1.87		1.92		1.94		1.94
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	0.01		0.01		0.02		0.02		0.02
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	0.13		0.13		0.14		0.14		0.14
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	0.01		0.01		0.01		0.01		0.01
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	1.75		1.77		1.78		1.78		1.78

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% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	11.80		12.04		12.07		12.09		12.09
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	19.95		19.35		19.25		19.24		19.24
THIRD-PARTY LIABILITY									
% Claims with TPL	0.32		0.36		0.38		0.39		0.39
Avg TPL Paid for Claims with TPL	$76		$76		$77		$78		$78
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE									
Physician Services (MAX TOS = 08)	9.57		9.75		9.83		9.85		9.85
Dental Services (MAX TOS = 09)	2.41		2.33		2.31		2.30		2.30
Other Practitioner Services (MAX TOS = 10)	1.40		1.39		1.38		1.38		1.38
Outpatient Services (MAX TOS = 11)	4.10		4.18		4.19		4.20		4.20
Clinic Services (MAX TOS = 12)	2.42		2.39		2.42		2.41		2.41
Home Health Services (MAX TOS = 13)	0.42		0.46		0.47		0.48		0.48
Lab/Xray Services (MAX TOS = 15)	11.10		11.22		11.26		11.26		11.26
Drugs (MAX TOS = 16)	0.18		0.19		0.19		0.19		0.19
Other Services (MAX TOS = 19)	16.33		16.92		16.99		17.05		17.04
Durable Medical Equipment (MAX TOS = 51)	2.88		2.98		3.01		3.03		3.03
Transportation Services (MAX TOS = 26)	5.66		5.65		5.71		5.74		5.74
Sterilizations (MAX TOS = 24)	0.03		0.03		0.03		0.03		0.03
Abortions (MAX TOS = 25)	0.00		0.00		0.00		0.00		0.00
Personal Care Services (MAX TOS = 30)	7.76		7.60		7.54		7.51		7.51
Targeted Case Management (MAX TOS = 31)	2.84		2.76		2.74		2.73		2.73
Rehabilitation Services (MAX TOS = 33)	0.38		0.41		0.45		0.45		0.45
PT/OT/Hearing/Speech Services (MAX TOS = 34)	1.99		2.10		2.12		2.13		2.13
Hospice Services (MAX TOS = 35)	0.05	X	0.05		0.06		0.06		0.06
Nurse Midwife Services (MAX TOS = 36)	0.00		0.00		0.00		0.00		0.00
Nurse Practitioner Services (MAX TOS = 37)	0.86		0.87		0.87		0.87		0.87
Private Nursing Services (MAX TOS = 38)	0.07		0.06		0.06		0.06		0.06
Religious Non-Medical Services (MAX TOS = 39)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	7.25		7.00		6.91		6.87		6.87
Psychiatric Services (MAX TOS = 53)	21.59		20.93		20.75		20.69		20.70
Adult Day Care (MAX TOS = 54)	0.70		0.67		0.67		0.66		0.66
Unknown Services (MAX TOS = 99)	0.05		0.05		0.05		0.05		0.05
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
Total	$81		$81		$81		$81		$81
Physician Services (MAX TOS = 08)	$84		$85		$86		$86		$86
Dental Services (MAX TOS = 09)	$47		$47		$47		$47		$47
Other Practitioner Services (MAX TOS = 10)	$69		$70		$70		$71		$71
Outpatient Services (MAX TOS = 11)	$138		$141		$142		$143		$143
Clinic Services (MAX TOS = 12)	$213		$216		$215		$216		$216
Home Health Services (MAX TOS = 13)	$107		$107		$107		$107		$107
Lab/Xray Services (MAX TOS = 15)	$29		$29		$29		$29		$29
Drugs (MAX TOS = 16)	$44		$44		$44		$44		$44
Other Services (MAX TOS = 19)	$51		$50		$49		$49		$49
Durable Medical Equipment (MAX TOS = 51)	$69		$70		$71		$72		$72

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Transportation Services (MAX TOS = 26)	$44		$44		$44		$44		$44
Personal Care Services (MAX TOS = 30)	$118		$117		$117		$117		$117
Targeted Case Management (MAX TOS = 31)	$60		$61		$61		$61		$61
Rehabilitation Services (MAX TOS = 33)	$115		$116		$113		$113		$113
PT/OT/Hearing/Speech Services (MAX TOS = 34)	$83		$84		$84		$83		$83
Hospice Services (MAX TOS = 35)	$1,395		$1,389		$1,358		$1,315		$1,315
Residential Care Services (MAX TOS = 52)	$134		$134		$134		$134		$134
Psychiatric Services (MAX TOS = 53)	$88		$89		$89		$89		$89
Adult Day Care (MAX TOS = 54)	$34		$34		$34		$34		$34
PERCENT OF CLAIMS BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	0.24	X	0.28		0.30		0.30		0.30
Rural Health Clinic (PGM TYPE = 3)	0.94		0.92		0.91		0.91		0.91
Federally Qualified Health Center (PGM TYPE = 4)	0.72		0.71		0.73		0.73		0.73
Indian Health Services (PGM TYPE = 5)	0.08		0.08		0.08		0.08		0.08
Home and Community Based Waiver (PGM TYPE = 6,7)	12.90		12.54		12.40		12.34		12.34
AVERAGE EXPENDITURES BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	$80		$72		$71		$71		$71
Rural Health Clinic (PGM TYPE = 3)	$94		$94		$94		$94		$94
Federally Qualified Health Center (PGM TYPE = 4)	$130		$130		$129		$129		$129
Indian Health Services (PGM TYPE = 5)	$248		$249		$249		$249		$249
Home and Community Based Waiver (PGM TYPE = 6,7)	$148		$148		$148		$148		$148
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	100.00		100.00		99.97		99.97		99.97
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Primary Diagnosis Claims with Secondary Diagnosis Code	20.75		21.06		21.18		21.21		21.21
% Primary Diagnosis Code Claims with Length = 3	11.19		10.84		10.76		10.73		10.73
% Primary Diagnosis Code Claims with Length = 4	54.11		54.02		54.04		54.02		54.02
% Primary Diagnosis Code Claims with Length = 5	34.70		35.14		35.20		35.25		35.25
% Claims with Procedure Code	95.34		95.18		95.13		95.12		95.12
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	100.00		100.00		100.00		100.00		100.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	98.36		98.07		98.00		97.98		97.98
% Other Claims with Procedure Code	98.84		98.75		98.70		98.69		98.69
% Claims with Procedure Code with CPT-4 Indicator	29.42		29.81		29.97		30.00		30.00
% Claims with Procedure Code with HCPCS (II & III) Indicator	14.10		14.02		14.06		14.10		14.10
% with Procedure Code with Other National Indicator	0.00		0.00		0.00		0.00		0.00
% with Procedure Code with State-Specific Indicator	56.48		56.17		55.97		55.90		55.90
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	100.00		100.00		100.00		100.00		100.00
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	100.00		100.00		100.00		100.00		100.00
PHYSICIAN SPECIALTY									
% Physician Claims with Physician Specialty	100.00		100.00		100.00		100.00		100.00
PERCENT OF CLAIMS BY CLTC CODE									

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Not a CLTC Claim (CLTC FLAG = 00)	73.40		73.81		73.95		73.99		73.99
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	13.70		13.64		13.66		13.68		13.68
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	3.50		3.43		3.42		3.41		3.41
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	0.07		0.06		0.06		0.06		0.06
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	0.56		0.54		0.53		0.53		0.53
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	0.42		0.46		0.47		0.48		0.48
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	0.07		0.07		0.07		0.07		0.07
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	0.23		0.26		0.27		0.27		0.27
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	2.56		2.48		2.46		2.45		2.45
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	4.64		4.61		4.61		4.63		4.63
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	0.05	X	0.05		0.06		0.06		0.06
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	1.60		1.68		1.71		1.72		1.72
CLTC Waiver Claims (CLTC FLAG = 30-40)	12.90		12.54		12.40		12.34		12.34
CLTC Other Waiver (CLTC FLAG = 30)	1.13		1.10		1.10		1.09		1.09
CLTC Waiver Personal Care (CLTC FLAG = 31)	4.26		4.17		4.12		4.10		4.10
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	0.14		0.14		0.14		0.14		0.14
CLTC Waiver Home Health (CLTC FLAG = 34)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Residential Care (CLTC FLAG = 35)	7.18		6.93		6.84		6.80		6.80
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Transportation (CLTC FLAG = 38)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Hospice (CLTC FLAG = 39)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	0.19		0.20		0.21		0.21		0.21
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	533,258		626,628		641,837		650,391		650,391
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$26		$26		$26		$27		$27
% Claims with Span Bill	1.73		1.65		1.67		1.67		1.67
% Outpatient Claims with Span Bill	0.01	X	0.03		0.03		0.03		0.03
% Home Health Claims with Span Bill	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Span Bill	2.22		2.12		2.11		2.12		2.12
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)									
Physician Services (MAX TOS = 08)	35.71		35.56		36.30		36.44		36.44
Other Practitioner Services (MAX TOS = 10)	4.30		4.34		4.35		4.32		4.32
Outpatient Services (MAX TOS = 11)	22.36		22.39		21.45		21.33		21.33
Clinic Services (MAX TOS = 12)	6.41		6.65		6.73		6.70		6.70
Home Health Services (MAX TOS = 13)	0.00		0.00		0.00		0.00		0.00
Lab/Xray Services (MAX TOS = 15)	9.42		9.33		9.30		9.24		9.24
Other Services (MAX TOS = 19)	12.89		12.69		12.68		12.73		12.73
Durable Medical Equipment (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
Transportation Services (MAX TOS = 26)	0.19		0.20		0.20		0.20		0.20
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00

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Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	0.43		0.45		0.46		0.48		0.48
PT/OT/Hearing/Speech Services (MAX TOS = 34)	6.82		6.71		6.77		6.82		6.82
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.00		0.00		0.00		0.00		0.00
Psychiatric Services (MAX TOS = 53)	0.00		0.00		0.00		0.00		0.00
Adult Day Care (MAX TOS = 54)	0.00		0.00		0.00		0.00		0.00
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Primary Diagnosis Claims with Secondary Diagnosis Code	60.35		60.72		60.73		60.74		60.74
% Primary Diagnosis Code Claims with Length = 3	6.59		6.55		6.56		6.55		6.55
% Primary Diagnosis Code Claims with Length = 4	44.94		44.98		44.97		44.96		44.96
% Primary Diagnosis Code Claims with Length = 5	48.47		48.47		48.47		48.49		48.49
% Claims with Procedure Code	0.00		0.00		0.00		0.00		0.00
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	0.00		0.00		0.00		0.00		0.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Procedure Code	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with CPT-4 Indicator	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Claims with Procedure Code with HCPCS (II & III) Indicator	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% with Procedure Code with Other Code Indicator	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PERCENT OF CLAIMS BY CLTC CODE									
Not a CLTC Claim (CLTC FLAG = 00)	97.91		97.66		97.59		97.57		97.57
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	2.09		2.34		2.41		2.43		2.43
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	1.47		1.69		1.75		1.75		1.75
CLTC Waiver Claims (CLTC FLAG = 30-40)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison RX Validation Table
State: ID

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All RX Claims									
Total Number of Claims	1,535,887		1,561,036		1,561,849		1,562,231		1,562,231
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	1,535,887		1,561,036		1,561,849		1,562,231		1,562,231
% Adjusted Claims	0.00	X	0.00		0.00		0.00		0.00
% Standard Adjustments	100.00		100.00		92.31		92.50		92.50
Avg Medicaid Paid, Adjusted Claims (Include $0)	$508	X	$254	X	$769		$799		$799
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	1,806		1,888		1,887		1,886		1,886
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	43.75		47.85		47.88		47.90		47.90
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Claims (Type of Claim = 1)									
Total Number of Claims	1,535,887		1,561,036		1,561,849		1,562,231		1,562,231
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$71		$72		$72		$72		$72
% Claims with TPL	4.70		4.71		4.71		4.71		4.71
Avg TPL Paid for Claims with TPL	$95		$95		$96		$96		$96
% Family Planning Claims (PGM TYPE = 2)	1.32		1.32		1.32		1.32		1.32
% Drug Claims (MAX TOS = 16)	100.00		100.00		100.00		100.00		100.00
% Durable Medical Equipment Claims (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Prescribing Physician	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Date Prescribed	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Quantity	99.85		99.85		99.85		99.85		99.85
% Drug Claims with Days Supply	100.00		100.00		100.00		100.00		100.00
DRUG CLASSIFICATION									
% Claims with Medispan	99.54		99.54		99.54		99.54		99.54
% Claims with Generic Therapeutic Class	99.68		99.67		99.67		99.67		99.67
% Claims with Specific Therapeutic Class	99.68		99.67		99.67		99.67		99.67
NDC CONFIGURATION INDICATOR									
% Prescription (NDC FMT IND = 0-3)	68.44		68.42		68.42		68.42		68.42
% Products (NDC FMT IND = 4-6)	31.21		31.23		31.23		31.23		31.23
% Health Related Item (NDC FMT IND = 7)	0.00		0.00		0.00		0.00		0.00
% Claims with Clinical Formulation Identifier	99.68		99.67		99.67		99.67		99.67
% Claims with Ingredient List Identifier	99.68		99.67		99.67		99.67		99.67
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	99.68		99.67		99.67		99.67		99.67
% Claims with Over-the-Counter Drug Class	2.39		2.39		2.39		2.39		2.39
% Claims with Prescription Drug Class	97.29		97.28		97.28		97.28		97.28
% Claims with Multiple Sources	66.66		66.71		66.71		66.71		66.71
% Claims with Single Source (No Generic)	28.95		28.93		28.93		28.93		28.93

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All Records									
Total Number of Records	236,870		242,177		242,863		243,016		243,016
Total Medicaid Paid	$1,140,842,920		$1,238,927,107		$1,257,613,469		$1,264,800,193		$1,264,800,193
% with No Services (RCPNT IND = 0)	9.04		7.96		7.79		7.78		7.78
% with FFS Only Claims (RCPNT IND = 1)	4.98		5.02		5.10		5.13		5.13
% with Only Capitation Claims (RCPNT IND = 2)	14.11		14.56		14.50		14.43		14.43
% with Only Encounter Claims (RCPNT IND = 3)	0.00		0.00		0.00		0.00		0.00
% with FFS and Capitation Claims (RCPNT IND = 4)	71.87		72.46		72.62		72.66		72.66
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	0.00		0.00		0.00		0.00		0.00
% with FFS and Encounter Claims Only (RCPNT IND = 6)	0.00		0.00		0.00		0.00		0.00
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	0.00		0.00		0.00		0.00		0.00
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	922		1,165		1,148		1,123		1,123
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.39		0.48		0.47		0.46		0.46
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$869,879	X	$1,178,933		$1,202,030		$1,203,255		$1,203,255
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$943		$1,012		$1,047		$1,071		$1,071
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	687		803		792		781		781
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.29		0.33		0.33		0.32		0.32
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$860,102	X	$1,165,856		$1,187,728		$1,188,974		$1,188,974
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$1,252		$1,452		$1,500		$1,522		$1,522
S-CHIP ENROLLMENT									
# with ONLY S-CHIP Enrollment	12,489		12,518		12,488		12,485		12,485
% with ONLY S-CHIP Enrollment	5.27		5.17		5.14		5.14		5.14
# with ANY S-CHIP Enrollment	25,399		25,797		25,800		25,800		25,800
% with ANY S-CHIP Enrollment	10.72		10.65		10.62		10.62		10.62
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	14,642		14,693		14,690		14,690		14,690
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)									
Total Medicaid Enrollees	223,459		228,494		229,227		229,408		229,408
Total Medicaid Person-Years of Enrollment	175,354		176,500		176,696		176,744		176,744
# with Any M-CHIP Enrollment	20,105		20,356		20,374		20,375		20,375
Total Person-Years of Enrollment Any M-CHIP	12,011		12,043		12,046		12,046		12,046
Demographic Characteristics									
% Records with Valid SSN Format	95.18		95.30		95.59		95.88		95.88
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	95.17		95.29		95.58		95.87		95.87
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	0.00	X	0.00	X	0.01	X	0.01		0.01

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% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	0.00		0.00		0.00		0.00		0.00
# Records Without Valid SSN	10,792		10,759		10,123		9,478		9,478
% Records Without Valid SSN	4.83		4.71		4.42		4.13		4.13
% for Children Under Age 21	88.53		87.56		87.19		86.60		86.60
% for Infants Under Age 1	45.54		46.52		45.69		44.20		44.20
% Ever Aliens Eligible for Only Emergency Services	0.00		0.00		0.00		0.00		0.00
# SSNs with More Than One MSIS ID	7	X	8	X	8	X	20		20
% Records with Duplicated SSNs	0.01	X	0.01	X	0.01	X	0.02		0.02
% for Children Under Age 21	100.00		100.00		100.00		100.00		100.00
% for Infants Under Age 1	14.29	X	12.50	X	12.50	X	5.00		5.00
% Ever Aliens Eligible for Only Emergency Services	0.00		0.00		0.00		0.00		0.00
% with External SSN from EDB (EXT SSN SRCE = 1)	15.39		15.28		15.28		15.30		15.30
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	0.00		0.00		0.00		0.00		0.00
% with County Code	98.44		98.15		97.78		97.45		97.45
% with Valid 5 Digit Zip Code Format	100.00		100.00		100.00		100.00		100.00
% White	95.04		95.02		95.02		95.01		95.01
% Black	1.32		1.32		1.32		1.32		1.32
% Native American/Alaskan Native	2.17		2.16		2.16		2.17		2.17
% Asian	0.71		0.71		0.71		0.71		0.71
% Native Hawaiian or Other Pacific Islander	0.15		0.14		0.14		0.14		0.14
% More Than One Race	0.00		0.00		0.00		0.00		0.00
% Unknown Race	0.60		0.65		0.65		0.65		0.65
% Hispanic/Latino (Included with Race Categories Prior to 2005)	0.60		0.65		0.65		0.65		0.65
% of Hispanic/Latino with Unknown Race	100.00		100.00		100.00		100.00		100.00
% Age 0	4.75		5.11		5.15		5.15		5.15
% Age 0-20 Years	69.01		68.85		68.79		68.76		N/A
% Age > 64 Years	7.37		7.33		7.32		7.32		N/A
% with Century of Birth '18' , '19', '20'	100.00		100.00		100.00		100.00		100.00
% with Gender Code 'M' or 'F'	100.00		100.00		100.00		100.00		100.00
% Enrollees with 12 Months Enrollment	52.54		51.89		51.80		51.77		51.77
% Aged Enrollees with 12 Months Enrollment	73.40		72.20		72.06		71.98		71.98
% Disabled Enrollees with 12 Months Enrollment	81.32		80.23		79.84		79.67		79.67
% Child Enrollees with 12 Months Enrollment	49.39		49.14		49.14		49.14		49.14
% Adult Enrollees with 12 Months Enrollment	16.81		16.35		16.27		16.26		16.26
% Enrollees with MSIS Date of Death During Year	0.95		1.02		1.02		1.02		1.02
% Enrollees with SSA Date of Death During Year	0.76		0.75		0.74		0.74		0.00
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	1.19		1.18		1.18		1.18		1.16
# with MSIS Date of Death ≠ SSA Date of Death	1,013	X	1,216	X	1,226	X	1,228	X	2,345
# with MSIS Date of Death Prior to 2007	0		0		0		0		0
# with SSA Date of Death Prior to 2007	55		55		55		55		0
EDB Dual Eligibles									
Total EDB Duals (Duals Confirmed by EDB)	32,231		32,672		32,741		32,786		32,786

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Total EDB Dual Person-Years of Enrollment	28,787		28,898		28,926		28,939		28,939
% Age > 64 Years Who Are EDB Duals	97.71		97.69		97.71		97.71		97.71
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	97.73		97.72		97.73		97.73		97.73
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	42.75		42.55		42.40		42.37		42.37
% EDB Only (EDB DUAL = 50)	3.85	X	2.94		2.79		2.65		2.65
% EDB QMB Only (EDB DUAL = 51)	14.59		14.53		14.48		14.46		14.46
% EDB QMB Plus (EDB DUAL = 52)	42.74		42.82		42.78		42.72		42.72
% EDB SLMB Only (EDB DUAL = 53)	9.71		9.73		9.76		9.81		9.81
% EDB SLMB Plus (EDB DUAL = 54)	4.75		4.80		4.79		4.78		4.78
% EDB QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% EDB QI-1 (EDB DUAL = 56)	4.39		4.44		4.48		4.50		4.50
% EDB QI-2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% EDB Other (EDB DUAL = 58)	19.98		20.73		20.92		21.09		21.09
% EDB Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Dual Status Unknown (EDB DUAL = 98)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	71.31		71.29		71.28		71.23		71.23
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	28.69		28.71		28.72		28.77		28.77
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	57	X	201	X	340	X	443		443
% Non-EDB Duals Without Valid SSN	0.00		0.00		0.00		0.00		0.00
% Non-EDB Duals Who Are Children/Adults	0.00	X	1.00		0.88		0.90		0.90
% EDB Duals with Spanish Language	1.57		1.57		1.57		1.57		1.57
% EDB Duals with EDB Date of Death During Year	7.10		7.02		7.01		7.00		7.00
% EDB Duals with MSIS Date of Death During Year	5.67		6.10		6.09		6.09		6.09
% EDB Duals with SSA Date of Death During Year	4.44		4.38		4.37		4.36		0.00
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	7.12		7.03		7.02		7.01		7.01
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	539	X	383		380		381		381
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	899	X	904	X	904	X	905	X	2,296
% EDB Duals with Medicaid Reported HIC	94.84		95.85		96.10		96.35		96.35
% EDB Duals with Medicaid Reported HIC = Medicare HIC	99.33		99.36		99.42		99.47		99.47
Total EDB Dual Enrollees in June	30,528		30,929		30,990		31,028		31,028
JUNE MEDICARE ELIGIBILITY GROUP									
June % with Part A Medicare only	1.00		1.11		1.14		1.17		1.17
June % with Part B Medicare only	0.18		0.18		0.18		0.18		0.18
June % Part A/B Medicare	98.81		98.71		98.67		98.65		98.65
ORIGINAL REASON FOR MEDICARE ENTITLEMENT									
% Aged (MDCR ORIG REAS CD = 0)	38.26		38.46		38.47		38.46		38.46
% Disabled (MDCR ORIG REAS CD = 1)	60.49		60.29		60.28		60.29		60.29
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	0.45		0.45		0.46		0.45		0.45
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	0.80		0.79		0.79		0.79		0.79
Other Eligibility Characteristics (All Enrollees)									
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	99.76		99.75		99.75		99.75		99.75
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	0.23		0.21		0.20		0.20		0.20
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	99.98		99.97		99.97		99.97		99.97
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	90.58		90.19		90.11		90.11		90.11

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% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged Total	16,409		16,692		16,731		16,751		16,751
Aged, Cash (MAX ELIG CD = 11)	2,473		2,468		2,459		2,462		2,462
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	4,690		4,760		4,776		4,791		4,791
Other Aged (MAX ELIG CD = 41)	9,246		9,464		9,496		9,498		9,498
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	37,540		38,120		38,317		38,407		38,407
Disabled, Cash (MAX ELIG CD = 12)	30,725		31,176		31,350		31,421		31,421
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	4,547		4,622		4,630		4,642		4,642
Other Disabled (MAX ELIG CD = 42)	2,268		2,322		2,337		2,344		2,344
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	142,232		144,997		145,293		145,335		145,335
AFDC Child, Cash (MAX ELIG CD = 14)	2		2		2		2		2
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	138,874		141,619		141,915		141,954		141,954
Other Child (MAX ELIG CD = 44)	11	X	8		9		9		9
Foster Care Child (MAX ELIG CD = 48)	3,345		3,368		3,367		3,370		3,370
1115 Child (MAX ELIG CD = 54)	0		0		0		0		0
Adult Total	27,278		28,685		28,886		28,915		28,915
AFDC Adult, Cash (MAX ELIG CD = 15)	12,055		12,665		12,727		12,739		12,739
AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	11,699		12,498		12,613		12,638		12,638
Other Adult (MAX ELIG CD = 45)	3,524		3,522		3,546		3,538		3,538
1115 Adult (MAX ELIG CD = 55)	0		0		0		0		0
Long-Term Care Enrollees									
INSTITUTIONAL STATUS									
# Enrollees with Any ILTC Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	6,177		6,585		6,689		6,718		6,718
% Enrollees with Any ILTC Claims	2.76		2.88		2.92		2.93		2.93
% Aged Enrollees with Any ILTC Claims	21.15		21.89		22.15		22.18		22.18
% Disabled Enrollees with Any ILTC Claims	5.32		5.57		5.65		5.68		5.68
% Child Enrollees with Any ILTC Claims	0.38		0.42		0.43		0.43		0.43
% Adult Enrollees with Any ILTC Claims	0.62		0.67		0.68		0.68		0.68
COMMUNITY LONG-TERM CARE STATUS									
# Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	14,719		15,471		15,672		15,747		15,747

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% Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	6.59		6.77		6.84		6.86		6.86
% Aged Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	32.71		33.61		33.87		33.90		33.90
% Disabled Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	23.47		24.21		24.41		24.47		24.47
% Child Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.32		0.36		0.37		0.38		0.38
% Adult Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.33		0.40		0.40		0.42		0.42
# Enrollees with ILTC Claims and CLTC Claims (Excludes CLTC FLAG = 16-20)	1,290		1,507		1,572		1,585		1,585
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	15,482		16,119		16,304		16,381		16,381
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT									
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	11,362		11,432		11,443		11,450		11,450
% Enrolled in Any Section 1915(c) Waiver	5.08		5.00		4.99		4.99		4.99
% Aged Enrollees in Section 1915(c) Waiver	30.64		30.40		30.36		30.34		30.34
% Disabled Enrollees in Section 1915(c) Waiver	16.84		16.64		16.57		16.55		16.55
% Child Enrollees in Section 1915(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees in Section 1915(c) Waiver	0.04		0.04		0.04		0.04		0.04
# Aged, EDB Dual	4,929		4,977		4,982		4,984		4,984
# Aged, Non-Dual	98		98		98		99		99
# Disabled, EDB Dual	3,628		3,639		3,644		3,647		3,647
# Disabled, Non-Dual	2,695		2,706		2,707		2,708		2,708
# Other (Child or Adult)	12		12		12		12		12
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	8,893		8,962		8,972		8,979		8,979
# Aged, EDB Dual	4,840		4,888		4,893		4,895		4,895
# Aged, Non-Dual	95		95		95		96		96
# Disabled, EDB Dual	2,488		2,498		2,502		2,505		2,505
# Disabled, Non-Dual	1,459		1,470		1,471		1,472		1,472
# Other (Child or Adult)	11		11		11		11		11
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0

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# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	2,469		2,470		2,471		2,471		2,471
# Aged, EDB Dual	89		89		89		89		89
# Aged, Non-Dual	3		3		3		3		3
# Disabled, EDB Dual	1,140		1,141		1,142		1,142		1,142
# Disabled, Non-Dual	1,236		1,236		1,236		1,236		1,236
# Other (Child or Adult)	1		1		1		1		1
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	10.24		9.01		8.88		8.92		8.92
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	0.19	X	0.28		0.27		0.27		0.27
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	0.79		0.68		0.68		0.68		0.00
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/HIOs with No Waiver claim (PGM TYPE = 6 or 7)	10.21		8.99		8.86		8.90		8.92

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# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	285		285		292		299		299
Other Waiver Enrollment (Enrolled Any Time During the Year)									
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	0		0		0		0		0
% Aged Enrollees with Any 1115 Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1115 Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any 1115 Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any 1115 Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Any 1915(b) Waiver (WVR TYPE = 2)	0		0		0		0		0
% Aged Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	0		0		0		0		0
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with 1115 HIFA Waiver (WVR TYPE = 5)	0		0		0		0		0
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	0		0		0		0		0
% Aged Enrollees with Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Other Type of Waiver (WVR TYPE = 7)	0		0		0		0		0
# with Unknown Type of Waiver (WVR TYPE = 9)	0		0		0		0		0
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	0		0		0		0		0
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	0		0		0		0		0
# of Waiver IDs with More than One Waiver Type	0		0		0		0		0
# of Waiver IDs with Reporting in January but Not December	1		1		1		1		1
# of Waiver IDs with Reporting in December but Not January	0		0		0		0		0
Enrollees with Restricted Benefits									
Family Planning enrollees with Restricted Benefits (RBF = 6)									
# with ONLY Family Planning Only Enrollment	0		0		0		0		0
# with ANY Family Planning Only Enrollment	0		0		0		0		0
# Person-Years of Enrollment ANY Family Planning Only Enrollment	0		0		0		0		0
Aliens with Restricted Benefits (RBF = 2)									
# Aliens with ONLY Restricted Benefits	0.00		0.00		0.00		0.00		0.00
# Aliens with ANY Restricted Benefits	0.00		0.00		0.00		0.00		0.00
# Person-Years of Enrollment Aliens with ANY Restricted Benefits	0.00		0.00		0.00		0.00		0.00

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EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
# EDB Duals with ONLY Restricted Benefits Enrollment	8,664		8,813		8,839		8,864		8,864
# EDB Duals with ANY Restricted Benefits Enrollment	9,838		10,027		10,055		10,084		10,084
# Person-Years of Enrollment EDB Duals with ANY Restricted Benefits	8,212		8,253		8,267		8,275		8,275
% EDB Duals with ONLY Restricted Benefits Enrollment	26.88		26.97		27.00		27.04		27.04
Prescription Drug Enrollees (RBF = X, Y, or Z)									
# with ONLY Prescription Drug Enrollment (May Have a Month or More of RBF = 3)	0		0		0		0		0
# with ANY Prescription Drug Enrollment	0		0		0		0		0
# Person-Years of ANY Prescription Drug Enrollment	0		0		0		0		0
Dual Prescription Drug Enrollees									
# with ONLY Prescription Drugs Who Are EDB Duals	0		0		0		0		0
June Eligibility Profile									
Total Enrollees in June	178,147		178,303		178,303		178,303		178,303
June % Full Scope Benefits (RBF = 1)	28.12		28.15		28.15		28.15		28.15
June % Restricted Benefits Alien (RBF = 2)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Dual (RBF = 3)	4.62		4.62		4.62		4.62		4.62
June % Restricted Benefits Pregnant (RBF = 4)	3.03		3.04		3.04		3.04		3.04
June % Restricted Benefits Other (RBF = 5)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Family Planning (RBF = 6)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Benchmark-Equivalent (RBF = 7)	64.23		64.19		64.19		64.19		64.19
June % Money Follows the Person Enrollee (RBF = 8)	0.00		0.00		0.00		0.00		0.00
June % Unknown Benefits (RBF = 9)	0.00		0.00		0.00		0.00		0.00
June % PRTF Enrollee (RBF = A)	0.00		0.00		0.00		0.00		0.00
June % Health Opportunity Account (RBF = B)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Non-Dual Enrollee (RBF = X)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Receiving Medicare Cost Sharing (RBF = Y)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Not Receiving Medicare Cost Sharing (RBF = Z)	0.00		0.00		0.00		0.00		0.00
June % Private Health Insurance (PVT INS CD = 2-4)	9.71		9.98		9.98		9.98		9.98
June Total Enrollees with TANF Flag (TANF FLAG = 2)	0.00		0.00		0.00		0.00		0.00
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	12,113		12,111		12,111		12,111		12,111
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	304		303		303		303		303
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	5,230		5,399		5,431		5,432		5,432
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	61		62		63		63		63
Medicaid Expenditures									
Total Medicaid Paid	$1,139,973,041		$1,237,748,174		$1,256,411,439		$1,263,596,938		$1,263,596,938
Avg Medicaid Paid per Enrollee	$5,101		$5,417		$5,481		$5,508		$5,508
25th Percentile	$257		$266		$270		$271		$271
50th Percentile (Median)	$674		$717		$727		$731		$731
75th Percentile	$2,764		$2,996		$3,040		$3,064		$3,064
95th Percentile	$26,605		$28,083		$28,355		$28,475		$28,475
99th Percentile	$65,248		$70,000		$70,822		$71,262		$71,262
Maximum Medicaid Paid	$2,088,843	X	$960,695		$960,695		$960,695		$960,695

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PERCENT OF ENROLLEES WITH ZERO EXPENDITURES									
% of Enrollees with Total Medicaid Paid = $0	3.99	X	2.95		2.80		2.80		2.80
Aged	19.72		19.44		19.31		19.34		19.34
Disabled	7.40		7.70		7.72		7.75		7.75
Child	1.42	X	0.24	X	0.11		0.10		0.10
Adult	3.25	X	0.76	X	0.26	X	0.21		0.21
NUMBER OF HIGH-COST ENROLLEES									
# of Enrollees with Total Medicaid Paid > $1,000,000	1.00		0.00		0.00		0.00		0.00
# of Enrollees with Total Medicaid Paid > $500,000	14.00		13.00		14.00		15.00		15.00
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$5,101		$5,417		$5,481		$5,508		$5,508
Aged	$12,199		$12,925		$13,022		$13,050		$13,050
Disabled	$15,545		$16,523		$16,681		$16,753		$16,753
Child	$1,733		$1,856		$1,884		$1,892		$1,892
Adult	$4,023		$4,287		$4,348		$4,376		$4,376
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$11,496		$12,168		$12,248		$12,267		$12,267
Aged	$12,150		$12,873		$12,966		$12,992		$12,992
Disabled	$10,835		$11,454		$11,518		$11,532		$11,532
EDB Only (EDB DUAL = 50)	$16,105		$15,506		$15,070		$14,292		$14,292
EDB QMB Only (EDB DUAL = 51)	$866		$967		$987		$999		$999
EDB QMB Plus (EDB DUAL = 52)	$13,279		$14,077		$14,185		$14,230		$14,230
EDB SLMB Only (EDB DUAL = 53)	$178	X	$111		$123		$123		$123
EDB SLMB Plus (EDB DUAL = 54)	$21,848		$23,442		$23,708		$23,775		$23,775
EDB QDWI (EDB DUAL = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QI-1 (EDB DUAL = 56)	$59		$56		$56		$56		$56
EDB QI-2 (EDB DUAL = 57)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Other (EDB DUAL = 58)	$20,111		$21,253		$21,348		$21,411		$21,411
EDB Dual Type Unknown (EDB DUAL = 59)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Dual Status Unknown (EDB DUAL = 98)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	$15,916		$16,853		$16,962		$16,998		$16,998
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	$510		$536		$548		$553		$553
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE									
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	$45,723		$47,243		$47,076		$47,145		$47,145
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	$26,522		$28,082		$28,256		$28,346		$28,346
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	$46,212		$48,012		$48,500		$48,773		$48,773
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT									
Avg Medicaid Paid per Section 1915(c) Enrollee	$25,783		$27,384		$27,583		$27,672		$27,672
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$20,201		$21,622		$21,845		$21,930		$21,930
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0

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Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$45,890		$48,293		$48,420		$48,537		$48,537
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT									
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	$12,342		$12,958		$12,977		$12,986		$12,986
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$8,266		$8,699		$8,709		$8,709		$8,709
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$27,023		$28,411		$28,471		$28,528		$28,528
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EXPENDITURES FOR RESTRICTED BENEFIT ENROLLEES									
Expenditures for Family Planning Enrollees with Restricted Benefits (RBF = 6)									
Total Medicaid Paid for ONLY Family Planning Only Enrollees	$0		$0		$0		$0		$0
Avg Medicaid Paid per ONLY Family Planning Only Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Aliens with Restricted Benefits (RBF = 2)									
Total Medicaid Paid for Aliens with Restricted Benefits ONLY Enrollment	$0		$0		$0		$0		$0
Avg Medicaid Paid per Alien Enrollee with Restricted Benefits ONLY	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
Total Medicaid Paid for EDB Duals with Only Restricted Benefits Enrollment	$2,643,078		$3,142,875		$3,227,111		$3,279,349		$3,279,349
Avg Medicaid Paid per EDB Dual with Only Restricted Benefits Enrollment	$305		$357		$365		$370		$370
Expenditures for Prescription Drug Enrollees (RBF = X, Y, or Z)									
Total Medicaid Paid for Prescription Drug ONLY Enrollees (May Have a Month or More of RBF = 3)	$0		$0		$0		$0		$0
Avg Medicaid Paid per Prescription Drug ONLY Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Dual Prescription Drug Enrollees									
Total Medicaid Paid for Prescription Drug ONLY Enrollees Who Are EDB Duals	$0		$0		$0		$0		$0
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.									
Total Medicaid Enrollees	214,795		219,681		220,388		220,544		220,544
Aged Total	11,903		12,106		12,128		12,133		12,133
Disabled Total	33,382		33,893		34,081		34,161		34,161
Child Total	142,232		144,997		145,293		145,335		145,335
Adult Total	27,278		28,685		28,886		28,915		28,915
Total Medicaid Person-Years of Enrollment	167,654		168,786		168,972		169,013		169,013
Total EDB Duals	23,567		23,859		23,902		23,922		23,922

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Aged	11,531		11,725		11,749		11,753		11,753
Disabled	11,891		11,993		12,012		12,028		12,028
TOTAL MEDICAID AMOUNT PAID									
Total Medicaid Paid	$1,137,329,963		$1,234,605,299		$1,253,184,328		$1,260,317,589		$1,260,317,589
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$5,295		$5,620		$5,686		$5,715		$5,715
Aged	$16,723		$17,713		$17,854		$17,905		$17,905
Disabled	$17,436		$18,530		$18,699		$18,780		$18,780
Child	$1,733		$1,856		$1,884		$1,892		$1,892
Adult	$4,023		$4,287		$4,348		$4,376		$4,376
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$15,610		$16,531		$16,642		$16,676		$16,676
Aged	$16,801		$17,797		$17,932		$17,981		$17,981
Disabled	$14,496		$15,338		$15,424		$15,444		$15,444
Managed CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.									
% Total Enrollees in MC Anytime During Year	94.30		94.02		94.13		94.34		94.33
Total MC Enrollees	202,553		206,552		207,443		208,051		208,034
Aged	7,888		7,890		7,889		7,890		7,881
Disabled	29,816		29,817		29,816		29,810		29,802
Child	139,362		142,019		142,464		142,747		142,747
Adult	25,487		26,826		27,274		27,604		27,604
% of MC Enrollees in HMO/HIO (MC TYPE = 1)	0.12		0.11		0.11		0.10		N/A
% of MC Enrollees in Dental (MC TYPE = 2)	77.79		78.29		78.41		78.49		N/A
% of MC Enrollees in BHO (MC TYPE = 3)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in Prenatal (MC TYPE = 4)	0.00		0.00		0.00		0.00		Div by 0
% of MC Enrollees in LTC (MC TYPE = 5)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PACE (MC TYPE = 6)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PCCM (MC TYPE = 7)	93.38		91.56		91.13		90.83		N/A
% of MC Enrollees in Other MC (MC TYPE = 8)	0.69		0.67		0.67		0.67		N/A
% EDB Duals Ever Enrolled in HMO/HIOs	0.53		0.45		0.45		0.45		0.00
% EDB Duals in PHP Only or PHP/PCCM Only	6.66		6.62		6.61		6.60		6.62
% EDB Duals in PCCM Only	70.02		69.19		69.05		68.98		69.36
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	0.79		0.68		0.68		0.68		0.00
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	4.11		4.09		4.08		4.09		4.09
% Section 1915(c) Waiver Enrollees in PCCM Only	83.94		83.55		83.52		83.51		84.16
Total Enrollees in June	170,458		170,629		170,633		170,635		170,635
June % HMO/HIO Only (MC COMBO = 01)	0.00		0.00		0.00		0.00		0.00
June % Dental Plan Only (MC COMBO = 02)	10.93		10.99		10.99		10.99		10.99
June % BHO Only (MC COMBO = 03)	0.00		0.00		0.00		0.00		0.00
June % PCCM Only (MC COMBO = 04)	23.44		23.39		23.39		23.39		23.39
June % Other MC Only (MC COMBO = 05)	0.63		0.63		0.63		0.63		0.63
June % HMO/HIO & Dental (MC COMBO = 06)	0.00		0.00		0.00		0.00		0.00

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June % HMO/HIO & BHO (MC COMBO = 07)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Other MC (MC COMBO = 08)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	0.00		0.00		0.00		0.00		0.00
June % Dental & PCCM (MC COMBO = 10)	59.60		59.49		59.48		59.48		59.48
June % BHO & PCCM (MC COMBO = 11)	0.00		0.00		0.00		0.00		0.00
June % Other MC & PCCM (MC COMBO = 12)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO & PCCM (MC COMBO = 13)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO (MC COMBO = 14)	0.00		0.00		0.00		0.00		0.00
June % Other Combinations (MC COMBO = 15)	0.00		0.00		0.00		0.00		0.00
June % FFS Only (MC COMBO = 16)	5.40		5.49		5.50		5.50		5.50
June % MC Status Unknown (MC COMBO = 99)	0.00		0.00		0.00		0.00		0.00
CAPITATION CLAIMS									
Total Capitation Payments	$33,813,141		$34,162,477		$34,227,790		$34,263,836		$34,262,738
HMO/HIO	$14,850		$14,850		$14,850		$14,850		$14,000
PHP	$27,132,663		$27,482,075		$27,547,464		$27,583,498		$27,583,498
PCCM	$6,665,628		$6,665,552		$6,665,476		$6,665,488		$6,665,240
Ratio of Capitation Claims to Person-Month Enrollment in MC	1.67		1.67		1.67		1.67		1.66
HMO/HIO	1.20		1.36		1.36		1.36		Div by 0
PHP	1.13		1.13		1.13		1.13		1.06
PCCM	1.00		1.00		1.00		1.00		1.00
Avg Capitation Payment per Person-Month Enrollment in MC	$18		$18		$18		$18		$18
HMO/HIO	$60		$68		$68		$68		Div by 0
PHP	$21		$21		$21		$21		$19
PCCM	$4		$4		$4		$4		$4
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY									
Total Capitation Payments	$31,953,944		$32,303,018		$32,369,187		$32,408,436		$32,414,053
Total Medicaid Paid	$322,920,790		$353,591,709		$360,659,235		$363,526,724		$363,644,276
Count of Enrollees	158,940		163,094		164,028		164,676		164,687
PERSONS ENROLLED IN PCCM ONLY									
Total Capitation Payments	$1,830,515		$1,834,390		$1,833,534		$1,830,331		$1,848,685
Count of Enrollees	43,365		43,240		43,197		43,157		43,347
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR									
Count of Enrollees	248		218		218		218		0
Aged	70		59		59		59		0
Disabled	165		150		150		150		0
Child	4		3		3		3		0
Adult	9		6		6		6		0
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	20		17		17		17		0
Total Capitation Payments	$28,682		$25,069		$25,069		$25,069		$0
Avg Capitation Payments	$116		$115		$115		$115		Div by 0
Aged	$112		$115		$115		$115		Div by 0
Disabled	$106		$107		$107		$107		Div by 0
Child	$227		$200		$200		$200		Div by 0
Adult	$267		$268		$268		$268		Div by 0

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Total FFS Payments	$5,351,086		$5,179,395		$5,256,012		$5,288,775		$0
Avg FFS Payments per Enrollee	$21,577		$23,759		$24,110		$24,260		Div by 0
Aged	$14,425		$16,937		$17,089		$17,454		Div by 0
Disabled	$25,424		$27,005		$27,452		$27,527		Div by 0
Child	$12,558		$16,162		$16,162		$16,162		Div by 0
Adult	$10,684		$13,478		$13,580		$13,583		Div by 0
Total FFS Payments by Type of Service									
IP (MAX TOS = 01)	$771,308		$748,031		$783,779		$783,779		$0
ILTC (MAX TOS = 02, 04, 05, 07)	$707,238		$744,469		$756,889		$780,315		$0
Drug (MAX TOS = 16)	$1,135,672		$1,063,003		$1,063,779		$1,063,789		$0
All Other (Excluding Capitation Payments)	$2,736,868		$2,623,892		$2,651,565		$2,660,892		$0
Average FFS Payments by Type of Service									
IP (MAX TOS = 01)	$3,110		$3,431		$3,595		$3,595		Div by 0
ILTC (MAX TOS = 02, 04, 05, 07)	$2,852		$3,415		$3,472		$3,579		Div by 0
Drug (MAX TOS = 16)	$4,579		$4,876		$4,880		$4,880		Div by 0
All Other (Excluding Capitation Payments)	$11,036		$12,036		$12,163		$12,206		Div by 0
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total Non-Dual FFS Enrollees	191,104		195,711		196,375		196,511		196,622
Total Non-Dual FFS Recipients	155,986		160,955		161,956		162,230		162,341
Total Non-Dual FFS Person-Years of Enrollment	146,445		147,493		147,662		147,696		147,805
Aged Total	367		378		376		377		380
Aged, Cash (MAX ELIG CD = 11)	150		148		148		149		151
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	9		9		9		9		9
Other Aged (MAX ELIG CD = 41)	208		221		219		219		220
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	21,384		21,801		21,970		22,034		22,133
Disabled, Cash (MAX ELIG CD = 12)	19,129		19,487		19,640		19,697		19,795
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	8	X	13		14		14		14
Other Disabled (MAX ELIG CD = 42)	2,247		2,301		2,316		2,323		2,324
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	142,227		144,993		145,289		145,331		145,334
AFDC Child, Cash (MAX ELIG CD = 14)	2		2		2		2		2
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	138,870		141,616		141,912		141,951		141,953
Other Child (MAX ELIG CD = 44)	11	X	8		9		9		9
Foster Care Child (MAX ELIG CD = 48)	3,344		3,367		3,366		3,369		3,370
1115 Child (MAX ELIG CD = 54)	0		0		0		0		0
Adult Total	27,126		28,539		28,740		28,769		28,775
AFDC Adult, Cash (MAX ELIG CD = 15)	11,936		12,554		12,615		12,627		12,632

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AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	11,680		12,478		12,593		12,618		12,618
Other Adult (MAX ELIG CD = 45)	3,510		3,507		3,532		3,524		3,525
1115 Adult (MAX ELIG CD = 55)	0		0		0		0		0
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	57	X	201	X	340	X	442		443
Total FFS Medicaid Paid	$734,379,300		$804,740,387		$819,849,788		$825,817,838		$829,483,358
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	$3,843		$4,112		$4,175		$4,202		$4,219
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	$4,708		$5,000		$5,062		$5,090		$5,110
Total Capitation Payments	$31,377,606		$31,833,454		$31,892,390		$31,903,744		$31,915,983
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	29	X	42	X	42	X	42	X	153
Total HMO/HIO Payments (Among People not Enrolled)	$1,450	X	$2,100	X	$2,100	X	$2,100	X	$7,700
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$14,188		$15,041		$15,330		$15,434		$15,495
Aged, Cash (MAX ELIG CD = 11)	$14,914		$16,549		$16,675		$16,902		$16,975
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$0	X	$1		$1		$1		$1
Other Aged (MAX ELIG CD = 41)	$14,278		$14,644		$15,051		$15,069		$15,112
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$18,958		$20,174		$20,377		$20,488		$20,553
Disabled, Cash (MAX ELIG CD = 12)	$19,365		$20,542		$20,738		$20,851		$20,923
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$0		$0		$0		$0		$0
Other Disabled (MAX ELIG CD = 42)	$15,553		$17,176		$17,431		$17,534		$17,529
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$1,543		$1,668		$1,696		$1,704		$1,704
AFDC Child, Cash (MAX ELIG CD = 14)	$0		$0		$0		$0		$0
AFDC-U Child, Cash (MAX ELIG CD = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child Poverty (MAX ELIG CD = 34)	$1,475		$1,597		$1,625		$1,632		$1,633
Other Child (MAX ELIG CD = 44)	$852	X	$594		$540		$540		$540
Foster Care Child (MAX ELIG CD = 48)	$4,386		$4,658		$4,699		$4,714		$4,719
1115 Child (MAX ELIG CD = 54)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult	$3,846		$4,115		$4,176		$4,205		$4,207
AFDC Adult, Cash (MAX ELIG CD = 15)	$3,865		$4,164		$4,229		$4,259		$4,264
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult, Poverty (MAX ELIG CD = 35)	$4,178		$4,401		$4,445		$4,479		$4,479
Other Adult (MAX ELIG CD = 45)	$2,678		$2,923		$3,026		$3,028		$3,027
1115 Adult (MAX ELIG CD = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$148,500,685		$169,250,859		$176,100,398		$178,247,359		$178,982,221
IP: Number of Users	17,315		19,641		20,056		20,192		20,222
IP: Avg Medicaid Paid per User	$8,576		$8,617		$8,780		$8,828		$8,851

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IP: Avg Medicaid Covered Days Per User	4.53		4.56		4.63		4.65		4.66
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$5,575,897		$6,536,219		$6,705,826		$6,876,624		$6,927,035
MH Aged: Number of Users	579		644		661		671		677
MH Aged: Avg Medicaid Paid per User	$9,630		$10,149		$10,145		$10,248		$10,232
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$9,137,768		$10,611,228		$10,823,142		$10,899,767		$10,899,767
IP Psych, Age < 21: Number of Users	844		945		959		963		963
IP Psych, Age < 21: Avg Medicaid Paid per User	$10,827		$11,229		$11,286		$11,319		$11,319
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$28,556,295		$30,481,550		$29,906,936		$29,931,629		$29,931,629
ICF/MR: Number of Users	263		267		268		268		268
ICF/MR: Avg Medicaid Paid per User	$108,579		$114,163		$111,593		$111,685		$111,685
NF: Total Medicaid Paid (MAX TOS = 07)	$12,629,841		$13,723,877		$13,890,824		$13,927,109		$14,019,298
NF: Number of Users	342		377		392		397		401
NF:Avg Medicaid Paid per User	$36,929		$36,403		$35,436		$35,081		$34,961
Physician: Total Medicaid Paid (MAX TOS = 08)	$58,204,749		$65,319,441		$67,230,430		$67,880,610		$68,076,779
Physician: Number of Users	118,200		124,624		126,031		126,452		126,562
Physician: Avg Medicaid Paid per User	$492		$524		$533		$537		$538
Dental: Total Medicaid Paid (MAX TOS = 09)	$5,526,014		$5,839,807		$5,890,924		$5,908,595		$5,922,980
Dental: Number of Users	14,339		14,857		14,933		14,966		14,995
Dental: Avg Medicaid Paid per User	$385		$393		$394		$395		$395
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$6,744,055		$7,411,385		$7,517,024		$7,559,994		$7,578,401
Other Practitioner: Number of Users	40,629		43,228		43,650		43,824		43,896
Other Practitioner: Avg Medicaid Paid per User	$166		$171		$172		$173		$173
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$40,418,751		$45,808,898		$46,879,713		$47,569,436		$47,782,687
Outpatient: Number of Users	57,014		61,108		61,734		61,959		62,045
Outpatient: Avg Medicaid Paid per User	$709		$750		$759		$768		$770
Clinic: Total Medicaid Paid (MAX TOS = 12)	$36,712,744		$39,881,183		$40,807,037		$41,075,022		$41,232,985
Clinic: Number of Users	52,018		54,788		55,773		55,907		56,001
Clinic: Avg Medicaid Paid per User	$706		$728		$732		$735		$736
Home Health: Total Medicaid Paid (MAX TOS = 13)	$2,510,072	X	$3,068,153		$3,187,934		$3,219,954		$3,264,286
Home Health: Number of Users	1,178		1,376		1,418		1,434		1,449
Home Health: Avg Medicaid Paid per User	$2,131		$2,230		$2,248		$2,245		$2,253
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$22,807,231		$25,264,902		$25,900,139		$26,065,198		$26,192,489
Lab/Xray: Number of Users	83,493		87,933		88,799		89,028		89,137
Lab/Xray:Avg Medicaid Paid per User	$273		$287		$292		$293		$294
Drugs: Total Medicaid Paid (MAX TOS = 16)	$103,710,494		$106,024,333		$106,197,265		$106,357,550		$107,402,278
Drugs: Number of Users	113,970		115,052		115,150		115,180		115,291
Drugs: Avg Medicaid Paid per User	$910		$922		$922		$923		$932
Other Services: Total Medicaid Paid (MAX TOS = 19)	$44,856,650		$50,105,058		$50,904,692		$51,231,658		$51,240,555
Other Services: Number of Users	15,273		16,385		16,723		16,938		16,948
Other Services: Avg Medicaid Paid per User	$2,937		$3,058		$3,044		$3,025		$3,023
Transportation: Total Medicaid Paid (MAX TOS = 26)	$12,049,655		$13,303,147		$13,655,596		$13,888,910		$13,933,704
Transportation: Number of Users	11,012		12,111		12,407		12,560		12,607
Transportation: Avg Medicaid Paid per User	$1,094		$1,098		$1,101		$1,106		$1,105
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$23,061,063		$24,446,677		$24,585,805		$24,643,551		$24,957,071

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Personal Care Services: Number of Users	2,251		2,330		2,352		2,374		2,397
Personal Care Services: Avg Medicaid Paid per User	$10,245		$10,492		$10,453		$10,381		$10,412
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$8,358,864		$8,992,943		$9,031,795		$9,043,201		$9,073,572
Targeted Case Management: Number of Users	8,363		8,666		8,697		8,700		8,717
Targeted Case Management: Avg Medicaid Paid per User	$1,000		$1,038		$1,038		$1,039		$1,041
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$3,044,604	X	$3,615,822		$3,859,308		$3,894,581		$3,895,877
Rehabilitation Services: Number of Users	5,977		6,451		6,774		6,793		6,808
Rehabilitation Services: Avg Medicaid Paid per User	$509		$561		$570		$573		$572
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$12,038,984		$13,900,182		$14,238,872		$14,358,480		$14,378,205
PT/OT/Speech/Hearing: Number of Users	8,215		9,129		9,318		9,374		9,403
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,465		$1,523		$1,528		$1,532		$1,529
Hospice: Total Medicaid Paid (MAX TOS = 35)	$859,452	X	$1,076,229		$1,131,304		$1,164,804		$1,164,804
Hospice: Number of Users	86	X	109		117		119		119
Hospice: Avg Medicaid Paid per User	$9,994		$9,874		$9,669		$9,788		$9,788
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$11,737,602		$13,525,975		$14,015,860		$14,211,173		$14,326,116
Durable Medical Equipment: Number of Users	34,568		37,108		37,528		37,790		37,886
Durable Medical Equipment: Avg Medicaid Paid per User	$340		$365		$373		$376		$378
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$23,566,612		$24,700,951		$24,709,756		$24,720,446		$24,811,224
Residential Care: Number of Users	1,419		1,449		1,453		1,453		1,461
Residential Care: Avg Medicaid Paid per User	$16,608		$17,047		$17,006		$17,013		$16,982
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$105,686,038		$112,922,205		$113,560,311		$113,957,705		$114,300,423
Psych Services: Number of Users	25,254		26,811		27,178		27,324		27,386
Psych Services: Avg Medicaid Paid per User	$4,185		$4,212		$4,178		$4,171		$4,174
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$610,628		$633,349		$643,771		$644,032		$644,032
Adult Day Care: Number of Users	266		272		274		274		274
Adult Day Care: Avg Medicaid Paid per User	$2,296		$2,328		$2,350		$2,350		$2,350
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$777		$865		$897		$907		$910
Aged	$2,218		$2,474		$2,568		$2,672		$2,651
Disabled	$2,471		$2,710		$2,863		$2,925		$2,943
Child	$352		$399		$412		$413		$413
Adult	$1,654		$1,799		$1,823		$1,835		$1,835
ILTC (MAX TOS = 02,04,05,07)	$293		$313		$312		$314		$314
Aged	$2,738		$2,834		$2,889		$2,861		$2,839
Disabled	$2,263		$2,416		$2,390		$2,395		$2,390
Child	$38		$44		$44		$45		$45
Adult	$41		$44		$45		$46		$46
Drugs (MAX TOS = 16)	$543		$542		$541		$541		$546
Aged	$2,056		$2,051		$2,058		$2,067		$2,100
Disabled	$3,162		$3,177		$3,160		$3,158		$3,189
Child	$168		$167		$167		$167		$167
Adult	$424		$411		$408		$407		$407
All Other Services	$2,231		$2,392		$2,425		$2,440		$2,448
Aged	$7,176		$7,683		$7,816		$7,833		$7,905

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Disabled	$11,061		$11,872		$11,964		$12,010		$12,030
Child	$986		$1,057		$1,072		$1,079		$1,079
Adult	$1,728		$1,861		$1,901		$1,917		$1,918
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	9.06		10.04		10.21		10.28		10.28
Aged	13.62		14.55		14.89		14.85		14.74
Disabled	9.97		10.90		11.14		11.23		11.30
Child	4.90		5.53		5.66		5.70		5.70
Adult	30.08		32.22		32.45		32.60		32.59
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	1.04		1.12		1.14		1.15		1.16
Aged	6.27		6.61		7.18		7.16		7.11
Disabled	5.95		6.31		6.40		6.45		6.47
Child	0.38		0.42		0.43		0.43		0.43
Adult	0.60		0.64		0.65		0.66		0.66
% with Ratio of ILTC Days/Enrollment Days > 1	4.16	X	5.37		5.26		5.30		5.32
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	59.64		58.79		58.64		58.61		58.64
Aged	78.75		77.51		77.39		77.45		77.63
Disabled	83.16		82.15		81.64		81.50		81.58
Child	54.68		54.05		53.96		53.95		53.95
Adult	66.84		64.76		64.44		64.41		64.42
% Non-Dual FFS Enrollees with All Other Claims	78.86		80.04		80.42		80.53		80.54
Aged	82.56		82.80		82.71		82.76		82.89
Disabled	92.41		92.52		92.55		92.58		92.61
Child	76.40		77.71		78.10		78.21		78.21
Adult	81.03		82.30		82.81		83.00		83.00
Avg # IP Days per Non-Dual FFS User	5		5		5		5		5
Aged	6		6		7		7		7
Disabled	9		9		10		10		10
Child	5		5		5		5		5
Adult	3		3		3		3		3
Avg # ILTC Days per Non-Dual FFS User	83		82		81		80		80
Aged	225		221		207		206		206
Disabled	120		120		118		117		116
Child	13		14		14		14		14
Adult	7		7		7		7		7
% Non-Dual FFS Enrollees with Maternal Delivery	4.36		4.77		4.81		4.83		4.83
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	1		0		0		0		0
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	13		12		12		13		13
Inpatient Hospital (MAX TOS = 01) > $500,000	7		7		7		8		8
ILTC (MAX TOS = 02,04,05,07) > $200,000	36		39		38		38		38
Drugs (MAX TOS = 16) > $200,000	4		4		4		5		5
All Other Services > $200,000	3	X	4		4		4		4
Maximum FFS Medicaid Paid	$2,088,608	X	$853,737		$953,963		$953,963		$953,963

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Inpatient Hospital (MAX TOS = 01)	$1,948,649	X	$798,115		$895,017		$895,017		$895,017
ILTC (MAX TOS = 02,04,05,07)	$276,722		$288,950		$288,950		$289,352		$289,352
Drugs (MAX TOS = 16)	$523,655		$523,655		$523,655		$523,655		$523,655
All Other Services	$289,463		$330,823		$335,533		$335,702		$335,702
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$2,299,914		$2,520,975		$2,588,589		$2,612,211		$2,614,221
FP: Number of Users	10,987		11,978		12,111		12,150		12,160
FP: Avg Medicaid Paid per User	$209		$210		$214		$215		$215
RHC: Total Medicaid Paid (PGM TYPE = 3)	$6,388,365		$6,777,983		$6,848,791		$6,862,457		$6,868,583
RHC: Number of Users	21,891		22,815		23,006		23,038		23,048
RHC: Avg Medicaid Paid per User	$292		$297		$298		$298		$298
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$6,460,563		$6,869,643		$7,171,303		$7,194,559		$7,277,230
FQHC: Number of Users	14,783		15,533		16,138		16,197		16,279
FQHC: Avg Medicaid Paid per User	$437		$442		$444		$444		$447
IHS: Total Medicaid Paid (PGM TYPE = 5)	$1,649,555		$1,756,370		$1,775,337		$1,786,249		$1,789,085
IHS: Number of Users	1,750		1,819		1,846		1,852		1,853
IHS: Avg Medicaid Paid per User	$943		$966		$962		$964		$966
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$46,388,568		$49,019,087		$49,130,980		$49,255,396		$49,598,705
Section 1915(c) Waiver: Number of Users	2,485		2,534		2,540		2,540		2,564
Section 1915(c) Waiver: Avg Medicaid Paid per User	$18,667		$19,345		$19,343		$19,392		$19,344
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$67,808,685		$72,160,435		$72,555,361		$72,779,314		$73,230,664
Number of Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	4,587		4,836		4,889		4,923		4,959
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	$14,783		$14,922		$14,841		$14,784		$14,767
Aged	$12,476		$12,823		$12,852		$12,854		$13,058
Disabled	$16,385		$16,768		$16,722		$16,697		$16,658
Child	$3,410		$3,229		$3,148		$3,096		$3,096
Adult	$2,634		$2,454		$2,434		$2,387		$2,387
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	2.40		2.47		2.49		2.51		2.52
Aged	25.61		25.93		26.06		25.99		26.32
Disabled	18.52		18.87		18.88		18.91		18.98
Child	0.32		0.36		0.37		0.38		0.38
Adult	0.31	X	0.37		0.37		0.39		0.39
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$46,388,568		$49,019,087		$49,130,980		$49,255,396		$49,598,705
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	2,485		2,534		2,540		2,540		2,564
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$18,667		$19,345		$19,343		$19,392		$19,344
Aged	$13,284		$13,525		$13,540		$13,543		$13,761
Disabled	$18,894		$19,600		$19,597		$19,647		$19,593
Child	$10,501		$11,177		$11,177		$11,177		$11,177
Adult	$4,648		$4,417		$4,426		$4,426		$4,426
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	1.30		1.29		1.29		1.29		1.30
Aged	22.07		22.49		22.61		22.55		22.89

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Disabled	11.20		11.19		11.13		11.10		11.15
Child	0.00		0.00		0.00		0.00		0.00
Adult	0.03		0.03		0.03		0.03		0.03
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total EDB Dual FFS Enrollees	23,443		23,752		23,795		23,815		23,922
Number of EDB Dual FFS Recipients	21,704		22,126		22,211		22,238		22,344
Total EDB Dual FFS Person-Years of Enrollment	20,967		21,080		21,098		21,104		21,208
% EDB Only Dual (EDB DUAL = 50)	5.27	X	4.03		3.82		3.64		3.63
% QMB Only (EDB DUAL = 51)	1.68		1.65		1.64		1.64		1.64
% QMB Plus (EDB DUAL = 52)	58.38		58.58		58.53		58.48		58.54
% SLMB Only (EDB DUAL = 53)	0.62		0.58		0.58		0.58		0.58
% SLMB Plus (EDB DUAL = 54)	6.49		6.57		6.57		6.55		6.55
% QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% QI 1 (EDB DUAL = 56)	0.18		0.16		0.16		0.16		0.16
% QI 2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% Other Type Dual (EDB DUAL = 58)	27.38		28.44		28.70		28.95		28.90
% Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	97.52		97.62		97.63		97.62		97.63
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	2.48		2.38		2.37		2.38		2.37
Aged EDB Dual FFS Total	11,466		11,669		11,693		11,697		11,753
Aged, Cash (MAX ELIG CD = 11)	2,298		2,302		2,293		2,295		2,311
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	175		165		164		164		164
Other Aged (MAX ELIG CD = 41)	8,993		9,202		9,236		9,238		9,278
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled EDB Dual FFS Total	11,833		11,942		11,961		11,977		12,028
Disabled, Cash (MAX ELIG CD = 12)	11,433		11,541		11,562		11,576		11,626
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	380		381		379		381		382
Other Disabled (MAX ELIG CD = 42)	20		20		20		20		20
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Total FFS Medicaid Paid	$363,769,351		$390,397,381		$393,729,114		$394,849,334		$396,472,589
Avg FFS Medicaid Paid per FFS Dual	$15,517		$16,436		$16,547		$16,580		$16,574
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	$16,760		$17,644		$17,727		$17,756		$17,744
Total Capitation Payments	$2,423,938		$2,429,613		$2,431,955		$2,432,829		$2,445,659
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	20	X	37	X	37	X	37	X	144
Total HMO/HIO Payments (Among People not Enrolled)	$1,000	X	$1,850	X	$1,850	X	$1,850	X	$7,200
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP									
Aged	$16,722		$17,709		$17,844		$17,892		$17,888
Aged, Cash (MAX ELIG CD = 11)	$6,492		$6,911		$6,936		$6,936		$6,943
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$3,400	X	$2,146		$2,207		$2,211		$2,211

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Other Aged (MAX ELIG CD = 41)	$19,595		$20,689		$20,830		$20,892		$20,891
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$14,390		$15,237		$15,323		$15,343		$15,333
Disabled, Cash (MAX ELIG CD = 12)	$14,756		$15,626		$15,711		$15,733		$15,721
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$3,649		$3,785		$3,806		$3,808		$3,817
Other Disabled (MAX ELIG CD = 42)	$8,888		$9,321		$9,620		$9,623		$9,623
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$8,946,606	X	$10,121,969		$11,060,390		$11,151,449		$11,200,366
IP: Number of Users	3,790		4,265		4,333		4,366		4,401
IP: Avg Medicaid Paid per User	$2,361		$2,373		$2,553		$2,554		$2,545
IP: Avg Medicaid Covered Days Per User	0.31		0.31		0.30		0.29		0.29
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$303,363		$331,143		$338,355		$338,355		$338,355
MH Aged: Number of Users	36		39		40		40		40
MH Aged: Avg Medicaid Paid per User	$8,427		$8,491		$8,459		$8,459		$8,459
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$107,064		$107,064		$107,064		$107,064		$107,064
IP Psych, Age < 21: Number of Users	9		9		9		9		9
IP Psych, Age < 21: Avg Medicaid Paid per User	$11,896		$11,896		$11,896		$11,896		$11,896
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$30,446,780		$32,661,220		$31,980,761		$31,951,710		$31,951,710
ICF/MR: Number of Users	295		299		299		299		299
ICF/MR: Avg Medicaid Paid per User	$103,209		$109,235		$106,959		$106,862		$106,862
NF: Total Medicaid Paid (MAX TOS = 07)	$138,579,001		$148,961,910		$150,399,055		$150,832,119		$151,469,834
NF: Number of Users	3,819		4,021		4,076		4,087		4,103
NF:Avg Medicaid Paid per User	$36,287		$37,046		$36,899		$36,905		$36,917
Physician: Total Medicaid Paid (MAX TOS = 08)	$4,251,190		$4,891,403		$5,109,296		$5,175,686		$5,217,911
Physician: Number of Users	16,459		17,130		17,352		17,439		17,542
Physician: Avg Medicaid Paid per User	$258		$286		$294		$297		$297
Dental: Total Medicaid Paid (MAX TOS = 09)	$2,775,976		$2,904,147		$2,922,733		$2,928,828		$2,938,121
Dental: Number of Users	6,328		6,480		6,499		6,518		6,535
Dental: Avg Medicaid Paid per User	$439		$448		$450		$449		$450
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$740,722		$830,806		$843,559		$847,841		$851,715
Other Practitioner: Number of Users	7,604		8,210		8,313		8,359		8,419
Other Practitioner: Avg Medicaid Paid per User	$97		$101		$101		$101		$101
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$5,422,003	X	$6,460,015		$6,664,730		$6,732,715		$6,783,096
Outpatient: Number of Users	10,589		11,390		11,176		11,217		11,288
Outpatient: Avg Medicaid Paid per User	$512		$567		$596		$600		$601
Clinic: Total Medicaid Paid (MAX TOS = 12)	$2,485,502	X	$2,992,591		$3,094,718		$3,116,236		$3,152,643
Clinic: Number of Users	7,431		8,098		8,244		8,290		8,364
Clinic: Avg Medicaid Paid per User	$334		$370		$375		$376		$377
Home Health: Total Medicaid Paid (MAX TOS = 13)	$755,627		$877,939		$900,621		$908,012		$908,115
Home Health: Number of Users	269		290		298		299		300
Home Health: Avg Medicaid Paid per User	$2,809		$3,027		$3,022		$3,037		$3,027
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$1,080,748		$1,172,499		$1,187,988		$1,189,017		$1,198,399

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Lab/Xray: Number of Users	10,371		11,150		11,306		11,354		11,421
Lab/Xray:Avg Medicaid Paid per User	$104		$105		$105		$105		$105
Drugs: Total Medicaid Paid (MAX TOS = 16)	$5,097,571		$5,198,027		$5,215,605		$5,216,199		$5,235,260
Drugs: Number of Users	8,475		8,582		8,599		8,605		8,658
Drugs: Avg Medicaid Paid per User	$601		$606		$607		$606		$605
Other Services: Total Medicaid Paid (MAX TOS = 19)	$17,993,291		$19,038,265		$19,158,943		$19,271,567		$19,286,896
Other Services: Number of Users	7,495		7,924		8,019		8,113		8,187
Other Services: Avg Medicaid Paid per User	$2,401		$2,403		$2,389		$2,375		$2,356
Transportation: Total Medicaid Paid (MAX TOS = 26)	$6,410,489		$6,827,352		$6,876,702		$6,933,230		$6,967,305
Transportation: Number of Users	4,746		4,943		4,988		5,006		5,043
Transportation: Avg Medicaid Paid per User	$1,351		$1,381		$1,379		$1,385		$1,382
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$43,947,172		$46,437,551		$46,533,306		$46,576,874		$46,919,666
Personal Care Services: Number of Users	4,459		4,527		4,530		4,531		4,573
Personal Care Services: Avg Medicaid Paid per User	$9,856		$10,258		$10,272		$10,280		$10,260
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$4,219,880		$4,463,923		$4,485,365		$4,498,493		$4,511,346
Targeted Case Management: Number of Users	3,409		3,453		3,458		3,462		3,474
Targeted Case Management: Avg Medicaid Paid per User	$1,238		$1,293		$1,297		$1,299		$1,299
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$220,694	X	$249,142		$276,919		$278,921		$279,774
Rehabilitation Services: Number of Users	1,695		1,822		1,869		1,877		1,887
Rehabilitation Services: Avg Medicaid Paid per User	$130		$137		$148		$149		$148
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$499,318	X	$576,305		$602,017		$619,549		$624,213
PT/OT/Speech/Hearing: Number of Users	2,076		2,321		2,399		2,454		2,476
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$241		$248		$251		$252		$252
Hospice: Total Medicaid Paid (MAX TOS = 35)	$3,794,594	X	$4,636,043		$4,987,775		$5,058,310		$5,058,930
Hospice: Number of Users	244	X	288		308		320		321
Hospice: Avg Medicaid Paid per User	$15,552		$16,097		$16,194		$15,807		$15,760
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$2,776,211		$3,174,107		$3,316,260		$3,399,032		$3,432,403
Durable Medical Equipment: Number of Users	6,866		7,390		7,503		7,537		7,596
Durable Medical Equipment: Avg Medicaid Paid per User	$404		$430		$442		$451		$452
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$47,859,431		$50,392,355		$50,486,729		$50,500,339		$50,688,815
Residential Care: Number of Users	3,787		3,914		3,927		3,930		3,945
Residential Care: Avg Medicaid Paid per User	$12,638		$12,875		$12,856		$12,850		$12,849
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$33,693,405		$35,633,589		$35,701,939		$35,732,484		$35,863,344
Psych Services: Number of Users	3,743		3,821		3,830		3,830		3,871
Psych Services: Avg Medicaid Paid per User	$9,002		$9,326		$9,322		$9,330		$9,265
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$1,141,040		$1,187,969		$1,198,253		$1,199,235		$1,199,514
Adult Day Care: Number of Users	396		409		410		410		411
Adult Day Care: Avg Medicaid Paid per User	$2,881		$2,905		$2,923		$2,925		$2,919
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$382		$426		$465		$468		$468
Aged	$291		$327		$332		$336		$337
Disabled	$450	X	$502		$575		$578		$577
ILTC (MAX TOS = 02,04,05,07)	$7,228		$7,665		$7,683		$7,694		$7,686
Aged	$10,766		$11,371		$11,450		$11,476		$11,461

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Disabled	$3,882		$4,129		$4,087		$4,086		$4,083
Drugs (MAX TOS = 16)	$217		$219		$219		$219		$219
Aged	$90		$89		$89		$89		$89
Disabled	$296		$301		$301		$301		$301
All Other Services	$7,691		$8,126		$8,179		$8,199		$8,200
Aged	$5,576		$5,921		$5,973		$5,991		$6,002
Disabled	$9,761		$10,305		$10,360		$10,378		$10,372
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Duals with IP Claims (MAX TOS = 01)	16.17		17.96		18.21		18.33		18.40
Aged	16.88		18.77		19.03		19.18		19.26
Disabled	15.41		17.12		17.36		17.47		17.51
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	17.71		18.35		18.55		18.58		18.56
Aged	29.96		30.98		31.34		31.41		31.35
Disabled	5.99		6.15		6.20		6.20		6.22
% FFS Duals with Drug Claims (MAX TOS = 16)	36.15		36.13		36.14		36.13		36.19
Aged	30.58		30.59		30.63		30.64		30.71
Disabled	40.92		40.96		40.93		40.90		40.96
% FFS Duals with All Other Claims	89.25		90.10		90.35		90.44		90.48
Aged	87.00		88.01		88.33		88.48		88.54
Disabled	91.37		92.04		92.23		92.26		92.28
Avg # IP Days per FFS Dual User (MAX TOS = 01)	0		0		0		0		0
Aged	0		0		0		0		0
Disabled	0		0		0		0		0
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	238		243		242		242		242
Aged	235		239		238		238		238
Disabled	258		266		265		265		265
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Duals with FFS Medicaid Paid > $500,000	1	X	1	X	2		2		2
Inpatient Hospital (MAX TOS = 01) > $500,000	0	X	0	X	1		1		1
ILTC (MAX TOS = 02,04,05,07) > $200,000	55		61		61		61		61
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	2		2		2		2		2
Maximum FFS Medicaid Paid	$958,710		$960,695		$960,695		$960,695		$960,695
Inpatient Hospital (MAX TOS = 01)	$315,977	X	$315,977	X	$683,032		$683,032		$683,032
ILTC (MAX TOS = 02,04,05,07)	$356,433	X	$447,984		$447,984		$447,984		$447,984
Drugs (MAX TOS = 16)	$65,455		$72,384		$72,384		$72,384		$72,384
All Other Services	$958,710		$960,695		$960,695		$960,695		$960,695
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$31,518		$35,553		$36,750		$37,335		$37,335
FP: Number of Users	186		196		202		207		207
FP: Avg Medicaid Paid per User	$169		$181		$182		$180		$180
RHC: Total Medicaid Paid (PGM TYPE = 3)	$582,213		$673,100		$688,806		$694,501		$694,506
RHC: Number of Users	3,055		3,253		3,305		3,330		3,332

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RHC: Avg Medicaid Paid per User	$191		$207		$208		$209		$208
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$822,367	X	$1,086,252		$1,131,750		$1,138,311		$1,168,248
FQHC: Number of Users	2,437		2,865		2,959		2,969		3,039
FQHC: Avg Medicaid Paid per User	$337		$379		$382		$383		$384
IHS: Total Medicaid Paid (PGM TYPE = 5)	$166,093		$191,841		$195,752		$196,457		$196,457
IHS: Number of Users	171		171		172		172		172
IHS: Avg Medicaid Paid per User	$971		$1,122		$1,138		$1,142		$1,142
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$93,779,345		$99,394,754		$99,610,745		$99,696,429		$100,020,222
Section 1915(c) Waiver: Number of Users	7,646		7,821		7,839		7,841		7,893
Section 1915(c) Waiver: Avg Medicaid Paid per User	$12,265		$12,709		$12,707		$12,715		$12,672
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$111,640,042		$118,243,435		$118,525,205		$118,633,309		$119,178,355
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	9,673		10,126		10,248		10,280		10,347
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	$11,541		$11,677		$11,566		$11,540		$11,518
Aged	$9,588		$9,746		$9,685		$9,676		$9,663
Disabled	$13,759		$13,857		$13,677		$13,627		$13,600
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	41.26		42.63		43.07		43.17		43.25
Aged	44.63		45.79		46.10		46.16		46.29
Disabled	38.43		39.98		40.54		40.68		40.71
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$93,779,345		$99,394,754		$99,610,745		$99,696,429		$100,020,222
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	7,646		7,821		7,839		7,841		7,893
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$12,265		$12,709		$12,707		$12,715		$12,672
Aged	$8,895		$9,210		$9,205		$9,209		$9,186
Disabled	$16,799		$17,472		$17,481		$17,493		$17,434
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	32.62		32.93		32.94		32.92		32.99
Aged	38.25		38.64		38.67		38.67		38.77
Disabled	27.55		27.73		27.73		27.70		27.74
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total FFS Enrollees	214,547		219,463		220,170		220,326		220,544
# FFS Recipients	177,690		183,081		184,167		184,468		184,685
% FFS Enrollees Who Are Recipients	82.82		83.42		83.65		83.73		83.74
% Aged Who Are Recipients	92.51		93.16		93.40		93.47		93.50
% Disabled Who Are Recipients	93.38		93.36		93.36		93.38		93.40
% Child Who Are Recipients	79.11		79.85		80.11		80.19		80.19
% Adults Who Are Recipients	85.11		85.70		85.95		86.09		86.09
Total FFS Person-Years of Enrollment	167,412		168,573		168,759		168,800		169,013
Aged Total	11,833		12,047		12,069		12,074		12,133
Aged, Cash (MAX ELIG CD = 11)	2,448		2,450		2,441		2,444		2,462
Aged, Medically Needy (MAX ELIG CD = 21)	0		0		0		0		0
Aged, Poverty (MAX ELIG CD = 31)	184		174		173		173		173

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Other Aged (MAX ELIG CD = 41)	9,201		9,423		9,455		9,457		9,498
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	33,217		33,743		33,931		34,011		34,161
Disabled, Cash (MAX ELIG CD = 12)	30,562		31,028		31,202		31,273		31,421
Disabled, Medically Needy (MAX ELIG CD = 22)	0		0		0		0		0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	388		394		393		395		396
Other Disabled (MAX ELIG CD = 42)	2,267		2,321		2,336		2,343		2,344
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	142,228		144,994		145,290		145,332		145,335
AFDC Child, Cash (MAX ELIG CD = 14)	2		2		2		2		2
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	0		0		0		0		0
Child Poverty (MAX ELIG CD = 34)	138,871		141,617		141,913		141,952		141,954
Other Child (MAX ELIG CD = 44)	11	X	8		9		9		9
Foster Care Child (MAX ELIG CD = 48)	3,344		3,367		3,366		3,369		3,370
1115 Child (MAX ELIG CD = 54)	0		0		0		0		0
Adult Total	27,269		28,679		28,880		28,909		28,915
AFDC Adult, Cash (MAX ELIG CD = 15)	12,049		12,660		12,722		12,734		12,739
AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	0		0		0		0		0
Adult, Poverty (MAX ELIG CD = 35)	11,699		12,498		12,613		12,638		12,638
Other Adult (MAX ELIG CD = 45)	3,521		3,521		3,545		3,537		3,538
1115 Adult (MAX ELIG CD = 55)	0		0		0		0		0
Total FFS Medicaid Paid	$1,098,148,651		$1,195,137,768		$1,213,578,902		$1,220,667,172		$1,225,955,947
Avg FFS Medicaid Paid per FFS Enrollee	$5,118		$5,446		$5,512		$5,540		$5,559
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	$6,180		$6,528		$6,590		$6,617		$6,638
Total Capitation Payments	$33,801,544		$34,263,067		$34,324,345		$34,336,573		$34,361,642
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	49	X	79	X	79	X	79	X	297
Total HMO/HIO Payments (Among People not Enrolled)	$2,450	X	$3,950	X	$3,950	X	$3,950	X	$14,900
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$16,643		$17,625		$17,765		$17,815		$17,813
Aged, Cash (MAX ELIG CD = 11)	$7,008		$7,493		$7,526		$7,544		$7,558
Aged, Medically Needy (MAX ELIG CD = 21)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Aged, Poverty (MAX ELIG CD = 31)	$3,234	X	$2,035		$2,092		$2,096		$2,096
Other Aged (MAX ELIG CD = 41)	$19,475		$20,547		$20,696		$20,757		$20,757
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$17,330		$18,427		$18,595		$18,676		$18,715
Disabled, Cash (MAX ELIG CD = 12)	$17,641		$18,713		$18,875		$18,956		$18,998
Disabled, Medically Needy (MAX ELIG CD = 22)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$3,574		$3,660		$3,671		$3,673		$3,682
Other Disabled (MAX ELIG CD = 42)	$15,495		$17,108		$17,364		$17,466		$17,461
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$1,543		$1,668		$1,696		$1,704		$1,704
AFDC Child, Cash (MAX ELIG CD = 14)	$0		$0		$0		$0		$0

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AFDC-U Child, Cash (MAX ELIG CD = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child Poverty (MAX ELIG CD = 34)	$1,475		$1,597		$1,625		$1,632		$1,633
Other Child (MAX ELIG CD = 44)	$852	X	$594		$540		$540		$540
Foster Care Child (MAX ELIG CD = 48)	$4,386		$4,658		$4,699		$4,714		$4,719
1115 Child (MAX ELIG CD = 54)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult	$3,891		$4,157		$4,218		$4,247		$4,248
AFDC Adult, Cash (MAX ELIG CD = 15)	$3,965		$4,259		$4,324		$4,354		$4,359
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Adult, Poverty (MAX ELIG CD = 35)	$4,176		$4,399		$4,443		$4,477		$4,477
Other Adult (MAX ELIG CD = 45)	$2,688		$2,934		$3,038		$3,037		$3,037
1115 Adult (MAX ELIG CD = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$157,447,291		$179,372,828		$187,160,788		$189,398,808		$190,182,587
IP: Number of Users	21,105		23,906		24,389		24,558		24,623
IP: Avg Medicaid Paid per User	$7,460		$7,503		$7,674		$7,712		$7,724
IP: Avg Medicaid Covered Days Per User	3.77		3.80		3.86		3.88		3.88
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$5,879,260		$6,867,362		$7,044,181		$7,214,979		$7,265,390
MH Aged: Number of Users	615		683		701		711		717
MH Aged: Avg Medicaid Paid per User	$9,560		$10,055		$10,049		$10,148		$10,133
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$9,244,832		$10,718,292		$10,930,206		$11,006,831		$11,006,831
IP Psych, Age < 21: Number of Users	853		954		968		972		972
IP Psych, Age < 21: Avg Medicaid Paid per User	$10,838		$11,235		$11,292		$11,324		$11,324
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$59,003,075		$63,142,770		$61,887,697		$61,883,339		$61,883,339
ICF/MR: Number of Users	558		566		567		567		567
ICF/MR: Avg Medicaid Paid per User	$105,740		$111,560		$109,149		$109,142		$109,142
NF: Total Medicaid Paid (MAX TOS = 07)	$151,208,842		$162,685,787		$164,289,879		$164,759,228		$165,489,132
NF: Number of Users	4,161		4,398		4,468		4,484		4,504
NF:Avg Medicaid Paid per User	$36,340		$36,991		$36,770		$36,744		$36,743
Physician: Total Medicaid Paid (MAX TOS = 08)	$62,455,939		$70,210,844		$72,339,726		$73,056,296		$73,294,690
Physician: Number of Users	134,659		141,754		143,383		143,891		144,104
Physician: Avg Medicaid Paid per User	$464		$495		$505		$508		$509
Dental: Total Medicaid Paid (MAX TOS = 09)	$8,301,990		$8,743,954		$8,813,657		$8,837,423		$8,861,101
Dental: Number of Users	20,667		21,337		21,432		21,484		21,530
Dental: Avg Medicaid Paid per User	$402		$410		$411		$411		$412
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$7,484,777		$8,242,191		$8,360,583		$8,407,835		$8,430,116
Other Practitioner: Number of Users	48,233		51,438		51,963		52,183		52,315
Other Practitioner: Avg Medicaid Paid per User	$155		$160		$161		$161		$161
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$45,840,754		$52,268,913		$53,544,443		$54,302,151		$54,565,783
Outpatient: Number of Users	67,603		72,498		72,910		73,176		73,333
Outpatient: Avg Medicaid Paid per User	$678		$721		$734		$742		$744
Clinic: Total Medicaid Paid (MAX TOS = 12)	$39,198,246		$42,873,774		$43,901,755		$44,191,258		$44,385,628
Clinic: Number of Users	59,449		62,886		64,017		64,197		64,365

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Clinic: Avg Medicaid Paid per User	$659		$682		$686		$688		$690
Home Health: Total Medicaid Paid (MAX TOS = 13)	$3,265,699	X	$3,946,092		$4,088,555		$4,127,966		$4,172,401
Home Health: Number of Users	1,447		1,666		1,716		1,733		1,749
Home Health: Avg Medicaid Paid per User	$2,257		$2,369		$2,383		$2,382		$2,386
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$23,887,979		$26,437,401		$27,088,127		$27,254,215		$27,390,888
Lab/Xray: Number of Users	93,864		99,083		100,105		100,382		100,558
Lab/Xray:Avg Medicaid Paid per User	$254		$267		$271		$272		$272
Drugs: Total Medicaid Paid (MAX TOS = 16)	$108,808,065		$111,222,360		$111,412,870		$111,573,749		$112,637,538
Drugs: Number of Users	122,445		123,634		123,749		123,785		123,949
Drugs: Avg Medicaid Paid per User	$889		$900		$900		$901		$909
Other Services: Total Medicaid Paid (MAX TOS = 19)	$62,849,941		$69,143,323		$70,063,635		$70,503,225		$70,527,451
Other Services: Number of Users	22,768		24,309		24,742		25,051		25,135
Other Services: Avg Medicaid Paid per User	$2,760		$2,844		$2,832		$2,814		$2,806
Transportation: Total Medicaid Paid (MAX TOS = 26)	$18,460,144		$20,130,499		$20,532,298		$20,822,140		$20,901,009
Transportation: Number of Users	15,758		17,054		17,395		17,566		17,650
Transportation: Avg Medicaid Paid per User	$1,171		$1,180		$1,180		$1,185		$1,184
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$67,008,235		$70,884,228		$71,119,111		$71,220,425		$71,876,737
Personal Care Services: Number of Users	6,710		6,857		6,882		6,905		6,970
Personal Care Services: Avg Medicaid Paid per User	$9,986		$10,337		$10,334		$10,314		$10,312
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$12,578,744		$13,456,866		$13,517,160		$13,541,694		$13,584,918
Targeted Case Management: Number of Users	11,772		12,119		12,155		12,162		12,191
Targeted Case Management: Avg Medicaid Paid per User	$1,069		$1,110		$1,112		$1,113		$1,114
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$3,265,298	X	$3,864,964		$4,136,227		$4,173,502		$4,175,651
Rehabilitation Services: Number of Users	7,672		8,273		8,643		8,670		8,695
Rehabilitation Services: Avg Medicaid Paid per User	$426		$467		$479		$481		$480
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$12,538,302		$14,476,487		$14,840,889		$14,978,029		$15,002,418
PT/OT/Speech/Hearing: Number of Users	10,291		11,450		11,717		11,828		11,879
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,218		$1,264		$1,267		$1,266		$1,263
Hospice: Total Medicaid Paid (MAX TOS = 35)	$4,654,046	X	$5,712,272		$6,119,079		$6,223,114		$6,223,734
Hospice: Number of Users	330	X	397		425		439		440
Hospice: Avg Medicaid Paid per User	$14,103		$14,389		$14,398		$14,176		$14,145
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$14,513,813		$16,700,082		$17,332,120		$17,610,205		$17,758,519
Durable Medical Equipment: Number of Users	41,434		44,498		45,031		45,327		45,482
Durable Medical Equipment: Avg Medicaid Paid per User	$350		$375		$385		$389		$390
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$71,426,043		$75,093,306		$75,196,485		$75,220,785		$75,500,039
Residential Care: Number of Users	5,206		5,363		5,380		5,383		5,406
Residential Care: Avg Medicaid Paid per User	$13,720		$14,002		$13,977		$13,974		$13,966
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$139,379,443		$148,555,794		$149,262,250		$149,690,189		$150,163,767
Psych Services: Number of Users	28,997		30,632		31,008		31,154		31,257
Psych Services: Avg Medicaid Paid per User	$4,807		$4,850		$4,814		$4,805		$4,804
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$1,751,668		$1,821,318		$1,842,024		$1,843,267		$1,843,546
Adult Day Care: Number of Users	662		681		684		684		685
Adult Day Care: Avg Medicaid Paid per User	$2,646		$2,674		$2,693		$2,695		$2,691
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE									

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Inpatient Hospital (MAX TOS = 01)	$734		$817		$850		$860		$862
Aged	$350		$395		$401		$409		$409
Disabled	$1,751		$1,929		$2,056		$2,099		$2,110
Child	$352		$399		$412		$413		$413
Adult	$1,655		$1,801		$1,825		$1,836		$1,837
ILTC (MAX TOS = 02,04,05,07)	$1,050		$1,109		$1,109		$1,111		$1,114
Aged	$10,517		$11,103		$11,183		$11,207		$11,191
Disabled	$2,840		$3,022		$2,988		$2,990		$2,986
Child	$38		$44		$44		$45		$45
Adult	$43		$46		$47		$48		$48
Drugs (MAX TOS = 16)	$507		$507		$506		$506		$511
Aged	$151		$151		$150		$151		$152
Disabled	$2,141		$2,159		$2,152		$2,152		$2,172
Child	$168		$167		$167		$167		$167
Adult	$442		$428		$425		$424		$425
All Other Services	$2,827		$3,012		$3,047		$3,063		$3,072
Aged	$5,625		$5,976		$6,031		$6,048		$6,061
Disabled	$10,598		$11,317		$11,399		$11,435		$11,446
Child	$986		$1,057		$1,072		$1,079		$1,079
Adult	$1,751		$1,882		$1,922		$1,938		$1,939
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Enrollees with IP Claims (MAX TOS = 01)	9.84		10.89		11.08		11.15		11.16
Aged	16.78		18.64		18.90		19.04		19.12
Disabled	11.91		13.10		13.34		13.43		13.49
Child	4.90		5.53		5.66		5.70		5.70
Adult	30.04		32.17		32.40		32.55		32.54
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	2.87		2.99		3.02		3.04		3.04
Aged	29.22		30.21		30.59		30.65		30.59
Disabled	5.96		6.25		6.33		6.36		6.38
Child	0.38		0.42		0.43		0.43		0.43
Adult	0.62		0.67		0.68		0.68		0.68
% FFS Enrollees with Drug Claims (MAX TOS = 16)	57.07		56.33		56.21		56.18		56.20
Aged	32.07		32.06		32.08		32.10		32.18
Disabled	68.11		67.57		67.29		67.20		67.28
Child	54.68		54.05		53.96		53.95		53.95
Adult	66.96		64.87		64.54		64.52		64.52
% FFS Enrollees with All Other Claims	79.99		81.13		81.49		81.60		81.62
Aged	86.86		87.85		88.15		88.31		88.36
Disabled	92.04		92.35		92.44		92.46		92.49
Child	76.40		77.71		78.10		78.21		78.21
Adult	81.10		82.37		82.89		83.07		83.08
Avg # IP Days per FFS User	4		4		4		4		4
Aged	0		0		0		0		0
Disabled	5		5		5		5		5

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Child	5		5		5		5		5
Adult	3		3		3		3		3
Avg # ILTC Days per FFS User	188		189		187		187		187
Aged	235		238		237		238		238
Disabled	169		170		169		168		167
Child	13		14		14		14		14
Adult	7		7		7		7		7
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	1		0		0		0		0
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	14		13		14		15		15
Inpatient Hospital (MAX TOS = 01) > $500,000	7	X	7	X	8		9		9
ILTC (MAX TOS = 02,04,05,07) > $200,000	91		100		99		99		99
Drugs (MAX TOS = 16) > $200,000	4		4		4		5		5
All Other Services > $200,000	5		6		6		6		6
Maximum FFS Medicaid Paid	$2,088,608	X	$960,695		$960,695		$960,695		$960,695
Inpatient Hospital (MAX TOS = 01)	$1,948,649	X	$798,115		$895,017		$895,017		$895,017
ILTC (MAX TOS = 02,04,05,07)	$356,433	X	$447,984		$447,984		$447,984		$447,984
Drugs (MAX TOS = 16)	$523,655		$523,655		$523,655		$523,655		$523,655
All Other Services	$958,710		$960,695		$960,695		$960,695		$960,695
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$2,331,432		$2,556,528		$2,625,339		$2,649,546		$2,651,556
FP: Number of Users	11,173		12,174		12,313		12,357		12,367
FP: Avg Medicaid Paid per User	$209		$210		$213		$214		$214
RHC: Total Medicaid Paid (PGM TYPE = 3)	$6,970,578		$7,451,083		$7,537,597		$7,556,958		$7,563,089
RHC: Number of Users	24,946		26,068		26,311		26,368		26,380
RHC: Avg Medicaid Paid per User	$279		$286		$286		$287		$287
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$7,282,930		$7,955,895		$8,303,053		$8,332,870		$8,445,478
FQHC: Number of Users	17,220		18,398		19,097		19,166		19,318
FQHC: Avg Medicaid Paid per User	$423		$432		$435		$435		$437
IHS: Total Medicaid Paid (PGM TYPE = 5)	$1,815,648		$1,948,211		$1,971,089		$1,982,706		$1,985,542
IHS: Number of Users	1,921		1,990		2,018		2,024		2,025
IHS: Avg Medicaid Paid per User	$945		$979		$977		$980		$981
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$140,167,913		$148,413,841		$148,741,725		$148,951,825		$149,618,927
Section 1915(c) Waiver: Number of Users	10,131		10,355		10,379		10,381		10,457
Section 1915(c) Waiver: Avg Medicaid Paid per User	$13,836		$14,333		$14,331		$14,349		$14,308
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$179,448,727		$190,403,870		$191,080,566		$191,412,623		$192,409,019
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	14,260		14,962		15,137		15,203		15,306
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	$12,584		$12,726		$12,623		$12,590		$12,571
Aged	$9,640		$9,801		$9,742		$9,733		$9,724
Disabled	$14,981		$15,204		$15,081		$15,042		$15,012
Child	$3,410		$3,229		$3,148		$3,096		$3,096
Adult	$2,419		$2,297		$2,261		$2,223		$2,223
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	6.65		6.82		6.88		6.90		6.94

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Aged	44.04		45.16		45.47		45.53		45.67
Disabled	25.61		26.34		26.51		26.57		26.63
Child	0.32		0.36		0.37		0.38		0.38
Adult	0.33		0.40		0.40		0.42		0.42
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$140,167,913		$148,413,841		$148,741,725		$148,951,825		$149,618,927
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	10,131		10,355		10,379		10,381		10,457
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$13,836		$14,333		$14,331		$14,349		$14,308
Aged	$8,975		$9,289		$9,285		$9,289		$9,271
Disabled	$17,686		$18,375		$18,379		$18,407		$18,352
Child	$10,501		$11,177		$11,177		$11,177		$11,177
Adult	$4,648		$4,417		$4,426		$4,426		$4,426
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	4.72		4.72		4.71		4.71		4.74
Aged	37.75		38.13		38.17		38.16		38.28
Disabled	17.03		17.05		16.98		16.95		16.99
Child	0.00		0.00		0.00		0.00		0.00
Adult	0.03		0.03		0.03		0.03		0.03

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All IP Claims									
Total Number of Claims	67,486		76,176		77,782		78,083		78,083
% Encounter Claims	8.81		8.57		8.54		8.54		8.54
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	61,542		69,650		71,143		71,414		71,414
% Crossover	26.41		27.28		27.44		27.58		27.58
% Adjusted Claims	3.44	X	16.89		16.80		16.92		16.92
% Standard Adjustments	96.18		98.48		98.21		98.08		98.08
Avg Medicaid Paid, Adjusted Claims (Include $0)	$7,184	X	$5,278		$5,275		$5,304		$5,304
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	71	X	528	X	753		797		797
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$7,506	X	$4,387		$4,461		$4,819		$4,819
# Claims with > $1 Million Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	45,287		50,649		51,624		51,721		51,721
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$4,718		$4,786		$4,802		$4,821		$4,821
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	$1,236		$1,258		$1,258		$1,258		$1,258
% Claims with TPL	1.67	X	2.09		2.27		2.40		2.40
Avg TPL Paid for Claims with TPL	$3,346		$3,539		$3,606		$3,762		$3,762
% Claims with UB-92 Accommodation Codes	99.86		99.87		99.87		99.86		99.86
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.11		1.11		1.11		1.11		1.11
% Claims with UB-92 Ancillary Codes	99.96		99.96		99.96		99.96		99.96
Avg # of UB-92 Ancillary Codes (> 0 Codes)	8.39		8.38		8.39		8.41		8.41
Avg Length of Stay	3.82		3.81		3.82		3.84		3.84
Avg Covered Days (> 0 Days)	3.82		3.81		3.82		3.84		3.84
% Begin Date = Admission Date	99.79		99.78		99.77		99.76		99.76
% IP Claims (MAX TOS = 01)	100.00		100.00		100.00		100.00		100.00
% Family Planning Claims (PGM TYPE = 2)	0.00		0.00		0.00		0.00		0.00
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	4.37		4.34		4.35		4.36		4.36
% Primary Diagnosis Code Claims with Length = 3	5.05		4.95		4.95		4.97		4.97
% Primary Diagnosis Code Claims with Length = 4	16.23		15.99		16.02		16.04		16.04
% Primary Diagnosis Code Claims with Length = 5	78.72		79.05		79.03		78.99		78.99
% Claims with a Procedure Code	62.76		62.69		62.66		62.67		62.67
Avg # of Procedure Codes (> 0 Codes)	1.95		1.97		1.98		1.98		1.98
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	99.73		99.71		99.72		99.71		99.71
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	99.99		99.98		99.98		99.98		99.98
% Claims with Diagnosis Related Group	99.70		99.61		99.58		99.52		99.52

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% Claims Maternal Delivery Indicator	27.49		27.24		27.13		27.15		27.15
% Claims Newborn Delivery Indicator (Only for Separate Infant Delivery Claims Using Mother's ID)	28.99		29.95		29.91		29.77		29.77
PATIENT STATUS									
% Home	83.30		83.00		82.99		82.94		82.94
% Transferred	11.76		11.76		11.77		11.81		11.81
% Still a Patient	3.26		3.57		3.54		3.54		3.54
% Died	0.48		0.50		0.53		0.54		0.54
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	16,255		19,001		19,519		19,693		19,693
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,087		$1,133		$1,156		$1,159		$1,159
% Claims with TPL	0.25	X	0.29	X	0.35		0.37		0.37
Avg TPL Paid for Claims with TPL	$539		$541		$545		$552		$552
% Claims with UB-92 Accommodation Codes	77.55		74.86		73.07		72.45		72.45
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.19		1.19		1.19		1.19		1.19
% Claims with UB-92 Ancillary Codes	78.51		75.91		74.09		73.46		73.46
Avg # of UB-92 Ancillary Codes (> 0 Codes)	11.55		11.51		11.51		11.51		11.51
Avg Length of Stay	5.12		5.22		5.29		5.32		5.32
% Begin Date = Admission Date	99.66		99.65		99.66		99.69		99.69
% IP Claims (MAX TOS = 01)	100.00		100.00		100.00		100.00		100.00
% Claims with Primary Diagnosis Code	78.52		75.92		74.11		73.49		73.49
Avg # of Diagnosis Codes (> 0 Codes)	7.68		7.68		7.68		7.68		7.68
% Primary Diagnosis Code Claims with Length = 3	8.34		8.32		8.29		8.27		8.27
% Primary Diagnosis Code Claims with Length = 4	36.05		36.36		36.41		36.45		36.45
% Primary Diagnosis Code Claims with Length = 5	55.61		55.32		55.30		55.28		55.28
% Claims with a Procedure Code	0.39	X	0.45		0.53		0.53		0.53
Avg # of Procedure Codes (> 0 Codes)	2.56		2.98		2.97		2.93		2.93
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	96.88		94.12		95.19		95.19		95.19
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.38	X	0.46		0.51		0.51		0.51

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All LT Claims									
Total Number of Claims	168,515		185,545		186,082		186,316		186,316
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	168,515		185,545		186,082		186,316		186,316
% Crossover	0.05	X	0.05		0.06		0.06		0.06
% Adjusted Claims	11.83	X	12.83	X	13.42	X	44.29		44.29
% Standard Adjustments	96.91		96.68		96.58		98.78		98.78
Avg Medicaid Paid, Adjusted Claims (Include $0)	$6,227	X	$6,308	X	$6,182	X	$3,887		$3,887
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	0	X	107	X	191		201		201
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	Div by 0		$2,669		$2,692		$2,717		$2,717
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	168,435		185,444		185,973		186,202		186,202
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
NF (MAX TOS = 07)	$103		$104		$104		$105		$105
ICF/MR (MAX TOS = 05)	$379		$381		$381		$381		$381
MH Aged (MAX TOS = 02)	$927		$940		$938		$938		$938
IP Psych, Age < 21 (MAX TOS = 04)	$184		$185		$185		$184		$184
TYPE OF SERVICE									
% NF (MAX TOS = 07)	82.89		82.94		82.96		82.98		82.98
% NF claims with NF Covered Days	99.79		99.77		99.76		99.75		99.75
Avg days for NF claims with Covered Days	29.21		29.19		29.16		29.14		29.14
% ICF/MR (MAX TOS = 05)	13.96		13.86		13.82		13.80		13.80
% ICF/MR claims with ICF/MR Covered Days	99.97		99.96		99.96		99.96		99.96
Avg days for ICF/MR claims with Covered Days	29.75		29.74		29.73		29.73		29.73
% MH Aged (MAX TOS = 02)	0.12		0.12		0.12		0.12		0.12
% MH Aged claims with MH Aged Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for MH Aged claims with Covered Days	15.01		15.02		15.14		15.22		15.22
% IP Psych, Age < 21 (MAX TOS = 04)	3.03		3.08		3.10		3.10		3.10
% IP Psych, Age < 21 Claims with IP Psych Covered Days	99.98		99.98		99.97		99.95		99.95
Avg days for IP Psych, Age < 21 Claims with Covered Days	26.71		26.69		26.68		26.67		26.67
LEAVE DAYS									
% Claims with Leave Days	7.27		7.55		7.62		7.69		7.69
ADMISSION DATE									
% Claims with Admission Date	88.06		88.19		88.21		88.20		88.20
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	87.87		87.99		87.98		87.97		87.97
% Primary Diagnosis Code Claims with Length = 3	13.75		13.74		13.74		13.75		13.75

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% Primary Diagnosis Code Claims with Length = 4	38.70		38.61		38.60		38.60		38.60
% Primary Diagnosis Code Claims with Length = 5	47.56		47.65		47.66		47.66		47.66
PATIENT STATUS									
% Claims with Patient Status	99.97		99.97		99.97		99.97		99.97
% Home	0.82		0.84		0.85		0.86		0.86
% Still a Patient	97.72		97.66		97.62		97.60		97.60
% Died	0.65		0.67		0.68		0.68		0.68
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	80	X	101		109		114		114
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,709		$1,775		$1,758		$1,718		$1,718
TYPE OF SERVICE									
% NF (MAX TOS = 07)	92.50		92.08		92.66		92.98		92.98
% ICF/MR (MAX TOS = 05)	0.00		0.00		0.00		0.00		0.00
% MH Aged (MAX TOS = 02)	5.00		5.94		5.50		5.26		5.26
% IP Psych, Age < 21 (MAX TOS = 04)	2.50	X	1.98		1.83		1.75		1.75
ADMISSION DATE									
% Claims with Admission Date	80.00		78.22		75.23		73.68		73.68
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	80.00		78.22		75.23		73.68		73.68
% Primary Diagnosis Code Claims with Length = 3	0.00		0.00		0.00		0.00		0.00
% Primary Diagnosis Code Claims with Length = 4	17.19		16.46		18.29		17.86		17.86
% Primary Diagnosis Code Claims with Length = 5	82.81		83.54		81.71		82.14		82.14
PATIENT STATUS									
% Claims with Patient Status	98.75		99.01		99.08		99.12		99.12
% Home	11.25		11.88		11.93		11.40		11.40
% Still a Patient	30.00		29.70		33.94		35.96		35.96
% Died	1.25	X	1.98		1.83		1.75		1.75

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All OT Claims									
Total Number of Claims	17,093,466		18,551,244		18,750,970		18,803,948		18,803,948
% Encounter Claims	4.04		4.05		4.05		4.05		4.05
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
% Capitation Claims **	28.87		27.51		27.21		27.14		27.14
Total FFS Claims Excluding Capitation Payments	11,468,019		12,697,446		12,888,847		12,939,531		12,939,531
% Crossover	24.20		25.04		25.06		25.10		25.10
% Adjusted Claims	2.31	X	3.27	X	4.11		5.09		5.09
% Standard Adjustments	67.10		70.82		73.90		68.59		68.59
Avg Medicaid Paid, Adjusted Claims (Include $0)	$205		$196		$210		$212		$212
% Claims with HMO Capitation Payment	0.33		0.30		0.30		0.30		0.30
% Claims with PHP Capitation Payment	21.48		19.99		19.78		19.72		19.72
% Claims with PCCM Capitation Payment	8.28		8.37		8.28		8.26		8.26
Avg Medicaid Paid per HMO Capitation Claim	$156		$157		$157		$157		$157
Avg Medicaid Paid per PHP Capitation Claim	$32		$32		$32		$32		$32
Avg Medicaid Paid per PCCM Capitation Claim	$2		$2		$2		$2		$2
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	1,545	X	11,896	X	19,408		22,091		22,091
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$90		$79		$78		$78		$78
# Claims with > $200,000 Paid	0		0		0		0		0
# Encounter Claims	690,616		751,086		759,431		761,860		761,860
% Encounter Claims for HMO or PACE	12.51		12.28		12.22		12.20		12.20
% Encounter Claims for PHP	86.75		86.97		87.02		87.04		87.04
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	8,693,046		9,517,550		9,659,513		9,691,508		9,691,508
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
% Claims with Span Bill	20.08		20.76		20.77		20.74		20.74
% Outpatient Claims with Span Bill	27.50		27.96		28.14		28.13		28.13
% Home Health Claims with Span Bill	95.03		94.81		94.82		94.81		94.81
% Other Claims with Span Bill	15.44		15.94		15.92		15.90		15.90
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	88.67		88.77		88.75		88.74		88.74
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	89.69		89.79		89.79		89.79		89.79
% Claims with Servicing Provider ID = Billing Provider ID	30.67		30.64		30.59		30.62		30.62
PLACE OF SERVICE									
% Claims with Place of Service	94.99		94.80		94.84		94.85		94.85
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	41.55		40.62		40.48		40.47		40.47
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	12.76		13.22		13.19		13.19		13.19
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	3.43		3.62		3.68		3.70		3.70
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	0.46		0.47		0.47		0.47		0.47
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	0.01	X	0.01		0.01		0.01		0.01
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	0.02		0.02		0.02		0.02		0.02
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	3.04		3.08		3.10		3.10		3.10

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% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	28.77		28.67		28.67		28.61		28.61
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	5.01		5.20		5.16		5.15		5.15
THIRD-PARTY LIABILITY									
% Claims with TPL	0.86	X	1.01		1.06		1.12		1.12
Avg TPL Paid for Claims with TPL	$81		$83		$86		$87		$87
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE									
Physician Services (MAX TOS = 08)	18.63		18.53		18.55		18.56		18.56
Dental Services (MAX TOS = 09)	10.16		9.69		9.60		9.59		9.59
Other Practitioner Services (MAX TOS = 10)	2.61		2.59		2.59		2.59		2.59
Outpatient Services (MAX TOS = 11)	11.39		11.37		11.35		11.31		11.31
Clinic Services (MAX TOS = 12)	5.59		5.68		5.71		5.74		5.74
Home Health Services (MAX TOS = 13)	4.10		4.39		4.39		4.39		4.39
Lab/Xray Services (MAX TOS = 15)	23.05		22.88		22.94		22.96		22.96
Drugs (MAX TOS = 16)	0.67		0.67		0.67		0.67		0.67
Other Services (MAX TOS = 19)	7.27		7.47		7.45		7.44		7.44
Durable Medical Equipment (MAX TOS = 51)	7.14		7.13		7.13		7.13		7.13
Transportation Services (MAX TOS = 26)	0.33		0.36		0.38		0.38		0.38
Sterilizations (MAX TOS = 24)	0.00		0.00		0.00		0.00		0.00
Abortions (MAX TOS = 25)	0.00		0.00		0.00		0.00		0.00
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00
Targeted Case Management (MAX TOS = 31)	1.36		1.40		1.39		1.39		1.39
Rehabilitation Services (MAX TOS = 33)	0.96		0.97		0.98		0.98		0.98
PT/OT/Hearing/Speech Services (MAX TOS = 34)	0.43		0.43		0.44		0.44		0.44
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Nurse Midwife Services (MAX TOS = 36)	0.06		0.06		0.06		0.06		0.06
Nurse Practitioner Services (MAX TOS = 37)	1.00		1.01		1.02		1.03		1.03
Private Nursing Services (MAX TOS = 38)	0.00		0.00		0.00		0.00		0.00
Religious Non-Medical Services (MAX TOS = 39)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	1.66		1.68		1.66		1.65		1.65
Psychiatric Services (MAX TOS = 53)	2.85		2.95		2.96		2.96		2.96
Adult Day Care (MAX TOS = 54)	0.72		0.73		0.72		0.72		0.72
Unknown Services (MAX TOS = 99)	0.02		0.03		0.03		0.03		0.03
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
Total	$119		$122		$121		$121		$121
Physician Services (MAX TOS = 08)	$79		$81		$81		$81		$81
Dental Services (MAX TOS = 09)	$48		$48		$48		$48		$48
Other Practitioner Services (MAX TOS = 10)	$51		$51		$51		$51		$51
Outpatient Services (MAX TOS = 11)	$86		$86		$86		$86		$86
Clinic Services (MAX TOS = 12)	$83		$81		$81		$81		$81
Home Health Services (MAX TOS = 13)	$248		$250		$250		$250		$250
Lab/Xray Services (MAX TOS = 15)	$38		$38		$38		$38		$38
Drugs (MAX TOS = 16)	$22		$23		$23		$23		$23
Other Services (MAX TOS = 19)	$266		$267		$267		$267		$267
Durable Medical Equipment (MAX TOS = 51)	$79		$81		$82		$82		$82

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Transportation Services (MAX TOS = 26)	$68		$68		$68		$68		$68
Personal Care Services (MAX TOS = 30)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management (MAX TOS = 31)	$259		$259		$260		$260		$260
Rehabilitation Services (MAX TOS = 33)	$69		$69		$68		$68		$68
PT/OT/Hearing/Speech Services (MAX TOS = 34)	$29		$30		$30		$30		$30
Hospice Services (MAX TOS = 35)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Residential Care Services (MAX TOS = 52)	$1,552		$1,544		$1,543		$1,542		$1,542
Psychiatric Services (MAX TOS = 53)	$209		$217		$217		$220		$220
Adult Day Care (MAX TOS = 54)	$434		$435		$436		$436		$436
PERCENT OF CLAIMS BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	3.02		2.98		2.99		2.99		2.99
Rural Health Clinic (PGM TYPE = 3)	1.19		1.18		1.18		1.18		1.18
Federally Qualified Health Center (PGM TYPE = 4)	1.31		1.29		1.28		1.28		1.28
Indian Health Services (PGM TYPE = 5)	0.00		0.00		0.00		0.00		0.00
Home and Community Based Waiver (PGM TYPE = 6,7)	7.31		7.47		7.41		7.39		7.39
AVERAGE EXPENDITURES BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	$54		$54		$54		$54		$54
Rural Health Clinic (PGM TYPE = 3)	$101		$101		$101		$101		$101
Federally Qualified Health Center (PGM TYPE = 4)	$146		$146		$146		$146		$146
Indian Health Services (PGM TYPE = 5)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Home and Community Based Waiver (PGM TYPE = 6,7)	$584		$575		$573		$573		$573
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	88.08		88.52		88.60		88.62		88.62
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
% Primary Diagnosis Claims with Secondary Diagnosis Code	36.97		37.06		37.07		37.03		37.03
% Primary Diagnosis Code Claims with Length = 3	4.09		4.09		4.08		4.08		4.08
% Primary Diagnosis Code Claims with Length = 4	46.45		46.24		46.29		46.31		46.31
% Primary Diagnosis Code Claims with Length = 5	49.46		49.67		49.63		49.61		49.61
% Claims with Procedure Code	100.00		100.00		100.00		100.00		100.00
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	100.00		100.00		100.00		100.00		100.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	100.00		100.00		100.00		100.00		100.00
% Other Claims with Procedure Code	100.00		100.00		100.00		100.00		100.00
% Claims with Procedure Code with CPT-4 Indicator	60.13		59.91		60.00		60.00		60.00
% Claims with Procedure Code with HCPCS (II & III) Indicator	33.09		33.06		32.97		32.98		32.98
% with Procedure Code with Other National Indicator	0.00		0.00		0.00		0.00		0.00
% with Procedure Code with State-Specific Indicator	6.77		7.03		7.03		7.02		7.02
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	100.00		100.00		100.00		100.00		100.00
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	100.00		100.00		100.00		100.00		100.00
PHYSICIAN SPECIALTY									
% Physician Claims with Physician Specialty	99.88		99.88		99.88		99.88		99.88
PERCENT OF CLAIMS BY CLTC CODE									

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Not a CLTC Claim (CLTC FLAG = 00)	82.50		81.98		82.04		82.06		82.06
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	10.18		10.55		10.55		10.55		10.55
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	0.27		0.28		0.27		0.27		0.27
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	4.10		4.39		4.39		4.39		4.39
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	0.74		0.75		0.76		0.75		0.75
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	1.28		1.32		1.31		1.31		1.31
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	0.16		0.18		0.18		0.18		0.18
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	3.63		3.64		3.64		3.65		3.65
CLTC Waiver Claims (CLTC FLAG = 30-40)	7.31		7.47		7.41		7.39		7.39
CLTC Other Waiver (CLTC FLAG = 30)	5.05		5.18		5.14		5.13		5.13
CLTC Waiver Personal Care (CLTC FLAG = 31)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	0.45		0.45		0.45		0.44		0.44
CLTC Waiver Home Health (CLTC FLAG = 34)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Residential Care (CLTC FLAG = 35)	1.66		1.68		1.66		1.65		1.65
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Transportation (CLTC FLAG = 38)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Hospice (CLTC FLAG = 39)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	0.16		0.16		0.16		0.16		0.16
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	2,774,973		3,179,896		3,229,334		3,248,023		3,248,023
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$21		$21		$22		$22		$22
% Claims with Span Bill	17.42		17.97		17.94		17.91		17.91
% Outpatient Claims with Span Bill	30.36		31.77		31.80		31.83		31.83
% Home Health Claims with Span Bill	22.59		22.67		22.78		22.81		22.81
% Other Claims with Span Bill	14.96		15.28		15.24		15.19		15.19
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)									
Physician Services (MAX TOS = 08)	28.10		27.83		27.87		27.91		27.91
Other Practitioner Services (MAX TOS = 10)	4.70		4.64		4.64		4.65		4.65
Outpatient Services (MAX TOS = 11)	15.18		15.59		15.57		15.57		15.57
Clinic Services (MAX TOS = 12)	1.09		1.10		1.13		1.14		1.14
Home Health Services (MAX TOS = 13)	1.66		1.63		1.62		1.61		1.61
Lab/Xray Services (MAX TOS = 15)	24.05		23.93		23.79		23.73		23.73
Other Services (MAX TOS = 19)	8.02		8.22		8.25		8.20		8.20
Durable Medical Equipment (MAX TOS = 51)	9.76		9.66		9.71		9.76		9.76
Transportation Services (MAX TOS = 26)	1.10		1.11		1.12		1.12		1.12
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison OT Validation Table
State: IA

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	0.09		0.09		0.09		0.09		0.09
PT/OT/Hearing/Speech Services (MAX TOS = 34)	0.62		0.62		0.62		0.62		0.62
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.00		0.00		0.00		0.00		0.00
Psychiatric Services (MAX TOS = 53)	5.05		4.99		4.98		4.98		4.98
Adult Day Care (MAX TOS = 54)	0.00		0.00		0.00		0.00		0.00
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	93.55		92.59		91.93		91.68		91.68
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	91.99		90.67		89.96		89.70		89.70
% Primary Diagnosis Claims with Secondary Diagnosis Code	52.25		52.78		52.80		52.75		52.75
% Primary Diagnosis Code Claims with Length = 3	6.24		6.23		6.23		6.21		6.21
% Primary Diagnosis Code Claims with Length = 4	44.25		44.40		44.40		44.37		44.37
% Primary Diagnosis Code Claims with Length = 5	49.51		49.37		49.38		49.42		49.42
% Claims with Procedure Code	59.32		58.76		58.93		59.03		59.03
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Other Claims with Procedure Code	71.33		70.99		71.16		71.28		71.28
% Claims with Procedure Code with CPT-4 Indicator	79.58		79.49		79.30		79.20		79.20
% Claims with Procedure Code with HCPCS (II & III) Indicator	20.42		20.51		20.70		20.80		20.80
% with Procedure Code with Other Code Indicator	0.00	X	0.00	X	0.00		0.00		0.00
PERCENT OF CLAIMS BY CLTC CODE									
Not a CLTC Claim (CLTC FLAG = 00)	87.40		87.53		87.49		87.44		87.44
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	12.60		12.47		12.51		12.56		12.56
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	1.66		1.63		1.62		1.61		1.61
CLTC Waiver Claims (CLTC FLAG = 30-40)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison RX Validation Table
State: IA

Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
All RX Claims									
Total Number of Claims	3,619,643		3,693,714		3,684,606		3,688,757		3,688,757
% Encounter Claims	0.00		0.00		0.00		0.00		0.00
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	3,619,643		3,693,714		3,684,606		3,688,757		3,688,757
% Adjusted Claims	5.00		5.74		6.09		6.15		6.15
% Standard Adjustments	99.79		99.73		99.76		99.75		99.75
Avg Medicaid Paid, Adjusted Claims (Include $0)	$76		$71		$68		$68		$68
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	23	X	679	X	1,285		1,569		1,569
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	21.35	X	36.66		32.46		34.39		34.39
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Claims (Type of Claim = 1)									
Total Number of Claims	3,619,643		3,693,714		3,684,606		3,688,757		3,688,757
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$63		$63		$62		$62		$62
% Claims with TPL	3.77	X	4.51		4.88		4.95		4.95
Avg TPL Paid for Claims with TPL	$93		$92		$90		$90		$90
% Family Planning Claims (PGM TYPE = 2)	1.11		1.13		1.13		1.13		1.13
% Drug Claims (MAX TOS = 16)	100.00		100.00		100.00		100.00		100.00
% Durable Medical Equipment Claims (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Prescribing Physician	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Date Prescribed	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Quantity	99.21		99.24		99.24		99.24		99.24
% Drug Claims with Days Supply	100.00		100.00		100.00		100.00		100.00
DRUG CLASSIFICATION									
% Claims with Medispan	99.69		99.69		99.69		99.69		99.69
% Claims with Generic Therapeutic Class	99.99		99.99		99.99		99.99		99.99
% Claims with Specific Therapeutic Class	99.99		99.99		99.99		99.99		99.99
NDC CONFIGURATION INDICATOR									
% Prescription (NDC FMT IND = 0-3)	69.22		69.24		69.26		69.27		69.27
% Products (NDC FMT IND = 4-6)	30.77		30.76		30.74		30.72		30.72
% Health Related Item (NDC FMT IND = 7)	0.00		0.00		0.00		0.00		0.00
% Claims with Clinical Formulation Identifier	99.99		99.99		99.99		99.99		99.99
% Claims with Ingredient List Identifier	99.99		99.99		99.99		99.99		99.99
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	99.99		99.99		99.99		99.99		99.99
% Claims with Over-the-Counter Drug Class	10.80		10.87		10.90		10.94		10.94
% Claims with Prescription Drug Class	89.20		89.13		89.09		89.06		89.06
% Claims with Multiple Sources	66.36		66.43		66.55		66.57		66.57
% Claims with Single Source (No Generic)	25.08		25.03		24.93		24.91		24.91

2008 BETA MAX Comparison PS Validation Table
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All Records									
Total Number of Records	497,019		498,677		499,270		499,396		499,396
Total Medicaid Paid	$2,395,259,669		$2,634,931,767		$2,657,511,988		$2,666,685,874		$2,666,685,874
% with No Services (RCPNT IND = 0)	13.70		11.72		11.63		11.60		11.60
% with FFS Only Claims (RCPNT IND = 1)	13.43		13.41		13.58		13.64		13.64
% with Only Capitation Claims (RCPNT IND = 2)	5.86		6.27		6.13		6.08		6.08
% with Only Encounter Claims (RCPNT IND = 3)	0.30		0.30		0.31		0.31		0.31
% with FFS and Capitation Claims (RCPNT IND = 4)	53.92		54.97		54.95		54.95		54.95
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	0.29		0.28		0.28		0.28		0.28
% with FFS and Encounter Claims Only (RCPNT IND = 6)	0.01	X	0.01		0.01		0.01		0.01
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	12.50		13.04		13.12		13.14		13.14
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	586	X	2,244	X	2,837		2,963		2,963
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.12	X	0.45	X	0.57		0.59		0.59
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$671,728	X	$3,568,907	X	$5,431,396		$6,153,471		$6,153,471
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$1,146	X	$1,590	X	$1,914		$2,077		$2,077
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	190	X	1,388	X	2,023		2,155		2,155
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.04	X	0.28	X	0.41		0.43		0.43
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$669,602	X	$3,555,654	X	$5,419,161		$6,141,489		$6,141,489
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$3,524	X	$2,562		$2,679		$2,850		$2,850
S-CHIP ENROLLMENT									
# with ONLY S-CHIP Enrollment	0		0		0		0		0
% with ONLY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
# with ANY S-CHIP Enrollment	0		0		0		0		0
% with ANY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	0		0		0		0		0
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)									
Total Medicaid Enrollees	496,433		496,433		496,433		496,433		496,433
Total Medicaid Person-Years of Enrollment	392,692		392,692		392,692		392,692		392,692
# with Any M-CHIP Enrollment	28,003		28,003		28,003		28,003		28,003
Total Person-Years of Enrollment Any M-CHIP	13,001		13,001		13,001		13,001		13,001
Demographic Characteristics									
% Records with Valid SSN Format	97.96		97.96		97.96		97.96		97.96
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	97.90		97.90		97.90		97.90		97.90
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	0.06		0.06		0.06		0.06		0.06

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% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	0.00		0.00		0.00		0.00		0.00
# Records Without Valid SSN	10,428		10,428		10,428		10,428		10,428
% Records Without Valid SSN	2.10		2.10		2.10		2.10		2.10
% for Children Under Age 21	82.59		82.59		82.59		82.59		82.59
% for Infants Under Age 1	63.41		63.41		63.41		63.41		63.41
% Ever Aliens Eligible for Only Emergency Services	12.11		12.11		12.11		12.11		12.11
# SSNs with More Than One MSIS ID	605		605		605		605		605
% Records with Duplicated SSNs	0.24		0.24		0.24		0.24		0.24
% for Children Under Age 21	96.86		96.86		96.86		96.86		96.86
% for Infants Under Age 1	1.16		1.16		1.16		1.16		1.16
% Ever Aliens Eligible for Only Emergency Services	0.08		0.08		0.08		0.08		0.08
% with External SSN from EDB (EXT SSN SRCE = 1)	17.81		17.81		17.81		17.81		17.81
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	0.00		0.00		0.00		0.00		0.00
% with County Code	100.00		100.00		100.00		100.00		100.00
% with Valid 5 Digit Zip Code Format	100.00		100.00		100.00		100.00		100.00
% White	52.84		52.84		52.84		52.84		52.84
% Black	6.53		6.53		6.53		6.53		6.53
% Native American/Alaskan Native	0.42		0.42		0.42		0.42		0.42
% Asian	0.78		0.78		0.78		0.78		0.78
% Native Hawaiian or Other Pacific Islander	0.07		0.07		0.07		0.07		0.07
% More Than One Race	0.00		0.00		0.00		0.00		0.00
% Unknown Race	39.36		39.36		39.36		39.36		39.36
% Hispanic/Latino (Included with Race Categories Prior to 2005)	6.42		6.42		6.42		6.42		6.42
% of Hispanic/Latino with Unknown Race	100.00		100.00		100.00		100.00		100.00
% Age 0	3.88		3.88		3.88		3.88		3.88
% Age 0-20 Years	53.30		53.30		53.30		53.30		N/A
% Age > 64 Years	8.64		8.64		8.64		8.64		N/A
% with Century of Birth '18' , '19', '20'	100.00		100.00		100.00		100.00		100.00
% with Gender Code 'M' or 'F'	100.00		100.00		100.00		100.00		100.00
% Enrollees with 12 Months Enrollment	56.95		56.95		56.95		56.95		56.95
% Aged Enrollees with 12 Months Enrollment	71.11		71.11		71.11		71.11		71.11
% Disabled Enrollees with 12 Months Enrollment	84.23		84.23		84.23		84.23		84.23
% Child Enrollees with 12 Months Enrollment	56.01		56.01		56.01		56.01		56.01
% Adult Enrollees with 12 Months Enrollment	39.69		39.69		39.69		39.69		39.69
% Enrollees with MSIS Date of Death During Year	1.46		1.46		1.46		1.46		1.46
% Enrollees with SSA Date of Death During Year	0.96		0.96		0.96		0.96		0.00
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	1.59		1.59		1.59		1.59		1.57
# with MSIS Date of Death ≠ SSA Date of Death	3,774	X	3,774	X	3,774	X	3,774	X	7,615
# with MSIS Date of Death Prior to 2007	369		369		369		369		369
# with SSA Date of Death Prior to 2007	469		469		469		469		0
EDB Dual Eligibles									
Total EDB Duals (Duals Confirmed by EDB)	81,339		81,339		81,339		81,339		81,339

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Total EDB Dual Person-Years of Enrollment	72,817		72,817		72,817		72,817		72,817
% Age > 64 Years Who Are EDB Duals	97.40		97.40		97.40		97.40		97.40
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	97.61		97.61		97.61		97.61		97.61
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	51.77		51.77		51.77		51.77		51.77
% EDB Only (EDB DUAL = 50)	1.00		1.00		1.00		1.00		1.00
% EDB QMB Only (EDB DUAL = 51)	7.96		7.96		7.96		7.96		7.96
% EDB QMB Plus (EDB DUAL = 52)	48.85		48.85		48.85		48.85		48.85
% EDB SLMB Only (EDB DUAL = 53)	5.06		5.06		5.06		5.06		5.06
% EDB SLMB Plus (EDB DUAL = 54)	11.52		11.52		11.52		11.52		11.52
% EDB QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% EDB QI-1 (EDB DUAL = 56)	3.17		3.17		3.17		3.17		3.17
% EDB QI-2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% EDB Other (EDB DUAL = 58)	22.44		22.44		22.44		22.44		22.44
% EDB Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Dual Status Unknown (EDB DUAL = 98)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	83.81		83.81		83.81		83.81		83.81
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	16.19		16.19		16.19		16.19		16.19
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	958		958		958		958		958
% Non-EDB Duals Without Valid SSN	0.00		0.00		0.00		0.00		0.00
% Non-EDB Duals Who Are Children/Adults	6.05		6.05		6.05		6.05		6.05
% EDB Duals with Spanish Language	0.40		0.40		0.40		0.40		0.40
% EDB Duals with EDB Date of Death During Year	8.34		8.34		8.34		8.34		8.34
% EDB Duals with MSIS Date of Death During Year	7.71		7.71		7.71		7.71		7.71
% EDB Duals with SSA Date of Death During Year	5.08		5.08		5.08		5.08		0.00
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	8.35		8.35		8.35		8.35		8.35
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	1,114		1,114		1,114		1,114		1,114
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	2,729	X	2,729	X	2,729	X	2,729	X	6,783
% EDB Duals with Medicaid Reported HIC	98.61		98.61		98.61		98.61		98.61
% EDB Duals with Medicaid Reported HIC = Medicare HIC	98.48		98.48		98.48		98.48		98.48
Total EDB Dual Enrollees in June	76,477		76,477		76,477		76,477		76,477
JUNE MEDICARE ELIGIBILITY GROUP									
June % with Part A Medicare only	0.83		0.83		0.83		0.83		0.83
June % with Part B Medicare only	1.25		1.25		1.25		1.25		1.25
June % Part A/B Medicare	97.92		97.92		97.92		97.92		97.92
ORIGINAL REASON FOR MEDICARE ENTITLEMENT									
% Aged (MDCR ORIG REAS CD = 0)	40.13		40.13		40.13		40.13		40.13
% Disabled (MDCR ORIG REAS CD = 1)	58.76		58.76		58.76		58.76		58.76
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	0.36		0.36		0.36		0.36		0.36
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	0.75		0.75		0.75		0.75		0.75
Other Eligibility Characteristics (All Enrollees)									
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	99.96		99.96		99.96		99.96		99.96
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	0.51		0.51		0.51		0.51		0.51
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	99.17		99.17		99.17		99.17		99.17
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	90.80		90.80		90.80		90.80		90.80

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% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	99.96		99.96		99.96		99.96		99.96
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	99.95		99.95		99.95		99.95		99.95
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	90.86		90.86		90.86		90.86		90.86
Aged Total	42,304		42,304		42,304		42,304		42,304
Aged, Cash (MAX ELIG CD = 11)	5,757		5,757		5,757		5,757		5,757
Aged, Medically Needy (MAX ELIG CD = 21)	696		696		696		696		696
Aged, Poverty (MAX ELIG CD = 31)	8,542		8,542		8,542		8,542		8,542
Other Aged (MAX ELIG CD = 41)	27,309		27,309		27,309		27,309		27,309
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	74,532		74,532		74,532		74,532		74,532
Disabled, Cash (MAX ELIG CD = 12)	38,272		38,272		38,272		38,272		38,272
Disabled, Medically Needy (MAX ELIG CD = 22)	562		562		562		562		562
Disabled, Poverty (MAX ELIG CD = 32, 3A)	5,040		5,040		5,040		5,040		5,040
Other Disabled (MAX ELIG CD = 42)	30,658		30,658		30,658		30,658		30,658
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	240,159		240,159		240,159		240,159		240,159
AFDC Child, Cash (MAX ELIG CD = 14)	63,782		63,782		63,782		63,782		63,782
AFDC-U Child, Cash (MAX ELIG CD = 16)	3,168		3,168		3,168		3,168		3,168
AFDC Child, Medically Needy (MAX ELIG CD = 24)	836		836		836		836		836
Child Poverty (MAX ELIG CD = 34)	125,315		125,315		125,315		125,315		125,315
Other Child (MAX ELIG CD = 44)	31,776		31,776		31,776		31,776		31,776
Foster Care Child (MAX ELIG CD = 48)	11,619		11,619		11,619		11,619		11,619
1115 Child (MAX ELIG CD = 54)	3,663		3,663		3,663		3,663		3,663
Adult Total	139,438		139,438		139,438		139,438		139,438
AFDC Adult, Cash (MAX ELIG CD = 15)	41,319		41,319		41,319		41,319		41,319
AFDC-U Adult, Cash (MAX ELIG CD = 17)	3,191		3,191		3,191		3,191		3,191
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	4,538		4,538		4,538		4,538		4,538
Adult, Poverty (MAX ELIG CD = 35)	12,679		12,679		12,679		12,679		12,679
Other Adult (MAX ELIG CD = 45)	12,939		12,939		12,939		12,939		12,939
1115 Adult (MAX ELIG CD = 55)	64,772		64,772		64,772		64,772		64,772
Long-Term Care Enrollees									
INSTITUTIONAL STATUS									
# Enrollees with Any ILTC Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	20,378		21,169		21,265		21,304		21,304
% Enrollees with Any ILTC Claims	4.10		4.26		4.28		4.29		4.29
% Aged Enrollees with Any ILTC Claims	35.63		36.98		37.11		37.17		37.17
% Disabled Enrollees with Any ILTC Claims	6.08		6.29		6.33		6.35		6.35
% Child Enrollees with Any ILTC Claims	0.32		0.34		0.34		0.34		0.34
% Adult Enrollees with Any ILTC Claims	0.01	X	0.01	X	0.01		0.02		0.02
COMMUNITY LONG-TERM CARE STATUS									
# Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	47,351		50,350		50,818		50,927		50,927

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% Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	9.54		10.14		10.24		10.26		10.26
% Aged Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	40.22		41.81		41.97		41.98		41.98
% Disabled Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	29.66		30.67		30.76		30.79		30.79
% Child Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	3.18		3.78		3.91		3.94		3.94
% Adult Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.42	X	0.52		0.54		0.55		0.55
# Enrollees with ILTC Claims and CLTC Claims (Excludes CLTC FLAG = 16-20)	5,064		5,821		5,943		5,972		5,972
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	48,487		51,059		51,504		51,609		51,609
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT									
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	28,317		28,317		28,317		28,317		28,317
% Enrolled in Any Section 1915(c) Waiver	5.70		5.70		5.70		5.70		5.70
% Aged Enrollees in Section 1915(c) Waiver	30.25		30.25		30.25		30.25		30.25
% Disabled Enrollees in Section 1915(c) Waiver	20.33		20.33		20.33		20.33		20.33
% Child Enrollees in Section 1915(c) Waiver	0.15		0.15		0.15		0.15		0.15
% Adult Enrollees in Section 1915(c) Waiver	0.00		0.00		0.00		0.00		0.00
# Aged, EDB Dual	12,605		12,605		12,605		12,605		12,605
# Aged, Non-Dual	193		193		193		193		193
# Disabled, EDB Dual	7,510		7,510		7,510		7,510		7,510
# Disabled, Non-Dual	7,646		7,646		7,646		7,646		7,646
# Other (Child or Adult)	363		363		363		363		363
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	12,391		12,391		12,391		12,391		12,391
# Aged, EDB Dual	12,195		12,195		12,195		12,195		12,195
# Aged, Non-Dual	184		184		184		184		184
# Disabled, EDB Dual	9		9		9		9		9
# Disabled, Non-Dual	3		3		3		3		3
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	3,801		3,801		3,801		3,801		3,801
# Aged, EDB Dual	2		2		2		2		2
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	1,750		1,750		1,750		1,750		1,750
# Disabled, Non-Dual	1,986		1,986		1,986		1,986		1,986
# Other (Child or Adult)	63		63		63		63		63
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	1,224		1,224		1,224		1,224		1,224
# Aged, EDB Dual	2		2		2		2		2
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	594		594		594		594		594
# Disabled, Non-Dual	571		571		571		571		571
# Other (Child or Adult)	57		57		57		57		57

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# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	54		54		54		54		54
# Aged, EDB Dual	2		2		2		2		2
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	42		42		42		42		42
# Disabled, Non-Dual	9		9		9		9		9
# Other (Child or Adult)	1		1		1		1		1
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	10,847		10,847		10,847		10,847		10,847
# Aged, EDB Dual	404		404		404		404		404
# Aged, Non-Dual	9		9		9		9		9
# Disabled, EDB Dual	5,115		5,115		5,115		5,115		5,115
# Disabled, Non-Dual	5,077		5,077		5,077		5,077		5,077
# Other (Child or Adult)	242		242		242		242		242
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	5.12	X	3.37		3.26		3.22		3.22
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	3.50		3.72		3.73		3.72		3.72
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	0.04		0.04		0.04		0.04		0.04
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/HIOs with No Waiver claim (PGM TYPE = 6 or 7)	5.11	X	3.35		3.24		3.21		3.21

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# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	303		303		303		303		303
Other Waiver Enrollment (Enrolled Any Time During the Year)									
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	75,284		75,284		75,284		75,284		75,284
% Aged Enrollees with Any 1115 Waiver	0.29		0.29		0.29		0.29		0.29
% Disabled Enrollees with Any 1115 Waiver	1.67		1.67		1.67		1.67		1.67
% Child Enrollees with Any 1115 Waiver	2.10		2.10		2.10		2.10		2.10
% Adult Enrollees with Any 1115 Waiver	49.39		49.39		49.39		49.39		49.39
% with Any HMO/HIO Enrollment	0.29		0.29		0.29		0.29		0.29
# with Any 1915(b) Waiver (WVR TYPE = 2)	380,975		380,975		380,975		380,975		380,975
% Aged Enrollees with Any 1915(b) Waiver	2.16		2.16		2.16		2.16		2.16
% Disabled Enrollees with Any 1915(b) Waiver	92.86		92.86		92.86		92.86		92.86
% Child Enrollees with Any 1915(b) Waiver	98.07		98.07		98.07		98.07		98.07
% Adult Enrollees with Any 1915(b) Waiver	54.03		54.03		54.03		54.03		54.03
% with Any HMO/HIO Enrollment	1.94		1.94		1.94		1.94		1.94
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	0		0		0		0		0
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with 1115 HIFA Waiver (WVR TYPE = 5)	0		0		0		0		0
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	0		0		0		0		0
% Aged Enrollees with Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Other Type of Waiver (WVR TYPE = 7)	0		0		0		0		0
# with Unknown Type of Waiver (WVR TYPE = 9)	0		0		0		0		0
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	0		0		0		0		0
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	38,019		38,019		38,019		38,019		38,019
# of Waiver IDs with More than One Waiver Type	0		0		0		0		0
# of Waiver IDs with Reporting in January but Not December	0		0		0		0		0
# of Waiver IDs with Reporting in December but Not January	0		0		0		0		0
Enrollees with Restricted Benefits									
Family Planning enrollees with Restricted Benefits (RBF = 6)									
# with ONLY Family Planning Only Enrollment	27,211		27,211		27,211		27,211		27,211
# with ANY Family Planning Only Enrollment	37,019		37,019		37,019		37,019		37,019
# Person-Years of Enrollment ANY Family Planning Only Enrollment	22,631		22,631		22,631		22,631		22,631
Aliens with Restricted Benefits (RBF = 2)									
# Aliens with ONLY Restricted Benefits	1,015.00		1,015.00		1,015.00		1,015.00		1,015.00
# Aliens with ANY Restricted Benefits	1,617.00		1,617.00		1,617.00		1,617.00		1,617.00
# Person-Years of Enrollment Aliens with ANY Restricted Benefits	175.75		175.75		175.75		175.75		175.75

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EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
# EDB Duals with ONLY Restricted Benefits Enrollment	11,858		11,858		11,858		11,858		11,858
# EDB Duals with ANY Restricted Benefits Enrollment	14,642		14,642		14,642		14,642		14,642
# Person-Years of Enrollment EDB Duals with ANY Restricted Benefits	11,519		11,519		11,519		11,519		11,519
% EDB Duals with ONLY Restricted Benefits Enrollment	14.58		14.58		14.58		14.58		14.58
Prescription Drug Enrollees (RBF = X, Y, or Z)									
# with ONLY Prescription Drug Enrollment (May Have a Month or More of RBF = 3)	0		0		0		0		0
# with ANY Prescription Drug Enrollment	0		0		0		0		0
# Person-Years of ANY Prescription Drug Enrollment	0		0		0		0		0
Dual Prescription Drug Enrollees									
# with ONLY Prescription Drugs Who Are EDB Duals	0		0		0		0		0
June Eligibility Profile									
Total Enrollees in June	386,727		386,727		386,727		386,727		386,727
June % Full Scope Benefits (RBF = 1)	91.35		91.35		91.35		91.35		91.35
June % Restricted Benefits Alien (RBF = 2)	0.05		0.05		0.05		0.05		0.05
June % Restricted Benefits Dual (RBF = 3)	2.96		2.96		2.96		2.96		2.96
June % Restricted Benefits Pregnant (RBF = 4)	0.09		0.09		0.09		0.09		0.09
June % Restricted Benefits Other (RBF = 5)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Family Planning (RBF = 6)	5.55		5.55		5.55		5.55		5.55
June % Restricted Benefits Benchmark-Equivalent (RBF = 7)	0.00		0.00		0.00		0.00		0.00
June % Money Follows the Person Enrollee (RBF = 8)	0.00		0.00		0.00		0.00		0.00
June % Unknown Benefits (RBF = 9)	0.00		0.00		0.00		0.00		0.00
June % PRTF Enrollee (RBF = A)	0.00		0.00		0.00		0.00		0.00
June % Health Opportunity Account (RBF = B)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Non-Dual Enrollee (RBF = X)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Receiving Medicare Cost Sharing (RBF = Y)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Not Receiving Medicare Cost Sharing (RBF = Z)	0.00		0.00		0.00		0.00		0.00
June % Private Health Insurance (PVT INS CD = 2-4)	14.49		14.49		14.49		14.49		14.49
June Total Enrollees with TANF Flag (TANF FLAG = 2)	0.00		0.00		0.00		0.00		0.00
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	12,415		12,415		12,415		12,415		12,415
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	293		293		293		293		293
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	0		0		0		0		0
Medicaid Expenditures									
Total Medicaid Paid	$2,394,587,941		$2,631,362,860		$2,652,080,592		$2,660,532,403		$2,660,532,403
Avg Medicaid Paid per Enrollee	$4,824		$5,301		$5,342		$5,359		$5,359
25th Percentile	$188		$217		$222		$223		$223
50th Percentile (Median)	$789		$864		$874		$876		$876
75th Percentile	$2,931		$3,214		$3,251		$3,264		$3,264
95th Percentile	$24,722		$27,270		$27,471		$27,590		$27,590
99th Percentile	$65,836		$72,510		$72,945		$72,984		$72,984
Maximum Medicaid Paid	$784,847		$809,726		$809,726		$809,726		$809,726

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PERCENT OF ENROLLEES WITH ZERO EXPENDITURES									
% of Enrollees with Total Medicaid Paid = $0	13.94		12.00		11.93		11.90		11.90
Aged	16.90		15.20		15.12		15.12		15.12
Disabled	4.03	X	3.17		3.14		3.13		3.13
Child	6.93	X	4.60		4.59		4.59		4.59
Adult	30.43		28.49		28.31		28.20		28.20
NUMBER OF HIGH-COST ENROLLEES									
# of Enrollees with Total Medicaid Paid > $1,000,000	0.00		0.00		0.00		0.00		0.00
# of Enrollees with Total Medicaid Paid > $500,000	14.00	X	17.00		18.00		19.00		19.00
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$4,824		$5,301		$5,342		$5,359		$5,359
Aged	$12,634		$14,042		$14,109		$14,185		$14,185
Disabled	$16,033		$17,632		$17,750		$17,784		$17,784
Child	$1,693		$1,834		$1,847		$1,851		$1,851
Adult	$1,855		$2,028		$2,071		$2,083		$2,083
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$12,952		$14,339		$14,418		$14,469		$14,469
Aged	$12,745		$14,167		$14,234		$14,310		$14,310
Disabled	$13,570		$14,967		$15,057		$15,083		$15,083
EDB Only (EDB DUAL = 50)	$9,091		$9,864		$10,042		$9,780		$9,780
EDB QMB Only (EDB DUAL = 51)	$1,025		$1,177		$1,201		$1,209		$1,209
EDB QMB Plus (EDB DUAL = 52)	$15,204		$16,807		$16,891		$16,948		$16,948
EDB SLMB Only (EDB DUAL = 53)	$194		$210		$219		$220		$220
EDB SLMB Plus (EDB DUAL = 54)	$17,407		$19,258		$19,377		$19,427		$19,427
EDB QDWI (EDB DUAL = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QI-1 (EDB DUAL = 56)	$164		$175		$180		$182		$182
EDB QI-2 (EDB DUAL = 57)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Other (EDB DUAL = 58)	$14,846		$16,494		$16,583		$16,670		$16,670
EDB Dual Type Unknown (EDB DUAL = 59)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Dual Status Unknown (EDB DUAL = 98)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	$15,338		$16,977		$17,069		$17,129		$17,129
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	$597		$678		$694		$698		$698
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE									
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	$39,328		$42,230		$42,285		$42,400		$42,400
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	$18,680		$20,170		$20,222		$20,245		$20,245
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	$28,149		$31,171		$31,443		$31,582		$31,582
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT									
Avg Medicaid Paid per Section 1915(c) Enrollee	$21,465		$23,912		$24,096		$24,143		$24,143
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Aged (WVR TYPE = H)	$10,344		$11,823		$11,930		$11,979		$11,979
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$20,494		$23,090		$23,456		$23,517		$23,517
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$29,430		$32,800		$33,186		$33,177		$33,177

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Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	$18,752		$20,109		$20,269		$20,293		$20,293
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$33,625		$37,025		$37,211		$37,257		$37,257
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT									
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	$12,712		$13,994		$14,032		$14,042		$14,042
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Aged (WVR TYPE = H)	$4,924		$5,507		$5,529		$5,535		$5,535
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$5,638		$6,244		$6,268		$6,274		$6,274
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$14,328		$15,825		$15,865		$15,853		$15,853
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	$7,729		$8,567		$8,657		$8,659		$8,659
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$23,928		$26,225		$26,286		$26,305		$26,305
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EXPENDITURES FOR RESTRICTED BENEFIT ENROLLEES									
Expenditures for Family Planning Enrollees with Restricted Benefits (RBF = 6)									
Total Medicaid Paid for ONLY Family Planning Only Enrollees	$6,682,396		$7,199,733		$7,365,531		$7,380,030		$7,380,030
Avg Medicaid Paid per ONLY Family Planning Only Enrollee	$246		$265		$271		$271		$271
Expenditures for Aliens with Restricted Benefits (RBF = 2)									
Total Medicaid Paid for Aliens with Restricted Benefits ONLY Enrollment	$3,258,119		$3,811,269		$3,861,221		$3,874,276		$3,874,276
Avg Medicaid Paid per Alien Enrollee with Restricted Benefits ONLY	$3,210		$3,755		$3,804		$3,817		$3,817
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
Total Medicaid Paid for EDB Duals with Only Restricted Benefits Enrollment	$4,304,654		$5,054,713		$5,184,309		$5,231,329		$5,231,329
Avg Medicaid Paid per EDB Dual with Only Restricted Benefits Enrollment	$363		$426		$437		$441		$441
Expenditures for Prescription Drug Enrollees (RBF = X, Y, or Z)									
Total Medicaid Paid for Prescription Drug ONLY Enrollees (May Have a Month or More of RBF = 3)	$0		$0		$0		$0		$0
Avg Medicaid Paid per Prescription Drug ONLY Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Dual Prescription Drug Enrollees									
Total Medicaid Paid for Prescription Drug ONLY Enrollees Who Are EDB Duals	$0		$0		$0		$0		$0
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.									
Total Medicaid Enrollees	456,349		456,349		456,349		456,349		456,349
Aged Total	34,379		34,379		34,379		34,379		34,379
Disabled Total	70,561		70,561		70,561		70,561		70,561
Child Total	236,604		236,604		236,604		236,604		236,604
Adult Total	114,805		114,805		114,805		114,805		114,805
Total Medicaid Person-Years of Enrollment	363,589		363,589		363,589		363,589		363,589
Total EDB Duals	69,451		69,451		69,451		69,451		69,451

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Aged	33,401		33,401		33,401		33,401		33,401
Disabled	34,619		34,619		34,619		34,619		34,619
TOTAL MEDICAID AMOUNT PAID									
Total Medicaid Paid	$2,380,342,772		$2,615,297,145		$2,635,669,531		$2,644,046,768		$2,644,046,768
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$5,216		$5,731		$5,776		$5,794		$5,794
Aged	$15,474		$17,193		$17,273		$17,366		$17,366
Disabled	$16,907		$18,590		$18,713		$18,749		$18,749
Child	$1,713		$1,856		$1,869		$1,873		$1,873
Adult	$2,178		$2,381		$2,431		$2,446		$2,446
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$15,106		$16,720		$16,811		$16,870		$16,870
Aged	$15,688		$17,433		$17,513		$17,607		$17,607
Disabled	$15,067		$16,614		$16,714		$16,742		$16,742
Managed CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.									
% Total Enrollees in MC Anytime During Year	83.49		83.49		83.49		83.49		83.49
Total MC Enrollees	380,990		380,990		380,990		380,990		380,990
Aged	923		923		923		923		923
Disabled	69,215		69,215		69,215		69,215		69,215
Child	235,519		235,519		235,519		235,519		235,519
Adult	75,333		75,333		75,333		75,333		75,333
% of MC Enrollees in HMO/HIO (MC TYPE = 1)	1.94		1.94		1.94		1.94		N/A
% of MC Enrollees in Dental (MC TYPE = 2)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in BHO (MC TYPE = 3)	100.00		100.00		100.00		100.00		N/A
% of MC Enrollees in Prenatal (MC TYPE = 4)	0.00		0.00		0.00		0.00		Div by 0
% of MC Enrollees in LTC (MC TYPE = 5)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PACE (MC TYPE = 6)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PCCM (MC TYPE = 7)	54.94		54.94		54.94		54.94		N/A
% of MC Enrollees in Other MC (MC TYPE = 8)	0.00		0.00		0.00		0.00		N/A
% EDB Duals Ever Enrolled in HMO/HIOs	0.03		0.03		0.03		0.03		0.03
% EDB Duals in PHP Only or PHP/PCCM Only	50.65		50.65		50.65		50.65		50.65
% EDB Duals in PCCM Only	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	0.04		0.04		0.04		0.04		0.04
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	55.82		55.82		55.82		55.82		55.82
% Section 1915(c) Waiver Enrollees in PCCM Only	0.00		0.00		0.00		0.00		0.00
Total Enrollees in June	358,736		358,736		358,736		358,736		358,736
June % HMO/HIO Only (MC COMBO = 01)	0.00		0.00		0.00		0.00		0.00
June % Dental Plan Only (MC COMBO = 02)	0.00		0.00		0.00		0.00		0.00
June % BHO Only (MC COMBO = 03)	40.59		40.59		40.59		40.59		40.59
June % PCCM Only (MC COMBO = 04)	0.00		0.00		0.00		0.00		0.00
June % Other MC Only (MC COMBO = 05)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental (MC COMBO = 06)	0.00		0.00		0.00		0.00		0.00

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June % HMO/HIO & BHO (MC COMBO = 07)	1.33		1.33		1.33		1.33		1.33
June % HMO/HIO & Other MC (MC COMBO = 08)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	0.00		0.00		0.00		0.00		0.00
June % Dental & PCCM (MC COMBO = 10)	0.00		0.00		0.00		0.00		0.00
June % BHO & PCCM (MC COMBO = 11)	40.15		40.15		40.15		40.15		40.15
June % Other MC & PCCM (MC COMBO = 12)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO & PCCM (MC COMBO = 13)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO (MC COMBO = 14)	0.00		0.00		0.00		0.00		0.00
June % Other Combinations (MC COMBO = 15)	0.00		0.00		0.00		0.00		0.00
June % FFS Only (MC COMBO = 16)	17.93		17.93		17.93		17.93		17.93
June % MC Status Unknown (MC COMBO = 99)	0.00		0.00		0.00		0.00		0.00
CAPITATION CLAIMS									
Total Capitation Payments	$125,317,275		$126,791,159		$126,780,942		$126,774,612		$126,774,612
HMO/HIO	$8,415,401		$8,502,313		$8,502,313		$8,502,313		$8,502,313
PHP	$114,185,852		$115,308,962		$115,298,533		$115,292,203		$115,292,203
PCCM	$2,716,022		$2,979,884		$2,980,096		$2,980,096		$2,980,096
Ratio of Capitation Claims to Person-Month Enrollment in MC	1.38		1.42		1.42		1.42		1.42
HMO/HIO	0.94		0.95		0.95		0.95		0.95
PHP	0.98		0.99		0.99		0.99		0.99
PCCM	0.78		0.86		0.86		0.86		0.86
Avg Capitation Payment per Person-Month Enrollment in MC	$35		$35		$35		$35		$35
HMO/HIO	$147		$149		$149		$149		$149
PHP	$32		$32		$32		$32		$32
PCCM	$2		$2		$2		$2		$2
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY									
Total Capitation Payments	$115,793,306		$117,169,085		$117,158,886		$117,152,556		$117,152,556
Total Medicaid Paid	$1,720,911,018		$1,881,718,017		$1,896,583,079		$1,900,484,209		$1,900,484,209
Count of Enrollees	373,572		373,572		373,572		373,572		373,572
PERSONS ENROLLED IN PCCM ONLY									
Total Capitation Payments	$0		$0		$0		$0		$0
Count of Enrollees	0		0		0		0		0
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR									
Count of Enrollees	7,418		7,418		7,418		7,418		7,418
Aged	10		10		10		10		10
Disabled	45		45		45		45		45
Child	5,455		5,455		5,455		5,455		5,455
Adult	1,908		1,908		1,908		1,908		1,908
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	4,765		4,765		4,765		4,765		4,765
Total Capitation Payments	$9,523,969		$9,622,074		$9,622,056		$9,622,056		$9,622,056
Avg Capitation Payments	$1,284		$1,297		$1,297		$1,297		$1,297
Aged	$6,769		$6,769		$6,769		$6,769		$6,769
Disabled	$2,377		$2,387		$2,387		$2,387		$2,387
Child	$992		$1,006		$1,006		$1,006		$1,006
Adult	$2,065		$2,074		$2,074		$2,074		$2,074

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Total FFS Payments	$7,593,115		$8,168,267		$8,140,465		$8,132,671		$8,132,671
Avg FFS Payments per Enrollee	$1,024		$1,101		$1,097		$1,096		$1,096
Aged	$3,220		$3,061		$3,026		$2,886		$2,886
Disabled	$16,840		$17,307		$17,390		$17,034		$17,034
Child	$759		$819		$824		$825		$825
Adult	$1,396		$1,516		$1,485		$1,486		$1,486
Total FFS Payments by Type of Service									
IP (MAX TOS = 01)	$1,806,439		$1,904,314		$1,832,107		$1,815,251		$1,815,251
ILTC (MAX TOS = 02, 04, 05, 07)	$191,266	X	$243,512		$243,512		$243,512		$243,512
Drug (MAX TOS = 16)	$1,856,526		$1,880,773		$1,865,041		$1,863,162		$1,863,162
All Other (Excluding Capitation Payments)	$3,738,884		$4,139,668		$4,199,805		$4,210,746		$4,210,746
Average FFS Payments by Type of Service									
IP (MAX TOS = 01)	$244		$257		$247		$245		$245
ILTC (MAX TOS = 02, 04, 05, 07)	$26	X	$33		$33		$33		$33
Drug (MAX TOS = 16)	$250		$254		$251		$251		$251
All Other (Excluding Capitation Payments)	$504		$558		$566		$568		$568
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total Non-Dual FFS Enrollees	379,502		379,502		379,502		379,502		379,502
Total Non-Dual FFS Recipients	299,096		305,183		305,939		306,242		306,242
Total Non-Dual FFS Person-Years of Enrollment	295,116		295,116		295,116		295,116		295,116
Aged Total	978		978		978		978		978
Aged, Cash (MAX ELIG CD = 11)	223		223		223		223		223
Aged, Medically Needy (MAX ELIG CD = 21)	112		112		112		112		112
Aged, Poverty (MAX ELIG CD = 31)	71		71		71		71		71
Other Aged (MAX ELIG CD = 41)	572		572		572		572		572
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	35,904		35,904		35,904		35,904		35,904
Disabled, Cash (MAX ELIG CD = 12)	25,921		25,921		25,921		25,921		25,921
Disabled, Medically Needy (MAX ELIG CD = 22)	252		252		252		252		252
Disabled, Poverty (MAX ELIG CD = 32, 3A)	335		335		335		335		335
Other Disabled (MAX ELIG CD = 42)	9,396		9,396		9,396		9,396		9,396
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	231,126		231,126		231,126		231,126		231,126
AFDC Child, Cash (MAX ELIG CD = 14)	62,110		62,110		62,110		62,110		62,110
AFDC-U Child, Cash (MAX ELIG CD = 16)	3,097		3,097		3,097		3,097		3,097
AFDC Child, Medically Needy (MAX ELIG CD = 24)	824		824		824		824		824
Child Poverty (MAX ELIG CD = 34)	122,449		122,449		122,449		122,449		122,449
Other Child (MAX ELIG CD = 44)	30,883		30,883		30,883		30,883		30,883
Foster Care Child (MAX ELIG CD = 48)	11,573		11,573		11,573		11,573		11,573
1115 Child (MAX ELIG CD = 54)	190		190		190		190		190
Adult Total	111,494		111,494		111,494		111,494		111,494
AFDC Adult, Cash (MAX ELIG CD = 15)	39,930		39,930		39,930		39,930		39,930

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AFDC-U Adult, Cash (MAX ELIG CD = 17)	3,094		3,094		3,094		3,094		3,094
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	4,385		4,385		4,385		4,385		4,385
Adult, Poverty (MAX ELIG CD = 35)	11,660		11,660		11,660		11,660		11,660
Other Adult (MAX ELIG CD = 45)	12,488		12,488		12,488		12,488		12,488
1115 Adult (MAX ELIG CD = 55)	39,937		39,937		39,937		39,937		39,937
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	955		955		955		955		955
Total FFS Medicaid Paid	$1,221,982,023		$1,343,170,166		$1,357,251,539		$1,361,511,716		$1,361,511,716
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	$3,220		$3,539		$3,576		$3,588		$3,588
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	$4,086		$4,401		$4,436		$4,446		$4,446
Total Capitation Payments	$92,350,802		$93,382,646		$93,373,488		$93,367,158		$93,367,158
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	0		0		0		0		0
Total HMO/HIO Payments (Among People not Enrolled)	$0		$0		$0		$0		$0
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$8,145		$8,996		$9,074		$9,108		$9,108
Aged, Cash (MAX ELIG CD = 11)	$8,739		$9,441		$9,542		$9,572		$9,572
Aged, Medically Needy (MAX ELIG CD = 21)	$4,860		$5,489		$5,543		$5,560		$5,560
Aged, Poverty (MAX ELIG CD = 31)	$178	X	$266	X	$422		$424		$424
Other Aged (MAX ELIG CD = 41)	$9,545		$10,593		$10,657		$10,699		$10,699
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$17,698		$19,512		$19,659		$19,704		$19,704
Disabled, Cash (MAX ELIG CD = 12)	$13,669		$14,924		$15,031		$15,063		$15,063
Disabled, Medically Needy (MAX ELIG CD = 22)	$13,136	X	$16,648		$17,297		$17,451		$17,451
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$13,366		$14,961		$15,208		$15,264		$15,264
Other Disabled (MAX ELIG CD = 42)	$29,090		$32,408		$32,647		$32,725		$32,725
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$1,544		$1,685		$1,698		$1,703		$1,703
AFDC Child, Cash (MAX ELIG CD = 14)	$1,523		$1,645		$1,662		$1,666		$1,666
AFDC-U Child, Cash (MAX ELIG CD = 16)	$1,532		$1,653		$1,664		$1,671		$1,671
AFDC Child, Medically Needy (MAX ELIG CD = 24)	$1,313		$1,479		$1,536		$1,523		$1,523
Child Poverty (MAX ELIG CD = 34)	$1,136		$1,244		$1,255		$1,257		$1,257
Other Child (MAX ELIG CD = 44)	$2,330		$2,563		$2,582		$2,586		$2,586
Foster Care Child (MAX ELIG CD = 48)	$3,881		$4,234		$4,245		$4,270		$4,270
1115 Child (MAX ELIG CD = 54)	$1,801		$1,844		$1,898		$1,903		$1,903
Adult	$1,989		$2,192		$2,242		$2,257		$2,257
AFDC Adult, Cash (MAX ELIG CD = 15)	$2,942		$3,187		$3,233		$3,240		$3,240
AFDC-U Adult, Cash (MAX ELIG CD = 17)	$2,984		$3,271		$3,302		$3,320		$3,320
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	$2,884		$3,240		$3,352		$3,361		$3,361
Adult, Poverty (MAX ELIG CD = 35)	$2,643		$3,206		$3,279		$3,288		$3,288
Other Adult (MAX ELIG CD = 45)	$2,215		$2,379		$2,409		$2,413		$2,413
1115 Adult (MAX ELIG CD = 55)	$601		$645		$693		$721		$721
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$202,249,613		$228,770,185		$233,083,492		$234,115,601		$234,115,601
IP: Number of Users	35,817		39,610		40,143		40,169		40,169
IP: Avg Medicaid Paid per User	$5,647		$5,776		$5,806		$5,828		$5,828

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IP: Avg Medicaid Covered Days Per User	4.60		4.61		4.63		4.65		4.65
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$855,075		$938,022		$938,022		$938,022		$938,022
MH Aged: Number of Users	5		5		5		5		5
MH Aged: Avg Medicaid Paid per User	$171,015		$187,604		$187,604		$187,604		$187,604
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$24,950,703		$28,024,913		$28,227,738		$28,134,802		$28,134,802
IP Psych, Age < 21: Number of Users	920		985		987		988		988
IP Psych, Age < 21: Avg Medicaid Paid per User	$27,120		$28,452		$28,600		$28,477		$28,477
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$100,239,887		$110,182,852		$110,253,333		$110,243,441		$110,243,441
ICF/MR: Number of Users	869		884		886		886		886
ICF/MR: Avg Medicaid Paid per User	$115,351		$124,641		$124,439		$124,428		$124,428
NF: Total Medicaid Paid (MAX TOS = 07)	$31,419,671		$36,384,469		$36,720,410		$36,949,869		$36,949,869
NF: Number of Users	899		985		1,013		1,021		1,021
NF:Avg Medicaid Paid per User	$34,950		$36,939		$36,249		$36,190		$36,190
Physician: Total Medicaid Paid (MAX TOS = 08)	$123,355,806		$136,720,095		$139,527,015		$140,198,207		$140,198,207
Physician: Number of Users	221,496		230,470		232,271		232,732		232,732
Physician: Avg Medicaid Paid per User	$557		$593		$601		$602		$602
Dental: Total Medicaid Paid (MAX TOS = 09)	$33,678,054		$35,525,877		$35,834,400		$35,940,791		$35,940,791
Dental: Number of Users	109,316		112,375		112,882		113,017		113,017
Dental: Avg Medicaid Paid per User	$308		$316		$317		$318		$318
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$10,677,468		$11,696,647		$11,889,000		$11,933,960		$11,933,960
Other Practitioner: Number of Users	74,003		78,250		79,026		79,240		79,240
Other Practitioner: Avg Medicaid Paid per User	$144		$149		$150		$151		$151
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$81,125,936		$88,715,683		$90,112,709		$90,062,883		$90,062,657
Outpatient: Number of Users	131,401		138,079		139,048		139,146		139,146
Outpatient: Avg Medicaid Paid per User	$617		$642		$648		$647		$647
Clinic: Total Medicaid Paid (MAX TOS = 12)	$36,624,060		$40,160,600		$40,832,772		$41,111,051		$41,111,051
Clinic: Number of Users	132,491		141,788		143,866		144,635		144,635
Clinic: Avg Medicaid Paid per User	$276		$283		$284		$284		$284
Home Health: Total Medicaid Paid (MAX TOS = 13)	$28,815,258		$34,068,766		$34,428,986		$34,539,069		$34,539,069
Home Health: Number of Users	11,021		12,872		13,239		13,334		13,334
Home Health: Avg Medicaid Paid per User	$2,615		$2,647		$2,601		$2,590		$2,590
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$72,190,126		$78,705,701		$79,908,529		$80,110,645		$80,110,645
Lab/Xray: Number of Users	185,996		194,126		195,778		196,668		196,668
Lab/Xray:Avg Medicaid Paid per User	$388		$405		$408		$407		$407
Drugs: Total Medicaid Paid (MAX TOS = 16)	$217,361,326		$219,885,048		$217,540,414		$217,409,611		$217,409,611
Drugs: Number of Users	235,554		237,691		237,690		237,761		237,761
Drugs: Avg Medicaid Paid per User	$923		$925		$915		$914		$914
Other Services: Total Medicaid Paid (MAX TOS = 19)	$66,912,935		$77,125,876		$78,911,487		$79,329,452		$79,329,452
Other Services: Number of Users	19,718		20,883		21,261		21,331		21,331
Other Services: Avg Medicaid Paid per User	$3,393		$3,693		$3,712		$3,719		$3,719
Transportation: Total Medicaid Paid (MAX TOS = 26)	$1,849,294	X	$2,247,025		$2,368,875		$2,397,085		$2,397,085
Transportation: Number of Users	8,085	X	9,659		10,134		10,220		10,220
Transportation: Avg Medicaid Paid per User	$229		$233		$234		$235		$235
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$0		$0		$0		$0		$0

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Personal Care Services: Number of Users	0		0		0		0		0
Personal Care Services: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$15,704,105		$17,802,818		$18,000,489		$18,010,956		$18,010,956
Targeted Case Management: Number of Users	6,179		6,373		6,392		6,394		6,394
Targeted Case Management: Avg Medicaid Paid per User	$2,542		$2,793		$2,816		$2,817		$2,817
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$5,677,685		$6,279,433		$6,376,578		$6,379,854		$6,379,854
Rehabilitation Services: Number of Users	1,749		1,891		1,925		1,941		1,941
Rehabilitation Services: Avg Medicaid Paid per User	$3,246		$3,321		$3,313		$3,287		$3,287
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$1,014,266		$1,120,930		$1,168,647		$1,174,190		$1,174,190
PT/OT/Speech/Hearing: Number of Users	3,164		3,535		3,682		3,701		3,701
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$321		$317		$317		$317		$317
Hospice: Total Medicaid Paid (MAX TOS = 35)	$0		$0		$0		$0		$0
Hospice: Number of Users	0		0		0		0		0
Hospice: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$35,080,750		$39,343,088		$40,207,583		$40,413,011		$40,413,237
Durable Medical Equipment: Number of Users	93,255		98,616		99,532		99,732		99,732
Durable Medical Equipment: Avg Medicaid Paid per User	$376		$399		$404		$405		$405
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$68,499,098		$75,371,922		$75,553,720		$75,587,225		$75,587,225
Residential Care: Number of Users	4,756		4,841		4,849		4,851		4,851
Residential Care: Avg Medicaid Paid per User	$14,403		$15,569		$15,581		$15,582		$15,582
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$50,836,465		$59,764,111		$60,875,573		$61,998,634		$62,016,634
Psych Services: Number of Users	32,165		34,680		35,492		35,846		35,847
Psych Services: Avg Medicaid Paid per User	$1,580		$1,723		$1,715		$1,730		$1,730
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$8,043,489		$8,994,998		$9,026,800		$9,038,254		$9,038,254
Adult Day Care: Number of Users	1,412		1,460		1,466		1,467		1,467
Adult Day Care: Avg Medicaid Paid per User	$5,697		$6,161		$6,157		$6,161		$6,161
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$533		$603		$614		$617		$617
Aged	$856		$947		$960		$963		$963
Disabled	$2,281		$2,561		$2,586		$2,597		$2,597
Child	$275		$309		$314		$313		$313
Adult	$502		$579		$599		$606		$606
ILTC (MAX TOS = 02,04,05,07)	$415		$463		$464		$464		$464
Aged	$3,544		$3,917		$3,944		$3,972		$3,972
Disabled	$3,680		$4,093		$4,105		$4,109		$4,109
Child	$94		$106		$107		$107		$107
Adult	$1		$1		$2		$2		$2
Drugs (MAX TOS = 16)	$573		$579		$573		$573		$573
Aged	$521		$531		$531		$531		$531
Disabled	$3,196		$3,246		$3,222		$3,222		$3,222
Child	$288		$289		$283		$282		$282
Adult	$319		$324		$323		$323		$323
All Other Services	$1,699		$1,895		$1,925		$1,933		$1,933
Aged	$3,224		$3,602		$3,639		$3,642		$3,642

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Disabled	$8,541		$9,613		$9,746		$9,775		$9,775
Child	$887		$981		$995		$1,001		$1,001
Adult	$1,167		$1,288		$1,319		$1,327		$1,327
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	9.44		10.44		10.58		10.58		10.58
Aged	10.94		12.07		12.47		12.58		12.58
Disabled	13.04		13.87		13.99		14.00		14.00
Child	7.45		8.35		8.44		8.42		8.42
Adult	12.39		13.64		13.89		13.96		13.96
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	0.70		0.75		0.76		0.76		0.76
Aged	15.54		16.56		16.67		16.67		16.67
Disabled	4.89		5.15		5.22		5.24		5.24
Child	0.33		0.35		0.35		0.35		0.35
Adult	0.01	X	0.01		0.01		0.01		0.01
% with Ratio of ILTC Days/Enrollment Days > 1	0.19	X	0.39	X	0.49		0.49		0.49
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	62.07		62.63		62.63		62.65		62.65
Aged	42.13		43.15		43.35		43.46		43.46
Disabled	85.39		85.86		85.84		85.85		85.85
Child	63.57		64.18		64.16		64.16		64.16
Adult	51.63		52.11		52.17		52.21		52.21
% Non-Dual FFS Enrollees with All Other Claims	76.41		78.47		78.78		78.89		78.89
Aged	53.68		54.81		55.21		55.21		55.21
Disabled	91.72		93.03		93.18		93.24		93.24
Child	82.05		84.46		84.79		84.89		84.89
Adult	59.98		61.59		61.90		62.04		62.04
Avg # IP Days per Non-Dual FFS User	5		5		5		5		5
Aged	5		5		5		5		5
Disabled	12		12		12		12		12
Child	4		4		4		4		4
Adult	3		3		3		3		3
Avg # ILTC Days per Non-Dual FFS User	216		226		224		223		223
Aged	217		223		223		224		224
Disabled	246		258		256		255		255
Child	148		154		155		155		155
Adult	91	X	59		53		53		53
% Non-Dual FFS Enrollees with Maternal Delivery	3.11		3.44		3.49		3.50		3.50
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	13	X	15		16		17		17
Inpatient Hospital (MAX TOS = 01) > $500,000	3	X	4		4		4		4
ILTC (MAX TOS = 02,04,05,07) > $200,000	155	X	194		194		194		194
Drugs (MAX TOS = 16) > $200,000	11		11		11		11		11
All Other Services > $200,000	16	X	23		24		24		24
Maximum FFS Medicaid Paid	$784,585		$809,192		$809,192		$809,192		$809,192

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Inpatient Hospital (MAX TOS = 01)	$597,594		$709,604		$709,604		$709,604		$709,604
ILTC (MAX TOS = 02,04,05,07)	$565,909		$619,685		$619,685		$619,685		$619,685
Drugs (MAX TOS = 16)	$723,589		$788,031		$788,031		$788,031		$788,031
All Other Services	$775,622		$775,664		$775,664		$775,664		$775,664
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$9,265,060		$9,990,019		$10,121,052		$10,155,633		$10,155,633
FP: Number of Users	34,395		35,709		35,926		35,991		35,991
FP: Avg Medicaid Paid per User	$269		$280		$282		$282		$282
RHC: Total Medicaid Paid (PGM TYPE = 3)	$10,271,411		$11,152,525		$11,306,951		$11,357,817		$11,357,817
RHC: Number of Users	28,762		30,301		30,617		30,712		30,712
RHC: Avg Medicaid Paid per User	$357		$368		$369		$370		$370
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$15,897,972		$17,032,208		$17,221,156		$17,283,823		$17,283,823
FQHC: Number of Users	34,453		35,966		36,280		36,404		36,404
FQHC: Avg Medicaid Paid per User	$461		$474		$475		$475		$475
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$119,133,388		$131,132,858		$131,472,235		$131,500,553		$131,500,553
Section 1915(c) Waiver: Number of Users	8,410		8,629		8,645		8,649		8,649
Section 1915(c) Waiver: Avg Medicaid Paid per User	$14,166		$15,197		$15,208		$15,204		$15,204
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$149,703,132		$167,155,299		$167,871,412		$168,020,881		$168,020,881
Number of Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	18,163		20,132		20,492		20,581		20,581
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	$8,242		$8,303		$8,192		$8,164		$8,164
Aged	$8,828		$9,598		$9,688		$9,674		$9,674
Disabled	$14,113		$15,115		$15,113		$15,110		$15,110
Child	$1,201		$1,160		$1,140		$1,138		$1,138
Adult	$715		$719		$716		$714		$714
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	4.79		5.30		5.40		5.42		5.42
Aged	20.45		21.27		21.27		21.27		21.27
Disabled	27.31		28.41		28.51		28.53		28.53
Child	3.29		3.91		4.04		4.07		4.07
Adult	0.49	X	0.61		0.63		0.64		0.64
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$119,133,388		$131,132,858		$131,472,235		$131,500,553		$131,500,553
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	8,410		8,629		8,645		8,649		8,649
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$14,166		$15,197		$15,208		$15,204		$15,204
Aged	$7,702		$8,513		$8,540		$8,546		$8,546
Disabled	$15,188		$16,389		$16,401		$16,399		$16,399
Child	$7,281		$7,548		$7,555		$7,534		$7,534
Adult	$3,802		$3,908		$3,908		$3,908		$3,908
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	2.22		2.27		2.28		2.28		2.28
Aged	14.72		15.03		15.03		15.03		15.03

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Disabled	20.38		20.75		20.79		20.80		20.80
Child	0.41		0.44		0.45		0.45		0.45
Adult	0.00		0.00		0.00		0.00		0.00
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total EDB Dual FFS Enrollees	69,429		69,429		69,429		69,429		69,429
Number of EDB Dual FFS Recipients	65,657		66,500		66,590		66,619		66,619
Total EDB Dual FFS Person-Years of Enrollment	62,433		62,433		62,433		62,433		62,433
% EDB Only Dual (EDB DUAL = 50)	1.17		1.17		1.17		1.17		1.17
% QMB Only (EDB DUAL = 51)	1.10		1.10		1.10		1.10		1.10
% QMB Plus (EDB DUAL = 52)	57.21		57.21		57.21		57.21		57.21
% SLMB Only (EDB DUAL = 53)	0.51		0.51		0.51		0.51		0.51
% SLMB Plus (EDB DUAL = 54)	13.49		13.49		13.49		13.49		13.49
% QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% QI 1 (EDB DUAL = 56)	0.27		0.27		0.27		0.27		0.27
% QI 2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% Other Type Dual (EDB DUAL = 58)	26.25		26.25		26.25		26.25		26.25
% Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	98.12		98.12		98.12		98.12		98.12
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	1.88		1.88		1.88		1.88		1.88
Aged EDB Dual FFS Total	33,391		33,391		33,391		33,391		33,391
Aged, Cash (MAX ELIG CD = 11)	5,534		5,534		5,534		5,534		5,534
Aged, Medically Needy (MAX ELIG CD = 21)	568		568		568		568		568
Aged, Poverty (MAX ELIG CD = 31)	580		580		580		580		580
Other Aged (MAX ELIG CD = 41)	26,709		26,709		26,709		26,709		26,709
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled EDB Dual FFS Total	34,612		34,612		34,612		34,612		34,612
Disabled, Cash (MAX ELIG CD = 12)	12,312		12,312		12,312		12,312		12,312
Disabled, Medically Needy (MAX ELIG CD = 22)	309		309		309		309		309
Disabled, Poverty (MAX ELIG CD = 32, 3A)	737		737		737		737		737
Other Disabled (MAX ELIG CD = 42)	21,254		21,254		21,254		21,254		21,254
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Total FFS Medicaid Paid	$1,025,428,725		$1,137,144,343		$1,143,473,375		$1,147,604,559		$1,147,604,559
Avg FFS Medicaid Paid per FFS Dual	$14,769		$16,379		$16,470		$16,529		$16,529
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	$15,618		$17,100		$17,172		$17,226		$17,226
Total Capitation Payments	$23,464,138		$23,809,649		$23,808,608		$23,808,608		$23,808,608
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	0		0		0		0		0
Total HMO/HIO Payments (Among People not Enrolled)	$0		$0		$0		$0		$0
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP									
Aged	$15,679		$17,425		$17,505		$17,599		$17,599
Aged, Cash (MAX ELIG CD = 11)	$4,996		$5,585		$5,655		$5,692		$5,692
Aged, Medically Needy (MAX ELIG CD = 21)	$961		$1,144		$1,155		$1,159		$1,159
Aged, Poverty (MAX ELIG CD = 31)	$2,091		$2,210		$2,265		$2,275		$2,275

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Other Aged (MAX ELIG CD = 41)	$18,500		$20,554		$20,639		$20,749		$20,749
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$14,405		$15,942		$16,041		$16,070		$16,070
Disabled, Cash (MAX ELIG CD = 12)	$5,650		$6,288		$6,360		$6,374		$6,374
Disabled, Medically Needy (MAX ELIG CD = 22)	$7,795		$9,058		$9,197		$9,390		$9,390
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$3,081		$3,433		$3,503		$3,487		$3,487
Other Disabled (MAX ELIG CD = 42)	$19,964		$22,068		$22,184		$22,219		$22,219
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$23,654,783		$27,220,507		$28,401,087		$28,601,725		$28,601,725
IP: Number of Users	12,752		14,323		14,607		14,681		14,681
IP: Avg Medicaid Paid per User	$1,855		$1,900		$1,944		$1,948		$1,948
IP: Avg Medicaid Covered Days Per User	0.37		0.32		0.32		0.32		0.32
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$1,862,357	X	$2,310,087		$2,357,038		$2,399,009		$2,399,009
MH Aged: Number of Users	13		14		15		15		15
MH Aged: Avg Medicaid Paid per User	$143,258		$165,006		$157,136		$159,934		$159,934
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$8,704		$8,704		$8,704		$8,704		$8,704
IP Psych, Age < 21: Number of Users	2		2		2		2		2
IP Psych, Age < 21: Avg Medicaid Paid per User	$4,352		$4,352		$4,352		$4,352		$4,352
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$164,707,990		$180,891,607		$180,935,934		$180,915,231		$180,915,231
ICF/MR: Number of Users	1,356		1,362		1,362		1,362		1,362
ICF/MR: Avg Medicaid Paid per User	$121,466		$132,813		$132,846		$132,831		$132,831
NF: Total Medicaid Paid (MAX TOS = 07)	$388,587,269		$428,437,892		$429,247,911		$432,108,365		$432,108,365
NF: Number of Users	16,352		16,964		17,027		17,055		17,055
NF:Avg Medicaid Paid per User	$23,764		$25,256		$25,210		$25,336		$25,336
Physician: Total Medicaid Paid (MAX TOS = 08)	$16,997,513		$19,020,851		$19,342,218		$19,473,979		$19,473,979
Physician: Number of Users	49,964		51,793		52,023		52,130		52,130
Physician: Avg Medicaid Paid per User	$340		$367		$372		$374		$374
Dental: Total Medicaid Paid (MAX TOS = 09)	$7,717,333		$8,153,870		$8,241,517		$8,263,879		$8,263,879
Dental: Number of Users	22,559		23,020		23,108		23,124		23,124
Dental: Avg Medicaid Paid per User	$342		$354		$357		$357		$357
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$2,276,833		$2,480,530		$2,517,472		$2,534,363		$2,534,363
Other Practitioner: Number of Users	29,648		31,284		31,564		31,675		31,675
Other Practitioner: Avg Medicaid Paid per User	$77		$79		$80		$80		$80
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$17,733,727		$20,675,756		$21,212,334		$21,062,897		$21,062,897
Outpatient: Number of Users	34,101		36,444		36,788		36,907		36,907
Outpatient: Avg Medicaid Paid per User	$520		$567		$577		$571		$571
Clinic: Total Medicaid Paid (MAX TOS = 12)	$1,640,913		$1,826,327		$1,879,388		$1,929,260		$1,929,260
Clinic: Number of Users	8,160		8,963		9,213		9,371		9,371
Clinic: Avg Medicaid Paid per User	$201		$204		$204		$206		$206
Home Health: Total Medicaid Paid (MAX TOS = 13)	$60,805,866		$71,382,643		$72,564,720		$72,780,946		$72,780,946
Home Health: Number of Users	17,695		18,684		18,833		18,879		18,879
Home Health: Avg Medicaid Paid per User	$3,436		$3,821		$3,853		$3,855		$3,855
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$10,287,640		$11,339,219		$11,444,884		$11,373,368		$11,373,368

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Lab/Xray: Number of Users	41,511		43,454		43,594		43,630		43,630
Lab/Xray:Avg Medicaid Paid per User	$248		$261		$263		$261		$261
Drugs: Total Medicaid Paid (MAX TOS = 16)	$11,101,131		$11,252,119		$11,246,239		$11,261,261		$11,261,261
Drugs: Number of Users	39,396		40,243		40,352		40,405		40,405
Drugs: Avg Medicaid Paid per User	$282		$280		$279		$279		$279
Other Services: Total Medicaid Paid (MAX TOS = 19)	$105,022,400		$117,132,504		$117,674,509		$118,126,823		$118,126,823
Other Services: Number of Users	28,148		29,581		29,761		29,791		29,791
Other Services: Avg Medicaid Paid per User	$3,731		$3,960		$3,954		$3,965		$3,965
Transportation: Total Medicaid Paid (MAX TOS = 26)	$1,384,735		$1,594,401		$1,629,596		$1,642,417		$1,642,417
Transportation: Number of Users	7,789		8,676		8,842		8,911		8,911
Transportation: Avg Medicaid Paid per User	$178		$184		$184		$184		$184
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$0		$0		$0		$0		$0
Personal Care Services: Number of Users	0		0		0		0		0
Personal Care Services: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$14,910,494		$16,750,649		$17,019,334		$17,017,957		$17,017,957
Targeted Case Management: Number of Users	5,936		5,993		6,004		6,005		6,005
Targeted Case Management: Avg Medicaid Paid per User	$2,512		$2,795		$2,835		$2,834		$2,834
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$99,964		$109,366		$112,141		$114,126		$114,126
Rehabilitation Services: Number of Users	172	X	213		220		232		232
Rehabilitation Services: Avg Medicaid Paid per User	$581		$513		$510		$492		$492
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$186,164		$207,264		$212,259		$213,286		$213,286
PT/OT/Speech/Hearing: Number of Users	1,967		2,242		2,310		2,333		2,333
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$95		$92		$92		$91		$91
Hospice: Total Medicaid Paid (MAX TOS = 35)	$0		$0		$0		$0		$0
Hospice: Number of Users	0		0		0		0		0
Hospice: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$16,312,834		$18,333,003		$18,736,641		$18,888,227		$18,888,227
Durable Medical Equipment: Number of Users	38,036		39,576		39,837		39,900		39,900
Durable Medical Equipment: Avg Medicaid Paid per User	$429		$463		$470		$473		$473
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$155,759,553		$170,955,544		$171,407,090		$171,544,017		$171,544,017
Residential Care: Number of Users	11,321		11,618		11,666		11,675		11,675
Residential Care: Avg Medicaid Paid per User	$13,758		$14,715		$14,693		$14,693		$14,693
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$4,465,831		$5,001,734		$5,071,109		$5,093,183		$5,093,183
Psych Services: Number of Users	21,251		22,348		22,581		22,665		22,665
Psych Services: Avg Medicaid Paid per User	$210		$224		$225		$225		$225
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$19,067,519		$21,108,105		$21,214,832		$21,240,010		$21,240,010
Adult Day Care: Number of Users	3,461		3,546		3,551		3,552		3,552
Adult Day Care: Avg Medicaid Paid per User	$5,509		$5,953		$5,974		$5,980		$5,980
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$341		$392		$409		$412		$412
Aged	$314		$367		$380		$382		$382
Disabled	$364		$415		$434		$437		$437
ILTC (MAX TOS = 02,04,05,07)	$7,996		$8,810		$8,823		$8,864		$8,864
Aged	$10,711		$11,795		$11,806		$11,884		$11,884

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Disabled	$5,706		$6,291		$6,306		$6,314		$6,314
Drugs (MAX TOS = 16)	$160		$162		$162		$162		$162
Aged	$83		$85		$85		$85		$85
Disabled	$207		$209		$209		$209		$209
All Other Services	$6,273		$7,015		$7,076		$7,091		$7,091
Aged	$4,571		$5,178		$5,234		$5,248		$5,248
Disabled	$8,127		$9,026		$9,092		$9,109		$9,109
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Duals with IP Claims (MAX TOS = 01)	18.37		20.63		21.04		21.15		21.15
Aged	19.15		21.61		21.96		22.07		22.07
Disabled	18.09		20.22		20.66		20.75		20.75
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	25.49		26.37		26.46		26.50		26.50
Aged	44.69		46.33		46.49		46.56		46.56
Disabled	8.01		8.20		8.22		8.23		8.23
% FFS Duals with Drug Claims (MAX TOS = 16)	56.74		57.96		58.12		58.20		58.20
Aged	60.83		62.36		62.54		62.64		62.64
Disabled	54.16		55.11		55.22		55.25		55.25
% FFS Duals with All Other Claims	89.91		91.88		92.08		92.13		92.13
Aged	86.93		89.95		90.13		90.14		90.14
Disabled	95.22		96.17		96.31		96.34		96.34
Avg # IP Days per FFS Dual User (MAX TOS = 01)	0		0		0		0		0
Aged	0		0		0		0		0
Disabled	0		0		0		0		0
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	245		260		259		259		259
Aged	239		253		252		252		252
Disabled	278		298		297		297		297
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Duals with FFS Medicaid Paid > $500,000	1	X	2		2		2		2
Inpatient Hospital (MAX TOS = 01) > $500,000	0		0		0		0		0
ILTC (MAX TOS = 02,04,05,07) > $200,000	349		388		390		391		391
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	3	X	2	X	2	X	1		1
Maximum FFS Medicaid Paid	$526,854		$629,199		$629,199		$629,199		$629,199
Inpatient Hospital (MAX TOS = 01)	$270,373		$271,397		$271,397		$271,397		$271,397
ILTC (MAX TOS = 02,04,05,07)	$526,478		$629,199		$629,199		$629,199		$629,199
Drugs (MAX TOS = 16)	$153,299		$153,299		$153,299		$153,299		$153,299
All Other Services	$298,683		$292,537		$288,211		$286,043		$286,043
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$175,079	X	$208,687		$217,069		$219,170		$219,170
FP: Number of Users	1,185		1,272		1,301		1,311		1,311
FP: Avg Medicaid Paid per User	$148		$164		$167		$167		$167
RHC: Total Medicaid Paid (PGM TYPE = 3)	$261,559		$292,299		$304,615		$309,867		$309,867
RHC: Number of Users	2,162	X	2,536		2,671		2,728		2,728

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RHC: Avg Medicaid Paid per User	$121		$115		$114		$114		$114
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$865,369		$940,856		$956,361		$966,673		$966,673
FQHC: Number of Users	3,940		4,215		4,305		4,344		4,344
FQHC: Avg Medicaid Paid per User	$220		$223		$222		$223		$223
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$252,087,579		$277,741,511		$278,514,262		$278,755,957		$278,755,957
Section 1915(c) Waiver: Number of Users	19,422		19,781		19,800		19,805		19,805
Section 1915(c) Waiver: Avg Medicaid Paid per User	$12,979		$14,041		$14,066		$14,075		$14,075
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$316,811,383		$353,440,099		$355,467,664		$355,943,829		$355,943,829
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	28,682		29,676		29,779		29,800		29,800
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	$11,046		$11,910		$11,937		$11,944		$11,944
Aged	$7,219		$7,864		$7,901		$7,913		$7,913
Disabled	$16,274		$17,500		$17,524		$17,522		$17,522
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	41.31		42.74		42.89		42.92		42.92
Aged	49.42		51.35		51.55		51.56		51.56
Disabled	35.07		36.06		36.16		36.20		36.20
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$252,087,579		$277,741,511		$278,514,262		$278,755,957		$278,755,957
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	19,422		19,781		19,800		19,805		19,805
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$12,979		$14,041		$14,066		$14,075		$14,075
Aged	$6,181		$6,732		$6,754		$6,760		$6,760
Disabled	$24,236		$26,254		$26,274		$26,282		$26,282
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	27.97		28.49		28.52		28.53		28.53
Aged	36.25		37.05		37.07		37.08		37.08
Disabled	21.12		21.39		21.42		21.43		21.43
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total FFS Enrollees	448,931		448,931		448,931		448,931		448,931
# FFS Recipients	364,753		371,683		372,529		372,861		372,861
% FFS Enrollees Who Are Recipients	81.25		82.79		82.98		83.06		83.06
% Aged Who Are Recipients	94.79		96.40		96.46		96.46		96.46
% Disabled Who Are Recipients	94.72		95.59		95.67		95.69		95.69
% Child Who Are Recipients	84.58		86.45		86.65		86.71		86.71
% Adults Who Are Recipients	61.89		63.17		63.45		63.60		63.60
Total FFS Person-Years of Enrollment	357,550		357,550		357,550		357,550		357,550
Aged Total	34,369		34,369		34,369		34,369		34,369
Aged, Cash (MAX ELIG CD = 11)	5,757		5,757		5,757		5,757		5,757
Aged, Medically Needy (MAX ELIG CD = 21)	680		680		680		680		680
Aged, Poverty (MAX ELIG CD = 31)	651		651		651		651		651

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Other Aged (MAX ELIG CD = 41)	27,281		27,281		27,281		27,281		27,281
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	70,516		70,516		70,516		70,516		70,516
Disabled, Cash (MAX ELIG CD = 12)	38,233		38,233		38,233		38,233		38,233
Disabled, Medically Needy (MAX ELIG CD = 22)	561		561		561		561		561
Disabled, Poverty (MAX ELIG CD = 32, 3A)	1,072		1,072		1,072		1,072		1,072
Other Disabled (MAX ELIG CD = 42)	30,650		30,650		30,650		30,650		30,650
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	231,149		231,149		231,149		231,149		231,149
AFDC Child, Cash (MAX ELIG CD = 14)	62,111		62,111		62,111		62,111		62,111
AFDC-U Child, Cash (MAX ELIG CD = 16)	3,097		3,097		3,097		3,097		3,097
AFDC Child, Medically Needy (MAX ELIG CD = 24)	826		826		826		826		826
Child Poverty (MAX ELIG CD = 34)	122,451		122,451		122,451		122,451		122,451
Other Child (MAX ELIG CD = 44)	30,893		30,893		30,893		30,893		30,893
Foster Care Child (MAX ELIG CD = 48)	11,581		11,581		11,581		11,581		11,581
1115 Child (MAX ELIG CD = 54)	190		190		190		190		190
Adult Total	112,897		112,897		112,897		112,897		112,897
AFDC Adult, Cash (MAX ELIG CD = 15)	40,141		40,141		40,141		40,141		40,141
AFDC-U Adult, Cash (MAX ELIG CD = 17)	3,116		3,116		3,116		3,116		3,116
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	4,472		4,472		4,472		4,472		4,472
Adult, Poverty (MAX ELIG CD = 35)	11,711		11,711		11,711		11,711		11,711
Other Adult (MAX ELIG CD = 45)	12,571		12,571		12,571		12,571		12,571
1115 Adult (MAX ELIG CD = 55)	40,886		40,886		40,886		40,886		40,886
Total FFS Medicaid Paid	$2,247,410,748		$2,480,314,509		$2,500,724,914		$2,509,116,275		$2,509,116,275
Avg FFS Medicaid Paid per FFS Enrollee	$5,006		$5,525		$5,570		$5,589		$5,589
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	$6,161		$6,673		$6,713		$6,729		$6,729
Total Capitation Payments	$115,814,940		$117,192,295		$117,182,096		$117,175,766		$117,175,766
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	0		0		0		0		0
Total HMO/HIO Payments (Among People not Enrolled)	$0		$0		$0		$0		$0
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$15,465		$17,185		$17,265		$17,357		$17,357
Aged, Cash (MAX ELIG CD = 11)	$5,141		$5,735		$5,806		$5,842		$5,842
Aged, Medically Needy (MAX ELIG CD = 21)	$1,604		$1,860		$1,877		$1,884		$1,884
Aged, Poverty (MAX ELIG CD = 31)	$1,882		$1,998		$2,064		$2,073		$2,073
Other Aged (MAX ELIG CD = 41)	$18,313		$20,345		$20,429		$20,538		$20,538
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$16,082		$17,760		$17,883		$17,920		$17,920
Disabled, Cash (MAX ELIG CD = 12)	$11,087		$12,143		$12,239		$12,265		$12,265
Disabled, Medically Needy (MAX ELIG CD = 22)	$10,194	X	$12,467		$12,835		$13,011		$13,011
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$6,295		$7,036		$7,161		$7,167		$7,167
Other Disabled (MAX ELIG CD = 42)	$22,762		$25,238		$25,391		$25,440		$25,440
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$1,544		$1,685		$1,699		$1,703		$1,703
AFDC Child, Cash (MAX ELIG CD = 14)	$1,523		$1,645		$1,662		$1,666		$1,666

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AFDC-U Child, Cash (MAX ELIG CD = 16)	$1,532		$1,653		$1,664		$1,671		$1,671
AFDC Child, Medically Needy (MAX ELIG CD = 24)	$1,312		$1,480		$1,535		$1,522		$1,522
Child Poverty (MAX ELIG CD = 34)	$1,137		$1,245		$1,255		$1,258		$1,258
Other Child (MAX ELIG CD = 44)	$2,332		$2,565		$2,584		$2,588		$2,588
Foster Care Child (MAX ELIG CD = 48)	$3,882		$4,235		$4,246		$4,271		$4,271
1115 Child (MAX ELIG CD = 54)	$1,801		$1,844		$1,898		$1,903		$1,903
Adult	$1,993		$2,195		$2,246		$2,261		$2,261
AFDC Adult, Cash (MAX ELIG CD = 15)	$2,968		$3,214		$3,260		$3,265		$3,265
AFDC-U Adult, Cash (MAX ELIG CD = 17)	$3,036		$3,322		$3,352		$3,370		$3,370
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	$2,878		$3,231		$3,339		$3,349		$3,349
Adult, Poverty (MAX ELIG CD = 35)	$2,638		$3,201		$3,273		$3,283		$3,283
Other Adult (MAX ELIG CD = 45)	$2,230		$2,396		$2,425		$2,429		$2,429
1115 Adult (MAX ELIG CD = 55)	$600		$645		$697		$727		$727
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$225,904,396		$255,990,692		$261,484,579		$262,717,326		$262,717,326
IP: Number of Users	48,569		53,933		54,750		54,850		54,850
IP: Avg Medicaid Paid per User	$4,651		$4,746		$4,776		$4,790		$4,790
IP: Avg Medicaid Covered Days Per User	3.49		3.47		3.48		3.49		3.49
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$2,717,432		$3,248,109		$3,295,060		$3,337,031		$3,337,031
MH Aged: Number of Users	18		19		20		20		20
MH Aged: Avg Medicaid Paid per User	$150,968		$170,953		$164,753		$166,852		$166,852
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$24,959,407		$28,033,617		$28,236,442		$28,143,506		$28,143,506
IP Psych, Age < 21: Number of Users	922		987		989		990		990
IP Psych, Age < 21: Avg Medicaid Paid per User	$27,071		$28,403		$28,550		$28,428		$28,428
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$264,947,877		$291,074,459		$291,189,267		$291,158,672		$291,158,672
ICF/MR: Number of Users	2,225		2,246		2,248		2,248		2,248
ICF/MR: Avg Medicaid Paid per User	$119,078		$129,597		$129,533		$129,519		$129,519
NF: Total Medicaid Paid (MAX TOS = 07)	$420,006,940		$464,822,361		$465,968,321		$469,058,234		$469,058,234
NF: Number of Users	17,251		17,949		18,040		18,076		18,076
NF:Avg Medicaid Paid per User	$24,347		$25,897		$25,830		$25,949		$25,949
Physician: Total Medicaid Paid (MAX TOS = 08)	$140,353,319		$155,740,946		$158,869,233		$159,672,186		$159,672,186
Physician: Number of Users	271,460		282,263		284,294		284,862		284,862
Physician: Avg Medicaid Paid per User	$517		$552		$559		$561		$561
Dental: Total Medicaid Paid (MAX TOS = 09)	$41,395,387		$43,679,747		$44,075,917		$44,204,670		$44,204,670
Dental: Number of Users	131,875		135,395		135,990		136,141		136,141
Dental: Avg Medicaid Paid per User	$314		$323		$324		$325		$325
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$12,954,301		$14,177,177		$14,406,472		$14,468,323		$14,468,323
Other Practitioner: Number of Users	103,651		109,534		110,590		110,915		110,915
Other Practitioner: Avg Medicaid Paid per User	$125		$129		$130		$130		$130
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$98,859,663		$109,391,439		$111,325,043		$111,125,780		$111,125,554
Outpatient: Number of Users	165,502		174,523		175,836		176,053		176,053
Outpatient: Avg Medicaid Paid per User	$597		$627		$633		$631		$631
Clinic: Total Medicaid Paid (MAX TOS = 12)	$38,264,973		$41,986,927		$42,712,160		$43,040,311		$43,040,311
Clinic: Number of Users	140,651		150,751		153,079		154,006		154,006

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Clinic: Avg Medicaid Paid per User	$272		$279		$279		$279		$279
Home Health: Total Medicaid Paid (MAX TOS = 13)	$89,621,124		$105,451,409		$106,993,706		$107,320,015		$107,320,015
Home Health: Number of Users	28,716		31,556		32,072		32,213		32,213
Home Health: Avg Medicaid Paid per User	$3,121		$3,342		$3,336		$3,332		$3,332
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$82,477,766		$90,044,920		$91,353,413		$91,484,013		$91,484,013
Lab/Xray: Number of Users	227,507		237,580		239,372		240,298		240,298
Lab/Xray:Avg Medicaid Paid per User	$363		$379		$382		$381		$381
Drugs: Total Medicaid Paid (MAX TOS = 16)	$228,462,457		$231,137,167		$228,786,653		$228,670,872		$228,670,872
Drugs: Number of Users	274,950		277,934		278,042		278,166		278,166
Drugs: Avg Medicaid Paid per User	$831		$832		$823		$822		$822
Other Services: Total Medicaid Paid (MAX TOS = 19)	$171,935,335		$194,258,380		$196,585,996		$197,456,275		$197,456,275
Other Services: Number of Users	47,866		50,464		51,022		51,122		51,122
Other Services: Avg Medicaid Paid per User	$3,592		$3,849		$3,853		$3,862		$3,862
Transportation: Total Medicaid Paid (MAX TOS = 26)	$3,234,029		$3,841,426		$3,998,471		$4,039,502		$4,039,502
Transportation: Number of Users	15,874		18,335		18,976		19,131		19,131
Transportation: Avg Medicaid Paid per User	$204		$210		$211		$211		$211
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$0		$0		$0		$0		$0
Personal Care Services: Number of Users	0		0		0		0		0
Personal Care Services: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$30,614,599		$34,553,467		$35,019,823		$35,028,913		$35,028,913
Targeted Case Management: Number of Users	12,115		12,366		12,396		12,399		12,399
Targeted Case Management: Avg Medicaid Paid per User	$2,527		$2,794		$2,825		$2,825		$2,825
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$5,777,649		$6,388,799		$6,488,719		$6,493,980		$6,493,980
Rehabilitation Services: Number of Users	1,921		2,104		2,145		2,173		2,173
Rehabilitation Services: Avg Medicaid Paid per User	$3,008		$3,037		$3,025		$2,988		$2,988
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$1,200,430		$1,328,194		$1,380,906		$1,387,476		$1,387,476
PT/OT/Speech/Hearing: Number of Users	5,131		5,777		5,992		6,034		6,034
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$234		$230		$230		$230		$230
Hospice: Total Medicaid Paid (MAX TOS = 35)	$0		$0		$0		$0		$0
Hospice: Number of Users	0		0		0		0		0
Hospice: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$51,393,584		$57,676,091		$58,944,224		$59,301,238		$59,301,464
Durable Medical Equipment: Number of Users	131,291		138,192		139,369		139,632		139,632
Durable Medical Equipment: Avg Medicaid Paid per User	$391		$417		$423		$425		$425
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$224,258,651		$246,327,466		$246,960,810		$247,131,242		$247,131,242
Residential Care: Number of Users	16,077		16,459		16,515		16,526		16,526
Residential Care: Avg Medicaid Paid per User	$13,949		$14,966		$14,954		$14,954		$14,954
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$55,302,296		$64,765,845		$65,946,682		$67,091,817		$67,109,817
Psych Services: Number of Users	53,416		57,028		58,073		58,511		58,512
Psych Services: Avg Medicaid Paid per User	$1,035		$1,136		$1,136		$1,147		$1,147
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$27,111,008		$30,103,103		$30,241,632		$30,278,264		$30,278,264
Adult Day Care: Number of Users	4,873		5,006		5,017		5,019		5,019
Adult Day Care: Avg Medicaid Paid per User	$5,564		$6,013		$6,028		$6,033		$6,033
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE									

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Inpatient Hospital (MAX TOS = 01)	$503		$570		$582		$585		$585
Aged	$330		$384		$396		$399		$399
Disabled	$1,340		$1,508		$1,530		$1,537		$1,537
Child	$275		$309		$314		$313		$313
Adult	$500		$577		$597		$604		$604
ILTC (MAX TOS = 02,04,05,07)	$1,587		$1,753		$1,757		$1,764		$1,764
Aged	$10,507		$11,570		$11,583		$11,659		$11,659
Disabled	$4,675		$5,172		$5,185		$5,192		$5,192
Child	$94		$106		$107		$107		$107
Adult	$2	X	$2		$2		$2		$2
Drugs (MAX TOS = 16)	$509		$515		$510		$509		$509
Aged	$96		$98		$98		$98		$98
Disabled	$1,729		$1,755		$1,743		$1,743		$1,743
Child	$288		$289		$283		$282		$282
Adult	$325		$330		$329		$329		$329
All Other Services	$2,407		$2,686		$2,721		$2,731		$2,731
Aged	$4,533		$5,133		$5,188		$5,202		$5,202
Disabled	$8,338		$9,325		$9,425		$9,448		$9,448
Child	$887		$981		$995		$1,001		$1,001
Adult	$1,166		$1,286		$1,318		$1,325		$1,325
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Enrollees with IP Claims (MAX TOS = 01)	10.82		12.01		12.20		12.22		12.22
Aged	18.92		21.34		21.69		21.80		21.80
Disabled	15.52		16.99		17.26		17.31		17.31
Child	7.45		8.35		8.44		8.42		8.42
Adult	12.32		13.57		13.83		13.90		13.90
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	4.54		4.71		4.73		4.74		4.74
Aged	43.86		45.48		45.64		45.71		45.71
Disabled	6.42		6.65		6.69		6.71		6.71
Child	0.33		0.35		0.35		0.35		0.35
Adult	0.01	X	0.01	X	0.02		0.02		0.02
% FFS Enrollees with Drug Claims (MAX TOS = 16)	61.25		61.91		61.93		61.96		61.96
Aged	60.30		61.82		62.00		62.10		62.10
Disabled	70.06		70.77		70.81		70.83		70.83
Child	63.57		64.18		64.16		64.16		64.16
Adult	51.27		51.75		51.82		51.87		51.87
% FFS Enrollees with All Other Claims	78.50		80.55		80.84		80.94		80.94
Aged	85.99		88.95		89.14		89.14		89.14
Disabled	93.44		94.57		94.72		94.76		94.76
Child	82.05		84.46		84.79		84.89		84.89
Adult	59.61		61.22		61.56		61.72		61.72
Avg # IP Days per FFS User	3		3		3		3		3
Aged	0		0		0		0		0
Disabled	5		5		5		5		5

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Child	4		4		4		4		4
Adult	3		3		3		3		3
Avg # ILTC Days per FFS User	241		255		254		254		254
Aged	238		252		252		251		251
Disabled	265		282		281		280		280
Child	148		154		155		155		155
Adult	88	X	65		57		56		56
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	14	X	17		18		19		19
Inpatient Hospital (MAX TOS = 01) > $500,000	3	X	4		4		4		4
ILTC (MAX TOS = 02,04,05,07) > $200,000	504		582		584		585		585
Drugs (MAX TOS = 16) > $200,000	11		11		11		11		11
All Other Services > $200,000	19	X	25		26		25		25
Maximum FFS Medicaid Paid	$784,585		$809,192		$809,192		$809,192		$809,192
Inpatient Hospital (MAX TOS = 01)	$597,594		$709,604		$709,604		$709,604		$709,604
ILTC (MAX TOS = 02,04,05,07)	$565,909		$629,199		$629,199		$629,199		$629,199
Drugs (MAX TOS = 16)	$723,589		$788,031		$788,031		$788,031		$788,031
All Other Services	$775,622		$775,664		$775,664		$775,664		$775,664
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$9,440,139		$10,198,706		$10,338,121		$10,374,803		$10,374,803
FP: Number of Users	35,580		36,981		37,227		37,302		37,302
FP: Avg Medicaid Paid per User	$265		$276		$278		$278		$278
RHC: Total Medicaid Paid (PGM TYPE = 3)	$10,532,970		$11,444,824		$11,611,566		$11,667,684		$11,667,684
RHC: Number of Users	30,924		32,837		33,288		33,440		33,440
RHC: Avg Medicaid Paid per User	$341		$349		$349		$349		$349
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$16,763,341		$17,973,064		$18,177,517		$18,250,496		$18,250,496
FQHC: Number of Users	38,393		40,181		40,585		40,748		40,748
FQHC: Avg Medicaid Paid per User	$437		$447		$448		$448		$448
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$371,220,967		$408,874,369		$409,986,497		$410,256,510		$410,256,510
Section 1915(c) Waiver: Number of Users	27,832		28,410		28,445		28,454		28,454
Section 1915(c) Waiver: Avg Medicaid Paid per User	$13,338		$14,392		$14,413		$14,418		$14,418
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$466,514,515		$520,595,398		$523,339,076		$523,964,710		$523,964,710
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	46,845		49,808		50,271		50,381		50,381
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	$9,959		$10,452		$10,410		$10,400		$10,400
Aged	$7,238		$7,885		$7,922		$7,934		$7,934
Disabled	$15,308		$16,427		$16,439		$16,437		$16,437
Child	$1,204		$1,162		$1,143		$1,141		$1,141
Adult	$927		$890		$878		$874		$874
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	10.43		11.09		11.20		11.22		11.22

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Aged	48.59		50.49		50.69		50.70		50.70
Disabled	31.12		32.17		32.26		32.29		32.29
Child	3.29		3.91		4.04		4.08		4.08
Adult	0.52	X	0.64		0.67		0.67		0.67
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$371,220,967		$408,874,369		$409,986,497		$410,256,510		$410,256,510
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	27,832		28,410		28,445		28,454		28,454
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$13,338		$14,392		$14,413		$14,418		$14,418
Aged	$6,198		$6,753		$6,775		$6,781		$6,781
Disabled	$19,710		$21,306		$21,322		$21,324		$21,324
Child	$7,280		$7,548		$7,555		$7,534		$7,534
Adult	$12,087		$12,157		$12,157		$12,157		$12,157
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	6.20		6.33		6.34		6.34		6.34
Aged	35.64		36.43		36.45		36.45		36.45
Disabled	20.74		21.06		21.10		21.11		21.11
Child	0.41		0.45		0.45		0.45		0.45
Adult	0.01		0.01		0.01		0.01		0.01

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All IP Claims									
Total Number of Claims	129,139	X	153,644		170,114		173,118		173,118
% Encounter Claims	49.09		48.37		50.50		49.88		49.88
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	65,742	X	79,319		84,201		86,770		86,770
% Crossover	37.25		35.76		34.88		34.32		34.32
% Adjusted Claims	1.94	X	2.02	X	4.50		4.65		4.65
% Standard Adjustments	98.67		97.69		97.68		97.35		97.35
Avg Medicaid Paid, Adjusted Claims (Include $0)	$8,964	X	$9,742	X	$13,693		$14,154		$14,154
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	54		61		56		66		66
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$15,894	X	$15,784	X	$11,040		$10,284		$10,284
# Claims with > $1 Million Paid	2		2		2		2		2
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	41,252	X	50,955		54,835		56,994		56,994
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$12,313		$11,925		$12,132		$12,216		$12,216
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	$1,825		$1,903		$1,940		$1,958		$1,958
% Claims with TPL	0.76	X	0.92	X	0.99		1.17		1.17
Avg TPL Paid for Claims with TPL	$7,052		$7,551		$7,867		$7,807		$7,807
% Claims with UB-92 Accommodation Codes	99.75		99.73		99.64		99.65		99.65
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.11		1.11		1.12		1.12		1.12
% Claims with UB-92 Ancillary Codes	98.44		98.49		98.53		98.48		98.48
Avg # of UB-92 Ancillary Codes (> 0 Codes)	9.67		9.75		9.86		9.93		9.93
Avg Length of Stay	5.98		5.44		5.43		5.41		5.41
Avg Covered Days (> 0 Days)	6.76		6.28		6.26		6.24		6.24
% Begin Date = Admission Date	96.28		96.38		96.36		96.36		96.36
% IP Claims (MAX TOS = 01)	99.83		99.77		99.78		99.75		99.75
% Family Planning Claims (PGM TYPE = 2)	0.08	X	0.11		0.12		0.13		0.13
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	4.88		4.88		4.88		4.88		4.88
% Primary Diagnosis Code Claims with Length = 3	5.14		5.15		5.21		5.23		5.23
% Primary Diagnosis Code Claims with Length = 4	21.13		21.47		22.12		22.59		22.59
% Primary Diagnosis Code Claims with Length = 5	73.73		73.38		72.67		72.17		72.17
% Claims with a Procedure Code	59.52		60.16		60.16		60.11		60.11
Avg # of Procedure Codes (> 0 Codes)	1.98		1.99		2.00		2.02		2.02
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	100.00		100.00		100.00		100.00		100.00
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

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% Claims Maternal Delivery Indicator	14.48		14.46		13.96		13.59		13.59
% Claims Newborn Delivery Indicator (Only for Separate Infant Delivery Claims Using Mother's ID)	17.77		17.66		17.13		16.70		16.70
PATIENT STATUS									
% Home	81.80		82.24		82.07		81.92		81.92
% Transferred	13.71		13.53		13.56		13.64		13.64
% Still a Patient	2.75		2.37		2.35		2.32		2.32
% Died	1.17		1.24		1.33		1.37		1.37
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	24,490		28,364		29,366		29,776		29,776
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,214		$1,241		$1,262		$1,274		$1,274
% Claims with TPL	0.29	X	0.39	X	0.48		0.55		0.55
Avg TPL Paid for Claims with TPL	$620	X	$756	X	$1,095		$1,349		$1,349
% Claims with UB-92 Accommodation Codes	92.20		89.71		86.69		85.37		85.37
Avg # of UB-92 Accomodation Codes (> 0 Codes)	1.18		1.18		1.18		1.18		1.18
% Claims with UB-92 Ancillary Codes	93.05		90.58		87.61		86.34		86.34
Avg # of UB-92 Ancillary Codes (> 0 Codes)	13.62		13.60		13.58		13.56		13.56
Avg Length of Stay	5.46		5.57		5.64		5.67		5.67
% Begin Date = Admission Date	97.48		97.54		97.48		97.36		97.36
% IP Claims (MAX TOS = 01)	100.00		100.00		100.00		100.00		100.00
% Claims with Primary Diagnosis Code	99.83		99.81		99.73		99.71		99.71
Avg # of Diagnosis Codes (> 0 Codes)	7.84		7.71		7.55		7.48		7.48
% Primary Diagnosis Code Claims with Length = 3	5.36		5.31		5.33		5.30		5.30
% Primary Diagnosis Code Claims with Length = 4	38.17		38.24		38.07		38.08		38.08
% Primary Diagnosis Code Claims with Length = 5	56.42		56.41		56.56		56.57		56.57
% Claims with a Procedure Code	48.45		46.94		45.28		44.58		44.58
Avg # of Procedure Codes (> 0 Codes)	2.42		2.42		2.43		2.43		2.43
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	100.00		100.00		100.00		100.00		100.00
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	0.00		0.00		0.00		0.00		0.00

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All LT Claims									
Total Number of Claims	187,552		210,720		214,141		215,305		215,305
% Encounter Claims	0.85		0.91		0.98		0.99		0.99
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	185,966		208,809		212,044		213,175		213,175
% Crossover	0.00		0.00		0.00		0.00		0.00
% Adjusted Claims	18.67	X	25.35	X	31.35		34.42		34.42
% Standard Adjustments	98.78		98.94		98.98		98.90		98.90
Avg Medicaid Paid, Adjusted Claims (Include $0)	$5,401		$6,019		$5,949		$5,917		$5,917
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	14		14		12	X	16		16
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$5,096		$5,096		$4,972		$4,992		$4,992
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	185,966		208,809		212,044		213,175		213,175
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
NF (MAX TOS = 07)	$185		$185		$185		$185		$185
ICF/MR (MAX TOS = 05)	$520		$646		$645		$645		$645
MH Aged (MAX TOS = 02)	$538		$545		$550		$550		$550
IP Psych, Age < 21 (MAX TOS = 04)	$440		$440		$441		$441		$441
TYPE OF SERVICE									
% NF (MAX TOS = 07)	92.81		92.92		92.89		92.87		92.87
% NF claims with NF Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for NF claims with Covered Days	28.72		28.61		28.55		28.53		28.53
% ICF/MR (MAX TOS = 05)	1.68		1.61		1.59		1.58		1.58
% ICF/MR claims with ICF/MR Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for ICF/MR claims with Covered Days	29.81		29.78		29.78		29.78		29.78
% MH Aged (MAX TOS = 02)	0.13		0.13		0.13		0.13		0.13
% MH Aged claims with MH Aged Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for MH Aged claims with Covered Days	28.49		28.54		28.51		28.52		28.52
% IP Psych, Age < 21 (MAX TOS = 04)	5.39		5.34		5.39		5.42		5.42
% IP Psych, Age < 21 Claims with IP Psych Covered Days	100.00		100.00		100.00		100.00		100.00
Avg days for IP Psych, Age < 21 Claims with Covered Days	18.63		18.79		18.95		18.98		18.98
LEAVE DAYS									
% Claims with Leave Days	0.00		0.00		0.00		0.00		0.00
ADMISSION DATE									
% Claims with Admission Date	99.95		99.95		99.94		99.94		99.94
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	63.97		63.82		63.74		63.74		63.74
% Primary Diagnosis Code Claims with Length = 3	13.14		13.08		13.10		13.09		13.09

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% Primary Diagnosis Code Claims with Length = 4	44.99		44.84		44.71		44.67		44.67
% Primary Diagnosis Code Claims with Length = 5	41.87		42.08		42.19		42.23		42.23
PATIENT STATUS									
% Claims with Patient Status	99.94		99.93		99.93		99.93		99.93
% Home	1.28		1.28		1.30		1.32		1.32
% Still a Patient	97.59		97.55		97.49		97.47		97.47
% Died	0.45		0.46		0.46		0.46		0.46
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	0		0		0		0		0
% Claims with > $0 Paid	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Claims with < $0 Paid	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid (Claims with > $0 Paid)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
TYPE OF SERVICE									
% NF (MAX TOS = 07)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICF/MR (MAX TOS = 05)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% MH Aged (MAX TOS = 02)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% IP Psych, Age < 21 (MAX TOS = 04)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
ADMISSION DATE									
% Claims with Admission Date	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Primary Diagnosis Code Claims with Length = 3	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Primary Diagnosis Code Claims with Length = 4	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Primary Diagnosis Code Claims with Length = 5	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PATIENT STATUS									
% Claims with Patient Status	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Home	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Still a Patient	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Died	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0

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All OT Claims									
Total Number of Claims	22,011,341		24,926,925		26,142,551		26,303,118		26,303,118
% Encounter Claims	17.36		18.31		19.92		19.92		19.92
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
% Capitation Claims **	16.41		14.54		13.87		13.79		13.79
Total FFS Claims Excluding Capitation Payments	12,516,886		14,672,221		15,241,601		15,368,639		15,368,639
% Crossover	13.43		13.33		13.37		13.42		13.42
% Adjusted Claims	0.73	X	0.75	X	3.42		4.12		4.12
% Standard Adjustments	96.61		96.70		99.11		98.93		98.93
Avg Medicaid Paid, Adjusted Claims (Include $0)	$131	X	$155	X	$131	X	$238		$238
% Claims with HMO Capitation Payment	19.86		17.80		17.32		17.22		17.22
% Claims with PHP Capitation Payment	0.00		0.00		0.00		0.00		0.00
% Claims with PCCM Capitation Payment	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid per HMO Capitation Claim	$345		$355		$356		$356		$356
Avg Medicaid Paid per PHP Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per PCCM Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	9,554	X	11,564		11,933		12,918		12,918
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$195		$177		$174		$177		$177
# Claims with > $200,000 Paid	0		0		0		0		0
# Encounter Claims	3,820,463	X	4,563,686		5,207,528		5,239,678		5,239,678
% Encounter Claims for HMO or PACE	99.52		99.50		99.41		99.40		99.40
% Encounter Claims for PHP	0.00		0.00		0.00		0.00		0.00
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	10,836,327		12,716,745		13,204,238		13,305,471		13,305,471
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
% Claims with Span Bill	0.04		0.04		0.04		0.05		0.05
% Outpatient Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Home Health Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Other Claims with Span Bill	0.05		0.05		0.05		0.05		0.05
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	0.00		0.00		0.00		0.00		0.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	0.00		0.00		0.00		0.00		0.00
% Claims with Servicing Provider ID = Billing Provider ID	79.15		77.44		77.28		77.23		77.23
PLACE OF SERVICE									
% Claims with Place of Service	98.76		98.76		98.69		98.66		98.66
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	16.54		16.82		17.21		17.28		17.28
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	67.63		67.33		66.37		66.12		66.12
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	3.41		3.62		3.81		3.91		3.91
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	1.13		1.08		1.06		1.06		1.06
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	0.12		0.12		0.12		0.12		0.12
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	0.00	X	0.00		0.00		0.00		0.00
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	1.76		1.78		1.84		1.86		1.86

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% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	3.08		3.00		2.99		3.00		3.00
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	0.00		0.00		0.00		0.00		0.00
THIRD-PARTY LIABILITY									
% Claims with TPL	0.09	X	0.10	X	0.12		0.14		0.14
Avg TPL Paid for Claims with TPL	$207		$201		$193		$185		$185
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE									
Physician Services (MAX TOS = 08)	5.74		5.91		6.15		6.28		6.28
Dental Services (MAX TOS = 09)	0.16		0.16		0.16		0.16		0.16
Other Practitioner Services (MAX TOS = 10)	0.00		0.00		0.00		0.00		0.00
Outpatient Services (MAX TOS = 11)	1.73		1.70		1.72		1.74		1.74
Clinic Services (MAX TOS = 12)	0.49		0.54		0.54		0.54		0.54
Home Health Services (MAX TOS = 13)	15.19		14.84		14.36		14.35		14.35
Lab/Xray Services (MAX TOS = 15)	4.56		4.52		4.63		4.67		4.67
Drugs (MAX TOS = 16)	0.20		0.20		0.21		0.21		0.21
Other Services (MAX TOS = 19)	3.38	X	5.25	X	6.46		6.65		6.65
Durable Medical Equipment (MAX TOS = 51)	2.92		2.76		2.71		2.71		2.71
Transportation Services (MAX TOS = 26)	0.13	X	0.14		0.15		0.17		0.17
Sterilizations (MAX TOS = 24)	0.00	X	0.00		0.00		0.00		0.00
Abortions (MAX TOS = 25)	0.03		0.03		0.03		0.03		0.03
Personal Care Services (MAX TOS = 30)	9.03		8.28		8.01		7.95		7.95
Targeted Case Management (MAX TOS = 31)	0.06		0.06		0.06		0.06		0.06
Rehabilitation Services (MAX TOS = 33)	0.01		0.00		0.00		0.00		0.00
PT/OT/Hearing/Speech Services (MAX TOS = 34)	5.08	X	5.78		6.39		6.41		6.41
Hospice Services (MAX TOS = 35)	0.04		0.04		0.04		0.05		0.05
Nurse Midwife Services (MAX TOS = 36)	0.06		0.06		0.06		0.06		0.06
Nurse Practitioner Services (MAX TOS = 37)	0.16		0.16		0.17		0.17		0.17
Private Nursing Services (MAX TOS = 38)	2.04		1.84		1.78		1.76		1.76
Religious Non-Medical Services (MAX TOS = 39)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	17.41		17.51		16.88		16.71		16.71
Psychiatric Services (MAX TOS = 53)	11.52		11.07		11.01		10.95		10.95
Adult Day Care (MAX TOS = 54)	20.06		19.13		18.48		18.36		18.36
Unknown Services (MAX TOS = 99)	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
Total	$121		$121		$120		$119		$119
Physician Services (MAX TOS = 08)	$86		$88		$89		$89		$89
Dental Services (MAX TOS = 09)	$44		$44		$45		$45		$45
Other Practitioner Services (MAX TOS = 10)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Outpatient Services (MAX TOS = 11)	$433		$431		$429		$429		$429
Clinic Services (MAX TOS = 12)	$169		$168		$168		$168		$168
Home Health Services (MAX TOS = 13)	$99		$98		$99		$99		$99
Lab/Xray Services (MAX TOS = 15)	$82		$81		$80		$80		$80
Drugs (MAX TOS = 16)	$16		$16		$16		$16		$16
Other Services (MAX TOS = 19)	$100		$89		$85		$85		$85
Durable Medical Equipment (MAX TOS = 51)	$131		$130		$130		$131		$131

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Transportation Services (MAX TOS = 26)	$100		$99		$99		$99		$99
Personal Care Services (MAX TOS = 30)	$31		$31		$32		$32		$32
Targeted Case Management (MAX TOS = 31)	$62		$62		$63		$63		$63
Rehabilitation Services (MAX TOS = 33)	$233		$233		$233		$232		$232
PT/OT/Hearing/Speech Services (MAX TOS = 34)	$75		$79		$79		$79		$79
Hospice Services (MAX TOS = 35)	$4,336		$4,341		$4,367		$4,371		$4,371
Residential Care Services (MAX TOS = 52)	$180		$181		$182		$183		$183
Psychiatric Services (MAX TOS = 53)	$161		$160		$157		$155		$155
Adult Day Care (MAX TOS = 54)	$75		$75		$75		$75		$75
PERCENT OF CLAIMS BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	0.20		0.19		0.19		0.20		0.20
Rural Health Clinic (PGM TYPE = 3)	0.00		0.00		0.00		0.00		0.00
Federally Qualified Health Center (PGM TYPE = 4)	0.30		0.32		0.33		0.33		0.33
Indian Health Services (PGM TYPE = 5)	0.00		0.00		0.00		0.00		0.00
Home and Community Based Waiver (PGM TYPE = 6,7)	41.29		41.18		39.76		39.56		39.56
AVERAGE EXPENDITURES BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	$133		$140		$142		$144		$144
Rural Health Clinic (PGM TYPE = 3)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Federally Qualified Health Center (PGM TYPE = 4)	$184		$185		$186		$186		$186
Indian Health Services (PGM TYPE = 5)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Home and Community Based Waiver (PGM TYPE = 6,7)	$120		$121		$121		$121		$121
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	95.97		96.33		96.45		96.47		96.47
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.88		99.87		99.88		99.89		99.89
% Primary Diagnosis Claims with Secondary Diagnosis Code	13.72		13.34		13.48		13.62		13.62
% Primary Diagnosis Code Claims with Length = 3	7.02		7.14		7.73		7.72		7.72
% Primary Diagnosis Code Claims with Length = 4	70.84		69.29		67.55		67.36		67.36
% Primary Diagnosis Code Claims with Length = 5	22.12		23.54		24.69		24.89		24.89
% Claims with Procedure Code	96.92		97.02		97.02		97.01		97.01
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	100.00		100.00		100.00		100.00		100.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	99.84		99.83		99.83		99.83		99.83
% Other Claims with Procedure Code	97.93		97.99		98.00		98.00		98.00
% Claims with Procedure Code with CPT-4 Indicator	23.26		23.34		23.75		23.89		23.89
% Claims with Procedure Code with HCPCS (II & III) Indicator	76.73		76.65		76.25		76.10		76.10
% with Procedure Code with Other National Indicator	0.01		0.01		0.01		0.01		0.01
% with Procedure Code with State-Specific Indicator	0.00	X	0.00		0.00		0.00		0.00
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	100.00		100.00		100.00		100.00		100.00
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	100.00		100.00		100.00		100.00		100.00
PHYSICIAN SPECIALTY									
% Physician Claims with Physician Specialty	100.00		100.00		100.00		100.00		100.00
PERCENT OF CLAIMS BY CLTC CODE									

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Not a CLTC Claim (CLTC FLAG = 00)	33.50		35.76		37.90		38.25		38.25
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	25.21		23.05		22.34		22.18		22.18
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	9.03		8.28		8.01		7.95		7.95
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	2.04		1.84		1.78		1.76		1.76
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	10.37		9.36		9.06		9.01		9.01
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	0.48		0.46		0.44		0.44		0.44
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	0.66	X	0.62		0.60		0.54		0.54
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	0.00		0.00		0.00		0.00		0.00
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	0.06		0.06		0.06		0.06		0.06
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	0.08	X	0.09		0.10		0.11		0.11
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	0.04		0.04		0.04		0.05		0.05
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	2.44		2.30		2.26		2.26		2.26
CLTC Waiver Claims (CLTC FLAG = 30-40)	41.29		41.18		39.76		39.56		39.56
CLTC Other Waiver (CLTC FLAG = 30)	0.04		0.03		0.03		0.03		0.03
CLTC Waiver Personal Care (CLTC FLAG = 31)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	9.69		9.77		9.42		9.35		9.35
CLTC Waiver Home Health (CLTC FLAG = 34)	14.71		14.39		13.92		13.91		13.91
CLTC Waiver Residential Care (CLTC FLAG = 35)	16.75		16.89		16.28		16.17		16.17
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Transportation (CLTC FLAG = 38)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Hospice (CLTC FLAG = 39)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	0.11		0.11		0.10		0.10		0.10
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	1,680,559		1,955,476		2,037,363		2,063,168		2,063,168
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$52		$51		$51		$51		$51
% Claims with Span Bill	11.04		11.14		11.16		11.19		11.19
% Outpatient Claims with Span Bill	13.17		13.19		13.33		13.41		13.41
% Home Health Claims with Span Bill	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Span Bill	10.88		10.99		11.00		11.04		11.04
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)									
Physician Services (MAX TOS = 08)	50.22		50.28		50.21		50.17		50.17
Other Practitioner Services (MAX TOS = 10)	2.77		2.84		2.86		2.88		2.88
Outpatient Services (MAX TOS = 11)	6.83		6.78		6.66		6.63		6.63
Clinic Services (MAX TOS = 12)	1.04		1.11		1.28		1.28		1.28
Home Health Services (MAX TOS = 13)	0.00		0.00		0.00		0.00		0.00
Lab/Xray Services (MAX TOS = 15)	17.08		16.92		16.73		16.67		16.67
Other Services (MAX TOS = 19)	2.94		2.92		2.92		2.94		2.94
Durable Medical Equipment (MAX TOS = 51)	6.54		6.41		6.45		6.50		6.50
Transportation Services (MAX TOS = 26)	1.96		1.96		1.99		2.00		2.00
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison OT Validation Table
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Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	0.00		0.00		0.00		0.00		0.00
PT/OT/Hearing/Speech Services (MAX TOS = 34)	1.81		1.84		1.83		1.85		1.85
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.00	X	0.00		0.00		0.00		0.00
Psychiatric Services (MAX TOS = 53)	8.11		8.23		8.36		8.38		8.38
Adult Day Care (MAX TOS = 54)	0.00		0.00		0.00		0.00		0.00
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	99.98		99.98		99.97		99.96		99.96
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.99		99.99		99.99		99.98		99.98
% Primary Diagnosis Claims with Secondary Diagnosis Code	56.16		56.12		55.61		55.43		55.43
% Primary Diagnosis Code Claims with Length = 3	5.76		5.73		5.74		5.74		5.74
% Primary Diagnosis Code Claims with Length = 4	41.86		41.83		41.71		41.68		41.68
% Primary Diagnosis Code Claims with Length = 5	52.38		52.44		52.56		52.57		52.57
% Claims with Procedure Code	99.10		98.98		98.82		98.73		98.73
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	99.99		99.99		99.99		99.99		99.99
% Home Health Claims with Procedure Code or UB-92 Revenue Code	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Other Claims with Procedure Code	99.71		99.64		99.56		99.50		99.50
% Claims with Procedure Code with CPT-4 Indicator	85.07		85.13		84.95		84.90		84.90
% Claims with Procedure Code with HCPCS (II & III) Indicator	14.29		14.25		14.45		14.51		14.51
% with Procedure Code with Other Code Indicator	0.01	X	0.01	X	0.01		0.01		0.01
PERCENT OF CLAIMS BY CLTC CODE									
Not a CLTC Claim (CLTC FLAG = 00)	91.54		91.67		91.60		91.54		91.54
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	8.46		8.33		8.40		8.46		8.46
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	0.00	X	0.00		0.00		0.00		0.00
CLTC Waiver Claims (CLTC FLAG = 30-40)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison RX Validation Table
State: MD

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All RX Claims									
Total Number of Claims	6,461,776		6,612,540		6,620,728		6,635,036		6,635,036
% Encounter Claims	66.51		66.36		66.28		66.31		66.31
% Supplemental Claims	0.00		0.00		0.00		0.00		0.00
Total FFS Claims	2,163,957		2,224,269		2,232,301		2,235,491		2,235,491
% Adjusted Claims	0.93		0.98		1.00		1.00		1.00
% Standard Adjustments	99.56		99.57		99.57		99.56		99.56
Avg Medicaid Paid, Adjusted Claims (Include $0)	$143		$140		$142		$142		$142
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	4,411		4,468		4,473		4,529		4,529
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	112.63		112.22		112.14		111.60		111.60
# Claims with > $200,000 Paid	0		0		0		0		0
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Claims (Type of Claim = 1)									
Total Number of Claims	2,163,957		2,224,269		2,232,301		2,235,491		2,235,491
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$114		$115		$115		$115		$115
% Claims with TPL	1.37		1.46		1.50		1.51		1.51
Avg TPL Paid for Claims with TPL	$91		$88		$88		$88		$88
% Family Planning Claims (PGM TYPE = 2)	0.00	X	0.00	X	0.00		0.00		0.00
% Drug Claims (MAX TOS = 16)	100.00		100.00		100.00		100.00		100.00
% Durable Medical Equipment Claims (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Prescribing Physician	99.49		99.50		99.50		99.50		99.50
% Drug Claims with Date Prescribed	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Quantity	99.93		99.93		99.93		99.93		99.93
% Drug Claims with Days Supply	100.00		100.00		100.00		100.00		100.00
DRUG CLASSIFICATION									
% Claims with Medispan	99.55		99.55		99.55		99.54		99.54
% Claims with Generic Therapeutic Class	99.69		99.68		99.68		99.67		99.67
% Claims with Specific Therapeutic Class	99.69		99.68		99.68		99.67		99.67
NDC CONFIGURATION INDICATOR									
% Prescription (NDC FMT IND = 0-3)	64.37		64.39		64.40		64.39		64.39
% Products (NDC FMT IND = 4-6)	35.06		35.00		34.98		34.98		34.98
% Health Related Item (NDC FMT IND = 7)	0.24		0.27		0.28		0.28		0.28
% Claims with Clinical Formulation Identifier	99.69		99.68		99.68		99.67		99.67
% Claims with Ingredient List Identifier	99.69		99.68		99.68		99.67		99.67
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	99.69		99.68		99.68		99.67		99.67
% Claims with Over-the-Counter Drug Class	1.94		2.00		2.01		2.02		2.02
% Claims with Prescription Drug Class	97.74		97.68		97.66		97.65		97.65
% Claims with Multiple Sources	59.43		59.56		59.59		59.59		59.59
% Claims with Single Source (No Generic)	35.21		35.15		35.12		35.11		35.11

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All Records									
Total Number of Records	898,325		898,520		898,722		900,240		900,240
Total Medicaid Paid	$5,056,118,152		$5,587,028,337		$5,719,415,340		$5,771,511,989		$5,771,511,989
% with No Services (RCPNT IND = 0)	12.73		11.29		10.89		10.87		10.87
% with FFS Only Claims (RCPNT IND = 1)	14.71		15.37		15.70		15.83		15.83
% with Only Capitation Claims (RCPNT IND = 2)	1.81		1.74		1.67		1.66		1.66
% with Only Encounter Claims (RCPNT IND = 3)	3.40		3.38		3.35		3.31		3.31
% with FFS and Capitation Claims (RCPNT IND = 4)	9.42		8.68		8.06		8.03		8.03
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	1.57		1.79		1.82		1.82		1.82
% with FFS and Encounter Claims Only (RCPNT IND = 6)	1.52	X	1.90		2.01		2.04		2.04
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	54.85		55.85		56.50		56.45		56.45
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	1,207		1,242		1,249		1,302		1,302
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.13		0.14		0.14		0.14		0.14
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$3,291,506		$3,586,353		$3,250,054		$3,551,637		$3,551,637
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$2,727		$2,888		$2,602		$2,728		$2,728
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	1,009		1,035		1,041		1,085		1,085
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.11		0.12		0.12		0.12		0.12
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$3,139,676		$3,428,964		$3,092,527		$3,390,882		$3,390,882
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$3,112		$3,313		$2,971		$3,125		$3,125
S-CHIP ENROLLMENT									
# with ONLY S-CHIP Enrollment	0		0		0		0		0
% with ONLY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
# with ANY S-CHIP Enrollment	0		0		0		0		0
% with ANY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	0		0		0		0		0
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)									
Total Medicaid Enrollees	897,118		897,278		897,473		898,938		898,938
Total Medicaid Person-Years of Enrollment	725,638		725,711		725,798		726,494		726,494
# with Any M-CHIP Enrollment	152,015		151,978		152,012		152,086		152,086
Total Person-Years of Enrollment Any M-CHIP	109,489		109,475		109,489		109,418		109,418
Demographic Characteristics									
% Records with Valid SSN Format	95.35		95.41		95.45		96.04		96.04
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	95.20		95.26		95.30		95.86		95.86
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	0.02		0.02		0.02		0.02		0.02
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	0.13		0.13		0.13		0.16		0.16

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% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	0.00		0.00		0.00		0.00		0.00
# Records Without Valid SSN	43,026		42,535		42,154		37,219		37,219
% Records Without Valid SSN	4.80		4.74		4.70		4.14		4.14
% for Children Under Age 21	82.24		82.07		81.93		79.95		79.95
% for Infants Under Age 1	37.84		37.55		37.36		33.30		33.30
% Ever Aliens Eligible for Only Emergency Services	15.79		15.98		16.13		18.34		18.34
# SSNs with More Than One MSIS ID	515		510		508		460		460
% Records with Duplicated SSNs	0.11		0.11		0.11		0.10		0.10
% for Children Under Age 21	90.39		90.49		90.45		90.65		90.65
% for Infants Under Age 1	5.44		5.49		5.51		5.98		5.98
% Ever Aliens Eligible for Only Emergency Services	0.49		0.49		0.49		0.54		0.54
% with External SSN from EDB (EXT SSN SRCE = 1)	13.89		13.90		13.90		13.92		13.92
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	0.00		0.00		0.00		0.00		0.00
% with County Code	99.86		99.86		99.86		99.86		99.86
% with Valid 5 Digit Zip Code Format	100.00		100.00		100.00		100.00		100.00
% White	31.10		31.11		31.11		31.11		31.11
% Black	50.29		50.29		50.29		50.31		50.31
% Native American/Alaskan Native	0.19		0.19		0.19		0.19		0.19
% Asian	3.05		3.05		3.05		3.05		3.05
% Native Hawaiian or Other Pacific Islander	0.05		0.05		0.05		0.05		0.05
% More Than One Race	0.00		0.00		0.00		0.00		0.00
% Unknown Race	15.32		15.32		15.32		15.29		15.29
% Hispanic/Latino (Included with Race Categories Prior to 2005)	10.35		10.35		10.35		10.34		10.34
% of Hispanic/Latino with Unknown Race	100.00		100.00		100.00		100.00		100.00
% Age 0	4.21		4.21		4.20		4.20		4.20
% Age 0-20 Years	59.01		59.00		58.99		58.92		N/A
% Age > 64 Years	8.16		8.16		8.16		8.16		N/A
% with Century of Birth '18' , '19', '20'	100.00		100.00		100.00		100.00		100.00
% with Gender Code 'M' or 'F'	100.00		100.00		100.00		100.00		100.00
% Enrollees with 12 Months Enrollment	61.69		61.69		61.68		61.63		61.63
% Aged Enrollees with 12 Months Enrollment	71.64		71.64		71.62		71.50		71.50
% Disabled Enrollees with 12 Months Enrollment	80.66		80.59		80.50		79.93		79.93
% Child Enrollees with 12 Months Enrollment	63.27		63.27		63.27		63.27		63.27
% Adult Enrollees with 12 Months Enrollment	40.08		40.08		40.07		40.05		40.05
% Enrollees with MSIS Date of Death During Year	1.05		1.05		1.05		1.06		1.06
% Enrollees with SSA Date of Death During Year	0.70		0.70		0.70		0.70		0.00
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	1.24		1.24		1.24		1.24		1.19
# with MSIS Date of Death ≠ SSA Date of Death	6,026	X	6,031	X	6,034	X	6,080	X	9,535
# with MSIS Date of Death Prior to 2007	31		31		31		29		29
# with SSA Date of Death Prior to 2007	468		469		468		466		0
EDB Dual Eligibles									
Total EDB Duals (Duals Confirmed by EDB)	111,829		111,855		111,878		112,198		112,198

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Total EDB Dual Person-Years of Enrollment	98,396		98,409		98,420		98,631		98,631
% Age > 64 Years Who Are EDB Duals	88.86		88.86		88.87		89.01		89.01
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	91.44		91.45		91.45		91.55		91.55
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	38.68		38.63		38.56		38.16		38.16
% EDB Only (EDB DUAL = 50)	2.15	X	2.15	X	2.15	X	1.58		1.58
% EDB QMB Only (EDB DUAL = 51)	19.43		19.42		19.41		19.38		19.38
% EDB QMB Plus (EDB DUAL = 52)	48.00		48.00		48.00		48.29		48.29
% EDB SLMB Only (EDB DUAL = 53)	8.38		8.37		8.37		8.37		8.37
% EDB SLMB Plus (EDB DUAL = 54)	0.00		0.00		0.00		0.00		0.00
% EDB QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% EDB QI-1 (EDB DUAL = 56)	4.00		4.00		4.00		4.00		4.00
% EDB QI-2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% EDB Other (EDB DUAL = 58)	18.06		18.06		18.07		18.38		18.38
% EDB Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Dual Status Unknown (EDB DUAL = 98)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	68.20		68.21		68.22		68.25		68.25
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	31.80		31.79		31.78		31.75		31.75
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	785		782		781		656		656
% Non-EDB Duals Without Valid SSN	0.00		0.00		0.00		0.00		0.00
% Non-EDB Duals Who Are Children/Adults	0.76		0.77		0.77		0.76		0.76
% EDB Duals with Spanish Language	1.09		1.09		1.09		1.09		1.09
% EDB Duals with EDB Date of Death During Year	7.30		7.30		7.30		7.28		7.28
% EDB Duals with MSIS Date of Death During Year	6.25		6.25		6.25		6.27		6.27
% EDB Duals with SSA Date of Death During Year	4.14		4.14		4.14		4.13		0.00
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	7.34		7.34		7.34		7.32		7.31
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	1,732		1,732		1,732		1,696		1,696
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	3,794	X	3,794	X	3,795	X	3,796	X	8,166
% EDB Duals with Medicaid Reported HIC	99.35		99.36		99.37		99.62		99.62
% EDB Duals with Medicaid Reported HIC = Medicare HIC	99.02		99.02		99.02		99.06		99.06
Total EDB Dual Enrollees in June	105,250		105,274		105,295		105,594		105,594
JUNE MEDICARE ELIGIBILITY GROUP									
June % with Part A Medicare only	1.66		1.66		1.66		1.68		1.68
June % with Part B Medicare only	0.15		0.15		0.15		0.15		0.15
June % Part A/B Medicare	98.20		98.19		98.19		98.18		98.18
ORIGINAL REASON FOR MEDICARE ENTITLEMENT									
% Aged (MDCR ORIG REAS CD = 0)	48.47		48.47		48.47		48.49		48.49
% Disabled (MDCR ORIG REAS CD = 1)	49.64		49.64		49.64		49.62		49.62
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	0.85		0.85		0.85		0.85		0.85
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	1.04		1.04		1.04		1.04		1.04
Other Eligibility Characteristics (All Enrollees)									
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	99.47		99.47		99.47		99.46		99.46
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	9.49		9.48		9.46		9.30		9.30
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	99.51		99.51		99.51		99.51		99.51
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	97.73		97.73		97.73		97.72		97.72

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% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	100.00		100.00		100.00		100.00		100.00
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	100.00		100.00		100.00		100.00		100.00
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	11.32		11.31		11.29		11.19		11.19
Aged Total	59,056		59,074		59,094		59,276		59,276
Aged, Cash (MAX ELIG CD = 11)	18,720		18,726		18,731		18,790		18,790
Aged, Medically Needy (MAX ELIG CD = 21)	20,955		20,969		20,985		21,111		21,111
Aged, Poverty (MAX ELIG CD = 31)	19,360		19,358		19,357		19,354		19,354
Other Aged (MAX ELIG CD = 41)	21		21		21		21		21
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	143,373		143,564		143,844		145,616		145,616
Disabled, Cash (MAX ELIG CD = 12)	99,541		99,580		99,629		100,090		100,090
Disabled, Medically Needy (MAX ELIG CD = 22)	21,029		21,186		21,417		22,742		22,742
Disabled, Poverty (MAX ELIG CD = 32, 3A)	17,071		17,066		17,066		17,056		17,056
Other Disabled (MAX ELIG CD = 42)	5,732		5,732		5,732		5,728		5,728
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	504,993		505,000		505,001		505,038		505,038
AFDC Child, Cash (MAX ELIG CD = 14)	141,434		141,490		141,529		142,070		142,070
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	6,750		6,750		6,747		6,741		6,741
Child Poverty (MAX ELIG CD = 34)	328,966		328,946		328,927		328,793		328,793
Other Child (MAX ELIG CD = 44)	6,121		6,092		6,077		5,728		5,728
Foster Care Child (MAX ELIG CD = 48)	17,926		17,926		17,926		17,920		17,920
1115 Child (MAX ELIG CD = 54)	3,796		3,796		3,795		3,786		3,786
Adult Total	189,696		189,640		189,534		189,008		189,008
AFDC Adult, Cash (MAX ELIG CD = 15)	76,491		76,524		76,554		76,940		76,940
AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	8,358		8,363		8,358		8,385		8,385
Adult, Poverty (MAX ELIG CD = 35)	13,193		13,196		13,199		13,191		13,191
Other Adult (MAX ELIG CD = 45)	12,945		12,932		12,938		12,752		12,752
1115 Adult (MAX ELIG CD = 55)	78,709		78,625		78,485		77,740		77,740
Long-Term Care Enrollees									
INSTITUTIONAL STATUS									
# Enrollees with Any ILTC Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	22,950		24,552		25,215		25,473		25,473
% Enrollees with Any ILTC Claims	2.56		2.74		2.81		2.83		2.83
% Aged Enrollees with Any ILTC Claims	26.33		28.00		28.75		28.93		28.93
% Disabled Enrollees with Any ILTC Claims	3.89		4.21		4.34		4.35		4.35
% Child Enrollees with Any ILTC Claims	0.35		0.38		0.38		0.38		0.38
% Adult Enrollees with Any ILTC Claims	0.03	X	0.04		0.04		0.04		0.04
COMMUNITY LONG-TERM CARE STATUS									
# Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	37,246		38,193		38,445		37,619		37,619

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% Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	4.15		4.26		4.28		4.18		4.18
% Aged Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	7.33		7.44		7.48		7.45		7.45
% Disabled Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	18.18		18.46		18.51		17.99		17.99
% Child Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	1.22		1.29		1.32		1.24		1.24
% Adult Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.37		0.40		0.40		0.39		0.39
# Enrollees with ILTC Claims and CLTC Claims (Excludes CLTC FLAG = 16-20)	1,153	X	1,387		1,458		1,450		1,450
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	38,097		38,915		39,120		38,291		38,325
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT									
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	16,812		16,812		16,813		16,808		20,216
% Enrolled in Any Section 1915(c) Waiver	1.87		1.87		1.87		1.87		2.25
% Aged Enrollees in Section 1915(c) Waiver	1.88	X	1.88	X	1.88	X	1.87	X	4.72
% Disabled Enrollees in Section 1915(c) Waiver	10.90		10.89		10.86		10.73		11.91
% Child Enrollees in Section 1915(c) Waiver	0.01		0.01		0.01		0.01		0.01
% Adult Enrollees in Section 1915(c) Waiver	0.01	X	0.01	X	0.01	X	0.01	X	0.01
# Aged, EDB Dual	1,029	X	1,030	X	1,030	X	1,029	X	2,630
# Aged, Non-Dual	82	X	82	X	82	X	81	X	167
# Disabled, EDB Dual	9,298		9,297		9,298		9,310		10,246
# Disabled, Non-Dual	6,330		6,330		6,330		6,315		7,091
# Other (Child or Adult)	73		73		73		73		82
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	3,575	X	3,575	X	3,575	X	3,569	X	6,989
# Aged, EDB Dual	925	X	926	X	926	X	926	X	2,527
# Aged, Non-Dual	60	X	60	X	60	X	58	X	144
# Disabled, EDB Dual	2,289	X	2,288	X	2,288	X	2,293	X	3,233
# Disabled, Non-Dual	300	X	300	X	300	X	291	X	1,075
# Other (Child or Adult)	1	X	1	X	1	X	1	X	10
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	449		449		449		449		449
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	1		1		1		1		1
# Disabled, EDB Dual	279		279		279		280		280
# Disabled, Non-Dual	167		167		167		166		166
# Other (Child or Adult)	2		2		2		2		2
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	33		33		33		33		33
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	19		19		19		19		19
# Disabled, Non-Dual	14		14		14		14		14
# Other (Child or Adult)	0		0		0		0		0

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# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	11,614		11,614		11,615		11,616		11,605
# Aged, EDB Dual	104		104		104		103		103
# Aged, Non-Dual	20		20		20		21		21
# Disabled, EDB Dual	6,701		6,701		6,702		6,708		6,704
# Disabled, Non-Dual	4,749		4,749		4,749		4,744		4,737
# Other (Child or Adult)	40		40		40		40		40
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	221		221		221		221		221
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	6		6		6		6		6
# Disabled, Non-Dual	212		212		212		212		212
# Other (Child or Adult)	3		3		3		3		3
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	920		920		920		920		919
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	1		1		1		1		1
# Disabled, EDB Dual	4		4		4		4		4
# Disabled, Non-Dual	888		888		888		888		887
# Other (Child or Adult)	27		27		27		27		27
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	6.43	X	5.39	X	5.07	X	5.03	X	20.89
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	2.06		2.09		2.09		2.15		1.96
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	35.17		35.17		35.17		35.16		32.66
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/HIOs with No Waiver claim (PGM TYPE = 6 or 7)	3.88	X	3.25	X	3.05	X	3.02	X	15.87

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# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	48	X	48	X	48	X	48	X	120
Other Waiver Enrollment (Enrolled Any Time During the Year)									
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	728,992		728,976		728,946		728,841		728,841
% Aged Enrollees with Any 1115 Waiver	1.03		1.03		1.03		1.03		1.03
% Disabled Enrollees with Any 1115 Waiver	54.29		54.27		54.25		54.11		54.11
% Child Enrollees with Any 1115 Waiver	96.29		96.29		96.28		96.25		96.25
% Adult Enrollees with Any 1115 Waiver	86.60		86.59		86.56		86.40		86.40
% with Any HMO/HIO Enrollment	95.13		95.13		95.13		95.12		95.12
# with Any 1915(b) Waiver (WVR TYPE = 2)	0		0		0		0		0
% Aged Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	0		0		0		0		0
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with 1115 HIFA Waiver (WVR TYPE = 5)	0		0		0		0		0
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	0		0		0		0		0
% Aged Enrollees with Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Other Type of Waiver (WVR TYPE = 7)	0		0		0		0		0
# with Unknown Type of Waiver (WVR TYPE = 9)	0		0		0		0		0
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	0		0		0		0		0
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	52,138		52,136		52,132		52,113		52,113
# of Waiver IDs with More than One Waiver Type	1		1		1		1		1
# of Waiver IDs with Reporting in January but Not December	0		0		0		0		0
# of Waiver IDs with Reporting in December but Not January	0		0		0		0		0
Enrollees with Restricted Benefits									
Family Planning enrollees with Restricted Benefits (RBF = 6)									
# with ONLY Family Planning Only Enrollment	27,897		27,894		27,891		27,860		27,860
# with ANY Family Planning Only Enrollment	52,131		52,129		52,125		52,106		52,106
# Person-Years of Enrollment ANY Family Planning Only Enrollment	32,207		32,205		32,201		32,181		32,181
Aliens with Restricted Benefits (RBF = 2)									
# Aliens with ONLY Restricted Benefits	10,538.00		10,546.00		10,559.00		10,615.00		10,615.00
# Aliens with ANY Restricted Benefits	10,714.00		10,723.00		10,736.00		10,795.00		10,795.00
# Person-Years of Enrollment Aliens with ANY Restricted Benefits	2,084.75		2,086.00		2,088.25		2,102.33		2,102.33

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EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
# EDB Duals with ONLY Restricted Benefits Enrollment	33,378		33,376		33,375		33,440		33,440
# EDB Duals with ANY Restricted Benefits Enrollment	36,931		36,933		36,932		37,027		37,027
# Person-Years of Enrollment EDB Duals with ANY Restricted Benefits	30,515		30,515		30,514		30,573		30,573
% EDB Duals with ONLY Restricted Benefits Enrollment	29.85		29.84		29.83		29.80		29.80
Prescription Drug Enrollees (RBF = X, Y, or Z)									
# with ONLY Prescription Drug Enrollment (May Have a Month or More of RBF = 3)	0		0		0		0		0
# with ANY Prescription Drug Enrollment	0		0		0		0		0
# Person-Years of ANY Prescription Drug Enrollment	0		0		0		0		0
Dual Prescription Drug Enrollees									
# with ONLY Prescription Drugs Who Are EDB Duals	0		0		0		0		0
June Eligibility Profile									
Total Enrollees in June	714,089		714,123		714,161		714,603		714,603
June % Full Scope Benefits (RBF = 1)	86.49		86.50		86.50		86.51		86.51
June % Restricted Benefits Alien (RBF = 2)	0.29		0.29		0.29		0.29		0.29
June % Restricted Benefits Dual (RBF = 3)	4.29		4.29		4.29		4.29		4.29
June % Restricted Benefits Pregnant (RBF = 4)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Other (RBF = 5)	4.38		4.38		4.37		4.36		4.36
June % Restricted Benefits Family Planning (RBF = 6)	4.54		4.54		4.54		4.54		4.54
June % Restricted Benefits Benchmark-Equivalent (RBF = 7)	0.00		0.00		0.00		0.00		0.00
June % Money Follows the Person Enrollee (RBF = 8)	0.00	X	0.00	X	0.00	X	4.55	X	0.01
June % Unknown Benefits (RBF = 9)	0.00		0.00		0.00		0.00		0.00
June % PRTF Enrollee (RBF = A)	0.00		0.00		0.00		0.00		0.00
June % Health Opportunity Account (RBF = B)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Non-Dual Enrollee (RBF = X)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Receiving Medicare Cost Sharing (RBF = Y)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Not Receiving Medicare Cost Sharing (RBF = Z)	0.00		0.00		0.00		0.00		0.00
June % Private Health Insurance (PVT INS CD = 2-4)	4.59		4.59		4.58		4.49		4.49
June Total Enrollees with TANF Flag (TANF FLAG = 2)	0.00		0.00		0.00		0.00		0.00
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	107,337		107,336		107,347		107,250		107,249
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	3,262		3,262		3,262		3,264		3,264
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	0		0		0		0		0
Medicaid Expenditures									
Total Medicaid Paid	$5,052,826,646		$5,583,441,984		$5,716,165,286		$5,767,960,352		$5,767,960,352
Avg Medicaid Paid per Enrollee	$5,632		$6,223		$6,369		$6,416		$6,416
25th Percentile	$456		$526		$545		$550		$550
50th Percentile (Median)	$1,176		$1,244		$1,272		$1,277		$1,277
75th Percentile	$3,091		$3,333		$3,374		$3,398		$3,398
95th Percentile	$25,637		$28,383		$29,360		$29,658		$29,658
99th Percentile	$72,999		$82,279		$83,507		$84,011		$84,011
Maximum Medicaid Paid	$3,246,845		$3,281,721		$3,281,904		$3,316,918		$3,316,918

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PERCENT OF ENROLLEES WITH ZERO EXPENDITURES									
% of Enrollees with Total Medicaid Paid = $0	16.15		14.69		14.25		14.19		14.19
Aged	24.44		22.19		21.21		21.05		21.05
Disabled	11.84	X	10.36		9.38		9.73		9.73
Child	6.73	X	5.69		5.55		5.54		5.54
Adult	41.90		39.59		38.96		38.61		38.61
NUMBER OF HIGH-COST ENROLLEES									
# of Enrollees with Total Medicaid Paid > $1,000,000	9.00		10.00		11.00		10.00		10.00
# of Enrollees with Total Medicaid Paid > $500,000	106.00		98.00		105.00		108.00		108.00
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$5,632		$6,223		$6,369		$6,416		$6,416
Aged	$15,177		$16,873		$17,134		$17,190		$17,190
Disabled	$17,290		$19,163		$19,584		$19,560		$19,560
Child	$2,191		$2,371		$2,434		$2,444		$2,444
Adult	$3,012		$3,367		$3,470		$3,527		$3,527
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$13,988		$15,725		$15,913		$15,951		$15,951
Aged	$15,227		$16,913		$17,160		$17,211		$17,211
Disabled	$13,219		$15,062		$15,196		$15,213		$15,213
EDB Only (EDB DUAL = 50)	$8,478		$10,283		$10,993	X	$8,869		$8,869
EDB QMB Only (EDB DUAL = 51)	$1,427		$1,620		$1,670		$1,691		$1,691
EDB QMB Plus (EDB DUAL = 52)	$12,297		$13,973		$14,085		$14,085		$14,085
EDB SLMB Only (EDB DUAL = 53)	$187		$198		$207		$210		$210
EDB SLMB Plus (EDB DUAL = 54)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QDWI (EDB DUAL = 55)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB QI-1 (EDB DUAL = 56)	$166		$172		$178		$179		$179
EDB QI-2 (EDB DUAL = 57)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Other (EDB DUAL = 58)	$42,111		$46,831		$47,419		$47,101		$47,101
EDB Dual Type Unknown (EDB DUAL = 59)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Dual Status Unknown (EDB DUAL = 98)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	$20,071		$22,558		$22,816		$22,856		$22,856
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	$942		$1,063		$1,097		$1,110		$1,110
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE									
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	$53,430		$57,765		$57,760		$57,815		$57,815
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	$33,644		$37,502		$37,812		$38,495		$38,495
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	$51,463		$56,537		$58,407		$59,240		$59,240
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT									
Avg Medicaid Paid per Section 1915(c) Enrollee	$44,039		$50,782		$51,082		$51,194		$46,918
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$32,189		$34,722		$34,964		$35,029		$30,525
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$48,708		$53,212		$53,603		$53,798		$53,798
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$101,779		$115,436		$119,324		$120,042		$120,042

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Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$46,396		$54,653		$54,952		$55,066		$55,096
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	$120,587		$130,450		$131,060		$131,167		$131,167
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	$37,595		$41,675		$41,961		$42,071		$42,059
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT									
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	$31,502		$37,281		$37,440		$37,492	X	$31,206
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$20,228	X	$21,760	X	$21,794	X	$21,818	X	$11,246
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$0		$0		$0		$0		$0
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$71,276		$84,438		$88,250		$88,925		$88,925
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$38,838		$46,658		$46,860		$46,918		$46,960
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	$5,052		$5,511		$5,514		$5,514		$5,514
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	$2,996		$3,353		$3,415		$3,420		$3,420
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EXPENDITURES FOR RESTRICTED BENEFIT ENROLLEES									
Expenditures for Family Planning Enrollees with Restricted Benefits (RBF = 6)									
Total Medicaid Paid for ONLY Family Planning Only Enrollees	$2,288,844		$2,418,098		$2,450,831		$2,472,643		$2,472,643
Avg Medicaid Paid per ONLY Family Planning Only Enrollee	$82		$87		$88		$89		$89
Expenditures for Aliens with Restricted Benefits (RBF = 2)									
Total Medicaid Paid for Aliens with Restricted Benefits ONLY Enrollment	$46,507,568	X	$62,685,632		$72,506,027		$77,994,845		$77,994,845
Avg Medicaid Paid per Alien Enrollee with Restricted Benefits ONLY	$4,413	X	$5,944		$6,867		$7,348		$7,348
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
Total Medicaid Paid for EDB Duals with Only Restricted Benefits Enrollment	$26,214,774		$30,028,555		$30,968,179		$31,366,571		$31,366,571
Avg Medicaid Paid per EDB Dual with Only Restricted Benefits Enrollment	$785		$900		$928		$938		$938
Expenditures for Prescription Drug Enrollees (RBF = X, Y, or Z)									
Total Medicaid Paid for Prescription Drug ONLY Enrollees (May Have a Month or More of RBF = 3)	$0		$0		$0		$0		$0
Avg Medicaid Paid per Prescription Drug ONLY Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Dual Prescription Drug Enrollees									
Total Medicaid Paid for Prescription Drug ONLY Enrollees Who Are EDB Duals	$0		$0		$0		$0		$0
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.									
Total Medicaid Enrollees	825,305		825,462		825,648		827,023		827,023
Aged Total	40,767		40,785		40,805		40,951		40,951
Disabled Total	128,284		128,477		128,758		130,501		130,501
Child Total	502,286		502,292		502,292		502,324		502,324
Adult Total	153,968		153,908		153,793		153,247		153,247
Total Medicaid Person-Years of Enrollment	674,066		674,142		674,231		674,902		674,902
Total EDB Duals	78,335		78,363		78,387		78,642		78,642

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Aged	35,714		35,733		35,754		35,945		35,945
Disabled	40,369		40,377		40,382		40,457		40,457
TOTAL MEDICAID AMOUNT PAID									
Total Medicaid Paid	$4,977,815,460		$5,488,309,699		$5,610,240,249		$5,656,126,293		$5,656,126,293
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$6,031		$6,649		$6,795		$6,839		$6,839
Aged	$21,700		$24,112		$24,476		$24,540		$24,540
Disabled	$19,210		$21,284		$21,745		$21,693		$21,693
Child	$2,190		$2,368		$2,430		$2,439		$2,439
Adult	$3,433		$3,777		$3,844		$3,883		$3,883
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$19,628		$22,054		$22,309		$22,350		$22,350
Aged	$22,698		$25,197		$25,552		$25,595		$25,595
Disabled	$17,800		$20,277		$20,448		$20,468		$20,468
Managed CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.									
% Total Enrollees in MC Anytime During Year	84.03		84.01		83.99		83.83		83.83
Total MC Enrollees	693,522		693,499		693,476		693,267		693,267
Aged	609		610		611		615		615
Disabled	77,543		77,614		77,730		78,433		78,433
Child	484,380		484,370		484,357		484,241		484,241
Adult	130,990		130,905		130,778		129,978		129,978
% of MC Enrollees in HMO/HIO (MC TYPE = 1)	99.98		99.98		99.98		99.98		N/A
% of MC Enrollees in Dental (MC TYPE = 2)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in BHO (MC TYPE = 3)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in Prenatal (MC TYPE = 4)	0.00		0.00		0.00		0.00		Div by 0
% of MC Enrollees in LTC (MC TYPE = 5)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in PACE (MC TYPE = 6)	0.02		0.02		0.02		0.02		N/A
% of MC Enrollees in PCCM (MC TYPE = 7)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in Other MC (MC TYPE = 8)	0.00		0.00		0.00		0.00		N/A
% EDB Duals Ever Enrolled in HMO/HIOs	7.92		7.92		7.92		7.90		7.90
% EDB Duals in PHP Only or PHP/PCCM Only	0.00		0.00		0.00		0.00		0.00
% EDB Duals in PCCM Only	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	35.20		35.20		35.20		35.19		32.69
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	0.00		0.00		0.00		0.00		0.00
% Section 1915(c) Waiver Enrollees in PCCM Only	0.00		0.00		0.00		0.00		0.00
Total Enrollees in June	662,946		662,983		663,023		663,449		663,449
June % HMO/HIO Only (MC COMBO = 01)	80.10		80.10		80.09		80.03		80.03
June % Dental Plan Only (MC COMBO = 02)	0.00		0.00		0.00		0.00		0.00
June % BHO Only (MC COMBO = 03)	0.00		0.00		0.00		0.00		0.00
June % PCCM Only (MC COMBO = 04)	0.00		0.00		0.00		0.00		0.00
June % Other MC Only (MC COMBO = 05)	0.02		0.02		0.02		0.02		0.02
June % HMO/HIO & Dental (MC COMBO = 06)	0.00		0.00		0.00		0.00		0.00

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June % HMO/HIO & BHO (MC COMBO = 07)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Other MC (MC COMBO = 08)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	0.00		0.00		0.00		0.00		0.00
June % Dental & PCCM (MC COMBO = 10)	0.00		0.00		0.00		0.00		0.00
June % BHO & PCCM (MC COMBO = 11)	0.00		0.00		0.00		0.00		0.00
June % Other MC & PCCM (MC COMBO = 12)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO & PCCM (MC COMBO = 13)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO (MC COMBO = 14)	0.00		0.00		0.00		0.00		0.00
June % Other Combinations (MC COMBO = 15)	0.00		0.00		0.00		0.00		0.00
June % FFS Only (MC COMBO = 16)	19.88		19.88		19.89		19.95		19.95
June % MC Status Unknown (MC COMBO = 99)	0.00		0.00		0.00		0.00		0.00
CAPITATION CLAIMS									
Total Capitation Payments	$1,244,840,700		$1,285,391,105		$1,288,990,368		$1,289,925,526		$1,289,925,526
HMO/HIO	$1,244,840,700		$1,285,391,105		$1,288,990,368		$1,289,925,526		$1,289,925,526
PHP	$0		$0		$0		$0		$0
PCCM	$0		$0		$0		$0		$0
Ratio of Capitation Claims to Person-Month Enrollment in MC	0.56		0.56		0.56		0.56		0.56
HMO/HIO	0.56		0.56		0.56		0.56		0.56
PHP	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PCCM	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Capitation Payment per Person-Month Enrollment in MC	$194		$200		$200		$201		$201
HMO/HIO	$194		$200		$200		$201		$201
PHP	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PCCM	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY									
Total Capitation Payments	$0		$0		$0		$0		$0
Total Medicaid Paid	$0		$0		$0		$0		$0
Count of Enrollees	0		0		0		0		0
PERSONS ENROLLED IN PCCM ONLY									
Total Capitation Payments	$0		$0		$0		$0		$0
Count of Enrollees	0		0		0		0		0
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR									
Count of Enrollees	693,522		693,499		693,476		693,267		693,267
Aged	609		610		611		615		615
Disabled	77,543		77,614		77,730		78,433		78,433
Child	484,380		484,370		484,357		484,241		484,241
Adult	130,990		130,905		130,778		129,978		129,978
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	535,905		535,887		535,863		535,714		535,714
Total Capitation Payments	$1,244,840,700		$1,285,391,105		$1,288,990,368		$1,289,925,526		$1,289,925,526
Avg Capitation Payments	$1,795		$1,853		$1,859		$1,861		$1,861
Aged	$5,620		$5,650		$5,717		$5,705		$5,705
Disabled	$5,694		$5,738		$5,740		$5,701		$5,701
Child	$970		$985		$988		$988		$988
Adult	$2,521		$2,745		$2,760		$2,777		$2,777

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Total FFS Payments	$1,579,217,525		$1,754,582,266		$1,803,675,621		$1,820,118,662		$1,820,118,662
Avg FFS Payments per Enrollee	$2,277		$2,530		$2,601		$2,625		$2,625
Aged	$8,909		$9,967		$10,012		$10,175		$10,175
Disabled	$11,171		$12,419		$12,671		$12,701		$12,701
Child	$1,093		$1,223		$1,274		$1,282		$1,282
Adult	$1,360		$1,467		$1,494		$1,516		$1,516
Total FFS Payments by Type of Service									
IP (MAX TOS = 01)	$218,372,136	X	$267,763,627		$282,657,978		$291,403,166		$291,403,166
ILTC (MAX TOS = 02, 04, 05, 07)	$47,638,413	X	$56,346,746		$59,300,985		$60,365,120		$60,365,120
Drug (MAX TOS = 16)	$176,364,409		$179,866,696		$180,070,294		$180,118,894		$180,118,894
All Other (Excluding Capitation Payments)	$1,136,842,567		$1,250,605,197		$1,281,646,364		$1,288,231,482		$1,288,231,482
Average FFS Payments by Type of Service									
IP (MAX TOS = 01)	$315	X	$386		$408		$420		$420
ILTC (MAX TOS = 02, 04, 05, 07)	$69	X	$81		$86		$87		$87
Drug (MAX TOS = 16)	$254		$259		$260		$260		$260
All Other (Excluding Capitation Payments)	$1,639		$1,803		$1,848		$1,858		$1,858
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total Non-Dual FFS Enrollees	59,655		59,807		59,991		61,326		61,326
Total Non-Dual FFS Recipients	20,928	X	26,286		28,558		29,515		29,515
Total Non-Dual FFS Person-Years of Enrollment	26,801		26,859		26,929		27,404		27,404
Aged Total	4,953		4,952		4,950		4,903		4,903
Aged, Cash (MAX ELIG CD = 11)	2,160		2,160		2,163		2,158		2,158
Aged, Medically Needy (MAX ELIG CD = 21)	2,587		2,588		2,583		2,565		2,565
Aged, Poverty (MAX ELIG CD = 31)	206		204		204		180		180
Other Aged (MAX ELIG CD = 41)	0		0		0		0		0
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	14,940		15,053		15,213		16,201		16,201
Disabled, Cash (MAX ELIG CD = 12)	8,308		8,324		8,350		8,555		8,555
Disabled, Medically Needy (MAX ELIG CD = 22)	5,683		5,779		5,913		6,728		6,728
Disabled, Poverty (MAX ELIG CD = 32, 3A)	576		577		577		554		554
Other Disabled (MAX ELIG CD = 42)	373		373		373		364		364
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	17,886		17,902		17,915		18,063		18,063
AFDC Child, Cash (MAX ELIG CD = 14)	7,967		7,975		7,976		8,054		8,054
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	1,313		1,314		1,315		1,326		1,326
Child Poverty (MAX ELIG CD = 34)	7,145		7,153		7,160		7,219		7,219
Other Child (MAX ELIG CD = 44)	220		219		223		221		221
Foster Care Child (MAX ELIG CD = 48)	989		989		989		991		991
1115 Child (MAX ELIG CD = 54)	252		252		252		252		252
Adult Total	21,876		21,900		21,913		22,159		22,159
AFDC Adult, Cash (MAX ELIG CD = 15)	10,856		10,875		10,897		11,038		11,038

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AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	3,272		3,277		3,275		3,314		3,314
Adult, Poverty (MAX ELIG CD = 35)	2,390		2,392		2,395		2,402		2,402
Other Adult (MAX ELIG CD = 45)	283		278		280		285		285
1115 Adult (MAX ELIG CD = 55)	5,075		5,078		5,066		5,120		5,120
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	759		756		755		638		638
Total FFS Medicaid Paid	$689,530,521	X	$798,875,060		$848,089,775		$867,596,109		$867,596,109
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	$11,559		$13,358		$14,137		$14,147		$14,147
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	$32,948		$30,392		$29,697		$29,395		$29,395
Total Capitation Payments	$605,222		$604,053		$604,456		$609,092		$609,092
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	355		357		358		362		362
Total HMO/HIO Payments (Among People not Enrolled)	$605,222		$604,053		$604,456		$609,092		$609,092
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$14,494		$16,265		$16,681		$16,768		$16,768
Aged, Cash (MAX ELIG CD = 11)	$17,681		$19,379		$19,664		$19,928		$19,928
Aged, Medically Needy (MAX ELIG CD = 21)	$12,940		$14,896		$15,446		$15,236		$15,236
Aged, Poverty (MAX ELIG CD = 31)	$588		$671		$690		$712		$712
Other Aged (MAX ELIG CD = 41)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$33,475		$38,094		$40,125		$38,689		$38,689
Disabled, Cash (MAX ELIG CD = 12)	$43,925		$48,071		$48,909		$48,005		$48,005
Disabled, Medically Needy (MAX ELIG CD = 22)	$18,247	X	$23,995		$28,194		$26,908		$26,908
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$9,707	X	$11,067		$11,799		$12,309		$12,309
Other Disabled (MAX ELIG CD = 42)	$69,442		$75,702		$76,439		$77,638		$77,638
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$5,587		$6,594		$6,900		$6,919		$6,919
AFDC Child, Cash (MAX ELIG CD = 14)	$938	X	$1,153		$1,337		$1,416		$1,416
AFDC-U Child, Cash (MAX ELIG CD = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	$34,705		$39,369		$40,282		$40,202		$40,202
Child Poverty (MAX ELIG CD = 34)	$3,368	X	$4,486		$4,781		$4,763		$4,763
Other Child (MAX ELIG CD = 44)	$774		$867	X	$895	X	$681		$681
Foster Care Child (MAX ELIG CD = 48)	$22,221		$24,391		$25,136		$25,273		$25,273
1115 Child (MAX ELIG CD = 54)	$2,677		$2,847		$2,759		$2,742		$2,742
Adult	$809	X	$1,226		$1,437		$1,516		$1,516
AFDC Adult, Cash (MAX ELIG CD = 15)	$455	X	$881	X	$1,164		$1,265		$1,265
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	$2,609	X	$3,321		$3,594		$3,728		$3,728
Adult, Poverty (MAX ELIG CD = 35)	$437	X	$1,103	X	$1,335		$1,409		$1,409
Other Adult (MAX ELIG CD = 45)	$345	X	$1,517		$1,648	X	$1,285		$1,285
1115 Adult (MAX ELIG CD = 55)	$608		$658		$664		$691		$691
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$195,479,002	X	$242,046,059		$276,144,018		$291,778,149		$291,778,149
IP: Number of Users	5,407	X	8,173		9,481		10,143		10,143
IP: Avg Medicaid Paid per User	$36,153	X	$29,615		$29,126		$28,766		$28,766

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IP: Avg Medicaid Covered Days Per User	16.89	X	13.32		12.82		12.61		12.61
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$1,384,748		$1,524,806		$1,524,806		$1,524,806		$1,524,806
MH Aged: Number of Users	12		12		12		12		12
MH Aged: Avg Medicaid Paid per User	$115,396		$127,067		$127,067		$127,067		$127,067
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$44,867,723		$49,349,123		$50,645,272		$50,965,874		$50,965,874
IP Psych, Age < 21: Number of Users	528		553		554		557		557
IP Psych, Age < 21: Avg Medicaid Paid per User	$84,977		$89,239		$91,417		$91,501		$91,501
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$11,302,974	X	$15,329,212		$15,352,223		$15,355,708		$15,355,708
ICF/MR: Number of Users	69		69		69		69		69
ICF/MR: Avg Medicaid Paid per User	$163,811	X	$222,162		$222,496		$222,546		$222,546
NF: Total Medicaid Paid (MAX TOS = 07)	$133,196,133		$149,848,261		$151,969,383		$152,271,020		$152,271,020
NF: Number of Users	2,425		2,622		2,728		2,757		2,757
NF:Avg Medicaid Paid per User	$54,926		$57,150		$55,707		$55,231		$55,231
Physician: Total Medicaid Paid (MAX TOS = 08)	$20,780,770	X	$26,633,707		$29,868,695		$31,318,008		$31,318,008
Physician: Number of Users	15,348	X	18,957		20,707		21,360		21,360
Physician: Avg Medicaid Paid per User	$1,354		$1,405		$1,442		$1,466		$1,466
Dental: Total Medicaid Paid (MAX TOS = 09)	$408,247	X	$491,465		$510,686		$514,410		$514,410
Dental: Number of Users	1,303		1,486		1,522		1,528		1,528
Dental: Avg Medicaid Paid per User	$313		$331		$336		$337		$337
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$6,715		$7,258		$7,524		$7,240		$7,240
Other Practitioner: Number of Users	144		149		152		143		143
Other Practitioner: Avg Medicaid Paid per User	$47		$49		$50		$51		$51
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$28,819,346	X	$33,883,683		$35,892,494		$36,713,266		$36,713,266
Outpatient: Number of Users	9,894	X	12,565		13,691		14,111		14,111
Outpatient: Avg Medicaid Paid per User	$2,913		$2,697		$2,622		$2,602		$2,602
Clinic: Total Medicaid Paid (MAX TOS = 12)	$931,906	X	$1,283,555		$1,408,826		$1,447,677		$1,447,677
Clinic: Number of Users	1,877	X	2,465		2,681		2,781		2,781
Clinic: Avg Medicaid Paid per User	$496		$521		$525		$521		$521
Home Health: Total Medicaid Paid (MAX TOS = 13)	$16,280,282		$18,495,434		$18,805,088		$18,693,357		$18,693,357
Home Health: Number of Users	4,269		4,483		4,583		4,588		4,588
Home Health: Avg Medicaid Paid per User	$3,814		$4,126		$4,103		$4,074		$4,074
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$17,723,351	X	$21,023,005		$22,175,228		$22,622,988		$22,622,988
Lab/Xray: Number of Users	14,386	X	17,001		18,143		18,572		18,572
Lab/Xray:Avg Medicaid Paid per User	$1,232		$1,237		$1,222		$1,218		$1,218
Drugs: Total Medicaid Paid (MAX TOS = 16)	$63,948,289		$68,257,629		$69,313,737		$69,451,007		$69,451,007
Drugs: Number of Users	16,523		17,424		17,645		17,718		17,718
Drugs: Avg Medicaid Paid per User	$3,870		$3,917		$3,928		$3,920		$3,920
Other Services: Total Medicaid Paid (MAX TOS = 19)	$7,600,042	X	$9,209,091		$10,361,582		$10,628,965		$10,628,965
Other Services: Number of Users	1,658	X	2,006		2,168		2,198		2,198
Other Services: Avg Medicaid Paid per User	$4,584		$4,591		$4,779		$4,836		$4,836
Transportation: Total Medicaid Paid (MAX TOS = 26)	$160,276	X	$213,130	X	$244,071		$279,411		$279,411
Transportation: Number of Users	986	X	1,250	X	1,412		1,564		1,564
Transportation: Avg Medicaid Paid per User	$163		$171		$173		$179		$179
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$2,616,559		$2,840,194		$2,880,389		$2,892,549		$2,892,549

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Personal Care Services: Number of Users	438		450		453		454		454
Personal Care Services: Avg Medicaid Paid per User	$5,974		$6,312		$6,358		$6,371		$6,371
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$26,880	X	$33,420		$36,100		$34,700		$34,700
Targeted Case Management: Number of Users	143		163		165		164		164
Targeted Case Management: Avg Medicaid Paid per User	$188		$205		$219		$212		$212
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$2,691		$2,940		$2,940		$2,940		$2,940
Rehabilitation Services: Number of Users	1		1		1		1		1
Rehabilitation Services: Avg Medicaid Paid per User	$2,691		$2,940		$2,940		$2,940		$2,940
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$3,825,328	X	$5,152,475		$5,811,945		$5,871,409		$5,871,409
PT/OT/Speech/Hearing: Number of Users	2,144		2,353		2,501		2,511		2,511
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$1,784	X	$2,190		$2,324		$2,338		$2,338
Hospice: Total Medicaid Paid (MAX TOS = 35)	$2,976,603	X	$3,706,698		$4,380,660		$4,452,320		$4,452,320
Hospice: Number of Users	248	X	300		314		324		324
Hospice: Avg Medicaid Paid per User	$12,002		$12,356		$13,951		$13,742		$13,742
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$21,705,756		$23,520,773		$24,033,680		$24,315,528		$24,315,528
Durable Medical Equipment: Number of Users	4,982		5,315		5,465		5,631		5,631
Durable Medical Equipment: Avg Medicaid Paid per User	$4,357		$4,425		$4,398		$4,318		$4,318
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$17,928,935		$21,310,650		$21,362,340		$21,399,121		$21,399,121
Residential Care: Number of Users	590		621		633		625		625
Residential Care: Avg Medicaid Paid per User	$30,388		$34,317		$33,748		$34,239		$34,239
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$6,744,377		$8,080,682		$8,528,284		$8,146,635		$8,146,635
Psych Services: Number of Users	4,382	X	5,271		5,792		5,981		5,981
Psych Services: Avg Medicaid Paid per User	$1,539		$1,533		$1,472		$1,362		$1,362
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$9,692,899		$10,748,029		$10,815,449		$10,794,516		$10,794,516
Adult Day Care: Number of Users	791		798		804		801		801
Adult Day Care: Avg Medicaid Paid per User	$12,254		$13,469		$13,452		$13,476		$13,476
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$3,277	X	$4,047		$4,603		$4,758		$4,758
Aged	$3,011	X	$3,539		$3,687		$3,786		$3,786
Disabled	$10,162	X	$12,040		$13,689		$13,652		$13,652
Child	$1,035	X	$1,511		$1,676		$1,705		$1,705
Adult	$468	X	$741	X	$895		$959		$959
ILTC (MAX TOS = 02,04,05,07)	$3,198		$3,612		$3,659		$3,589		$3,589
Aged	$6,905		$7,730		$7,830		$7,745		$7,745
Disabled	$7,882		$8,968		$8,993		$8,513		$8,513
Child	$2,164		$2,385		$2,446		$2,443		$2,443
Adult	$3	X	$4	X	$5		$5		$5
Drugs (MAX TOS = 16)	$1,072		$1,141		$1,155		$1,132		$1,132
Aged	$1,455		$1,490		$1,497		$1,509		$1,509
Disabled	$2,853		$3,023		$3,051		$2,867		$2,867
Child	$725		$791		$797		$796		$796
Adult	$52		$55		$56		$55		$55
All Other Services	$4,012		$4,557		$4,720		$4,668		$4,668
Aged	$3,123		$3,507		$3,668		$3,728		$3,728

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Disabled	$12,577		$14,063		$14,392		$13,657		$13,657
Child	$1,662		$1,907		$1,981		$1,975		$1,975
Adult	$286	X	$426		$481		$498		$498
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	9.06	X	13.67		15.80		16.54		16.54
Aged	13.99		15.87		16.36		16.54		16.54
Disabled	20.04	X	25.27		29.45		30.12		30.12
Child	3.91	X	11.54		13.52		14.04		14.04
Adult	4.66	X	6.93		8.07		8.65		8.65
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	5.08		5.44		5.60		5.53		5.53
Aged	13.83		14.84		15.37		15.19		15.19
Disabled	12.66		13.56		13.92		13.33		13.33
Child	2.50		2.63		2.63		2.62		2.62
Adult	0.03	X	0.03	X	0.05		0.05		0.05
% with Ratio of ILTC Days/Enrollment Days > 1	0.00		0.00		0.00		0.00		0.00
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	27.70		29.13		29.41		28.89		28.89
Aged	65.82		66.62		66.97		67.39		67.39
Disabled	55.16		56.31		56.43		53.31		53.31
Child	13.79		15.63		16.00		15.96		15.96
Adult	11.68		13.01		13.14		13.06		13.06
% Non-Dual FFS Enrollees with All Other Claims	31.83	X	40.61		44.36		44.97		44.97
Aged	69.59		71.39		72.24		72.45		72.45
Disabled	62.26		69.28		74.88		73.51		73.51
Child	16.55	X	28.71		32.28		33.11		33.11
Adult	15.00	X	23.68		26.74		27.69		27.69
Avg # IP Days per Non-Dual FFS User	17	X	13		13		13		13
Aged	9		9		10		10		10
Disabled	24	X	21		20		20		20
Child	11	X	7		6		6		6
Adult	4		4		4		4		4
Avg # ILTC Days per Non-Dual FFS User	243		253		249		246		246
Aged	246		257		251		249		249
Disabled	249		259		254		250		250
Child	215		225		230		230		230
Adult	44		44		42		37		37
% Non-Dual FFS Enrollees with Maternal Delivery	0.91	X	1.18		1.26		1.28		1.28
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	8		8		9		8		8
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	66		65		68		67		67
Inpatient Hospital (MAX TOS = 01) > $500,000	51	X	44		44		40		40
ILTC (MAX TOS = 02,04,05,07) > $200,000	11	X	43		43		43		43
Drugs (MAX TOS = 16) > $200,000	6	X	12	X	16		17		17
All Other Services > $200,000	156	X	203		207		208		208
Maximum FFS Medicaid Paid	$3,246,845		$3,281,721		$3,281,904		$3,316,918		$3,316,918

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Inpatient Hospital (MAX TOS = 01)	$3,135,787		$3,166,090		$3,169,406		$3,203,201		$3,203,201
ILTC (MAX TOS = 02,04,05,07)	$267,599	X	$359,276		$359,276		$359,276		$359,276
Drugs (MAX TOS = 16)	$1,529,916		$1,709,853		$1,709,853		$1,709,853		$1,709,853
All Other Services	$371,360		$403,018		$403,018		$403,018		$403,018
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$398,873	X	$491,857		$525,866		$598,463		$598,463
FP: Number of Users	906	X	1,065		1,125		1,171		1,171
FP: Avg Medicaid Paid per User	$440		$462		$467		$511		$511
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$680,367	X	$942,113		$1,057,717		$1,092,988		$1,092,988
FQHC: Number of Users	1,275	X	1,758		1,957		2,047		2,047
FQHC: Avg Medicaid Paid per User	$534		$536		$540		$534		$534
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$30,047,810		$35,559,933		$35,874,451		$35,731,152		$35,731,152
Section 1915(c) Waiver: Number of Users	991		1,007		1,021		1,013		1,013
Section 1915(c) Waiver: Avg Medicaid Paid per User	$30,321		$35,313		$35,137		$35,273		$35,273
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$126,853,413		$138,267,597		$138,813,811		$138,768,475		$138,768,475
Number of Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	4,876		5,109		5,222		5,220		5,220
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	$26,016		$27,064		$26,582		$26,584		$26,584
Aged	$12,853		$13,450		$13,389		$13,520		$13,520
Disabled	$32,130		$34,476		$34,268		$34,214		$34,214
Child	$13,290		$12,573		$11,941		$11,978		$11,978
Adult	$1,764	X	$1,487		$1,447		$1,436		$1,436
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	8.17		8.54		8.70		8.51		8.51
Aged	7.23		7.49		7.58		7.59		7.59
Disabled	22.25		22.53		22.53		21.18		21.18
Child	6.47		7.22		7.61		7.52		7.52
Adult	0.16	X	0.24		0.26		0.27		0.27
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$30,047,810		$35,559,933		$35,874,451		$35,731,152		$35,731,152
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	991		1,007		1,021		1,013		1,013
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$30,321		$35,313		$35,137		$35,273		$35,273
Aged	$30,053		$33,408		$33,412		$34,585		$34,585
Disabled	$30,574		$35,783		$35,583		$35,642		$35,642
Child	$12,384		$12,102		$12,102		$12,104		$12,104
Adult	$17,163		$17,745		$17,745		$17,745		$17,745
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	1.66		1.68		1.70		1.65		1.65
Aged	1.45		1.45		1.45		1.43		1.43

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Disabled	6.07		6.13		6.15		5.74		5.74
Child	0.06		0.07		0.07		0.07		0.07
Adult	0.00		0.00		0.00		0.00		0.00
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total EDB Dual FFS Enrollees	72,128		72,156		72,181		72,430		72,430
Number of EDB Dual FFS Recipients	64,199		65,697		66,432		66,758		66,758
Total EDB Dual FFS Person-Years of Enrollment	63,909		63,923		63,935		64,100		64,100
% EDB Only Dual (EDB DUAL = 50)	1.65	X	1.66	X	1.67	X	1.17		1.17
% QMB Only (EDB DUAL = 51)	1.33		1.32		1.32		1.32		1.32
% QMB Plus (EDB DUAL = 52)	68.37		68.36		68.35		68.39		68.39
% SLMB Only (EDB DUAL = 53)	0.64		0.64		0.64		0.64		0.64
% SLMB Plus (EDB DUAL = 54)	0.00		0.00		0.00		0.00		0.00
% QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% QI 1 (EDB DUAL = 56)	0.30		0.30		0.30		0.29		0.29
% QI 2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% Other Type Dual (EDB DUAL = 58)	27.71		27.72		27.72		28.18		28.18
% Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	97.74		97.74		97.74		97.75		97.75
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	2.26		2.26		2.26		2.25		2.25
Aged EDB Dual FFS Total	35,205		35,223		35,244		35,433		35,433
Aged, Cash (MAX ELIG CD = 11)	16,234		16,239		16,241		16,300		16,300
Aged, Medically Needy (MAX ELIG CD = 21)	18,205		18,218		18,238		18,381		18,381
Aged, Poverty (MAX ELIG CD = 31)	746		746		745		732		732
Other Aged (MAX ELIG CD = 41)	20		20		20		20		20
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled EDB Dual FFS Total	35,801		35,810		35,815		35,867		35,867
Disabled, Cash (MAX ELIG CD = 12)	26,383		26,385		26,387		26,405		26,405
Disabled, Medically Needy (MAX ELIG CD = 22)	4,121		4,130		4,132		4,176		4,176
Disabled, Poverty (MAX ELIG CD = 32, 3A)	947		945		946		930		930
Other Disabled (MAX ELIG CD = 42)	4,350		4,350		4,350		4,356		4,356
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Total FFS Medicaid Paid	$1,463,608,234		$1,648,843,957		$1,668,866,771		$1,677,863,646		$1,677,863,646
Avg FFS Medicaid Paid per FFS Dual	$20,292		$22,851		$23,121		$23,165		$23,165
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	$22,798		$25,098		$25,121		$25,134		$25,134
Total Capitation Payments	$13,258		$13,258		$13,258		$13,258		$13,258
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	8		8		8		8		8
Total HMO/HIO Payments (Among People not Enrolled)	$13,258		$13,258		$13,258		$13,258		$13,258
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP									
Aged	$22,838		$25,362		$25,722		$25,765		$25,765
Aged, Cash (MAX ELIG CD = 11)	$7,785		$8,487		$8,598		$8,566		$8,566
Aged, Medically Needy (MAX ELIG CD = 21)	$37,105		$41,347		$41,922		$41,940		$41,940
Aged, Poverty (MAX ELIG CD = 31)	$2,757		$2,897		$3,044		$3,179		$3,179

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Other Aged (MAX ELIG CD = 41)	$3,728		$4,460		$4,486		$4,325		$4,325
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$18,328		$20,985		$21,165		$21,202		$21,202
Disabled, Cash (MAX ELIG CD = 12)	$12,226		$14,209		$14,327		$14,310		$14,310
Disabled, Medically Needy (MAX ELIG CD = 22)	$43,972		$48,949		$49,473		$49,461		$49,461
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$3,336		$3,640		$3,780		$3,903		$3,903
Other Disabled (MAX ELIG CD = 42)	$34,304		$39,304		$39,531		$39,581		$39,581
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$79,754,321		$75,222,895		$77,909,467		$80,246,342		$80,246,342
IP: Number of Users	14,613		16,231		16,687		16,883		16,883
IP: Avg Medicaid Paid per User	$5,458		$4,635		$4,669		$4,753		$4,753
IP: Avg Medicaid Covered Days Per User	2.88	X	2.19		2.14		2.15		2.15
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$2,209,592		$2,553,071		$2,678,347		$2,714,649		$2,714,649
MH Aged: Number of Users	22		24		25		26		26
MH Aged: Avg Medicaid Paid per User	$100,436		$106,378		$107,134		$104,410		$104,410
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$274,101		$261,130		$261,130		$261,130		$261,130
IP Psych, Age < 21: Number of Users	3	X	2		2		2		2
IP Psych, Age < 21: Avg Medicaid Paid per User	$91,367	X	$130,565		$130,565		$130,565		$130,565
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$36,283,069	X	$48,689,738		$48,713,384		$48,713,204		$48,713,204
ICF/MR: Number of Users	232		232		232		232		232
ICF/MR: Avg Medicaid Paid per User	$156,393	X	$209,870		$209,971		$209,971		$209,971
NF: Total Medicaid Paid (MAX TOS = 07)	$772,550,750		$863,462,481		$873,538,348		$878,034,907		$878,034,907
NF: Number of Users	17,428		18,518		19,003		19,198		19,198
NF:Avg Medicaid Paid per User	$44,328		$46,628		$45,968		$45,736		$45,736
Physician: Total Medicaid Paid (MAX TOS = 08)	$22,773,515		$25,934,790		$26,927,919		$27,300,054		$27,300,054
Physician: Number of Users	52,941		54,624		55,357		55,724		55,724
Physician: Avg Medicaid Paid per User	$430		$475		$486		$490		$490
Dental: Total Medicaid Paid (MAX TOS = 09)	$9,589		$11,355		$11,677		$11,728		$11,728
Dental: Number of Users	58		66		69		70		70
Dental: Avg Medicaid Paid per User	$165		$172		$169		$168		$168
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$710,985		$805,380		$836,394		$849,850		$849,850
Other Practitioner: Number of Users	15,396		16,804		17,296		17,489		17,489
Other Practitioner: Avg Medicaid Paid per User	$46		$48		$48		$49		$49
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$14,717,725		$16,872,237		$17,403,925		$17,718,883		$17,718,883
Outpatient: Number of Users	24,627		26,509		26,949		27,148		27,148
Outpatient: Avg Medicaid Paid per User	$598		$636		$646		$653		$653
Clinic: Total Medicaid Paid (MAX TOS = 12)	$370,181	X	$439,817		$513,688		$521,457		$521,457
Clinic: Number of Users	3,599		4,021		4,356		4,414		4,414
Clinic: Avg Medicaid Paid per User	$103		$109		$118		$118		$118
Home Health: Total Medicaid Paid (MAX TOS = 13)	$100,134,905		$113,288,470		$114,376,994		$114,829,839		$114,829,839
Home Health: Number of Users	7,641		7,719		7,734		7,746		7,746
Home Health: Avg Medicaid Paid per User	$13,105		$14,677		$14,789		$14,824		$14,824
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$8,507,108		$9,492,558		$9,848,995		$10,036,701		$10,036,701

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Lab/Xray: Number of Users	39,227		41,430		42,012		42,273		42,273
Lab/Xray:Avg Medicaid Paid per User	$217		$229		$234		$237		$237
Drugs: Total Medicaid Paid (MAX TOS = 16)	$7,926,135		$8,261,956		$8,389,778		$8,572,551		$8,572,551
Drugs: Number of Users	25,495		26,417		26,736		26,896		26,896
Drugs: Avg Medicaid Paid per User	$311		$313		$314		$319		$319
Other Services: Total Medicaid Paid (MAX TOS = 19)	$20,923,558		$23,371,250		$23,664,656		$23,958,076		$23,958,076
Other Services: Number of Users	11,110		12,080		12,488		12,654		12,654
Other Services: Avg Medicaid Paid per User	$1,883		$1,935		$1,895		$1,893		$1,893
Transportation: Total Medicaid Paid (MAX TOS = 26)	$2,028,045	X	$2,388,471		$2,515,372		$2,578,832		$2,578,832
Transportation: Number of Users	10,327		11,558		12,035		12,269		12,269
Transportation: Avg Medicaid Paid per User	$196		$207		$209		$210		$210
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$21,467,277		$23,296,714		$23,761,107		$23,760,342		$23,760,342
Personal Care Services: Number of Users	3,162		3,227		3,261		3,262		3,262
Personal Care Services: Avg Medicaid Paid per User	$6,789		$7,219		$7,286		$7,284		$7,284
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$244,180	X	$285,980		$312,800		$316,455		$316,455
Targeted Case Management: Number of Users	1,093		1,157		1,180		1,184		1,184
Targeted Case Management: Avg Medicaid Paid per User	$223		$247		$265		$267		$267
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$50,815		$59,487		$61,626		$61,386		$61,386
Rehabilitation Services: Number of Users	48		54		54		54		54
Rehabilitation Services: Avg Medicaid Paid per User	$1,059		$1,102		$1,141		$1,137		$1,137
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$2,216,037	X	$2,761,411		$2,890,344		$2,979,192		$2,979,192
PT/OT/Speech/Hearing: Number of Users	6,454		7,266		7,516		7,689		7,689
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$343		$380		$385		$387		$387
Hospice: Total Medicaid Paid (MAX TOS = 35)	$15,046,997	X	$19,521,110		$20,614,000		$21,635,737		$21,635,737
Hospice: Number of Users	1,022	X	1,235		1,307		1,354		1,354
Hospice: Avg Medicaid Paid per User	$14,723		$15,807		$15,772		$15,979		$15,979
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$21,058,136		$23,569,852		$24,082,563		$24,356,880		$24,356,880
Durable Medical Equipment: Number of Users	20,028		21,064		21,412		21,680		21,680
Durable Medical Equipment: Avg Medicaid Paid per User	$1,051		$1,119		$1,125		$1,123		$1,123
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$203,058,482		$241,816,397		$242,319,219		$242,739,856		$242,739,856
Residential Care: Number of Users	6,308		6,422		6,438		6,295		6,295
Residential Care: Avg Medicaid Paid per User	$32,191		$37,654		$37,639		$38,561		$38,561
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$40,017,802		$45,056,133		$45,441,142		$43,710,020		$43,710,020
Psych Services: Number of Users	18,275		19,473		20,039		20,246		20,246
Psych Services: Avg Medicaid Paid per User	$2,190		$2,314		$2,268		$2,159		$2,159
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$89,391,349		$99,393,181		$99,750,748		$99,895,230		$99,895,230
Adult Day Care: Number of Users	7,480		7,564		7,589		7,598		7,598
Adult Day Care: Avg Medicaid Paid per User	$11,951		$13,140		$13,144		$13,148		$13,148
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$1,106		$1,043		$1,079		$1,108		$1,108
Aged	$1,021		$936		$970		$988		$988
Disabled	$1,207		$1,156		$1,194		$1,231		$1,231
ILTC (MAX TOS = 02,04,05,07)	$11,248		$12,680		$12,818		$12,836		$12,836
Aged	$18,532		$20,744		$20,988		$20,984		$20,984

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Measure	BETA-MAX 2008 v1 Value	BETA-MAX 2008 v1 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v2 Value	BETA-MAX 2008 v2 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v3 Value	BETA-MAX 2008 v3 Less than 80% or More than 120% of full MAX value	BETA-MAX 2008 v4 Value	BETA-MAX 2008 v4 Less than 80% or More than 120% of full MAX value	MAX 2008 Value
Disabled	$4,418		$5,124		$5,156		$5,168		$5,168
Drugs (MAX TOS = 16)	$110		$115		$116		$118		$118
Aged	$112		$119		$123		$124		$124
Disabled	$103		$106		$106		$109		$109
All Other Services	$7,828		$9,014		$9,107		$9,103		$9,103
Aged	$3,173		$3,562		$3,642		$3,669		$3,669
Disabled	$12,600		$14,599		$14,708		$14,694		$14,694
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Duals with IP Claims (MAX TOS = 01)	20.26		22.49		23.12		23.31		23.31
Aged	18.67		20.87		21.49		21.73		21.73
Disabled	21.95		24.18		24.78		24.93		24.93
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	24.52		26.02		26.68		26.86		26.86
Aged	42.13		44.73		45.89		46.12		46.12
Disabled	7.94		8.41		8.59		8.66		8.66
% FFS Duals with Drug Claims (MAX TOS = 16)	35.35		36.61		37.04		37.13		37.13
Aged	38.05		39.83		40.51		40.64		40.64
Disabled	33.00		33.77		33.96		34.01		34.01
% FFS Duals with All Other Claims	82.92		85.05		86.06		86.28		86.28
Aged	78.32		81.01		82.23		82.57		82.57
Disabled	88.25		89.64		90.35		90.46		90.46
Avg # IP Days per FFS Dual User (MAX TOS = 01)	3	X	2		2		2		2
Aged	3	X	2		2		2		2
Disabled	3	X	2		2		2		2
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	248		261		257		256		256
Aged	248		261		257		256		256
Disabled	249		261		258		257		257
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	0		0		0		0		0
Number of FFS Duals with FFS Medicaid Paid > $500,000	31	X	20		20		22		22
Inpatient Hospital (MAX TOS = 01) > $500,000	31	X	19		19		20		20
ILTC (MAX TOS = 02,04,05,07) > $200,000	30	X	149		148		148		148
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	7	X	27		27		27		27
Maximum FFS Medicaid Paid	$885,067	X	$725,229		$725,229		$725,229		$725,229
Inpatient Hospital (MAX TOS = 01)	$883,476	X	$719,337		$719,337		$719,337		$719,337
ILTC (MAX TOS = 02,04,05,07)	$259,290	X	$359,276		$359,276		$359,276		$359,276
Drugs (MAX TOS = 16)	$80,634		$80,634		$80,634		$86,899		$86,899
All Other Services	$282,965		$328,949		$328,954		$328,961		$328,961
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$56,645	X	$62,236	X	$63,910	X	$87,523		$87,523
FP: Number of Users	46	X	57	X	60		72		72
FP: Avg Medicaid Paid per User	$1,231		$1,092		$1,065		$1,216		$1,216
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0

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RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$240,161	X	$297,084	X	$368,468		$375,270		$375,270
FQHC: Number of Users	2,063	X	2,339		2,649		2,694		2,694
FQHC: Avg Medicaid Paid per User	$116		$127		$139		$139		$139
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$336,915,471		$395,707,381		$397,066,048		$397,746,312		$397,746,312
Section 1915(c) Waiver: Number of Users	9,418		9,514		9,537		9,554		9,554
Section 1915(c) Waiver: Avg Medicaid Paid per User	$35,774		$41,592		$41,634		$41,631		$41,631
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$416,948,655		$480,918,773		$483,353,697		$484,377,063		$484,377,063
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	15,571		15,756		15,809		15,688		15,688
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	$26,777		$30,523		$30,575		$30,876		$30,876
Aged	$15,818		$16,768		$16,810		$16,814		$16,814
Disabled	$30,490		$35,193		$35,266		$35,713		$35,713
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	21.59		21.84		21.90		21.66		21.66
Aged	11.14		11.27		11.33		11.27		11.27
Disabled	32.47		32.84		32.92		32.53		32.53
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$336,915,471		$395,707,381		$397,066,048		$397,746,312		$397,746,312
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	9,418		9,514		9,537		9,554		9,554
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$35,774		$41,592		$41,634		$41,631		$41,631
Aged	$25,266		$26,883		$26,920		$26,924		$26,924
Disabled	$36,963		$43,287		$43,327		$43,324		$43,324
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	13.06		13.19		13.21		13.19		13.19
Aged	2.71		2.79		2.79		2.78		2.78
Disabled	23.63		23.82		23.88		23.88		23.88
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total FFS Enrollees	131,783		131,963		132,172		133,756		133,756
# FFS Recipients	85,127		91,983		94,990		96,273		96,273
% FFS Enrollees Who Are Recipients	64.60		69.70		71.87		71.98		71.98
% Aged Who Are Recipients	87.24		89.78		91.01		91.19		91.19
% Disabled Who Are Recipients	82.56		85.53		87.66		87.10		87.10
% Child Who Are Recipients	19.37	X	32.19		35.38		36.10		36.10
% Adults Who Are Recipients	20.61	X	28.88		31.87		32.72		32.72
Total FFS Person-Years of Enrollment	90,710		90,782		90,864		91,503		91,503
Aged Total	40,158		40,175		40,194		40,336		40,336
Aged, Cash (MAX ELIG CD = 11)	18,394		18,399		18,404		18,458		18,458
Aged, Medically Needy (MAX ELIG CD = 21)	20,792		20,806		20,821		20,946		20,946
Aged, Poverty (MAX ELIG CD = 31)	952		950		949		912		912

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Other Aged (MAX ELIG CD = 41)	20		20		20		20		20
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	50,741		50,863		51,028		52,068		52,068
Disabled, Cash (MAX ELIG CD = 12)	34,691		34,709		34,737		34,960		34,960
Disabled, Medically Needy (MAX ELIG CD = 22)	9,804		9,909		10,045		10,904		10,904
Disabled, Poverty (MAX ELIG CD = 32, 3A)	1,523		1,522		1,523		1,484		1,484
Other Disabled (MAX ELIG CD = 42)	4,723		4,723		4,723		4,720		4,720
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	17,906		17,922		17,935		18,083		18,083
AFDC Child, Cash (MAX ELIG CD = 14)	7,970		7,978		7,979		8,057		8,057
AFDC-U Child, Cash (MAX ELIG CD = 16)	0		0		0		0		0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	1,318		1,319		1,320		1,331		1,331
Child Poverty (MAX ELIG CD = 34)	7,151		7,159		7,166		7,225		7,225
Other Child (MAX ELIG CD = 44)	220		219		223		221		221
Foster Care Child (MAX ELIG CD = 48)	995		995		995		997		997
1115 Child (MAX ELIG CD = 54)	252		252		252		252		252
Adult Total	22,978		23,003		23,015		23,269		23,269
AFDC Adult, Cash (MAX ELIG CD = 15)	11,652		11,671		11,692		11,838		11,838
AFDC-U Adult, Cash (MAX ELIG CD = 17)	0		0		0		0		0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	3,436		3,441		3,439		3,480		3,480
Adult, Poverty (MAX ELIG CD = 35)	2,438		2,440		2,443		2,450		2,450
Other Adult (MAX ELIG CD = 45)	313		309		311		313		313
1115 Adult (MAX ELIG CD = 55)	5,139		5,142		5,130		5,188		5,188
Total FFS Medicaid Paid	$2,153,138,755		$2,447,719,017		$2,516,956,546		$2,545,459,755		$2,545,459,755
Avg FFS Medicaid Paid per FFS Enrollee	$16,339		$18,549		$19,043		$19,031		$19,031
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	$25,293		$26,611		$26,497		$26,440		$26,440
Total Capitation Payments	$618,480		$617,311		$617,714		$622,350		$622,350
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	363		365		366		370		370
Total HMO/HIO Payments (Among People not Enrolled)	$618,480		$617,311		$617,714		$622,350		$622,350
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$21,809		$24,241		$24,609		$24,672		$24,672
Aged, Cash (MAX ELIG CD = 11)	$8,947		$9,766		$9,898		$9,894		$9,894
Aged, Medically Needy (MAX ELIG CD = 21)	$34,099		$38,057		$38,637		$38,670		$38,670
Aged, Poverty (MAX ELIG CD = 31)	$2,288		$2,419		$2,538		$2,692		$2,692
Other Aged (MAX ELIG CD = 41)	$3,728		$4,460		$4,486		$4,325		$4,325
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$22,788		$26,048		$26,817		$26,643		$26,643
Disabled, Cash (MAX ELIG CD = 12)	$19,817		$22,330		$22,640		$22,555		$22,555
Disabled, Medically Needy (MAX ELIG CD = 22)	$29,060		$34,395		$36,947		$35,545		$35,545
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$5,745		$6,456		$6,818		$7,041		$7,041
Other Disabled (MAX ELIG CD = 42)	$37,079		$42,179		$42,446		$42,516		$42,516
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$5,637		$6,650		$6,957		$6,976		$6,976
AFDC Child, Cash (MAX ELIG CD = 14)	$938	X	$1,153		$1,337		$1,416		$1,416

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AFDC-U Child, Cash (MAX ELIG CD = 16)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	$34,986		$39,687		$40,597		$40,515		$40,515
Child Poverty (MAX ELIG CD = 34)	$3,370	X	$4,488		$4,784		$4,767		$4,767
Other Child (MAX ELIG CD = 44)	$774		$867	X	$895	X	$681		$681
Foster Care Child (MAX ELIG CD = 48)	$22,519		$24,730		$25,472		$25,606		$25,606
1115 Child (MAX ELIG CD = 54)	$2,677		$2,847		$2,759		$2,742		$2,742
Adult	$876	X	$1,293		$1,504		$1,586		$1,586
AFDC Adult, Cash (MAX ELIG CD = 15)	$534	X	$960	X	$1,238		$1,343		$1,343
AFDC-U Adult, Cash (MAX ELIG CD = 17)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	$2,761	X	$3,467		$3,745		$3,876		$3,876
Adult, Poverty (MAX ELIG CD = 35)	$452	X	$1,112	X	$1,342		$1,416		$1,416
Other Adult (MAX ELIG CD = 45)	$532	X	$1,626		$1,751	X	$1,431		$1,431
1115 Adult (MAX ELIG CD = 55)	$613		$662		$669		$695		$695
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$275,233,323	X	$317,268,954		$354,053,485		$372,024,491		$372,024,491
IP: Number of Users	20,020	X	24,404		26,168		27,026		27,026
IP: Avg Medicaid Paid per User	$13,748		$13,001		$13,530		$13,765		$13,765
IP: Avg Medicaid Covered Days Per User	6.66		5.92		6.01		6.07		6.07
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$3,594,340		$4,077,877		$4,203,153		$4,239,455		$4,239,455
MH Aged: Number of Users	34		36		37		38		38
MH Aged: Avg Medicaid Paid per User	$105,716		$113,274		$113,599		$111,565		$111,565
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$45,141,824		$49,610,253		$50,906,402		$51,227,004		$51,227,004
IP Psych, Age < 21: Number of Users	531		555		556		559		559
IP Psych, Age < 21: Avg Medicaid Paid per User	$85,013		$89,388		$91,558		$91,640		$91,640
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$47,586,043	X	$64,018,950		$64,065,607		$64,068,912		$64,068,912
ICF/MR: Number of Users	301		301		301		301		301
ICF/MR: Avg Medicaid Paid per User	$158,093	X	$212,688		$212,843		$212,854		$212,854
NF: Total Medicaid Paid (MAX TOS = 07)	$905,746,883		$1,013,310,742		$1,025,507,731		$1,030,305,927		$1,030,305,927
NF: Number of Users	19,853		21,140		21,731		21,955		21,955
NF:Avg Medicaid Paid per User	$45,623		$47,933		$47,191		$46,928		$46,928
Physician: Total Medicaid Paid (MAX TOS = 08)	$43,554,285	X	$52,568,497		$56,796,614		$58,618,062		$58,618,062
Physician: Number of Users	68,289		73,581		76,064		77,084		77,084
Physician: Avg Medicaid Paid per User	$638		$714		$747		$760		$760
Dental: Total Medicaid Paid (MAX TOS = 09)	$417,836	X	$502,820		$522,363		$526,138		$526,138
Dental: Number of Users	1,361		1,552		1,591		1,598		1,598
Dental: Avg Medicaid Paid per User	$307		$324		$328		$329		$329
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$717,700		$812,638		$843,918		$857,090		$857,090
Other Practitioner: Number of Users	15,540		16,953		17,448		17,632		17,632
Other Practitioner: Avg Medicaid Paid per User	$46		$48		$48		$49		$49
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$43,537,071	X	$50,755,920		$53,296,419		$54,432,149		$54,432,149
Outpatient: Number of Users	34,521		39,074		40,640		41,259		41,259
Outpatient: Avg Medicaid Paid per User	$1,261		$1,299		$1,311		$1,319		$1,319
Clinic: Total Medicaid Paid (MAX TOS = 12)	$1,302,087	X	$1,723,372		$1,922,514		$1,969,134		$1,969,134
Clinic: Number of Users	5,476	X	6,486		7,037		7,195		7,195

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Clinic: Avg Medicaid Paid per User	$238		$266		$273		$274		$274
Home Health: Total Medicaid Paid (MAX TOS = 13)	$116,415,187		$131,783,904		$133,182,082		$133,523,196		$133,523,196
Home Health: Number of Users	11,910		12,202		12,317		12,334		12,334
Home Health: Avg Medicaid Paid per User	$9,775		$10,800		$10,813		$10,826		$10,826
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$26,230,459		$30,515,563		$32,024,223		$32,659,689		$32,659,689
Lab/Xray: Number of Users	53,613		58,431		60,155		60,845		60,845
Lab/Xray:Avg Medicaid Paid per User	$489		$522		$532		$537		$537
Drugs: Total Medicaid Paid (MAX TOS = 16)	$71,874,424		$76,519,585		$77,703,515		$78,023,558		$78,023,558
Drugs: Number of Users	42,018		43,841		44,381		44,614		44,614
Drugs: Avg Medicaid Paid per User	$1,711		$1,745		$1,751		$1,749		$1,749
Other Services: Total Medicaid Paid (MAX TOS = 19)	$28,523,600		$32,580,341		$34,026,238		$34,587,041		$34,587,041
Other Services: Number of Users	12,768		14,086		14,656		14,852		14,852
Other Services: Avg Medicaid Paid per User	$2,234		$2,313		$2,322		$2,329		$2,329
Transportation: Total Medicaid Paid (MAX TOS = 26)	$2,188,321	X	$2,601,601		$2,759,443		$2,858,243		$2,858,243
Transportation: Number of Users	11,313		12,808		13,447		13,833		13,833
Transportation: Avg Medicaid Paid per User	$193		$203		$205		$207		$207
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$24,083,836		$26,136,908		$26,641,496		$26,652,891		$26,652,891
Personal Care Services: Number of Users	3,600		3,677		3,714		3,716		3,716
Personal Care Services: Avg Medicaid Paid per User	$6,690		$7,108		$7,173		$7,172		$7,172
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$271,060	X	$319,400		$348,900		$351,155		$351,155
Targeted Case Management: Number of Users	1,236		1,320		1,345		1,348		1,348
Targeted Case Management: Avg Medicaid Paid per User	$219		$242		$259		$261		$261
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$53,506		$62,427		$64,566		$64,326		$64,326
Rehabilitation Services: Number of Users	49		55		55		55		55
Rehabilitation Services: Avg Medicaid Paid per User	$1,092		$1,135		$1,174		$1,170		$1,170
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$6,041,365	X	$7,913,886		$8,702,289		$8,850,601		$8,850,601
PT/OT/Speech/Hearing: Number of Users	8,598		9,619		10,017		10,200		10,200
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$703		$823		$869		$868		$868
Hospice: Total Medicaid Paid (MAX TOS = 35)	$18,023,600	X	$23,227,808		$24,994,660		$26,088,057		$26,088,057
Hospice: Number of Users	1,270	X	1,535		1,621		1,678		1,678
Hospice: Avg Medicaid Paid per User	$14,192		$15,132		$15,419		$15,547		$15,547
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$42,763,892		$47,090,625		$48,116,243		$48,672,408		$48,672,408
Durable Medical Equipment: Number of Users	25,010		26,379		26,877		27,311		27,311
Durable Medical Equipment: Avg Medicaid Paid per User	$1,710		$1,785		$1,790		$1,782		$1,782
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$220,987,417		$263,127,047		$263,681,559		$264,138,977		$264,138,977
Residential Care: Number of Users	6,898		7,043		7,071		6,920		6,920
Residential Care: Avg Medicaid Paid per User	$32,036		$37,360		$37,291		$38,170		$38,170
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$46,762,179		$53,136,815		$53,969,426		$51,856,655		$51,856,655
Psych Services: Number of Users	22,657		24,744		25,831		26,227		26,227
Psych Services: Avg Medicaid Paid per User	$2,064		$2,147		$2,089		$1,977		$1,977
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$99,084,248		$110,141,210		$110,566,197		$110,689,746		$110,689,746
Adult Day Care: Number of Users	8,271		8,362		8,393		8,399		8,399
Adult Day Care: Avg Medicaid Paid per User	$11,980		$13,172		$13,174		$13,179		$13,179
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE									

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Inpatient Hospital (MAX TOS = 01)	$2,089	X	$2,404		$2,679		$2,781		$2,781
Aged	$1,266		$1,257		$1,304		$1,328		$1,328
Disabled	$3,844	X	$4,377		$4,919		$5,096		$5,096
Child	$1,034	X	$1,510		$1,674		$1,704		$1,704
Adult	$472	X	$742	X	$894		$959		$959
ILTC (MAX TOS = 02,04,05,07)	$7,604		$8,571		$8,661		$8,597		$8,597
Aged	$17,098		$19,140		$19,368		$19,375		$19,375
Disabled	$5,438		$6,262		$6,300		$6,209		$6,209
Child	$2,192		$2,416		$2,477		$2,474		$2,474
Adult	$12		$12		$13		$13		$13
Drugs (MAX TOS = 16)	$545		$580		$588		$583		$583
Aged	$278		$288		$292		$292		$292
Disabled	$913		$969		$984		$967		$967
Child	$726		$791		$797		$796		$796
Adult	$61		$64		$64		$64		$64
All Other Services	$6,101		$6,994		$7,116		$7,069		$7,069
Aged	$3,167		$3,555		$3,645		$3,676		$3,676
Disabled	$12,593		$14,440		$14,614		$14,371		$14,371
Child	$1,686		$1,933		$2,008		$2,002		$2,002
Adult	$331	X	$476		$532		$551		$551
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Enrollees with IP Claims (MAX TOS = 01)	15.19	X	18.49		19.80		20.21		20.21
Aged	18.09		20.25		20.86		21.10		21.10
Disabled	21.39		24.50		26.17		26.54		26.54
Child	3.93	X	11.56		13.54		14.05		14.05
Adult	5.22	X	7.54		8.70		9.26		9.26
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	15.72		16.69		17.11		17.08		17.08
Aged	38.64		41.04		42.13		42.36		42.36
Disabled	9.33		9.93		10.18		10.11		10.11
Child	2.53		2.65		2.65		2.65		2.65
Adult	0.05	X	0.05	X	0.07		0.07		0.07
% FFS Enrollees with Drug Claims (MAX TOS = 16)	31.88		33.22		33.58		33.35		33.35
Aged	41.48		43.13		43.77		43.89		43.89
Disabled	39.52		40.44		40.66		40.02		40.02
Child	13.83		15.67		16.04		16.00		16.00
Adult	12.32		13.62		13.75		13.67		13.67
% FFS Enrollees with All Other Claims	59.80		64.91		67.13		67.34		67.34
Aged	77.24		79.83		81.00		81.34		81.34
Disabled	80.60		83.62		85.74		85.18		85.18
Child	16.63	X	28.77		32.34		33.17		33.17
Adult	17.01	X	25.66		28.77		29.69		29.69
Avg # IP Days per FFS User	7		6		6		6		6
Aged	4	X	3		3		3		3
Disabled	9		8		8		8		8

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Child	11	X	7		6		6		6
Adult	4		4		4		4		4
Avg # ILTC Days per FFS User	247		260		256		254		254
Aged	248		260		257		255		255
Disabled	249		260		256		254		254
Child	215		225		231		231		231
Adult	103	X	103	X	92		82		82
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	8		8		9		8		8
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	97		85		88		89		89
Inpatient Hospital (MAX TOS = 01) > $500,000	82	X	63		63		60		60
ILTC (MAX TOS = 02,04,05,07) > $200,000	41	X	192		191		191		191
Drugs (MAX TOS = 16) > $200,000	6	X	12	X	16		17		17
All Other Services > $200,000	163	X	230		234		235		235
Maximum FFS Medicaid Paid	$3,246,845		$3,281,721		$3,281,904		$3,316,918		$3,316,918
Inpatient Hospital (MAX TOS = 01)	$3,135,787		$3,166,090		$3,169,406		$3,203,201		$3,203,201
ILTC (MAX TOS = 02,04,05,07)	$267,599	X	$359,276		$359,276		$359,276		$359,276
Drugs (MAX TOS = 16)	$1,529,916		$1,709,853		$1,709,853		$1,709,853		$1,709,853
All Other Services	$371,360		$403,018		$403,018		$403,018		$403,018
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$455,518	X	$554,093		$589,776		$685,986		$685,986
FP: Number of Users	952	X	1,122		1,185		1,243		1,243
FP: Avg Medicaid Paid per User	$478		$494		$498		$552		$552
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$920,528	X	$1,239,197		$1,426,185		$1,468,258		$1,468,258
FQHC: Number of Users	3,338	X	4,097		4,606		4,741		4,741
FQHC: Avg Medicaid Paid per User	$276		$302		$310		$310		$310
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$366,963,281		$431,267,314		$432,940,499		$433,477,464		$433,477,464
Section 1915(c) Waiver: Number of Users	10,409		10,521		10,558		10,567		10,567
Section 1915(c) Waiver: Avg Medicaid Paid per User	$35,254		$40,991		$41,006		$41,022		$41,022
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$543,802,068		$619,186,370		$622,167,508		$623,145,538		$623,145,538
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	20,447		20,865		21,031		20,908		20,908
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	$26,596		$29,676		$29,583		$29,804		$29,804
Aged	$15,570		$16,485		$16,516		$16,534		$16,534
Disabled	$30,855		$35,033		$35,041		$35,372		$35,372
Child	$13,541		$12,841		$12,197		$12,235		$12,235
Adult	$2,719		$2,333		$2,246		$2,351		$2,351
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	15.52		15.81		15.91		15.63		15.63

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Aged	10.66		10.81		10.86		10.82		10.82
Disabled	29.46		29.79		29.82		29.00		29.00
Child	6.49		7.24		7.62		7.53		7.53
Adult	0.24	X	0.33		0.35		0.35		0.35
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$366,963,281		$431,267,314		$432,940,499		$433,477,464		$433,477,464
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	10,409		10,521		10,558		10,567		10,567
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$35,254		$40,991		$41,006		$41,022		$41,022
Aged	$25,601		$27,329		$27,363		$27,433		$27,433
Disabled	$36,344		$42,555		$42,563		$42,572		$42,572
Child	$18,687		$19,239		$19,239		$19,241		$19,241
Adult	$11,413		$13,145		$13,145		$13,149		$13,149
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	7.90		7.97		7.99		7.90		7.90
Aged	2.56		2.62		2.62		2.61		2.61
Disabled	18.46		18.58		18.59		18.24		18.24
Child	0.07		0.07		0.07		0.07		0.07
Adult	0.02		0.02		0.02		0.02		0.02

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All IP Claims									
Total Number of Claims	1,254,216		1,383,390		1,450,933		1,485,761		1,485,761
% Encounter Claims	22.86	X	27.60		28.95		30.28		30.28
% Supplemental Claims	23.46	X	19.15		19.08		18.42		18.42
Total FFS Claims	673,284		736,561		754,105		762,229		762,229
% Crossover	21.17		22.24		22.38		22.48		22.48
% Adjusted Claims	56.56		63.86		62.41		63.24		63.24
% Standard Adjustments	97.00		97.06		97.20		96.90		96.90
Avg Medicaid Paid, Adjusted Claims (Include $0)	$7,318		$7,322		$7,359		$7,688		$7,688
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	8,778	X	11,143	X	17,825		20,718		20,718
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$12,564	X	$11,327		$9,354		$9,553		$9,553
# Claims with > $1 Million Paid	1	X	2		2		2		2
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	530,731		572,753		585,349		590,917		590,917
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$6,936		$6,999		$7,063		$7,286		$7,286
Avg Medicaid Paid per Covered Day (> $0 Paid and > 0 Days)	$1,661		$1,679		$1,680		$1,726		$1,726
% Claims with TPL	4.60		4.63		4.63		4.63		4.63
Avg TPL Paid for Claims with TPL	$4,675		$4,719		$4,747		$4,782		$4,782
% Claims with UB-92 Accommodation Codes	0.00		0.00		0.00		0.00		0.00
Avg # of UB-92 Accomodation Codes (> 0 Codes)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Claims with UB-92 Ancillary Codes	0.00		0.00		0.00		0.00		0.00
Avg # of UB-92 Ancillary Codes (> 0 Codes)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Length of Stay	4.21		4.22		4.27		4.29		4.29
Avg Covered Days (> 0 Days)	4.22		4.22		4.26		4.28		4.28
% Begin Date = Admission Date	51.42		52.54		53.35		53.77		53.77
% IP Claims (MAX TOS = 01)	99.85		99.85		99.85		99.85		99.85
% Family Planning Claims (PGM TYPE = 2)	0.17		0.16		0.16		0.16		0.16
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	4.50		4.50		4.51		4.51		4.51
% Primary Diagnosis Code Claims with Length = 3	5.03		4.99		4.97		4.97		4.97
% Primary Diagnosis Code Claims with Length = 4	23.02		23.05		23.15		23.23		23.23
% Primary Diagnosis Code Claims with Length = 5	71.94		71.97		71.88		71.80		71.80
% Claims with a Procedure Code	66.61		67.12		67.18		67.33		67.33
Avg # of Procedure Codes (> 0 Codes)	2.22		2.22		2.23		2.23		2.23
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	98.13		97.97		97.86		97.77		97.77
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	38.27		39.93		40.74		41.15		41.15

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% Claims Maternal Delivery Indicator	15.09		14.75		14.53		14.41		14.41
% Claims Newborn Delivery Indicator (Only for Separate Infant Delivery Claims Using Mother's ID)	15.64		15.98		15.96		15.92		15.92
PATIENT STATUS									
% Home	81.72		82.00		82.01		81.96		81.96
% Transferred	11.03		11.04		11.08		11.14		11.14
% Still a Patient	4.77		4.41		4.33		4.30		4.30
% Died	0.90		0.93		0.95		0.96		0.96
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	142,553		163,808		168,756		171,312		171,312
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$1,549		$1,587		$1,609		$1,620		$1,620
% Claims with TPL	0.72	X	0.82		0.92		0.95		0.95
Avg TPL Paid for Claims with TPL	$1,082		$997		$959		$950		$950
% Claims with UB-92 Accommodation Codes	0.00		0.00		0.00		0.00		0.00
Avg # of UB-92 Accomodation Codes (> 0 Codes)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% Claims with UB-92 Ancillary Codes	0.00		0.00		0.00		0.00		0.00
Avg # of UB-92 Ancillary Codes (> 0 Codes)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Length of Stay	7.62		7.71		7.77		7.79		7.79
% Begin Date = Admission Date	99.86		99.84		99.83		99.83		99.83
% IP Claims (MAX TOS = 01)	99.99		100.00		99.99		99.99		99.99
% Claims with Primary Diagnosis Code	100.00		100.00		100.00		100.00		100.00
Avg # of Diagnosis Codes (> 0 Codes)	7.06		7.06		7.05		7.05		7.05
% Primary Diagnosis Code Claims with Length = 3	5.82		5.81		5.79		5.79		5.79
% Primary Diagnosis Code Claims with Length = 4	38.78		38.80		38.75		38.72		38.72
% Primary Diagnosis Code Claims with Length = 5	55.40		55.39		55.45		55.49		55.49
% Claims with a Procedure Code	66.28		66.13		65.98		65.96		65.96
Avg # of Procedure Codes (> 0 Codes)	2.66		2.66		2.65		2.65		2.65
% Claims with Procedure Code with CPT-4 Indicator	0.00		0.00		0.00		0.00		0.00
% Claims with Procedure Code with ICD-9 Indicator	2.36		2.41		2.53		2.56		2.56
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
% ICD-9-CM Indicator Claims with ICD-9-CM Format = 3 or 4 Digits	100.00		100.00		100.00		100.00		100.00
% Claims with Diagnosis Related Group	92.45		92.30		92.10		92.05		92.05

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All LT Claims									
Total Number of Claims	16,610,461	X	12,190,849		12,348,128		12,716,819		12,716,819
% Encounter Claims	0.10	X	0.17	X	0.18	X	0.25		0.25
% Supplemental Claims	0.09		0.09		0.09		0.09		0.09
Total FFS Claims	16,577,870	X	12,159,284		12,314,979		12,673,798		12,673,798
% Crossover	0.56	X	0.84		0.87		0.86		0.86
% Adjusted Claims	72.30		73.20		72.94		74.47		74.47
% Standard Adjustments	8.32	X	40.75		40.33		38.33		38.33
Avg Medicaid Paid, Adjusted Claims (Include $0)	$498	X	$973		$970		$977		$977
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	2,923	X	4,876	X	25,680	X	52,034		52,034
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$907		$928		$949	X	$788		$788
# Claims with > $200,000 Paid	24		27		26		26		26
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	16,485,079	X	12,056,651		12,207,978		12,565,213		12,565,213
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID PER COVERED DAY BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
NF (MAX TOS = 07)	$86		$76		$77		$76		$76
ICF/MR (MAX TOS = 05)	$810	X	$707		$700		$634		$634
MH Aged (MAX TOS = 02)	$558		$590		$595		$636		$636
IP Psych, Age < 21 (MAX TOS = 04)	$554		$582		$582		$585		$585
TYPE OF SERVICE									
% NF (MAX TOS = 07)	94.98		92.15		92.17		92.14		92.14
% NF claims with NF Covered Days	72.60	X	59.30		59.39		59.30		59.30
Avg days for NF claims with Covered Days	5.43		4.71		4.76		4.82		4.82
% ICF/MR (MAX TOS = 05)	4.62	X	7.29		7.27		7.32		7.32
% ICF/MR claims with ICF/MR Covered Days	99.96		99.96		99.96		99.96		99.96
Avg days for ICF/MR claims with Covered Days	4.41		5.03		5.04		5.47		5.47
% MH Aged (MAX TOS = 02)	0.04	X	0.06		0.07		0.06		0.06
% MH Aged claims with MH Aged Covered Days	98.72		98.23		98.07		97.85		97.85
Avg days for MH Aged claims with Covered Days	20.49		20.74		20.84		20.68		20.68
% IP Psych, Age < 21 (MAX TOS = 04)	0.36	X	0.50		0.49		0.48		0.48
% IP Psych, Age < 21 Claims with IP Psych Covered Days	99.44		99.33		99.28		99.25		99.25
Avg days for IP Psych, Age < 21 Claims with Covered Days	10.37		10.41		10.44		10.47		10.47
LEAVE DAYS									
% Claims with Leave Days	1.73		1.60		1.61		1.65		1.65
ADMISSION DATE									
% Claims with Admission Date	0.40	X	0.56		0.56		0.54		0.54
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	99.32		99.13		99.11		99.09		99.09
% Primary Diagnosis Code Claims with Length = 3	12.16		11.34		11.33		11.36		11.36

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% Primary Diagnosis Code Claims with Length = 4	56.94		58.86		58.82		58.72		58.72
% Primary Diagnosis Code Claims with Length = 5	30.86		29.74		29.79		29.86		29.86
PATIENT STATUS									
% Claims with Patient Status	100.00		100.00		100.00		100.00		100.00
% Home	0.58	X	0.76		0.76		0.75		0.75
% Still a Patient	99.18		98.99		98.98		98.99		98.99
% Died	0.09		0.09		0.09		0.09		0.09
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	92,791		102,633		107,001		108,585		108,585
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$780		$807		$819		$824		$824
TYPE OF SERVICE									
% NF (MAX TOS = 07)	97.41		97.23		97.19		97.17		97.17
% ICF/MR (MAX TOS = 05)	0.00		0.00		0.00		0.00		0.00
% MH Aged (MAX TOS = 02)	2.52		2.70		2.74		2.76		2.76
% IP Psych, Age < 21 (MAX TOS = 04)	0.07		0.07		0.07		0.07		0.07
ADMISSION DATE									
% Claims with Admission Date	2.59		2.77		2.81		2.83		2.83
DIAGNOSIS CODES									
% Claims with Primary Diagnosis Code	99.84		99.83		99.80		99.78		99.78
% Primary Diagnosis Code Claims with Length = 3	11.44		11.41		11.30		11.21		11.21
% Primary Diagnosis Code Claims with Length = 4	50.95		50.89		50.74		50.78		50.78
% Primary Diagnosis Code Claims with Length = 5	37.59		37.68		37.95		38.00		38.00
PATIENT STATUS									
% Claims with Patient Status	99.99		99.99		99.99		99.99		99.99
% Home	2.12		2.45		2.44		2.44		2.44
% Still a Patient	95.66		95.23		95.18		95.15		95.15
% Died	0.19		0.19		0.19		0.19		0.19

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All OT Claims									
Total Number of Claims	168,168,739		190,013,814		199,229,722		204,181,576		204,181,576
% Encounter Claims	26.39		29.18		30.85		31.87		31.87
% Supplemental Claims	3.03		2.68		2.59		2.56		2.56
% Capitation Claims **	18.14	X	16.10		15.37		15.01		15.01
Total FFS Claims Excluding Capitation Payments	87,942,369		98,620,148		101,708,476		102,963,685		102,963,685
% Crossover	12.17		13.32		13.92		14.29		14.29
% Adjusted Claims	29.10		29.48		33.07		33.19		33.19
% Standard Adjustments	94.61		93.17		93.30		93.17		93.17
Avg Medicaid Paid, Adjusted Claims (Include $0)	$189		$224		$234		$236		$236
% Claims with HMO Capitation Payment	25.70		23.63		23.09		22.90		22.90
% Claims with PHP Capitation Payment	0.00		0.00		0.00		0.00		0.00
% Claims with PCCM Capitation Payment	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid per HMO Capitation Claim	$252		$253		$254		$254		$254
Avg Medicaid Paid per PHP Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per PCCM Capitation Claim	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	29,926	X	34,937	X	57,206	X	77,257		77,257
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	$89	X	$87	X	$114		$115		$115
# Claims with > $200,000 Paid	2	X	5	X	7	X	17		17
# Encounter Claims	44,384,081	X	55,454,573		61,466,719		65,063,936		65,063,936
% Encounter Claims for HMO or PACE	0.00	X	0.00	X	0.00	X	0.00	X	49.10
% Encounter Claims for PHP	0.00	X	0.00	X	0.00	X	0.00	X	3.44
FFS Non-Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 0)									
Total Number of Claims	77,237,292		85,482,865		87,555,404		88,248,581		88,248,581
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
% Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Outpatient Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Home Health Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Other Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Waiver Claims (PGM TYPE = 6,7) with Span Bill	0.00		0.00		0.00		0.00		0.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Span Bill	0.00		0.00		0.00		0.00		0.00
% Claims with Servicing Provider ID = Billing Provider ID	64.84		64.75		64.86		64.79		64.79
PLACE OF SERVICE									
% Claims with Place of Service	92.66		92.73		92.81		92.82		92.82
% Claims with Place of Service = Office (PLC OF SVC CD = 11)	7.40		7.20		7.14		7.12		7.12
% Claims with Place of Service = Home (PLC OF SVC CD = 12)	44.15		43.50		42.80		42.62		42.62
% Claims with Place of Service = Hospital (PLC OF SVC CD = 21)	1.92		2.07		2.16		2.20		2.20
% Claims with Place of Service = Nursing Facility (PLC OF SVC CD = 32)	0.13	X	0.51	X	0.61		0.64		0.64
% Claims with Place of Service = Inpatient Psychiatric (PLC OF SVC CD = 51)	0.02		0.02		0.02		0.02		0.02
% Claims with Place of Service = ICF/MR (PLC OF SVC CD = 54)	0.00		0.00		0.00		0.00		0.00
% Claims with Place of Service = Psychiatric Residential (PLC OF SVC CD = 56)	1.02		0.99		1.00		1.01		1.01
% Claims with Place of Service = Emergency Room (PLC OF SVC CD = 23)	1.41		1.52		1.58		1.62		1.62

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% Claims with Place of Service = Outpatient (PLC OF SVC CD = 22)	23.78		24.33		25.04		25.15		25.15
% Claims with Place of Service = Unknown/Other (PLC OF SVC CD = 99)	6.28		6.29		6.24		6.23		6.23
THIRD-PARTY LIABILITY									
% Claims with TPL	0.15	X	0.17		0.19		0.19		0.19
Avg TPL Paid for Claims with TPL	$63		$64		$64		$64		$64
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE									
Physician Services (MAX TOS = 08)	3.71		3.93		4.06		4.15		4.15
Dental Services (MAX TOS = 09)	5.69		5.42		5.33		5.32		5.32
Other Practitioner Services (MAX TOS = 10)	0.09		0.08		0.08		0.08		0.08
Outpatient Services (MAX TOS = 11)	3.47		3.43		3.52		3.55		3.55
Clinic Services (MAX TOS = 12)	3.92		3.91		3.91		3.93		3.93
Home Health Services (MAX TOS = 13)	11.93		12.19		12.08		12.07		12.07
Lab/Xray Services (MAX TOS = 15)	4.08		4.20		4.29		4.34		4.34
Drugs (MAX TOS = 16)	0.26		0.26		0.26		0.26		0.26
Other Services (MAX TOS = 19)	8.41		8.09		7.95		7.92		7.92
Durable Medical Equipment (MAX TOS = 51)	1.20		1.24		1.24		1.24		1.24
Transportation Services (MAX TOS = 26)	6.86		6.89		6.84		6.83		6.83
Sterilizations (MAX TOS = 24)	0.00	X	0.00		0.00		0.00		0.00
Abortions (MAX TOS = 25)	0.00		0.00		0.00		0.00		0.00
Personal Care Services (MAX TOS = 30)	22.87		22.22		21.79		21.67		21.67
Targeted Case Management (MAX TOS = 31)	0.47	X	0.78		0.81		0.82		0.82
Rehabilitation Services (MAX TOS = 33)	2.85	X	3.61		4.29		4.34		4.34
PT/OT/Hearing/Speech Services (MAX TOS = 34)	0.02		0.02		0.02		0.02		0.02
Hospice Services (MAX TOS = 35)	0.06		0.06		0.06		0.06		0.06
Nurse Midwife Services (MAX TOS = 36)	0.01		0.01		0.01		0.01		0.01
Nurse Practitioner Services (MAX TOS = 37)	0.09		0.09		0.09		0.10		0.10
Private Nursing Services (MAX TOS = 38)	0.85		0.83		0.81		0.81		0.81
Religious Non-Medical Services (MAX TOS = 39)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	2.26		2.25		2.24		2.23		2.23
Psychiatric Services (MAX TOS = 53)	10.80		10.42		10.32		10.31		10.31
Adult Day Care (MAX TOS = 54)	10.10		10.06		9.97		9.93		9.93
Unknown Services (MAX TOS = 99)	0.00		0.00		0.00		0.00		0.00
AVERAGE MEDICAID AMOUNT PAID BY MAX TYPE OF SERVICE (CLAIMS WITH >$0 PAID)									
Total	$161		$158		$158		$158		$158
Physician Services (MAX TOS = 08)	$36		$36		$36		$36		$36
Dental Services (MAX TOS = 09)	$79		$80		$80		$80		$80
Other Practitioner Services (MAX TOS = 10)	$19		$19		$19		$19		$19
Outpatient Services (MAX TOS = 11)	$184		$198		$194		$193		$193
Clinic Services (MAX TOS = 12)	$121		$120		$121		$121		$121
Home Health Services (MAX TOS = 13)	$140		$139		$139		$139		$139
Lab/Xray Services (MAX TOS = 15)	$24		$24		$24		$24		$24
Drugs (MAX TOS = 16)	$21		$21		$21		$21		$21
Other Services (MAX TOS = 19)	$99		$102		$103		$103		$103
Durable Medical Equipment (MAX TOS = 51)	$82		$83		$83		$83		$83

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Transportation Services (MAX TOS = 26)	$54		$54		$54		$54		$54
Personal Care Services (MAX TOS = 30)	$136		$135		$135		$135		$135
Targeted Case Management (MAX TOS = 31)	$32	X	$26		$26		$26		$26
Rehabilitation Services (MAX TOS = 33)	$216		$193		$183		$185		$185
PT/OT/Hearing/Speech Services (MAX TOS = 34)	$12		$12		$12		$12		$12
Hospice Services (MAX TOS = 35)	$1,985		$1,996		$1,991		$2,011		$2,011
Residential Care Services (MAX TOS = 52)	$1,913		$1,809		$1,794		$1,805		$1,805
Psychiatric Services (MAX TOS = 53)	$135		$135		$135		$135		$135
Adult Day Care (MAX TOS = 54)	$149		$149		$148		$148		$148
PERCENT OF CLAIMS BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	0.33		0.33		0.33		0.33		0.33
Rural Health Clinic (PGM TYPE = 3)	0.00		0.00		0.00		0.00		0.00
Federally Qualified Health Center (PGM TYPE = 4)	1.72		1.65		1.70		1.73		1.73
Indian Health Services (PGM TYPE = 5)	0.00		0.00		0.00		0.00		0.00
Home and Community Based Waiver (PGM TYPE = 6,7)	12.57		12.28		12.08		12.00		12.00
AVERAGE EXPENDITURES BY PROGRAM TYPE									
Family Planning (PGM TYPE = 2)	$82		$83		$83		$84		$84
Rural Health Clinic (PGM TYPE = 3)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Federally Qualified Health Center (PGM TYPE = 4)	$93		$93		$95		$94		$94
Indian Health Services (PGM TYPE = 5)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Home and Community Based Waiver (PGM TYPE = 6,7)	$463		$454		$454		$457		$457
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	85.40		85.87		86.09		86.15		86.15
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.86		99.87		99.87		99.88		99.88
% Primary Diagnosis Claims with Secondary Diagnosis Code	0.00		0.00		0.00		0.00		0.00
% Primary Diagnosis Code Claims with Length = 3	7.47		7.44		7.43		7.41		7.41
% Primary Diagnosis Code Claims with Length = 4	60.59		60.60		60.71		60.66		60.66
% Primary Diagnosis Code Claims with Length = 5	31.93		31.89		31.79		31.86		31.86
% Claims with Procedure Code	97.11		97.34		97.40		97.42		97.42
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	98.49		98.66		98.68		98.69		98.69
% Waiver Claims (PGM TYPE = 6,7) with Procedure Code	100.00		100.00		100.00		100.00		100.00
% CLTC Claims (Excluding CLTC Flag = 16-20) with Procedure Code	99.64		99.68		99.68		99.68		99.68
% Other Claims with Procedure Code	96.80		97.04		97.11		97.13		97.13
% Claims with Procedure Code with CPT-4 Indicator	8.82		9.16		9.40		9.55		9.55
% Claims with Procedure Code with HCPCS (II & III) Indicator	6.91		6.78		6.70		6.67		6.67
% with Procedure Code with Other National Indicator	0.00		0.00		0.00		0.00		0.00
% with Procedure Code with State-Specific Indicator	84.27		84.05		83.90		83.78		83.78
% CPT-4 Indicator Claims with CPT-4 Format = 5 Digits	100.00		100.00		100.00		100.00		100.00
% HCPCS (II & III) Indicator Claims with HCPCS Format = Either 1 Character and 4 Digits or 2 Characters and 3 Digits	100.00		100.00		100.00		100.00		100.00
PHYSICIAN SPECIALTY									
% Physician Claims with Physician Specialty	92.65		92.50		92.36		92.28		92.28
PERCENT OF CLAIMS BY CLTC CODE									

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Not a CLTC Claim (CLTC FLAG = 00)	40.17		40.25		40.76		40.95		40.95
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	47.27		47.48		47.15		47.04		47.04
CLTC Non-Waiver Personal Care (CLTC FLAG = 11)	22.87		22.22		21.79		21.67		21.67
CLTC Non-Waiver Private Duty Nurse (CLTC FLAG = 12)	0.85		0.83		0.81		0.81		0.81
CLTC Non-Waiver Adult Day Care (CLTC FLAG = 13)	2.43		2.64		2.69		2.69		2.69
CLTC Non-Waiver Home Health (CLTC FLAG = 14)	11.93		12.19		12.07		12.07		12.07
CLTC Non-Waiver Residential Care (CLTC FLAG = 15)	0.11		0.11		0.11		0.11		0.11
CLTC Non-Waiver Rehabilitation (CLTC FLAG = 16)	1.48	X	1.73		1.97		2.00		2.00
CLTC Non-Waiver Targeted Case Management (CLTC FLAG = 17)	0.10	X	0.16		0.17		0.17		0.17
CLTC Non-Waiver Transportation (CLTC FLAG = 18)	6.48		6.51		6.45		6.44		6.44
CLTC Non-Waiver Hospice (CLTC FLAG = 19)	0.06		0.06		0.06		0.06		0.06
CLTC Non-Waiver Durable Medical Equipment (CLTC FLAG = 20)	0.97		1.02		1.02		1.02		1.02
CLTC Waiver Claims (CLTC FLAG = 30-40)	12.57		12.28		12.08		12.00		12.00
CLTC Other Waiver (CLTC FLAG = 30)	2.73		2.70		2.66		2.65		2.65
CLTC Waiver Personal Care (CLTC FLAG = 31)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Private Duty Nurse (CLTC FLAG = 32)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Adult Day Care (CLTC FLAG = 33)	7.67		7.42		7.28		7.23		7.23
CLTC Waiver Home Health (CLTC FLAG = 34)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Residential Care (CLTC FLAG = 35)	2.15		2.14		2.13		2.12		2.12
CLTC Waiver Rehabilitation (CLTC FLAG = 36)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Targeted Case Management (CLTC FLAG = 37)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Transportation (CLTC FLAG = 38)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Hospice (CLTC FLAG = 39)	0.00		0.00		0.00		0.00		0.00
CLTC Waiver Durable Medical Equipment (CLTC FLAG = 40)	0.01		0.01		0.01		0.01		0.01
FFS Crossover Claims (Type of Claim = 1, Crossover Claim Indicator = 1)									
Total Number of Claims	10,705,077	X	13,137,283		14,153,072		14,715,104		14,715,104
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$32		$32		$31		$31		$31
% Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Outpatient Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Home Health Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
% Other Claims with Span Bill	0.00		0.00		0.00		0.00		0.00
PERCENT OF CLAIMS BY MAX TYPE OF SERVICE (EXCLUDING 20-22)									
Physician Services (MAX TOS = 08)	42.07		43.46		44.22		44.57		44.57
Other Practitioner Services (MAX TOS = 10)	4.82		4.96		4.92		4.90		4.90
Outpatient Services (MAX TOS = 11)	9.21		8.64		8.56		8.43		8.43
Clinic Services (MAX TOS = 12)	4.42		4.32		4.25		4.20		4.20
Home Health Services (MAX TOS = 13)	3.12	X	2.56		2.38		2.29		2.29
Lab/Xray Services (MAX TOS = 15)	10.71		10.55		10.42		10.33		10.33
Other Services (MAX TOS = 19)	4.03	X	3.50		3.33		3.26		3.26
Durable Medical Equipment (MAX TOS = 51)	4.45		5.00		5.11		5.12		5.12
Transportation Services (MAX TOS = 26)	3.71		3.58		3.42		3.33		3.33
Personal Care Services (MAX TOS = 30)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison OT Validation Table
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Targeted Case Management (MAX TOS = 31)	0.00		0.00		0.00		0.00		0.00
Rehabilitation Services (MAX TOS = 33)	0.00	X	0.01		0.01		0.01		0.01
PT/OT/Hearing/Speech Services (MAX TOS = 34)	3.72		3.66		3.82		4.08		4.08
Hospice Services (MAX TOS = 35)	0.00		0.00		0.00		0.00		0.00
Residential Care Services (MAX TOS = 52)	0.00		0.00		0.00		0.00		0.00
Psychiatric Services (MAX TOS = 53)	8.10		8.18		8.05		7.98		7.98
Adult Day Care (MAX TOS = 54)	0.54		0.53		0.51		0.51		0.51
DIAGNOSIS AND PROCEDURE CODES									
% Claims with Primary Diagnosis Code	97.08		97.32		97.43		97.49		97.49
% Physician, Outpatient, or Clinic Claims with Primary Diagnosis Code	99.99		99.99		99.99		99.99		99.99
% Primary Diagnosis Claims with Secondary Diagnosis Code	0.00		0.00		0.00		0.00		0.00
% Primary Diagnosis Code Claims with Length = 3	5.99		5.91		5.84		5.77		5.77
% Primary Diagnosis Code Claims with Length = 4	45.57		45.40		45.54		45.68		45.68
% Primary Diagnosis Code Claims with Length = 5	48.40		48.65		48.58		48.52		48.52
% Claims with Procedure Code	93.75		94.87		95.24		95.42		95.42
% Outpatient Claims with Procedure Code or UB-92 Revenue Code	100.00		100.00		100.00		100.00		100.00
% Home Health Claims with Procedure Code or UB-92 Revenue Code	0.85	X	1.41		1.54		1.58		1.58
% Other Claims with Procedure Code	96.40		97.07		97.28		97.39		97.39
% Claims with Procedure Code with CPT-4 Indicator	69.81		70.49		70.96		71.28		71.28
% Claims with Procedure Code with HCPCS (II & III) Indicator	6.38		6.98		7.12		7.20		7.20
% with Procedure Code with Other Code Indicator	23.80		22.53		21.92		21.53		21.53
PERCENT OF CLAIMS BY CLTC CODE									
Not a CLTC Claim (CLTC FLAG = 00)	88.56		88.67		88.91		89.07		89.07
CLTC Non-Waiver Claims (CLTC FLAG = 11-20)	11.44		11.33		11.09		10.93		10.93
CLTC Non-Waiver Claims (CLTC Flag = 11-15)	3.68	X	3.10		2.90		2.80		2.80
CLTC Waiver Claims (CLTC FLAG = 30-40)	0.00		0.00		0.00		0.00		0.00

2008 BETA MAX Comparison RX Validation Table
State: NY

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All RX Claims									
Total Number of Claims	44,964,025		45,893,682		46,010,158		46,032,985		46,032,985
% Encounter Claims	8.72		8.82		9.02		9.06		9.06
% Supplemental Claims	0.31		0.30		0.30		0.30		0.30
Total FFS Claims	40,907,815		41,704,999		41,718,522		41,724,324		41,724,324
% Adjusted Claims	4.37		4.45		4.45		4.46		4.46
% Standard Adjustments	81.52		82.11		82.12		82.13		82.13
Avg Medicaid Paid, Adjusted Claims (Include $0)	$127		$128		$128		$128		$128
# of Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	1,607	X	1,555	X	1,800		2,111		2,111
Avg Medicaid Paid for Claims with Missing Medicaid Eligibility and > $0 Paid (Excludes S-CHIP Only)	100.28		104.53		119.12		113.09		113.09
# Claims with > $200,000 Paid	4		4		4		4		4
% Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	0.00		0.00		0.00		0.00		0.00
Total Medicaid Paid among Section 1915(c) Waiver Claims (PGM TYPE = 6, 7)	$0		$0		$0		$0		$0
FFS Claims (Type of Claim = 1)									
Total Number of Claims	40,907,815		41,704,999		41,718,522		41,724,324		41,724,324
% Claims with > $0 Paid	100.00		100.00		100.00		100.00		100.00
% Claims with < $0 Paid	0.00		0.00		0.00		0.00		0.00
Avg Medicaid Paid (Claims with > $0 Paid)	$83		$83		$83		$83		$83
% Claims with TPL	0.81		0.81		0.81		0.81		0.81
Avg TPL Paid for Claims with TPL	$121		$121		$121		$121		$121
% Family Planning Claims (PGM TYPE = 2)	1.53		1.53		1.53		1.53		1.53
% Drug Claims (MAX TOS = 16)	100.00		100.00		100.00		100.00		100.00
% Durable Medical Equipment Claims (MAX TOS = 51)	0.00		0.00		0.00		0.00		0.00
% Drug Claims with Prescribing Physician	96.77		96.60		96.60		96.60		96.60
% Drug Claims with Date Prescribed	100.00		100.00		100.00		100.00		100.00
% Drug Claims with Quantity	99.40		99.41		99.41		99.41		99.41
% Drug Claims with Days Supply	100.00		100.00		100.00		100.00		100.00
DRUG CLASSIFICATION									
% Claims with Medispan	99.23		99.24		99.24		99.24		99.24
% Claims with Generic Therapeutic Class	99.90		99.90		99.90		99.90		99.90
% Claims with Specific Therapeutic Class	99.90		99.90		99.90		99.90		99.90
NDC CONFIGURATION INDICATOR									
% Prescription (NDC FMT IND = 0-3)	67.08		67.06		67.07		67.07		67.07
% Products (NDC FMT IND = 4-6)	32.79		32.81		32.81		32.81		32.81
% Health Related Item (NDC FMT IND = 7)	0.00		0.00		0.00		0.00		0.00
% Claims with Clinical Formulation Identifier	99.90		99.90		99.90		99.90		99.90
% Claims with Ingredient List Identifier	99.90		99.90		99.90		99.90		99.90
% Claims with Hierarchical Specific Therapeutic Class Code Sequence Number	99.90		99.90		99.90		99.90		99.90
% Claims with Over-the-Counter Drug Class	18.76		18.73		18.73		18.73		18.73
% Claims with Prescription Drug Class	81.14		81.17		81.17		81.17		81.17
% Claims with Multiple Sources	63.80		63.84		63.84		63.84		63.84
% Claims with Single Source (No Generic)	31.45		31.44		31.44		31.44		31.44

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All Records									
Total Number of Records	5,031,846		5,103,704		5,109,089		5,112,507		5,112,507
Total Medicaid Paid	$38,543,150,817		$41,200,579,626		$41,793,394,322		$42,419,679,526		$42,419,679,526
% with No Services (RCPNT IND = 0)	14.61		14.56		14.26		14.14		14.14
% with FFS Only Claims (RCPNT IND = 1)	21.22		21.83		22.09		22.20		22.20
% with Only Capitation Claims (RCPNT IND = 2)	9.11		8.08		7.88		7.80		7.80
% with Only Encounter Claims (RCPNT IND = 3)	0.03	X	0.04		0.04		0.05		0.05
% with FFS and Capitation Claims (RCPNT IND = 4)	6.12	X	4.13		3.78		3.73		3.73
% with Capitation and Encounter Claims Only (RCPNT IND = 5)	7.80		8.19		8.25		8.25		8.25
% with FFS and Encounter Claims Only (RCPNT IND = 6)	0.17	X	0.21		0.23		0.24		0.24
% with FFS, Capitation, and Encounter Claims (RCPNT IND = 7)	40.95		42.96		43.46		43.59		43.59
# with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	8,529	X	9,782	X	15,167		18,585		18,585
% with Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.17	X	0.19	X	0.30		0.36		0.36
Total Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$115,772,243	X	$133,943,537	X	$197,815,380	X	$248,078,331		$248,078,331
Avg Medicaid Paid for People Missing Medicaid Eligibility (Excludes S-CHIP Only Enrollees)	$13,574		$13,693		$13,042		$13,348		$13,348
# with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	8,419	X	9,675	X	15,017		18,419		18,419
% with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	0.17	X	0.19	X	0.29		0.36		0.36
Total Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$115,709,698	X	$133,887,851	X	$197,652,137	X	$247,884,456		$247,884,456
Avg Medicaid Paid for People with FFS Claims and Missing Medicaid Eligibility (Excludes S-CHIP Only)	$13,744		$13,839		$13,162		$13,458		$13,458
S-CHIP ENROLLMENT									
# with ONLY S-CHIP Enrollment	0		0		0		0		0
% with ONLY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
# with ANY S-CHIP Enrollment	0		0		0		0		0
% with ANY S-CHIP Enrollment	0.00		0.00		0.00		0.00		0.00
Total Person-Years of Enrollment with ANY S-CHIP Enrollment	0		0		0		0		0
Total Medicaid Enrollees (excludes people with missing Medicaid eligibility information or S-CHIP only)									
Total Medicaid Enrollees	5,023,317		5,093,922		5,093,922		5,093,922		5,093,922
Total Medicaid Person-Years of Enrollment	4,140,865		4,155,116		4,155,116		4,155,116		4,155,116
# with Any M-CHIP Enrollment	0		0		0		0		0
Total Person-Years of Enrollment Any M-CHIP	0		0		0		0		0
Demographic Characteristics									
% Records with Valid SSN Format	92.40		92.71		92.71		92.71		92.71
% Records Whose MSIS SSN Passed High Group Test (HGT FLAG = 1)	92.34		92.60		92.60		92.60		92.60
% Records Whose MSIS SSN Failed High Group Test Due to Invalid AAA (HGT FLAG = 2)	0.02		0.02		0.02		0.02		0.02
% Records Whose MSIS SSN Failed High Group Test Due to GG = 00 (HGT FLAG = 3)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to SSSS = 0000 (HGT FLAG = 4)	0.00		0.00		0.00		0.00		0.00
% Records Whose MSIS SSN Failed High Group Test Due to GG Not Yet Issued (HGT FLAG = 5)	0.04	X	0.10		0.10		0.10		0.10

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% Records Whose MSIS SSN Failed High Group Test Due to Railroad Retirement Number with Invalid DOB (HGT FLAG = 6)	0.00		0.00		0.00		0.00		0.00
# Records Without Valid SSN	384,743		376,998		376,998		376,998		376,998
% Records Without Valid SSN	7.66		7.40		7.40		7.40		7.40
% for Children Under Age 21	53.95		49.94		49.94		49.94		49.94
% for Infants Under Age 1	23.70		20.90		20.90		20.90		20.90
% Ever Aliens Eligible for Only Emergency Services	5.47		6.49		6.49		6.49		6.49
# SSNs with More Than One MSIS ID	56,960		59,943		59,943		59,943		59,943
% Records with Duplicated SSNs	2.28		2.37		2.37		2.37		2.37
% for Children Under Age 21	53.66		53.95		53.95		53.95		53.95
% for Infants Under Age 1	1.42	X	1.94		1.94		1.94		1.94
% Ever Aliens Eligible for Only Emergency Services	0.87		0.92		0.92		0.92		0.92
% with External SSN from EDB (EXT SSN SRCE = 1)	16.36		16.31		16.31		16.31		16.31
% with External SSN from State-Provided Cross-Reference File (EXT SSN SRCE = 2)	0.00		0.00		0.00		0.00		0.00
% with County Code	99.65		99.66		99.66		99.66		99.66
% with Valid 5 Digit Zip Code Format	99.89		99.89		99.89		99.89		99.89
% White	50.58		50.77		50.77		50.77		50.77
% Black	29.09		29.29		29.29		29.29		29.29
% Native American/Alaskan Native	2.28		2.27		2.27		2.27		2.27
% Asian	10.90		10.90		10.90		10.90		10.90
% Native Hawaiian or Other Pacific Islander	1.90		1.86		1.86		1.86		1.86
% More Than One Race	2.46		2.45		2.45		2.45		2.45
% Unknown Race	9.63		9.22		9.22		9.22		9.22
% Hispanic/Latino (Included with Race Categories Prior to 2005)	27.11		27.27		27.27		27.27		27.27
% of Hispanic/Latino with Unknown Race	10.08		9.95		9.95		9.95		9.95
% Age 0	2.81		2.85		2.85		2.85		2.85
% Age 0-20 Years	39.59		39.41		39.41		39.41		N/A
% Age > 64 Years	11.52		11.52		11.52		11.52		N/A
% with Century of Birth '18' , '19', '20'	98.27		98.15		98.15		98.15		98.15
% with Gender Code 'M' or 'F'	98.29		98.54		98.54		98.54		98.54
% Enrollees with 12 Months Enrollment	62.32		61.60		61.60		61.60		61.60
% Aged Enrollees with 12 Months Enrollment	72.32		71.23		71.23		71.23		71.23
% Disabled Enrollees with 12 Months Enrollment	86.01		85.49		85.49		85.49		85.49
% Child Enrollees with 12 Months Enrollment	61.07		60.47		60.47		60.47		60.47
% Adult Enrollees with 12 Months Enrollment	51.43		50.62		50.62		50.62		50.62
% Enrollees with MSIS Date of Death During Year	0.88		0.92		0.92		0.92		0.92
% Enrollees with SSA Date of Death During Year	0.65		0.64		0.64		0.64		0.00
% Enrollees with MSIS, SSA, or EDB Date of Death During Year	1.21		1.21		1.21		1.21		1.16
# with MSIS Date of Death ≠ SSA Date of Death	38,719		41,227		41,227		41,227		46,892
# with MSIS Date of Death Prior to 2007	5	X	9		9		9		9
# with SSA Date of Death Prior to 2007	4,337		4,347		4,347		4,347		0
EDB Dual Eligibles									
Total EDB Duals (Duals Confirmed by EDB)	746,181		754,470		754,470		754,470		754,597

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Total EDB Dual Person-Years of Enrollment	673,242		675,392		675,392		675,392		675,464
% Age > 64 Years Who Are EDB Duals	87.90		87.87		87.87		87.87		87.88
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are EDB Duals	86.76		86.73		86.73		86.73		86.74
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are EDB Duals	42.99		42.60		42.60		42.60		42.61
% EDB Only (EDB DUAL = 50)	2.40	X	1.71		1.71		1.71		1.72
% EDB QMB Only (EDB DUAL = 51)	3.07		3.04		3.04		3.04		3.04
% EDB QMB Plus (EDB DUAL = 52)	39.09		38.94		38.94		38.94		38.94
% EDB SLMB Only (EDB DUAL = 53)	3.40		3.50		3.50		3.50		3.50
% EDB SLMB Plus (EDB DUAL = 54)	1.08		1.12		1.12		1.12		1.12
% EDB QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% EDB QI-1 (EDB DUAL = 56)	4.14		4.17		4.17		4.17		4.17
% EDB QI-2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% EDB Other (EDB DUAL = 58)	46.82		47.51		47.51		47.51		47.51
% EDB Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Dual Status Unknown (EDB DUAL = 98)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	89.39		89.28		89.28		89.28		89.28
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	10.61		10.72		10.72		10.72		10.72
Total Non-EDB Duals (Duals Reported in MSIS, Not Found in EDB)	13,262		13,373		13,373		13,373		13,320
% Non-EDB Duals Without Valid SSN	0.07		0.06		0.06		0.06		0.06
% Non-EDB Duals Who Are Children/Adults	8.26		8.43		8.43		8.43		8.45
% EDB Duals with Spanish Language	8.76		8.72		8.72		8.72		8.72
% EDB Duals with EDB Date of Death During Year	6.21		6.18		6.18		6.18		6.18
% EDB Duals with MSIS Date of Death During Year	4.38		4.58		4.58		4.58		4.58
% EDB Duals with SSA Date of Death During Year	3.56		3.52		3.52		3.52		0.00
% EDB Duals with EDB, MSIS, or SSA Date of Death During Year	6.23		6.20		6.20		6.20		6.20
# EDB Duals with EDB Date of Death ≠ MSIS Date of Death	22,453		20,994		20,994		20,994		20,999
# EDB Duals with EDB Date of Death ≠ SSA Date of Death	20,766	X	21,065	X	21,065	X	21,065	X	46,619
% EDB Duals with Medicaid Reported HIC	97.52		98.22		98.22		98.22		98.21
% EDB Duals with Medicaid Reported HIC = Medicare HIC	98.98		99.09		99.09		99.09		99.09
Total EDB Dual Enrollees in June	706,174		714,150		714,150		714,150		714,266
JUNE MEDICARE ELIGIBILITY GROUP									
June % with Part A Medicare only	2.24		2.28		2.28		2.28		2.28
June % with Part B Medicare only	4.31		4.27		4.27		4.27		4.27
June % Part A/B Medicare	93.45		93.45		93.45		93.45		93.45
ORIGINAL REASON FOR MEDICARE ENTITLEMENT									
% Aged (MDCR ORIG REAS CD = 0)	58.45		58.59		58.59		58.59		58.59
% Disabled (MDCR ORIG REAS CD = 1)	40.39		40.25		40.25		40.25		40.25
% End Stage Renal Disease (MDCR ORIG REAS CD = 2)	0.51		0.51		0.51		0.51		0.51
% Disabled with End Stage Renal Disease (MDCR ORIG REAS CD = 3)	0.65		0.65		0.65		0.65		0.65
Other Eligibility Characteristics (All Enrollees)									
% Aged Groups (MAX ELIG CD = 11,21,31,41,51) Who Are > 64 Years	100.00		99.99		99.99		99.99		99.99
% Disabled Groups (MAX ELIG CD = 12,22,32,3A,42,52) Who Are > 64 Years	14.87		14.55		14.55		14.55		14.55
% Child Groups (MAX ELIG CD = 14,16, 24, 34, 44, 48, 54) Who Are < 21 Years	95.05		94.77		94.77		94.77		94.77
% Adult Groups (MAX ELIG CD = 15,17,25,35,45,55) Who Are > 20 Years	100.00		100.00		100.00		100.00		100.00

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% MAX 1115 Expansion Enrollees (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	100.00		100.00		100.00		100.00		100.00
JUNE % MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55) with 1115 Waiver Enrollment (WVR TYPE = 1,5,6,A,F)	100.00		100.00		100.00		100.00		100.00
% MAX 1115 Waiver Enrollees (WVR TYPE = 1,5,6,A,F) in MAX 1115 Expansion Group (MAX ELIG CD = 51,52,54,55)	34.29		34.46		34.46		34.46		34.46
Aged Total	465,553		474,535		474,535		474,535		474,535
Aged, Cash (MAX ELIG CD = 11)	166,012		167,334		167,334		167,334		167,334
Aged, Medically Needy (MAX ELIG CD = 21)	213,652		219,726		219,726		219,726		219,726
Aged, Poverty (MAX ELIG CD = 31)	61,612		62,983		62,983		62,983		62,983
Other Aged (MAX ELIG CD = 41)	24,249		24,464		24,464		24,464		24,464
1115 Aged (MAX ELIG CD = 51)	28		28		28		28		28
Disabled Total	755,128		764,270		764,270		764,270		764,270
Disabled, Cash (MAX ELIG CD = 12)	569,761		575,090		575,090		575,090		575,090
Disabled, Medically Needy (MAX ELIG CD = 22)	157,427		160,444		160,444		160,444		160,444
Disabled, Poverty (MAX ELIG CD = 32, 3A)	18,818		19,160		19,160		19,160		19,160
Other Disabled (MAX ELIG CD = 42)	9,122		9,576		9,576		9,576		9,576
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	1,957,796		1,980,568		1,980,568		1,980,568		1,980,568
AFDC Child, Cash (MAX ELIG CD = 14)	937,770		949,384		949,384		949,384		949,384
AFDC-U Child, Cash (MAX ELIG CD = 16)	5		5		5		5		5
AFDC Child, Medically Needy (MAX ELIG CD = 24)	317,608		322,997		322,997		322,997		322,997
Child Poverty (MAX ELIG CD = 34)	609,589		613,057		613,057		613,057		613,057
Other Child (MAX ELIG CD = 44)	18,386		19,815		19,815		19,815		19,815
Foster Care Child (MAX ELIG CD = 48)	57,432		58,083		58,083		58,083		58,083
1115 Child (MAX ELIG CD = 54)	17,006		17,227		17,227		17,227		17,227
Adult Total	1,844,840		1,874,549		1,874,549		1,874,549		1,874,549
AFDC Adult, Cash (MAX ELIG CD = 15)	347,484		355,047		355,047		355,047		355,047
AFDC-U Adult, Cash (MAX ELIG CD = 17)	12		11		11		11		11
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	217,289		219,597		219,597		219,597		219,597
Adult, Poverty (MAX ELIG CD = 35)	1,461		1,422		1,422		1,422		1,422
Other Adult (MAX ELIG CD = 45)	32,730		39,554		39,554		39,554		39,554
1115 Adult (MAX ELIG CD = 55)	1,245,864		1,258,918		1,258,918		1,258,918		1,258,918
Long-Term Care Enrollees									
INSTITUTIONAL STATUS									
# Enrollees with Any ILTC Claims (Includes NF, ICF/MR, Aged Mental Hospital, IP Psych Age < 21 years, MAX TOS = 02, 04, 05, 07)	160,602		169,509		172,904		174,010		174,010
% Enrollees with Any ILTC Claims	3.20		3.33		3.39		3.42		3.42
% Aged Enrollees with Any ILTC Claims	20.51		21.36		21.84		21.98		21.98
% Disabled Enrollees with Any ILTC Claims	6.41		6.64		6.75		6.79		6.79
% Child Enrollees with Any ILTC Claims	0.56		0.57		0.58		0.58		0.58
% Adult Enrollees with Any ILTC Claims	0.31		0.32		0.33		0.34		0.34
COMMUNITY LONG-TERM CARE STATUS									
# Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	273,737		285,089		287,094		287,980		287,980

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% Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	5.45		5.60		5.64		5.65		5.65
% Aged Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	18.08		18.61		18.70		18.75		18.75
% Disabled Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	20.98		21.40		21.52		21.57		21.57
% Child Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	1.01		1.06		1.08		1.09		1.09
% Adult Enrollees with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	0.62		0.65		0.67		0.67		0.67
# Enrollees with ILTC Claims and CLTC Claims (Excludes CLTC FLAG = 16-20)	28,941	X	35,601		36,724		37,191		37,191
# Ever Enrolled in Section 1915(c) Waiver or with Any CLTC Claims (Excludes CLTC FLAG = 16-20)	282,028		292,943		294,527		295,310		295,346
SECTION 1915(c) WAIVER ENROLLMENT - MOST RECENT									
# Ever Enrolled in Any Section 1915(c) Waiver (WVR TYPE = G-P)	94,835		97,328		97,328		97,328		97,642
% Enrolled in Any Section 1915(c) Waiver	1.89		1.91		1.91		1.91		1.92
% Aged Enrollees in Section 1915(c) Waiver	3.63		3.64		3.64		3.64		3.64
% Disabled Enrollees in Section 1915(c) Waiver	10.03		10.11		10.11		10.11		10.12
% Child Enrollees in Section 1915(c) Waiver	0.08	X	0.11		0.11		0.11		0.12
% Adult Enrollees in Section 1915(c) Waiver	0.03		0.04		0.04		0.04		0.04
# Aged, EDB Dual	16,437		16,792		16,792		16,792		16,794
# Aged, Non-Dual	460		483		483		483		481
# Disabled, EDB Dual	39,250		39,357		39,357		39,357		39,363
# Disabled, Non-Dual	36,508		37,942		37,942		37,942		37,963
# Other (Child or Adult)	2,180	X	2,754		2,754		2,754		3,041
# with Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	24,262		24,623		24,623		24,623		24,623
# Aged, EDB Dual	13,631		13,978		13,978		13,978		13,980
# Aged, Non-Dual	436		458		458		458		456
# Disabled, EDB Dual	6,123		6,067		6,067		6,067		6,067
# Disabled, Non-Dual	3,708		3,759		3,759		3,759		3,759
# Other (Child or Adult)	364		361		361		361		361
# with Section 1915(c) Waiver for Aged (WVR TYPE = H)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	405		414		414		414		414
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	1		1		1		1		1
# Disabled, Non-Dual	378		387		387		387		387
# Other (Child or Adult)	26		26		26		26		26
# with Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	2,867		2,903		2,903		2,903		2,903
# Aged, EDB Dual	26		27		27		27		27
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	1,756		1,773		1,773		1,773		1,773
# Disabled, Non-Dual	980		1,001		1,001		1,001		1,001
# Other (Child or Adult)	105		102		102		102		102

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# with Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	67,301		68,042		68,042		68,042		68,092
# Aged, EDB Dual	2,780		2,787		2,787		2,787		2,787
# Aged, Non-Dual	24		25		25		25		25
# Disabled, EDB Dual	31,370		31,516		31,516		31,516		31,521
# Disabled, Non-Dual	31,442		31,989		31,989		31,989		31,989
# Other (Child or Adult)	1,685		1,725		1,725		1,725		1,770
# with Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	0	X	1,346		1,346		1,346		1,601
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0	X	0	X	0	X	0	X	1
# Disabled, Non-Dual	0	X	806		806		806		826
# Other (Child or Adult)	0	X	540	X	540	X	540	X	774
# with Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	0	X	0	X	0	X	0	X	9
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0	X	0	X	0	X	0	X	1
# Other (Child or Adult)	0	X	0	X	0	X	0	X	8
# with Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
# with Section 1915(c) Waiver for Unspecified or Unknown Populations (WVR TYPE = O)	0		0		0		0		0
# Aged, EDB Dual	0		0		0		0		0
# Aged, Non-Dual	0		0		0		0		0
# Disabled, EDB Dual	0		0		0		0		0
# Disabled, Non-Dual	0		0		0		0		0
# Other (Child or Adult)	0		0		0		0		0
% of Section 1915(c) Waiver Enrollees with No Waiver claim (PGM TYPE = 6 or 7)	35.56		34.77		34.19		34.10		34.27
% of Section 1915(c) Claim (PGM TYPE = 6 or 7) Recipients with No Waiver Enrollment	2.97	X	1.44		1.58		1.69		1.62
% of Section 1915(c) Waiver Enrollees with Any HMO/HIO Enrollment	4.37		5.02		5.02		5.02		5.01
% of Section 1915(c) Waiver Enrollees not Enrolled in HMOs/HIOs with No Waiver claim (PGM TYPE = 6 or 7)	34.08		33.30		32.78		32.72		32.88

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# Section 1915(c) Waiver Enrollees Enrolled in More Than One Section 1915(c) Waiver During the Year	68		80		80		80		81
Other Waiver Enrollment (Enrolled Any Time During the Year)									
# with Any 1115 Waiver (WVR TYPE = 1,5,6,A,F)	3,683,162		3,703,243		3,703,243		3,703,243		3,703,243
% Aged Enrollees with Any 1115 Waiver	15.33		15.08		15.08		15.08		15.08
% Disabled Enrollees with Any 1115 Waiver	35.75		36.06		36.06		36.06		36.06
% Child Enrollees with Any 1115 Waiver	82.34		81.34		81.34		81.34		81.34
% Adult Enrollees with Any 1115 Waiver	93.77		93.10		93.10		93.10		93.10
% with Any HMO/HIO Enrollment	92.59		92.08		92.08		92.08		92.08
# with Any 1915(b) Waiver (WVR TYPE = 2)	0		0		0		0		0
% Aged Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any 1915(b) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Any Combined 1915(b)(c) Waiver (WVR TYPE = 4)	0		0		0		0		0
% Aged Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Combined 1915(b)(c) Waiver	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with 1115 HIFA Waiver (WVR TYPE = 5)	0		0		0		0		0
# with 1115 Pharmacy Waiver Coverage (WVR TYPE = 6)	0		0		0		0		0
% Aged Enrollees with Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Disabled Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Child Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% Adult Enrollees with Any Pharmacy Waiver Coverage	0.00		0.00		0.00		0.00		0.00
% with Any HMO/HIO Enrollment	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
# with Other Type of Waiver (WVR TYPE = 7)	0		0		0		0		0
# with Unknown Type of Waiver (WVR TYPE = 9)	0		0		0		0		0
# with 1115 Disaster-Related Waiver (WVR TYPE = A)	0		0		0		0		0
# with 1115 Family Planning Only Waiver (WVR TYPE = F)	70,626		71,895		71,895		71,895		71,895
# of Waiver IDs with More than One Waiver Type	0		0		0		0		0
# of Waiver IDs with Reporting in January but Not December	0		0		0		0		0
# of Waiver IDs with Reporting in December but Not January	1	X	5		5		5		5
Enrollees with Restricted Benefits									
Family Planning enrollees with Restricted Benefits (RBF = 6)									
# with ONLY Family Planning Only Enrollment	49,447		50,011		50,011		50,011		50,011
# with ANY Family Planning Only Enrollment	70,610		71,879		71,879		71,879		71,879
# Person-Years of Enrollment ANY Family Planning Only Enrollment	39,420		39,563		39,563		39,563		39,563
Aliens with Restricted Benefits (RBF = 2)									
# Aliens with ONLY Restricted Benefits	39,267.00		46,210.00		46,210.00		46,210.00		46,210.00
# Aliens with ANY Restricted Benefits	76,151.00		84,358.00		84,358.00		84,358.00		84,358.00
# Person-Years of Enrollment Aliens with ANY Restricted Benefits	17,602.42		18,645.42		18,645.42		18,645.42		18,645.42

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EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
# EDB Duals with ONLY Restricted Benefits Enrollment	78,212		79,718		79,718		79,718		79,722
# EDB Duals with ANY Restricted Benefits Enrollment	88,433		90,680		90,680		90,680		90,686
# Person-Years of Enrollment EDB Duals with ANY Restricted Benefits	70,455		70,881		70,881		70,881		70,883
% EDB Duals with ONLY Restricted Benefits Enrollment	10.48		10.57		10.57		10.57		10.56
Prescription Drug Enrollees (RBF = X, Y, or Z)									
# with ONLY Prescription Drug Enrollment (May Have a Month or More of RBF = 3)	0		0		0		0		0
# with ANY Prescription Drug Enrollment	0		0		0		0		0
# Person-Years of ANY Prescription Drug Enrollment	0		0		0		0		0
Dual Prescription Drug Enrollees									
# with ONLY Prescription Drugs Who Are EDB Duals	0		0		0		0		0
June Eligibility Profile									
Total Enrollees in June	4,087,504		4,087,504		4,087,504		4,087,504		4,087,504
June % Full Scope Benefits (RBF = 1)	81.55		81.55		81.55		81.55		81.55
June % Restricted Benefits Alien (RBF = 2)	0.05		0.05		0.05		0.05		0.05
June % Restricted Benefits Dual (RBF = 3)	1.69		1.69		1.69		1.69		1.69
June % Restricted Benefits Pregnant (RBF = 4)	0.23		0.23		0.23		0.23		0.23
June % Restricted Benefits Other (RBF = 5)	15.51		15.51		15.51		15.51		15.51
June % Restricted Benefits Family Planning (RBF = 6)	0.96		0.96		0.96		0.96		0.96
June % Restricted Benefits Benchmark-Equivalent (RBF = 7)	0.00		0.00		0.00		0.00		0.00
June % Money Follows the Person Enrollee (RBF = 8)	0.00		0.00		0.00		0.00		0.00
June % Unknown Benefits (RBF = 9)	0.00		0.00		0.00		0.00		0.00
June % PRTF Enrollee (RBF = A)	0.00		0.00		0.00		0.00		0.00
June % Health Opportunity Account (RBF = B)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Non-Dual Enrollee (RBF = X)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Receiving Medicare Cost Sharing (RBF = Y)	0.00		0.00		0.00		0.00		0.00
June % Restricted Benefits Pharm Plus Dual Not Receiving Medicare Cost Sharing (RBF = Z)	0.00		0.00		0.00		0.00		0.00
June % Private Health Insurance (PVT INS CD = 2-4)	7.02		7.02		7.02		7.02		7.02
June Total Enrollees with TANF Flag (TANF FLAG = 2)	241609.00		241609.00		241609.00		241609.00		241609.00
June # with M-CHIP (SCHIP = 2) - Child (Age < 19 Years)	0		0		0		0		0
June # with M-CHIP (SCHIP = 2) - Adult (Age > 18 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Child (Age < 19 Years)	0		0		0		0		0
June # with S-CHIP (SCHIP = 3) - Adult (Age > 18 Years)	0		0		0		0		0
Medicaid Expenditures									
Total Medicaid Paid	$38,427,378,574		$41,066,636,089		$41,595,578,942		$42,171,601,195		$42,171,601,195
Avg Medicaid Paid per Enrollee	$7,650		$8,062		$8,166		$8,279		$8,279
25th Percentile	$551		$564		$584		$593		$593
50th Percentile (Median)	$1,691		$1,723		$1,746		$1,758		$1,758
75th Percentile	$3,824		$3,966		$4,046		$4,109		$4,109
95th Percentile	$37,098		$38,897		$39,441		$40,068		$40,068
99th Percentile	$106,267		$110,884		$111,817		$113,138		$113,138
Maximum Medicaid Paid	$2,941,283		$3,053,344		$3,069,506		$3,071,827		$3,071,827

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PERCENT OF ENROLLEES WITH ZERO EXPENDITURES									
% of Enrollees with Total Medicaid Paid = $0	14.66		14.62		14.34		14.24		14.24
Aged	27.20		26.57		25.99		25.79		25.79
Disabled	9.25		9.01		8.77		8.67		8.67
Child	12.03		12.08		11.89		11.82		11.82
Adult	16.49		16.58		16.26		16.15		16.15
NUMBER OF HIGH-COST ENROLLEES									
# of Enrollees with Total Medicaid Paid > $1,000,000	1465.00		1505.00		1509.00		1513.00		1513.00
# of Enrollees with Total Medicaid Paid > $500,000	1787.00		1856.00		1885.00		1906.00		1906.00
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$7,650		$8,062		$8,166		$8,279		$8,279
Aged	$19,866		$20,988		$21,257		$21,570		$21,570
Disabled	$24,215		$25,794		$26,073		$26,409		$26,409
Child	$2,074		$2,187		$2,239		$2,277		$2,277
Adult	$3,703		$3,767		$3,812		$3,864		$3,864
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$22,174		$23,654		$23,917		$24,244		$24,241
Aged	$21,368		$22,586		$22,874		$23,209		$23,207
Disabled	$24,053		$25,928		$26,172		$26,500		$26,496
EDB Only (EDB DUAL = 50)	$18,794		$19,048		$19,783		$19,998		$19,947
EDB QMB Only (EDB DUAL = 51)	$400		$352		$376		$393		$393
EDB QMB Plus (EDB DUAL = 52)	$21,361		$22,996		$23,176		$23,458		$23,457
EDB SLMB Only (EDB DUAL = 53)	$197		$179		$196		$215		$215
EDB SLMB Plus (EDB DUAL = 54)	$53,927		$57,146		$57,670		$58,706		$58,706
EDB QDWI (EDB DUAL = 55)	$8,705		$7,305		$7,455		$7,531		$7,531
EDB QI-1 (EDB DUAL = 56)	$1,462		$1,592		$1,631		$1,662		$1,662
EDB QI-2 (EDB DUAL = 57)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Other (EDB DUAL = 58)	$27,145		$28,729		$29,090		$29,509		$29,507
EDB Dual Type Unknown (EDB DUAL = 59)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EDB Dual Status Unknown (EDB DUAL = 98)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Avg Medicaid Paid per EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	$24,716		$26,399		$26,691		$27,054		$27,051
Avg Medicaid Paid per EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	$752		$780		$808		$831		$831
AVERAGE MEDICAID AMOUNT PAID PER LONG-TERM CARE ENROLLEE									
Avg Medicaid Paid per Enrollee with ILTC Claims (MAX TOS = 02, 04, 05, 07)	$71,134		$74,327		$74,073		$75,039		$75,039
Avg Medicaid Paid per Enrollee with CLTC Claims (Excluding CLTC FLAG = 16-20)	$47,427		$49,918		$50,255		$50,690		$50,690
Avg Medicaid Paid per Enrollee with ILTC (MAX TOS = 02, 04, 05, 07) and CLTC Claims (Excluding CLTC FLAG = 16-20)	$72,449		$72,190		$72,196		$72,770		$72,770
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE IN 1915(c) WAIVER - MOST RECENT									
Avg Medicaid Paid per Section 1915(c) Enrollee	$67,648		$71,426		$72,201		$72,961		$72,839
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$38,073		$41,802		$42,370		$42,959		$42,959
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$45,146		$49,045		$49,925		$50,520		$50,520
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$52,423		$56,718		$57,626		$58,004		$58,004

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Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$79,094		$83,365		$84,205		$85,048		$85,006
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		$48,468		$49,421		$49,969		$47,499
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		$84,832
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
AVERAGE 1915(c) WAIVER AMOUNT PAID (PROGRAM TYPES 6 OR 7) PER ENROLLEE IN ANY 1915(c) WAIVER - MOST RECENT									
Avg 1915(c) Waiver Amount Paid per Section 1915(c) Enrollee	$47,022		$48,753		$49,137		$49,584		$49,427
Section 1915(c) Waiver for Aged and Disabled (WVR TYPE = G)	$2	X	$6		$7		$8		$8
Section 1915(c) Waiver for Aged (WVR TYPE = H)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for Physically Disabled (WVR TYPE = I)	$861	X	$880	X	$880	X	$667		$667
Section 1915(c) Waiver for People with Brain Injuries (WVR TYPE = J)	$32,075		$34,587		$35,104		$35,204		$35,204
Section 1915(c) Waiver for People with HIV/AIDS (WVR TYPE = K)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for People with MR/DD (WVR TYPE = L)	$64,888		$67,855		$68,373		$69,009		$68,958
Section 1915(c) Waiver for People with MI/SED (WVR TYPE = M)	Div by 0		$20,163		$20,594		$20,646		$17,454
Section 1915(c) Waiver for Tech Dependent/Medically Fragile (WVR TYPE = N)	Div by 0		Div by 0		Div by 0		Div by 0		$425
Section 1915(c) Waiver for People with Autism/ASD (WVR TYPE = P)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver for None of the Above (WVR TYPE = O)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
EXPENDITURES FOR RESTRICTED BENEFIT ENROLLEES									
Expenditures for Family Planning Enrollees with Restricted Benefits (RBF = 6)									
Total Medicaid Paid for ONLY Family Planning Only Enrollees	$6,900,214		$7,483,238		$7,875,960		$8,118,590		$8,118,590
Avg Medicaid Paid per ONLY Family Planning Only Enrollee	$140		$150		$157		$162		$162
Expenditures for Aliens with Restricted Benefits (RBF = 2)									
Total Medicaid Paid for Aliens with Restricted Benefits ONLY Enrollment	$335,145,804	X	$417,272,717		$433,951,359		$448,550,899		$448,550,899
Avg Medicaid Paid per Alien Enrollee with Restricted Benefits ONLY	$8,535		$9,030		$9,391		$9,707		$9,707
Expenditures for EDB Duals with Restricted Benefits (Medicare Cost Sharing Only - RBF = 3)									
Total Medicaid Paid for EDB Duals with Only Restricted Benefits Enrollment	$2,467,437	X	$2,944,669	X	$3,832,958		$4,565,738		$4,565,738
Avg Medicaid Paid per EDB Dual with Only Restricted Benefits Enrollment	$32	X	$37	X	$48		$57		$57
Expenditures for Prescription Drug Enrollees (RBF = X, Y, or Z)									
Total Medicaid Paid for Prescription Drug ONLY Enrollees (May Have a Month or More of RBF = 3)	$0		$0		$0		$0		$0
Avg Medicaid Paid per Prescription Drug ONLY Enrollee	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Expenditures for Dual Prescription Drug Enrollees									
Total Medicaid Paid for Prescription Drug ONLY Enrollees Who Are EDB Duals	$0		$0		$0		$0		$0
MEDICAID ENROLLEES - EXCLUDING SELECT RESTRICTED BENEFIT GROUPS (excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003.									
Total Medicaid Enrollees	4,856,391		4,917,983		4,917,983		4,917,983		4,917,979
Aged Total	390,488		397,600		397,600		397,600		397,598
Disabled Total	738,642		747,442		747,442		747,442		747,440
Child Total	1,937,747		1,959,480		1,959,480		1,959,480		1,959,480
Adult Total	1,789,514		1,813,461		1,813,461		1,813,461		1,813,461
Total Medicaid Person-Years of Enrollment	4,032,684		4,046,149		4,046,149		4,046,149		4,046,147
Total EDB Duals	666,902		673,678		673,678		673,678		673,801

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Aged	340,746		347,180		347,180		347,180		347,215
Disabled	308,972		309,623		309,623		309,623		309,707
TOTAL MEDICAID AMOUNT PAID									
Total Medicaid Paid	$38,082,865,119		$40,638,935,465		$41,149,918,665		$41,710,365,968		$41,710,365,968
AVERAGE MEDICAID AMOUNT PAID PER ENROLLEE BY MAX ELIGIBILITY GROUP									
Avg Medicaid Paid per Enrollee	$7,842		$8,263		$8,367		$8,481		$8,481
Aged	$23,424		$24,753		$25,064		$25,429		$25,429
Disabled	$24,685		$26,291		$26,575		$26,917		$26,917
Child	$2,090		$2,203		$2,256		$2,294		$2,294
Adult	$3,718		$3,766		$3,805		$3,853		$3,853
AVERAGE MEDICAID AMOUNT PAID PER EDB DUAL ENROLLEE									
Avg Medicaid Paid per EDB Dual Enrollee	$24,804		$26,483		$26,777		$27,142		$27,139
Aged	$25,322		$26,768		$27,106		$27,501		$27,499
Disabled	$25,268		$27,259		$27,516		$27,861		$27,857
Managed CARE PLAN INFORMATION (Enrollees in Capitated Plans - PCCM, HMO, HIO, & PHPs, excludes people with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2003. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees are grouped with HMO/HIO rather than PHP enrollees as of 2007.									
% Total Enrollees in MC Anytime During Year	71.52		70.63		70.63		70.63		70.63
Total MC Enrollees	3,473,160		3,473,506		3,473,506		3,473,506		3,473,506
Aged	70,242		70,439		70,439		70,439		70,439
Disabled	264,928		269,490		269,490		269,490		269,490
Child	1,604,450		1,603,145		1,603,145		1,603,145		1,603,145
Adult	1,533,540		1,530,432		1,530,432		1,530,432		1,530,432
% of MC Enrollees in HMO/HIO (MC TYPE = 1)	98.57		98.57		98.57		98.57		N/A
% of MC Enrollees in Dental (MC TYPE = 2)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in BHO (MC TYPE = 3)	0.00		0.00		0.00		0.00		N/A
% of MC Enrollees in Prenatal (MC TYPE = 4)	0.00		0.00		0.00		0.00		Div by 0
% of MC Enrollees in LTC (MC TYPE = 5)	0.75		0.75		0.75		0.75		N/A
% of MC Enrollees in PACE (MC TYPE = 6)	0.10		0.10		0.10		0.10		N/A
% of MC Enrollees in PCCM (MC TYPE = 7)	0.64		0.64		0.64		0.64		N/A
% of MC Enrollees in Other MC (MC TYPE = 8)	0.00		0.00		0.00		0.00		N/A
% EDB Duals Ever Enrolled in HMO/HIOs	6.78		6.73		6.73		6.73		6.74
% EDB Duals in PHP Only or PHP/PCCM Only	3.36		3.32		3.32		3.32		3.32
% EDB Duals in PCCM Only	0.20		0.20		0.20		0.20		0.20
% Section 1915(c) Waiver Enrollees Ever Enrolled in HMO/HIOs	4.38		5.03		5.03		5.03		5.02
% Section 1915(c) Waiver Enrollees in PHP Only or PHP and PCCM Only	0.26		0.25		0.25		0.25		0.25
% Section 1915(c) Waiver Enrollees in PCCM Only	0.24		0.25		0.25		0.25		0.25
Total Enrollees in June	3,989,554		3,990,296		3,990,296		3,990,296		3,990,295
June % HMO/HIO Only (MC COMBO = 01)	66.80		66.78		66.78		66.78		66.78
June % Dental Plan Only (MC COMBO = 02)	0.00		0.00		0.00		0.00		0.00
June % BHO Only (MC COMBO = 03)	0.00		0.00		0.00		0.00		0.00
June % PCCM Only (MC COMBO = 04)	0.43		0.43		0.43		0.43		0.43
June % Other MC Only (MC COMBO = 05)	0.60		0.60		0.60		0.60		0.60
June % HMO/HIO & Dental (MC COMBO = 06)	0.00		0.00		0.00		0.00		0.00

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June % HMO/HIO & BHO (MC COMBO = 07)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Other MC (MC COMBO = 08)	0.00		0.00		0.00		0.00		0.00
June % HMO/HIO & Dental & BHO (MC COMBO = 09)	0.00		0.00		0.00		0.00		0.00
June % Dental & PCCM (MC COMBO = 10)	0.00		0.00		0.00		0.00		0.00
June % BHO & PCCM (MC COMBO = 11)	0.00		0.00		0.00		0.00		0.00
June % Other MC & PCCM (MC COMBO = 12)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO & PCCM (MC COMBO = 13)	0.00		0.00		0.00		0.00		0.00
June % Dental & BHO (MC COMBO = 14)	0.00		0.00		0.00		0.00		0.00
June % Other Combinations (MC COMBO = 15)	0.00		0.00		0.00		0.00		0.00
June % FFS Only (MC COMBO = 16)	32.18		32.19		32.19		32.19		32.19
June % MC Status Unknown (MC COMBO = 99)	0.00		0.00		0.00		0.00		0.00
CAPITATION CLAIMS									
Total Capitation Payments	$7,639,984,524		$7,689,196,577		$7,717,056,860		$7,762,233,493		$7,762,233,493
HMO/HIO	$7,639,984,524		$7,689,196,577		$7,717,056,860		$7,762,233,493		$7,762,233,493
PHP	$0		$0		$0		$0		$0
PCCM	$0		$0		$0		$0		$0
Ratio of Capitation Claims to Person-Month Enrollment in MC	0.93		0.93		0.93		0.93		0.93
HMO/HIO	0.94		0.94		0.94		0.94		0.94
PHP	0.00		0.00		0.00		0.00		0.00
PCCM	0.00		0.00		0.00		0.00		0.00
Avg Capitation Payment per Person-Month Enrollment in MC	$235		$237		$238		$239		$239
HMO/HIO	$239		$240		$241		$242		$242
PHP	$0		$0		$0		$0		$0
PCCM	$0		$0		$0		$0		$0
PERSONS ENROLLED IN PHP ONLY OR PHP AND PCCM ONLY									
Total Capitation Payments	$868,425,585		$880,400,056		$880,759,185		$896,561,190		$896,561,190
Total Medicaid Paid	$1,047,420,325		$1,076,343,616		$1,080,936,085		$1,100,566,765		$1,100,566,765
Count of Enrollees	25,127		25,137		25,137		25,137		25,137
PERSONS ENROLLED IN PCCM ONLY									
Total Capitation Payments	$3,911,142		$4,211,908		$4,299,387		$4,392,121		$4,392,121
Count of Enrollees	20,852		20,851		20,851		20,851		20,851
PERSONS EVER ENROLLED IN HMO OR HIO DURING YEAR									
Count of Enrollees	3,427,181		3,427,518		3,427,518		3,427,518		3,427,518
Aged	50,252		50,426		50,426		50,426		50,426
Disabled	254,199		258,727		258,727		258,727		258,727
Child	1,594,634		1,593,341		1,593,341		1,593,341		1,593,341
Adult	1,528,096		1,525,024		1,525,024		1,525,024		1,525,024
Total Ever Enrolled in HMO/HIO Person-Years of Enrollment	2,669,236		2,669,073		2,669,073		2,669,073		2,669,073
Total Capitation Payments	$6,767,647,797		$6,804,584,613		$6,831,998,288		$6,861,280,182		$6,861,280,182
Avg Capitation Payments	$1,975		$1,985		$1,993		$2,002		$2,002
Aged	$4,854		$4,870		$4,876		$4,913		$4,913
Disabled	$4,965		$4,917		$4,931		$4,982		$4,982
Child	$1,210		$1,243		$1,252		$1,258		$1,258
Adult	$2,181		$2,169		$2,174		$2,177		$2,177

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Total FFS Payments	$5,632,882,169		$6,006,824,066		$6,142,343,533		$6,218,174,857		$6,218,174,857
Avg FFS Payments per Enrollee	$1,644		$1,753		$1,792		$1,814		$1,814
Aged	$2,901		$3,118		$3,154		$3,195		$3,195
Disabled	$9,072		$9,594		$9,763		$9,838		$9,838
Child	$792		$867		$906		$924		$924
Adult	$1,255		$1,302		$1,320		$1,338		$1,338
Total FFS Payments by Type of Service									
IP (MAX TOS = 01)	$1,623,110,677		$1,716,417,288		$1,739,308,935		$1,784,153,002		$1,784,153,002
ILTC (MAX TOS = 02, 04, 05, 07)	$157,487,896		$173,514,276		$177,981,316		$181,016,588		$181,016,588
Drug (MAX TOS = 16)	$2,060,281,257		$2,101,289,939		$2,101,916,165		$2,102,067,014		$2,102,067,014
All Other (Excluding Capitation Payments)	$1,792,002,339		$2,015,602,563		$2,123,137,117		$2,150,938,253		$2,150,938,253
Average FFS Payments by Type of Service									
IP (MAX TOS = 01)	$474		$501		$507		$521		$521
ILTC (MAX TOS = 02, 04, 05, 07)	$46		$51		$52		$53		$53
Drug (MAX TOS = 16)	$601		$613		$613		$613		$613
All Other (Excluding Capitation Payments)	$523		$588		$619		$628		$628
FFS INFORMATION FOR NON-DUAL MEDICAID ENROLLEES (excludes EDB Duals, people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total Non-Dual FFS Enrollees	807,546		862,149		862,149		862,149		862,048
Total Non-Dual FFS Recipients	519,904		556,738		565,139		568,293		568,244
Total Non-Dual FFS Person-Years of Enrollment	539,299		548,125		548,125		548,125		548,071
Aged Total	16,180		16,813		16,813		16,813		16,784
Aged, Cash (MAX ELIG CD = 11)	4,531		4,589		4,589		4,589		4,573
Aged, Medically Needy (MAX ELIG CD = 21)	9,375		9,926		9,926		9,926		9,914
Aged, Poverty (MAX ELIG CD = 31)	372		364		364		364		363
Other Aged (MAX ELIG CD = 41)	1,902		1,934		1,934		1,934		1,934
1115 Aged (MAX ELIG CD = 51)	0		0		0		0		0
Disabled Total	195,146		199,072		199,072		199,072		199,001
Disabled, Cash (MAX ELIG CD = 12)	159,931		162,376		162,376		162,376		162,321
Disabled, Medically Needy (MAX ELIG CD = 22)	32,773		34,084		34,084		34,084		34,070
Disabled, Poverty (MAX ELIG CD = 32, 3A)	920		926		926		926		924
Other Disabled (MAX ELIG CD = 42)	1,522		1,686		1,686		1,686		1,686
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	343,060		366,088		366,088		366,088		366,088
AFDC Child, Cash (MAX ELIG CD = 14)	144,787		155,219		155,219		155,219		155,219
AFDC-U Child, Cash (MAX ELIG CD = 16)	2		2		2		2		2
AFDC Child, Medically Needy (MAX ELIG CD = 24)	63,502		69,791		69,791		69,791		69,791
Child Poverty (MAX ELIG CD = 34)	83,476		89,042		89,042		89,042		89,042
Other Child (MAX ELIG CD = 44)	5,995		6,238		6,238		6,238		6,238
Foster Care Child (MAX ELIG CD = 48)	44,443		44,922		44,922		44,922		44,922
1115 Child (MAX ELIG CD = 54)	855		874		874		874		874
Adult Total	253,160		280,176		280,176		280,176		280,175
AFDC Adult, Cash (MAX ELIG CD = 15)	60,497		66,393		66,393		66,393		66,393

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AFDC-U Adult, Cash (MAX ELIG CD = 17)	5		5		5		5		5
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	25,658		28,482		28,482		28,482		28,482
Adult, Poverty (MAX ELIG CD = 35)	45		39		39		39		39
Other Adult (MAX ELIG CD = 45)	11,823		12,724		12,724		12,724		12,724
1115 Adult (MAX ELIG CD = 55)	155,132		172,533		172,533		172,533		172,532
# Non-Dual FFS Enrollees with MSIS Dual Code but No EDB Confirmation	12,389		12,477		12,477		12,477		12,427
Total FFS Medicaid Paid	$9,436,904,704		$10,291,102,275		$10,441,504,862		$10,652,115,213		$10,650,905,148
Avg FFS Medicaid Paid per Non-Dual FFS Enrollee	$11,686		$11,937		$12,111		$12,355		$12,355
Avg FFS Medicaid Paid per Non-Dual FFS Recipient (User of Any service)	$18,151		$18,485		$18,476		$18,744		$18,744
Total Capitation Payments	$142,010,259		$148,245,035		$151,079,865		$154,609,163		$154,605,938
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	44,198		47,529		50,754		52,685		52,683
Total HMO/HIO Payments (Among People not Enrolled)	$142,010,259		$148,245,035		$151,079,865		$154,609,163		$154,605,938
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$18,113		$18,890		$19,215		$19,544		$19,564
Aged, Cash (MAX ELIG CD = 11)	$15,876		$17,271		$17,475		$17,726		$17,781
Aged, Medically Needy (MAX ELIG CD = 21)	$20,892		$21,283		$21,712		$22,095		$22,102
Aged, Poverty (MAX ELIG CD = 31)	$729		$807		$808		$817		$819
Other Aged (MAX ELIG CD = 41)	$13,143		$13,855		$13,993		$14,286		$14,286
1115 Aged (MAX ELIG CD = 51)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Disabled	$35,645		$37,975		$38,406		$38,986		$38,996
Disabled, Cash (MAX ELIG CD = 12)	$36,182		$38,542		$38,883		$39,423		$39,432
Disabled, Medically Needy (MAX ELIG CD = 22)	$34,136		$36,531		$37,400		$38,192		$38,202
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$8,529		$9,363		$9,584		$9,897		$9,918
Other Disabled (MAX ELIG CD = 42)	$28,145		$28,298		$28,592		$28,992		$28,992
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$2,478		$2,586		$2,653		$2,753		$2,753
AFDC Child, Cash (MAX ELIG CD = 14)	$2,268		$2,344		$2,422		$2,531		$2,531
AFDC-U Child, Cash (MAX ELIG CD = 16)	$0		$0		$0		$0		$0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	$1,105		$1,121		$1,163		$1,216		$1,216
Child Poverty (MAX ELIG CD = 34)	$1,508		$1,580		$1,626		$1,738		$1,738
Other Child (MAX ELIG CD = 44)	$1,440		$1,602		$1,637		$1,741		$1,741
Foster Care Child (MAX ELIG CD = 48)	$7,115		$7,865		$7,975		$8,093		$8,093
1115 Child (MAX ELIG CD = 54)	$910		$949		$961		$987		$987
Adult	$5,285		$5,235		$5,360		$5,549		$5,549
AFDC Adult, Cash (MAX ELIG CD = 15)	$3,145		$3,185		$3,252		$3,386		$3,386
AFDC-U Adult, Cash (MAX ELIG CD = 17)	$3,320	X	$12,490		$12,490		$12,490		$12,490
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	$2,563		$2,682		$2,772		$2,967		$2,967
Adult, Poverty (MAX ELIG CD = 35)	$4,310		$4,534		$4,244		$4,348		$4,348
Other Adult (MAX ELIG CD = 45)	$1,628	X	$1,851		$1,921		$2,075		$2,075
1115 Adult (MAX ELIG CD = 55)	$6,848		$6,695		$6,852		$7,064		$7,063
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$2,353,675,600		$2,597,208,768		$2,653,034,289		$2,784,074,919		$2,784,021,479
IP: Number of Users	102,680		116,747		119,538		120,440		120,428
IP: Avg Medicaid Paid per User	$22,922		$22,246		$22,194		$23,116		$23,118

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IP: Avg Medicaid Covered Days Per User	15.85		14.14		14.23		14.12		14.12
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$13,799,723		$15,109,532		$15,341,100		$15,380,258		$15,190,856
MH Aged: Number of Users	293		318		321		323		322
MH Aged: Avg Medicaid Paid per User	$47,098		$47,514		$47,792		$47,617		$47,177
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$263,198,800		$285,919,608		$287,629,030		$291,161,456		$291,161,456
IP Psych, Age < 21: Number of Users	5,640		6,152		6,253		6,312		6,312
IP Psych, Age < 21: Avg Medicaid Paid per User	$46,666		$46,476		$45,999		$46,128		$46,128
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$1,105,117,547		$1,275,379,040		$1,280,603,279		$1,305,780,335		$1,305,756,417
ICF/MR: Number of Users	3,082		3,123		3,135		3,139		3,138
ICF/MR: Avg Medicaid Paid per User	$358,572		$408,383		$408,486		$415,986		$416,111
NF: Total Medicaid Paid (MAX TOS = 07)	$939,441,145		$987,426,351		$999,050,256		$1,012,662,148		$1,012,338,512
NF: Number of Users	15,507		16,455		16,822		16,941		16,933
NF:Avg Medicaid Paid per User	$60,582		$60,008		$59,390		$59,776		$59,785
Physician: Total Medicaid Paid (MAX TOS = 08)	$70,931,123	X	$83,967,665		$88,297,351		$90,395,804		$90,392,041
Physician: Number of Users	273,805		304,423		315,228		320,324		320,292
Physician: Avg Medicaid Paid per User	$259		$276		$280		$282		$282
Dental: Total Medicaid Paid (MAX TOS = 09)	$80,543,464		$85,371,711		$86,132,004		$86,572,281		$86,566,597
Dental: Number of Users	163,365		169,657		170,703		171,234		171,221
Dental: Avg Medicaid Paid per User	$493		$503		$505		$506		$506
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$1,024,322		$1,126,818		$1,161,005		$1,171,858		$1,171,721
Other Practitioner: Number of Users	28,022		30,330		31,091		31,313		31,307
Other Practitioner: Avg Medicaid Paid per User	$37		$37		$37		$37		$37
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$273,297,413		$328,463,091		$336,884,210		$340,799,171		$340,786,486
Outpatient: Number of Users	290,654		318,523		326,336		329,259		329,238
Outpatient: Avg Medicaid Paid per User	$940		$1,031		$1,032		$1,035		$1,035
Clinic: Total Medicaid Paid (MAX TOS = 12)	$186,833,496		$205,122,372		$209,673,045		$211,737,523		$211,693,544
Clinic: Number of Users	141,714		153,544		156,586		158,937		158,926
Clinic: Avg Medicaid Paid per User	$1,318		$1,336		$1,339		$1,332		$1,332
Home Health: Total Medicaid Paid (MAX TOS = 13)	$234,451,513		$260,633,663		$263,531,477		$265,583,308		$265,543,448
Home Health: Number of Users	40,227		42,424		42,950		43,226		43,219
Home Health: Avg Medicaid Paid per User	$5,828		$6,144		$6,136		$6,144		$6,144
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$52,743,686		$61,165,764		$63,936,826		$65,170,431		$65,168,014
Lab/Xray: Number of Users	252,057		276,803		285,291		289,632		289,613
Lab/Xray:Avg Medicaid Paid per User	$209		$221		$224		$225		$225
Drugs: Total Medicaid Paid (MAX TOS = 16)	$1,239,124,572		$1,263,278,791		$1,264,226,571		$1,264,392,433		$1,264,311,837
Drugs: Number of Users	385,675		392,589		393,387		393,834		393,813
Drugs: Avg Medicaid Paid per User	$3,213		$3,218		$3,214		$3,210		$3,210
Other Services: Total Medicaid Paid (MAX TOS = 19)	$220,793,508		$243,418,989		$245,558,248		$247,688,590		$247,684,331
Other Services: Number of Users	133,376		138,343		139,241		139,614		139,598
Other Services: Avg Medicaid Paid per User	$1,655		$1,760		$1,764		$1,774		$1,774
Transportation: Total Medicaid Paid (MAX TOS = 26)	$61,849,078		$69,094,293		$70,792,291		$71,337,627		$71,334,117
Transportation: Number of Users	65,855		71,406		72,810		73,203		73,191
Transportation: Avg Medicaid Paid per User	$939		$968		$972		$975		$975
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$258,721,075		$279,634,733		$282,676,950		$283,404,494		$283,390,678

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Personal Care Services: Number of Users	10,983		11,166		11,200		11,210		11,209
Personal Care Services: Avg Medicaid Paid per User	$23,557		$25,043		$25,239		$25,281		$25,282
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$1,487,470	X	$2,185,561		$2,311,431		$2,404,679		$2,404,679
Targeted Case Management: Number of Users	3,640	X	4,754		5,017		5,140		5,140
Targeted Case Management: Avg Medicaid Paid per User	$409		$460		$461		$468		$468
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$141,323,046	X	$178,681,033		$203,558,142		$212,799,699		$212,795,037
Rehabilitation Services: Number of Users	26,700	X	30,591		32,894		33,891		33,890
Rehabilitation Services: Avg Medicaid Paid per User	$5,293		$5,841		$6,188		$6,279		$6,279
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$171,505	X	$194,668		$212,419		$219,470		$219,470
PT/OT/Speech/Hearing: Number of Users	1,501	X	1,656		1,782		1,890		1,890
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$114		$118		$119		$116		$116
Hospice: Total Medicaid Paid (MAX TOS = 35)	$13,220,991		$14,783,883		$15,020,703		$15,215,612		$15,178,582
Hospice: Number of Users	848		952		978		992		990
Hospice: Avg Medicaid Paid per User	$15,591		$15,529		$15,359		$15,338		$15,332
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$33,211,489		$39,114,048		$40,312,615		$40,793,019		$40,791,699
Durable Medical Equipment: Number of Users	85,324		91,460		92,569		93,029		93,017
Durable Medical Equipment: Avg Medicaid Paid per User	$389		$428		$435		$438		$439
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$936,732,069		$982,103,562		$990,005,688		$997,124,126		$996,828,945
Residential Care: Number of Users	22,122		22,710		23,212		23,267		23,263
Residential Care: Avg Medicaid Paid per User	$42,344		$43,245		$42,651		$42,856		$42,850
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$475,754,057		$509,464,454		$515,733,174		$518,639,070		$518,629,176
Psych Services: Number of Users	153,256		162,453		165,085		166,226		166,253
Psych Services: Avg Medicaid Paid per User	$3,104		$3,136		$3,124		$3,120		$3,120
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$357,662,449		$389,774,133		$391,920,433		$393,427,014		$393,366,198
Adult Day Care: Number of Users	17,790		19,376		19,502		19,564		19,561
Adult Day Care: Avg Medicaid Paid per User	$20,105		$20,116		$20,096		$20,110		$20,110
AVERAGE FFS MEDICAID AMOUNT PAID PER NON-DUAL FFS ENROLLEE BY MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$2,915		$3,012		$3,077		$3,229		$3,230
Aged	$3,948		$4,223		$4,316		$4,474		$4,482
Disabled	$6,723		$7,214		$7,324		$7,587		$7,590
Child	$847		$874		$901		$980		$980
Adult	$2,715		$2,749		$2,829		$2,997		$2,997
ILTC (MAX TOS = 02,04,05,07)	$2,875		$2,974		$2,996		$3,045		$3,044
Aged	$8,790		$9,002		$9,153		$9,282		$9,288
Disabled	$10,375		$11,261		$11,327		$11,518		$11,521
Child	$370		$386		$390		$393		$393
Adult	$110		$104		$111		$115		$114
Drugs (MAX TOS = 16)	$1,534		$1,465		$1,466		$1,467		$1,467
Aged	$664		$655		$655		$656		$657
Disabled	$4,467		$4,491		$4,493		$4,494		$4,495
Child	$238		$227		$228		$228		$228
Adult	$1,086		$981		$983		$983		$983
All Other Services	$4,362		$4,485		$4,572		$4,615		$4,615
Aged	$4,711		$5,010		$5,090		$5,131		$5,137

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Disabled	$14,080		$15,010		$15,262		$15,387		$15,390
Child	$1,023		$1,099		$1,134		$1,152		$1,152
Adult	$1,373		$1,400		$1,437		$1,454		$1,454
PERCENT OF NON-DUAL FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% Non-Dual FFS Enrollees with IP Claims (MAX TOS = 01)	12.72		13.54		13.87		13.97		13.97
Aged	16.02		17.47		17.90		18.03		18.05
Disabled	17.95		18.78		18.94		19.01		19.01
Child	7.41		8.24		8.50		8.60		8.60
Adult	15.66		16.52		17.03		17.16		17.16
% Non-Dual FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	3.01		3.00		3.05		3.07		3.07
Aged	14.53		14.84		15.28		15.40		15.41
Disabled	8.67		8.96		9.08		9.14		9.14
Child	1.02		1.03		1.04		1.05		1.05
Adult	0.61		0.62		0.66		0.67		0.67
% with Ratio of ILTC Days/Enrollment Days > 1	42.11	X	23.10		23.38		24.19		24.19
% Non-Dual FFS Enrollees with Drug Claims (MAX TOS = 16)	47.76		45.54		45.63		45.68		45.68
Aged	34.85		34.06		34.15		34.21		34.25
Disabled	74.52		73.90		73.96		73.97		73.99
Child	36.61		35.07		35.17		35.24		35.24
Adult	43.06		39.75		39.86		39.90		39.90
% Non-Dual FFS Enrollees with All Other Claims	60.59		61.36		62.53		62.97		62.97
Aged	49.45		50.41		51.41		51.82		51.84
Disabled	83.41		83.84		84.34		84.57		84.59
Child	50.81		51.57		52.58		52.99		52.99
Adult	56.96		58.85		60.69		61.33		61.33
Avg # IP Days per Non-Dual FFS User	16		14		14		14		14
Aged	12		11		11		11		11
Disabled	25		23		24		24		24
Child	7		6		6		6		6
Adult	14		12		12		12		12
Avg # ILTC Days per Non-Dual FFS User	327	X	211		212		224		224
Aged	489	X	236		235		243		243
Disabled	375	X	250		253		267		267
Child	88		81		81		83		83
Adult	95	X	52		55		61		61
% Non-Dual FFS Enrollees with Maternal Delivery	1.89		1.99		2.02		2.03		2.03
HIGH-COST FFS NON-DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Non-Duals with FFS Medicaid Paid > $1,000,000	613		638		640		641		641
Number of FFS Non-Duals with FFS Medicaid Paid > $500,000	838		889		906		923		923
Inpatient Hospital (MAX TOS = 01) > $500,000	119	X	131		138		151		151
ILTC (MAX TOS = 02,04,05,07) > $200,000	1,623		1,750		1,752		1,808		1,808
Drugs (MAX TOS = 16) > $200,000	39		40		40		40		40
All Other Services > $200,000	1,168	X	1,430		1,448		1,478		1,478
Maximum FFS Medicaid Paid	$1,956,349		$2,282,620		$2,283,846		$2,289,934		$2,289,934

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Inpatient Hospital (MAX TOS = 01)	$1,923,063		$2,246,798		$2,246,798		$2,252,880		$2,252,880
ILTC (MAX TOS = 02,04,05,07)	$1,210,227		$1,436,172		$1,436,172		$1,472,660		$1,472,660
Drugs (MAX TOS = 16)	$1,305,131		$1,362,415		$1,362,415		$1,362,415		$1,362,415
All Other Services	$1,043,737		$1,238,384		$1,238,414		$1,238,414		$1,238,414
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$10,595,312		$11,709,944		$11,928,065		$12,220,216		$12,220,187
FP: Number of Users	43,768		47,474		48,239		48,729		48,728
FP: Avg Medicaid Paid per User	$242		$247		$247		$251		$251
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$14,489,991	X	$17,163,590		$18,287,928		$18,832,360		$18,830,549
FQHC: Number of Users	25,141	X	29,676		33,078		34,434		34,431
FQHC: Avg Medicaid Paid per User	$576		$578		$553		$547		$547
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$1,220,048,032		$1,295,141,925		$1,305,508,264		$1,313,475,288		$1,313,117,021
Section 1915(c) Waiver: Number of Users	25,522		26,407		26,698		26,773		26,768
Section 1915(c) Waiver: Avg Medicaid Paid per User	$47,804		$49,045		$48,899		$49,060		$49,055
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$2,004,961,389		$2,153,209,722		$2,172,063,237		$2,184,275,665		$2,183,863,722
Number of Non-Dual CLTC Users (Excludes CLTC FLAG = 16-20)	75,522		79,313		80,113		80,470		80,459
Avg FFS CLTC Medicaid Paid per Non-Dual User (Excludes CLTC FLAG = 16-20)	$26,548		$27,148		$27,112		$27,144		$27,143
Aged	$29,435		$30,423		$30,605		$30,642		$30,673
Disabled	$34,588		$35,653		$35,695		$35,793		$35,791
Child	$6,290		$6,629		$6,593		$6,608		$6,608
Adult	$3,894		$3,768		$3,761		$3,766		$3,766
% Non-Dual FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	9.35		9.20		9.29		9.33		9.33
Aged	11.84		12.09		12.15		12.19		12.20
Disabled	27.15		27.64		27.84		27.91		27.92
Child	4.36		4.35		4.42		4.46		4.46
Adult	2.25		2.25		2.30		2.33		2.33
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$1,220,048,032		$1,295,141,925		$1,305,508,264		$1,313,475,288		$1,313,117,021
# Non-Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	25,522		26,407		26,698		26,773		26,768
Avg FFS CLTC Medicaid Paid per Non-Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$47,804		$49,045		$48,899		$49,060		$49,055
Aged	$130,601		$135,792		$131,458		$132,706		$132,706
Disabled	$49,256		$50,639		$50,519		$50,707		$50,703
Child	$15,328		$15,363		$15,242		$15,115		$15,115
Adult	$33,593		$32,433		$32,582		$33,879		$33,879
% Non-Dual FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	3.16		3.06		3.10		3.11		3.11
Aged	0.13		0.13		0.14		0.14		0.14

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Disabled	12.45		12.60		12.73		12.76		12.76
Child	0.32		0.32		0.33		0.34		0.34
Adult	0.04		0.04		0.04		0.04		0.04
FFS INFORMATION FOR DUAL MEDICAID ENROLLEES (excludes non-EDB duals, duals ever enrolled in HMO/HIOs or PACE, duals with only restricted benefits, duals with missing eligibility information, and prescription drug only enrollees)---NOTE: non-EDB duals and duals with restricted benefits were not excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total EDB Dual FFS Enrollees	621,664		628,316		628,316		628,316		628,413
Number of EDB Dual FFS Recipients	549,977		559,807		563,096		564,199		564,248
Total EDB Dual FFS Person-Years of Enrollment	564,782		566,776		566,776		566,776		566,828
% EDB Only Dual (EDB DUAL = 50)	1.55	X	1.14		1.14		1.14		1.14
% QMB Only (EDB DUAL = 51)	0.62		0.59		0.59		0.59		0.59
% QMB Plus (EDB DUAL = 52)	45.48		45.29		45.29		45.29		45.28
% SLMB Only (EDB DUAL = 53)	0.44		0.43		0.43		0.43		0.43
% SLMB Plus (EDB DUAL = 54)	1.27		1.31		1.31		1.31		1.31
% QDWI (EDB DUAL = 55)	0.00		0.00		0.00		0.00		0.00
% QI 1 (EDB DUAL = 56)	0.45		0.46		0.46		0.46		0.46
% QI 2 (EDB DUAL = 57)	0.00		0.00		0.00		0.00		0.00
% Other Type Dual (EDB DUAL = 58)	50.19		50.78		50.78		50.78		50.78
% Dual Type Unknown (EDB DUAL = 59)	0.00		0.00		0.00		0.00		0.00
% EDB Duals with Full Benefits (EDB DUAL = 50,52,54,58)	98.49		98.52		98.52		98.52		98.52
% EDB Duals with Restricted Benefits (EDB DUAL = 51,53,55,56,57)	1.51		1.48		1.48		1.48		1.48
Aged EDB Dual FFS Total	324,056		330,361		330,361		330,361		330,388
Aged, Cash (MAX ELIG CD = 11)	152,832		153,861		153,861		153,861		153,877
Aged, Medically Needy (MAX ELIG CD = 21)	162,622		167,954		167,954		167,954		167,964
Aged, Poverty (MAX ELIG CD = 31)	5,467		5,463		5,463		5,463		5,464
Other Aged (MAX ELIG CD = 41)	3,134		3,082		3,082		3,082		3,082
1115 Aged (MAX ELIG CD = 51)	1		1		1		1		1
Disabled EDB Dual FFS Total	289,297		289,643		289,643		289,643		289,712
Disabled, Cash (MAX ELIG CD = 12)	184,796		183,820		183,820		183,820		183,875
Disabled, Medically Needy (MAX ELIG CD = 22)	94,346		95,612		95,612		95,612		95,626
Disabled, Poverty (MAX ELIG CD = 32, 3A)	3,917		3,873		3,873		3,873		3,873
Other Disabled (MAX ELIG CD = 42)	6,238		6,338		6,338		6,338		6,338
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Total FFS Medicaid Paid	$15,320,553,674		$16,594,009,876		$16,788,312,889		$17,015,409,605		$17,016,619,670
Avg FFS Medicaid Paid per FFS Dual	$24,644		$26,410		$26,720		$27,081		$27,079
Avg FFS Medicaid Paid per FFS Dual Recipient (User of Any Service)	$27,857		$29,642		$29,814		$30,159		$30,158
Total Capitation Payments	$782,866,516		$794,169,600		$794,679,228		$808,776,948		$808,780,173
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	27,861		27,970		28,007		28,046		28,048
Total HMO/HIO Payments (Among People not Enrolled)	$782,866,516		$794,169,600		$794,679,228		$808,776,948		$808,780,173
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY MAX ELIGIBILITY GROUP									
Aged	$24,034		$25,539		$25,889		$26,262		$26,261
Aged, Cash (MAX ELIG CD = 11)	$14,799		$16,057		$16,243		$16,394		$16,393
Aged, Medically Needy (MAX ELIG CD = 21)	$33,629		$35,154		$35,660		$36,247		$36,246
Aged, Poverty (MAX ELIG CD = 31)	$6,539		$7,111		$7,343		$7,492		$7,491

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Other Aged (MAX ELIG CD = 41)	$7,052		$7,628		$7,859		$8,061		$8,061
1115 Aged (MAX ELIG CD = 51)	$1,856		$1,927		$1,934		$1,934		$1,934
Disabled	$25,877		$27,988		$28,257		$28,613		$28,608
Disabled, Cash (MAX ELIG CD = 12)	$18,633		$19,859		$20,076		$20,234		$20,232
Disabled, Medically Needy (MAX ELIG CD = 22)	$41,478		$45,148		$45,522		$46,275		$46,270
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$3,423		$3,487		$3,544		$3,613		$3,613
Other Disabled (MAX ELIG CD = 42)	$18,614		$19,861		$20,184		$20,431		$20,431
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$432,708,193		$498,069,266		$515,918,375		$532,123,915		$532,177,355
IP: Number of Users	117,079		130,164		133,432		135,149		135,161
IP: Avg Medicaid Paid per User	$3,696		$3,826		$3,867		$3,937		$3,937
IP: Avg Medicaid Covered Days Per User	1.58		1.53		1.63		1.62		1.62
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$71,619,805		$83,446,022		$86,449,870		$89,292,958		$89,482,360
MH Aged: Number of Users	2,691		3,105		3,238		3,290		3,291
MH Aged: Avg Medicaid Paid per User	$26,615		$26,875		$26,699		$27,141		$27,190
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$1,016,150		$1,097,950		$1,103,806		$1,110,438		$1,110,438
IP Psych, Age < 21: Number of Users	62		66		68		68		68
IP Psych, Age < 21: Avg Medicaid Paid per User	$16,390		$16,636		$16,232		$16,330		$16,330
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$1,607,134,391		$1,845,214,462		$1,847,351,039		$1,881,821,569		$1,881,845,487
ICF/MR: Number of Users	5,022		5,057		5,068		5,072		5,073
ICF/MR: Avg Medicaid Paid per User	$320,019		$364,883		$364,513		$371,022		$370,953
NF: Total Medicaid Paid (MAX TOS = 07)	$5,421,980,044		$5,749,765,186		$5,819,486,390		$5,918,745,858		$5,919,069,494
NF: Number of Users	112,727		119,091		121,662		122,394		122,402
NF:Avg Medicaid Paid per User	$48,098		$48,280		$47,833		$48,358		$48,358
Physician: Total Medicaid Paid (MAX TOS = 08)	$51,455,867	X	$61,907,468		$67,203,254		$70,491,406		$70,495,169
Physician: Number of Users	353,855		374,954		384,337		388,951		388,983
Physician: Avg Medicaid Paid per User	$145		$165		$175		$181		$181
Dental: Total Medicaid Paid (MAX TOS = 09)	$81,775,548		$86,383,536		$87,417,180		$87,921,906		$87,927,590
Dental: Number of Users	149,222		152,836		153,943		154,428		154,441
Dental: Avg Medicaid Paid per User	$548		$565		$568		$569		$569
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$3,932,133		$4,464,421		$4,673,632		$4,816,535		$4,816,672
Other Practitioner: Number of Users	128,585		143,133		148,226		150,911		150,917
Other Practitioner: Avg Medicaid Paid per User	$31		$31		$32		$32		$32
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$162,424,613		$190,184,314		$195,342,315		$197,643,393		$197,652,929
Outpatient: Number of Users	229,865		245,039		250,722		253,491		253,502
Outpatient: Avg Medicaid Paid per User	$707		$776		$779		$780		$780
Clinic: Total Medicaid Paid (MAX TOS = 12)	$81,705,776		$94,072,784		$98,450,337		$100,188,918		$100,223,482
Clinic: Number of Users	81,442		87,840		90,367		92,216		92,224
Clinic: Avg Medicaid Paid per User	$1,003		$1,071		$1,089		$1,086		$1,087
Home Health: Total Medicaid Paid (MAX TOS = 13)	$1,034,402,961		$1,166,265,461		$1,180,599,375		$1,189,192,322		$1,189,232,182
Home Health: Number of Users	107,528		110,061		110,605		110,924		110,931
Home Health: Avg Medicaid Paid per User	$9,620		$10,597		$10,674		$10,721		$10,720
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$28,044,923	X	$32,869,239		$34,773,289		$35,796,886		$35,799,303

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Lab/Xray: Number of Users	249,231		271,766		279,571		283,544		283,563
Lab/Xray:Avg Medicaid Paid per User	$113		$121		$124		$126		$126
Drugs: Total Medicaid Paid (MAX TOS = 16)	$87,124,187		$88,764,245		$88,956,309		$89,043,036		$89,123,632
Drugs: Number of Users	327,082		329,182		329,555		329,996		330,017
Drugs: Avg Medicaid Paid per User	$266		$270		$270		$270		$270
Other Services: Total Medicaid Paid (MAX TOS = 19)	$337,199,935		$367,347,068		$376,464,222		$380,178,504		$380,182,763
Other Services: Number of Users	226,217		233,492		235,407		236,341		236,357
Other Services: Avg Medicaid Paid per User	$1,491		$1,573		$1,599		$1,609		$1,609
Transportation: Total Medicaid Paid (MAX TOS = 26)	$223,119,576		$248,087,691		$251,836,631		$253,451,618		$253,455,128
Transportation: Number of Users	188,807		200,737		203,277		204,313		204,325
Transportation: Avg Medicaid Paid per User	$1,182		$1,236		$1,239		$1,241		$1,240
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$1,966,055,776		$2,101,989,701		$2,114,321,979		$2,119,764,555		$2,119,778,371
Personal Care Services: Number of Users	72,004		73,158		73,429		73,535		73,536
Personal Care Services: Avg Medicaid Paid per User	$27,305		$28,732		$28,794		$28,827		$28,826
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$3,503	X	$3,910		$4,461		$4,509		$4,509
Targeted Case Management: Number of Users	6		6		6		6		6
Targeted Case Management: Avg Medicaid Paid per User	$584	X	$652		$744		$752		$752
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$134,646,770		$142,257,026		$143,766,588		$144,254,378		$144,259,040
Rehabilitation Services: Number of Users	18,782		20,111		20,548		20,705		20,706
Rehabilitation Services: Avg Medicaid Paid per User	$7,169		$7,074		$6,997		$6,967		$6,967
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$2,856,691	X	$3,412,760	X	$4,491,844		$5,055,318		$5,055,318
PT/OT/Speech/Hearing: Number of Users	9,359	X	10,885		11,853		13,015		13,015
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$305	X	$314		$379		$388		$388
Hospice: Total Medicaid Paid (MAX TOS = 35)	$76,084,969		$85,688,198		$87,539,641		$89,356,154		$89,393,184
Hospice: Number of Users	5,059		5,608		5,787		5,856		5,858
Hospice: Avg Medicaid Paid per User	$15,040		$15,280		$15,127		$15,259		$15,260
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$76,652,981	X	$93,067,754		$98,416,980		$100,933,309		$100,934,629
Durable Medical Equipment: Number of Users	186,469		203,277		208,340		211,001		211,013
Durable Medical Equipment: Avg Medicaid Paid per User	$411		$458		$472		$478		$478
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$2,365,685,235		$2,466,347,845		$2,487,771,587		$2,517,055,827		$2,517,351,008
Residential Care: Number of Users	24,765		24,963		26,775		26,798		26,802
Residential Care: Avg Medicaid Paid per User	$95,525		$98,800		$92,914		$93,927		$93,924
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$296,566,499		$322,749,045		$329,072,779		$332,958,114		$332,980,572
Psych Services: Number of Users	150,846		163,091		169,238		172,238		172,260
Psych Services: Avg Medicaid Paid per User	$1,966		$1,979		$1,944		$1,933		$1,933
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$745,775,480		$827,339,124		$833,480,422		$840,746,180		$840,806,996
Adult Day Care: Number of Users	32,361	X	41,372		41,846		42,037		42,040
Adult Day Care: Avg Medicaid Paid per User	$23,046		$19,998		$19,918		$20,000		$20,000
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS DUAL BY SELECTED MAX TYPE OF SERVICE									
Inpatient Hospital (MAX TOS = 01)	$696		$793		$821		$847		$847
Aged	$638		$729		$758		$783		$783
Disabled	$742		$848		$876		$903		$903
ILTC (MAX TOS = 02,04,05,07)	$11,424		$12,222		$12,342		$12,559		$12,558
Aged	$14,279		$14,959		$15,146		$15,413		$15,412

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Disabled	$8,538		$9,434		$9,479		$9,645		$9,644
Drugs (MAX TOS = 16)	$140		$141		$142		$142		$142
Aged	$61		$62		$62		$62		$62
Disabled	$210		$214		$215		$215		$215
All Other Services	$12,384		$13,254		$13,415		$13,533		$13,532
Aged	$9,056		$9,790		$9,924		$10,005		$10,004
Disabled	$16,387		$17,492		$17,687		$17,849		$17,847
PERCENT OF FFS DUALS WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Duals with IP Claims (MAX TOS = 01)	18.83		20.72		21.24		21.51		21.51
Aged	19.53		21.53		22.14		22.45		22.45
Disabled	18.10		19.83		20.26		20.49		20.49
% FFS Duals with ILTC Claims (MAX TOS = 02,04,05,07)	19.18		20.02		20.44		20.56		20.56
Aged	28.51		29.66		30.31		30.49		30.49
Disabled	9.23		9.56		9.72		9.78		9.78
% FFS Duals with Drug Claims (MAX TOS = 16)	52.61		52.39		52.45		52.52		52.52
Aged	49.17		48.89		48.97		49.07		49.07
Disabled	56.52		56.44		56.48		56.51		56.50
% FFS Duals with All Other Claims	82.72		83.79		84.51		84.83		84.83
Aged	79.05		80.35		81.29		81.71		81.71
Disabled	87.12		87.98		88.44		88.65		88.64
Avg # IP Days per FFS Dual User (MAX TOS = 01)	2		2		2		2		2
Aged	1		1		1		1		1
Disabled	2		2		2		2		2
Avg # ILTC Days per FFS Dual User (MAX TOS = 02, 04, 05, 07)	470	X	240		240		247		247
Aged	488	X	234		234		240		240
Disabled	409	X	262		262		275		275
HIGH-COST FFS DUALS AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Duals with FFS Medicaid Paid > $1,000,000	846		860		862		865		865
Number of FFS Duals with FFS Medicaid Paid > $500,000	908		923		930		931		931
Inpatient Hospital (MAX TOS = 01) > $500,000	10	X	14	X	18		18		18
ILTC (MAX TOS = 02,04,05,07) > $200,000	1,584		1,727		1,740		1,765		1,765
Drugs (MAX TOS = 16) > $200,000	0		0		0		0		0
All Other Services > $200,000	5,604		6,083		6,123		6,164		6,164
Maximum FFS Medicaid Paid	$1,258,491		$1,484,102		$1,484,102		$1,512,647		$1,512,647
Inpatient Hospital (MAX TOS = 01)	$752,728		$752,728		$834,814		$834,814		$834,814
ILTC (MAX TOS = 02,04,05,07)	$1,209,337		$1,435,307		$1,435,307		$1,471,797		$1,471,797
Drugs (MAX TOS = 16)	$173,288		$180,800		$180,800		$180,800		$180,800
All Other Services	$396,918		$445,518		$444,437		$444,437		$444,437
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$543,502	X	$623,633		$660,515		$682,901		$682,930
FP: Number of Users	4,734		5,235		5,405		5,500		5,501
FP: Avg Medicaid Paid per User	$115		$119		$122		$124		$124
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0

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RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$4,187,340	X	$5,174,215		$5,733,770		$5,857,469		$5,859,280
FQHC: Number of Users	13,149	X	14,751		16,316		16,795		16,798
FQHC: Avg Medicaid Paid per User	$318		$351		$351		$349		$349
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$3,206,007,233		$3,384,382,234		$3,411,495,737		$3,447,499,546		$3,447,857,813
Section 1915(c) Waiver: Number of Users	33,919		34,170		34,467		34,511		34,516
Section 1915(c) Waiver: Avg Medicaid Paid per User	$94,520		$99,045		$98,979		$99,896		$99,892
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$6,324,135,413		$6,791,326,117		$6,848,126,840		$6,899,615,905		$6,900,027,848
Number of Dual CLTC Users (Excludes CLTC FLAG = 16-20)	169,229		174,885		175,702		176,052		176,063
Avg FFS CLTC Medicaid Paid per Dual User (Excludes CLTC FLAG = 16-20)	$37,370		$38,833		$38,976		$39,191		$39,191
Aged	$30,576		$31,996		$32,125		$32,250		$32,249
Disabled	$43,776		$45,435		$45,599		$45,906		$45,906
% FFS Dual Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	27.22		27.83		27.96		28.02		28.02
Aged	24.80		25.48		25.61		25.66		25.66
Disabled	30.47		31.07		31.20		31.25		31.25
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$3,206,007,233		$3,384,382,234		$3,411,495,737		$3,447,499,546		$3,447,857,813
# Dual CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	33,919		34,170		34,467		34,511		34,516
Avg CLTC Medicaid Paid per Dual User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$94,520		$99,045		$98,979		$99,896		$99,892
Aged	$132,753		$140,330		$137,473		$139,530		$139,530
Disabled	$91,376		$95,631		$95,697		$96,517		$96,513
% FFS Dual Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	5.46		5.44		5.49		5.49		5.49
Aged	0.81		0.80		0.83		0.83		0.83
Disabled	10.80		10.86		10.93		10.94		10.94
FFS INFORMATION FOR TOTAL MEDICAID ENROLLEES (excludes people ever enrolled in HMO/HIOs or PACE, with missing eligibility information, S-CHIP only, FP Only, Aliens with only restricted benefits, duals with restricted benefits only, and prescription drug only enrollees) ---- NOTE: S-CHIP only, FP Only, duals with restricted benefits, and Aliens with restricted benefits were NOT excluded prior to 2001. Prescription drug only enrollees were NOT excluded prior to 2003. PACE enrollees were not excluded prior to 2007.									
Total FFS Enrollees	1,429,210		1,490,465		1,490,465		1,490,465		1,490,461
# FFS Recipients	1,069,881		1,116,545		1,128,235		1,132,492		1,132,492
% FFS Enrollees Who Are Recipients	74.86		74.91		75.70		75.98		75.98
% Aged Who Are Recipients	85.91		86.60		87.29		87.50		87.50
% Disabled Who Are Recipients	88.47		88.81		89.16		89.31		89.31
% Child Who Are Recipients	54.56		54.69		55.55		55.91		55.91
% Adults Who Are Recipients	61.88		62.96		64.50		65.02		65.02
Total FFS Person-Years of Enrollment	1,104,081		1,114,901		1,114,901		1,114,901		1,114,899
Aged Total	340,236		347,174		347,174		347,174		347,172
Aged, Cash (MAX ELIG CD = 11)	157,363		158,450		158,450		158,450		158,450
Aged, Medically Needy (MAX ELIG CD = 21)	171,997		177,880		177,880		177,880		177,878
Aged, Poverty (MAX ELIG CD = 31)	5,839		5,827		5,827		5,827		5,827

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Other Aged (MAX ELIG CD = 41)	5,036		5,016		5,016		5,016		5,016
1115 Aged (MAX ELIG CD = 51)	1		1		1		1		1
Disabled Total	484,443		488,715		488,715		488,715		488,713
Disabled, Cash (MAX ELIG CD = 12)	344,727		346,196		346,196		346,196		346,196
Disabled, Medically Needy (MAX ELIG CD = 22)	127,119		129,696		129,696		129,696		129,696
Disabled, Poverty (MAX ELIG CD = 32, 3A)	4,837		4,799		4,799		4,799		4,797
Other Disabled (MAX ELIG CD = 42)	7,760		8,024		8,024		8,024		8,024
1115 Disabled (MAX ELIG CD = 52)	0		0		0		0		0
Child Total	343,113		366,139		366,139		366,139		366,139
AFDC Child, Cash (MAX ELIG CD = 14)	144,809		155,240		155,240		155,240		155,240
AFDC-U Child, Cash (MAX ELIG CD = 16)	2		2		2		2		2
AFDC Child, Medically Needy (MAX ELIG CD = 24)	63,511		69,799		69,799		69,799		69,799
Child Poverty (MAX ELIG CD = 34)	83,481		89,046		89,046		89,046		89,046
Other Child (MAX ELIG CD = 44)	5,995		6,238		6,238		6,238		6,238
Foster Care Child (MAX ELIG CD = 48)	44,460		44,940		44,940		44,940		44,940
1115 Child (MAX ELIG CD = 54)	855		874		874		874		874
Adult Total	261,418		288,437		288,437		288,437		288,437
AFDC Adult, Cash (MAX ELIG CD = 15)	62,167		68,072		68,072		68,072		68,072
AFDC-U Adult, Cash (MAX ELIG CD = 17)	6		6		6		6		6
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	27,764		30,603		30,603		30,603		30,603
Adult, Poverty (MAX ELIG CD = 35)	45		39		39		39		39
Other Adult (MAX ELIG CD = 45)	11,912		12,822		12,822		12,822		12,822
1115 Adult (MAX ELIG CD = 55)	159,524		176,895		176,895		176,895		176,895
Total FFS Medicaid Paid	$24,757,458,378		$26,885,112,151		$27,229,817,751		$27,667,524,818		$27,667,524,818
Avg FFS Medicaid Paid per FFS Enrollee	$17,322		$18,038		$18,269		$18,563		$18,563
Avg FFS Medicaid Paid per FFS Recipient (User of Any Service)	$23,140		$24,079		$24,135		$24,431		$24,431
Total Capitation Payments	$924,876,775		$942,414,635		$945,759,093		$963,386,111		$963,386,111
# Enrollees with HMO/HIO Payments but No Enrollment in HMO/HIO or PACE	72,059		75,499		78,761		80,731		80,731
Total HMO/HIO Payments (Among People not Enrolled)	$924,876,775		$942,414,635		$945,759,093		$963,386,111		$963,386,111
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY MAX ELIGIBILITY GROUP									
Aged	$23,752		$25,217		$25,566		$25,937		$25,937
Aged, Cash (MAX ELIG CD = 11)	$14,830		$16,092		$16,278		$16,433		$16,433
Aged, Medically Needy (MAX ELIG CD = 21)	$32,935		$34,380		$34,882		$35,457		$35,457
Aged, Poverty (MAX ELIG CD = 31)	$6,169		$6,717		$6,935		$7,075		$7,075
Other Aged (MAX ELIG CD = 41)	$9,352		$10,029		$10,224		$10,461		$10,461
1115 Aged (MAX ELIG CD = 51)	$1,856		$1,927		$1,934		$1,934		$1,934
Disabled	$29,812		$32,057		$32,391		$32,838		$32,838
Disabled, Cash (MAX ELIG CD = 12)	$26,775		$28,622		$28,897		$29,234		$29,234
Disabled, Medically Needy (MAX ELIG CD = 22)	$39,585		$42,884		$43,387		$44,151		$44,151
Disabled, Poverty (MAX ELIG CD = 32, 3A)	$4,394		$4,621		$4,709		$4,826		$4,828
Other Disabled (MAX ELIG CD = 42)	$20,483		$21,634		$21,950		$22,230		$22,230
1115 Disabled (MAX ELIG CD = 52)	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Child	$2,480		$2,589		$2,656		$2,755		$2,755
AFDC Child, Cash (MAX ELIG CD = 14)	$2,270		$2,346		$2,425		$2,533		$2,533

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AFDC-U Child, Cash (MAX ELIG CD = 16)	$0		$0		$0		$0		$0
AFDC Child, Medically Needy (MAX ELIG CD = 24)	$1,108		$1,124		$1,166		$1,219		$1,219
Child Poverty (MAX ELIG CD = 34)	$1,510		$1,582		$1,627		$1,740		$1,740
Other Child (MAX ELIG CD = 44)	$1,440		$1,602		$1,637		$1,741		$1,741
Foster Care Child (MAX ELIG CD = 48)	$7,119		$7,869		$7,979		$8,098		$8,098
1115 Child (MAX ELIG CD = 54)	$910		$949		$961		$987		$987
Adult	$5,290		$5,255		$5,380		$5,567		$5,567
AFDC Adult, Cash (MAX ELIG CD = 15)	$3,185		$3,227		$3,293		$3,425		$3,425
AFDC-U Adult, Cash (MAX ELIG CD = 17)	$2,907	X	$10,589		$10,599		$10,599		$10,599
AFDC Adult, Medically Needy (MAX ELIG CD = 25)	$2,631		$2,828		$2,918		$3,105		$3,105
Adult, Poverty (MAX ELIG CD = 35)	$4,310		$4,534		$4,244		$4,348		$4,348
Other Adult (MAX ELIG CD = 45)	$1,636	X	$1,857		$1,927		$2,080		$2,080
1115 Adult (MAX ELIG CD = 55)	$6,846		$6,702		$6,859		$7,069		$7,069
FFS EXPENDITURES AND USERS BY MAX TYPE OF SERVICE									
IP: Total Medicaid Paid (MAX TOS = 01)	$2,786,383,793		$3,095,278,034		$3,168,952,664		$3,316,198,834		$3,316,198,834
IP: Number of Users	219,759		246,911		252,970		255,589		255,589
IP: Avg Medicaid Paid per User	$12,679		$12,536		$12,527		$12,975		$12,975
IP: Avg Medicaid Covered Days Per User	8.25		7.49		7.58		7.51		7.51
MH Aged: Total Medicaid Paid (MAX TOS = 02)	$85,419,528		$98,555,554		$101,790,970		$104,673,216		$104,673,216
MH Aged: Number of Users	2,984		3,423		3,559		3,613		3,613
MH Aged: Avg Medicaid Paid per User	$28,626		$28,792		$28,601		$28,971		$28,971
IP Psych, Age < 21: Total Medicaid Paid (MAX TOS = 04)	$264,214,950		$287,017,558		$288,732,836		$292,271,894		$292,271,894
IP Psych, Age < 21: Number of Users	5,702		6,218		6,321		6,380		6,380
IP Psych, Age < 21: Avg Medicaid Paid per User	$46,337		$46,159		$45,678		$45,811		$45,811
ICF/MR: Total Medicaid Paid (MAX TOS = 05)	$2,712,251,938		$3,120,593,502		$3,127,954,318		$3,187,601,904		$3,187,601,904
ICF/MR: Number of Users	8,104		8,180		8,203		8,211		8,211
ICF/MR: Avg Medicaid Paid per User	$334,681		$381,491		$381,318		$388,211		$388,211
NF: Total Medicaid Paid (MAX TOS = 07)	$6,361,421,189		$6,737,191,537		$6,818,536,646		$6,931,408,006		$6,931,408,006
NF: Number of Users	128,234		135,546		138,484		139,335		139,335
NF:Avg Medicaid Paid per User	$49,608		$49,704		$49,237		$49,746		$49,746
Physician: Total Medicaid Paid (MAX TOS = 08)	$122,386,990	X	$145,875,133		$155,500,605		$160,887,210		$160,887,210
Physician: Number of Users	627,660		679,377		699,565		709,275		709,275
Physician: Avg Medicaid Paid per User	$195		$215		$222		$227		$227
Dental: Total Medicaid Paid (MAX TOS = 09)	$162,319,012		$171,755,247		$173,549,184		$174,494,187		$174,494,187
Dental: Number of Users	312,587		322,493		324,646		325,662		325,662
Dental: Avg Medicaid Paid per User	$519		$533		$535		$536		$536
Other Practitioner: Total Medicaid Paid (MAX TOS = 10)	$4,956,455		$5,591,239		$5,834,637		$5,988,393		$5,988,393
Other Practitioner: Number of Users	156,607		173,463		179,317		182,224		182,224
Other Practitioner: Avg Medicaid Paid per User	$32		$32		$33		$33		$33
Outpatient: Total Medicaid Paid (MAX TOS = 11)	$435,722,026		$518,647,405		$532,226,525		$538,442,564		$538,439,415
Outpatient: Number of Users	520,519		563,562		577,058		582,750		582,740
Outpatient: Avg Medicaid Paid per User	$837		$920		$922		$924		$924
Clinic: Total Medicaid Paid (MAX TOS = 12)	$268,539,272		$299,195,156		$308,123,382		$311,926,441		$311,917,026
Clinic: Number of Users	223,156		241,384		246,953		251,153		251,150

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Clinic: Avg Medicaid Paid per User	$1,203		$1,239		$1,248		$1,242		$1,242
Home Health: Total Medicaid Paid (MAX TOS = 13)	$1,268,854,474		$1,426,899,124		$1,444,130,852		$1,454,775,630		$1,454,775,630
Home Health: Number of Users	147,755		152,485		153,555		154,150		154,150
Home Health: Avg Medicaid Paid per User	$8,588		$9,358		$9,405		$9,437		$9,437
Lab/Xray: Total Medicaid Paid (MAX TOS = 15)	$80,788,609		$94,035,003		$98,710,115		$100,967,317		$100,967,317
Lab/Xray: Number of Users	501,288		548,569		564,862		573,176		573,176
Lab/Xray:Avg Medicaid Paid per User	$161		$171		$175		$176		$176
Drugs: Total Medicaid Paid (MAX TOS = 16)	$1,326,248,759		$1,352,043,036		$1,353,182,880		$1,353,435,469		$1,353,435,469
Drugs: Number of Users	712,757		721,771		722,942		723,830		723,830
Drugs: Avg Medicaid Paid per User	$1,861		$1,873		$1,872		$1,870		$1,870
Other Services: Total Medicaid Paid (MAX TOS = 19)	$557,993,443		$610,766,057		$622,022,470		$627,867,094		$627,867,094
Other Services: Number of Users	359,593		371,835		374,648		375,955		375,955
Other Services: Avg Medicaid Paid per User	$1,552		$1,643		$1,660		$1,670		$1,670
Transportation: Total Medicaid Paid (MAX TOS = 26)	$284,968,654		$317,181,984		$322,628,922		$324,789,245		$324,789,245
Transportation: Number of Users	254,662		272,143		276,087		277,516		277,516
Transportation: Avg Medicaid Paid per User	$1,119		$1,165		$1,169		$1,170		$1,170
Personal Care Services: Total Medicaid Paid (MAX TOS = 30)	$2,224,776,851		$2,381,624,434		$2,396,998,929		$2,403,169,049		$2,403,169,049
Personal Care Services: Number of Users	82,987		84,324		84,629		84,745		84,745
Personal Care Services: Avg Medicaid Paid per User	$26,809		$28,244		$28,324		$28,358		$28,358
Targeted Case Management: Total Medicaid Paid (MAX TOS = 31)	$1,490,973	X	$2,189,471		$2,315,892		$2,409,188		$2,409,188
Targeted Case Management: Number of Users	3,646	X	4,760		5,023		5,146		5,146
Targeted Case Management: Avg Medicaid Paid per User	$409		$460		$461		$468		$468
Rehabilitation Services: Total Medicaid Paid (MAX TOS = 33)	$275,969,816	X	$320,938,059		$347,324,730		$357,054,077		$357,054,077
Rehabilitation Services: Number of Users	45,482		50,702		53,442		54,596		54,596
Rehabilitation Services: Avg Medicaid Paid per User	$6,068		$6,330		$6,499		$6,540		$6,540
PT/OT/Speech/Hearing: Total Medicaid Paid (MAX TOS = 34)	$3,028,196	X	$3,607,428	X	$4,704,263		$5,274,788		$5,274,788
PT/OT/Speech/Hearing: Number of Users	10,860	X	12,541		13,635		14,905		14,905
PT/OT/Speech/Hearing: Avg Medicaid Paid per User	$279	X	$288		$345		$354		$354
Hospice: Total Medicaid Paid (MAX TOS = 35)	$89,305,960		$100,472,081		$102,560,344		$104,571,766		$104,571,766
Hospice: Number of Users	5,907		6,560		6,765		6,848		6,848
Hospice: Avg Medicaid Paid per User	$15,119		$15,316		$15,160		$15,270		$15,270
Durable Medical Equipment: Total Medicaid Paid (MAX TOS = 51)	$109,864,470	X	$132,181,802		$138,729,595		$141,726,328		$141,726,328
Durable Medical Equipment: Number of Users	271,793		294,737		300,909		304,030		304,030
Durable Medical Equipment: Avg Medicaid Paid per User	$404		$448		$461		$466		$466
Residential Care: Total Medicaid Paid (MAX TOS = 52)	$3,302,417,304		$3,448,451,407		$3,477,777,275		$3,514,179,953		$3,514,179,953
Residential Care: Number of Users	46,887		47,673		49,987		50,065		50,065
Residential Care: Avg Medicaid Paid per User	$70,434		$72,336		$69,574		$70,192		$70,192
Psych Services: Total Medicaid Paid (MAX TOS = 53)	$772,320,556		$832,213,499		$844,805,953		$851,597,184		$851,609,748
Psych Services: Number of Users	304,102		325,544		334,323		338,464		338,513
Psych Services: Avg Medicaid Paid per User	$2,540		$2,556		$2,527		$2,516		$2,516
Adult Day Care: Total Medicaid Paid (MAX TOS = 54)	$1,103,437,929		$1,217,113,257		$1,225,400,855		$1,234,173,194		$1,234,173,194
Adult Day Care: Number of Users	50,151		60,748		61,348		61,601		61,601
Adult Day Care: Avg Medicaid Paid per User	$22,002		$20,035		$19,975		$20,035		$20,035
AVERAGE FFS MEDICAID AMOUNT PAID PER FFS ENROLLEE BY SELECTED MAX TYPE OF SERVICE									

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Inpatient Hospital (MAX TOS = 01)	$1,950		$2,077		$2,126		$2,225		$2,225
Aged	$796		$898		$930		$962		$962
Disabled	$3,151		$3,441		$3,503		$3,626		$3,626
Child	$847		$874		$901		$980		$980
Adult	$2,672		$2,710		$2,789		$2,953		$2,953
ILTC (MAX TOS = 02,04,05,07)	$6,593		$6,873		$6,935		$7,055		$7,056
Aged	$14,018		$14,670		$14,855		$15,116		$15,116
Disabled	$9,278		$10,178		$10,232		$10,408		$10,408
Child	$371		$387		$391		$394		$394
Adult	$122		$118		$125		$129		$129
Drugs (MAX TOS = 16)	$928		$907		$908		$908		$908
Aged	$89		$90		$91		$91		$91
Disabled	$1,925		$1,956		$1,958		$1,958		$1,958
Child	$238		$228		$228		$228		$228
Adult	$1,077		$975		$976		$976		$976
All Other Services	$7,852		$8,182		$8,300		$8,375		$8,375
Aged	$8,849		$9,558		$9,690		$9,769		$9,769
Disabled	$15,458		$16,481		$16,699		$16,846		$16,846
Child	$1,025		$1,101		$1,136		$1,154		$1,154
Adult	$1,418		$1,452		$1,490		$1,508		$1,508
PERCENT OF FFS ENROLLEES WITH CLAIMS BY SELECTED MAX TYPE OF SERVICE									
% FFS Enrollees with IP Claims (MAX TOS = 01)	15.38		16.57		16.97		17.15		17.15
Aged	19.36		21.34		21.93		22.24		22.24
Disabled	18.04		19.40		19.73		19.88		19.88
Child	7.41		8.24		8.50		8.60		8.60
Adult	15.71		16.58		17.10		17.23		17.23
% FFS Enrollees with ILTC Claims (MAX TOS = 02,04,05,07)	10.04		10.17		10.38		10.44		10.45
Aged	27.85		28.94		29.58		29.76		29.76
Disabled	9.00		9.32		9.46		9.52		9.52
Child	1.02		1.03		1.04		1.05		1.05
Adult	0.64		0.64		0.68		0.69		0.69
% FFS Enrollees with Drug Claims (MAX TOS = 16)	49.87		48.43		48.50		48.56		48.56
Aged	48.49		48.17		48.25		48.35		48.35
Disabled	63.77		63.56		63.60		63.62		63.62
Child	36.62		35.07		35.17		35.25		35.25
Adult	43.31		40.05		40.16		40.21		40.21
% FFS Enrollees with All Other Claims	70.21		70.82		71.79		72.19		72.19
Aged	77.64		78.90		79.84		80.26		80.27
Disabled	85.62		86.29		86.77		86.99		86.99
Child	50.81		51.57		52.58		52.99		52.99
Adult	57.47		59.30		61.12		61.75		61.75
Avg # IP Days per FFS User	8		7		8		8		8
Aged	2		1		2		2		2
Disabled	11		10		11		10		10

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Child	7		6		6		6		6
Adult	13		12		12		12		12
Avg # ILTC Days per FFS User	446	X	235		235		243		243
Aged	488	X	234		234		240		240
Disabled	396	X	257		259		272		272
Child	89		81		81		83		83
Adult	107	X	60		62		68		68
HIGH-COST FFS ENROLLEES AND EXPENDITURES BY SELECTED MAX TYPE OF SERVICE									
Number of FFS Enrollees with FFS Medicaid Paid > $1,000,000	1,459		1,498		1,502		1,506		1,506
Number of FFS Enrollees with FFS Medicaid Paid > $500,000	1,746		1,812		1,836		1,854		1,854
Inpatient Hospital (MAX TOS = 01) > $500,000	129	X	145		156		169		169
ILTC (MAX TOS = 02,04,05,07) > $200,000	3,207		3,477		3,492		3,573		3,573
Drugs (MAX TOS = 16) > $200,000	39		40		40		40		40
All Other Services > $200,000	6,772		7,513		7,571		7,642		7,642
Maximum FFS Medicaid Paid	$1,956,349		$2,282,620		$2,283,846		$2,289,934		$2,289,934
Inpatient Hospital (MAX TOS = 01)	$1,923,063		$2,246,798		$2,246,798		$2,252,880		$2,252,880
ILTC (MAX TOS = 02,04,05,07)	$1,210,227		$1,436,172		$1,436,172		$1,472,660		$1,472,660
Drugs (MAX TOS = 16)	$1,305,131		$1,362,415		$1,362,415		$1,362,415		$1,362,415
All Other Services	$1,043,737		$1,238,384		$1,238,414		$1,238,414		$1,238,414
FFS EXPENDITURES AND USERS BY MAX PROGRAM TYPE									
FP: Total Medicaid Paid (PGM TYPE = 2)	$11,138,814		$12,333,577		$12,588,580		$12,903,117		$12,903,117
FP: Number of Users	48,502		52,709		53,644		54,229		54,229
FP: Avg Medicaid Paid per User	$230		$234		$235		$238		$238
RHC: Total Medicaid Paid (PGM TYPE = 3)	$0		$0		$0		$0		$0
RHC: Number of Users	0		0		0		0		0
RHC: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
FQHC: Total Medicaid Paid (PGM TYPE = 4)	$18,677,331	X	$22,337,805		$24,021,698		$24,689,829		$24,689,829
FQHC: Number of Users	38,290	X	44,427		49,394		51,229		51,229
FQHC: Avg Medicaid Paid per User	$488		$503		$486		$482		$482
IHS: Total Medicaid Paid (PGM TYPE = 5)	$0		$0		$0		$0		$0
IHS: Number of Users	0		0		0		0		0
IHS: Avg Medicaid Paid per User	Div by 0		Div by 0		Div by 0		Div by 0		Div by 0
Section 1915(c) Waiver: Total Medicaid Paid (PGM TYPE = 6,7)	$4,426,055,265		$4,679,524,159		$4,717,004,001		$4,760,974,834		$4,760,974,834
Section 1915(c) Waiver: Number of Users	59,441		60,577		61,165		61,284		61,284
Section 1915(c) Waiver: Avg Medicaid Paid per User	$74,461		$77,249		$77,119		$77,687		$77,687
FFS COMMUNITY-BASED LONG-TERM CARE EXPENDITURES AND USERS									
Total FFS CLTC Medicaid Paid (Excludes CLTC FLAG = 16-20)	$8,329,096,802		$8,944,535,839		$9,020,190,077		$9,083,891,570		$9,083,891,570
Number of CLTC Users (Excludes CLTC FLAG = 16-20)	244,751		254,198		255,815		256,522		256,522
Avg FFS CLTC Medicaid Paid per User (Excludes CLTC FLAG = 16-20)	$34,031		$35,187		$35,261		$35,412		$35,412
Aged	$30,550		$31,959		$32,090		$32,212		$32,212
Disabled	$40,327		$41,723		$41,834		$42,059		$42,059
Child	$6,313		$6,651		$6,616		$6,631		$6,631
Adult	$4,594		$4,694		$4,687		$4,692		$4,692
% FFS Enrollees with CLTC Claims (Excludes CLTC FLAG = 16-20)	17.12		17.05		17.16		17.21		17.21

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Aged	24.19		24.83		24.95		25.01		25.01
Disabled	29.13		29.67		29.83		29.89		29.89
Child	4.36		4.36		4.42		4.46		4.46
Adult	2.44		2.44		2.49		2.52		2.52
Total FFS CLTC Medicaid Paid (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$4,426,055,265		$4,679,524,159		$4,717,004,001		$4,760,974,834		$4,760,974,834
Number of CLTC Users (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	59,441		60,577		61,165		61,284		61,284
Avg FFS CLTC Medicaid Paid per User (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	$74,461		$77,249		$77,119		$77,687		$77,687
Aged	$132,735		$140,293		$137,423		$139,474		$139,474
Disabled	$72,949		$75,672		$75,612		$76,140		$76,140
Child	$15,530		$15,541		$15,417		$15,291		$15,291
Adult	$32,887	X	$40,862		$40,645		$41,758		$41,758
% FFS Enrollees with CLTC Claims (Section 1915(c) Claims Only - Excludes CLTC FLAG = 11-20)	4.16		4.06		4.10		4.11		4.11
Aged	0.78		0.77		0.80		0.80		0.80
Disabled	11.47		11.57		11.66		11.68		11.68
Child	0.32		0.33		0.33		0.34		0.34
Adult	0.06		0.06		0.06		0.06		0.06

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