KAISER COMMISSION ON MEDICAID AND THE UNINSURED

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MEDICAID: A PRIMER

JULY 2005

Medicaid: A Primer

Key Background Information on the Nation's Health Insurance Program for Low-Income Americans

July 2005

Introduction

Since Congress established the Medicaid program in 1965, it has become a linchpin in our health care system, covering health and long-term care services for many of the sickest and poorest Americans. In 2003, over 52 million people were covered by Medicaid. In the absence of the program, the vast majority of its enrollees would join the ranks of the 45 million uninsured.

Medicaid accounts for 1 of every 6 dollars spent on personal health care in the U.S. and nearly half of national spending on long-term care. The program is also the largest source of public funding for mental health services and covers more than half of all Americans living with AIDS. Medicaid is an essential source of financing for safety net providers that serve the low-income population and is a major engine in state economies, supporting millions of jobs.

Medicaid operates as 51 separate programs, (one in each state and the District of Columbia), each with its own policies and procedures. The decentralized nature of Medicaid has tended to obscure the view of the program as a key component of our national health care system. The purpose of this primer is to provide basic background information on Medicaid to inform public discussion about the roles Medicaid plays and implications of proposed changes to the structure or scope of the program.

WHAT IS MEDICAID?

Medicaid is the nation's public health insurance program for low-income people. Enacted in 1965 under Title XIX of the Social Security Act, Medicaid was initially created to provide medical assistance to individuals and families receiving cash welfare. Over the years, Congress has incrementally expanded the scope of the program. Today, Medicaid is no longer a welfare program; rather, it is a health and long-term care program for a broader population of low-income Americans.

Medicaid fills in holes in our health care system. Medicaid provides health coverage for 39 million children and parents in low-income families, medical and long-term care coverage for 8 million individuals with disabilities, and assistance with premiums and cost-sharing and long-term care for over 6 million low-income Medicare beneficiaries.

Medicaid is financed jointly by the federal government and the states. The federal government matches state spending on Medicaid. Through this partnership, the federal government and the states share the cost of providing health and long-term care assistance to the low-income population.

The states administer Medicaid within broad federal guidelines. State agencies administer Medicaid, subject to oversight by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. Although state participation in Medicaid is voluntary, all states participate. Federal law outlines broad requirements that all state Medicaid programs must fulfill. However, states have considerable discretion regarding program parameters such as eligibility, benefits, and provider payment. As a result, Medicaid operates as 51 distinct programs – one in each state and the District of Columbia.

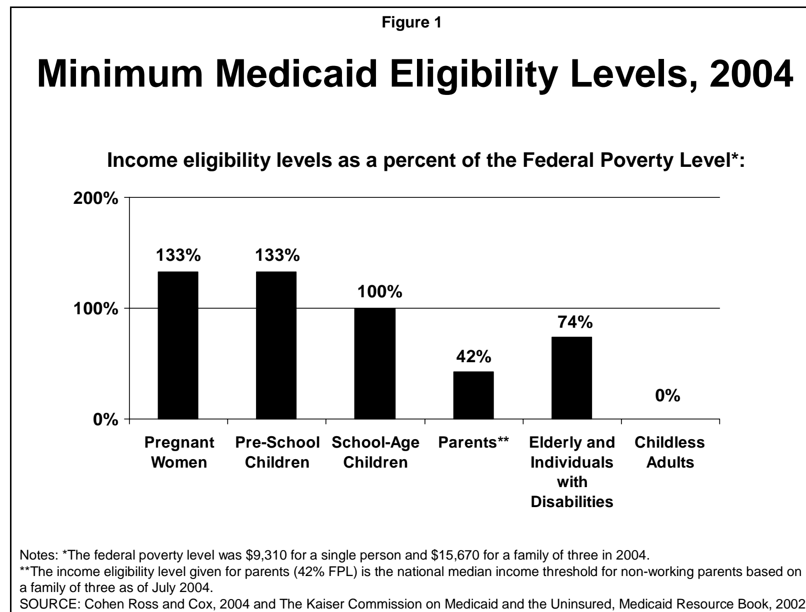
Medicaid buys services primarily in the private health care sector. Medicaid is an insurance program rather than a health care delivery system. States pay health care providers for services on behalf of Medicaid beneficiaries. States may purchase services on a fee-for-service basis or by paying premiums to managed care plans.

States may obtain federal waivers to operate their Medicaid programs outside of federal guidelines. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs, including Medicaid. States can apply for Section 1115 waivers to operate their Medicaid programs in ways that do not conform to federal standards. Waivers can enable states to test new models of coverage and care delivery for the low-income population.

Medicaid's structure enables the program to evolve and to incorporate innovations in health care. The combination of broad state flexibility in Medicaid design and guaranteed federal matching funds has allowed states to adapt to changing conditions and emerging needs. As a major source of health care financing, the Medicaid program has leveraged improvements in health care, incorporating managed care delivery systems, disease management, and home- and community-based long-term care.

WHO IS COVERED BY MEDICAID?

To qualify for Medicaid, an individual must meet income and asset requirements and also fall into one of the categories of eligible populations. In order to receive federal matching funds, state Medicaid programs must cover certain "mandatory" populations, including pregnant women and children under age 6 with family income below 133% of poverty, older children with family income below 100% of poverty, parents with income below states' welfare eligibility levels (often below 50% of poverty), and most elderly and persons with disabilities receiving cash assistance (Figure 1).



Beyond federal minimum eligibility requirements, states have flexibility to cover additional "optional" population groups. Optional eligibility categories include children, pregnant women, and parents with incomes above mandatory coverage limits; persons with disabilities and the elderly up to 100% of poverty; persons residing in nursing facilities with incomes less than 300% of Supplemental Security Income (SSI) standards; and "medically needy" individuals who have high recurring health expenses. States have expanded Medicaid coverage to optional populations extensively, but variably. As a result, Medicaid eligibility above the federal requirements varies widely from state to state.

Medicaid covers over 39 million low-income children and parents, over two-thirds of whom are in working families. Medicaid is the largest source of health insurance for children in the U.S., covering 25 million- or 1 in every 4- children.[1] The State Children's Health Insurance Program (SCHIP) supplements Medicaid by providing coverage for 4 million low-income children who do not qualify for Medicaid and are not covered by private insurance.

Medicaid is a key source of coverage for low-income pregnant women. Many states have expanded coverage of pregnant women beyond the federal minimum income eligibility level of 133% of poverty. Medicaid improves access to prenatal care and neonatal intensive care for low-income pregnant women, helping to improve maternal health and reduce infant mortality, low-weight births, and avoidable birth defects.[2] Medicaid funds over one-third of all births in the U.S. and is the nation's largest source of public funding for family planning.[3]

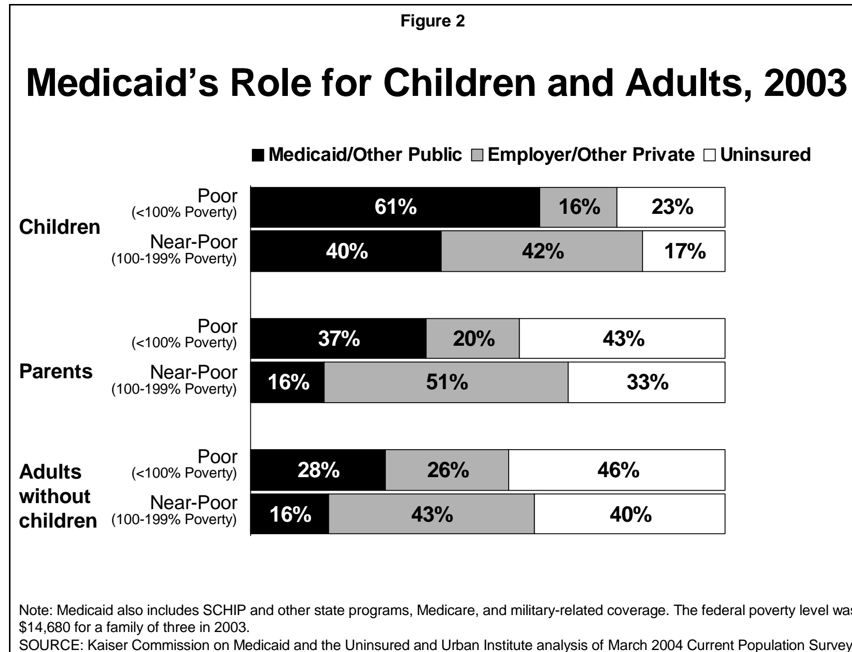
Medicaid fills in the gaps in Medicare coverage for 7 million low-income Medicare beneficiaries. Medicare is a federal health insurance program that provides coverage to 35 million elderly Americans and 6 million nonelderly people with permanent disabilities. Nearly 1 in 5 Medicare beneficiaries is also enrolled in Medicaid; these individuals are known as "dual eligibles." As compared to other Medicare beneficiaries, dual eligibles are typically much poorer and in worse health. Medicaid covers services that Medicare does not cover, including long-term care, vision and dental care, and prescription drugs.[4] In addition, for most dual eligibles, Medicaid subsidizes Medicare's premium and cost-sharing requirements.

Medicaid is the primary source of health and long-term care coverage for over 8 million low-income Americans with disabilities and chronic illnesses.[5] Medicaid covers a broad set of acute and long-term care services designed to meet the diverse and extensive needs of people with disabilities and chronic illnesses. Medicaid coverage is broader than private insurance and enables low-income adults with disabilities to obtain the full range of services they require, maximize their independence, and in some cases, participate in the workforce. Medicaid also covers the majority of poor children with disabilities.

Low-income Americans who qualify for Medicaid are guaranteed coverage. All individuals who meet their state's Medicaid eligibility criteria have a legal right to enroll in the Medicaid program and obtain coverage for medically necessary services that are included in their state's Medicaid benefit package. A state cannot cap enrollment of eligible individuals unless the state obtains a federal waiver exempting it from federal Medicaid program rules.

Overall, Medicaid enrollees are much poorer and in markedly worse health than the privately insured population. Compared to the low-income privately insured population, Medicaid beneficiaries are more likely to be poor, to have health conditions that limit work, and to be in fair or poor health. Most Medicaid beneficiaries do not have access to private health insurance because their employers do not offer it. Among firms that offer coverage, many low-wage workers decline because they cannot afford their share of the premium. Without Medicaid, the vast majority of its beneficiaries would join the growing ranks of the nation's uninsured.

Medicaid coverage is not available to all of the low-income population. Although Medicaid covers millions of poor and near-poor Americans, it is not a comprehensive source of coverage for the low-income population due to the combination of categorical and income eligibility restrictions. A significant share of poor and near-poor Americans remain uninsured (Figure 2).



Note: Medicaid also includes SCHIP and other state programs, Medicare, and military-related coverage. The federal poverty level was $14,680 for a family of three in 2003.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of March 2004 Current Population Survey.

- **Parents:** While all poor children are eligible for Medicaid, many of their parents are not. Most states apply much lower income eligibility thresholds for parents than for children. In 14 states, working parents with incomes at 50% of poverty, ($7,835 per year for a family of three), earn too much to qualify for Medicaid.[6]

- **Adults without children:** States cannot receive federal matching funds to extend Medicaid to non-disabled adults under age 65 without children. As a result, over 40% of low-income adults without children are uninsured, accounting for over half of the 45 million Americans who lack health insurance.

- **Immigrants:** Most legal immigrants who would otherwise qualify for Medicaid are eligible for Medicaid coverage only for emergency services during their first five years in the U.S.; after that period, states have the option to extend them full Medicaid eligibility. Undocumented immigrants who meet all other Medicaid eligibility criteria qualify only for coverage of emergency services under Medicaid.

Some low-income Americans who are eligible for Medicaid coverage do not participate in the program. For example, it is estimated that 62% of uninsured children are in fact eligible for Medicaid or SCHIP.[7] Beginning in the 1990s, state efforts to improve outreach and simplify Medicaid enrollment processes resulted in significant increases in enrollment. However, over the last few years, financial stress has led many states to take actions that restrict Medicaid and SCHIP enrollment for eligible children and parents.[8]

WHAT SERVICES DOES MEDICAID COVER?

All state Medicaid programs are required to cover a minimum set of benefits in order to receive federal matching funds. Most Medicaid beneficiaries are entitled to coverage of the following services if they are "medically necessary," as determined by state Medicaid programs or the managed care organizations with which they contract:

- Physician services
- Hospital services (inpatient and outpatient)
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Medical and surgical dental services
- Rural and federally-qualified health center services
- Family planning
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health care for persons eligible for nursing facility services

States have the option of covering additional services and are entitled to receive federal matching funds for these "optional" services, which include:

- Prescription drugs
- Clinic services
- Dental and vision services and supplies
- Prosthetic devices
- Physical therapy and rehab services
- TB-related services
- Primary care case management
- Nursing facility services for individuals under 21
- Intermediate care facilities for individuals with mental retardation (ICF/MR) services
- Home- and community-based care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Hospice services

Many of the benefits offered at state option are particularly important for persons with disabilities and the elderly. The term "optional" is a statutory designation and reflects that these services are offered at the states' option -- not required by federal law. However, many of these services are important to meet the diverse and complex health needs of the program's enrollees, who include many with severe physical and mental disabilities. All state Medicaid programs cover prescription drugs and certain other optional services. States have a variety of administrative tools for managing utilization of services, such as prior authorization and case management.

The scope of Medicaid benefits varies considerably across the states. States have substantial discretion in designing their Medicaid benefit packages.[9] [10] While federal law requires that Medicaid benefits are covered subject to medical necessity, the definition and application of this standard varies from state to state. States also define

the amount, duration, and scope of coverage for each benefit. For example, states can limit the number of physician visits or prescription drugs they will cover.

Medicaid is the nation's major source of long-term care services and supports. Nearly 10 million Americans, primarily the elderly and people with severe disabilities, need long-term care.[11] However, neither Medicare nor private insurance covers substantial long-term care benefits; Medicaid is generally the sole source of assistance for these high-cost services. In 2003, Medicaid financed 40% of the $151 billion spent nationally on long-term care.[12]

Through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, Medicaid provides health insurance coverage for children with a broad range of health needs. According to EPSDT requirements, children enrolled in Medicaid are entitled to all of the services authorized by federal law, including optional services. While state variation in Medicaid coverage exists, EPSDT approximates a uniform federal benefit package for children.

Medicaid is a major source of coverage for low-income individuals who need mental health services and substance abuse treatment. Many state Medicaid programs cover mental and behavioral health services that are often not available under other sources of health insurance. Eleven percent of Medicaid enrollees use mental health and/or substance abuse services.[13] Medicaid is a major payer in the mental health system, accounting for 44% of public mental health spending.[14]

States can impose nominal co-payments for some services on some groups of Medicaid enrollees. States may require co-payments for prescription drugs and certain other non-emergency Medicaid services. However, federal law limits cost-sharing under Medicaid and prohibits it altogether for children, pregnant women, and elderly and disabled beneficiaries who receive Supplemental Security Income (SSI) cash assistance.[15]

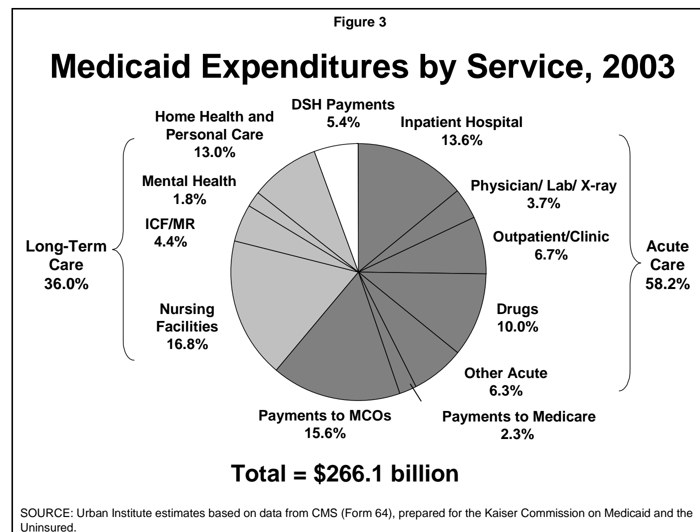
HOW MUCH DOES MEDICAID COST?

Total Medicaid spending in FY 2004 was just over $300 billion.[16] Medicaid provides a substantial share of health care financing in the U.S., accounting for:

- 17% of national spending on personal health care
- 17% of national spending on hospital care
- 46% of national spending on nursing home care
- 19% of national spending on prescription drugs

Medicaid spending is divided among acute and long-term care services, supplemental payments to hospitals serving a disproportionate share of low-income or uninsured patients (DSH), and administrative expenses. In 2003, total Medicaid spending was $275 billion. Over 90% of this spending ($252 billion) went toward services. Medicaid spending on services and DSH payments totaled $266 billion (Figure 3).

Figure 3

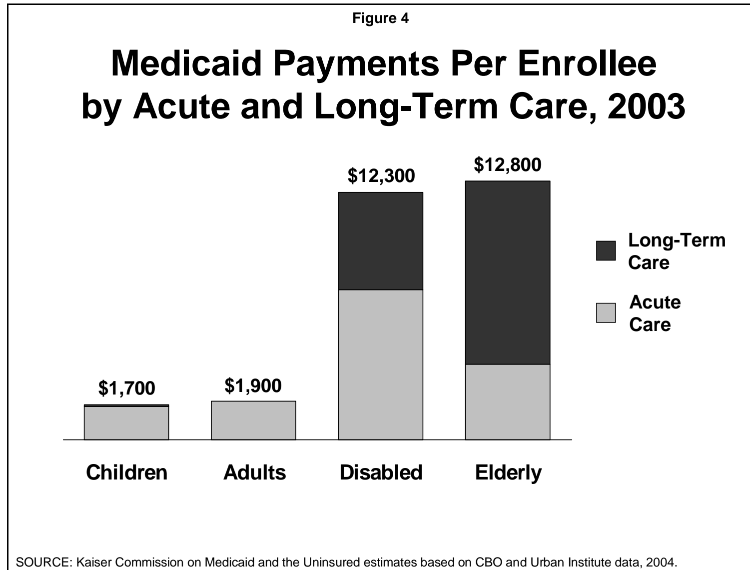


SOURCE: Urban Institute estimates based on data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.

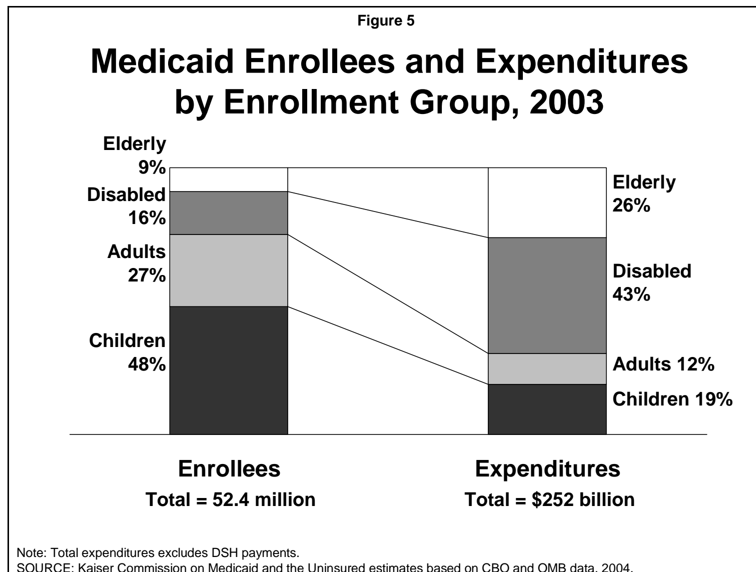
Medicaid is a comparatively low-cost health insurance program, once the health status of Medicaid beneficiaries is taken into account.[17] Because the overall Medicaid population has markedly worse health status than the privately insured population, per capita spending under Medicaid is higher than under private insurance. However, if adjusted for health status to make the Medicaid and privately insured populations more comparable, adult per capita spending is lower under Medicaid than under private insurance. Per capita spending for children is significantly lower under Medicaid than under private coverage.

Over the last several years, Medicaid per capita costs have grown at slower rates than private health insurance premiums. Between 2000 and 2003, Medicaid spending growth was predominately the result of enrollment growth. Over this period, Medicaid acute care spending per enrollee grew by an average annual rate of 6.9%. Over the same period, per capita spending under private coverage grew at an average annual rate of 9.0%, and monthly premiums for employer-sponsored insurance grew at an average annual rate of 12.6%.[18 19]

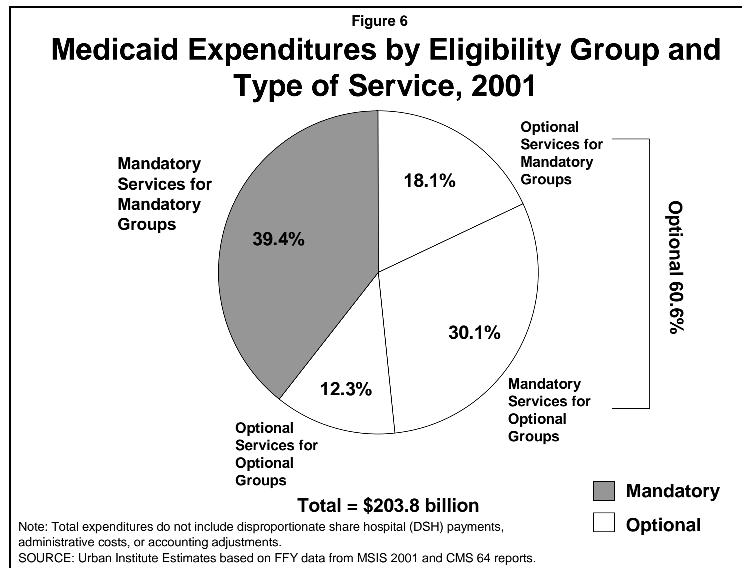
Medicaid spending per enrollee varies considerably by eligibility group. In 2003, the per capita cost for children covered by Medicaid was $1,700, compared to $12,300 per disabled enrollee and $12,800 per elderly enrollee (Figure 4). Higher per capita expenditures for disabled and elderly beneficiaries reflect their intensive use of acute and long-term care services.



Children and their parents make up the bulk of the Medicaid population, but the majority of Medicaid spending goes toward services for the elderly and persons with disabilities. Children, parents, and pregnant women make up three-quarters of the Medicaid population and account for 30% of Medicaid spending on services. The elderly and disabled, who make up the remaining quarter of the Medicaid population, account for about 70% of Medicaid spending on services (Figure 5).[20]



The majority of Medicaid spending is attributable to services and/or groups covered at state option. Thirty-nine percent of Medicaid spending goes toward services for eligibility groups required by federal statute, while 61% of Medicaid spending goes toward optional services and/or optional eligibility groups (Figure 6). Eighty-six percent of optional spending goes toward care of the elderly and people with disabilities. Nearly three quarters (72%) of optional spending by service goes toward long-term care and prescription drugs.[21]



A significant share of Medicaid spending is attributable to "dual eligibles," low-income Medicare beneficiaries who are also enrolled in Medicaid. While dual eligibles make up 14% of the Medicaid population, they account for 42% of Medicaid spending on services. Medicaid fills in Medicare's gaps for dual eligibles, paying for Medicare premiums and cost-sharing and covering important services that Medicare does not cover, such as long-term care.

Medicaid is a major source of financing for health care providers and institutions that serve the low-income and uninsured populations. Medicaid is the largest source of third-party payments to community health centers, accounting for over one-third of their operating revenues. Medicaid also provides 37% of public hospital net revenues.[22]

Medicaid makes supplemental payments to hospitals that serve a disproportionate share of low-income or uninsured patients (DSH). For many safety net hospitals, DSH payments represent a critical source of financing for uncompensated care provided to low-income and uninsured patients. The amount of federal matching funds that a state can use to make DSH payments in any given year is capped at an amount specified in the federal Medicaid statute.

WHO PAYS FOR MEDICAID?

Medicaid is financed jointly by the federal government and the states. The federal government matches state Medicaid spending on services at least dollar for dollar. The federal share of Medicaid spending is determined by the Federal Medical Assistance Percentage (FMAP), which varies by state based on state per capita income relative to the national average. The FMAP is at least 50% in every state and is greater in relatively poor states, reaching 77% in the poorest state.[23] Consistent with the federal guarantee of Medicaid coverage for all eligible individuals, federal Medicaid matching dollars are guaranteed to states on an uncapped basis. This approach directs funding based on actual, rather than predicted, need.

The federal government funds about 57% of all Medicaid spending. The Medicaid program accounts for 8% of total federal outlays and 43% of all federal grants to state and local governments.[24] Federal matching dollars support states' ability to meet the health needs of the low-income population.

States commit substantial resources to Medicaid. On average, states spend about 17% of their general funds on Medicaid, making it the second largest item in state budgets, following elementary and secondary education.[25] Medicaid costs are a recurrent issue at the state level, as states have a more limited fiscal capacity than the federal government, and most states are required to balance their budgets.

Medicaid is a major engine in state economies. The infusion of federal matching dollars into state economies generates economic activity, including the creation of jobs and additional income and state tax revenues. According to one study, total state Medicaid spending generated nearly 3 million new jobs and over $100 billion in wages in FY 2001.[26] The Medicaid program also supports the low-wage employment sector and the private insurance market by providing health insurance coverage to the lowest-income working families and individuals with extensive health needs.

Medicaid's current financing structure, with uncapped federal matching funds, gives states flexibility to respond to changing and emerging health care needs. Federal matching dollars increase to match increased state spending to address the challenges of rising health care costs, increasing enrollment, growing demand for costly long-term care, and public health crises such as the HIV/AIDS pandemic. During the recent economic downturn, Medicaid played an important role in offsetting declines in employer-sponsored coverage, stemming the increase in the number of uninsured.[27]

The federal government matches state spending on allowable Medicaid administrative costs at a matching rate of 50% for most types of costs. Federal matching payments for administrative costs are open-ended and the matching rates are uniform across all states.[28]

Endnotes

[1] Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office (CBO) and Office of Management and Budget (OMB) data, 2004.
[2] Wachino V, A Schneider, D Rousseau. 2004. *Financing the Medicaid Program: The Many Roles of Federal and State Matching Funds*. Kaiser Commission on Medicaid and the Uninsured. Pub. No. 7000 (January).
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[4] Beginning in January 2006, dual eligibles will lose Medicaid prescription drug coverage and will instead be offered drug coverage under new Medicare Part D prescription drug plans.
[5] Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office (CBO) and Office of Management and Budget (OMB) data, 2004.
[6] Cohen Ross D and L Cox. 2004. *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families.* Kaiser Commission on Medicaid and the Uninsured. Pub. No. 7191 (October).
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[11] Georgetown University Health Policy Institute Analysis of the 2000 National Health Interview Survey and Jones A. 2002. "The National Nursing Home Survey: 1999 Summary." *Vital Health Statistics* 13(152).
[12] Centers for Medicare and Medicaid Services. 2005. National Health Accounts.
[13] Buck J, JL Teich, and K Miller. 2003. "Use of Mental Health and Substance Abuse services Among High-Cost Medicaid Enrollees." *Administration and Policy in Mental Health* 31(1).
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[16] Kaiser Commission on Medicaid and the Uninsured analysis of the March 2005 Congressional Budget Office (CBO) Baseline, 2005.
[17] Hadley J and J Holahan. 2004. "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40(4).
[18] Strunk BC and PB Ginsburg. 2004. "Tracking Health Care Costs: Trends Turn Downward in 2003." *Health Affairs* (Web Exclusive: W4-354-62).
[19] Kaiser Family Foundation and Health Research and Educational Trust. 2004. *Employer Health Benefits Annual Survey 2004*. Pub. No. 7148 (September).
[20] Kaiser Commission on Medicaid and the Uninsured estimates based on Congressional Budget Office (CBO) and Office of Management and Budget (OMB) data, 2004.
[21] Urban Institute analysis of FY 2001 MSIS and CMS 64 reports prepared for the Kaiser Commission on Medicaid and the Uninsured, 2005.
[22] National Association of Public Hospitals and Health Systems Annual Survey 2002 and Center for Health Services Research and Policy analysis of 2002 UDS data.
See also: Rosenbaum S, P Shin, J Darnell. 2004. *Economic Stress and the Safety Net: A Health Center Update*. Kaiser Commission on Medicaid and the Uninsured. Pub. No. 7122 (June).

[23] Department of Health and Human Services Office of the Secretary. 2003. Federal Matching Shares for Medicaid for October 1, 2004 through September 30, 2005. Federal Register 68(232).
[24] Office of Management and Budget. 2004. Analytical Perspectives, Budget of the United States Government, Fiscal Year 2005.
[25] The proportion of state general funds spent on Medicaid (16.5%) is less than half that spent on primary and secondary education (35.5%). Only when federal as well as state funds spent by states are included does Medicaid spending exceed elementary and secondary education spending as a proportion of state budgets.
National Association of State Budget Officers. 2004. *2003 State Expenditure Report*.
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See also: Kaiser Commission on Medicaid and the Uninsured. 2004. *The Role of Medicaid in State Economies: A Look at the Research.* Pub. No. 7075 (April).
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Table 1

Medicaid Expenditures by Type of Service, FFY 2003

	Expenditures (in millions)						
	Total	Acute Care*		Long-Term Care*		DSH Payments	
State	$	$	%	$	%	$	%
United States	**$266,817**	**$155,518**	**58%**	**$97,026**	**36%**	**$14,273**	**5%**
Alabama	3,506	1,969	56%	1,183	34%	354	10%
Alaska	834	548	66%	271	32%	16	2%
Arizona**	4,222	2,885	68%	1,164	28%	173	4%
Arkansas	2,465	1,452	59%	982	40%	31	1%
California	30,411	19,295	63%	9,281	31%	1,835	6%
Colorado	2,568	1,485	58%	922	36%	160	6%
Connecticut	3,684	1,555	42%	1,901	52%	228	6%
Delaware	720	442	61%	276	38%	3	0%
District of Columbia	1,086	735	68%	313	29%	38	3%
Florida	10,989	7,134	65%	3,584	33%	271	2%
Georgia	7,592	4,300	57%	2,926	39%	366	5%
Hawaii	775	513	66%	262	34%	0	0%
Idaho	826	484	59%	331	40%	10	1%
Illinois	9,452	6,373	67%	2,762	29%	317	3%
Indiana	4,386	2,429	55%	1,713	39%	243	6%
Iowa	2,169	1,138	52%	1,004	46%	26	1%
Kansas	1,783	936	52%	805	45%	42	2%
Kentucky	3,819	2,524	66%	1,127	30%	168	4%
Louisiana	4,573	2,526	55%	1,223	27%	824	18%
Maine	1,806	1,080	60%	683	38%	43	2%
Maryland	4,435	2,718	61%	1,659	37%	59	1%
Massachusetts	8,190	4,614	56%	3,166	39%	410	5%
Michigan	8,030	5,845	73%	1,752	22%	433	5%
Minnesota	4,921	2,227	45%	2,636	54%	58	1%
Mississippi	2,893	1,859	64%	871	30%	164	6%
Missouri	5,591	3,287	59%	1,779	32%	525	9%
Montana	518	262	51%	256	49%	0	0%
Nebraska	1,356	721	53%	635	47%	0	0%
Nevada	1,019	705	69%	243	24%	72	7%
New Hampshire	924	408	44%	311	34%	204	22%
New Jersey	7,896	3,293	42%	3,489	44%	1,114	14%
New Mexico	2,009	1,452	72%	551	27%	6	0%
New York	40,570	21,433	53%	16,735	41%	2,402	6%
North Carolina	7,266	4,557	63%	2,341	32%	368	5%
North Dakota	473	185	39%	287	61%	1	0%
Ohio	10,273	5,045	49%	4,990	49%	238	2%
Oklahoma	2,376	1,394	59%	959	40%	23	1%
Oregon	2,718	1,659	61%	1,021	38%	38	1%
Pennsylvania	12,865	6,527	51%	5,690	44%	647	5%
Rhode Island	1,456	860	59%	501	34%	95	7%
South Carolina	3,616	2,266	63%	1,004	28%	346	10%
South Dakota	542	314	58%	227	42%	1	0%
Tennessee	6,379	4,903	77%	1,476	23%	0	0%
Texas	15,281	9,246	61%	4,716	31%	1,319	9%
Utah	1,111	785	71%	314	28%	12	1%
Vermont	709	441	62%	239	34%	29	4%
Virginia	3,613	2,022	56%	1,435	40%	155	4%
Washington	5,053	3,136	62%	1,638	32%	280	6%
West Virginia	1,881	1,125	60%	678	36%	78	4%
Wisconsin	4,846	2,255	47%	2,546	53%	44	1%
Wyoming	341	172	50%	169	50%	0	0%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS (Form 64).
Note: Does not include administrative costs, accounting adjustments, or the U.S. Territories. Total Medicaid spending including these additional items was $275.5 billion in FFY 2003. Figures may not sum to totals due to rounding.

* For more information on these spending categories, see notes to Tables 2 and 3 at http://www.kff.org/medicaid/kcmu012605oth.cfm

** Of $3.4 billion in prepaid/managed care expenditures reported by Arizona, 67% was assumed to pay for acute care and 33% was assumed to pay for long-term care. These proportions are based on data from the "2003 AHCCCS Overview" (http://www.ahcccs.state.az.us/Publications/overview/2003/contents.asp).

Table 2

Federal Medical Assistance Percentages, FY 2004-2006

State	FY 2004	FY 2005	FY 2006	Federal Funds Sent to State for Each Dollar in State Medicaid Spending, FY 2006
Alabama	70.8%	70.8%	69.5%	$2.28
Alaska	58.4%	57.6%	50.2%	$1.01
Arizona	67.3%	67.5%	67.0%	$2.03
Arkansas	74.7%	74.8%	73.8%	$2.81
California	50.0%	50.0%	50.0%	$1.00
Colorado	50.0%	50.0%	50.0%	$1.00
Connecticut	50.0%	50.0%	50.0%	$1.00
Delaware	50.0%	50.4%	50.1%	$1.00
District of Columbia	70.0%	70.0%	70.0%	$2.33
Florida	58.9%	58.9%	58.9%	$1.43
Georgia	59.6%	60.4%	60.6%	$1.54
Hawaii	58.9%	58.5%	58.8%	$1.43
Idaho	70.5%	70.6%	69.9%	$2.32
Illinois	50.0%	50.0%	50.0%	$1.00
Indiana	62.3%	62.8%	63.0%	$1.70
Iowa	63.9%	63.6%	63.6%	$1.75
Kansas	60.8%	61.0%	60.4%	$1.53
Kentucky	70.1%	69.6%	69.3%	$2.25
Louisiana	71.6%	71.0%	69.8%	$2.31
Maine	66.0%	64.9%	62.9%	$1.70
Maryland	50.0%	50.0%	50.0%	$1.00
Massachusetts	50.0%	50.0%	50.0%	$1.00
Michigan	55.9%	56.7%	56.6%	$1.30
Minnesota	50.0%	50.0%	50.0%	$1.00
Mississippi	77.1%	77.1%	76.0%	$3.17
Missouri	61.5%	61.2%	61.9%	$1.63
Montana	72.9%	71.9%	70.5%	$2.39
Nebraska	59.9%	59.6%	59.7%	$1.48
Nevada	54.9%	55.9%	54.8%	$1.21
New Hampshire	50.0%	50.0%	50.0%	$1.00
New Jersey	50.0%	50.0%	50.0%	$1.00
New Mexico	74.9%	74.3%	71.2%	$2.47
New York	50.0%	50.0%	50.0%	$1.00
North Carolina	62.9%	63.6%	63.5%	$1.74
North Dakota	68.3%	67.5%	65.9%	$1.93
Ohio	59.2%	59.7%	59.9%	$1.49
Oklahoma	70.2%	70.2%	67.9%	$2.12
Oregon	60.8%	61.1%	61.6%	$1.60
Pennsylvania	54.8%	53.8%	55.1%	$1.22
Rhode Island	56.0%	55.4%	54.5%	$1.20
South Carolina	69.9%	69.9%	69.3%	$2.26
South Dakota	65.7%	66.0%	65.1%	$1.86
Tennessee	64.4%	64.8%	64.0%	$1.78
Texas	60.2%	60.9%	60.7%	$1.54
Utah	71.7%	72.1%	70.8%	$2.42
Vermont	61.3%	60.1%	58.5%	$1.41
Virginia	50.0%	50.0%	50.0%	$1.00
Washington	50.0%	50.0%	50.0%	$1.00
West Virginia	75.2%	74.7%	73.0%	$2.70
Wisconsin	58.4%	58.3%	57.7%	$1.36
Wyoming	59.8%	57.9%	54.2%	$1.18

Source: Kaiser Commission on Medicaid and the Uninsured calculations based on FFY 2004-2006 FMAPs as published in the Federal Register as follows:
FY 2004 FMAP Vol. 67, No. 221, pp. 69223-69225; FY 2005 FMAP Vol. 68, No. 232, pp. 67676-67678; FY 2006 FMAP Vol. 69, No. 226, pp. 68370-28373.

Table 3

Medicaid Enrollment by Group, FFY 2001

State	Total	Aged		Disabled		Adult		Children	
	Enrollment (rounded to nearest 100)								
	Number	Number	%	Number	%	Number	%	Number	%
United States	**47,060,700**	**5,132,900**	**11%**	**7,009,300**	**15%**	**11,538,000**	**25%**	**23,380,500**	**50%**
Alabama	780,500	111,500	14%	160,800	21%	125,400	16%	382,800	49%
Alaska	100,300	6,200	6%	10,000	10%	21,000	21%	63,100	63%
Arizona	808,300	49,500	6%	91,200	11%	229,200	28%	438,400	54%
Arkansas	550,700	64,500	12%	92,200	17%	120,800	22%	273,200	50%
California	8,528,300	787,100	9%	803,200	9%	3,597,700	42%	3,340,300	39%
Colorado	410,700	47,800	12%	64,400	16%	79,400	19%	219,100	53%
Connecticut	444,200	60,000	14%	57,300	13%	84,000	19%	242,900	55%
Delaware	133,100	10,100	8%	16,300	12%	45,300	34%	61,400	46%
District of Columbia	152,600	14,100	9%	27,400	18%	34,800	23%	76,300	50%
Florida	2,462,200	321,000	13%	406,600	17%	503,500	20%	1,231,100	50%
Georgia	1,328,400	135,400	10%	203,900	15%	253,300	19%	735,800	55%
Hawaii	190,000	20,100	11%	20,800	11%	61,000	32%	88,100	46%
Idaho	172,400	11,900	7%	24,700	14%	25,800	15%	110,000	64%
Illinois	1,798,800	151,600	8%	244,100	14%	367,900	20%	1,035,200	58%
Indiana	825,500	78,800	10%	113,300	14%	137,300	17%	496,100	60%
Iowa	331,100	41,600	13%	57,000	17%	65,500	20%	167,000	50%
Kansas	281,100	31,800	11%	47,600	17%	43,500	15%	158,200	56%
Kentucky	761,900	92,600	12%	185,100	24%	101,500	13%	382,700	50%
Louisiana	886,500	101,200	11%	173,500	20%	102,500	12%	509,300	57%
Maine	277,900	62,400	22%	69,600	25%	51,100	18%	94,800	34%
Maryland	704,600	66,200	9%	103,800	15%	131,900	19%	402,700	57%
Massachusetts	1,125,600	139,900	12%	209,100	19%	322,600	29%	454,000	40%
Michigan	1,430,200	129,700	9%	259,300	18%	255,700	18%	785,500	55%
Minnesota	658,500	90,400	14%	86,600	13%	159,000	24%	322,500	49%
Mississippi	681,200	93,700	14%	139,700	21%	74,900	11%	372,900	55%
Missouri	1,032,300	99,100	10%	137,700	13%	233,300	23%	562,200	54%
Montana	101,900	10,900	11%	16,800	16%	19,300	19%	54,900	54%
Nebraska	249,200	23,500	9%	28,600	11%	47,900	19%	149,200	60%
Nevada	167,200	19,000	11%	28,900	17%	35,200	21%	84,100	50%
New Hampshire	108,500	12,900	12%	13,400	12%	15,700	14%	66,500	61%
New Jersey	923,100	143,900	16%	133,700	14%	189,600	21%	455,900	49%
New Mexico	423,500	29,900	7%	43,000	10%	78,600	19%	272,000	64%
New York	3,548,600	470,300	13%	600,200	17%	824,900	23%	1,653,200	47%
North Carolina	1,375,800	179,500	13%	228,800	17%	278,000	20%	689,500	50%
North Dakota	65,400	10,300	16%	9,600	15%	14,000	21%	31,500	48%
Ohio	1,660,400	147,600	9%	261,800	16%	348,800	21%	902,200	54%
Oklahoma	677,700	64,700	10%	80,600	12%	93,700	14%	438,700	65%
Oregon	594,600	45,100	8%	63,500	11%	236,800	40%	249,200	42%
Pennsylvania	1,647,500	207,300	13%	363,900	22%	275,100	17%	801,200	49%
Rhode Island	193,800	23,000	12%	32,500	17%	48,700	25%	89,600	46%
South Carolina	871,600	79,600	9%	119,200	14%	220,500	25%	452,300	52%
South Dakota	106,200	11,800	11%	14,200	13%	16,700	16%	63,500	60%
Tennessee	1,603,300	153,900	10%	284,200	18%	470,700	29%	694,500	43%
Texas	2,729,600	353,000	13%	361,100	13%	458,000	17%	1,557,500	57%
Utah	214,700	12,600	6%	25,700	12%	50,600	24%	125,800	59%
Vermont	152,100	21,000	14%	17,200	11%	46,600	31%	67,300	44%
Virginia	700,600	101,000	14%	133,600	19%	92,200	13%	373,800	53%
Washington	1,005,400	76,900	8%	133,900	13%	218,900	22%	575,700	57%
West Virginia	351,600	33,400	9%	84,400	24%	58,900	17%	174,900	50%
Wisconsin	673,600	78,600	12%	116,900	17%	160,100	24%	318,000	47%
Wyoming	57,900	5,000	9%	8,400	15%	10,600	18%	33,900	59%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2005.

Table 4

Medicaid Payments by Group, FFY 2001

	Payments (in millions)										
	Total	Aged		Disabled		Adult		Children		Unknown	
State	$	$	%	$	%	$	%	$	%	$	%
United States	**$188,752**	**$54,505**	**29%**	**$74,591**	**40%**	**$20,032**	**11%**	**$30,745**	**16%**	**$8,880**	**5%**
Alabama	$2,950	$855	29%	$779	26%	$131	4%	$532	18%	$654	22%
Alaska	$560	$84	15%	$181	32%	$77	14%	$166	30%	$52	9%
Arizona	$2,453	$498	20%	$914	37%	$440	18%	$583	24%	$17	1%
Arkansas	$1,685	$487	29%	$719	43%	$105	6%	$353	21%	$20	1%
California	$19,825	$5,421	27%	$7,648	39%	$2,768	14%	$3,548	18%	$441	2%
Colorado	$2,010	$543	27%	$811	40%	$154	8%	$370	18%	$131	7%
Connecticut	$2,963	$1,257	42%	$1,136	38%	$106	4%	$295	10%	$168	6%
Delaware	$601	$137	23%	$238	40%	$114	19%	$107	18%	$4	1%
District of Columbia	$830	$197	24%	$393	47%	$83	10%	$151	18%	$6	1%
Florida	$8,588	$2,498	29%	$3,475	40%	$751	9%	$1,280	15%	$583	7%
Georgia	$4,034	$1,053	26%	$1,414	35%	$517	13%	$832	21%	$218	5%
Hawaii	$593	$158	27%	$173	29%	$106	18%	$98	16%	$59	10%
Idaho	$714	$166	23%	$351	49%	$70	10%	$118	16%	$9	1%
Illinois	$8,151	$1,728	21%	$3,087	38%	$831	10%	$1,391	17%	$1,114	14%
Indiana	$3,358	$1,034	31%	$1,369	41%	$278	8%	$651	19%	$26	1%
Iowa	$1,662	$499	30%	$740	45%	$142	9%	$242	15%	$38	2%
Kansas	$1,371	$439	32%	$643	47%	$76	6%	$192	14%	$21	2%
Kentucky	$3,252	$879	27%	$1,417	44%	$267	8%	$644	20%	$45	1%
Louisiana	$2,882	$752	26%	$1,358	47%	$234	8%	$435	15%	$102	4%
Maine	$1,461	$318	22%	$701	48%	$132	9%	$297	20%	$12	1%
Maryland	$3,905	$888	23%	$1,664	43%	$455	12%	$848	22%	$50	1%
Massachusetts	$5,787	$1,895	33%	$2,603	45%	$566	10%	$669	12%	$53	1%
Michigan	$5,316	$1,297	24%	$1,542	29%	$433	8%	$699	13%	$1,345	25%
Minnesota	$3,749	$1,205	32%	$1,567	42%	$325	9%	$624	17%	$28	1%
Mississippi	$2,181	$694	32%	$910	42%	$187	9%	$375	17%	$16	1%
Missouri	$3,630	$1,114	31%	$1,405	39%	$300	8%	$793	22%	$18	0%
Montana	$476	$139	29%	$176	37%	$47	10%	$103	22%	$12	2%
Nebraska	$1,092	$314	29%	$392	36%	$92	8%	$235	22%	$59	5%
Nevada	$608	$124	20%	$249	41%	$76	13%	$116	19%	$42	7%
New Hampshire	$692	$235	34%	$265	38%	$37	5%	$151	22%	$4	1%
New Jersey	$5,018	$1,900	38%	$1,682	34%	$680	14%	$698	14%	$58	1%
New Mexico	$1,483	$289	20%	$486	33%	$134	9%	$441	30%	$133	9%
New York	$27,741	$9,184	33%	$12,306	44%	$3,132	11%	$2,876	10%	$243	1%
North Carolina	$5,502	$1,628	30%	$2,365	43%	$612	11%	$850	15%	$47	1%
North Dakota	$377	$151	40%	$152	40%	$25	7%	$43	12%	$6	2%
Ohio	$8,013	$2,697	34%	$3,383	42%	$632	8%	$1,054	13%	$247	3%
Oklahoma	$2,238	$605	27%	$827	37%	$119	5%	$530	24%	$156	7%
Oregon	$1,889	$443	23%	$586	31%	$476	25%	$367	19%	$16	1%
Pennsylvania	$7,634	$2,778	36%	$3,006	39%	$570	7%	$1,249	16%	$31	0%
Rhode Island	$1,096	$358	33%	$470	43%	$93	8%	$167	15%	$9	1%
South Carolina	$3,097	$638	21%	$1,029	33%	$250	8%	$573	18%	$608	20%
South Dakota	$427	$135	32%	$170	40%	$35	8%	$83	19%	$5	1%
Tennessee	$4,081	$795	19%	$1,383	34%	$1,119	27%	$780	19%	$4	0%
Texas	$9,646	$2,686	28%	$3,575	37%	$1,037	11%	$2,122	22%	$226	2%
Utah	$1,060	$127	12%	$361	34%	$101	10%	$212	20%	$260	24%
Vermont	$542	$145	27%	$200	37%	$73	14%	$120	22%	$4	1%
Virginia	$2,716	$822	30%	$1,242	46%	$184	7%	$444	16%	$25	1%
Washington	$3,978	$649	16%	$906	23%	$520	13%	$613	15%	$1,289	32%
West Virginia	$1,567	$382	24%	$668	43%	$115	7%	$256	16%	$146	9%
Wisconsin	$3,030	$1,121	37%	$1,365	45%	$198	7%	$326	11%	$21	1%
Wyoming	$242	$64	26%	$111	46%	$26	11%	$42	17%	$0	0%

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2005.

Note: The basis of eligibility for some enrollees and the payments made on their behalf is reported as "unknown" in MSIS. For more information on MSIS eligibility groups, see http://www.kff.org/medicaid/kcmu031104pkg.cfm

Table 5

Medicaid Payments Per Enrollee by Group, FFY 2001

State	Payments per Enrollee				
	Total	Aged	Disabled	Adult	Children
United States	**$4,011**	**$10,619**	**$10,642**	**$1,736**	**$1,315**
Alabama	$3,780	$7,664	$4,843	$1,048	$1,389
Alaska	$5,588	$13,502	$18,131	$3,669	$2,631
Arizona	$3,035	$10,069	$10,025	$1,922	$1,330
Arkansas	$3,059	$7,558	$7,803	$869	$1,293
California	$2,325	$6,887	$9,521	$769	$1,062
Colorado	$4,893	$11,368	$12,591	$1,941	$1,688
Connecticut	$6,670	$20,954	$19,833	$1,266	$1,214
Delaware	$4,518	$13,602	$14,599	$2,520	$1,749
District of Columbia	$5,441	$13,995	$14,359	$2,391	$1,973
Florida	$3,488	$7,783	$8,547	$1,493	$1,040
Georgia	$3,036	$7,777	$6,933	$2,040	$1,131
Hawaii	$3,119	$7,837	$8,323	$1,732	$1,109
Idaho	$4,139	$13,961	$14,202	$2,722	$1,069
Illinois	$4,531	$11,399	$12,645	$2,259	$1,343
Indiana	$4,067	$13,121	$12,080	$2,025	$1,313
Iowa	$5,018	$12,005	$12,983	$2,161	$1,450
Kansas	$4,877	$13,800	$13,507	$1,743	$1,213
Kentucky	$4,268	$9,487	$7,654	$2,635	$1,683
Louisiana	$3,251	$7,433	$7,828	$2,280	$855
Maine	$5,257	$5,098	$10,073	$2,584	$3,136
Maryland	$5,542	$13,407	$16,034	$3,447	$2,107
Massachusetts	$5,141	$13,544	$12,450	$1,756	$1,474
Michigan	$3,717	$10,001	$5,946	$1,695	$890
Minnesota	$5,693	$13,329	$18,094	$2,045	$1,936
Mississippi	$3,202	$7,401	$6,512	$2,501	$1,006
Missouri	$3,516	$11,244	$10,201	$1,287	$1,410
Montana	$4,670	$12,706	$10,467	$2,441	$1,868
Nebraska	$4,382	$13,365	$13,713	$1,915	$1,575
Nevada	$3,635	$6,519	$8,629	$2,158	$1,380
New Hampshire	$6,381	$18,238	$19,755	$2,356	$2,276
New Jersey	$5,437	$13,205	$12,582	$3,587	$1,532
New Mexico	$3,501	$9,675	$11,294	$1,699	$1,623
New York	$7,817	$19,529	$20,503	$3,796	$1,740
North Carolina	$3,999	$9,072	$10,334	$2,202	$1,233
North Dakota	$5,766	$14,622	$15,824	$1,785	$1,378
Ohio	$4,826	$18,273	$12,921	$1,811	$1,168
Oklahoma	$3,302	$9,346	$10,266	$1,274	$1,208
Oregon	$3,177	$9,826	$9,234	$2,011	$1,474
Pennsylvania	$4,634	$13,401	$8,260	$2,072	$1,559
Rhode Island	$5,656	$15,582	$14,449	$1,901	$1,863
South Carolina	$3,553	$8,014	$8,630	$1,135	$1,266
South Dakota	$4,018	$11,418	$11,980	$2,077	$1,300
Tennessee	$2,545	$5,164	$4,866	$2,377	$1,123
Texas	$3,534	$7,609	$9,900	$2,265	$1,362
Utah	$4,937	$10,062	$14,031	$1,991	$1,687
Vermont	$3,561	$6,886	$11,640	$1,575	$1,776
Virginia	$3,877	$8,137	$9,295	$1,990	$1,189
Washington	$3,956	$8,444	$6,765	$2,377	$1,064
West Virginia	$4,457	$11,444	$7,917	$1,946	$1,464
Wisconsin	$4,498	$14,260	$11,673	$1,234	$1,025
Wyoming	$4,184	$12,722	$13,219	$2,409	$1,236

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from MSIS, 2005.

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.