MSIS Table Notes, FFY 2002

Table 1, 1A

General Notes

- Enrollment estimates are rounded to the nearest 100.

- "Enrollees" are individuals who participate in Medicaid for any length of time during the federal fiscal year. They may not actually use any services during this period, but they are reported as enrolled in the program and are eligible to receive services in at least one month. Tables produces by CMS may use the term "eligibles" to describe these individuals.

- Enrollees are presumed to be unduplicated (each person is only counted once), though limited duplication may occur. The number of duplicate records that were deleted: Delaware (2), Hawaii (6), Idaho (2,033), Illinois (5,857), Minnesota (80), North Carolina (23,500), Rhode Island (308), Virginia (27), Vermont (2,808).

- "Aged" includes all people age 65 and older. "Disabled" includes non-elderly adults and children who are reported as eligible due to a disability. "Adults" are generally people age 18 to 64 and "children" are generally people age 17 and younger. However, some adults may be classified as "children" depending on why they qualify for the program and each state's practices.

- Our enrollment estimates differ slightly from similar estimates posted by CMS on their Web site (http://www.cms.hhs.gov/medicaid/msis/tables2002.asp) because we made adjustments to data from several states where we noticed that certain individuals appeared to be categorized incorrectly, and to make the data more consistent with our needs for other Urban Institute/Kaiser Family Foundation tasks that require use of these data. Our most common adjustment was to shift people age 65 and older to the aged category, and our second most common adjustment was to shift individuals under age 65 out of the aged category and into the disabled category.

- Some enrollees are only eligible for a limited set of benefits. A small fraction of elderly and disabled enrollees in every state qualify only for assistance with their Medicare premiums and coinsurance. In 2002, a few states also had waivers that allowed them to enroll relatively large numbers of people in Medicaid-funded programs for family planning-related services or prescription drug coverage, as indicated in the specific notes, below. These individuals, and their expenditures, are included in all tables.

Specific Notes

- Enrollment increased substantially among certain eligibility groups from FFY 2001 to FFY 2002 for Arizona, the District of Columbia, Maine, Nevada, New York, and Wisconsin.
  - Increases in the adult eligibility category:
    - Arizona -- expanded coverage in November 2001 to childless adults with adjusted net family income ≤100% FPL. Expanded coverage in October 2002 to individuals with adjusted net family income >100% FPL and ≤200% FPL whose children are enrolled in the Arizona Medicaid or SCHIP programs, but who themselves are not eligible for either program.

        - New York – has an 1115 waiver extending full Medicaid benefits to childless adults. In FFY 2002, major increases in adult enrollment occurred as a result of the September 11, 2001 terrorist attack.
    - Increases in other eligibility categories:
        - A noticeable increase in aged enrollees occurred in Washington, DC. This occurred when the District began reporting several restricted benefit dual groups for the first time.
        - Some of the increase in disabled enrollees in Washington, DC may be attributable to the CMS's December 2001 approval of an amendment to the District's 1915(c) MR/DD Waiver. This increased the number of funded services and the number of people the Waiver can serve.
        - Increases in Maine occurred primarily in the disabled category. This is most likely because in FFY 2002, state group 53 (disabled boarding home enrollees) began to be reported. They were omitted from earlier data by mistake.
        - Increases in Wisconsin occurred primarily in the aged category. This is most likely attributable to the September 2002 implementation of its 1115 SeniorCare program, which extended prescription drug benefits to low income aged individuals not otherwise eligible for Medicaid.

- Several states offer eligibility waivers from CMS that allow states to provide Medicaid-funded family planning services and supplies to populations either losing Medicaid or above certain income limits. The following 15 states had family planning waivers implemented by December 2002: AL, AR, AZ, CA, DE, FL, MD, MO, NM, NY, OR, RI, SC, VA, WA.

- In 2002, several states offered eligibility waivers from CMS that allowed states to provide Medicaid-funded prescription drug coverage to certain individuals who would not otherwise have qualified for Medicaid. The following 8 states had some form of prescription drug waiver program implemented as of December 2002: MD, ME, FL, IL, TN, VT, WI. Maine's program was shut down as a result of a court ruling in January 2003.

- We estimate that 1.9 million enrollees received less than full Medicaid services and never received full benefits in any month. In addition, 4.0 million beneficiaries were receiving restricted-benefits at some point in time over the entire year. These included enrollees in family planning waivers programs, those receiving restricted benefits because of their eligibility status as aliens, dual Medicare-Medicaid eligibles, and a small number of enrollees eligible for prescription drug coverage.

- Our data source for the District of Columbia shows significantly higher enrollment numbers for all eligibility groups than what is currently reported on the CMS Datamart.

- Our source data for New Mexico for FY 2002 are incorrect; data from FY 2001 are substituted in all tables.

Table 2

General Notes

- These figures represent the average (mean) level of payments across all Medicaid enrollees in the specific groups.

Specific Notes

- Our data source for the District of Columbia shows significantly higher enrollment numbers for all eligibility groups than what is currently reported on the CMS Datamart. However, our reported expenditure amounts are very similar to what is currently reported by CMS. Therefore, our payments per enrollee are lower than those in the Datamart.

- Payments per enrollee changed significantly among certain eligibility groups from FFY 2001 to FFY 2002. Changes occurred in the following states: AL, AZ, CT, ME, MI, NJ, NM, SD, UT, WA, WI.
  - Overall decreases in payments per enrollee occurred in Michigan (-22.6%), Utah (-20.6%), and Washington State (-33.0%). It is likely that these changes are attributable to the distribution of enrollment changes among BOEs. In these states, enrollment increases were concentrated among children and non-disabled adults. Members of these groups generally incur lower costs than do the disabled or elderly, possibly leading to the overall decreases in payments per enrollee.
  - Maine—reported a significant decrease in payments per disabled enrollee (-29.5%). This is due to a large increase in the number of disabled enrollees in FY 2002 who had been previously incorrectly underreported.
  - Wisconsin—reported a 23% decrease in payments per aged enrollee, which is most likely due to the addition of a new prescription drug-only program, which greatly increased the number of aged beneficiaries (see Table 1, 1A notes.)

- Our source data for New Mexico for FY 2002 are incorrect; data from FY 2001 are substituted in all tables.

Tables 3-15

General Notes

- Please refer to the separate document entitled "A Brief Overview of Our Medicaid Data Sources" for important background information concerning the estimates shown in these tables.

- The expenditure amounts from our source data reflect spending for services during federal fiscal year 2002, based on date of payment. Payments to Medicare ($5.7 billion in FFY 2002), Disproportionate Share Hospital Payments or DSH ($15.9 billion in FFY 2002), and administrative payments ($11.9 billion in FFY 2002) are generally not included in MSIS. These amounts are Form CMS-64 data.

- Expenditures are displayed in millions.

- In some states, significant expenditures may be included or excluded from the source data. For example, data for some states clearly include expenditures that cannot (and often should not) be attributed to specific enrollees, such as disproportionate share hospital (DSH) payments and enhanced payments made under upper-payment level (UPL) financing arrangements.

- Expenditures for specific service types (i.e., inpatient, outpatient, prescribed drugs) reflect fee-for-service expenditures only. They do not include payments made for those services by managed care organizations. Most capitation and other payments to Medicaid managed care organizations are grouped under the heading "Prepaid and Managed Care" in the tables, though some may also be reported under "Other Care."

- Our source data for New Mexico for FY 2002 are incorrect; data from FY 2001 are substituted in all tables.

Table 3, 3A

- Our source data contain no inpatient mental health payments for Georgia or Hawaii. Hawaii Medicaid covers some inpatient mental health services. Georgia does not cover inpatient mental health services.

- A high percentage of total payments in Michigan (21.5%) and Washington (32.0%) are reported as payments for unknown or invalid services. In Michigan's case, this may be due to the state's inability to assign the Type of Service for many claims or inability to identify Type of Provider.

- Our source data indicate that there were no home- and community-based waiver payments or personal care payments for Hawaii and Washington state in 2002, although both states are known to have operated home and community-based waiver programs totaling $63 million in Hawaii and $517 million in Washington in FFY 2002, according to the Form CMS 64.

Table 4, 4A

- A high percentage of total payments for all services in Alabama (26.7%), Michigan (25.7%), South Carolina (20.3%), Utah (24.9%), and Washington (32.6%) went to individuals of unknown eligibility.

Table 5, 5A

- A high percentage of total payments for inpatient hospital services in Florida (34.0%), Illinois (27.6%), Michigan (28.8%), Nevada (20.5%), Oklahoma (31.3%), South Carolina (48.2%) and West Virginia (35.8%) went to individuals of unknown eligibility.

Table 6, 6A

- Most nursing facilities services in Arizona are covered under the Arizona Long-Term Care System (ALTCS), which is a capitated program. These payments will be reflected in the prepaid services payments reported in Table 12.

Table 7, 7A

- The New York bundled nursing home rate includes maintenance drugs. Therefore claims for those drugs do not appear separately in the file.

- Prior to 2002 all prescribed drugs in Tennessee were covered under the capitated program Tenncare, and therefore all payments for drugs were reflected under prepaid services. This could be related to a new payment arrangement with managed care plans beginning in July 2002, through which the state pays the plan on a fee-for-service basis for prescribed drugs.

Table 8, 8A

- A high percentage of total payments for physicians and other practitioners in the District of Columbia (79.9%) went to individuals of unknown eligibility

- Most physicians/other practitioner services in Arizona are covered under the Arizona Health Care Cost Containment System (AHCCCS), which is a capitated program. These payments will be reflected in the prepaid services payments reported in Table 12.

Table 9, 9A

- A high percentage of total payments for outpatient hospital/clinic services in Illinois (33.5%), and South Carolina (22.1%) went to individuals of unknown eligibility.

- Most outpatient hospital/clinic services in Arizona are covered under the Arizona Health Care Cost Containment System (AHCCCS), which is a capitated program. These payments will be reflected in the prepaid services payments reported in Table 12.

Table 10, 10A

- A high percentage of total payments for ICF-MR services in Hawaii (22.0%) went to individuals of unknown eligibility.

- Alaska does not cover ICF-MR services.

Table 11, 11A

- A high percentage of total payments for inpatient mental health facilities in Florida (92.3%), Illinois (47.4%), South Carolina (50.3%) and West Virginia (39.8%) went to individuals of unknown eligibility.

- Most inpatient mental health services in Arizona are covered under the Arizona Health Care Cost Containment System (AHCCCS), which is a capitated program. These payments will be reflected in the prepaid services payments reported in Table 12.

- Our source data contain no inpatient mental health payments for Georgia or Hawaii. Hawaii Medicaid covers some inpatient mental health services. Georgia does not cover inpatient mental health services.

Table 12, 12A

- A high percentage of total payments for managed care in Alabama (50.1%), North Dakota (77.1%), and Utah (25.3%) went to individuals of unknown eligibility.

- Our source data contain no payments for managed care for Alaska or Wyoming. Both states do not have managed care programs.

- Prior to 1999, virtually all Tennessee enrollees were enrolled in managed care plans in which all medical services were paid for on a capitated basis. Starting in July 2002, Tennessee began paying managed care plans a $10 administrative fee per member and then paid the plan on a FFS basis for medical services provided to their members. This explains significant decreases in reported spending for managed care services and significant increases in reported spending for inpatient hospital services, physicians and other practitioners, drugs, outpatient and clinic services, and "other" services.

- In October 201, the Wellness Plan of North Carolina was terminated, causing a noticeable drop in HMO enrollment. In December 2002, United Health Care was terminated, also causing an enrollment drop.

Table 13, 13A

- Our source data indicate that there were no home- and community-based waiver payments or personal care payments for Hawaii and Washington state in 2002, although both states are known to have operated home and community-based waiver programs totaling $63 million in Hawaii and $517 million in Washington in FFY 2002, according to the Form CMS 64.

Table 14, 14A

- A high percentage of total payments for other services in Washington, DC (30.8%) and Utah (83.6%) went to individuals of unknown eligibility

Table 15, 15A

- Roughly 100% of total payments for unknown services went to individuals of unknown eligibility in the following states: Alabama, Colorado, District of Columbia, Florida, Michigan, Minnesota, Montana, Oklahoma, South Carolina, Utah, Washington, West Virginia, and Wyoming. Maryland also had a high percentage (44.4%).