MSIS Table Notes

Tables 1, 1a – Enrollment

General notes

- Enrollment estimates are rounded to the nearest 100.
- Spending data in MSIS do **not** include Disproportionate Share Hospital (DSH) payments.
- "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 eligible to receive services in at least one month. Tables produced by CMS may use the term “eligibles” to describe these individuals.
- Enrollees are presumed to be unduplicated (each person is counted only once), though limited duplication may occur.
- “Aged” includes all people age 65 and older. “Disabled” includes younger persons (age 64 and under) 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 people under age 18 may be classified as “adults” and some people age 18 and older 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://cms.hhs.gov/medicaid/msis/msis99sr.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 into or out of 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 2000, a few states also had waivers that allowed them to enroll relatively large numbers of people in special Medicaid-funded programs for family planning-related services or prescription drug coverage, as indicated in the specific notes, below.

Specific notes

- Several states offer eligibility under waivers from CMS that allow states to provide Medicaid-funded family planning services and supplies to populations either losing Medicaid eligibility or below certain income limits. Thirteen states had such waivers in 2000. Seven states (**AZ, DE, FL, MD, MO, NY and RI**) extended coverage for women losing Medicaid postpartum. Four states extended coverage to women (and some men) below certain income limits (**AR, CA, NM and OR**). Two states (**AL and SC**) offered both postpartum and income-related coverage.

It is often difficult (if not impossible) to separate family planning waiver enrollees from "regular" Medicaid enrollees using our source data, so these individuals are included in the enrollment figures. **California** operates the largest of these programs; our source data indicate that as many as 1.6 million people may have been enrolled in this program for at least one month during federal fiscal year 2000. **Arkansas** and **South Carolina** also had relatively large shares of family planning waiver enrollees relative to "regular" Medicaid enrollees.

- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- **Vermont** has a waiver to use Medicaid funds to cover prescription drugs for non-Medicaid eligible elderly and certain disabled individuals with incomes up to 175% of the federal poverty level. Over 8,000 people participated in this program in 2000, most of whom are reported as "elderly" in these tables.

Table 2 – Payments per Enrollee

General notes

- In a number of instances, we adjusted payment amounts reported in MSIS to arrive at the estimates shown in these tables. More specific notes are listed separately for each of the detailed payments tables (Tables 5 to 15a).
- These figures represent the average (mean) level of payments across all Medicaid enrollees in the specified groups. As explained in the notes for table 1, some enrollees may not actually use any services during the period covered. Average payments for people using services (i.e., payments per recipient) would be higher.

Specific notes

- Our estimates of **Alabama**'s payments per enrollee are lower than expected for all groups, but especially disabled enrollees, due to inability to attribute a large amount of the state's total payments to particular groups and/or services. See the specific notes for table 3, 3a for more information.
- The family planning waiver programs discussed in the notes for tables 1 and 1a also influence payments per enrollee. Per capita costs are very low under these waivers, which reduces average payments per enrollee. The impact of these waivers on payments per enrollee is greatest in states that offer family planning to people who would not otherwise qualify for Medicaid (**AL, AR, CA, NM, OR, and SC**). For example, payments per enrollee are considerably lower for non-disabled adults that they are for children in **Arkansas**, **California**, and **South Carolina**, which are all states that enroll large numbers of adults in family planning waivers relative to "regular" Medicaid-eligible adults.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- Our estimate of **Maine**'s payments per enrollee for children is much higher than expected. This is largely due to much higher than average amounts of payments reported under "other services" for this group. It is unlikely that all of the payments attributed to children actually should be attributed to children, or at least to those children currently enrolled in the program.

- Our estimates of **Michigan**'s payments per enrollee for all groups are lower than expected, but especially disabled enrollees, due to inability to attribute a large amount of the state's total payments to particular groups. See the specific notes for tables 4, 4a for more information.
- Our estimate of **New Jersey**'s payments per enrollee for non-disabled adults is much higher than expected.
- Our estimate of **New York**'s payments per enrollee for non-disabled adults is higher than expected. This is largely due to much-higher-than-average inpatient hospital payments for this group. We were unable to determine if New York actually spends much more than average for non-disabled adults or if this is an erroneous result caused by data problems.
- Our estimate of **Tennessee**'s payments per enrollee for aged enrollees is much lower than expected and is not accurate. This occurs because our source data contain mostly negative payments for nursing facilities in Tennessee in FFY 2000. According to CMS, the state changed its reimbursement methodology, resulting in "massive payment adjustments affecting mostly the aged population." These adjustments lead to the "negative" payments, masking the true payments for nursing facilities for aged enrollees and leading to erroneous results.
- Our estimate of payments per enrollee is relatively low for elderly enrollees in **Vermont** due to a waiver program that added many enrollees who only receive coverage for prescription drugs and have very low per-capita costs. See notes to tables 1, 1a for more information about this program.
- Our source data do not include any home- and community-based waiver payments for **Washington**, although the state operated several waiver programs at a total cost of nearly $500 million in FFY 2000 according to other data sources. Since we could not account for the missing payments, our estimates of payments per enrollee are too low for disabled and, to a lesser extent, aged enrollees.

Tables 3 to 15a – Payments

General notes

- Please refer to the separate document titled "A Brief Overview of Our Medicaid Data Sources" for important background information concerning the estimates shown in these tables.
- The payment amounts from our source data reflect payments for services during federal fiscal year 2000, based on date of payment.
- Payments are displayed in millions.
- In some states, significant amounts of payments may be included or excluded from the source data. For example, data for some states clearly include payments 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. In other cases, we noticed that states did not include significant amounts of payments, such as their payments for home and community based waivers.

- Payments for specific service types (i.e., inpatient, outpatient, prescribed drugs) reflect fee-for-service payments 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."

Specific notes: Tables 3, 3a

- In a number of instances, we adjusted MSIS dollar amounts to arrive at the estimates shown in these tables. The issues mentioned in specific notes for tables 5 – 15a also affect the results shown in this table.
- A very high percentage (25.4%) of total payments in **Alabama** are not attributed to a particular service type. We could not allocate any of this amount ($606.4 million) to particular services. Most of these payments are probably payments for Alabama's Partnership Hospital Program, a capitated program for inpatient hospital services. However, the total likely includes payments for non-inpatient services as well.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- Our source data show negative total payments for nursing facilities in **Tennessee** in FFY 2000. According to CMS, the state changed its reimbursement methodology, resulting in "massive payment adjustments affecting mostly the aged population." See the specific notes to Tables 2, 2a for more information.
- Our source data do not include any home- and community-based waiver payments for **Washington** state, although the state is known to have operated several waiver programs adding up to nearly $500 million in FFY 2000.

Specific notes: Tables 4, 4a

- In a number of instances, we adjusted MSIS dollar amounts to arrive at the estimates shown in these tables. The issues mentioned in specific notes for tables 5 – 15a also affect the results shown in this table.
- A very high percentage (25.3%) of total payments in **Alabama** are not attributed to specific individuals in our source data. We could not allocate any of these payments ($603.9 million) to particular individuals or enrollment groups. Most of these payments appear to be for the state's Partnership Hospital Program. We could not allocate any of the more than $600 million in this category to particular individuals or enrollment groups.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- A very high percentage of total payments in **Michigan** are reported as payments that are not attributed to specific individuals. We could not allocate any of the more than $600 million in this category to particular individuals or enrollment groups.
- Our source data show negative total payments for nursing facilities in **Tennessee** in FFY 2000. According to CMS, the state changed its reimbursement methodology, resulting in "massive payment adjustments affecting mostly the aged population." As a result, total payments and payments for aged enrollees are significantly understated in this table.

- A very high percentage of total payments in **Utah** are reported as payments for unknown or invalid service types. Apparently, this happens because the state accepts a place of service code of "other" from providers. We could not allocate any of the more than $270 million in payments in this category to particular individuals or enrollment groups.

Specific notes: Tables 5, 5a

- **Alabama**'s inpatient hospital payments are underreported in our source data. The amount shown in table 5 ($148.9 million) appears to exclude payments for Alabama's Partnership Hospital Program, a capitated program for inpatient hospital services. The Alabama Medicaid Agency reports that inpatient hospital payments (without DSH) were $563.5 million in FFY 2000.[1]
- Our estimates of inpatient hospital payments in **Florida** exclude $168 million claimed in a single record that is not attributed to a specific individual or enrollment group. We assume that this amount reflects payments under a UPL or DSH program, and do not apply directly to current Medicaid beneficiaries.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- Our estimates of inpatient hospital payments in **Illinois** exclude nearly $800 million in a single record that was not attributed to a specific individual or enrollment group. According to the U.S. Department of Health and Human Services' Office of Inspector General, Illinois makes enhanced payments to three hospitals and associated clinics operated by Cook County. This $800 million reflects the payments to these hospitals in 2000. The OIG reports that most of these payments are returned to the county, and a large share of the funds that stay with the hospitals appear to pay for services for non-Medicaid eligible persons.
- Our estimates of **Iowa**'s inpatient hospital payments include $31 million in a single record that is not attributed to a specific individual or enrollment group. Unlike similar instances in other states, we do no exclude this record because it does not appear to reflect DSH or UPL payments. The amount exceeds the state's DSH allotment for FFY 2000 under federal law, and recent studies suggest that the state does not have a UPL program for inpatient hospitals.[2]
- There are more than 700 records in our source data for **Louisiana** that show total inpatient payments ranging from $20,000 to more than $500,000 that are not attributed to specific individuals or enrollment groups. These records sum to about $37 million, or about 12% of total inpatient payments.
- Almost 40% of **Michigan**'s inpatient hospital payments is contained in roughly 1,750 records showing hospital payments ranging from $20,000 up to about $15 million, none of which are identified with specific individuals or enrollment groups. Many

[1] See Alabama's 2000 Annual Report at http://www.medicaid.state.al.us/ABOUT/reports.htm. Last accessed November 4, 2003.

[2] There is no mention of an inpatient UPL program in Iowa's response to a recent Urban Institute survey of states' DSH/UPL programs or in Michael F. Mangano, "Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers." Doc. no. A-03-00-00216. (U.S. Department of Health and Human Services, Office of Inspector General, September 11, 2001).

values are repeated, often in groups of 12 or 24. These seem to be "service-tracking" records that were included in the file to keep track of overall payments, but which are not specific enough to allow allocation of payments across groups.

- Our estimates of inpatient hospital payments in **Minnesota** exclude $24 million claimed in a single record that was not attributable to a specific individual or enrollment group. We assume that this amount reflects payments under a UPL or DSH program, and do not apply directly to current Medicaid beneficiaries.
- About 18% of **Nevada**'s inpatient hospital payments are in several records that were not attributed to specific individuals or enrollment groups. Inpatient payments in most of these records range from $20,000 to over $100,000.
- Our estimates of inpatient payments in **New Mexico** exclude $85.4 million claimed in a single record that was not attributable to a specific individual or enrollment group. We assume that this amount reflects payments under a UPL or DSH program, and do not apply directly to current Medicaid beneficiaries.
- Our estimates of inpatient payments in **Oklahoma** exclude $56 million claimed in a single record that was not attributable to a specific individual or enrollment group. We assumed that this amount reflected payments under a UPL program.[3]
- In our source data, **South Carolina**'s inpatient hospital payments appear to include DSH payments. There are many records with large inpatient payments ranging from $200,000 up to nearly $20 million. All of these records are not attributable to a specific individual or enrollment group. When all of these records are excluded, total payments for inpatient hospital services in our source data are very close to the amount reported as regular inpatient hospital expenditures on CMS Form 64, and the amount excluded is comparable to the amount reported as DSH payments to acute (non-psychiatric) hospitals on that form. We exclude all of these records from our estimates.
- **West Virginia**'s inpatient hospital payments also appear to include DSH payments. There are many records with large inpatient payment amounts ranging from $200,000 up to nearly $2.8 million. All of these records are not attributable to a specific individual or enrollment group. When all of these records are excluded, total payments for inpatient hospital services in our source data are very close to the amount reported as regular inpatient hospital expenditures on CMS Form 64, and the amount excluded is comparable to the amount reported as DSH payments to acute (non-psychiatric) hospitals on that form. We exclude all of these records from our estimates.

Specific notes: Tables 6, 6a

- Most nursing facility 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.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.

[3] In a survey of states' DSH/UPL programs conducted by the Urban Institute, Oklahoma officials reported that the state spent $51 million on an inpatient UPL program in state fiscal year (SFY) 2000-2001 and $63 million in SFY 2001-2002.

- There appears to be some crossover of ICF-MR claims into nursing facility services in **Illinois**, leading to much-higher-than-average share of nursing facility payments for disabled enrollees.
- The relatively large amount of nursing facility payments attributed to children in **Illinois** occurs because the state classified claims for inpatient psychiatric services for children under age 21 as nursing facility services.
- Our source data show negative total payments for nursing facilities in **Tennessee** in FFY 2000. According to CMS, the state changed its reimbursement methodology, resulting in "massive payment adjustments affecting mostly the aged population." As a result, Tennessee's nursing home payments could not be estimated.

Specific notes: Tables 7, 7a

- Most prescribed drugs 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.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- The amount of payments for prescribed drugs in our source data for **Maryland** is much higher than expected when compared to drug payments claimed on CMS Form 64. As a result, we may overestimate payments for prescribed drugs.
- All prescribed drugs in **Tennessee** are covered under TennCare, which is a capitated program. These payments will be reflected in the prepaid services payments reported in Table 12.

Specific notes: Tables 8, 8a

- Most physician/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.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- Of the $33 million of **Michigan**'s physician/other practitioner payments that is not attributed to specific individuals or enrollment groups, about $25 million is contained in roughly 230 observations with total payments for these services ranging from $20,000 to more than $600,000. Many totals are repeated, typically 3 to 5 times. These appear to be "service-tracking" records that were included in the file to keep track of overall payments, but which are not specific enough to allow allocation of payments across groups.

Specific notes: Tables 9, 9a

- 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.

- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- Our estimates of outpatient hospital/clinic payments in **Illinois** exclude $215 million in a single record that was not attributed to a specific individual or enrollment group. According to the U.S. Department of Health and Human Services' Office of Inspector General, Illinois makes enhanced payments to three hospitals and associated clinics managed by Cook County. This $215 reflects the payments to the clinics. The OIG reports that most of these payments are returned to the county, and a large share of the funds that stay with the facilities are likely applied to services for non-Medicaid eligible persons.
- In our source data, most of **Michigan**'s payments for outpatient/clinic services are not attributed to specific individuals or enrollment groups. Many of these "unknown" records contain large payment amounts ($20,000 up to more than $16 million). These appear to be "service-tracking" records that were included in the file to keep track of overall payments, but which are not specific enough to allow allocation of payments across groups. Among the highest amounts, payments seem to bunch into groups of 10. That is, 10 observations are around $16 million, then 10 more are around $12 million, then 10 more are around $6 million. The state has an outpatient hospital UPL program that is reported to account for around $300 million each year, which may explain some of these records. A CMS contractor also indicated that some behavioral health capitation amounts might be mixed in here.
- Our estimates of outpatient hospital/clinic payments in **New Mexico** exclude $8.1 million claimed in a single record that was not attributable to a specific individual or enrollment group. We assume that this amount reflects payments under an UPL program, and do not apply directly to current Medicaid beneficiaries.

Specific notes: Tables 10, 10a

- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.

Specific notes: Tables 11, 11a

- 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.
- About 20% of the **District of Columbia**'s inpatient mental health payments are in several records that were not attributed to specific individuals or enrollment groups.
- Our estimates of inpatient mental health payments in **Florida** exclude nearly $78 million claimed in a single record that is not attributed to a specific individual or enrollment group. We assume that this amount reflects payments under a UPL or DSH program, and do not apply directly to current Medicaid beneficiaries.
- Our source data contain no inpatient mental health payments for **Georgia**.
- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.

- About 25% of the **Illinois**' inpatient mental health payments are in several records that were not attributed to specific individuals or enrollment groups.
- In our source data, **South Carolina**'s inpatient mental health payments appear to include DSH payments. There are 9 records with large amounts of total payments for inpatient mental health services ($3.7 million and up). These records can further be divided into three sets of repeated values. All of these records are not attributable to a specific individual or enrollment group. Without these records, our estimated total payments for inpatient mental health services are comparable to the amount reported as inpatient mental health expenditures on CMS Form 64, and the amount excluded is comparable to the amount reported as DSH payments to psychiatric hospitals on that form. We exclude all of these records from our estimates.
- Of the $1.8 million of **South Dakota**'s inpatient mental health payments that are not attributable to specific individuals or enrollment groups, about $1.5 million is in a single record. This record may reflect two years' worth of DSH payments to a state-owned psychiatric hospital, though this is not certain.
- Our source data contain no inpatient mental health payments for **Tennessee**.

Specific notes: Tables 12, 12a

- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- About 10% of prepaid payments in our source data for **Kansas** are not attributed to specific individuals or enrollment groups.
- Most of the prepaid payments in **Mississippi** are for PCCM. Mississippi ended its HMO program prior to the beginning of federal fiscal year 2000, but a few lagged payments appear in our source data. The negative value for "unknown" enrollees likely reflects lagged collections for previous HMO overpayments.
- About 12% of prepaid payments in our source data for **Utah** are not attributed to specific individuals or enrollment groups.

Specific notes: Tables 13, 13a

- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.
- In our source data, all of **Nebraska**'s payments for home- and community-based waiver services are not attributed to specific individuals or enrollment groups, leading to the high share of payments in the "unknown" column of this table.
- Our source data indicate that there were no home- and community-based waiver payments or personal care payments for **Washington** (state) in 2000. This is not accurate. Washington has made a significant investment in home and community-based services, and according to the CMS Form 64, the state spent over $600 million on these services 2000.

Specific notes: Tables 14, 14a

- **Hawaii** did not provide data for federal fiscal year 2000; data for federal fiscal year 1999 are substituted in this table.

- About 25% of other payments in our source data for **Michigan** are not attributed to specific individuals or enrollment groups. The vast majority of these payments seem to come from "service-tracking" records that were included in the file to keep track of overall payments, but which are not specific enough to allow allocation of payments across groups.
- Most of other payments in **New Mexico** are not attributed to specific individuals or enrollment groups. This is primarily due to one record in our source data that shows payments of $7.2 million for transportation. This is probably a service-tracking record that was included in the file to keep track of overall payments, but which is not specific enough to allow allocation of payments across groups.
- About 13% of other payments in our source data for **South Carolina** are not attributed to specific individuals or enrollment groups. These payments are spread across numerous records, and several amounts exceed $100,000.
- Over 87% of other payments in **Utah** are not attributed to specific individuals or enrollment groups. Apparently, this happens because the state accepts a place of service code of "other" from providers. Most of these payments end up under the service category of "other care" (which is included in this table) or "unknown" (which is shown in table 15).

Specific notes: Tables 15, 15a

- A very high percentage (25.4%) of total payments in **Alabama** is not attributed to a particular service type. We could not allocate any of this amount ($606.4 million) to particular services. Most of these payments are probably payments for Alabama's Partnership Hospital Program, a capitated program for inpatient hospital services. However, the total likely includes payments for non-inpatient services as well.