

**Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding**  
**A Toolkit for States**

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Key leaders in Congress and high-ranking members of the Trump Administration are proposing major changes to Medicaid financing through the adoption of a block grant or per capita caps. To assist states in assessing the potential implications of proposals to cap federal Medicaid funding, this toolkit provides state-by-state data on Medicaid enrollment and expenditure trends—factors that are central to establishing the amount each state would be allocated under various capped funding proposals. As more details become available on particular block grant or per capita cap proposals, it will be possible to offer more specific estimates of their likely effect on individual states. For now, however, these data offer some indication of the ways in which a block grant or per capita cap might play out for states.

***I. Data Elements Included in the Toolkit***

All block grant and per capita cap proposals utilize the same basic formula. A “base” spending level is established for each state and it is trended forward by an annual “trend rate,” often linked to Consumer Price Index (CPI) or Gross Domestic Product (GDP) growth. The data book included with this toolkit provides information on the factors that go into setting the “base” and the “trend rate.”<sup>1</sup> It also includes some additional “context-setting” data that may help states assess the potential implications of capped funding on their state budgets and on their ability to reduce the uninsured rate in future years.

Table Number	Content
<b>Base Data</b>	
1	Medicaid/CHIP Enrollment and Growth by State, 2013-2016
2	Medicaid Total and New Adult Enrollment by State, 2014-2016
3	Medicaid Total and New Adult Spending by Source of Funds and State, CY 2015

<sup>1</sup> Although not addressed in this toolkit, another key element of any block grant or per capita cap proposal will be how it treats state spending requirements. For example, does the proposal retain the existing matching rate structure and require states to match federal Medicaid funding up to the cap? Alternatively, it might require states to maintain their spending at specified levels or simply eliminate any state spending requirement.

Table Number	Content
4	Medicaid Benefit Spending by Type of Service and State, FY 2015
5	Medicaid Supplemental Payments by State, FY 2015
6	Medicaid Spending by Eligibility Group and State, FY 2011
7	Medicaid Enrollment by Eligibility Group and State, FY 2011
8*	Medicaid Spending Per Full Benefit Enrollee by Eligibility Group and State, FY 2011
<b>Trend Data</b>	
9*	Growth in Medicaid Spending Per Full Benefit Enrollee by Eligibility Group and State, FY 2000-2011
10*	Growth in Medicaid Benefit Spending by State, FY 2000-2011
11	Growth in National Health Expenditure, Gross Domestic Product, and Consumer Price Index Values, CY 2000-2025
12*	Growth in Medicaid Enrollment by Eligibility Group and State, FY 2000-2011
13*	Population Projections by State, CY 2005-2025
<b>Context-Setting Data</b>	
14	Medicaid and Other Major Categories of Spending as a Share of Total, State, and Federal Funds in State Budgets, SFY 2015
15*	Uninsured Rate by State, CY 2013-2015

\*Includes rankings by state.

## ***II. A Note on the Data***

Most of the data included in this toolkit are drawn from publicly available sources that reflect information reported to the Centers for Medicare & Medicaid Services (CMS) by all 50 states and the District of Columbia. Although individual states will have more recent data available on their specific expenditure and enrollment trends, national data are used here to allow states to see how they fare on various measures compared to other states. Ultimately, a block grant or per capita cap is likely to result in both major cuts in federal Medicaid expenditures and disparate impacts across states, making it important to see how a state ranks on various metrics. Moreover, data that have been collected in a consistent and comparable manner for all states would likely be used in establishing base funding levels in any effort to design a block grant or per capita cap.<sup>2</sup>

In a number of instances the data are several years out of date. Specifically, the toolkit uses federal fiscal year (FY) 2000 - 2011 data prepared by the Kaiser Family Foundation because this is the most recent year for which per enrollee spending levels and historical growth rates are

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<sup>2</sup> Block grant and per capita cap proposals often specify that base allotments should be established using the best data available for states. It is unlikely, however, that any final version of a block grant or per capita cap proposal will allow individual states to present the data that they would like used to establish their base allotments.

publicly available by eligibility group using consistent data and methods across states.<sup>3</sup> The lack of recent data is a major barrier to understanding the potential implications of a block grant or per capita cap. An extraordinary amount has changed in Medicaid since FY 2011 due to implementation of the Affordable Care Act (ACA), changes in the larger health care landscape, and state-driven initiatives to reform the way Medicaid operates. Notably, Congress also will face the same lack of recent, reliable data in any effort to design a new Medicaid financing structure.

### ***III. Explanation of Tables Included in the Toolkit***

For each table in the data book, we provide highlights of the data and a brief discussion of why they may be helpful to states in assessing the potential impact of a block grant or per capita cap. The tables are grouped into data relevant to (1) the **base** amount available to each state, (2) **trend** rates, and (3) other **context-setting data** on potential implications of capped funding.

#### **A. The Base**

Tables 1 through 8 provide information related to the size of a state’s potential base spending amount for a block grant or per capita cap. They include state-by-state data on recent Medicaid enrollment levels and trends, Medicaid expenditures broken down various ways (e.g., by benefit category, eligibility group), supplemental payments (which may or may not be included in the base depending on formula), and per enrollee spending by eligibility group, which is essential to establishing the base for a per capita cap.

#### **Table 1: Medicaid and CHIP Enrollment**

##### *Data Highlight*

Medicaid and CHIP enrollment increased from 56.4 to 74.4 million between 2013 and 2016 as states expanded Medicaid and saw more uptake among already-eligible individuals, a jump of about a third for the country as a whole.<sup>4</sup> The rate of enrollment growth varied from less than 5 percent in several states to more than doubling.

##### *Implications for Fixed Funding*

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<sup>3</sup> Katherine Young, Robin Rudowitz, Saman Rouhani, and Rachel Garfield, *Medicaid Per Enrollee Spending: Variation Across States*, Kaiser Family Foundation, January 28, 2015 available at <http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/>. Even the Medicaid and CHIP Payment and Access Commission (“MACPAC”), which is given special access to Medicaid data to allow it to implement its congressionally-mandated obligations, does not have 50-state information on several of the key indicators past FY 2013.

<sup>4</sup> Note that these figures exclude dually eligible enrollees who only receive assistance with Medicare premiums and cost sharing, individuals whose benefits are limited to family planning services, and other individuals who do not receive a comprehensive Medicaid benefit package.

Under a block grant, states with little or no enrollment growth in recent years could receive a relatively modest “base amount” compared to their counterparts that have grown more rapidly. As illustrated in Table 2, some of the difference in enrollment growth across states is attributable to expansion decisions, raising the question of whether expansion expenditures would be included in a state’s base or not.

## **Table 2: Medicaid New Adult Enrollment**

### *Data Highlight*

Thirty-one states and the District of Columbia have expanded Medicaid to low-income adults up to 138 percent of the federal poverty line (FPL). By March of 2016, these states covered 14.27 million people in the “new adult” group.

### *Implications for Fixed Funding*

If Congress repeals the Medicaid expansion under ACA and moves to a capped funding structure, it is an open question as to whether states would be allowed—or would be able to afford—to cover these newly eligible adults.

## **Table 3: Medicaid Spending by Source of Funds, Total and for New Adults**

### *Data Highlight*

Total Medicaid spending in calendar year 2015 was an estimated \$535 billion with \$336.7 billion in federal expenditures and \$198.3 billion in state expenditures. Total spending ranged by state from a low of \$838.1 million to a high of \$83.4 billion with a median of \$7.5 billion. More than 30 percent of federal dollars spent on Medicaid in the 31 states and D.C. that have expanded Medicaid are now attributable to the expansion. Together, these states received an estimated \$72.6 billion in calendar year 2015 for their expansions.<sup>5</sup>

### *Implications for Fixed Funding*

These data (or comparable data from different sources and years) are most likely the starting point for any block grant or per capita cap formula rooted in historical spending. The amount of federal funding that each state receives is a function of multiple factors, including the population and income distribution of the state and a range of policy choices regarding eligibility thresholds, benefits, and provider and plan reimbursement rates.

Table 3 highlights that any proposal to convert Medicaid to a block grant or per capita cap will need to address the major differences in Medicaid spending between expansion and non-

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<sup>5</sup> These data include spending on newly-eligible adults as well as the federal dollars invested in helping “leader states” sustain expansions that were in place prior to passage of the ACA.

expansion states. Depending on how a fixed funding proposal is designed, expansion states could have a significant funding advantage relative to non-expansion states (e.g., if they receive a base allotment under a block grant that includes expenditures on newly eligible adults). On the other hand, if Congress repeals the expansion or uses Medicaid restructuring to “even out” spending between expansion and non-expansion states, they could face a major loss of federal funds with considerable implications for their state budgets.

#### **Table 4: Medicaid Spending by Type of Service**

##### *Data Highlight*

States vary widely in the services they cover and how they pay for those services, including the extent to which they rely on Medicaid managed care rather than a fee-for-service system to pay for hospital care, physician services, prescriptions drugs, and other services. On average, 43 percent of Medicaid dollars now are spent on Medicaid capitation payments, but this varies from little to no spending on managed care in some states to more than 80 percent in others.

##### *Implications for Fixed Funding*

Under either a block grant or a per capita cap proposal, states that already have moved more aggressively to use Medicaid managed care may have fewer options for responding to new cuts and fixed funding. Under a per capita cap, for example, states that have already made expansive use of Medicaid managed care to drive greater efficiencies in their programs may not have the same “room” to find further savings without cutting back on covered services, shifting costs to consumers, and/or reducing payment rates for hospitals, nursing homes, and other providers.

#### **Table 5: Role of Medicaid Supplemental Payments**

##### *Data Highlight*

Nationally, supplemental payments—defined in these data to include disproportionate share hospital (DSH) payments; upper payment limit (UPL) and graduate medical education amounts; uncompensated care pools, delivery system reform incentive payments, and other non-DSH amounts under Section 1115 waiver authority—make up more than one in ten Medicaid dollars (10.4 percent of Medicaid benefit spending). In some states, supplemental payments are not a significant source of Medicaid spending while in others they represent more than one in five Medicaid dollars.

##### *Implications for Fixed Funding*

To date, most block grant and per capita cap proposals have been silent on the treatment of supplemental payments. In any effort to cap federal Medicaid funding, Congress would need to decide if it wants to include supplemental payments in the formula used to set state-specific

block grant allotments or per capita caps. Building these resources into the allotment formula would be to the advantage of states with significant supplemental payments; it would also create equity issues for states that were planning to expand their use of these payments. For example, there were 11 states that received a combined total of \$11.9 billion in Section 1115 waiver funds in FY 2015 to drive innovation and finance uncompensated care. A capped funding proposal likely would preclude other states from following suit.<sup>6</sup>

## **Tables 6 and 7: Medicaid Enrollment and Spending by Eligibility Group**

### *Data Highlights*

In FY 2011, people with disabilities accounted for 42 percent of Medicaid expenditures, followed by seniors at 21 percent, children at 21 percent, and adults (mostly pregnant women and very low-income parents) at 15 percent. Taken together, seniors and people with disabilities accounted for more than two-thirds (64 percent) of Medicaid spending. In 10 states, seniors and people with disabilities accounted for 70 percent or more of Medicaid spending. In comparison, these groups accounted for only 24 percent of enrollment. The expansion of Medicaid to low-income adults in 31 states and D.C. undoubtedly has shifted the distribution of spending in these states, but, as of now, updated expenditure data by eligibility group are not yet available from the federal government.

### *Implications for Fixed Funding*

In both designing and evaluating block grant and per cap funding models, policy makers at all levels of government will confront the fact that seniors and people with disabilities account for the vast majority of spending in Medicaid. Any cuts implemented through a block grant or per capita cap are likely to affect them disproportionately.

## **Table 8: Medicaid Spending Per Full-Benefit Enrollee**

### *Data Highlight*

The amount of per enrollee spending in Medicaid varies dramatically by eligibility group and by state. For example, in FY 2011, average spending per child enrollee ranged from \$1,656 to \$5,214 across states.<sup>7</sup> This same pattern holds true across other eligibility groups with some

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<sup>6</sup> On a related note, it also is unclear if states will be permitted to finance the nonfederal share of supplemental payments through the same mechanisms that are currently in use—provider and health plan assessments, intergovernmental transfers, and with respect to waivers, “costs not otherwise matchable.” In at least one major restructuring proposal (Speaker Paul Ryan’s “A Better Way”), the latter explicitly would be banned.

<sup>7</sup> These data are based on expenditures for enrollees that receive a full Medicaid benefit package.

states dedicating two or even three times as much per person as states with low per enrollee spending.<sup>8</sup>

### *Implications for Fixed Funding*

The wide range in per enrollee spending poses major challenges in converting Medicaid to a fixed funding structure. States with low per enrollee spending risk being “locked into” those low spending levels, making it more difficult to cope with federal cuts or to absorb new costs, such as breakthrough drugs, innovative new treatment options for genetic conditions, or demand for new benefits (e.g., better substance use disorder benefits in response to the opioid epidemic). In contrast, states with high per enrollee spending may have more “wiggle room” to address federal cuts or emerging public health imperatives, but also could find that Congress expects them to move toward the median over time, regardless of whether the median is appropriate for any given state in light of its health care system and coverage and delivery system reform goals. In addition, while a state’s per enrollee spending may be high relative to other states, it may accurately reflect beneficiary health needs and service costs in the state—and, as with lower spending states, provide little cushion to absorb federal funding cuts or address emerging health care needs.

### **B. Trend Rates**

The tables in this section provide state-specific data on historical growth in Medicaid expenditures overall and by eligibility group, and data to compare this growth to the trend factors that would likely be used in a block grant or per capita cap proposal.

### **Tables 9 and 10: Growth in Medicaid Spending per Enrollee and Overall**

#### *Data Highlight*

The rate of growth in Medicaid spending—both in the aggregate and on a per capita basis—is consistently higher than some of the metrics that have been proposed as trend rates in capped funding proposals. From FY 2000-2011, average annual growth in spending per full-benefit enrollee was 5.3 percent for children across all states, 5.6 percent for adults, 4.5 percent for people with disabilities, and 3.7 percent for seniors. In comparison, average annual growth in per capita GDP and CPI—metrics most often looked to as source for a potential trend for a per capita cap—was 2.9 percent and 2.5 percent, respectively. With regard to aggregate Medicaid spending (as under a block grant), which includes the effects of both per enrollee amounts and

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<sup>8</sup> While the spending per enrollee figures provided in this toolkit reflect amounts for full-benefit enrollees, it is important to note that some states have a substantial number of enrollees with more limited coverage—including some dually eligible individuals who only receive assistance with Medicare premiums and cost sharing, and individuals whose benefits are limited to family planning. The inclusion or exclusion of these individuals (for whom, by definition, states spend substantially less) can have a substantial impact on the calculation of spending per enrollee amounts for certain states and eligibility groups.

total enrollment, average annual growth was 6.9 percent nationally—ranging from about 4 percent in the lowest states to 9 percent or more in the highest.

### *Implications for Fixed Funding*

As important as the base rate is in determining the amount of federal dollars that a state would receive under block grant or per capita cap proposals, the trend rate is likewise important. Recent proposals have used trend rates linked to GDP or CPI, increased by one percentage point in some cases. States will want to compare their historical growth rates to potential trend factors to gain a sense of how they might fare in the future under a potential block grant or per capita cap. If the trend rate does not keep pace with a state’s recent Medicaid spending growth, it is a warning sign that it will face pressure to limit benefits, reduce provider reimbursement rates, cut eligibility or use state funds to fill the gap left by the federal government. At the same time, states with relatively low historic growth rates may find that they have used up many of the options available to their faster-growing counterparts to contain costs in the future. While the initial base rate is critical, even if it is adequate in the first year, it almost certainly will not be in future years if the trend rate fails to keep pace with Medicaid costs.

### **Table 11: GDP, CPI, and Other Potential Trend Rates**

#### *Data Highlights*

To put the data in Tables 9 and 10 in perspective, Table 11 provides detailed information on GDP, CPI, and growth in national health expenditures, both in the aggregate and on a per capita basis. Earlier proposals to cap federal Medicaid funding to states have established trend rates based on GDP growth or CPI, sometimes adding an additional percentage point to create more room for Medicaid expenditure growth. Between 2000 and 2016, per capita GDP growth ranged from negative 2.7 percent to a positive 5.9 percent while CPI ranged from negative 0.4 percent to a positive 3.8 percent. In contrast, the annual rate of growth in national per capita health expenditures varied from a low of 2.2 percent to a high of 8.6 percent during this period.

### *Implications for Fixed Funding*

The fact that per capita GDP growth and CPI consistently grow more slowly than per capita national health care expenditures suggests that, if used as trend rates, they would impose a significant squeeze on state Medicaid programs. Even with an extra percentage point added to per capita GDP growth or CPI, it may prove difficult to establish a trend rate that provides states with the resources they need to provide coverage to their low-income residents.

Moreover, GDP is relatively volatile, shrinking during recessions and increasing during better economic times. If GDP is used in a trend rate formula, it could disrupt Medicaid’s role as a countercyclical fiscal stimulus during recessions. This is most obvious in a block grant scenario in which state allotments linked to GDP would increase little or not at all during economic

downturns even as more people seek and use coverage. Even under a per capita cap—which does send additional money to states when they enroll more people during downturns—using these trend rates could still dampen Medicaid spending during a recession if per capita amounts are trended forward at the same rate as a sluggish economy. While less volatile in recent years than GDP, CPI growth is typically lower than GDP and may also slow or decline during economic downturns.

### **Table 12: Growth in Medicaid Enrollees, 2000 - 2011**

#### *Data Highlight*

On average, the number of full and partial benefit enrollees increased 4 percent a year for the nation as a whole between FY 2000 and FY 2011. Among states, the rate ranged from .1 percent to a high of 8.5 percent, but virtually all states had average annual enrollment growth in excess of population growth (see data below). At 5.8 percent and 3.8 percent, adults and children were the fastest growing eligibility groups in the nation, reflecting presumably higher enrollment due to economic conditions, state-level expansions and, in some states, extension of family planning-only services that drove up partial-benefit adult enrollment. They were followed by people with disabilities at 3.6 percent annual growth and seniors at 2.3 percent. Notably, a number of the states with relatively little enrollment growth are “leading” states with a long history of using Medicaid to provide their residents with affordable coverage options, highlighting that enrollment growth will slow down and level off when uninsured rates fall to sufficiently low levels.

#### *Data Implications*

Under a block grant, if states were to experience enrollment growth comparable to that experienced in recent years, they would need to choose whether to shut down enrollment, scale back on eligibility, reduce the cost of serving people by cutting provider reimbursement rates or benefits, or use state dollars to cover the cost of enrolling new people. The data also suggest that while nearly all states are likely to find that growth in the number of people without other coverage options will continue to outpace population growth, some states will face far more enrollment pressure than others given their economic conditions, demographic trends, and the size of their remaining uninsured population.

### **Table 13: Population Growth and Aging of the Population**

#### *Data Highlight*

The more people in a state, the more people who are potentially eligible for Medicaid based on their income and other characteristics. Current projections indicate that the United States population will grow at an average rate of about 1 percent per year between 2015 and 2025, for a cumulative increase of about 8 percent. States, however, vary widely in projected population growth—four states and D.C. are expected to see a decline in their total populations

while several others will experience a jump of 20 percent or more. A block grant formula that does not account for this wide variation in population growth would be particularly challenging for rapidly growing states.

Among seniors, defined as people who are 65 or older, population growth is projected to be relatively rapid in nearly all states. Between 2015 and 2025, growth in the 65 and older population is projected to average about 3 percent per year, for a cumulative increase of 36 percent—more than four times the growth for the population as a whole. More than a dozen states are expected to experience growth for the 65+ population of 40 percent or more. Among those over 85, the projected rate of increase also is relatively rapid compared to general population growth.

### *Implications for Fixed Funding*

For those states that are growing quickly or facing a population that is aging relatively rapidly—as nearly all states are—block grants would likely fail to keep up with Medicaid costs due to enrollment growth. A per capita cap would respond to population-driven growth in Medicaid spending, but would not necessarily address the cost pressures generated by the changing composition of a particular eligibility group. For example, growth in the over 85 population could drive up the per capita cost of serving “seniors” (i.e., those over 65), generating fiscal pressure for states unless the per capita cap is designed to take this within-eligibility group demographic shift into account (e.g., by establishing a separate per capita limit for those ages 65 to 85 versus 85+).

### **C. Context-Setting Data**

The context-setting data provides state-by-state information on Medicaid’s role in state budgets, as well as the size of each state’s uninsured population. Although these factors would not likely be used to set the base or trend rate for a block grant or per capita cap, they offer important context on how changes in Medicaid funding might affect each state.

#### **Table 14: Medicaid’s Role in State Budgets**

##### *Data Highlight*

In state fiscal year (SFY) 2015, close to one out of every six state dollars (15.8 percent) was spent on Medicaid, with some states spending less than one in twenty dollars on the program and other spending more than one in four state dollars. When taking into account the federal Medicaid funds that flow to states, the program’s share of state budgets is significantly larger (28 percent on average). The jump in Medicaid as a share of state budgets that occurs when considering federal (not just state) funds reflects that federal Medicaid dollars are the single largest source of federal funding for states. In SFY 2015, federal Medicaid funds accounted for more than half of all federal dollars received by states (56 percent); in five states they represented more than two-thirds of federal revenue.

### *Implications for Fixed Funding*

The integral role of Medicaid in state budgets, particularly when federal Medicaid funds are taken into account, highlights the potential risk that states face under block grant and per capita cap proposals designed to cut federal Medicaid spending. With more than half of all federal funds to states coming from Medicaid, states will want to assess block grant and per capita cap proposals through the lens of implications for their overall fiscal stability.

### **Table 15: Uninsured Rate**

Nationally, the uninsured rate for people of all ages dropped from 14.4 percent in 2013 to 9.4 percent in 2015, reflecting the availability of Marketplace coverage, Medicaid expansion, growth in enrollment among already-eligible beneficiaries, and a number of other factors. All states shared in the progress, but there is still substantial variation across states in uninsured rates. In 2015, the uninsured rate among states varied from a low of 2.8 percent to a high of 16.9 percent. Some, but not all, of the disparity across states is driven by expansion decisions—even among non-expansion states, the uninsured rate varied from a low of 5.7 percent to a high of 16.9 percent.

### *Implications for Fixed Funding*

States that continue to have a relatively high uninsured rate may be particularly hard-pressed under a capped funding model to make progress in future years. They have a bigger “hole” to fill, but would be operating under a funding formula that does not necessarily take into account the size of their remaining uninsured population. (Depending on how it is designed, a per capita cap might offer resources to cover additional uninsured people, such as if states are allowed to receive a per capita amount for newly-eligible adults.) At the same time, states that have made the most progress in reducing the number of uninsured will need to monitor capped funding proposals to assess whether those proposals will make it harder to sustain their gains in future years. Many of these states have relied heavily on Medicaid as a foundation for their successful coverage initiatives.

## Appendix: Key Data Sources for State-Level Medicaid Data

At the national level, most data on Medicaid consist of information reported by states to CMS on their program policies, the characteristics and service use of their enrollees, and their program spending. Three key sources of national Medicaid data used in this toolkit are described below.

- **CMS-64 expenditure and enrollment reports:** CMS-64 data are available through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES), with the most recent publicly available expenditures through FY 2015 and enrollment through March 2016. This source consists of aggregate data that are submitted by states to receive federal reimbursement for a share of their Medicaid and CHIP spending. It provides the most recent information available on Medicaid spending and enrollment for newly eligible adults, but a key drawback is that it cannot be used to break out spending for other eligibility groups. In addition, states frequently submit updated CMS-64 data, making the information contained in this source a constantly moving target.
- **Medicaid Statistical Information System (MSIS) data:** Summary statistics based on MSIS data are a frequently used data source in this toolkit. MSIS contains demographic and enrollment-related information on each person enrolled in Medicaid, and, at state option, separate CHIP programs, as well as a record of each claim paid for most services an enrollee receives. MSIS is the only national Medicaid data source that allows for detailed analysis of enrollment and costs by eligibility group and other enrollee characteristics. However, delays in state submissions of MSIS data and a recent effort to revamp state reporting as part of a Transformed MSIS (T-MSIS) initiative mean the most recent publicly available data are several years old, a major drawback to this data source.
- **Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports:** Also known as the Performance Indicator Reports, this monthly data source includes the number of applications received and eligibility determinations made by Medicaid and CHIP agencies, and the total number of individuals enrolled in the Medicaid and CHIP programs who are receiving comprehensive benefits. At the time of creation of this toolkit, this data source provides the most recent information on full-benefit Medicaid and CHIP enrollment by state (November 2016).

Enrollment and spending numbers from national Medicaid data sources reported to CMS are often inconsistent. These inconsistencies are driven by the varied nature of the sources, such as state-level reporting in the CMS-64 data versus person-level reporting in MSIS; that fact that different individuals or departments within states may have responsibility for reporting each data source; and differences in timing, with some data changing over time as adjustments and corrections are continuously made. These inconsistencies mean there is not a source of truth on current Medicaid spending and enrollment, a problematic situation when considering the development of block grants or per capita caps.