Analyses of MAX Claims: SAMHSA Fee-for-Service Spending Estimates, Medicare-Medicaid Enrollee Analysis, and Managed Care Summary

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U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Center for Substance Abuse Treatment

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Overview and Objectives

The SAMHSA Spending Estimates document spending information for treatment of mental and substance use disorders by major payers in the United States.[1] These estimates document Medicaid as the largest single financer of mental health treatment: Medicaid was responsible for 27 percent of all mental health treatment spending in 2009.[2] Medicaid also accounted for a large share of treatment spending for substance use disorders—21 percent in 2009, which was second only to other state and local funding.

The SAMHSA Spending Estimates (SSE) reports[3] have relied on information from various surveys and administrative records to estimate payments by payer, but these estimates could be improved with claims data. Because Medicaid is such an important financer of behavioral health treatment, Medicaid Analytic eXtract (MAX) data for 2008 were obtained and analyzed. The goals of obtaining the MAX data were to:

1. Improve the accuracy of the national and state spending estimates
2. Examine the differences in Medicaid spending for Medicare-Medicaid Enrollees compared with non-Medicare-Medicaid Enrollees
3. Provide more accurate information on Medicaid spending for behavioral health conditions to support policy decisions.

This report focuses on the first and second goals and is divided into three sections, as described below. Each section focuses on an alternative method by which Medicaid provides enrollee benefits: fee-for-service (FFS) spending, fee-for-service payments for dual Medicare-Medicaid Enrollees, and managed care spending. In order to improve the accuracy of the SSEs, it is necessary to summarize each type of claim from the MAX data.

Section 1 reports Medicaid spending by provider and medication type for FFS claims. Included in the $295 billion Medicaid paid for medical care on behalf of 61.9 million enrollees in 2008,[4] was $216 billion (73 percent of all Medicaid payments) paid for FFS claims. This represented 42.4 million individuals in 2008 who had FFS claims.[5]

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[1] Substance Abuse and Mental Health Services Administration. *National expenditures for mental health services and substance abuse treatment, 1986–2009*. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Retrieved from http://store.samhsa.gov/shin/content/SMA13-4740/SMA13-4740.pdf.

[2] Levit, K. R., Mark, T. L., Coffey, R. M., Frankel, S., Santora, P., Vandivort-Warren, R., & Malone K. (2013). Federal spending on behavioral health accelerated during the recession as individuals lost employer insurance. *Health Affairs, 32*(5), 952–962.

[3] Posted at http://www.samhsa.gov/health-financing/enrollment-initiatives-research.

[4] Centers for Medicare & Medicaid Services. *Medicaid MAX validation reports*. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MAXGeneralInformation.html

[5] Identified by at least one claim paid on their behalf on an FFS basis or because they used no services and had no claims for a premium payment by a managed care plan in 2008.

Section 2 reports Medicaid FFS spending on health care for a subset of individuals who are dually enrolled in Medicare and FFS Medicaid, compared with those who are not enrolled in both programs. This comparison will meet CMS Data Use Agreement requirements. In 2008, one-fifth (8.5 million) of the 42.4 million FFS enrollees were Medicare-Medicaid Enrollees. For these enrollees, Medicare serves as the primary insurance and Medicaid the secondary insurance. As a result, Medicaid pays for copayments and cost sharing for these individuals and also covers services that are not provided through Medicare, either fully or partially, depending on the enrollee's status under Medicare. Included are long-term care services, medications not covered under Medicare Part D, and other specialized services such as Assertive Community Treatment for individuals with severe mental illness. Despite the fact that Medicare pays for the bulk of their inpatient and outpatient medical care, these dually enrolled individuals account for a disproportionately large share (44 percent) of Medicaid FFS spending. This report covers only the Medicaid portion of spending for the dually enrolled population.

Section 3 summarizes Medicaid enrollment in managed care, discusses the imputation methodology that can be used to examine managed care encounter claims, and applies this methodology to the pharmaceutical data. It contains a separate analysis of spending via managed care premiums. Managed care records must be processed separately from FFS records to address three limitations. First, the event-level records for many managed care plans, called *encounter records*, contain no payment information. Payments must be imputed to these encounter records to make them useful in spending analyses. Second, the completeness of encounter reporting for each plan is unknown and needs to be analyzed against FFS claim counts for similar enrollees to determine if their reporting is comprehensive. Third, some plans report no encounter records. For these plans, the amount of services must be imputed based on the geographic location of the plan, the type of plan (e.g., comprehensive, dental, behavioral health, family planning benefits only) and the level (partial or full) of an enrollee's benefits. Because plan type and plan identification number (ID) were not available in the 2008 MAX data set, we were not able to make full use of the service-level records to perform all of the managed care imputations that are required. Instead, we provide (1) a summation of enrollment and spending on Medicaid managed care based on information in the person-level summary record and (2) the Truven Health recommendations for analysis of Medicaid managed care spending for Medicare-Medicaid Enrollees. To the extent possible, we examine the imputation methodology using prescription data.

Section 1: Fee-for-Service Medicaid Tabulations of MAX Claims Data

Section 1 presents fee-for-service (FFS) Medicaid spending for inpatient, other therapies (e.g., outpatient or physician services), and long-term care services by provider type and for prescription claims by therapeutic class. Service and prescription drug data are presented by broad behavioral health diagnosis of mental and substance use disorders and for all health diagnoses.

This section begins with a brief overview of the data and methods and then summarizes the results. States vary in the amount of Medicaid spending they provide through FFS claims. The amount of spending on managed care premiums and managed care enrollment are summarized here to provide a context for the national and state results and helps the reader interpret FFS spending. A detailed discussion of managed care benefits is found in Section 3. Additional Microsoft® Excel files that provide more detailed information on spending and other analytic variables at the national level and by state are available from the authors.

1.1 Methods

Data

We used data from the 2008 Medicaid Analytic eXtract (MAX) data set, which consists of five component files: *personal summary* (**PS**) files that contain characteristics of the Medicaid enrollees and summary information about their enrollment status and payments on their behalf; service files for *inpatient* (**IP**), *other therapy* (**OT**), and *long-term care* (**LT**); and a *product* (**RX**) file that contains claims for prescription drugs and durable medical equipment (DME). These files can be linked by a unique identifier for each beneficiary. The Maine 2008 MAX data set only included PS and RX files, which limited analyses for this state to prescription drug spending. Other analyses contained data from all states except for Maine. We included all MAX FFS claims with nonzero payment amounts. FFS claims with zero payments may be claims where Medicaid is the secondary payer, such as where Medicare or another payer is responsible for the entire bill.

Managed Care Spending and Enrollment

A preliminary analysis was conducted to establish the extent and distribution of managed care spending and enrollment among the states. This preliminary analysis provides context in order to interpret the FFS analyses. We used the PS summary information regarding payments for enrollees to calculate the percentage of Medicaid spending on managed care premiums by state. For each state, we summed the managed care premiums paid across enrollees, as well as the total spending across enrollees. We then divided the managed care premiums by total spending for each state.

We used the summary information regarding enrollment contained in the PS file to estimate the amount of enrollment in managed care plans. We classified managed care enrollment into the following categories:

1. Enrollment in **any comprehensive managed care plan**. This category included enrollment in a comprehensive plan only, a comprehensive plan and dental plan, a comprehensive plan and behavioral plan, a comprehensive plan and other managed care plan, and a combined comprehensive plan, dental plan, and behavioral plan.
2. Enrollment in **any behavioral managed care plan**. This category included enrollment in a behavioral plan only; a comprehensive plan and behavioral plan; a comprehensive plan, dental plan, and behavioral plan; a primary care case management (PCCM) plan and behavioral plan; a PCCM plan, dental plan, and behavioral plan; and a dental plan and behavioral plan.
3. **Any enrollment in other managed care plans**. This category included a dental plan only, a PCCM plan only, another managed care plan only, a PCCM plan and dental plan, a PCCM plan and other managed care plan, and other combinations.

Note that these categories are not mutually exclusive because individuals could be enrolled in comprehensive managed care and behavioral managed care at the same time. These combinations in the first two categories above were included because it is important to know the enrollment in both categories separately in order to understand the spending estimates. To calculate the enrollment percentage for each category, we summed the number of months of enrollment across enrollees for each classification and divided it by the total months of enrollment across enrollees by state.

For the state results, we noted which states have greater than 50 percent of Medicaid dollars going to managed care premiums, greater than 50 percent enrollment in comprehensive managed care plans, and greater than 50 percent enrollment in behavioral managed care plans.

Claims for Services

Provider Categories

We tabulated spending by provider type and diagnosis. We created provider categories based on the *type of service* and *place of service* variables available in MAX to match as closely as possible to the provider categories used in the SSE. The SSE provider categories are modeled after the National Health Expenditure Accounts (NHEAs) prepared by CMS.[6] These provider definitions are designed to measure spending according to the facility, professional entity, or retail outlet that received payment for the services. Unfortunately, the variables currently available in MAX do not identify providers in this way. Instead, they identify the type of service

[6] National Health Account definitions are available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/quickref.pdf

and the place of service, which may or may not be the same as the entity that is paid for that service.

- Example 1. Physician services (a MAX type of service) may be provided in an inpatient psychiatric hospital (place of service). From this information, we do not know if the physician is independently practicing and billing separately for the services or if the physician is employed by the hospital and billing through the hospital.
- Example 2. Medicaid is billed for a durable medical equipment (DME) product provided in an inpatient hospital setting. In this case, we assumed that the hospital billed Medicaid for that service, and we classified the products or services delivered to a patient as part of an inpatient hospital stay as a hospital service.

This combination of type of service and place of service variables matches as closely as possible to the provider definition used in the National Health Accounts. However, the limitation of this methodology is that it must make some assumptions regarding the appropriate billing entity to be consistent with the National Health Expenditures Account as illustrated in Example 1 above. In this case, services were classified as physician services—inpatient.

We also identified specialty mental health and specialty substance use centers that focus treatment on behavioral health conditions. These providers were not separately identified in the National Health Expenditure Accounts (NHEAs).

The resulting provider categories included:

- Hospital care
- Physician services
- Dentist services
- Other professional services
- Nursing home care
- Home health services
- Transportation
- Durable medical equipment
- Specialty mental health centers
- Specialty substance use centers
- Day care
- Prescription drugs

Providers were further categorized into inpatient, outpatient, and residential services—also known as settings of care. Settings of care are shown at the all-provider level on the tables in this report.

Appendix A contains a description of the MAX data files and of data variables and elements within those files that are used to classify claims by provider. For each provider category, we tabulated total Medicaid payments, the number of claims, and the number of unique users.

Diagnostic Categories

We used the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnoses to classify claims as mental or substance use disorders. We defined these classifications using the principal diagnosis contained on each claim. We used the ICD-9-CM codes in the mental disorders section (i.e., codes in sections 290 through 319) as well as two complications mainly related to pregnancy: drug dependence (648.3) and mental disorders (648.4). Appendix B contains the detailed list of ICD-9-CM codes and the diagnostic classifications to which they are assigned for this study. We excluded the following codes as outside the scope of this project: dementias (290); transient mental disorders caused by conditions classified elsewhere (293); persistent mental disorders caused by conditions classified elsewhere, including cerebral degenerations such as Alzheimer's disease (294); nondependent use of drugs-tobacco abuse disorder (305.1); specific delays in development (315); psychic factors associated with disease classified elsewhere (316); and mental retardation (317–319).

Service Claims with Missing Diagnoses or Unknown Providers

Service claims that did not meet the criteria for one of the provider categories described above were compiled into an "unknown" provider category. Six percent of FFS claims nationwide fell into this category and 12 percent of FFS payments nationwide came from claims with a missing diagnosis. Of claims missing provider information, one-third also were among those missing a diagnosis. By state, claims with unknown diagnoses ranged from zero percent in Arizona, Arkansas, Idaho, Minnesota, Rhode Island, and Vermont to 52 percent in Massachusetts and 53 percent in South Dakota (Appendix C).[7] By provider, 90 percent of claims with a missing diagnosis came from dental (15 percent), other professional (13 percent), home health (28 percent), and nursing home (34 percent) services (Appendix D). Results for states with a high percentage of unknown providers are less reliable (Appendix E).

Mental and substance use disorder percentages vary by provider; therefore, it is important to assign payments from claims with an unknown diagnosis by provider type. We estimated spending among claims with unknown diagnoses and unknown providers for each state using claims with a reported diagnosis and provider. First, we summed the total payments for claims with an unknown diagnosis and those with a known diagnosis for each provider type. Next, within each provider type, we distributed the total payments for claims with a missing diagnosis according to the distribution of spending among claims with a known diagnosis. For example,

[7] Large shares of payments for claims with missing diagnoses were for dental services (91 percent) and transportation services (41 percent).

for specialty mental health centers, since found that approximately 76 percent of the payments from claims reporting a diagnosis were for mental disorders; we assigned this same percentage of payments from claims without a diagnosis to mental disorders.

In some states, certain services had a high percentage (defined as >75 percent) of claims with a missing or unknown primary diagnosis. Allocating the payments of these claims in proportion to the reported claims for mental health, alcohol use, and drug use would have resulted in drastically inflated payments. Instead, we calculated mental health, alcohol use, and drug use claims as a percentage of "all-health" claims at the national level. We then allocated payments according to these percentages when a state had over 75 percent missing/unknown primary diagnosis data for a given service. These percentages were calculated separately for Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees to more accurately reflect differences in utilization between these two populations.

For example, 99 percent of adult day care claims for non-Medicare-Medicaid Enrollees in Florida had a missing/unknown diagnosis. Rather than allocate missing/unknown diagnosis payments in proportion to the 1 percent of reported claims in Florida, we allocated payments according to the national percentage of adult day care claims for non-Medicare-Medicaid enrollees that were related to mental health and/or substance use.

If actual payments for mental health and/or substance use exceeded our calculated payments using this methodology, we instead reported the actual payments. The reason for this is that actual, reported payments reflect real-world usage more accurately than the aforementioned allocation methodology. We calculated these percentages separately for Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees to accurately reflect differences in utilization between these populations.

Finally, we assumed that no claims for dentists or DME that had a missing/unknown primary diagnosis were associated with a mental health or substance use diagnosis. Therefore, none of these claims were allocated to mental health or substance use.

We assigned the small share of unknown provider payments to providers using a procedure that was similar to the one that was used for payments with a missing diagnosis. First, we summed the total payments for claims with an unknown provider and those with a known provider for each diagnosis. Next, within each diagnostic category, we distributed the total payments—including payments for claims with a missing provider—according to the distribution of spending among claims with a known provider.

Claims for Prescriptions

The payments for prescription drug claims in the RX file are for medications purchased in retail outlets and through mail order. Within the SSE, we identified specific medications that were

used primarily to treat mental and substance use disorders. Mental health medications fell within the following therapeutic classes and are specified in Appendix F:

- Antidepressants
- Antipsychotics
- Stimulants and other central nervous system (CNS) medications
- Anxiolytics, sedatives, and hypnotics (ASH), benzodiazepines
- Anxiolytics, sedatives, and hypnotics (ASH), non-benzodiazepines
- Mood stabilizers
- Substance use disorder medications

We also combined medications for mental disorders and substance use disorders to estimate spending on and use of mental health and substance abuse (MHSA) medications. Appendix F lists the medications included in each therapeutic class, although we recognize that some medications may be used for multiple disorders.[8]

Based on the classification provided above, we captured and matched the National Drug Codes (NDCs) for the MHSA medications provided in the Truven Health Analytics RED BOOK™ to the NDCs provided in the MAX RX file to identify relevant medication claims.

For each class of medications, we counted the total number of claims, payments, and unique users. We then calculated the average payment per claim and average payment per user. Finally, for each therapeutic class, we calculated its percentage of total medication spending, total behavioral health medication spending, and total spending on medications for mental or substance use conditions (as appropriate).

Since virtually all FFS claims contained NDCs, no adjustments were needed for missing codes.

1.2 Results

Summary of Managed Care Spending and Enrollment

A substantial portion of Medicaid spending in the United States is now comprised of expenditures to managed care plans. The ratio of FFS payments and managed care payments varies substantially by state. Understanding the extent of that amount of FFS and managed care spending by state is important to understanding how complete a picture the FFS payments provide. For states with high rates of spending or enrollment in comprehensive managed care plans, the FFS estimates strongly underestimate total Medicaid spending. In states with high enrollment in behavioral managed care plans, FFS estimates of behavioral health spending may appear to underestimate spending on behavioral health care.

[8] The SSE does not include methadone as a medication for treating opioid use disorder because, when it is dispensed at an opioid treatment center, the claims do not appear in the RX file; rather, they are captured as part of the payment to the dispensing facility.

In 2008, Medicaid paid 23.5 percent of its expenditures to managed care plans (Table 1). Contributions to managed care premiums from individual states ranged from zero percent in states with no managed care to 84.9 percent in Arizona, which has high rates of managed care enrollment. Four states paid over 50 percent of their Medicaid expenditures as premiums: Arizona, New Mexico, Pennsylvania, and Michigan.

Enrollment in comprehensive managed care plans in the United States was 40.4 percent, overall, and it ranged from zero percent to 77.3 percent in individual states. Eighteen states had greater than 50 percent enrollment in comprehensive managed care plans: Arizona, Hawaii, Maryland, New Jersey, Ohio, Delaware, Oregon, New Mexico, New York, District of Columbia, Indiana, Michigan, Rhode Island, Minnesota, Georgia, Virginia, Pennsylvania, and Washington.

Enrollment in behavioral managed care plans in the United States was 17.6 percent, overall, and it ranged from zero percent to 99.7 percent in individual states. Six states had rates of behavioral managed care enrollment greater than 80 percent: Washington, Tennessee, Colorado, Kansas, Pennsylvania, and Nebraska. An additional four states had rates between 50 percent and 80 percent: Michigan, Arizona, Iowa, and New Mexico.

Fee-for-Service Medicaid Spending

Aggregate Spending

In 2008, Medicaid paid $216.8 billion in FFS claims for all users (Table 2). Spending from claims with missing diagnoses was imputed for approximately 12 percent of all revenue.

Spending on MHSA

Of the $216.8 billion in Medicaid FFS spending, 13 percent (about $28.4 billion) was attributed to the treatment of mental and substance use disorders (Table 2). This included services for 9.0 million individuals, who were represented in over 189 million claims. MHSA spending per MHSA user averaged $3,243; the cost per claim averaged $140. Medicaid FFS payments for MHSA treatment were highest for outpatient services ($13.1 billion) followed by inpatient services ($4.8 billion) and residential care ($4.3 billion) (Table 2 shows these numbers separately for mental health and substance use services).

For MHSA treatment by provider, Medicaid paid $4.8 billion for FFS inpatient, outpatient, and residential treatment in general hospitals and $2.1 billion for treatment in specialty hospitals (e.g., psychiatric and substance use hospitals). Another $4.1 billion was paid to nursing home facilities for services for individuals with primary mental or substance use disorders, and $2.1 billion was paid to home health providers. Medicaid spent $1.0 billion for physicians' services and $6.6 billion for services of other medical professionals for behavioral health treatment.

Medicaid spending on FFS MHSA treatment varied across states (Table 3), in part, because some states are more heavily invested in managed care than others. Total FFS Medicaid payments for

treatment of mental and substance use disorders ranged from $55 *million* in New Mexico to $4.3 *billion* in New York. Total FFS claims for MHSA services ranged from approximately 9,000 in Arizona, a state with high enrollment in behavioral health managed care, to 827,000 users in California, a state with low enrollment in behavioral health managed care.

Alaska recorded the highest per enrollee FFS spending on MHSA services at $1,699 per enrollee, followed by Rhode Island ($1,654) and New Hampshire ($1,552) (Table 2). Spending per Medicaid enrollee was lowest for New Mexico ($243) and Tennessee ($209)—states with a high share of behavioral health managed care enrollment. Alaska ($9,005) and Arizona ($7,705) had the highest average spending per user on FFS treatment for behavioral health conditions, whereas Michigan ($1,036) and Tennessee ($1,105)—again, states with high behavioral health managed care enrollment—had the lowest. Behavioral health FFS spending as a share of all Medicaid FFS spending was highest in South Dakota (23 percent) and Alaska (22 percent).[9] These states were unusual in that they had higher-than-average spending for MHSA in hospitals and specialty MH centers as well as higher spending for other professionals; drug spending was also somewhat higher than average. Behavioral health FFS spending represented the smallest proportion of Medicaid spending in New Mexico (5 percent), Tennessee (6 percent), and Arizona (6 percent), where the share of Medicaid recipients in managed behavioral health care plans was high.

Prescription Drugs

In 2008, Medicaid spent about $24.2 billion on FFS claims for prescription medications (Table 4). Of that amount, $6.3 billion was spent on medications for mental and substance use disorders—comprising 26 percent of total prescription drug spending by Medicaid. Of the 23 million Medicaid FFS users of Medicaid prescription drug benefits, 6.3 million purchased medications to treat mental and substance use disorders. Medicaid spent $1,041 per user annually or $71 per claim on all FFS medications. In comparison, Medicaid spent approximately the same amount per user ($1,000) but more per claim ($106) on drugs used to treat mental and substance use disorders.

FFS payments for medications used to treat substance use conditions comprised 1.4 percent of all Medicaid spending on these types of medications. Medicaid spent 87 percent of substance use medication spending on opiate partial agonists (buprenorphine or buprenorphine/naloxone combinations) to treat drug-use conditions. Additionally, Medicaid spent 6 percent on opiate antagonists (naltrexone HCL) that can be used for alcohol or drug addictions and 6 percent on miscellaneous therapeutic agents (disulfiram and acamposate), which are used to treat alcohol addictions.

[9] Maine was excluded from the comparison because it did not report these data.

Payments for medications commonly used to treat mental disorders as opposed to substance use disorders comprised 98.6 percent of total Medicaid FFS spending on MHSA prescription drugs. Among these medications, the therapeutic class of psychotherapeutics, tranquilizers, and antipsychotics accounted for 62 percent of Medicaid's mental health drug spending—$3.9 billion. Another 15 percent was spent on the purchase of antidepressants, and 16 percent was spent on stimulants and CNS agents used primarily for the treatment of attention deficit hyperactivity disorder. The price per claim for antidepressants was less than one-quarter of the price of tranquilizers and antipsychotics, primarily because most products in the antidepressant therapeutic class have generic equivalents that are offered at substantially lower prices than branded product equivalents. In contrast, tranquilizers and antipsychotic medications have few generic equivalents, although the expiration of patents over the next few years should lead to substantially reduced prices in the near future.

Most states manage Medicaid drug spending directly through FFS claims, often with the use of a pharmacy benefit manager. This is because states benefit by capturing pharmacy rebates from manufacturers when specific medications are placed on the state's Medicaid formulary and are paid through FFS claims. In most states, spending on MHSA prescriptions ranged from 20 percent to 37 percent of total Medicaid FFS drug spending, making these therapeutic classes of medications important drivers of Medicaid drug spending (Table 5). In a few states (Maryland, Michigan, and Oregon), a substantially larger portion of the Medicaid FFS spending (49 percent to 57 percent) was for medications used to treat mental and substance use disorders. In contrast, Arizona and New Mexico allocated the smallest shares (9 percent and 15 percent, respectively) to drugs used to treat mental and substance use disorders. In cases of very high or very low percentages of drug spending on behavioral health medications, these variations may be related to missing managed care encounter claims that were not included in the FFS analysis. High percentages of MHSA drug spending in FFS claims may suggest that certain medications are covered through Medicaid but not through the prescription benefit included in managed care plans. Arizona and New Mexico had an unusually low percentage of medication spending on MHSA medications. Both states had over 90 percent of medication claims as encounter claims that were not included in the FFS analysis. As a result, estimates are unreliable for these states.

Fee-for-service Medicaid payment per claim for MHSA medications ranged from a low of $66 in Pennsylvania to a high of $166 in California and the District of Columbia. Payments per user ranged from $303 in New Mexico to $1,788 in the District of Columbia, with the difference likely related to state-by-state differences in FFS and managed care enrollment and payment practices.

1.3 Limitations

There are a few limitations to our estimates. First, our national estimates do not include spending in the state of Maine for any services other than RX, because the 2008 MAX files did

not contain claims data for non-RX services in this state. Second, some claims did not report a diagnosis and/or a provider of service. These missing diagnoses and providers affected states and providers in different ways. Some states had a larger proportion of estimated spending or a larger proportion of certain providers than others, thereby increasing the margin for error for these estimates. Appendix C provides information about missing diagnoses by state, permitting an assessment of the relative impact of the missing data by state. The missing diagnoses occur most frequently in dentists, DME, and transportation (Appendix D). As noted above, the percentage of claims missing information about providers is more limited (6% of FFS claims nationwide) and Appendix E provides information about missing provider information by state. These missing data were handled as discussed above in section 1.1. Third, the estimates of prescription drugs do not account for rebates received from manufacturers, which would reduce the level of Medicaid spending on these products. Last, the analyses in this section of the report cover only FFS claims; addition of managed care claims will alter aggregate spending at the national and state level and may also affect average spending.

1.4 Summary

Tabulations presented in this report are estimates of spending by Medicaid for all fee-for-service claims and for fee-for-service claims for Medicare-Medicaid enrollees. These results document the large share of Medicaid fee-for-service spending that is used to treat mental and substance use disorders. Because a large proportion (24 percent) of Medicaid spending to treat behavioral health conditions is for prescription drugs and because these purchases make up such a large share (26 percent) of Medicaid drug spending, prescription medications are an important area of analysis. Almost two-thirds of drug spending on behavioral health drugs in 2008 was for antipsychotics. A study underway as part of the SAMHSA Spending Estimate projections suggests that the prices of antipsychotics will be dropping dramatically over the next few years as existing products go off patent and generic alternatives become available.[10] This should result in important savings to Medicaid.

Results from this analysis of fee-for-service claims provide basic data for improving the estimates of Medicaid spending for mental and substance use disorders. Spending from claims with missing diagnoses was imputed for approximately 12 percent of all revenue; nonetheless, these data will greatly improve the accuracy of the SAMHSA Spending Estimates nationally and by state. At the national level, current methods rely on nationwide survey data. More importantly, these results will fill the information gap at the state level, where there are currently no available spending estimates for treatment of mental and substance use disorders paid by Medicaid.

[10] Hodgkin, D., Thomas, C. P., O'Brien, P., Levit, K., Richardson, J., & Mark, T.L. *Projections of national spending on psychotropic medications, 2013–2020*. Draft report delivered to SAMHSA on July 31, 2013 under Contract HHSS283200700029I/HHSS28342002T.

Table 1. Summary of Medicaid Payments to Managed Care and Managed Care Enrollment, by State, 2008

State	Medicaid Payments Paid as Managed Care Premiums (%)	Enrollees in Comprehensive Managed Care Plans (%)	Enrollees in Behavioral Health Managed Care Plans (%)	Enrollees in All Other Managed Care Plans (%)
All United States	**23.5**	**40.4**	**17.6**	**22.1**
Alabama	14.1	2.8	0.0	63.4
Alaska	0.0	0.0	0.0	0.0
Arizona	84.9	77.3	77.2	4.6
Arkansas	0.7	0.0	0.0	78.5
California	20.5	40.5	0.0	29.0
Colorado	13.3	8.8	93.7	0.3
Connecticut	1.6	5.8	0.0	0.0
Delaware	39.5	67.8	0.0	19.2
Dist. of Columbia	18.9	64.1	0.0	27.4
Florida	22.2	34.2	22.1	4.4
Georgia	33.1	58.0	0.0	33.8
Hawaii	36.9	74.7	1.8	0.0
Idaho	2.7	0.0	0.0	89.7
Illinois	2.4	5.3	0.0	60.0
Indiana	24.4	63.9	0.0	5.2
Iowa	4.8	1.2	76.0	0.0
Kansas	23.3	45.8	88.7	0.1
Kentucky	14.1	19.5	0.0	70.8
Louisiana	0.5	0.0	0.0	65.8
Maine	0.0	0.0	0.0	51.5
Maryland	22.4	73.7	0.0	0.0

Table 1. Summary of Medicaid Payments to Managed Care and Managed Care Enrollment, by State, 2008 (Continued)

State	Medicaid Payments Paid as Managed Care Premiums (%)	Enrollees in Comprehensive Managed Care Plans (%)	Enrollees in Behavioral Health Managed Care Plans (%)	Enrollees in All Other Managed Care Plans (%)
Massachusetts	27.5	30.5	24.0	1.3
Michigan	50.7	62.7	79.5	0.1
Minnesota	29.8	61.2	0.0	0.0
Mississippi	0.0	0.0	0.0	83.3
Missouri	20.5	44.9	0.0	0.0
Montana	0.2	0.0	0.0	40.7
Nebraska	5.0	15.6	82.2	0.0
Nevada	14.0	45.9	0.0	35.8
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	23.1	69.7	0.0	0.0
New Mexico	57.8	66.9	61.7	1.4
New York	18.6	64.2	0.0	1.0
North Carolina	1.9	0.0	4.8	59.8
North Dakota	0.1	0.0	0.0	59.0
Ohio	32.2	69.5	0.0	0.0
Oklahoma	3.6	0.0	0.0	82.8
Oregon	46.4	67.1	15.2	3.4
Pennsylvania	55.0	54.0	82.4	5.7
Rhode Island	21.7	62.1	0.0	0.1

Table 1. Summary of Medicaid Payments to Managed Care and Managed Care Enrollment, by State, 2008 (Continued)

State	Medicaid Payments Paid as Managed Care Premiums (%)	Enrollees in Comprehensive Managed Care Plans (%)	Enrollees in Behavioral Health Managed Care Plans (%)	Enrollees in All Other Managed Care Plans (%)
South Carolina	11.3	22.3	0.0	68.9
South Dakota	0.5	0.0	0.0	71.4
Tennessee	29.5	33.5	95.2	0.0
Texas	21.7	42.3	10.2	21.7
Utah	9.7	0.0	10.2	77.4
Vermont	0.6	0.0	0.0	61.7
Virginia	32.8	55.3	0.0	6.8
Washington	25.0	54.0	99.7	0.0
West Virginia	10.8	43.2	0.0	5.9
Wisconsin	33.8	47.7	0.1	4.5
Wyoming	0.0	0.0	0.0	0.0

Source: 2008 Medicaid Analytic eXtract (MAX) files

Table 2. Medicaid Mental Health and Substance Use Services by Provider Type: Fee-for-Service Claims, Users, and Payments for All Users, 2008

Diagnosis, Services, and Products	Number of Fee-for-Service			Fee-for-Service Payments				Distribution of Fee-for-Service Payments
	Claims (Thousands)[1]	Users (Thousands)	Claims Per User[2]	Amount ($ Millions)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	
All Health								
Total all services and products	1,291,520	36,610	35.3	216,764	5,107	168	5,921	100
Total All Service Providers	952,760	30,070	31.7	192,585	4,538	177	5,617	89
Total inpatient	67,284	6,104	11.0	38,259	901	565	6,224	18
Total outpatient	826,622	28,974	28.5	82,938	1,954	82	2,330	38
Total residential	58,338	2,032	28.7	71,389	1,682	1,086	31,188	33
All hospitals	100,899	14,349	7.0	46,056	1,085	452	3,176	21
General hospitals	99,003	14,311	6.9	43,808	1,032	438	3,032	20
Specialty hospitals	1,896	169	11.2	2,248	53	1,153	12,974	1
Physicians	426,812	26,106	16.3	23,178	546	53	866	11
Dentists	6,717	1,092	6.2	3,943	93	55	339	2
Other professionals	124,007	9,313	13.3	15,538	366	99	1,325	7
Home health	200,047	3,903	51.3	27,871	657	106	5,446	13
Nursing home	51,961	1,709	30.4	70,925	1,671	1,211	36,832	33
Transportation	20,817	2,357	8.8	1,917	45	54	474	1
Durable medical equipment (DME)	3,116	812	3.8	605	14	95	364	0
Other personal and public health	14,852	629	23.6	1,630	38	109	2,565	1
Specialty mental health centers	14,532	614	23.7	1,582	37	108	2,551	1
Substance abuse treatment	320	17	18.3	48	1	148	2,709	0
Day care[4]	3,015	77	39.3	922	22	263	10,305	0
Prescription Drugs	338,760	23,224	14.6	24,178	570	71	1,041	11

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine. MH = mental health; SUD = substance use disorder. Zeroes represent amounts less than 0.5.

[1] Total all services and products includes claims from unidentified providers that are not shown separately.

[2] Calculation includes only those claims with a diagnosis and provider category.

[3] Fee-for-service enrollment in 2008 was 42,441,776.

[4] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 2. Medicaid Mental Health and Substance Use Services by Provider Type: Fee-for-Service Claims, Users, and Payments for All Users, 2008 (Continued)

Diagnosis, Services, and Products	Number of Fee-for-Service			Fee-for-Service Payments				Distribution of Fee-for-Service Payments
	Claims (Thousands)[1]	Users (Thousands)	Claims Per User[2]	Amount ($ Millions)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	
Mental Health								
Total all services and products	170,363	8,436	20.2	26,302	620	154	3,118	100
Total All Service Providers	110,945	4,840	22.9	20,068	473	165	3,792	76
Total inpatient	4,304	538	8.0	4,184	99	959	7,668	16
Total outpatient	101,388	4,584	22.1	11,854	279	106	2,342	45
Total residential	5,247	263	19.9	4,031	95	665	13,245	15
All hospitals	14,754	1,223	12.1	5,740	135	384	4,638	22
General hospitals	13,175	1,161	11.3	3,709	87	280	3,183	14
Specialty hospitals	1,580	145	10.9	2,032	48	1,251	13,655	8
Physicians	13,639	2,302	5.9	782	18	56	331	3
Dentists	1	1	2.4	9	0	44	104	0
Other professionals	49,585	2,362	21.0	6,295	148	111	2,321	24
Home health	15,197	374	40.6	2,079	49	123	5,016	8
Nursing home	4,336	201	21.6	3,870	91	768	16,559	15
Transportation	693	132	5.2	95	2	61	318	0
Durable medical equipment (DME)	90	8	11.5	6	0	47	543	0
Other personal and public health	12,489	510	24.5	1,153	27	92	2,243	4
Specialty mental health centers	12,469	509	24.5	1,147	27	91	2,234	4
Substance abuse treatment	20	1	20.2	6	0	310	6,250	0
Day care[4]	154	4	40.4	39	1	238	9,600	0
Prescription Drugs	59,418	6,309	9.4	6,233	147	105	988	24
MH share of all health	13.2%	23.0%	57.2%	12.1%	12.1%	92.0%	52.7%	

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine. MH = mental health; SUD = substance use disorder. Zeroes represent amounts less than 0.5.

[1] Total all services and products includes claims from unidentified providers that are not shown separately.

[2] Calculation includes only those claims with a diagnosis and provider category.

[3] Fee-for-service enrollment in 2008 was 42,441,776.

[4] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 2. Medicaid Mental Health and Substance Use Services by Provider Type: Fee-for-Service Claims, Users, and Payments for All Users, 2008 (Continued)

Diagnosis, Services, and Products	Number of Fee-for-Service			Fee-for-Service Payments				Distribution of Fee-for-Service Payments
	Claims (Thousands)[1]	Users (Thousands)	Claims Per User[2]	Amount ($ Millions)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	
Substance Use Disorders								
Total all services and products	18,956	596	31.8	2,086	49	110	3,497	100
Total All Service Providers	18,507	623	29.7	1,998	47	101	2,992	96
Total inpatient	534	101	5.3	568	13	1,059	5,620	27
Total outpatient	17,521	564	31.1	1,202	28	63	1,947	58
Total residential	451	27	16.5	228	5	444	7,311	11
All hospitals	6,080	278	21.9	1,132	27	182	3,982	54
General hospitals	6,021	273	22.1	1,077	25	175	3,863	52
Specialty hospitals	58	9	6.7	55	1	907	6,059	3
Physicians	6,030	336	18.0	239	6	38	679	11
Dentists	0	0	1.6	1	0	98	159	0
Other professionals	5,145	149	34.5	313	7	50	1,716	15
Home health	177	7	27.0	29	1	129	3,480	1
Nursing home	146	10	14.5	187	4	1,097	15,960	9
Transportation	55	19	2.9	9	0	87	255	0
Durable medical equipment (DME)	4	2	2.0	0	0	34	69	0
Other personal and public health	871	47	18.6	86	2	98	1,815	4
Specialty mental health centers	583	32	18.1	47	1	79	1,426	2
Substance abuse treatment	288	16	18.1	39	1	136	2,453	2
Day care[4]	1	0	33.8	0	0	427	12,777	0
Prescription Drugs	449	67	6.7	88	2	196	1,304	4
SUD share of all health	1.5%	1.6%	90.1%	1.0%	1.0%	65.6%	59.1%	

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine. MH = mental health; SUD = substance use disorder. Zeroes represent amounts less than 0.5.

[1] Total all services and products includes claims from unidentified providers that are not shown separately.

[2] Calculation includes only those claims with a diagnosis and provider category.

[3] Fee-for-service enrollment in 2008 was 42,441,776.

[4] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 3. Medicaid Services and Products for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for All Users, by State, 2008

State	Number of MHSA Fee-for-Service				Fee-for-Service Payments for MHSA Services				
	Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Total ($ Millions)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health (%)
All United States	**42,088**	**188,466**	**8,674**	**21.7**	**$28,770**	**684**	**153**	**3,317**	**13**
Alabama	827	3,468	168	20.6	$361	437	104	2,150	13
Alaska	127	954	24	39.8	$216	1,699	182	9,005	22
Arizona[2,3,5]	262	146	9	16.5	$68	260	468	7,705	6
Arkansas	743	5,524	156	35.3	$596	802	108	3,812	18
California	4,252	21,887	827	26.5	$3,976	935	154	4,809	17
Colorado[4]	462	1,322	77	17.1	$174	376	132	2,248	7
Connecticut	527	3,817	136	28.2	$552	1,047	145	4,075	15
Delaware[3]	165	396	38	10.4	$97	588	233	2,554	14
Dist. of Columbia[3]	74	604	20	30.3	$115	1,545	171	5,769	9
Florida	2,197	5,484	357	15.3	$1,067	485	104	2,984	11
Georgia[3]	938	3,235	173	18.7	$394	421	120	2,281	9
Hawaii[3]	129	438	20	21.5	$81	629	186	3,990	13
Idaho	193	2,422	47	51.5	$216	1,120	89	4,599	18
Illinois	2,435	9,082	427	21.3	$1,401	575	150	3,281	14
Indiana[3]	759	6,297	164	38.5	$539	710	85	3,294	14
Iowa[5]	461	1,530	107	14.3	$277	601	170	2,585	11
Kansas[4]	253	759	54	13.9	$158	624	207	2,894	9
Kentucky	693	4,162	229	18.2	$670	967	161	2,931	16
Louisiana	1,085	2,951	215	13.7	$407	375	130	1,894	8
Maine[6]	-	-	-	-	-	-	-	-	-

Table 3. Medicaid Services and Products for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for All Users, by State, 2008 (Continued)

State	Number of MHSA Fee-for-Service				Fee-for-Service Payments for MHSA Services				
	Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Total ($ Millions)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health (%)
Maryland[3]	833	3,391	154	22.0	$705	846	200	4,580	19
Massachusetts	1,310	4,804	255	18.8	$709	541	94	2,780	11
Michigan[2,3,5]	1,371	3,485	359	9.7	$372	271	103	1,036	11
Minnesota[3]	483	4,584	121	38.0	$747	1,546	162	6,192	17
Mississippi	735	2,695	133	20.3	$410	557	152	3,085	13
Missouri	704	5,771	214	26.9	$685	973	118	3,195	17
Montana	102	1,159	28	41.2	$140	1,380	121	4,984	22
Nebraska[4]	255	1,415	65	21.8	$223	875	149	3,440	16
Nevada	146	802	32	25.4	$167	1,138	192	5,280	18
New Hampshire	149	1,287	43	29.6	$183	1,228	133	4,212	20
New Jersey[3]	521	5,727	159	36.1	$809	1,552	141	5,102	14
New Mexico[2,3,5]	228	180	20	8.8	$55	243	112	2,704	5
New York[3]	4,221	21,312	806	26.4	$4,310	1,021	201	5,347	13
North Carolina	1,669	13,742	407	33.8	$1,645	986	120	4,047	19
North Dakota	68	470	18	25.7	$64	944	136	3,518	12
Ohio[3]	1,149	9,531	400	23.8	$1,077	937	105	2,688	13
Oklahoma	721	3,437	156	22.0	$487	675	132	3,112	15
Oregon[3]	299	1,190	88	13.5	$262	876	120	2,981	19
Pennsylvania[2,3,4]	969	2,357	208	11.3	$388	401	149	1,868	7
Rhode Island[3]	139	855	33	25.8	$229	1,654	268	6,923	19

Table 3. Medicaid Services and Products for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for All Users, by State, 2008 (Continued)

State	Number of MHSA Fee-for-Service				Fee-for-Service Payments for MHSA Services				
	Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Total ($ Millions)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health (%)
South Carolina	803	2,834	164	17.3	$377	469	112	2,292	12
South Dakota	118	368	24	15.2	$152	1,292	166	6,292	23
Tennessee[4]	1,142	1,755	216	8.1	$239	209	136	1,105	6
Texas	3,949	6,244	536	11.7	$1,005	254	136	1,876	8
Utah	245	727	55	13.3	$104	423	143	1,902	10
Vermont	159	1,434	56	25.8	$202	1,273	141	3,639	22
Virginia[3]	678	2,478	138	18.0	$653	963	261	4,739	19
Washington[3,4]	957	3,181	179	17.8	$270	282	75	1,506	11
West Virginia	373	2,367	121	19.6	$285	764	120	2,354	15
Wisconsin	931	4,035	221	18.2	$370	398	92	1,673	12
Wyoming	77	373	16	22.8	$82	1,060	185	5,027	16

Source: 2008 Medicaid Analytic eXtract (MAX) files.

Note: MHSA = mental health and substance abuse.

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine is excluded from the comparison because it reports only spending for prescription drugs on the MAX files.

Table 4. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders by Diagnosis and Therapeutic Class: Fee-for-Service Claims, Users, and Payments for All Users, 2008

	Number of Fee-for-Service Drug			Fee-for-Service Drug Payments				Distribution of Fee-for-Service Payments Among		
Drug Spending by Diagnosis and Therapeutic Class	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee[2] ($)	Per Claim[1] ($)	Per User[1] ($)	All Drugs (%)	MHSA Drugs (%)	MH and SA Drugs Separately (%)
All Drugs	**338,760**	**23,224**	**14.6**	**24,178**	**570**	**71**	**1,041**	**100**	-	-
Total MHSA drugs	59,866	6,324	9.5	6,321	149	106	1,000	26	100	-
Total SA Drugs	**449**	**67**	**6.7**	**88**	**2**	**196**	**1,304**	**0**	**1**	**100**
Opiate partial agonists[3]	354	44	8.1	77	2	217	1,748	0	1	87
Opiate antagonists, NEC[4]	44	10	4.6	6	0	128	594	0	0	6
Misc. therapeutic agents, NEC[5]	51	16	3.2	6	0	109	348	0	0	6
Total MH Drugs	**59,418**	**6,309**	**9.4**	**6,233**	**147**	**105**	**988**	**26**	**99**	**100**
Psychotherapeutic, antidepressants	18,764	2,865	6.5	934	22	50	326	4	15	15
Psychotherapeutic, tranquilizers/antipsychotics	12,878	1,470	8.8	3,884	92	302	2,643	16	61	62
Stimulants and CNS agents, misc.	8,421	1,260	6.7	1,007	24	120	799	4	16	16
Anxiolytics, sedatives, hypnotics (ASH), benzo.	13,180	2,281	5.8	198	5	15	87	1	3	3
Anxiolytics, sedatives, hypnotics (ASH), NEC	5,442	1,351	4.0	194	5	36	143	1	3	3
Antimanic agents, NEC	733	117	6.3	17	0	23	144	0	0	0

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: benzo = benzodiazepines; MH = mental health; misc. = miscellaneous; NEC = not elsewhere classified; SA = substance abuse

[1] Calculation includes only those claims with a national drug code (NDC).

[2] Fee-for-service enrollment in 2008 was 42,441,776

[3] Includes buprenorphine hydrochloride and buprenophine/naloxone combination.

[4] Includes naltrexone HCl used to treat alcohol and drug addiction.

[5] Includes disulfiram and acamprosate used to treat alcohol addiction.

Table 5. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for All Users, by State, 2008

State	Number of Enrollees	Number of Fee-for-Service MHSA Drug: Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Fee-for-Service MHSA Drug Payments: Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health Drugs (%)
All United States	**42,088**	**59,866**	**6,324**	**9.5**	**6,321**	**150**	**106**	**1,000**	**26**
Alabama	827	1,195	131	9.1	114	138	95	869	25
Alaska	127	214	16	13.4	23	179	106	1,430	30
Arizona[2,3,5]	262	4	1	5.2	0	2	109	570	9
Arkansas	743	883	116	7.6	107	143	121	919	31
California	4,252	4,598	476	9.7	763	179	166	1,601	26
Colorado[4]	462	617	60	10.2	75	162	121	1,237	27
Connecticut	527	1,226	109	11.3	105	200	86	970	26
Delaware[3]	165	312	33	9.4	29	176	93	878	24
Dist. of Columbia[3]	74	126	12	10.8	21	282	166	1,788	22
Florida	2,197	2,507	270	9.3	228	104	91	844	21
Georgia[3]	938	1,246	127	9.8	121	130	98	959	27
Hawaii[3]	129	107	11	10.0	16	122	148	1,478	30
Idaho	193	389	32	12.2	41	212	106	1,286	37
Illinois	2,435	3,052	324	9.4	279	115	91	862	24
Indiana[3]	759	970	94	10.4	96	126	99	1,022	32
Iowa[5]	461	906	85	10.6	85	184	94	996	37
Kansas[4]	253	553	47	11.8	59	234	107	1,261	37
Kentucky	693	1,584	150	10.6	128	185	81	853	21
Louisiana	1,085	1,445	182	8.0	159	146	110	875	20
Maine[6]	353	852	80	10.6	67	189	78	829	31

Table 5. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for All Users, by State, 2008 (Continued)

State	Number of Enrollees	Number of Fee-for-Service MHSA Drug: Claims (Thousands)	Number of Fee-for-Service MHSA Drug: Users (Thousands)	Number of Fee-for-Service MHSA Drug: Claims Per User[1]	Fee-for-Service MHSA Drug Payments: Amount (Millions $)	Fee-for-Service MHSA Drug Payments: Per Enrollee ($)	Fee-for-Service MHSA Drug Payments: Per Claim[1] ($)	Fee-for-Service MHSA Drug Payments: Per User[1] ($)	Fee-for-Service MHSA Drug Payments: As a Share of All-Health Drugs (%)
Maryland[3]	833	1,084	106	10.2	126	152	117	1,194	49
Massachusetts	1,310	1,880	184	10.2	147	112	78	798	30
Michigan[2,3,5]	1,371	2,724	290	9.4	237	173	87	816	51
Minnesota[3]	483	732	74	9.9	82	170	112	1,110	34
Mississippi	735	606	90	6.8	68	92	112	755	22
Missouri	704	1,853	156	11.9	174	247	94	1,113	26
Montana	102	196	18	10.9	22	218	113	1,229	34
Nebraska[4]	255	444	44	10.1	53	206	119	1,202	34
Nevada	146	263	24	11.0	26	176	98	1,071	28
New Hampshire	149	286	28	10.2	26	177	92	940	33
New Jersey[3]	521	1,149	102	11.3	139	267	121	1,365	25
New Mexico[2,3,5]	228	34	7	4.5	2	10	67	303	15
New York[3]	4,221	5,474	556	9.9	708	168	129	1,274	20
North Carolina	1,669	2,577	299	8.6	273	164	106	912	26
North Dakota	68	128	13	10.1	11	157	84	844	34
Ohio[3]	1,149	1,660	192	8.7	155	135	93	809	31
Oklahoma	721	880	109	8.0	93	129	106	853	27
Oregon[3]	299	804	78	10.3	78	260	97	999	57
Pennsylvania[2,3,4]	969	1,753	173	10.2	116	120	66	672	28
Rhode Island[3]	139	203	21	9.8	18	127	86	845	34

Table 5. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for All Users, by State, 2008 (Continued)

State	Number of Enrollees	Number of Fee-for-Service MHSA Drug: Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Fee-for-Service MHSA Drug Payments: Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health Drugs (%)
South Carolina	803	926	121	7.7	87	109	94	723	25
South Dakota	118	158	16	9.8	16	139	104	1,012	31
Tennessee[4]	1,142	1,598	205	7.8	179	157	112	873	25
Texas	3,949	3,181	444	7.2	455	115	143	1,026	24
Utah	245	453	47	9.6	46	188	102	984	33
Vermont	159	460	41	11.4	37	234	81	918	32
Virginia[3]	678	761	80	9.5	65	96	86	813	29
Washington[3,4]	957	1,822	156	11.7	126	131	69	807	28
West Virginia	373	1,114	99	11.3	86	232	77	877	25
Wisconsin	931	1,772	187	9.5	142	152	80	757	24
Wyoming	77	105	11	9.8	12	155	114	1,125	32

Source: 2008 Medicaid Analytic eXtract files

Note: MHSA = mental health and substance abuse

[1] Calculation includes only those claims with a national drug code (NDC).

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Section 2: Analysis of Fee-for-Service Spending on Medicare-Medicaid Enrollees

Medicare-Medicaid enrollees refer to beneficiaries who qualify for both Medicare and Medicaid. In most cases, beneficiaries who qualify for both insurance programs are either individuals with disability or adults aged 65 years and older with low incomes. In 2008, there were 61.9 million Medicaid enrollees. Of those, 15 percent, or 9.3 million, were dually enrolled in Medicare and Medicaid. Further, Medicare-Medicaid Enrollees represented 25 percent of FFS Medicaid enrollees and 49 percent of FFS expenditures.[11]

Generally, Medicare pays for basic health insurance (outpatient and inpatient care) for individuals aged 65 and older as well as for individuals younger than 65 years who receive Social Security benefits for at least 2 years, regardless of income. Out-of-pocket costs for Medicare include premiums, cost-sharing payments, and payments for uncovered services such as long-term-care, dental or vision services, and other wrap-around services. When individuals also qualify for Medicaid through federal and state income and resource criteria, Medicaid pays for costs and services not covered by Medicare such as deductibles, cost sharing, and long-term care. Medicaid can also pay Medicare premiums on behalf of individuals who are dually enrolled; however, these premiums are not included in the MAX dataset. Medicaid spending on many health services such as inpatient hospitalizations, short-term nursing home stays, outpatient services, and prescriptions for Medicare-Medicaid Enrollees is much lower than if Medicaid covered all MME health spending. As a result, estimates of Medicaid spending on these services does not reflect the total cost of care of these services for Medicare-Medicaid Enrollees. Moreover, coverage of drug benefits for Medicare-Medicaid Enrollees was transferred from Medicaid to Medicare in 2006. As a result, spending on prescription drugs for this high-use population was limited to copayments, medications not covered by Medicare Part D or Medicare's managed care plans, and the "donut hole" payments required of Medicare beneficiaries who reach a high payment threshold. Essentially, Medicare acts as the primary insurance and Medicaid provides wrap-around coverage.

Individuals who are dually eligible for Medicare and Medicaid fall into two general categories: those who are eligible for full Medicaid benefits and those who are eligible for Medicare cost savings (i.e., those who are "partially eligible"). Medicare-Medicaid Enrollees qualify for full Medicaid benefits through five pathways, only one of which is mandatory for states. The federal government mandates that states provide full Medicaid benefits to individuals receiving Supplemental Security Income (SSI) cash assistance and who meet income eligibility and asset limits. Additional classifications of individuals who may receive Medicaid benefits include

[11] Borck, R., Dodd, A. H., Zlatinov, A., Verghese, S., Malsberger, R., & Petroski, C. *Medicaid Analytic eXtract 2008 Chartbook*. Centers for Medicare & Medicaid Services. 2012. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MAX_Chartbooks.html.

those who are at a specified poverty level, are medically-needy, reside in a nursing home, or receive home- and community-based services under waivers and would be eligible if they resided in a nursing home. Individuals who are eligible for Medicare cost savings do not receive full Medicaid benefits. Instead, Medicaid only pays for Medicare premiums and cost sharing. Individuals qualify for Medicare cost savings through the following pathways: Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs), and Qualifying Individuals (QIs). Medicaid pays Medicare Part A and Part B premiums as well as cost sharing for QMBs. Medicaid pays Medicare Part A premiums for QDWIs and Part B premiums for SLMBs and QIs.

The present analysis captures Medicaid FFS payments for Medicare-Medicaid Enrollees as well as any cost sharing with Medicare. However, premiums paid to Medicare are not captured in the MAX files; therefore, they are excluded from this analysis.

2.1 Objectives

Although Medicaid payments represent only a fraction of total health care costs for Medicare-Medicaid Enrollees, the large percentage of FFS expenditures on Medicare-Medicaid Enrollees makes this group of beneficiaries particularly important to Medicaid funding and planning. Understanding how this group of beneficiaries utilizes resources as well as how behavioral health conditions interact with Medicaid spending on Medicare-Medicaid Enrollees provides important information to help policymakers as they decide which types of services they will cover.

The analyses in this section answer the following research questions regarding Medicaid spending on general and behavioral health care, overall and by specific provider types, for Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees:

- How much money is spent in aggregate dollars and per enrollee on all health care treatment for Medicare-Medicaid Enrollees? How much is spent specifically for behavioral health, mental health, and substance use treatment? How do these spending patterns differ for non-Medicare-Medicaid Enrollees?
- What share of Medicaid spending is on all behavioral health treatment for Medicare-Medicaid Enrollees? What shares are specifically on mental health and substance use treatment? How do these shares differ for non-MMEs?
- What shares of all behavioral health, mental health, and substance use spending are for MMEs?
- How much money does Medicaid spend on all health care for MMEs among specific providers, including general medical providers as well as those specializing in behavioral health treatment? How much of this health care spending is on behavioral health, mental

health, and substance use treatment? How do these spending patterns differ for non-MMEs?

- What is the distribution of Medicaid spending among providers for Medicare-Medicaid Enrollees? How does the distribution of Medicaid spending among providers for Medicare-Medicaid Enrollees differ between behavioral health and all health? How do these distributions differ for non-Medicare-Medicaid Enrollees?
- What share of funding for each provider type comes from Medicaid spending on behavioral health, mental health, and substance use treatment for Medicare-Medicaid Enrollees?

2.2 Methods

Identification of Medicare-Medicaid Enrollees

We identified Medicare-Medicaid Enrollees through the Medicare crossover annual variable (EL_MDCR_DUAL_ANN) with values ranging from 50–59. As a result, only Medicare-Medicaid Enrollees verified in the Medicare enrollment database were used in these tabulations. All other individuals were considered non-Medicare-Medicaid Enrollees.

Estimation of Fee-for-Service Spending on Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

Using the same process described in Section 1, we calculated the payment amount, number of claims, and unique users for MMEs based on the claims data. We then subtracted these numbers from the combined MME and non-MME counts to calculate the payment amount, number of claims, and unique users for non-MMEs. We applied the same imputation method to handle claims with missing diagnoses or providers separately for these two subgroups to estimate spending where claims were missing information that was important for our classification system.

Analysis

As in Section 1, our analyses provide a context for the FFS component by also summarizing the degree to which Medicare-Medicaid Enrollees are part of managed care plans and the effect of those plans on spending. We provide descriptive summary tables that include MME and non-MME results to facilitate comparisons. The first table examines managed care penetration in both populations by state to provide context for the FFS analysis and to identify states that may have differential percentages of spending in managed care for Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees. We provide aggregate and per enrollee/per user national and state estimates of general health care spending, as well as behavioral, mental, and substance use spending for Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees. We describe the national and state share of spending that is dedicated to behavioral health, mental health, and substance use disorders for Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees.

We then present the percentages of total spending for Medicare-Medicaid Enrollees on behavioral health, mental health, and substance use disorders. Finally, we present similar national spending trends by provider type and prescription drug classification. Detailed tables for Medicare-Medicaid Enrollees that are similar to those presented in Section 1 are included in Appendices G through J. Detailed state tables by provider are available by request.

2.3 Results

Enrollment in Medicaid Managed Care

A lower percentage of Medicare-Medicaid Enrollees are enrolled in managed care plans than are non-Medicare-Medicaid Enrollees. In 2008, 7.7 percent of Medicare-Medicaid Enrollees were enrolled in comprehensive managed care plans, compared with 46.9 percent of non-Medicare-Medicaid Enrollees (Table 6). States varied in their managed care arrangements. A total of 19 states and the District of Columbia had large differences between MME and non-MME enrollments in comprehensive managed care plans. The 19 states were Delaware, Georgia, Hawaii, Indiana, Kansas, Maryland, Michigan, Missouri, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Virginia, Washington, West Virginia, and Wisconsin. Alabama was the only state with a higher percentage of MME than non-MME enrollment in comprehensive managed care plans.

In the United States, 12.7 percent of Medicare-Medicaid Enrollees and 19.6 percent of non-Medicare-Medicaid Enrollees were enrolled in behavioral health managed care. States varied in their percentages of enrollment, although overall the percentages of Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees enrolled in behavioral health managed care were more similar than those for comprehensive managed care. Only New Mexico had a large group difference: there were substantially more non-Medicare-Medicaid Enrollees (69 percent) than Medicare-Medicaid Enrollees (0 percent) enrolled in behavioral health managed care. Colorado had the opposite pattern, with a much higher enrollment in behavioral health managed care for Medicare-Medicaid Enrollees (74 percent) than non-Medicare-Medicaid Enrollees (21 percent).

Aggregate FFS Spending

In 2008, Medicaid paid $95 billion for FFS claims for Medicare-Medicaid Enrollees and $122 billion for non-Medicare-Medicaid Enrollees (Table 7a). This amount represents 44 percent of all FFS claims. For the United States as a whole and for most individual states, the amount spent per enrollee and per user for Medicare-Medicaid Enrollees was two to four times that spent for non-Medicare-Medicaid Enrollees. The average payment per enrollee across the United States was $11,161 for Medicare-Medicaid Enrollees and $3,588 for non-Medicare-Medicaid Enrollees. State Medicaid payments per MME ranged from $2,786 in Arizona to $29,210 in the District of Columbia (note that Maine was excluded from this analysis because this state did not submit claims data for inpatient, long-term care, and other therapies). In contrast, the amount spent per

non-MME enrollee ranged from $1,574 in Michigan to $13,763 in the District of Columbia. Many states that reported low spending, such as Arizona and Michigan, had a large proportion of their population in managed care; thus, we cannot directly compare spending between populations.

Spending on MHSA

Medicaid spent about $7 billion in FFS payments for behavioral health treatment for Medicare-Medicaid Enrollees and about $22 billion for non-Medicare-Medicaid Enrollees in 2008 (Table 7b). Unlike average payments for all health services, the average payment per enrollee and per user for behavioral health services for Medicare-Medicaid Enrollees was similar to payments for non-Medicare-Medicaid Enrollees, despite the fact that Medicare pays for many hospital services, outpatient services, and prescriptions. The average payments for behavioral health services in the United States were $843 for Medicare-Medicaid Enrollees and $638 for non-Medicare-Medicaid Enrollees. The average payments per user for behavioral health services were $3,187 for Medicare-Medicaid Enrollees and $3,331 for non-Medicare-Medicaid Enrollees. Several states (Alaska, Minnesota, Oregon, Rhode Island, and South Dakota) registered average FFS spending on treatment for behavioral health conditions per MME user in excess of $7,000. Similar trends were observed when spending was examined separately for mental health and substance use (Tables 7c and 7d).

Because Medicare pays for the majority of inpatient, outpatient, and prescription claims, Medicaid spent only 7.5 percent (about $7.1 billion) of its total FFS spending for Medicare-Medicaid Enrollees on the treatment of mental and substance use disorders (Table 8). In contrast, Medicaid spent 17.8 percent of its total spending for non-Medicare-Medicaid Enrollees on these types of treatment. States varied in the percentage of their spending for Medicare-Medicaid Enrollees on the treatment of mental and substance use disorders, ranging from 3.1 percent in Tennessee to 20.6 percent in Oregon. Of particular note, 4.3 percent of spending for Medicare-Medicaid Enrollees in Oregon was on substance use disorders. Overall, the percentage of funds spent on substance use treatment was significantly less than that spent on mental health.

In the United States in 2008, 25 percent of the total behavioral health care spending was for Medicare-Medicaid Enrollees (Table 9). This percentage was slightly higher than the percentage of Medicare-Medicaid Enrollees (20.1 percent) in the United States. The percentage of behavioral health spending for Medicare-Medicaid Enrollees varied across states; this spending percentage was greater than the percentage of Medicare-Medicaid Enrollees in some states and less than the percentage of Medicare-Medicaid Enrollees in others. At the low end of the range, Arizona spent only 7 percent of FFS total spending for Medicare-Medicaid Enrollees on behavioral health care. At the other extreme, Massachusetts spent 51 percent of this spending on behavioral health care. Massachusetts also had the largest difference between the percentage of behavioral health spending for Medicare-Medicaid Enrollees and the percentage of Medicare-

Medicaid Enrollees. These high percentages occurred despite the fact that Medicare was the primary payer for all hospital and outpatient services.

Spending by Provider

Overall, FFS spending for Medicare-Medicaid Enrollees compared with non-Medicare-Medicaid Enrollees focused on Medicaid wrap-around services that are not funded through Medicare. For all health care for MMEs, Medicaid spent the most on nursing homes ($58 billion), home health ($17 billion), and hospitals ($6.1 billion) (Table 10a). In contrast, for non-Medicare-Medicaid Enrollees, Medicaid spent the most on hospitals ($40 billion), prescription drugs ($23 billion), and physician services ($19 billion). For mental health and substance use services for Medicare-Medicaid Enrollees, Medicaid spent $2.8 billion on nursing homes, $1.6 billion on other professionals, and $1.0 billion on hospital services (Table 10b). For non-Medicare-Medicaid Enrollees, Medicaid spent almost $6.0 billion on prescription drugs, $5.8 billion on hospitals, and $5.2 billion on other professionals.

The distribution of Medicaid FFS spending on general health differed significantly between Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees (Figure 1). Overall, Medicaid spent 61 percent of general health funds for Medicare-Medicaid Enrollees on nursing homes, 18 percent on home health, and 6 percent on hospitals. For non-Medicare-Medicaid Enrollees, Medicaid spent 33 percent of general health funds on hospitals, 19 percent on prescription medications, and 15 percent on physicians. The distribution of spending for mental health and substance use services for Medicare-Medicaid Enrollees showed that Medicaid spent 40 percent of behavioral health funds on nursing homes, 22 percent on professionals, 14 percent on hospitals, and 11 percent on home health (Figure 2). For non-Medicare-Medicaid Enrollees, Medicaid spent 28 percent of mental health and substance use funds on prescription medications, 27 percent on hospitals, and 24 percent on other professionals.

Overall, Medicare-Medicaid Enrollees accounted for a disproportionate amount of spending on Medicaid wrap-around services for overall health services and mental health and substance use services. Although Medicare-Medicaid Enrollees comprised only 21 percent of Medicaid enrollees, they accounted for over 81 percent of Medicaid spending on nursing homes, 65 percent on day care, 62 percent on home health, 49 percent on DME, and 47 percent on transportation (Table 11). For mental health and substance use services, Medicare-Medicaid Enrollees accounted for over 70 percent of spending on nursing home services, 43 percent on day care, and 36 percent on home health.

Prescription Drugs

In 2008, the Medicaid program spent $1.5 billion on FFS prescription claims for Medicare-Medicaid Enrollees (Table 10e). Twenty-two percent of drug spending for Medicare-Medicaid Enrollees, or $327 million, was spent on medications used to treat mental and substance use. For non-Medicare-Medicaid enrollees, 26 percent of the $23 billion spent on prescription drugs was

for medications used to treat mental and substance use (Table 10e). Medicaid spending on medications per MME user was smaller than for all users ($445 for Medicare-Medicaid Enrollees and $1,142 for all users for all drugs); the average payments per user were even smaller for MHSA medications ($231 for Medicare-Medicaid Enrollees and $1,221 for all users). (Table 10e) This lower spending reflects the fact that Medicare pays the majority of the costs for this population. Of Medicare-Medicaid Enrollees who used their FFS prescription drug benefit, 49 percent used a medication to treat a mental or substance use condition.

Pharmaceutical spending for Medicare-Medicaid Enrollees on behavioral health medications was dominated by antipsychotics (47 percent) and benzodiazepines (29 percent) (Figure 3). For non-Medicare-Medicaid Enrollees, antipsychotics also represented the majority of medication spending (62 percent), followed by stimulants (17 percent), and antidepressants (15 percent). Although antipsychotics accounted for the largest share of payments for Medicare-Medicaid Enrollees, benzodiazepines accounted for the largest share of claims and users (Appendix I). The large number of claims for benzodiazepines reflected the fact that Medicare Part D programs are not required to cover this class of medications.

2.4 Limitations

These estimates have several limitations. First, estimates for Medicare-Medicaid Enrollees only include Medicaid spending and not total health care spending for these beneficiaries. As a result, this analysis does not reflect the distribution of health care spending for this population; rather, it represents only Medicaid spending, which is heavily influenced by the services not covered by Medicare. Second, premiums paid by Medicaid to Medicare are not included in the MAX files. As a result, these estimates underestimate the total amount Medicaid pays for Medicare-Medicaid Enrollees. Third, this section only examines FFS claims. As discussed in Section 3, because managed care penetration varies by state and by MME status, the addition of managed care estimates may alter aggregate, average, and comparative spending. Finally, these estimates are subject to the same limitations described in Section 1 regarding missing diagnoses and providers, prescription rebates, and missing data from Maine.

2.5 Summary

Despite the fact that Medicare-Medicaid enrollees represent only 21 percent of Medicaid recipients and that Medicare covers most of their hospital, outpatient physician service, and prescription medication spending, this population uses over 44 percent fee-for-service spending. The bulk of this spending is for wrap-around services that are not available through Medicare, such as long-term care services, or for medications that are not available through Medicare Part D plans, such as benzodiazepines. Nursing home care dominates spending on mental health and substance use services.

Medicare-Medicaid enrollees represent a vulnerable population, and the services they require through Medicaid differ significantly from the services Medicaid provides to non-Medicare-Medicaid Enrollees. Individuals who are disabled may have a different distribution of provider spending than adults aged 65 years and older (including a smaller percentage dedicated to nursing homes); therefore, further analysis of spending for Medicare-Medicaid Enrollees on the basis of eligibility is important.

Table 6. Number of Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees in Fee-for-Service, Comprehensive Managed Care, and Prepaid Behavioral Health Plans

		Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees		
State	Enrollees[1] (Thousands)	Enrollees (% of N)	Any Combination with a Comprehensive Managed Care Plan (%)	Any Combination with a Behavioral Health Plan with BH (%)	All Other Mgd Care Combos (%)	Any Combination with a Comprehensive Managed Care Plan (%)	Any Combination with a Behavioral Health Plan with BH (%)	All Other Mgd Care Combos (%)
All United States	**42,442**	**20.1**	**7.7**	**12.7**	**20.5**	**46.9**	**19.6**	**20.7**
Alabama	827	22.4	11.5	0.0	3.2	0.0	0.0	82.9
Alaska	127	11.1	0.0	0.0	0.0	0.0	0.0	0.0
Arizona[2,3,5]	262	15.2	53.2	53.4	17.9	80.3	79.9	3.0
Arkansas	743	16.6	0.0	0.0	54.8	0.0	0.0	83.3
California	4,252	23.5	16.8	0.0	81.2	44.1	0.0	12.2
Colorado[4]	462	16.2	4.5	73.8	1.8	9.6	21.2	0.0
Connecticut	527	19.9	0.0	0.0	0.0	7.2	0.0	0.0
Delaware[3]	165	14.5	0.5	0.0	0.0	78.5	0.0	15.0
Dist. of Columbia[3]	74	27.4	1.2	0.0	80.9	73.7	0.0	19.2
Florida	2,197	26.0	5.1	0.4	0.5	42.5	28.4	4.7
Georgia[3]	938	27.7	0.1	0.0	55.2	70.8	0.0	29.1
Hawaii[3]	129	25.4	0.4	1.0	0.0	86.9	2.0	0.0
Idaho	193	16.3	0.0	0.0	53.3	0.0	0.0	83.7
Illinois	2,435	13.4	0.0	0.0	0.8	6.1	0.0	68.3
Indiana[3]	759	21.4	0.3	0.0	0.8	74.7	0.0	5.9
Iowa[5]	461	17.4	0.0	43.4	0.0	1.5	83.2	0.0
Kansas[4]	253	25.1	0.2	53.0	0.4	57.3	97.7	0.0
Kentucky	693	22.8	8.2	0.0	51.8	22.6	0.0	76.0
Louisiana	1,085	16.5	0.0	0.0	0.6	0.0	0.0	77.9
Maine[6]	353	26.3	0.0	0.0	0.2	0.0	0.0	71.2

Table 6. Number of Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees in Fee-for-Service, Comprehensive Managed Care, and Prepaid Behavioral Health Plans (Continued)

		Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees		
State	Enrollees[1] (Thousands)	Enrollees (% of N)	Any Combination with a Comprehensive Managed Care Plan (%)	Any Combination with a Behavioral Health Plan with BH (%)	All Other Mgd Care Combos (%)	Any Combination with a Comprehensive Managed Care Plan (%)	Any Combination with a Behavioral Health Plan with BH (%)	All Other Mgd Care Combos (%)
Maryland[3]	833	13.4	1.7	0.0	0.1	84.7	0.0	0.0
Massachusetts	1,310	19.1	0.4	0.7	6.0	36.9	28.9	0.4
Michigan[2,3,5]	1,371	19.1	2.0	89.2	0.1	72.3	90.4	0.0
Minnesota[3]	483	25.6	41.8	0.0	0.0	65.6	0.0	0.0
Mississippi	735	20.9	0.0	0.0	54.1	0.0	0.0	91.8
Missouri	704	23.9	0.2	0.0	0.1	54.2	0.0	0.0
Montana	102	18.2	0.0	0.0	0.8	0.0	0.0	49.6
Nebraska[4]	255	16.5	0.1	53.7	0.0	18.8	88.2	0.0
Nevada	146	27.2	0.1	0.0	53.2	55.8	0.0	32.1
New Hampshire	149	19.8	0.0	0.0	0.0	0.0	0.0	0.0
New Jersey[3]	521	38.0	9.5	0.0	0.0	84.6	0.0	0.0
New Mexico[2,3,5]	228	23.8	0.0	0.0	11.6	74.8	69.0	0.2
New York[3]	4,221	17.6	1.5	0.0	3.4	75.9	0.0	0.5
North Carolina	1,669	18.8	0.0	4.7	15.0	0.0	4.8	71.0
North Dakota	68	22.7	0.0	0.0	0.2	0.0	0.0	77.3
Ohio[3]	1,149	26.9	1.3	0.0	0.0	80.8	0.0	0.0
Oklahoma	721	15.0	0.0	0.0	77.5	0.0	0.0	83.8
Oregon[3]	299	25.7	38.7	61.6	4.6	74.1	85.5	1.0
Pennsylvania[2,3,4]	969	32.6	1.4	60.5	4.1	66.1	87.4	6.1
Rhode Island[3]	139	29.0	0.3	0.0	0.3	77.4	0.0	0.0

Table 6. Number of Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees in Fee-for-Service, Comprehensive Managed Care, and Prepaid Behavioral Health Plans (Continued)

		Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees		
State	Enrollees[1] (Thousands)	Enrollees (% of N)	Any Combination with a Comprehensive Managed Care Plan (%)	Any Combination with a Behavioral Health Plan with BH (%)	All Other Mgd Care Combos (%)	Any Combination with a Comprehensive Managed Care Plan (%)	Any Combination with a Behavioral Health Plan with BH (%)	All Other Mgd Care Combos (%)
South Carolina	803	17.3	0.4	0.0	87.6	27.2	0.0	64.7
South Dakota	118	14.6	0.0	0.0	0.1	0.0	0.0	86.2
Tennessee[4]	1,142	14.8	25.7	76.6	0.1	35.5	99.9	0.0
Texas	3,949	14.8	20.5	4.6	0.3	47.1	11.4	26.4
Utah	245	11.0	0.0	11.8	76.8	0.0	10.0	77.5
Vermont	159	20.5	0.0	0.0	1.5	0.0	0.0	77.1
Virginia[3]	678	25.4	0.2	0.0	0.2	69.1	0.0	8.5
Washington[3,4]	957	16.3	0.4	99.8	0.2	62.4	99.7	0.0
West Virginia	373	21.4	0.2	0.0	0.0	54.9	0.0	7.5
Wisconsin	931	22.3	1.5	0.0	9.6	60.2	0.1	3.1
Wyoming	77	13.2	0.0	0.0	0.0	0.0	0.0	0.0

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Table 7a. Total Fee-for-Service Health Care Spending per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
All United States	**95,024**	**240**	**11,161**	**14,113**	**121,529**	**136**	**3,588**	**4,074**
Alabama	1,208	331	6,510	9,689	1,660	79	2,588	2,746
Alaska	256	291	18,160	19,814	712	252	6,299	7,451
Arizona[2,3,5]	111	272	2,786	12,148	1,029	509	4,630	9,817
Arkansas	1,291	125	10,487	13,308	1,969	80	3,173	3,411
California	9,871	354	9,869	10,172	13,767	158	4,234	4,564
Colorado[4]	1,025	258	13,698	16,236	1,459	125	3,765	3,814
Connecticut	2,387	181	22,772	27,719	1,416	133	3,350	4,098
Delaware[3]	320	375	13,363	18,513	377	128	2,661	2,872
Dist. of Columbia[3]	596	308	29,210	31,601	744	235	13,763	15,188
Florida	3,675	453	6,428	10,219	5,809	123	3,574	4,031
Georgia[3]	1,711	180	6,591	8,768	2,827	153	4,168	4,457
Hawaii[3]	352	244	10,743	12,520	293	209	3,040	3,223
Idaho	398	141	12,644	15,445	801	106	4,961	4,984
Illinois	3,210	233	9,840	11,893	6,458	126	3,063	3,380
Indiana[3]	2,003	243	12,316	15,749	1,775	135	2,978	3,325
Iowa[5]	1,153	240	14,366	16,168	1,357	128	3,564	4,076
Kansas[4]	847	268	13,361	16,147	816	171	4,310	4,359
Kentucky	1,341	176	8,469	10,630	2,959	117	5,531	5,585
Louisiana	1,557	182	8,688	11,982	3,291	112	3,633	3,809
Maine[6]	-	-	-	-	-	-	-	-

Table 7a. Total Fee-for-Service Health Care Spending per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
Maryland[3]	1,716	224	15,383	19,169	2,067	222	2,866	7,775
Massachusetts	3,346	389	13,407	15,497	3,002	162	2,831	4,150
Michigan[2,3,5]	1,662	218	6,339	7,651	1,745	120	1,574	1,832
Minnesota[3]	2,318	269	18,721	25,333	2,067	147	5,749	6,536
Mississippi	1,151	280	7,505	9,794	1,911	119	3,285	3,862
Missouri	1,858	102	11,047	11,538	2,284	107	4,267	4,774
Montana	241	235	13,033	14,813	396	138	4,762	5,190
Nebraska[4]	596	216	14,118	15,987	805	109	3,778	4,101
Nevada	309	239	7,749	10,897	609	199	5,713	6,392
New Hampshire	435	176	14,745	17,794	500	124	4,185	4,768
New Jersey[3]	3,405	282	17,199	21,483	2,298	169	7,109	8,356
New Mexico[2,3,5]	565	335	10,429	11,833	532	233	3,063	3,838
New York[3]	17,262	255	23,227	28,699	16,576	202	4,767	5,734
North Carolina	2,856	111	9,118	11,465	5,883	102	4,339	4,573
North Dakota	308	450	19,839	23,331	235	129	4,449	4,765
Ohio[3]	4,668	131	15,113	17,856	3,545	116	4,221	4,731
Oklahoma	1,108	114	10,240	12,313	2,127	133	3,471	3,697
Oregon[3]	679	680	8,812	11,549	678	189	3,047	3,507
Pennsylvania[2,3,4]	3,884	861	12,278	14,914	2,020	115	3,096	3,379
Rhode Island[3]	694	544	17,264	20,890	530	205	5,381	5,733

Table 7a. Total Fee-for-Service Health Care Spending per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
South Carolina	1,063	289	7,627	8,870	2,091	120	3,150	3,297
South Dakota	250	1,912	14,499	14,911	411	186	4,080	4,201
Tennessee[4]	1,625	801	9,609	14,937	2,714	112	2,789	2,809
Texas	4,384	457	7,490	12,167	8,987	127	2,672	2,850
Utah	276	359	10,274	11,124	748	172	3,426	3,603
Vermont	327	170	10,037	10,812	576	113	4,561	4,999
Virginia[3]	1,596	330	9,279	11,931	1,865	207	3,686	4,133
Washington[3,4]	727	104	4,672	5,572	1,757	111	2,192	2,468
West Virginia	718	290	9,013	11,651	1,143	100	3,899	4,106
Wisconsin	1,479	167	7,123	8,207	1,603	90	2,216	2,432
Wyoming	207	349	20,184	25,018	304	174	4,526	5,377

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Table 7b. Fee-for-Service Health Care Spending on Behavioral Health (MH and SA) Disorders per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
All United States	**7,171**	**158**	**843**	**3,187**	**21,599**	**151**	**638**	**3,331**
Alabama	87	108	467	2,387	275	103	428	2,085
Alaska	34	201	2,400	7,636	182	232	1,612	9,315
Arizona[2,3,5]	5	533	115	5,651	64	464	286	7,911
Arkansas	108	96	875	3,596	488	111	787	3,864
California	799	189	798	3,646	3,177	180	977	5,229
Colorado[4]	54	232	719	2,811	120	110	310	2,062
Connecticut	183	118	1,746	4,143	369	163	873	4,041
Delaware[3]	20	464	828	3,760	77	219	547	2,360
Dist. of Columbia[3]	27	189	1,318	5,700	88	191	1,631	5,790
Florida	428	340	749	3,734	638	151	393	2,629
Georgia[3]	86	117	330	1,698	309	123	455	2,521
Hawaii[3]	19	139	571	2,556	63	207	649	4,793
Idaho	44	84	1,407	4,512	172	91	1,064	4,622
Illinois	380	154	1,166	3,979	1,021	154	484	3,079
Indiana[3]	180	75	1,105	3,484	359	92	602	3,206
Iowa[5]	79	198	988	2,612	198	175	519	2,574
Kansas[4]	37	153	586	1,831	120	233	636	3,525
Kentucky	125	172	790	2,668	545	159	1,019	2,999
Louisiana	86	187	482	2,262	320	129	353	1,814
Maine[6]	-	-	-	-	-	-	-	-

Table 7b. Fee-for-Service Health Care Spending on Behavioral Health (MH and SA) Disorders per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
Maryland[3]	126	250	1,132	3,969	578	200	802	4,740
Massachusetts	360	151	1,441	3,576	349	144	329	2,262
Michigan[2,3,5]	86	111	327	844	286	105	258	1,111
Minnesota[3]	289	186	2,334	7,394	458	151	1,274	5,616
Mississippi	83	151	543	2,427	326	152	561	3,315
Missouri	197	112	1,174	2,753	487	121	910	3,418
Montana	28	109	1,536	4,458	112	124	1,346	5,138
Nebraska[4]	53	144	1,248	3,225	171	163	801	3,512
Nevada	17	122	428	1,776	149	226	1,403	6,813
New Hampshire	69	146	2,327	5,693	114	140	956	3,642
New Jersey[3]	237	128	1,195	4,253	572	148	1,770	5,561
New Mexico[2,3,5]	26	345	485	2,899	29	281	168	2,549
New York[3]	1,014	208	1,364	5,366	3,296	201	948	5,341
North Carolina	250	98	798	2,541	1,395	125	1,029	4,528
North Dakota	19	139	1,214	3,745	46	136	864	3,433
Ohio[3]	312	137	1,009	2,773	765	105	911	2,655
Oklahoma	80	108	742	2,374	407	151	664	3,315
Oregon[3]	140	635	1,816	7,462	122	126	551	1,768
Pennsylvania[2,3,4]	175	294	555	2,333	213	121	326	1,604
Rhode Island[3]	104	392	2,578	7,493	126	213	1,277	6,515

Table 7b. Fee-for-Service Health Care Spending on Behavioral Health (MH and SA) Disorders per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
South Carolina	74	121	533	1,821	302	136	455	2,447
South Dakota	43	764	2,493	11,154	109	351	1,087	5,373
Tennessee[4]	50	567	298	3,353	189	113	194	937
Texas	148	168	253	1,559	857	160	255	1,944
Utah	20	155	758	1,779	83	140	382	1,934
Vermont	23	135	712	1,838	179	142	1,417	4,168
Virginia[3]	147	229	853	3,190	506	275	1,001	5,513
Washington[3,4]	48	50	311	739	221	100	276	1,947
West Virginia	48	114	601	2,022	237	122	808	2,435
Wisconsin	108	79	521	1,526	262	98	362	1,742
Wyoming	16	191	1,593	5,145	66	229	979	4,999

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: MHSA = mental health and substance abuse

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Table 7c. Fee-for-Service Health Care Spending on Mental Health Issues per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
All United States	**6,826**	**161**	**802**	**3,075**	**19,875**	**156**	**587**	**3,206**
Alabama	83	41	447	2,316	271	104	422	2,079
Alaska	32	196	2,254	7,388	176	235	1,555	9,380
Arizona[2,3,5]	4	641	97	5,646	32	334	146	5,014
Arkansas	105	94	854	3,533	486	111	784	3,862
California	756	224	755	3,538	3,032	208	932	5,241
Colorado[4]	49	223	658	2,628	111	109	287	1,976
Connecticut	171	115	1,628	3,920	330	169	781	3,789
Delaware[3]	19	457	793	3,656	72	209	507	2,219
Dist. of Columbia[3]	26	189	1,274	5,631	83	196	1,542	5,679
Florida	416	336	727	3,657	603	151	371	2,563
Georgia[3]	82	116	314	1,642	300	124	442	2,483
Hawaii[3]	18	142	544	2,464	59	212	616	4,878
Idaho	44	83	1,389	4,492	170	90	1,050	4,588
Illinois	366	150	1,121	3,862	920	150	436	2,852
Indiana[3]	176	75	1,080	3,439	350	93	587	3,214
Iowa[5]	77	197	961	2,555	196	175	516	2,569
Kansas[4]	36	150	564	1,772	119	234	630	3,528
Kentucky	122	170	773	2,632	514	154	961	2,869
Louisiana	84	184	467	2,217	311	127	344	1,780
Maine[6]	-	-	-	-	-	-	-	-

Table 7c. Fee-for-Service Health Care Spending on Mental Health Issues per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
Maryland[3]	123	255	1,105	3,953	568	199	788	4,702
Massachusetts	331	168	1,326	3,373	303	146	286	2,064
Michigan[2,3,5]	83	109	316	819	281	105	254	1,101
Minnesota[3]	278	190	2,243	7,200	432	153	1,202	5,396
Mississippi	80	149	522	2,386	311	149	535	3,211
Missouri	192	113	1,139	2,691	453	127	846	3,260
Montana	26	103	1,424	4,199	108	124	1,302	5,075
Nebraska[4]	51	141	1,202	3,123	157	156	737	3,279
Nevada	16	119	411	1,725	147	225	1,377	6,779
New Hampshire	66	152	2,251	5,591	109	156	913	3,539
New Jersey[3]	231	140	1,169	4,220	547	186	1,692	5,547
New Mexico[2,3,5]	25	337	461	2,848	27	276	155	2,485
New York[3]	950	216	1,278	5,169	2,534	226	729	4,548
North Carolina	242	98	771	2,480	1,359	127	1,002	4,483
North Dakota	18	136	1,143	3,558	43	139	807	3,273
Ohio[3]	298	139	964	2,681	684	112	815	2,497
Oklahoma	78	107	723	2,329	400	150	652	3,293
Oregon[3]	111	541	1,438	5,973	110	127	494	1,627
Pennsylvania[2,3,4]	170	288	538	2,277	203	123	311	1,629
Rhode Island[3]	100	424	2,481	7,422	119	224	1,210	6,464

Table 7c. Fee-for-Service Health Care Spending on Mental Health Issues per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
South Carolina	72	120	515	1,778	286	136	430	2,363
South Dakota	41	722	2,355	10,543	99	325	981	4,916
Tennessee[4]	49	560	290	3,304	181	111	186	908
Texas	145	166	248	1,530	848	161	252	1,941
Utah	19	163	718	1,709	76	147	350	1,819
Vermont	21	130	640	1,677	153	141	1,210	3,701
Virginia[3]	143	226	832	3,135	499	276	987	5,501
Washington[3,4]	43	50	274	656	167	114	209	1,579
West Virginia	47	113	586	1,988	226	121	771	2,349
Wisconsin	100	76	481	1,422	242	100	334	1,630
Wyoming	15	184	1,491	4,902	64	233	960	5,007

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: AA = alcohol abuse; DA = drug abuse

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Table 7d. Fee-for-Service Health Care Spending on Substance Use (AA and DA) Disorders per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
All United States	**345**	**114**	**41**	**3,917**	**1,725**	**109**	**51**	**3,408**
Alabama	4	106	19	3,105	4	60	6	735
Alaska	2	312	147	6,054	6	173	56	3,044
Arizona[2,3,5]	1	276	17	4,251	31	776	140	11,889
Arkansas	3	295	22	3,775	2	154	3	1,009
California	43	50	43	3,679	145	47	45	2,388
Colorado[4]	5	393	61	5,141	9	129	23	1,784
Connecticut	12	177	117	4,048	39	125	92	3,240
Delaware[3]	1	700	35	3,983	6	622	40	4,163
Dist. of Columbia[3]	1	195	44	3,238	5	129	89	2,530
Florida	13	580	22	5,187	35	149	22	2,227
Georgia[3]	4	142	16	2,172	9	118	13	1,490
Hawaii[3]	1	102	26	2,650	3	139	34	1,664
Idaho	1	166	18	1,521	2	210	13	2,066
Illinois	15	426	45	5,271	101	207	48	3,996
Indiana[3]	4	93	25	3,091	9	68	15	1,290
Iowa[5]	2	229	27	2,870	1	198	4	873
Kansas[4]	1	394	23	3,343	1	157	6	869
Kentucky	3	451	18	2,579	31	318	58	3,169
Louisiana	3	373	14	2,349	9	263	10	1,705
Maine[6]	-	-	-	-	-	-	-	-

Table 7d. Fee-for-Service Health Care Spending on Substance Use (AA and DA) Disorders per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
Maryland[3]	3	134	27	1,886	10	303	14	3,051
Massachusetts	28	70	114	3,303	46	129	43	1,926
Michigan[2,3,5]	3	333	11	2,034	5	167	4	688
Minnesota[3]	11	124	91	4,868	26	130	72	4,689
Mississippi	3	183	21	1,601	15	295	26	2,910
Missouri	6	93	35	2,239	35	76	65	3,130
Montana	2	445	112	6,606	4	139	44	2,407
Nebraska[4]	2	399	45	4,205	14	298	65	4,459
Nevada	1	257	17	2,360	3	277	27	2,605
New Hampshire	2	68	76	3,649	5	43	43	2,291
New Jersey[3]	5	25	26	2,554	25	27	77	2,382
New Mexico[2,3,5]	1	630	24	2,288	2	363	13	2,270
New York[3]	64	130	86	5,104	762	145	219	5,998
North Carolina	9	87	27	2,284	36	70	27	2,062
North Dakota	1	230	71	6,079	3	105	57	2,939
Ohio[3]	14	101	45	3,003	81	71	96	2,849
Oklahoma	2	159	19	2,028	7	176	11	1,636
Oregon[3]	29	1,911	378	67,674	13	119	57	3,096
Pennsylvania[2,3,4]	5	899	16	6,024	10	92	15	696
Rhode Island[3]	4	136	98	3,205	7	111	67	2,521

Table 7d. Fee-for-Service Health Care Spending on Substance Use (AA and DA) Disorders per Enrollee for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]	Total Payments ($ Millions)	Avg. Payment per Claim ($)[1]	Avg. Payment per Enrollee ($)	Avg. Payment per User ($)[1]
South Carolina	2	153	18	2,146	17	139	25	2,370
South Dakota	2	36,655	138	264,728	11	1,432	105	13,201
Tennessee[4]	1	985	9	3,839	8	254	8	1,385
Texas	3	458	5	6,453	8	103	2	816
Utah	1	82	40	1,822	7	91	32	2,113
Vermont	2	192	72	3,661	26	145	207	4,184
Virginia[3]	4	408	21	3,663	7	235	14	2,139
Washington[3,4]	6	50	38	2,202	54	72	67	3,441
West Virginia	1	149	15	2,025	11	133	37	2,060
Wisconsin	8	174	40	3,893	20	77	28	2,575
Wyoming	1	384	102	6,669	1	128	19	1,518

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: AA = alcohol abuse; DA = drug abuse

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Table 8. Percentage of Total Medicaid Fee-for-Service Spending on Behavioral Health Conditions for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Spending ($ Millions)	Spending on Behavioral Health Disorders(%)	Spending on Mental Health Disorders (%)	Spending on Substance Use Disorders (%)	Total Spending ($ Millions)	Spending on Behavioral Health Disorders(%)	Spending on Mental Health Disorders (%)	Spending on Substance Use Disorders (%)
All United States	**95,024**	**7.5**	**7.2**	**0.4**	**121,529**	**17.8**	**16.4**	**1.4**
Alabama	1,208	7.2	6.9	0.3	1,660	16.5	16.3	0.2
Alaska	256	13.2	12.4	0.8	712	25.6	24.7	0.9
Arizona[1,2,4]	111	4.1	3.5	0.6	1,029	6.2	3.2	3.0
Arkansas	1,291	8.3	8.1	0.2	1,969	24.8	24.7	0.1
California	9,871	8.1	7.7	0.4	13,767	23.1	22.0	1.1
Colorado[3]	1,025	5.3	4.8	0.4	1,459	8.2	7.6	0.6
Connecticut	2,387	7.7	7.2	0.5	1,416	26.1	23.3	2.8
Delaware[2]	320	6.2	5.9	0.3	377	20.6	19.1	1.5
Dist. of Columbia[2]	596	4.5	4.4	0.1	744	11.9	11.2	0.6
Florida	3,675	11.7	11.3	0.3	5,809	11.0	10.4	0.6
Georgia[2]	1,711	5.0	4.8	0.2	2,827	10.9	10.6	0.3
Hawaii[2]	352	5.3	5.1	0.2	293	21.4	20.2	1.1
Idaho	398	11.1	11.0	0.1	801	21.4	21.2	0.3
Illinois	3,210	11.8	11.4	0.5	6,458	15.8	14.2	1.6
Indiana[2]	2,003	9.0	8.8	0.2	1,775	20.2	19.7	0.5
Iowa[4]	1,153	6.9	6.7	0.2	1,357	14.6	14.5	0.1
Kansas[3]	847	4.4	4.2	0.2	816	14.8	14.6	0.1
Kentucky	1,341	9.3	9.1	0.2	2,959	18.4	17.4	1.0
Louisiana	1,557	5.5	5.4	0.2	3,291	9.7	9.5	0.3
Maine[5]	-	-	-	-	-	-	-	-

Table 8. Percentage of Total Medicaid Fee-for-Service Spending on Behavioral Health Conditions for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
State	Total Spending ($ Millions)	Spending on Behavioral Health Disorders(%)	Spending on Mental Health Disorders (%)	Spending on Substance Use Disorders (%)	Total Spending ($ Millions)	Spending on Behavioral Health Disorders(%)	Spending on Mental Health Disorders (%)	Spending on Substance Use Disorders (%)
Maryland[2]	1,716	7.4	7.2	0.2	2,067	28.0	27.5	0.5
Massachusetts	3,346	10.7	9.9	0.9	3,002	11.6	10.1	1.5
Michigan[1,2,4]	1,662	5.2	5.0	0.2	1,745	16.4	16.1	0.3
Minnesota[2]	2,318	12.5	12.0	0.5	2,067	22.2	20.9	1.2
Mississippi	1,151	7.2	7.0	0.3	1,911	17.1	16.3	0.8
Missouri	1,858	10.6	10.3	0.3	2,284	21.3	19.8	1.5
Montana	241	11.8	10.9	0.9	396	28.3	27.3	0.9
Nebraska[4]	596	8.8	8.5	0.3	805	21.2	19.5	1.7
Nevada	309	5.5	5.3	0.2	609	24.6	24.1	0.5
New Hampshire	435	15.8	15.3	0.5	500	22.9	21.8	1.0
New Jersey[2]	3,405	7.0	6.8	0.2	2,298	24.9	23.8	1.1
New Mexico[1,2,4]	565	4.7	4.4	0.2	532	5.5	5.1	0.4
New York[2]	17,262	5.9	5.5	0.4	16,576	19.9	15.3	4.6
North Carolina	2,856	8.8	8.5	0.3	5,883	23.7	23.1	0.6
North Dakota	308	6.1	5.8	0.4	235	19.4	18.1	1.3
Ohio[2]	4,668	6.7	6.4	0.3	3,545	21.6	19.3	2.3
Oklahoma	1,108	7.2	7.1	0.2	2,127	19.1	18.8	0.3
Oregon[2]	679	20.6	16.3	4.3	678	18.1	16.2	1.9
Pennsylvania[1,2,3]	3,884	4.5	4.4	0.1	2,020	10.5	10.1	0.5
Rhode Island[2]	694	14.9	14.4	0.6	530	23.7	22.5	1.2

Table 8. Percentage of Total Medicaid Fee-for-Service Spending on Behavioral Health Conditions for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees (Continued)

State	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
	Total Spending ($ Millions)	Spending on Behavioral Health Disorders(%)	Spending on Mental Health Disorders (%)	Spending on Substance Use Disorders (%)	Total Spending ($ Millions)	Spending on Behavioral Health Disorders(%)	Spending on Mental Health Disorders (%)	Spending on Substance Use Disorders (%)
South Carolina	1,063	7.0	6.8	0.2	2,091	14.5	13.7	0.8
South Dakota	250	17.2	16.2	1.0	411	26.6	24.1	2.6
Tennessee[3]	1,625	3.1	3.0	0.1	2,714	7.0	6.7	0.3
Texas	4,384	3.4	3.3	0.1	8,987	9.5	9.4	0.1
Utah	276	7.4	7.0	0.4	748	11.1	10.2	0.9
Vermont	327	7.1	6.4	0.7	576	31.1	26.5	4.5
Virginia[2]	1,596	9.2	9.0	0.2	1,865	27.1	26.8	0.4
Washington[2,3]	727	6.7	5.9	0.8	1,757	12.6	9.5	3.1
West Virginia	718	6.7	6.5	0.2	1,143	20.7	19.8	1.0
Wisconsin	1,479	7.3	6.8	0.6	1,603	16.3	15.1	1.3
Wyoming	207	7.9	7.4	0.5	304	21.6	21.2	0.4

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] States paid over 50% of their Medicaid expenditures as premiums.

[2] States had greater than 50% enrollment in comprehensive managed care plans.

[3] States had rates of behavioral managed care enrollment greater than 80%.

[4] States had rates of behavioral managed care enrollment greater than 50%.

[5] Maine provides only prescription drug claims in MAX.

Table 9. Percentage of Fee-for-Service Behavioral Health Spending on Medicare-Medicaid Enrollees

State	Percentage of MMEs	Total Spending for MMEs ($ Millions)			Spending for MMEs (%)		
		Behavioral Health Disorders	Mental Health Disorders	Substance Use Disorders	Behavioral Health Disorders	Mental Health Disorders	Substance Use Disorders
All United States	**20.1**	**7,171**	**6,826**	**345**	**24.9**	**23.7**	**1.2**
Alabama	22.4	87	83	4	24.0	23.0	1.0
Alaska	11.1	34	32	2	15.6	14.7	1.0
Arizona[1,2,4]	15.2	5	4	1	6.7	5.7	1.0
Arkansas	16.6	108	105	3	18.1	17.6	0.4
California	23.5	799	756	43	20.1	19.0	1.1
Colorado[3]	16.2	54	49	5	31.0	28.3	2.6
Connecticut	19.9	183	171	12	33.1	30.9	2.2
Delaware[2]	14.5	20	19	1	20.4	19.5	0.9
Dist. of Columbia[2]	27.4	27	26	1	23.4	22.6	0.8
Florida	26.0	428	416	13	40.2	39.0	1.2
Georgia[2]	27.7	86	82	4	21.7	20.7	1.0
Hawaii[2]	25.4	19	18	1	23.0	21.9	1.1
Idaho	16.3	44	44	1	20.5	20.2	0.3
Illinois	13.4	380	366	15	27.1	26.1	1.1
Indiana[2]	21.4	180	176	4	33.4	32.6	0.7
Iowa[4]	17.4	79	77	2	28.6	27.8	0.8
Kansas[3]	25.1	37	36	1	23.6	22.7	0.9
Kentucky	22.8	125	122	3	18.7	18.2	0.4
Louisiana	16.5	86	84	3	21.2	20.6	0.6
Maine[5]	-	-	-	-	-	-	-

Table 9. Percentage of Fee-for-Service Behavioral Health Spending on Medicare-Medicaid Enrollees (Continued)

State	Percentage of MMEs	Total Spending for MMEs ($ Millions)			Spending for MMEs (%)		
		Behavioral Health Disorders	Mental Health Disorders	Substance Use Disorders	Behavioral Health Disorders	Mental Health Disorders	Substance Use Disorders
Maryland[2]	13.4	126	123	3	17.9	17.5	0.4
Massachusetts	19.1	360	331	28	50.7	46.7	4.0
Michigan[1,2,4]	19.1	86	83	3	23.1	22.3	0.8
Minnesota[2]	25.6	289	278	11	38.7	37.2	1.5
Mississippi	20.9	83	80	3	20.3	19.5	0.8
Missouri	23.9	197	192	6	28.8	28.0	0.8
Montana	18.2	28	26	2	20.2	18.8	1.5
Nebraska[3]	16.5	53	51	2	23.6	22.7	0.9
Nevada	27.2	17	16	1	10.2	9.8	0.4
New Hampshire	19.8	69	66	2	37.5	36.3	1.2
New Jersey[2]	38.0	237	231	5	29.3	28.6	0.6
New Mexico[1,2,4,]	23.8	26	25	1	47.5	45.2	2.3
New York[2]	17.6	1,014	950	64	23.5	22.0	1.5
North Carolina	18.8	250	242	9	15.2	14.7	0.5
North Dakota	22.7	19	18	1	29.2	27.5	1.7
Ohio[2]	26.9	312	298	14	29.0	27.7	1.3
Oklahoma	15.0	80	78	2	16.5	16.0	0.4
Oregon[2]	25.7	140	111	29	53.3	42.2	11.1
Pennsylvania[1,2,3]	32.6	175	170	5	45.2	43.8	1.3
Rhode Island[2]	29.0	104	100	4	45.2	43.5	1.7

Table 9. Percentage of Fee-for-Service Behavioral Health Spending on Medicare-Medicaid Enrollees (Continued)

State	Percentage of MMEs	Total Spending for MMEs ($ Millions)			Spending for MMEs (%)		
		Behavioral Health Disorders	Mental Health Disorders	Substance Use Disorders	Behavioral Health Disorders	Mental Health Disorders	Substance Use Disorders
South Carolina	17.3	74	72	2	19.7	19.1	0.7
South Dakota	14.6	43	41	2	28.2	26.6	1.6
Tennessee[3]	14.8	50	49	1	21.1	20.5	0.6
Texas	14.8	148	145	3	14.7	14.4	0.3
Utah	11.0	20	19	1	19.6	18.6	1.0
Vermont	20.5	23	21	2	11.5	10.3	1.2
Virginia[2]	25.4	147	143	4	22.5	21.9	0.5
Washington[2,3]	16.3	48	43	6	18.0	15.8	2.2
West Virginia	21.4	48	47	1	16.8	16.4	0.4
Wisconsin	22.3	108	100	8	29.2	27.0	2.3
Wyoming	13.2	16	15	1	19.9	18.6	1.3

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] States paid over 50% of their Medicaid expenditures as premiums.

[2] States had greater than 50% enrollment in comprehensive managed care plans.

[3] States had rates of behavioral managed care enrollment greater than 80%.

[4] States had rates of behavioral managed care enrollment greater than 50%.

[5] Maine provides only prescription drug claims in MAX.

Table 10a. Fee-for-Service Spending by Provider on Total Health Care for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
Services and Products	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)
Total all services and products	95,037	240	11,162	14,115	121,727	136	3,588	4,074
Total all service providers	93,537	272	10,986	15,073	99,049	163	2,919	4,150
All hospitals	6,132	284	720	2,060	39,924	503	1,177	3,511
Physicians	4,618	49	542	901	18,560	56	547	885
Dentists	388	409	46	2,318	3,555	616	105	3,845
Other professionals	5,221	152	613	2,278	10,318	115	304	1,470
Nursing home	57,550	1,422	6,759	41,233	13,376	1,163	394	42,747
Home health	17,299	130	2,032	9,064	10,571	159	312	5,301
Transportation	902	89	106	1,100	1,015	95	30	660
Durable medical equipment (DME)	295	226	35	1,318	310	171	9	528
Other personal and public health	529	106	62	3,266	1,101	112	32	2,357
Day care[3]	604	276	71	12,117	319	385	9	11,878
Prescription drugs	1,501	29	176.2	445	22,678	79	668	1,142

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine.

[1] Calculation includes only those claims with a diagnosis and provider category.

[2] Fee-for-service enrollment in 2008 was 8,514,234 for MMEs and 33,927,542 for non-MMEs.

[3] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 10b. Fee-for-Service Spending by Provider on Behavioral Health Care for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
Services and Products	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)
Total all services and products	7,175	158	843	3,187	21,662	151	638	3,331
Total all service providers	6,847	196	804	5,262	15,669	166	462	4,020
All hospitals	1,021	212	120	2,837	5,823	364	172	5,461
Physicians	212	45	25	355	806	54	24	416
Dentists	0	31	0	70	0	91	0	253
Other professionals	1,603	124	188	2,907	5,170	124	152	2,698
Nursing home	2,860	1,177	336	21,114	1,214	591	36	16,355
Home health	761	147	89	7,774	1,682	165	50	5,980
Transportation	26	90	3	527	53	115	2	539
Durable medical equipment (DME)	1	112	0	688	3	36	0	393
Other personal and public health	346	78	41	2,367	891	100	26	2,209
Day care[3]	17	193	2	11,291	26	32	1	11,302
Prescription drugs	327	31	38.5	231	5,994	122	177	1,221

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine.

[1] Calculation includes only those claims with a diagnosis and provider category.

[2] Fee-for-service enrollment in 2008 was 8,514,234 for MMEs and 33,927,542 for non-MMEs.

[3] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 10c. Fee-for-Service Spending by Provider on Mental Health Care for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
Services and Products	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)
Total all services and products	6,829	161	802	3,075	19,931	156	587	3,206
Total all service providers	6,504	204	764	5,201	14,023	177	413	3,907
All hospitals	936	224	110	2,835	4,786	452	141	5,361
Physicians	174	47	20	309	607	61	18	349
Dentists	0	32	0	74	0	78	0	213
Other professionals	1,520	129	179	2,840	4,933	131	145	2,701
Nursing home	2,749	1,163	323	20,892	1,140	578	34	16,374
Home health	748	147	88	7,745	1,665	165	49	5,998
Transportation	24	89	3	539	47	110	1	532
Durable medical equipment (DME)	1	116	0	769	3	36	0	472
Other personal and public health	334	78	39	2,372	817	100	24	2,213
Day care[3]	17	192	2	11,235	26	395	1	11,307
Prescription drugs	325	31	38.2	230	5,908	121	174	1,207

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine.

[1] Calculation includes only those claims with a diagnosis and provider category.

[2] Fee-for-service enrollment in 2008 was 8,514,234 for MMEs and 33,927,542 for non-MMEs.

[3] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 10d. Fee-for-Service Spending by Provider on Substance Use Treatment for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
Services and Products	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)	Total Payments ($ Millions)	Avg. Payment per Claim[1] ($)	Avg. Payment per Enrollee[2] ($)	Avg. Payment per User[1] ($)
Total all services and products	346	114	41	3,917	1,732	109	51	3,408
Total all service providers	343	113	40	3,226	1,646	106	49	3,186
All hospitals	85	131	10	1,893	1,037	191	31	4,439
Physicians	38	37	4	745	199	40	6	699
Dentists	0	12	0	15	0	267	0	1,025
Other professionals	83	79	10	3,302	238	58	7	1,918
Nursing home	111	1,719	13	24,960	74	920	2	13,397
Home health	13	171	2	7,605	17	175	1	3,621
Transportation	2	105	0	305	6	160	0	470
Durable medical equipment (DME)	0	51	0	145	0	29	0	54
Other personal and public health	12	79	1	1,639	74	103	2	1,869
Day care[3]	0	470	0	17,765	0	658	0	5,264
Prescription drugs	2	151	0.3	727	86	198	3	1,331

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine.

[1] Calculation includes only those claims with a diagnosis and provider category.

[2] Fee-for-service enrollment in 2008 was 8,514,234 for MMEs and 33,927,542 for non-MMEs.

[3] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Table 10e. Fee-for-Service Spending on Prescription Medications for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees

	Medicare-Medicaid Enrollees				Non-Medicare-Medicaid Enrollees			
Drug Spending by Diagnosis and Therapeutic Class	**Total Payments ($ Millions)**	**Avg. Payment per Claim[1] ($)**	**Avg. Payment per Enrollee[2] ($)**	**Avg. Payment per User[1] ($)**	**Total Payments ($ Millions)**	**Avg. Payment per Claim[1] ($)**	**Avg. Payment per Enrollee[2] ($)**	**Avg. Payment per User[1] ($)**
All Drugs	**1,501**	**29**	**176**	**445**	**22,678**	**79**	**668**	**1,142**
Total MHSA drugs	327	31	38	231	5,994	122	177	1,221
Total SA Drugs	**2**	**151**	**0**	**727**	**86**	**198**	**3**	**1,331**
Opiate partial agonists[3]	2	200	0	1,223	75	217	2	1,765
Opiate antagonists, NEC[4]	0	93	0	376	5	131	0	610
Misc. therapeutic agents, NEC[5]	0	80	0	259	5	111	0	354
Total MH Drugs	**325**	**31**	**38**	**230**	**5,908**	**121**	**174**	**1,207**
Psychotherapeutic, antidepressants	56	36	7	224	878	51	26	336
Psychotherapeutic, tranquilizers/antipsychotics	153	187	18	1,279	3,730	309	110	2,764
Stimulants and CNS agents, misc.	7	112	1	567	999	120	29	801
Anxiolytics, sedatives, hypnotics (ASH), benzo.	94	13	11	81	104	18	3	93
Anxiolytics, sedatives, hypnotics (ASH), NEC	14	18	2	108	179	39	5	147
Antimanic agents, NEC	1	15	0	74	16	23	0	150

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: benzo = benzodiazepines; MH = mental health; misc. = miscellaneous; NEC = not elsewhere classified; SA = substance abuse

[1] Calculation includes only those claims with a national drug code (NDC).

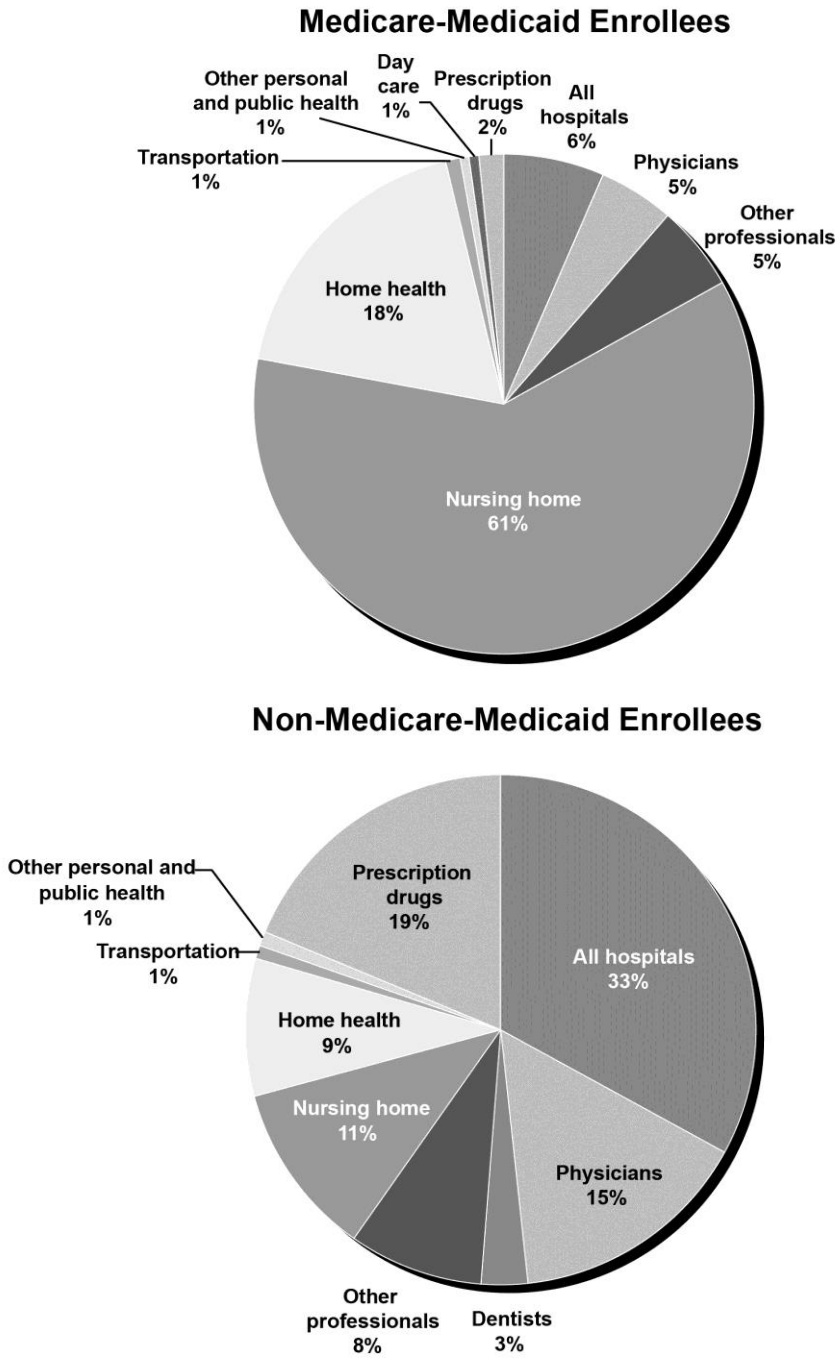
[2] Fee-for-service enrollment in 2008 was 8,514,234 for MMEs and 33,927,542 for non-MMEs.

[3] Includes buprenorphine hydrochloride and buprenophine/naloxone combination.

[4] Includes naltrexone HCl used to treat alcohol and drug addiction.

[5] Includes disulfiram and acamprosate used to treat alcohol addiction.

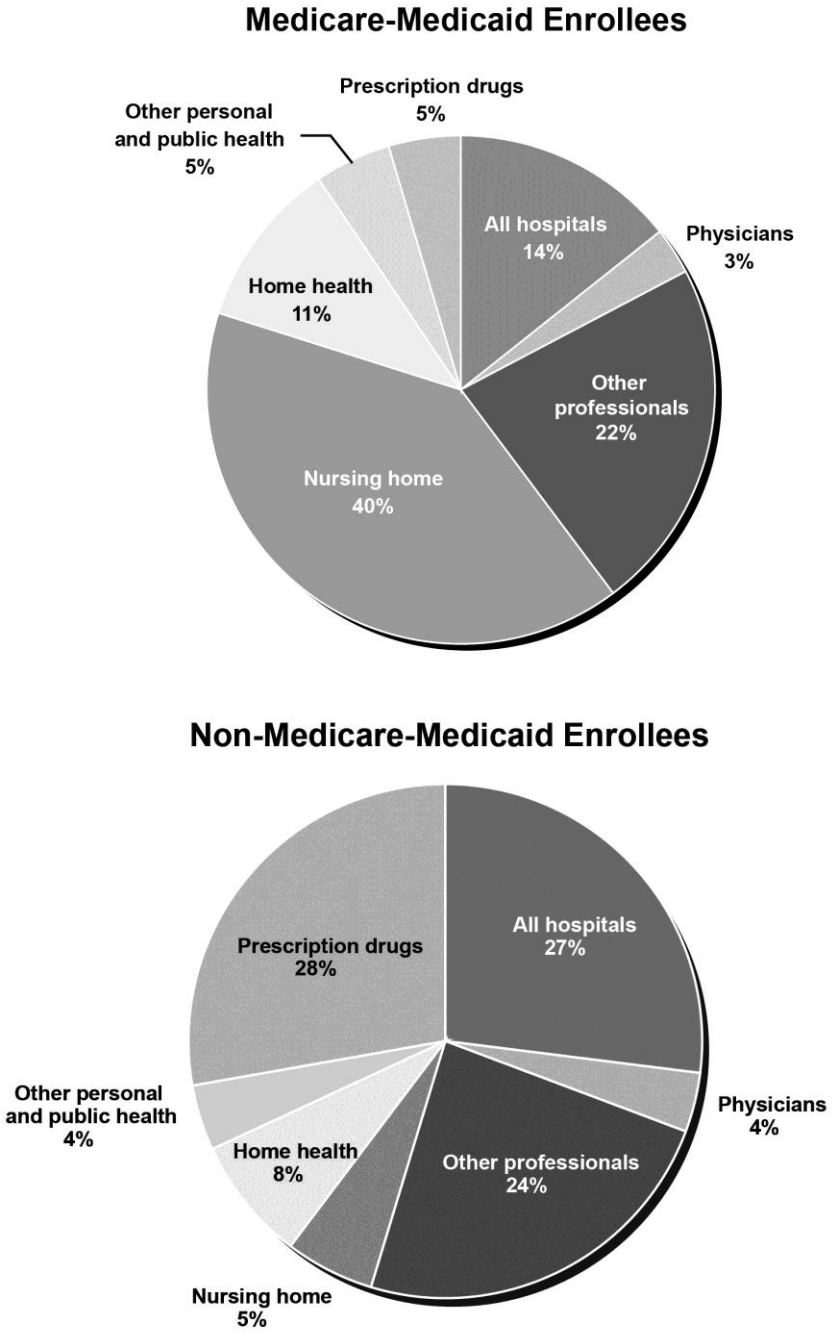
Figure 1. Distribution of Medicaid Spending on General Health for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees



Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: There was less than 1% of spending on the following provider types for Medicare-Medicaid enrollees: dentists and durable medical equipment (DME). There was less than 1% of spending on the following provider types for Non-Medicare-Medicaid enrollees: durable medical equipment (DME) and day care.

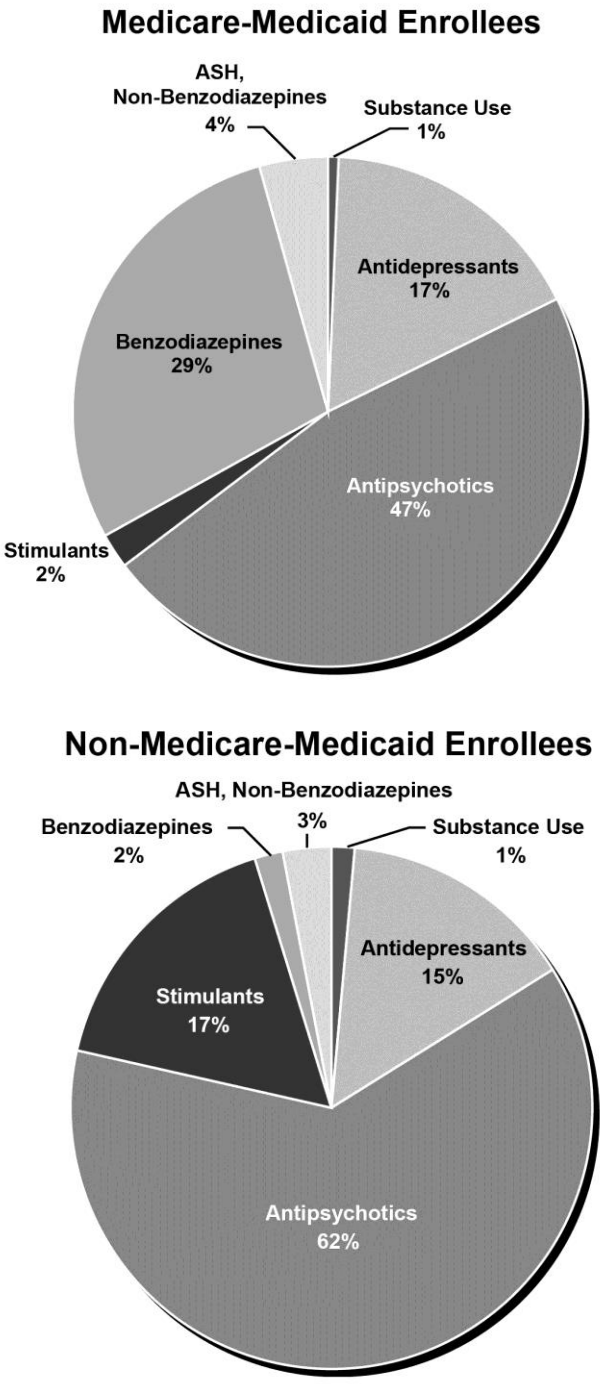
Figure 2. Distribution of Medicaid Spending on Behavioral Health for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees



Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: There was less than 1% of spending on the following provider types for both Medicare-Medicaid enrollees and non-Medicare-Medicaid enrollees: dentists, transportation, day care, and durable medical equipment (DME).

Figure 3. Distribution of Medicaid Spending on Behavioral Health Prescriptions for Medicare-Medicaid Enrollees and Non-Medicare-Medicaid Enrollees



Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: ASH = anxiolytics, sedatives, and hypnotics

Note: There was less than 1% of spending on antimanic agents.

Table 11. Share of Medicaid Fee-for-Service Spending by Provider Type for Medicare-Medicaid Enrollees

Provider Type	All Health (%)	General Health (%)	Behavioral Health (%)	Mental Health (%)	Substance Use (%)
Total all services and products	43.8	46.6	25.3	26.0	16.6
Total all service providers	48.6	50.8	31.0	32.4	17.2
All hospitals	13.3	13.0	14.9	16.3	7.5
Physicians	19.9	19.9	20.8	22.3	15.9
Dentists	9.8	9.9	0.3	0.3	0.1
Other professionals	33.6	40.5	24.3	24.2	26.4
Nursing home	81.1	81.8	70.5	71.0	59.4
Home health	62.1	64.2	36.1	36.0	44.9
Transportation	47.0	48.3	24.5	25.3	16.4
Durable medical equipment (DME)	48.7	48.9	25.2	25.4	19.6
Other personal and public health	32.4	46.7	28.0	29.0	13.8
Day care[1]	65.5	66.4	43.3	43.0	105.7
Prescription drugs	6.2	6.6	5.2	5.2	2.5

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Section 3: Managed Care Tabulations of MAX Medicaid Claims

Medicaid paid 23.5 percent of its spending to managed care companies in the form of premiums in 2008 (Table 1). Managed care plans (including limited benefit plans, such as behavioral health or dental carve-outs) providing full or partial coverage in combination with FFS coverage accounted for more than 70 percent of Medicaid enrollment at the national level (Table 12). Medicaid managed care plans included comprehensive plans, limited benefit plans (such as behavioral health or dental), primary care case management (PCCM) plans, long-term care plans, and the Program for All-inclusive Care for the Elderly (PACE). Although comprehensive plan premiums may account for nearly all health services an enrollee uses, other managed care plans are very specific in the services covered by premiums. For example, PCCM premiums typically account for a bundled payment for all PCCM services only; all other services (including primary care physician visits) are paid on a fee-for-service basis.

Section 1 and Section 2 of this report do not reflect spending by managed care plans. Despite the prevalence of managed care coverage in Medicaid, analyzing health services utilization and spending for managed care enrollees is a challenge, because Medicaid payments made to service providers are not included on records in the MAX databases as they are for FFS enrollees. Specific challenges in imputing spending estimates for managed care plans are listed below.

- Many managed care plans do not submit encounter records for services used by enrollees.
- For those that submit encounter claims, some payments are missing and must be imputed.
- For plans submitting encounter records, it is difficult to determine the completeness of the records submitted. For example, a plan may submit records for inpatient hospitalizations but none for outpatient care; alternatively, prescription drug claims may be missing because they were not submitted or because drugs are carved out of the plan.
- Differences among plans in the benefits they provide and the populations they serve make it difficult to identify an acceptable range of encounter records per enrollee (for the purpose of assessing the completeness of encounter claims).

These challenges mean that the estimates of spending by provider for managed care enrollees must be developed from partial information, and these records are handled in a different way than FFS records. Because critical data elements were not available in the 2008 MAX data set, we were not able to perform all of the managed care imputations that are required. As a result, this section of the report presents three types of information:

- Summary statistics of managed care enrollment and premium payments by eligibility status and dual enrollment status
- The methodology planned for the 2011 MAX data analysis.
- Results from imputations performed on 2008 MAX prescription claims data

3.1 Summary Statistics on Managed Care Enrollment

Methods

Using the person summary file, we tabulated the number of months each beneficiary was enrolled in the different combinations of managed care plans. Using MC_COMBO_MO, we summed the total months of enrollment across beneficiaries in each type of managed care combination as well as the total months of enrollment across beneficiaries by state. Percentages were calculated by counting months of enrollment for each Medicaid enrollee in a managed care plan combination or in fee-for-service, divided by total months of enrollment in Medicaid overall. We categorized the plan combination into the following types:

1. **Comprehensive plan + behavioral plan**
2. **Other behavioral plan combinations**, which consisted of behavioral plan only; comprehensive plan, dental plan, and behavioral plan; PCCM and behavioral plan; PCCM, dental plan, and behavioral plan; and dental plan and behavioral plan
3. **Comprehensive managed care plans without behavioral plans**, which consisted of comprehensive plan only, comprehensive plan and dental plan, and comprehensive plan and other managed care plan
4. **All other managed care combinations without behavioral plans**, which consisted of dental plan only, PCCM plan only, other managed care plan only, PCCM and dental plan, PCCM and other managed care plan, and other combinations.

Using the person summary file, we tabulated the amount spent on managed care premiums as well as the total amount spent by state. We then divided the amount spent on premiums by the total amount spent for an enrollee subgroup to obtain the percentage of spending on managed care premiums for that subgroup.

Results

Medicaid Enrollment in Managed Care Plans versus Fee-for-Service, by Eligibility

Managed care plans provided full or partial coverage for more than 70 percent of Medicaid enrollee months at a national level in 2008. In our analysis that focused on behavioral health coverage in managed care, the most prevalent managed care plan type or combination was a comprehensive plan without a behavioral plan (31 percent of enrollee months in 2008), followed by other managed care combinations without a behavioral plan (see Table 12). Likewise, the most common managed care plans for each eligibility group generally did not include a behavioral plan.

In aggregate, children and adults younger than 65 years were typically enrolled in general comprehensive plans without a separate behavioral plan, whereas individuals aged 65 years and older and those who were disabled tended to have other combinations of plans, such as PCCM or dental-only plans. This finding suggests that the majority of their Medicaid spending was

captured in the FFS claims. For plan combinations that included a behavioral plan, the combination of a comprehensive plan and a behavioral plan was more common than other managed care arrangements involving a behavioral plan for children and adults aged 18–64 years.

Medicaid programs varied across states in overall managed care penetration, ranging from 88.5 percent for Arizona to 8 percent for Connecticut. Alaska, New Hampshire, and Wyoming were the only states that did not have managed care plans (Appendix K). Across states, there was a fair amount of variation in how populations were covered by eligibility status (See Appendix K). For example, several states primarily enrolled children aged 0–18 years in comprehensive managed care plans with a behavioral health carve-out; however, other states covered children only through PCCM plans. Approximately half of all states covered disabled Medicaid enrollees largely on a fee-for-service basis. Many states enrolled the largest portion of adults in comprehensive plans without a behavioral plan or in other managed care plan combinations without a behavioral plan.

Medicaid Expenditures to Managed Care Plans and Fee-for-Service: Medicare-Medicaid Enrollees versus Non-Medicare-Medicaid Enrollees

As discussed earlier, approximately 15 percent of Medicaid enrollees were dually enrolled in Medicare and Medicaid in 2008. Generally, individuals who were disabled or aged 65 years and older accounted for the majority of Medicare-Medicaid Enrollees, given the eligibility requirements for Medicare. MME services are primarily paid on a fee-for-service basis, because the majority of their health services are covered by Medicare. For example, among disabled Medicare-Medicaid Enrollees in 2008, a total of approximately $42 billion was paid by Medicaid on a fee-for-service basis, whereas only $3 billion was paid to managed care plan premiums (see Appendix L). Adults accounted for a minority of Medicare-Medicaid Enrollees compared with individuals who were disabled; however, about 46 percent of Medicaid payments for adults were for managed care premiums.

Appendix L illustrates Medicaid expenditures on premiums or FFS claims among Medicare-Medicaid Enrollees and non-Medicare-Medicaid Enrollees by state and eligibility. A summary of managed care premium expenditures for Medicare-Medicaid Enrollees versus non-Medicare-Medicaid Enrollees for each state by eligibility is shown in Table 13. States that primarily used FFS, such as Alaska and New Hampshire, did not have any premiums paid to managed care plans. There was variability in the share of payments for Medicaid premiums within and among states, depending on the enrollee's eligibility. States with a high penetration of managed care enrollment, such as Arizona and Maryland, paid a high share of total spending on premiums, regardless of MME status. However, the majority of states paid for the majority of MME care on a fee-for-service basis.

3.2 Methodology for Imputing Managed Care Spending

Encounter records contain information about outpatient visits, inpatient stays, and purchases of prescriptions and durable medical equipment under managed care plans. Encounter records are similar to FFS claims, except that there are no dollar amounts attached to the record. Depending on the specific MAX file type, encounter records as a percentage of all MAX records can vary. In 2008, encounter records were 2 percent of claims in the long-term care (LT) file, 17 percent in the other therapy (OT) file, 20 percent of prescription drug claims in the drug (RX) file, and 22 percent of claims in the inpatient (IP) file. Within each file, the percentage of encounter records by state varies greatly. Some states report no encounter records, including those that have managed care enrollees. For other states (e.g., Arizona), more than 99 percent of claims for prescription drugs are recorded as encounter records.

Managed care encounter records are identified on the IP, OT, LT, and RX files based on the type of claim code. In future analyses and to the extent possible, we will use 2009 encounter records to estimate spending. Encounter records provide information about the diagnosis, type of service, and place of service that is essential in assigning the encounter to a "provider of service," according to the SAMHSA Spending Estimate definitions. To estimate total expenditures by provider and diagnostic category for managed care enrollees, we will first impute a cost to all encounter records using the average FFS amount paid for a service or product. Capitation rates for managed care plans have historically been set using FFS rates,[12] so this approach should provide a reasonable estimate of payments for a managed care encounter.

For the overall approach, payments will be imputed to encounter records using the average FFS price per diagnosis-related group (DRG) for inpatient services, the procedure code (Current Procedural Terminology [CPT®] or alternative code) for outpatient services, and the National Drug Code (NDC) for prescription drugs. Average FFS amounts specific to the state will be used if there are five or more FFS claims in that state for that DRG or procedure code. If not, the Census region average payment will be used. If neither of these criteria is met, the national average will be used. A few additional issues will need further investigation to refine this methodology, including the impact of outlier payments on average FFS payment calculations and cost imputation methods for a limited number of claims with too few or no matching DRG, procedure code, or NDC.

The methodology for estimating payments for the LT file requires further investigation, because of the higher proportion of missing diagnosis and procedure codes in these encounter records. To the extent possible, we will parallel the approach employed in the IP, OT, and RX files by

[12] Zuckerman, S., Williams, A. F., & Stockley, K. E. (2009). Trends in Medicaid physician fees, 2003–2008. *Health Affairs*, *28*(3), w510–w519.

using an average FFS payment per covered day by location, provider type, and/or patient characteristics, rather than basing the imputation on diagnosis or procedure codes.

To compute average payments for services, we will construct tables using FFS claims by state, Census region, and for the United States for each type of MAX file (IP, OT, RX). The tables will contain information based on average DRG, CPT procedure codes, ICD-9 diagnostic codes, ICD-9 procedure codes, clinical classifications software (CCS) codes[13] for procedures and diagnoses, and NDCs for prescription drugs. The CCS codes are summary codes of similar procedures and diagnoses that allow a smaller number of clinically meaningful categories containing a larger number of claims. We use the CCS codes principally when more narrowly defined categories of clinical events have fewer than five claims in a state, region, or national cell.

Once we have imputed payments to encounter records across the IP, OT, LT, and RX files, we can sum these imputed payments by plan across all enrollees in a plan and compare these amounts to the total premium amount that was paid to that plan in that year. If the imputed payments meet a minimum threshold share of the premium, we can assume that the encounter claims are complete. Otherwise, we will assume that the encounter records are incomplete and an alternative imputation method for that plan will be employed.

Plans With Incomplete or Missing Encounter Records

For plans that do not submit or have incomplete encounter data, we will summarize their total Medicaid premium payments and assume that 85 percent is paid out in benefits.[14,15] We will estimate the distribution of these benefit payments based on the provider distribution from a similar plan that reports encounter information or from a similar FFS population cohort in the same state. Plan types include medical or comprehensive, dental, behavioral health, prenatal and delivery, long-term care managed care, PACE, PCCM, and other miscellaneous plans. The FFS population cohorts might be defined using variables such as the basis of eligibility, demographic characteristics, and restricted benefit and dual enrollment status. The variables chosen will be those that have the highest predictive strength based on our analysis of claims.

Experience With Encounter Records

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[13] Healthcare Cost and Utilization Project (HCUP) *HCUP Clinical Classifications Software (CCS) for ICD-9-CM*. 2009. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp.

[14] Packer-Tursman, J. (2009, October 19). Medicaid medical loss ratios may deteriorate and leave nonprofit plans with losses. *Medicare Advantage News*. Note: Oppenheimer Equity Research is cited as providing estimates of medical loss ratios in the range of 85 percent, with some variation by market area.

[15] Emanuel, E., Tanden, N., Altman, S., Armstrong, S., Berwick, D., de Brantes, F. & Spiro, T. (2012). A systemic approach to containing health care spending. New England Journal of Medicine, 367(10), 949-954.

We used the proposed methodology on the 2008 MAX inpatient data. We began the imputation process on the IP file, in part because the file was noted for a high degree of completeness and quality, had a smaller number of claims, accounted for a large proportion of Medicaid spending, and had a high likelihood of DRGs being included in the records.[16] We imputed payments to encounter records using the average FFS payments by DRG and CCS when DRG was not available as described above, with the exception that if no DRG or principal CCS diagnosis was present, the encounter record was assigned a payment based on the state FFS average cost per day for an inpatient stay.

Some key findings and issues from this process include:

- A total of 29 states had encounter records, for a total of 1,947,019 records.
- A total of 4,971 encounter records had DRG or CCS codes that had less than five corresponding FFS claims. These encounters represented about 0.3 percent of total encounter records in the IP file.
- DRGs or CCS codes that had less than five FFS claims at the national level represented a variety of diagnosis groups, from specific congenital anomalies to generalized codes for "other injuries and conditions due to external causes." Some codes were identified as residual or unclassified and may be errant codes.
- Encounter records do not contain any information on the managed care plan identification number or plan type. Inability to link any encounter records to a plan identifier or plan type in the state would prevent us from validating the imputed costs against total premiums using the 2008 data—a step that we feel is crucial to test the completeness of encounter record submissions for each plan.

3.3 Imputations of Prescription Claims Data

Methods

Using the methods described above, we examined the 2008 Medicaid prescription claims data. The NDC code was used to impute average cost for that NDC code based on the state prescription FFS data. If there were fewer than five matching FFS claims at the state level, we used the FFS cost at the Census level. If there were fewer than five matching claims at the Census level, we used FFS costs from national data. We were unable to match 1.4 percent of encounter claims at the national level (Table 14). For the most common medications that remained unmatched, we examined the NDC codes individually and found that they usually corresponded to over-the-counter medications used for physical conditions; as a result, we assigned the unmatched encounter claims to non-MHSA medications. We imputed their cost based on the average spending per FFS claim for non-MHSA medications.

[16] Byrd, V. L., & Dodd, A. H. (2012). *Assessing the usability of encounter data for enrollees in comprehensive managed care across MAX, 2007–2009.* Washington, DC: Mathematica Policy Research.

We created summary tables of the results. The first table describes two measures used to assess the quality of the data: average number of encounter claims per user and percentage of capitated payments to comprehensive managed care plans that we estimate is spent on medications. We present the national tables on medication spending by therapeutic class (found in Section 1) for managed care only and also for the combination of managed care and FFS. We then present spending on MHSA medications by state for managed care only and for the combination of managed care and FFS.

Results

In 2008, there were 87 million encounter prescription claims, representing 20.4 percent of all Medicaid prescription claims for managed care and FFS, combined. Nineteen states submitted encounter prescription data (Table 14). Encounter claims account for 34.4 percent of prescription claims from these 19 states. The percentage of prescription claims that were encounter claims ranged from 2.3 percent in Florida and 3.5 percent in Wisconsin to 99.5 percent in Arizona and 90.2 percent in New Mexico.

To evaluate the quality of our data, we examined several measures (Table 14). The number of prescription claims per user ranged from 2.9 claims per user in Wisconsin to 16.9 in Minnesota. As a comparison, the national average for Medicaid FFS prescription claims was 14.6. Overall, we estimated that 9.4 percent of premium payments to comprehensive managed care plans were for prescription medications. By state, the percentages ranged from 0.6 percent in Florida and 1.4 percent in Oregon to 15.9 percent in Indiana and 18.4 percent in California. As a comparison, the national percentage of Medicaid FFS claims spent on medications was 11 percent. The states with low percentages may be explained by variability within states regarding what percentage of comprehensive managed care plans cover prescription claims, what eligibility groups are enrolled in managed care plans that provide prescription coverage, and what medication classes are included in managed care prescriptions plans. These quality measures suggest that several states may have unreliable data. States with an average number of medication claims per user of less than five or with less than 4 percent of managed care premiums spent on medications included Florida, New York, Oregon, and Wisconsin.

In 2008, Medicaid spent almost $4.0 billion on prescription encounter claims (Table 15). Slightly over 16 percent of these prescription encounter claims were for MHSA medications, compared with 26 percent for FFS prescription claims (see Table 4). Over 98 percent of MHSA spending on prescription encounter claims was for mental health medications, which was similar to prescription FFS claims. In the encounter claims, the plurality of the MHSA prescription spending was for antipsychotics (41.5 percent). This percentage was slightly lower than the percentage spent on antipsychotics (61 percent) in the FFS prescription claims. Antipsychotics were followed by stimulants (27.0 percent) and antidepressants (23.0 percent). The average price per claim for the encounter prescription claims was $77, which was slightly lower than that for FFS prescription claims ($106). The total amount spent per user for MHSA medications in

encounter claims was $916, as opposed to $1,000 in FFS medication claims (see Table 16). These smaller amounts for encounter prescription claims compared with FFS claims were likely a result of the lower percentage of antipsychotics (the most expensive medications) in encounter claims. Finally, the average amount paid per enrollee for MHSA medications in the encounter prescription claims was $142, compared with $149 in FFS prescription claims.

When the managed care spending was combined with FFS claims, Medicaid spent $28 billion on medications (Table 16). MHSA medications accounted for 24.8 percent of Medicaid spending on drugs. On average, Medicaid paid $142 per enrollee for MHSA medications, $102 per MHSA medication claim, and $916 per user. Opiate partial agonists (e.g., buprenorphine) comprised the majority of claims for substance use medications as well as 87.4 percent of spending on prescription medications used for substance use. Antipsychotics comprised the majority (60.5 percent) of spending on mental health medications, whereas antidepressants represented the drug classification with the highest number of claims.

The amount spent for prescription encounter claims and the percentage of Medicaid spending on MHSA medications varied significantly by state (Table 17). Some states, such as Oregon ($14 million) and Maryland ($29 million), spent relatively little on MHSA medications through managed care plans, compared with other states, such as California ($1,782 million) and Arizona ($1,503 million). These state differences reflect the numbers of enrollees for each state as well as the percentages of prescription claims that were encounter claims. The amount spent on prescription encounter claims per enrollee ranged from $1 in Michigan to $167 in Kentucky; the amount spent per MHSA encounter claim ranged from $15 in Michigan to $154 in Maryland; and the amount spent per user for MHSA medications ranged from $31 in Michigan to $1,044 in Maryland. Finally, the percentage of Medicaid spending on MHSA medications through managed care, as opposed to FFS, ranged from 0 percent in Michigan to 38 percent in Indiana. These large variations may result from differences in the types of populations enrolled in managed care plans within each state and from state Medicaid policies regarding which medication classes are covered by managed care plans (e.g., some states may exclude antipsychotics or other behavioral health medications).

When data from the FFS and managed care analyses were combined, the variation between states observed in the FFS and managed care data decreased (Table 18). MHSA payments per enrollee went from $64 to $272; payments per user went from $663 to $1788; and payments per claim went from $66 to $827. The percentage of prescription spending on MHSA medications ranged from 20 percent in Louisiana and New York to 52 percent in Oregon. As expected, many of the low outliers (such as Arizona in the FFS tables or Michigan in the managed care tables) disappeared when the data were combined (Table 19). Overall, combining the FFS and managed care estimates did not have a large impact on national per enrollee, per user, or per claim MHSA spending, but it did improve the accuracy of the state estimates for states with a significant number of medication encounter claims.

3.4 Summary

Medicaid spends almost one-quarter of its expenditures on managed care premiums, and over 70 percent of Medicaid enrollee months are in some type of Medicaid managed care, although not all are in comprehensive plans. Almost 40 percent of Medicaid enrollee months are in a comprehensive managed care plan, and another 18 percent are in behavioral health managed care plans. When examined on the basis of eligibility, beneficiaries with less intensive average health care use—such as children and adults younger than age 65—are more likely than individuals who are disabled or aged 65 years and older to be enrolled in comprehensive managed care plans (with or without a behavioral plan). Other managed care plan types without a behavioral plan—such as primary care case management—are the most common managed care plan types among individuals who are disabled or in the older age group. Similarly, the majority of states in 2008 paid for Medicare-Medicaid enrollees through fee-for-service arrangements rather than managed care arrangements.

Because of 2008 data limitations, we were unable to complete with confidence the managed care imputation based on the methodology outlined above. However, when the methodology was applied to the prescription claims encounter data and those estimates were combined with the fee-for-service estimates, the variability of the estimates decreased. Many of the outliers based on fee-for-service claims data alone or on managed care claims data alone were eliminated. At the same time, the limited quality checks we could perform with the current data suggested the need to investigate a handful of states more closely once the new data elements are available in the 2011 data.

Table 12. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Enrollee Eligibility, 2008

	Comprehensive Plan + Behavioral Plan[1]	Other Behavioral Plan Combinations[2]	Comprehensive Managed Care Plans[3]	All Other Managed Care Combinations[4]	Fee-for-Service Only[5]
Number of Enrollee Months (Thousands)					
All United States	52,643	55,824	179,548	129,602	168,522
Children	33,296	27,779	117,294	73,679	38,034
Adults	11,210	9,069	44,512	15,583	54,632
Disabled	7,226	14,261	13,985	28,524	40,402
Aged	911	4,715	3,758	11,816	35,454
Percentage of Total Enrollees					
All United States	9.0	9.5	30.6	22.1	28.8
Children	11.5	9.6	40.4	25.4	13.1
Adults	8.3	6.7	33.0	11.5	40.5
Disabled	6.9	13.7	13.4	27.3	38.7
Aged	1.6	8.3	6.6	20.9	62.6

Source: 2008 Medicaid Analytic eXtract (MAX) files

Notes: Percentages were calculated by counting months of enrollment for each Medicaid enrollee in a managed care plan combination or fee-for-service (FFS) divided over total months of enrollment in Medicaid overall.

Plan Definitions:

[1] Comprehensive plan with behavioral plan

[2] Behavioral plan only, comprehensive plan with behavioral and dental plans, behavioral plan with Primary Care Case Management (PCCM), behavioral and dental plans with PCCM, behavioral and dental plans only

[3] Comprehensive plan only, comprehensive plan with dental plan only, comprehensive plan with other managed care plan

[4] Dental plan only, PCCM only, PCCM and dental plan, PCCM and other managed care plan, other managed care plan only, other combination [5] FFS ONLY with no associated managed care plan

[5] FFS ONLY with no associated managed care plan

Table 13. Percentage of Medicaid Expenditures to Managed Care Plans for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008

	Percentage of Medicaid Expenditures on Premiums								
	Children (0–18 Years)		Adults (19–64 Years)		Disabled		Adults (65+ Years)		Total Medicaid Premium ($ Millions)
State	MMEs	Non-MMEs	MMEs	Non-MMEs	MMEs	Non-MMEs	MMEs	Non-MMEs	
All United States	**15.1**	**44.3**	**1.2**	**46.3**	**6.9**	**18.5**	**7.7**	**19.4**	**68,677**
Alabama	38.5	36.2	8.8	7.8	1.3	10.7	0.5	3.1	474
Alaska	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Arizona	100.0	83.1	95.2	84.5	87.8	83.1	95.2	64.8	6,478
Arkansas	0.5	1.9	0.3	0.8	0.1	0.4	0.1	0.2	23
California	4.2	50.2	27.8	24.4	12.7	9.8	14.8	8.0	6,698
Colorado	11.7	24.2	13.8	10.0	8.7	12.5	8.9	7.8	388
Connecticut	0.0	8.6	0.4	11.2	0.0	0.0	0.0	0.0	63
Delaware	18.7	51.3	26.6	70.8	2.2	35.5	0.6	37.1	459
Dist. of Columbia	62.7	52.2	9.9	73.1	1.0	10.9	0.5	0.6	317
Florida	3.3	39.8	14.9	23.7	4.7	25.8	9.9	51.6	2,790
Georgia	5.6	70.9	50.2	67.5	2.8	1.8	0.9	0.7	2,279
Hawaii	89.1	82.8	50.4	84.7	0.6	2.8	0.2	3.0	383
Idaho	0.0	9.9	0.7	2.9	0.7	0.2	0.5	0.2	34
Illinois	0.2	6.4	0.7	6.7	0.1	0.1	0.2	0.3	242
Indiana	6.3	61.8	74.5	79.2	0.2	6.3	0.0	0.9	1,242
Iowa	9.5	10.1	7.0	7.8	4.0	4.7	0.1	0.6	127
Kansas	4.8	58.6	62.8	73.3	5.7	11.4	2.5	4.8	514
Kentucky	18.2	24.1	13.8	19.0	5.1	15.3	1.8	17.6	716
Louisiana	0.0	1.8	0.2	0.4	0.0	0.1	0.2	0.1	26
Maine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0

Table 13. Percentage of Medicaid Expenditures to Managed Care Plans for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (Continued)

	Percentage of Medicaid Expenditures on Premiums								
	Children (0–18 Years)		Adults (19–64 Years)		Disabled		Adults (65+ Years)		Total Medicaid Premium ($ Millions)
State	MMEs	Non-MMEs	MMEs	Non-MMEs	MMEs	Non-MMEs	MMEs	Non-MMEs	
Maryland	50.6	38.8	30.3	54.0	68.7	21.5	56.2	0.5	1,291
Massachusetts	4.5	59.7	20.7	48.0	2.1	25.9	12.8	13.7	2,440
Michigan	46.0	65.5	92.3	69.4	45.0	59.0	5.1	7.4	3,555
Minnesota	3.4	69.2	37.9	72.6	3.8	4.0	33.1	70.0	1,899
Mississippi	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Missouri	1.7	55.7	19.2	55.9	1.1	1.0	1.2	1.1	1,106
Montana	0.1	0.5	0.0	0.2	0.0	0.1	0.0	0.0	1
Nebraska	0.1	9.1	2.0	14.0	0.3	5.0	0.0	7.9	75
Nevada	13.9	35.2	10.3	43.1	0.4	0.4	0.3	0.1	158
New Hampshire	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
New Jersey	33.9	59.3	80.9	79.8	3.7	18.8	0.6	21.4	1,791
New Mexico	14.6	81.2	25.2	81.6	3.0	58.4	3.9	40.3	1,588
New York	4.4	44.7	18.5	46.4	2.4	11.3	8.5	20.4	7,825
North Carolina	1.9	3.1	0.6	0.9	2.8	1.9	0.3	0.5	171
North Dakota	0.0	0.5	0.1	0.3	0.0	0.0	0.0	0.0	1
Ohio	34.0	74.1	40.0	82.6	2.3	30.0	0.3	18.6	3,958
Oklahoma	1.5	8.0	1.5	2.6	1.2	2.3	1.2	0.9	123
Oregon	23.7	67.2	59.7	71.6	25.3	47.6	12.1	49.1	1,193
Pennsylvania	68.5	85.2	70.1	81.7	17.5	71.8	5.7	58.6	7,309
Rhode Island	0.0	56.4	21.4	88.6	0.1	9.8	0.0	0.0	343

Table 13. Percentage of Medicaid Expenditures to Managed Care Plans for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (Continued)

	Percentage of Medicaid Expenditures on Premiums								
	Children (0–18 Years)		Adults (19–64 Years)		Disabled		Adults (65+ Years)		Total Medicaid Premium ($ Millions)
State	MMEs	Non-MMEs	MMEs	Non-MMEs	MMEs	Non-MMEs	MMEs	Non-MMEs	
South Carolina	0.9	19.7	5.4	17.0	1.8	11.3	2.0	1.3	408
South Dakota	0.6	1.5	0.3	0.6	0.1	0.1	0.1	0.1	4
Tennessee	22.4	43.0	53.5	45.1	23.1	25.3	6.4	20.3	1,828
Texas	10.8	40.6	14.2	31.0	9.0	10.2	9.3	10.0	3,733
Utah	100.0	7.8	9.2	4.5	18.7	11.4	4.0	3.3	111
Vermont	0.3	1.3	0.4	1.1	0.0	0.2	0.0	0.1	5
Virginia	0.7	49.4	36.0	69.2	2.3	37.4	0.3	44.7	1,720
Washington	0.0	69.3	7.6	65.0	0.6	2.1	1.0	1.9	1,254
West Virginia	25.4	37.5	21.1	42.5	0.1	0.2	0.0	0.0	230
Wisconsin	2.4	49.2	18.2	58.1	35.0	20.7	21.4	26.5	1,578
Wyoming	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0

Source: 2008 Medicaid Analytic eXtract (MAX) files

MME = Medicare-Medicaid Enrollee

Table 14. Summary of Quality Measures for Medicaid Managed Care Prescription (RX) Data

State	Number of Prescription Encounter Claims (Thousands)	Prescription Claims That are Encounter Claims (%)	Prescription Encounter Claims per User, Mean[1]	Capitated Payments to Comprehensive Managed Care Plans That Are Spent on Medications (%)[2]	Unmatched Encounter Claims (%)
All United States[3]	**86,830**	**34.4**	**10.1**	**9.4**	**1.4**
Arizona	9,443	99.5	12.9	9.1	1.0
California	23,598	43.2	9.8	18.4	1.4
Florida	319	2.3	4.4	0.6	2.6
Georgia	4,736	42.5	6.9	7.5	1.8
Indiana	4,255	51.6	8.7	15.9	0.9
Kansas	865	26.0	7.3	11.7	1.0
Kentucky	1,458	11.5	11.9	11.7	2.1
Maryland	4,396	66.3	10.4	15.0	2.1
Michigan	10,193	61.3	12.1	9.2	1.7
Minnesota	5,663	63.4	16.9	13.8	1.3
Missouri	2,077	18.0	7.9	10.5	1.9
New Jersey	4,140	42.3	8.7	11.7	2.0
New Mexico	3,355	90.2	12.0	11.9	1.3
New York	4,169	9.1	11.6	3.2	0.9
Oregon	367	16.6	4.9	1.4	1.1
Rhode Island	1,034	55.2	10.2	13.5	3.0
Virginia	3,872	48.5	11.7	13.6	1.0
Washington	2,542	19.0	6.9	5.3	1.5
Wisconsin	348	3.5	2.9	1.7	1.0

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] The average number of prescriptions per user for fee-for-services claims is 14.6

[2] Medicaid spent 11% of fee-for-service claims on medications

[3] "All United States" only includes the managed care encounter claims from the states listed in the table.

Table 15. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders by Therapeutic Class: Managed Care Claims, Users, and Payments, 2008[1]

Drug Spending by Diagnosis and Therapeutic Class	Number of Managed Care Drug Encounters			Managed Care Drug Payments				Distribution of Managed Care Payments Among		
	Claims (Thousands)	Users (Thousands)	Claims Per User[2]	Amount (Thousands $)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	All Drugs (%)	MHSA Drugs (%)	MH and SA Drugs Separately (%)
All Drugs	**86,830**	**8,614**	**10.1**	**3,953**	**275**	**46**	**459**	**100.0**	**N/A**	**N/A**
Total MHSA drugs	8,463	1,282	6.6	648	45	77	505	16.4	100.0	N/A
Total SA Drugs	**59**	**11**	**5.4**	**11**	**1**	**184**	**996**	**0.3**	**1.7**	**100.0**
Opiate partial agonists[4]	48	7	6.6	10	1	203	1,332	0.2	1.5	89.0
Opiate antagonists, NEC[5]	5	2	3.2	1	0	109	350	0.0	0.1	5.1
Misc. therapeutic agents, NEC[6]	6	2	2.7	1	0	102	280	0.0	0.1	5.9
Total MH Drugs	**8,404**	**1,277**	**6.6**	**637**	**44**	**76**	**499**	**16.1**	**98.3**	**100.0**
Psychotherapeutic, antidepressants	3,402	645	5.3	149	10	44	231	3.8	23.0	23.4
Psychotherapeutic, tranquilizers/antipsychotics	1,014	156	6.5	269	19	265	1,722	6.8	41.5	42.3
Stimulants and CNS agents, miscellaneous	1,549	267	5.8	175	12	113	656	4.4	27.0	27.5
Anxiolytics, sedatives, hypnotics (ASH), benzo.	1,470	341	4.3	21	1	15	63	0.5	3.3	3.4
Anxiolytics, sedatives, hypnotics (ASH), NEC	892	337	2.7	21	1	24	63	0.5	3.3	3.3
Antimanic agents, NEC	76	15	5.0	1	0	19	96	0.0	0.2	0.2

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: benzo = benzodiazepines; MH = mental health; NEC = not elsewhere classified; SA = substance abuse

[1] This table includes managed care encounter claims from 19 states: Arizona, California, Florida, Georgia, Indiana, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, Oregon, Rhode Island, Virginia, Washington, Wisconsin.

[2] Calculation includes only those claims with a national drug code (NDC).

[3] Comprehensive managed care plan enrollment in 2008 was 14,361,102 person-years .

[4] Includes buprenorphine hydrochloride and buprenophine/naloxone combination.

[5] Includes naltrexone HCl used to treat alcohol and drug addiction.

[6] Includes disulfiram and acamprosate used to treat alcohol addiction.

Table 16. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders by Therapeutic Class: Fee-for-Service and Managed Care Claims, Users, and Payments, 2008

	Number of Managed Care Drug Encounters			Managed Care Drug Payments				Distribution of Managed Care Payments Among		
Drug Spending by Diagnosis and Therapeutic Class	Claims (Thousands)	Users (Thousands)	Claims Per User[2]	Amount (Thousands $)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	All Drugs (%)	MHSA Drugs (%)	MH and SA Drugs Separately (%)
All Drugs	**425,590**	**31,838**	**13.4**	**28,132**	**574**	**66**	**884**	**100.0**	**N/A**	**N/A**
Total MHSA drugs	68,330	7,606	9.0	6,969	142	102	916	24.8	100.0	N/A
Total SA Drugs	**508**	**78**	**6.5**	**99**	**2**	**195**	**1,261**	**0.4**	**1.4**	**100.0**
Opiate partial agonists[3]	402	51	7.8	86	2	215	1,689	0.3	1.2	87.4
Opiate antagonists, NEC[4]	50	11	4.4	6	0	127	559	0.0	0.1	6.3
Misc. therapeutic agents, NEC[5]	57	18	3.1	6	0	108	339	0.0	0.1	6.2
Total MH Drugs	**67,822**	**7,586**	**8.9**	**6,870**	**140**	**101**	**906**	**24.4**	**98.6**	**100.0**
Psychotherapeutic, antidepressants	22,167	3,510	6.3	1,082	22	49	308	3.8	15.5	15.8
Psychotherapeutic, tranquilizers/antipsychotics	13,892	1,626	8.5	4,153	85	299	2,554	14.8	59.6	60.5
Stimulants and CNS agents, miscellaneous	9,969	1,527	6.5	1,182	24	119	774	4.2	17.0	17.2
Anxiolytics, sedatives, hypnotics (ASH), benzo.	14,650	2,622	5.6	220	4	15	84	0.8	3.2	3.2
Anxiolytics, sedatives, hypnotics (ASH), NEC	6,335	1,688	3.8	215	4	34	127	0.8	3.1	3.1
Antimanic agents, NEC	809	132	6.1	18	0	23	139	0.1	0.3	0.3

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: benzo = benzodiazepines; MH = mental health; NEC = not elsewhere classified; SA = substance abuse

[1] Calculation includes only those claims with a national drug code (NDC).

[2] Fee-for-service and comprehensive managed care plan enrollment in 2008 was 48,974,906 person-years.

[3] Includes buprenorphine hydrochloride and buprenophine/naloxone combination.

[4] Includes naltrexone HCl used to treat alcohol and drug addiction.

[5] Includes disulfiram and acamprosate used to treat alcohol addiction.

Table 17. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Managed Care Claims, Users, and Payments for All Users, by State, 2008

State	Number of Managed Care MHSA Drug				Managed Care MHSA Drug Payments				
	Number of Enrollee-Years (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health Drugs (%)
All United States	**14,361**	**8,463**	**1,282**	**6.6**	**648**	**45**	**77**	**505**	**16**
Arizona[2]	913	1,503	166	9.1	118	130	79	714	24
California[4]	3,358	1,782	305	5.8	100	30	56	329	9
Florida[5]	789	45	14	3.2	4	5	95	303	26
Georgia[4]	747	493	101	4.9	38	51	78	380	23
Indiana[3]	575	819	110	7.5	75	131	92	689	38
Kansas[4]	124	130	19	6.7	12	99	94	631	30
Kentucky[4]	141	246	32	7.6	24	167	96	727	31
Maryland[3]	536	29	4	6.8	4	8	154	1,044	2
Michigan[3]	1,038	55	26	2.1	1	1	15	31	0
Minnesota[3]	383	706	85	8.3	49	128	70	579	19
Missouri[4]	386	356	47	7.6	37	97	105	800	33
New Jersey	663	272	54	5.0	18	28	68	339	9
New Mexico[2]	314	526	60	8.8	46	147	88	771	29
New York[5]	2,666	318	63	5.0	24	9	77	386	10
Oregon[4]	266	14	7	2.1	1	3	51	108	5
Rhode Island[3]	110	182	24	7.7	13	117	71	542	28
Virginia[4]	421	620	75	8.3	61	146	99	817	26
Washington[4]	513	308	56	5.5	15	29	49	267	22
Wisconsin[5]	417	59	34	1.8	5	11	79	139	27

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: MHSA = Mental Health and Substance Abuse.

[1] Calculation includes only those claims with a national drug code (NDC).

[2] These states have more than 90% of their prescription claims as encounter claims.

[3] These states have between 50-90% of their prescription claims as encounter claims.

[4] These states have between 10-50% of their claims as encounter claims.

[5] These states have less than 10% of their prescription claims as encounter claims.

Table 18. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service and Managed Care Claims, Users, and Payments for All Users, by State, 2008

State	Number of Fee-for-Service and Managed Care MHSA Drug				Fee-for-Service and Managed Care MHSA Drug Payments				
	Number of Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health Drugs (%)
All United States	**48,975**	**68,330**	**7,606**	**1.4**	**6,969**	**142**	**102**	**916**	**25**
Alabama	762	1,195	131	1.6	114	150	95	869	25
Alaska	96	214	16	2.2	23	237	106	1,430	30
Arizona[2]	1,182	1,507	166	1.3	119	100	79	714	24
Arkansas	623	883	116	1.4	107	171	121	919	31
California[4]	8,289	6,380	782	0.8	863	104	135	1,104	21
Colorado	429	617	60	1.4	75	175	121	1,237	27
Connecticut	475	1,226	109	2.6	105	222	86	970	26
Delaware	155	312	33	2.0	29	188	93	878	24
Dist. of Columbia	146	126	12	0.9	21	144	166	1,788	22
Florida[5]	2,306	2,552	284	1.1	232	101	91	818	21
Georgia[4]	1,288	1,739	227	1.3	160	124	92	703	26
Hawaii	202	107	11	0.5	16	78	148	1,478	30
Idaho	177	389	32	2.2	41	232	106	1,286	37
Illinois	2,282	3,052	324	1.3	279	122	91	862	24
Indiana[3]	900	1,789	203	2.0	171	190	96	842	34
Iowa	393	906	85	2.3	85	216	94	996	37
Kansas[4]	270	682	66	2.5	71	264	105	1,077	36
Kentucky[4]	726	1,830	182	2.5	152	209	83	831	22
Louisiana	1,051	1,445	182	1.4	159	151	110	875	20
Maine	305	852	80	2.8	67	219	78	829	31

Table 18. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service and Managed Care Claims, Users, and Payments for All Users, by State, 2008 (Continued)

State	Number of Fee-for-Service and Managed Care MHSA Drug				Fee-for-Service and Managed Care MHSA Drug Payments				
	Number of Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health Drugs (%)
Maryland[3]	727	1,113	110	1.5	131	180	118	1,189	29
Massachusetts	1,297	1,880	184	1.4	147	113	78	798	30
Michigan[3]	1,656	2,780	317	1.7	238	144	86	751	32
Minnesota[3]	626	159	159	0.3	131	210	210	827	26
Mississippi	610	606	90	1.0	68	111	112	755	22
Missouri[4]	859	2,208	203	2.6	211	246	96	1,041	27
Montana	81	196	18	2.4	22	272	113	1,229	34
Nebraska	209	444	44	2.1	53	252	119	1,202	34
Nevada	192	263	24	1.4	26	134	98	1,071	28
New Hampshire	118	286	28	2.4	26	224	92	940	33
New Jersey	950	1,421	156	1.5	158	166	111	1,009	21
New Mexico[2]	469	560	67	1.2	48	103	87	720	28
New York[5]	4,155	5,792	619	1.4	733	176	126	1,184	20
North Carolina	1,406	2,577	299	1.8	273	194	106	912	26
North Dakota	55	128	13	2.3	11	195	84	844	34
Ohio	1,816	1,660	192	0.9	155	85	93	809	31
Oklahoma	620	880	109	1.4	93	150	106	853	27
Oregon[4]	397	818	85	2.1	79	198	96	929	52
Pennsylvania	1,824	1,753	173	1.0	116	64	66	672	28
Rhode Island[3]	178	386	45	2.2	30	171	79	684	31

Table 18. Medicaid Prescription Drugs for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service and Managed Care Claims, Users, and Payments for All Users, by State, 2008 (Continued)

	Number of Fee-for-Service and Managed Care MHSA Drug				Fee-for-Service and Managed Care MHSA Drug Payments				
State	Number of Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of All-Health Drugs (%)
South Carolina	746	926	121	1.2	87	117	94	723	25
South Dakota	105	158	16	1.5	16	156	104	1,012	31
Tennessee	1,279	1,598	205	1.2	179	140	112	873	25
Texas	3,233	3,181	444	1.0	455	141	143	1,026	24
Utah	202	453	47	2.2	46	228	102	984	33
Vermont	137	460	41	3.4	37	271	81	918	32
Virginia[4]	760	1,381	155	1.8	126	166	92	815	28
Washington[4]	951	2,130	212	2.2	141	148	66	664	27
West Virginia	326	1,114	99	3.4	86	265	77	877	25
Wisconsin[5]	875	1,831	221	2.1	146	167	80	663	25
Wyoming	58	105	11	1.8	12	206	114	1,125	32

Source: 2008 Medicaid Analytic eXtract (MAX) files

Note: MHSA = mental health and substance abuse

[1] Calculation includes only those claims with a national drug code (NDC).

[2] These states have more than 90% of their prescription claims as encounter claims.

[3] These states have between 50-90% of their prescription claims as encounter claims.

[4] These states have between 10-50% of their claims as encounter claims.

[5] These states have less than 10% of their prescription claims as encounter claims.

Table 19. Comparison of Key Metrics for Prescription Claims: Fee-for-Service, Managed Care, and Combined Claims

	Estimate From		
	Fee-for-Service Claims	Managed Care Encounter Claims	Combined Fee-for-Service and Managed Care Encounter Claims
MHSA prescription spending per enrollee ($)	149	45	142
MHSA prescription spending per user ($)	1000	505	916
MHSA prescription spedinng per claim ($)	106	77	102
MHSA prescription spending as a percentage of all prescription spending (%)			
National	26	16	25
Outlier states[1]			
Arizona	9	24	24
California	26	9	21
Maryland	49	2	29
Michigan	51	0	32
New Jersey	25	9	21
New Mexico	15	29	28
Oregon	56	5	52

Source: 2008 Medicaid Analytic eXtract (MAX) files

[1] States with unusually high or low percentage when examining either the fee-for-service claims or managed care claims alone

Appendix A. MAX Data Elements Used to Classify Providers

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
General Hospitals						
Inpatient Hospital	X				IP file does not contain a place of service indicator	All claims = inpatient hospital
		X			21 = Inpatient Hospital 61 = Comprehensive inpatient rehabilitation facility	11 = Outpatient hospital 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 33 = Rehabilitation services 35 = Hospice benefits 37 = Nurse practitioner services 51 = Durable medical equipment and supplies 52 = Residential care 53 = Psychiatric services 54 = Adult day care 99 = Unknown

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Outpatient Hospital		X			Any place of service EXCEPT: 21 = Inpatient hospital 51 = Inpatient psychiatric facility 52 = Psychiatric facility partial hospitalization 61 = Comprehensive inpatient rehabilitation facility	11 = Outpatient hospital
		X			16 = Mobile unit 22 = Outpatient Hospital 23 = Emergency room - hospital	16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 33 = Rehabilitation services 35 = Hospice benefits 37 = Nurse practitioner services 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown
					22 = Outpatient Hospital 23 = Emergency Room - Hospital	10 = Other practitioners 31 = Targeted case management 34 = PT, OT, speech, hearing services 36 = Nurse midwife services 38 = Private duty nursing 52 = Residential care

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Specialty Hospitals						
Inpatient			X		LT file does not contain a place of service indicator	02 = Mental Hospital Services for the Aged 04 = Inpatient Psychiatric Facility for Individuals under the age of 21
		X			51 = Inpatient psychiatric facility	8 = Physicians 10 = Other practitioners 11 = Outpatient hospital 12 = Clinic 15 = Lab and x-ray 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 31 = Targeted case management 33 = Rehabilitation services 34 = PT, OT, speech, hearing services 35 = Hospice benefits 36 = Nurse midwife services 37 = Nurse practitioner services 38 = Private duty nursing 51 = Durable medical equipment and supplies 52 = Residential services 53 = Psychiatric services 54 = Adult day care 99 = Unknown

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Outpatient		X			52 = Psychiatric facility partial hospitalization	8 = Physicians 10 = Other practitioners 11 = Outpatient hospital 12 = Clinic 15 = Lab and x-ray 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 31 = Targeted case management 33 = Rehabilitation services 34 = PT, OT, speech, hearing services 35 = Hospice benefits 36 = Nurse midwife services 37 = Nurse practitioner services 38 = Private duty nursing 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown
Physicians						
Inpatient		X			21 = Inpatient Hospital 61 = Comprehensive inpatient rehabilitation facility	08 = Physicians 12 = Clinic 15 = Lab and x-ray

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Outpatient		X			Any Place of Service Code Except 21 = Inpatient Hospital 32 =Nursing facility 33 =Custodial care facility 54 = Intermediate care facility for the mentally retarded 61 = Comprehensive inpatient rehabilitation facility	08 = Physicians 12 = Clinic 15 = Lab and x-ray
		X			05 = Indian health service free-standing facility 06 = Indian health service provider-based facility 07 = Tribal 638 free-standing facility 08 = Tribal 638 provider-based facility 11 = Office 20 = Urgent care facility 24 = Ambulatory surgery center 25 = Birthing center 26 = Military treatment facility 50 = Federally qualified health center 60 = Mass immunization center 62 = Comprehensive outpatient rehabilitation facility 65 = End stage renal disease treatment facility 71 = State or local public health clinic 72 = Rural health clinic 81 = Independent laboratory	16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 33 = Rehabilitation services 37 = Nurse practitioner services 51 = Durable medical equipment and supplies 54 = Adult day care 99 = Unknown

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
		X			'.' OR 0-2 OR 9 -10 OR 13-15 OR 17-19 OR 27-31 OR 35-40 OR 43-49 OR 57-59 OR 63-64 OR 66-70 OR 73-80 OR 82-87 OR 89-98 = State specific codes for unknown providers 03 = School 04 = Homeless shelter 99 = Unknown	24 = Sterilizations 25 = Abortions
Residential		X			32 = Nursing facility 33 = Custodial care facility 54 = Intermediate care facility for the mentally retarded	08 = Physicians 12 = Clinic 15 = Lab and x-ray
Dentists						
Inpatient		X			21 = Inpatient hospital 51 = Inpatient psychiatric facility 61 = Comprehensive inpatient rehabilitation facility	09 = Dental
Outpatient		X			Any Place of Service Code except: 21 = Inpatient hospital32 =Nursing facility 32 = Nursing facility 33 = Custodial care facility 51 = Inpatient psychiatric facility54 = Intermediate care facility for the mentally retarded 54 = Intermediate care facility for the mentally retarded 55 = Residential substance abuse treatment facility	09 = Dental

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
					56 = Psychiatric residential treatment center 61 = Comprehensive inpatient rehabilitation facility	
Residential		X			32 = Nursing facility 33 = Custodial care facility 54 = Intermediate care facility for the mentally retarded 55 = Residential substance abuse treatment facility 56 = Psychiatric residential treatment center	09 = Dental
Other Professionals						
Inpatient		X			21 = Inpatient hospital 61 = Comprehensive inpatient rehabilitation facility	10 = Other practitioners 31 = Targeted case management 34 = PT, OT, speech, hearing services 36 = Nurse midwife services 38 = Private duty nursing

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Outpatient		X			Any place of service code EXCEPT: 21 = Inpatient hospital 22 = Outpatient hospital 23 = Emergency room - hospital 32 =Nursing facility 33 =Custodial care facility 51 = Inpatient psychiatric facility 52 = Psychiatric facility partial hospitalization 53 = Community mental health center 54 = Intermediate care facility for the mentally retarded 55 = Residential substance abuse treatment facility 56 = Psychiatric residential treatment center 61 = Comprehensive inpatient rehabilitation facility	10 = Other practitioners 31 = Targeted case management 34 = PT, OT, speech, hearing services 36 = Nurse midwife services 38 = Private duty nursing

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
		X			Any place of service code EXCEPT: 12 = Patient's home 16 = Mobile unit 21 = Inpatient hospital 22 = Outpatient hospital 23 = Emergency room - hospital 32 = Nursing facility 33 = Custodial care facility 34 = Hospice 41 = ambulance - land 42 = Ambulance - air or water 51 = Inpatient psychiatric facility 52 = Psychiatric facility partial hospitalization 53 = Community mental health center 54 = Intermediate care for the mentally retarded 55 = Residential substance abuse treatment facility 56 = Psychiatric residential treatment center 61 = Comprehensive inpatient rehabilitation facility	53 = Psychiatric services
		X			'.' OR 0-2 OR 9 -10 OR 13-15 OR 17-19 OR 27-31 OR 35-40 OR 43-49 OR 57-59 OR 63-64 OR 66-70 OR 73-80 OR 82-87 OR 89-98 = State specific codes for unknown providers 03 = School 04 = Homeless shelter 99 = Unknown	19 = Other services 33 = Rehabilitation services 37 = Nurse practitioner services

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Residential		X			32 = Nursing facility 33 = Custodial care facility	10 = Other practitioners 31 = Targeted case management 34 = PT, OT, speech, hearing services 36 = Nurse midwife services 38 = Private duty nursing

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Nursing Home						
Residential			X		LT file does not contain a place of service indicator	05 = Intermediate care facility for the mentally retarded 07 = Nursing facility services – all other 99 = Unknown
		X			32 = Nursing facility 33 = Custodial care facility 54 = Intermediate care facility for the mentally retarded	10 = Other practitioners 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 31 = Targeted case management 33 = Rehabilitation Services 34 = PT, OT, speech, hearing services 35 = Hospice benefits 36 = Nurse midwife services 37 = Nurse practitioner services 38 = Private duty nursing 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown
		X			Any place of service EXCEPT: 21 = Inpatient hospital 51 = Inpatient psychiatric facility 61 = Comprehensive inpatient rehabilitation facility	52 = Residential care

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Home Health						
Outpatient		X			Any place of service	13 = Home health 30 = Personal care services
		X			12 = Patient's home 34 = Hospice	16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 33 = Rehabilitation services 35 = Hospice benefits 37 = Nurse practitioner services 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
		X			Any place of service EXCEPT: 16 = Mobile unit 21 = Inpatient hospital 22 = Outpatient hospital 23 = Emergency room--hospital 32 = Nursing facility 33 = Custodial care facility 34 = Hospice 51 = Inpatient psychiatric facility 52 = Psychiatric facility partial hospitalization 53 = Community mental health center 54 = Intermediate care facility for mentally retarded 55 = residential substance abuse treatment facility 56 = psychiatric residential treatment center 61 = comprehensive inpatient rehabilitation facility	35 = Hospice services
Transportation						
Outpatient		X			Any place of service	26 = Transportation services

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
		X			41 = Ambulance - land 42 = Ambulance – air or water	16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 33 = Rehabilitation services 37 = Nurse practitioner services 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown
Durable Medical Equipment (DME)						
Outpatient		X			03 = School 04 = Homeless shelter 99 = Unknown place	51 = Durable medical equipment and supplies
				X	RX file does not contain a place of service indicator	51 = Durable medical equipment

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Specialty Mental Health Centers						
Outpatient		X			53 = Community mental health center	8 = Physicians 10 = Other practitioners 12 = Clinic 15 = Lab and x-ray 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 31 = Targeted case management 33 = Rehabilitation services 34 = PT, OT, speech, hearing services 35 = Hospice benefits 36 = Nurse midwife services 37 = Nurse practitioner services 38 = Private duty nursing 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Residential		X			56 = Psychiatric residential treatment center	8 = Physicians 10 = Other practitioners 12 = Clinic 15 = Lab and x-ray 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 31 = Targeted case management 33 = Rehabilitation services 34 = PT, OT, speech, hearing services 35 = Hospice benefits 36 = Nurse midwife services 37 = Nurse practitioner services 38 = Private duty nursing 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Specialty Substance Use Centers						
Residential		X			55 = Residential substance abuse treatment facility	8 = Physicians 10 = Other practitioners 12 = Clinic 15 = Lab and x-ray 16 = Drugs 19 = Other services 24 = Sterilizations 25 = Abortions 31 = Targeted case management 33 = Rehabilitation services 34 = PT, OT, speech, hearing services 35 = Hospice benefits 36 = Nurse midwife services 37 = Nurse practitioner services 38 = Private duty nursing 51 = Durable medical equipment and supplies 53 = Psychiatric services 54 = Adult day care 99 = Unknown
Adult Day Care						
Outpatient		X			99 = Unknown	54 = Adult day care

SAMHSA Spending Estimate Category	File[a]				MAX Place of Service (PLC_OF_SRVC_CD)	MAX Type of Service (MAX_TOS)
	IP	OT	LT	RX		
Unknown						
Outpatient		X			'.' OR 0-2 OR 9 -10 OR 13-15 OR 17-19 OR 27-31 OR 35-40 OR 43-49 OR 57-59 OR 63-64 OR 66-70 OR 73-80 OR 82-87 OR 89-98 = State specific codes for unknown providers 03 = School 04 = Homeless shelter 99 = Unknown	16 = Drugs 54 = Adult day care 99 = Unknown

[a] IP, Inpatient; LT, long-term care; OT, other therapy; RX, prescription drugs and durable medical equipment. Other abbreviations: OT (data code), occupational therapy; PT, physical therapy.

Appendix B. ICD-9-CM Diagnostic Codes for Mental Disorders and Alcohol and Drug Use Conditions

ICD-9 Code	ICD-9 Disease Category	Included in MH/SA
	MENTAL CONDITIONS	
290–299	Psychoses	
291	Alcohol-induced mental disorders	SA (Alcohol)
292	Drug-induced disorders	SA (Drug)
295	Schizophrenic disorders	MH
296	Episodic mood disorders	MH
297	Delusional disorders	MH
298	Other nonorganic psychoses	MH
299	Pervasive developmental disorders	MH
300–316	Neurotic disorders, personality disorders, and other nonpsychotic mental disorders	
300	Anxiety, dissociative and somatoform disorders	MH
301	Personality disorders	MH
302	Sexual and gender identity disorders	MH
303	Alcohol dependence syndrome	SA (Alcohol)
304	Drug dependence	SA (Drug)
305.0, 305.2–305.9	Nondependent abuse of drugs – except tobacco abuse disorder	SA (Drug)
306	Physiological malfunction arising from mental factors	MH
307	Special symptoms and syndromes, not elsewhere classified	MH
308	Acute reaction to stress	MH
309	Adjustment reaction	MH
310	Specific nonpsychotic mental disorders due to brain damage	MH
311	Depressive disorder, not elsewhere classified	MH
312	Disturbance of conduct, not elsewhere classified	MH
313	Disturbance of emotions to childhood and adolescence	MH
314	Hyperkinetic syndrome of childhood	MH

ICD-9 Code	ICD-9 Disease Category	Included in MH/SA
	COMPLICATIONS IN PREGNANCY	
648.3	Complications mainly related to pregnancy—drug dependence	SA (Drug)
648.4	Complications mainly related to pregnancy—mental disorders	MH
	SUPPLEMENTARY CLASSIFICATION OF FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES	
V40.2	Other mental problems	MH
V40.3	Other behavioral problems	MH
V40.9	Unspecified mental or behavioral problem	MH
V61	Other family circumstances	MH
V66.3	Following psychotherapy and other treatment for mental disorder	MH
V67.3	Follow-up examination, following psychotherapy and other treatment for mental disorder	MH
V70.1	General psychiatric examination, requested by the authority	MH
V70.2	General psychiatric examination, other and unspecified	MH
V71.0	Observation for suspected mental condition	MH

Abbreviations: ICD-9-CM, International Classification of Diseases, Ninth Revision, Clinical Modification; MH, mental health; SA, substance abuse

Appendix C. Percentage of Payments from Claims With Unknown Diagnosis by State

State	Percent of Payments from Claims with Unknown Diagnosis (%)	State	Percent of Payments from Claims with Unknown Diagnosis (%)	State	Percent of Payments from Claims with Unknown Diagnosis (%)
All United States	12				
Alabama	3	Kentucky	2	North Dakota	2
Alaska	29	Louisiana	12	Ohio	12
Arizona	0	Maine	-	Oklahoma	8
Arkansas	0	Maryland	12	Oregon	37
California	24	Massachusetts	52	Pennsylvania	11
Colorado	3	Michigan	11	Rhode Island	0
Connecticut	2	Minnesota	0	South Carolina	30
Delaware	5	Mississippi	2	South Dakota	53
Dist. of Columbia	19	Missouri	2	Tennessee	4
Florida	39	Montana	2	Texas	21
Georgia	4	Nebraska	2	Utah	4
Hawaii	3	Nevada	12	Vermont	0
Idaho	0	New Hampshire	9	Virginia	4
Illinois	6	New Jersey	2	Washington	27
Indiana	9	New Mexico	46	West Virginia	3
Iowa	14	New York	3	Wisconsin	1
Kansas	3	North Carolina	4	Wyoming	20

Source: 2008 Medicaid Analytic Files

Note: Zero represents an amount less than 0.5 percent. '-' means that no claims were reported for services and therefore there were no claims with a missing diagnosis.

Appendix D. Payment from Claims With Unknown Diagnosis by Provider

Provider Category	Payments from Claims with Missing Diagnosis: Percent of Provider Category Payments (%)	Payments from Claims with Missing Diagnosis: Distribution among Providers (%)
Total all service providers	**12**	**100**
Total inpatient	0	0
Total outpatient	19	66
Total residential	11	34
All hospitals	1	2
General hospitals	1	2
Specialty hospitals	3	0
All physicians	2	2
Dentists	91	15
Other professionals	21	13
Free-standing home health	24	28
Free-standing nursing home	11	34
Transportation	42	3
Durable medical equipment (DME)	51	1
Other personal and public health	1	0
Specialty mental health centers	1	0
Specialty SA centers	1	0
Adult day care	14	1
Adult day care	14	1
Unknown	9	0

Source: 2008 Medicaid Analytic Files

Appendix E. Percentage of Payments From Claims With Unknown Provider by State

State	Percent of Payments from Claims with Unknown Provider (%)	State	Percent of Payments from Claims with Unknown Provider (%)	State	Percent of Payments from Claims with Unknown Provider (%)
All United States	6				
Alabama	7	Kentucky	12	North Dakota	1
Alaska	4	Louisiana	6	Ohio	0
Arizona	0	Maine	-	Oklahoma	4
Arkansas	2	Maryland	2	Oregon	1
California	17	Massachusetts	3	Pennsylvania	2
Colorado	3	Michigan	4	Rhode Island	3
Connecticut	2	Minnesota	6	South Carolina	18
Delaware	7	Mississippi	4	South Dakota	2
Dist. of Columbia	6	Missouri	5	Tennessee	1
Florida	4	Montana	7	Texas	14
Georgia	6	Nebraska	6	Utah	9
Hawaii	7	Nevada	4	Vermont	11
Idaho	9	New Hampshire	27	Virginia	2
Illinois	2	New Jersey	7	Washington	2
Indiana	3	New Mexico	8	West Virginia	6
Iowa	6	New York	1	Wisconsin	3
Kansas	10	North Carolina	5	Wyoming	3

Source: 2008 Medicaid Analytic Files

Note: Zero represents an amount less than 0.5 percent. '-' means that no claims were reported for services and therefore there were no claims with a missing provider.

Appendix F. Prescription Medications by Therapeutic Class

Psychotherapeutic, Antidepressants

- Amitriptyline Hydrochloride
- Amitriptyline Hydrochloride/Chlordiazepoxide
- Amitriptyline Hydrochloride/Perphenazine
- Amoxapine
- Bupropion Hydrochloride
- Citalopram Hydrobromide
- Clomipramine Hydrochloride
- Desipramine Hydrochloride
- Desvenlafaxine Succinate
- Doxepin Hydrochloride
- Duloxetine Hydrochloride
- Escitalopram Oxalate
- Fluoxetine Hydrochloride
- Fluvoxamine Maleate
- Imipramine Hydrochloride
- Imipramine Pamoate
- Maprotiline Hydrochloride
- Mirtazapine
- Nefazodone Hydrochloride
- Nortriptyline Hydrochloride
- Paroxetine Hydrochloride
- Phenelzine Sulfate
- Protriptyline Hydrochloride
- Sertraline Hydrochloride
- Tranylcypromine Sulfate
- Trazodone Hydrochloride
- Trimipramine Maleate
- Venlafaxine Hydrochloride
- Vilazodone Hydrochloride

Psychotherapeutic, Tranquilizers/Antipsychotics

- Aripiprazole
- Asenapine
- Chlorpromazine
- Chlorpromazine Hydrochloride
- Chlorprothixene
- Clozapine
- Fluphenazine Decanoate
- Fluphenazine Hydrochloride
- Haloperidol
- Haloperidol Decanoate
- Haloperidol Lactate
- Iloperidone
- Loxapine Hydrochloride
- Loxapine Succinate
- Lurasidone Hydrochloride
- Mesoridazine Besylate
- Molindone Hydrochloride
- Olanzapine
- Olanzapine Pamoate
- Paliperidone
- Paliperidone Palmitate
- Pentaerythritol/Phenobarbital
- Perphenazine
- Pimozide
- Piperacetazine
- Prochlorperazine
- Prochlorperazine Edisylate
- Prochlorperazine Maleate
- Promazine Hydrochloride
- Quetiapine Fumarate
- Risperidone
- Thioridazine
- Thioridazine Hydrochloride
- Thiothixene
- Thiothixene Hydrochloride
- Trifluoperazine Hydrochloride
- Triflupromazine Hydrochloride
- Ziprasidone Hydrochloride
- Ziprasidone Mesylate

Appendix F. Prescription Medications by Therapeutic Class (Continued)

Stimulants and CNS Agents, Misc.
- Amphetamine Resin Complex/ Dextroamphetamine Resin
- Amphetamine Sulfate
- Amphetamine/Dextroamphetamine
- Armodafinil
- Dextroamphetamine Sulfate
- Lisdexamfetamine Dimesylate
- Methamphetamine Hydrochloride
- Methylphenidate
- Methylphenidate Hydrochloride
- Modafinil
- Pemoline

CNS Agents, Misc
- Atomoxetine Hydrochloride
- Fluoxetine Hydrochloride/Olanzapine

Anxiolytics, Sedatives, Hypnotics (ASH), NEC
- Ethanol/Phenobarbital
- Phenobarbital
- Phenobarbital Sodium
- Buspirone Hydrochloride
- Chloral Hydrate
- Doxepin Hydrochloride
- Eszopiclone
- Hydroxyzine Hydrochloride
- Hydroxyzine Pamoate
- Meprobamate
- Meprobamate W/Petn
- Meprobamate/Tridihexethyl
- Meprobamate---Ethopheptazine---Asa
- Ramelteon
- Zaleplon
- Zolpidem Tartrate

Anxiolytics, Sedatives, Hypnotics (ASH), Benzodiazepines
- Alprazolam
- Chlordiazepoxide
- Chlordiazepoxide Hydrochloride
- Clorazepate Dipotassium
- Dextrose/Lorazepam
- Dextrose/Midazolam Hydrochloride
- Diazepam
- Estazolam
- Flurazepam Hydrochloride
- Halazepam
- Lorazepam
- Lorazepam/Sodium Chloride
- Midazolam Hydrochloride
- Midazolam Hydrochloride/Sodium Chloride
- Oxazepam
- Prazepam
- Quazepam
- Temazepam
- Triazolam

Antimanic Agents, NEC
- Carbamazepine
- Lithium
- Lithium Carbonate
- Lithium Citrate
- Lithium Orotate

Opiate Part Agonist
- Buprenorphine Hydrochloride
- Buprenorphine Hydrochloride/Naloxone Hydrochloride
- Naloxone Hydrochloride

Opiate Antagonists, NEC
- Naltrexone
- Naltrexone Hydrochloride

Misc. Therapeutic Agents, NEC
- Disulfiram
- Acamprosate Calcium

Appendix G. Medicaid Mental Health and Substance Use Services by Provider Type: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, 2008

Diagnosis, Services., and Products	Number of MME Fee-for-Service			MME Fee-for-Service Payments				Distribution of Dual Fee-for-Service Payments (%)
	Claims[1] (Thousands)	Users (Thousands)	Claims Per User[2]	Amount ($ Millions)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	
All Health								
Total all services and products	395,852	6,733	58.8	95,037	11,162	240	14,115	100
Total All Service Providers	344,149	6,206	55.5	93,537	10,986	230	12,733	98
Total inpatient	17,880	1,601	11.2	3,719	437	205	2,291	4
Total outpatient	282,224	5,735	49.2	32,098	3,770	86	4,233	34
Total residential	43,960	1,508	29.2	57,720	6,779	1,161	33,864	61
All hospitals	21,581	2,977	7.2	6,132	720	269	1,947	6
General hospitals	21,043	2,967	7.1	5,802	681	261	1,853	6
Specialty hospitals	538	48	11.1	331	39	558	6,213	0
Physicians	94,512	5,126	18.4	4,618	542	46	852	5
Dentists	949	167	5.7	388	46	63	355	0
Other professionals	34,327	2,292	15.0	5,221	613	102	1,525	5
Home health	133,574	1,909	70.0	17,299	2,032	95	6,652	18
Nursing home	40,462	1,396	29.0	57,550	6,759	1,260	36,515	61
Transportation	10,162	820	12.4	902	106	43	531	1
Durable medical equipment (DME)	1,305	223	5.8	295	35	115	674	0
Other personal and public health	5,004	162	30.9	529	62	105	3,230	1
Specialty mental health centers	4,973	160	16.7	524	62	139	2,321	1
Substance abuse treatment	31	2	31.0	4	1	104	3,233	0
Day care[4]	2,188	50	43.9	604	71	234	10,260	1
Prescription Drugs	51,703	3,369	15.3	1,501	176	29	445	2

Source: 2008 Medicaid Analytic Files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine. MME = Medicaid and Medicaid enrollees who are enrolled in both programs simultaneously; MHSA = mental health and substance abuse; MH = mental health; SUD = substance use disorder.

[1] Total all services and products includes claims from unidentified providers that are not shown separately.

[2] Calculation includes only those claims with a diagnosis and provider category.

[3] Fee-for-service enrollment for dual Medicare and Medicaid enrollees in 2008 was 8,514,234.

[4] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Appendix G. Medicaid Mental Health and Substance Use Services by Provider Type: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, 2008 (Continued)

	Number of MME Fee-for-Service			MME Fee-for-Service Payments				
Diagnosis, Services., and Products	Claims[1] (Thousands)	Users (Thousands)	Claims Per User[2]	Amount ($ Millions)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	Distribution of Dual Fee-for-Service Payments (%)
Mental Health								
Total all services and products	42,477	2,221	19.1	6,829	802	161	3,075	100
Total All Service Providers	31,850	1,251	25.5	6,504	764	169	4,314	95
Total inpatient	996	174	5.7	493	58	481	2,753	7
Total outpatient	28,098	1,094	25.7	3,226	379	89	2,295	47
Total residential	2,749	173	15.9	2,785	327	875	13,925	41
All hospitals	4,172	330	12.6	936	110	220	2,775	14
General hospitals	3,794	313	12.1	675	79	176	2,136	10
Specialty hospitals	379	37	10.3	262	31	657	6,800	4
Physicians	3,700	564	6.6	174	20	45	295	3
Dentists	1	0	2.3	0	0	32	74	0
Other professionals	11,824	535	22.1	1,520	179	89	1,955	22
Home health	5,099	97	52.8	748	88	104	5,504	11
Nursing home	2,364	132	18.0	2,749	323	1,005	18,062	40
Transportation	269	45	6.0	24	3	37	225	0
Durable medical equipment (DME)	12	2	6.6	1	0	116	769	0
Other personal and public health	4,314	141	30.6	334	39	77	2,353	5
Specialty mental health centers	4,310	141	28.3	334	39	243	6,871	5
Substance abuse treatment	4	0	30.6	1	0	77	2,347	0
Day care[4]	88	1	58.6	17	2	151	8,855	0
Prescription Drugs	10,627	1,415	7.5	325	38	31	230	5
MH share of all health	11%	33%	33%	7.2%	7%	67%	22%	

Source: 2008 Medicaid Analytic Files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine. MME = Medicaid and Medicaid enrollees who are enrolled in both programs simultaneously; MHSA = mental health and substance abuse; MH = mental health; SUD = substance use disorder.

[1] Total all services and products includes claims from unidentified providers that are not shown separately.

[2] Calculation includes only those claims with a diagnosis and provider category.

[3] Fee-for-service enrollment for dual Medicare and Medicaid enrollees in 2008 was 8,514,234.

[4] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Appendix G. Medicaid Mental Health and Substance Use Services by Provider Type: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, 2008 (Continued)

	Number of MME Fee-for-Service			MME Fee-for-Service Payments				
Diagnosis, Services., and Products	Claims[1] (Thousands)	Users (Thousands)	Claims Per User[2]	Amount ($ Millions)	Per Enrollee[3] ($)	Per Claim[2] ($)	Per User[2] ($)	Distribution of Dual Fee-for-Service Payments (%)
Substance Use Disorders								
Total all services and products	3,042	88	34.5	346	41	114	3,917	100
Total All Service Providers	3,027	106	28.4	343	40	91	2,600	99
Total inpatient	70	22	3.2	32	4	439	1,398	9
Total outpatient	2,858	90	31.8	196	23	49	1,573	57
Total residential	98	7	14.0	115	14	1,063	14,855	33
All hospitals	647	45	14.5	85	10	120	1,731	24
General hospitals	637	43	14.7	79	9	114	1,679	23
Specialty hospitals	10	2	4.1	5	1	480	1,991	1
Physicians	1,019	51	20.0	38	4	35	705	11
Dentists	0	0	1.3	0	0	12	15	0
Other professionals	1,053	25	42.0	83	10	39	1,631	24
Home health	77	2	44.4	13	2	116	5,154	4
Nursing home	65	4	14.5	111	13	1,559	22,643	32
Transportation	15	5	2.9	2	0	50	147	0
Durable medical equipment (DME)	1	0	2.8	0	0	51	145	0
Other personal and public health	150	7	20.8	12	1	78	1,623	3
Specialty mental health centers	123	6	16.5	8	1	125	2,052	2
Substance abuse treatment	27	2	21.5	3	0	68	1,453	1
Day care[4]	0	0	37.8	0	0	422	15,944	0
Prescription Drugs	14	3	4.8	2	0	151	727	1
SUD share of all health	0.8%	1.3%	58.6%	0.4%	0.4%	47%	28%	

Source: 2008 Medicaid Analytic Files

Note: Estimates other than for prescription drugs and DME estimates do not include Maine. MME = Medicaid and Medicaid enrollees who are enrolled in both programs simultaneously; MHSA = mental health and substance abuse; MH = mental health; SUD = substance use disorder.

[1] Total all services and products includes claims from unidentified providers that are not shown separately.

[2] Calculation includes only those claims with a diagnosis and provider category.

[3] Fee-for-service enrollment for dual Medicare and Medicaid enrollees in 2008 was 8,514,234.

[4] Includes only day care in unknown provider settings. Otherwise, day care is included with the provider where the service was received.

Appendix H. Medicaid Services and Products for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Enrollees, Claims, Users, and Payments for Medicare-Medicaid Enrollees, by State, 2008

		Number of MME MHSA Fee-for-Service			MME Fee-for-Service Payments for MHSA Services				
State	Number of Dual Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims per User[1]	Amount ($ Millions)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of Dual All-Health (%)
All United States	**8,421**	**45,284**	**2,252**	**20.1**	**7,152**	**849**	**158**	**3,176**	**7.5**
Alabama	186	801	36	22.1	87	467	108	2,387	7.0
Alaska	14	168	4	38.1	34	2,400	201	7,636	13.2
Arizona[2,3,5]	40	9	1	10.6	5	115	533	5,651	4.1
Arkansas	123	1,123	30	37.5	108	875	96	3,596	8.3
California	1,000	4,221	219	19.3	799	798	189	3,646	7.1
Colorado[4]	75	232	19	12.1	54	719	232	2,811	5.3
Connecticut	105	1,551	44	35.1	183	1,746	118	4,143	7.7
Delaware[3]	24	43	5	8.1	20	828	464	3,760	6.5
Dist. of Columbia[3]	20	142	5	30.1	27	1,318	189	5,700	2.8
Florida	572	1,260	115	11.0	428	749	340	3,734	11.8
Georgia[3]	260	733	50	14.5	86	330	117	1,698	5.0
Hawaii[3]	33	134	7	18.4	19	571	139	2,556	5.3
Idaho	32	528	10	53.8	44	1,407	84	4,512	11.1
Illinois	326	2,469	96	25.8	380	1,166	154	3,979	12.0
Indiana[3]	163	2,382	52	46.2	180	1,105	75	3,484	9.0
Iowa[5]	80	401	30	13.2	79	988	198	2,612	6.9
Kansas[4]	63	242	20	11.9	37	586	153	1,831	4.4
Kentucky	158	726	47	15.5	125	790	172	2,668	9.3
Louisiana	179	463	38	12.1	86	482	187	2,262	5.5
Maine[6]	-	-	-	-	-	-	-	-	-

Appendix H. Medicaid Services and Products for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Enrollees, Claims, Users, and Payments for Medicare-Medicaid Enrollees, by State, 2008 (Continued)

		Number of MME MHSA Fee-for-Service			MME Fee-for-Service Payments for MHSA Services				
State	Number of Dual Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims per User[1]	Amount ($ Millions)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of Dual All-Health (%)
Maryland[3]	112	505	32	15.9	126	1,132	250	3,969	7.4
Massachusetts	250	2,374	101	23.6	360	1,441	151	3,576	10.9
Michigan[2,3,5]	262	771	102	7.6	86	327	111	844	5.2
Minnesota[3]	124	1,555	39	39.8	289	2,334	186	7,394	12.5
Mississippi	153	553	34	16.1	83	543	151	2,427	7.2
Missouri	168	1,758	72	24.5	197	1,174	112	2,753	10.6
Montana	18	261	6	40.9	28	1,536	109	4,458	11.8
Nebraska[4]	42	365	16	22.3	53	1,248	144	3,225	8.8
Nevada	40	140	10	14.6	17	428	122	1,776	5.8
New Hampshire	29	469	12	38.9	69	2,327	146	5,693	15.8
New Jersey[3]	198	1,856	56	33.3	237	1,195	128	4,253	6.9
New Mexico[2,3,5]	54	76	9	8.4	26	485	345	2,899	4.2
New York[3]	743	4,881	189	25.8	1,014	1,364	208	5,366	5.9
North Carolina	313	2,555	98	26.0	250	798	98	2,541	8.8
North Dakota	16	135	5	26.9	19	1,214	139	3,745	6.1
Ohio[3]	309	2,281	112	20.3	312	1,009	137	2,773	6.7
Oklahoma	108	741	34	21.9	80	742	108	2,374	7.3
Oregon[3]	77	220	19	11.7	140	1,816	635	7,462	20.6
Pennsylvania[2,3,4]	316	597	75	7.9	175	555	294	2,333	4.5
Rhode Island[3]	40	264	14	19.1	104	2,578	392	7,493	14.9

Appendix H. Medicaid Services and Products for Treatment of Mental Health and Substance Use Disorders: Fee-for-Service Enrollees, Claims, Users, and Payments for Medicare-Medicaid Enrollees, by State, 2008 (Continued)

		Number of MME MHSA Fee-for-Service			MME Fee-for-Service Payments for MHSA Services				
State	Number of Dual Enrollees (Thousands)	Claims (Thousands)	Users (Thousands)	Claims per User[1]	Amount ($ Millions)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of Dual All-Health (%)
South Carolina	139	612	41	15.0	74	533	121	1,821	4.4
South Dakota	17	56	4	14.6	43	2,493	764	11,154	15.6
Tennessee[4]	169	89	15	5.9	50	298	567	3,353	3.1
Texas	585	881	95	9.3	148	253	168	1,559	3.4
Utah	27	132	11	11.5	20	758	155	1,779	7.4
Vermont	33	172	13	13.6	23	712	135	1,838	7.1
Virginia[3]	172	640	46	13.9	147	853	229	3,190	9.2
Washington[3,4]	156	959	65	14.7	48	311	50	739	5.5
West Virginia	80	421	24	17.8	48	601	114	2,022	6.7
Wisconsin	208	1,366	71	19.3	108	521	79	1,526	7.3
Wyoming	10	86	3	27.0	16	1,593	191	5,145	7.9

Source: 2008 Medicaid Analytic Files

Note: MHSA = Mental Health and Substance Abuse; MME = Medicaid and Medicaid enrollees who are enrolled in both programs simultaneously.

[1] Calculation of claims and users includes those with a missing diagnosis or missing provider category.

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Appendix I. Medicaid Prescription Drugs for Treatment of Mental and Substance Use Disorders by Diagnosis and Therapeutic Class: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, 2008

	Number of MME Fee-for-Service Drug			MME Fee-for-Service Drug Payments				Distribution of MME Fee-for-Service Payments Among		
Mental Health and Substance Abuse Drug Subtotals by Therapeutic Class	**Claims (Thousands)**	**Users (Thousands)**	**Claims Per User**	**Amount (Millions $)**	**Per Enrollee[1] ($)**	**Per Claim ($)**	**Per User ($)**	**All Drugs (%)**	**MHSA Drugs (%)**	**MH and SA Drugs Separately (%)**
All Drugs	**51,703.3**	**3,368.8**	**15.3**	**1,500.6**	**176.25**	**29.02**	**445**	**100.0**	**-**	**-**
Total MHSA drugs	10,641.8	1,415.4	7.5	327.5	38.46	30.77	231	21.8	100	-
Total SA Drugs	**14.5**	**3.0**	**4.8**	**2.2**	**0.26**	**150.73**	**727**	**0.1**	**1**	**100**
Opiate partial agonists[2]	8.2	1.3	6.1	1.6	0.19	199.73	1,223	0.1	1	76
Opiate antagonists, NEC[3]	2.7	0.7	4.0	0.2	0.03	93.01	376	0.0	0	11
Misc. therapeutic agents, NEC[4]	3.6	1.1	3.2	0.3	0.03	80.20	259	0.0	0	13
Total MH Drugs	**10,627.4**	**1,415.1**	**7.5**	**325.3**	**38.20**	**30.61**	**230**	**21.7**	**99**	**100**
Psychotherapeutic, antidepressants	1,526.7	249.1	6.1	55.7	6.54	36.48	224	3.7	17	17
Psychotherapeutic, tranquilizers/antipsychotics	820.5	120.0	6.8	153.5	18.03	187.06	1,279	10.2	47	47
Stimulants and CNS agents, misc.	64.8	12.8	5.1	7.3	0.85	112.23	567	0.5	2	2
Anxiolytics, sedatives, hypnotics (ASH), benzo.	7,361.1	1,155.7	6.4	93.9	11.03	12.76	81	6.3	29	29
Anxiolytics, sedatives, hypnotics (ASH), NEC	806.3	131.2	6.1	14.2	1.66	17.57	108	0.9	4	4
Antimanic agents, NEC	48.0	9.7	5.0	0.7	0.08	14.96	74	0.0	0	0

Source: 2008 Medicaid Analytic Files

Note: MME = Medicaid and Medicaid enrollees who are enrolled in both programs simultaneously; Misc. = Miscellaneous; NEC = Not Elsewhere Classified' benzo = benzodiazepines MHSA = Mental Health and Substance Abuse; SA = Substance Abuse; MH = Mental Health.

[1] Fee-for-service enrollment for dual Medicare and Medicaid enrollees in 2008 was 8,514,234.

[2] Includes buprenorphine hydrochloride and buprenophine/naloxone combination.

[3] Includes naltrexone HCl used to treat alcohol and drug addiction.

[4] Includes disulfiram and acamprosate used to treat alcohol addiction.

Appendix J. Medicaid Prescription Drugs for Treatment of Mental and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, by State, 2008

State	Number of Enrollees	Number of MME Fee-for-Service MHSA Drug			MME Fee-for-Service MHSA Drug Payments				
		Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of MME All-Health Drugs (%)
All United States	**8,421**	**10,642**	**1,415**	**7.5**	**327.5**	**39**	**31**	**231**	**22**
Alabama	186	163	23	7.2	3.7	20	23	164	26
Alaska	14	17	2	7.7	0.9	63	52	398	30
Arizona[2,3,5]	40	0	0	3.5	0.0	0	93	327	13
Arkansas	123	125	18	7.1	5.8	47	47	333	34
California	1,000	762	131	5.8	40.7	41	53	310	17
Colorado[4]	75	78	11	7.2	3.5	47	46	327	32
Connecticut	105	436	37	11.6	8.8	84	20	235	20
Delaware[3]	24	23	3	7.4	1.2	50	52	384	22
Dist. of Columbia[3]	20	13	2	6.6	1.0	51	79	521	20
Florida	572	595	78	7.7	11.3	20	19	145	22
Georgia[3]	260	193	28	6.8	5.9	23	31	209	24
Hawaii[3]	33	21	4	5.8	0.8	25	39	227	19
Idaho	32	41	5	8.0	1.7	55	42	334	35
Illinois	326	488	65	7.6	12.1	37	25	188	21
Indiana[3]	163	204	27	7.7	7.1	44	35	266	29
Iowa[5]	80	141	18	7.8	3.7	46	26	204	33
Kansas[4]	63	154	16	9.7	2.9	45	19	180	28
Kentucky	158	227	25	9.1	3.5	22	16	141	14
Louisiana	179	159	23	6.9	5.6	31	35	245	24
Maine[6]	93	117	15	7.7	3.6	39	30	236	26

Appendix J. Medicaid Prescription Drugs for Treatment of Mental and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, by State, 2008 (Continued)

State	Number of Enrollees	Number of MME Fee-for-Service MHSA Drug			MME Fee-for-Service MHSA Drug Payments				
		Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of MME All-Health Drugs (%)
Maryland[3]	112	110	15	7.3	4.9	44	44	322	35
Massachusetts	250	353	52	6.8	8.1	32	23	155	24
Michigan[2,3,5]	262	412	55	7.5	13.1	50	32	237	45
Minnesota[3]	124	96	14	6.9	4.7	38	50	340	32
Mississippi	153	93	15	6.3	4.0	26	43	267	24
Missouri	168	380	45	8.4	13.6	81	36	299	24
Montana	18	24	3	7.2	0.9	49	38	275	31
Nebraska[4]	42	74	10	7.5	2.2	53	30	227	26
Nevada	40	69	7	9.5	1.4	34	19	185	23
New Hampshire	29	45	6	7.4	1.6	53	35	259	28
New Jersey[3]	198	295	40	7.3	9.9	50	34	245	22
New Mexico[2,3,5]	54	8	2	4.3	0.2	3	24	103	14
New York[3]	743	569	85	6.7	35.2	47	62	414	22
North Carolina	313	489	68	7.2	15.3	49	31	226	24
North Dakota	16	17	2	7.5	0.4	28	25	192	24
Ohio[3]	309	470	61	7.7	9.1	30	19	150	23
Oklahoma	108	122	20	6.1	3.3	30	27	163	32
Oregon[3]	77	99	14	6.9	3.9	50	39	268	40
Pennsylvania[2,3,4]	316	531	69	7.7	9.4	30	18	135	24
Rhode Island[3]	40	53	8	6.8	1.6	40	30	205	31

Appendix J. Medicaid Prescription Drugs for Treatment of Mental and Substance Use Disorders: Fee-for-Service Claims, Users, and Payments for Medicare-Medicaid Enrollees, by State, 2008 (Continued)

State	Number of Enrollees	Number of MME Fee-for-Service MHSA Drug			MME Fee-for-Service MHSA Drug Payments				
		Claims (Thousands)	Users (Thousands)	Claims Per User[1]	Amount (Millions $)	Per Enrollee ($)	Per Claim[1] ($)	Per User[1] ($)	As a Share of MME All-Health Drugs (%)
South Carolina	139	210	29	7.1	3.9	28	18	132	22
South Dakota	17	20	3	7.3	0.6	32	28	202	30
Tennessee[4]	169	57	8	6.7	6.6	39	116	779	23
Texas	585	463	81	5.7	17.0	29	37	210	26
Utah	27	57	8	7.6	2.7	99	46	354	33
Vermont	33	96	10	9.7	2.4	73	25	238	18
Virginia[3]	172	201	26	7.6	3.2	18	16	120	17
Washington[3,4]	156	696	59	11.8	9.2	59	13	156	20
West Virginia	80	140	15	9.1	3.2	40	23	210	28
Wisconsin	208	427	52	8.3	11.9	57	28	230	9
Wyoming	10	10	2	6.8	0.4	43	43	289	31

Source: 2008 Medicaid Analytic Files

MME = Medicare and Medicaid Enrollee; MHSA = Mental Health and Substance Abuse; SA = Substance Abuse; MH = Mental Health

[1] Calculation includes only those claims with a national drug code (NDC).

[2] States paid over 50% of their Medicaid expenditures as premiums.

[3] States had greater than 50% enrollment in comprehensive managed care plans.

[4] States had rates of behavioral managed care enrollment greater than 80%.

[5] States had rates of behavioral managed care enrollment greater than 50%.

[6] Maine provides only prescription drug claims in MAX.

Appendix K. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Eligibility for All Enrollees, by State, 2008

	Children (0–18 Years) Percentage of Total Enrollment					Adults (19–64 Years) Percentage of Total Enrollment				
State	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]
All United States	**11.5**	**9.6**	**40.3**	**25.3**	**13.3**	**8.3**	**6.7**	**32.7**	**11.5**	**39.8**
Alabama	0.0	0.0	0.0	95.6	4.4	0.0	0.0	0.0	20.6	79.4
Alaska	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0
Arizona	86.8	0.2	0.0	1.5	11.5	74.9	0.4	0.9	0.0	23.7
Arkansas	0.0	0.0	0.0	91.9	8.1	0.0	0.0	0.0	34.5	65.5
California	0.0	0.0	66.6	22.4	11.0	0.0	0.0	24.2	8.6	67.3
Colorado	9.6	89.1	0.0	0.0	1.2	7.5	85.0	0.0	0.0	7.6
Connecticut	0.0	0.0	7.9	0.0	92.1	0.0	0.0	7.3	0.0	92.7
Delaware	0.0	0.0	81.9	16.4	1.7	0.0	0.0	73.7	12.9	13.4
Dist. of Columbia	0.0	0.0	87.7	5.0	7.3	0.0	0.0	88.7	2.7	8.6
Florida	0.0	30.3	47.4	5.3	17.0	0.0	13.7	32.0	2.1	52.2
Georgia	0.0	0.0	83.2	16.8	0.0	0.0	0.0	77.1	22.1	0.8
Hawaii	2.7	0.0	93.4	0.0	3.9	0.4	0.0	90.0	0.0	9.5
Idaho	0.0	0.0	0.0	98.6	1.4	0.0	0.0	0.0	97.5	2.5
Illinois	0.0	0.0	7.5	76.7	15.7	0.0	0.0	4.6	52.1	21.6
Indiana	0.0	0.0	82.8	1.9	15.2	0.0	0.0	76.7	0.1	23.2
Iowa	1.9	95.7	0.0	0.0	2.3	1.1	49.9	0.0	0.0	49.0
Kansas	69.0	30.4	0.0	0.0	0.5	67.5	31.4	0.0	0.0	1.0
Kentucky	0.0	0.0	24.6	74.6	0.8	0.0	0.0	20.7	78.7	0.6
Louisiana	0.0	0.0	0.0	90.6	9.4	0.0	0.0	0.0	40.9	59.1
Maine	0.0	0.0	0.0	78.6	21.4	0.0	0.0	0.0	78.2	21.8

Appendix K. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Eligibility for All Enrollees, by State, 2008 (Continued)

	Children (0–18 Years) Percentage of Total Enrollment					Adults (19–64 Years) Percentage of Total Enrollment				
State	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]
Maryland	0.0	0.0	93.5	0.0	6.5	0.0	0.0	60.5	0.0	39.5
Massachusetts	0.1	25.9	55.9	0.3	17.8	0.0	25.2	24.9	0.2	49.7
Michigan	55.9	41.7	0.1	0.1	2.1	48.8	20.6	14.7	0.0	15.9
Minnesota	0.0	0.0	77.0	0.0	23.0	0.0	0.0	65.1	0.0	34.9
Mississippi	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	59.7	40.3
Missouri	0.0	0.0	64.9	0.0	35.1	0.0	0.0	53.0	0.0	47.0
Montana	0.0	0.0	0.0	50.8	49.2	0.0	0.0	0.0	31.5	68.5
Nebraska	18.9	72.5	0.0	0.0	8.5	18.6	60.1	0.0	0.0	21.3
Nevada	0.0	0.0	65.1	23.3	11.6	0.0	0.0	60.0	22.8	17.2
New Hampshire	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0
New Jersey	0.0	0.0	89.2	0.0	10.8	0.0	0.0	86.1	0.0	13.9
New Mexico	80.1	0.2	0.1	0.0	19.7	37.2	0.0	22.8	0.0	40.0
New York	0.0	0.0	78.6	0.5	20.9	0.0	0.0	80.3	0.3	19.5
North Carolina	0.0	4.8	0.0	79.4	15.8	0.0	4.7	0.0	48.7	46.6
North Dakota	0.0	0.0	0.0	83.4	16.6	0.0	0.0	0.0	88.8	11.2
Ohio	0.0	0.0	86.0	0.0	14.0	0.0	0.0	84.9	0.0	15.1
Oklahoma	0.0	0.0	0.0	90.3	9.7	0.0	0.0	0.0	47.3	52.7
Oregon	0.8	87.0	0.6	3.3	8.2	0.7	76.9	0.9	1.7	19.7
Pennsylvania	67.3	21.5	0.3	6.4	4.5	61.1	20.7	0.1	5.5	12.6
Rhode Island	0.0	0.0	89.3	0.0	10.7	0.0	0.0	86.0	0.0	14.0

Appendix K. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Eligibility for All Enrollees, by State, 2008 (Continued)

State	Children (0–18 Years) Percentage of Total Enrollment					Adults (19–64 Years) Percentage of Total Enrollment				
	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]
South Carolina	0.0	0.0	31.9	67.8	0.2	0.0	0.0	17.6	48.9	33.5
South Dakota	0.0	0.0	0.0	90.2	9.8	0.0	0.0	0.0	88.3	11.7
Tennessee	38.2	61.7	0.0	0.0	0.1	37.7	62.2	0.0	0.0	0.1
Texas	10.0	2.5	42.1	29.1	16.3	4.5	1.0	25.6	15.7	53.2
Utah	0.0	0.0	0.0	99.4	0.6	0.0	35.3	0.0	20.6	44.2
Vermont	0.0	0.0	0.0	78.1	21.9	0.0	0.0	0.0	75.8	24.2
Virginia	0.0	0.0	72.2	7.6	20.1	0.0	0.0	62.7	7.5	29.8
Washington	79.2	20.8	0.0	0.0	0.0	46.8	51.9	0.0	0.0	1.3
West Virginia	0.0	0.0	76.4	9.9	13.7	0.0	0.0	62.4	7.5	30.0
Wisconsin	0.0	0.1	71.6	0.0	28.2	0.0	0.0	60.5	0.1	39.4
Wyoming	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0

Source: 2008 Medicaid Analytic eXtract (MAX) files

Notes: Percentages were calculated by counting months of enrollment for each Medicaid enrollee in a managed care plan combination or fee-for-service divided over total months of enrollment in Medicaid overall. BH = behavioral health; combo = combination; FFS = fee-for-service; Mgd = managed.

Plan Definitions:

[1] Comprehensive plan with behavioral plan

[2] Behavioral plan only, comprehensive plan with behavioral and dental plans, behavioral plan with Primary Care Case Management (PCCM), behavioral and dental plans with PCCM, behavioral and dental plans only

[3] Comprehensive plan only, comprehensive plan with dental plan only, comprehensive plan with other managed care plan

[4] Dental plan only, PCCM only, PCCM and dental plan, PCCM and other managed care plan, other managed care plan only, other combination

[5] FFS ONLY with no associated managed care plan

Appendix K. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Eligibility for All Enrollees, by State, 2008 (Continued)

State	Disabled Percentage of Total Enrollment					Aged (65+ Years) % of total enrollment					Total Medicaid FFS Payments ($ Millions)	Total Medicaid Premium Payments ($ Millions)
	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]		
All United States	**6.9**	**13.7**	**13.4**	**27.3**	**38.7**	**1.6**	**8.3**	**6.6**	**20.9**	**62.5**	**224,204**	**68,951**
Alabama	0.0	0.0	5.2	54.4	40.4	0.0	0.0	11.8	1.9	86.3	2,900	474
Alaska	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	977	0
Arizona	62.2	0.5	0.0	23.2	14.1	43.5	0.0	0.0	20.5	36.1	1,156	6,478
Arkansas	0.0	0.0	0.0	80.3	19.7	0.0	0.0	0.0	59.0	41.0	3,278	23
California	0.0	0.0	24.0	75.5	0.5	0.0	0.0	15.8	79.5	4.7	26,024	6,698
Colorado	8.9	79.2	0.0	0.3	11.6	5.6	72.9	0.0	2.5	19.0	2,536	388
Connecticut	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	3,834	63
Delaware	0.0	0.0	45.8	31.1	23.1	0.0	0.0	4.2	41.4	54.4	703	459
Dist. of Columbia	0.0	0.0	10.8	81.3	7.9	0.0	0.0	0.1	81.1	18.8	1,363	317
Florida	0.0	21.9	22.6	6.4	49.1	0.0	2.3	6.4	0.5	90.8	9,788	2,790
Georgia	0.0	0.0	1.7	82.7	15.6	0.0	0.0	0.0	47.5	52.5	4,606	2,279
Hawaii	0.2	2.9	7.7	0.0	89.2	0.0	0.1	0.7	0.0	99.2	655	383
Idaho	0.0	0.0	0.0	75.6	24.4	0.0	0.0	0.0	45.3	54.7	1,229	34
Illinois	0.0	0.0	0.0	27.8	72.1	0.0	0.0	0.0	6.6	93.4	9,731	242
Indiana	0.0	0.0	10.8	24.2	65.0	0.0	0.0	0.0	2.1	97.8	3,838	1,242
Iowa	0.0	91.3	0.0	0.0	8.7	0.0	1.1	0.0	0.0	98.8	2,534	127
Kansas	1.0	79.7	0.0	0.1	19.2	0.0	41.0	0.0	0.5	58.4	1,690	514
Kentucky	0.0	0.0	15.4	68.0	16.6	0.0	0.0	6.7	53.8	39.5	4,368	716
Louisiana	0.0	0.0	0.0	37.4	62.6	0.0	0.0	0.0	0.7	99.3	5,041	26
Maine	0.0	0.0	0.0	4.8	95.2	0.0	0.0	0.0	0.1	99.9	211	474

Appendix K. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Eligibility for All Enrollees, by State, 2008 (Continued)

State	Disabled Percentage of Total Enrollment					Aged (65+ Years) % of total enrollment					Total Medicaid FFS Payments ($ Millions)	Total Medicaid Premium Payments ($ Millions)
	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]		
Maryland	0.0	0.0	51.4	0.0	48.6	0.0	0.0	0.5	0.2	99.3	4,477	1,291
Massachusetts	0.0	31.6	14.2	0.5	53.7	0.0	0.8	0.5	9.9	88.8	6,438	2,440
Michigan	44.8	49.6	0.5	0.0	5.1	1.0	84.1	0.0	0.2	14.6	3,457	3,555
Minnesota	0.0	0.0	6.1	0.0	93.9	0.0	0.0	69.4	0.0	30.6	4,474	1,899
Mississippi	0.0	0.0	0.0	81.9	18.1	0.0	0.0	0.0	49.6	50.4	3,096	0
Missouri	0.0	0.0	1.2	0.0	98.8	0.0	0.0	0.0	0.2	99.8	4,279	1,106
Montana	0.0	0.0	0.0	38.9	60.5	0.0	0.0	0.0	0.5	98.4	3,457	3,555
Nebraska	8.4	62.0	0.0	0.0	29.6	1.2	42.8	0.0	0.0	55.9	1,418	75
Nevada	0.0	0.0	0.8	73.3	25.9	0.0	0.0	0.0	58.0	42.0	973	158
New Hampshire	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	947	0
New Jersey	0.0	0.0	39.6	0.0	60.4	0.0	0.0	7.3	0.0	92.7	5,959	1,791
New Mexico	44.8	0.2	0.3	6.5	48.3	0.6	0.0	0.1	10.5	88.8	1,159	1,588
New York	0.0	0.0	30.8	1.5	67.7	0.0	0.0	8.4	4.6	86.9	34,347	7,825
North Carolina	0.0	4.9	0.0	43.5	51.5	0.0	4.7	0.0	10.5	84.8	8,881	171
North Dakota	0.0	0.0	0.0	4.9	95.1	0.0	0.0	0.0	0.2	99.8	552	1
Ohio	0.0	0.0	34.6	0.0	65.4	0.0	0.0	3.9	0.0	96.1	8,344	3,958
Oklahoma	0.0	0.0	0.0	83.2	16.8	0.0	0.0	0.0	79.5	20.5	3,270	123
Oregon	1.3	76.3	0.5	3.5	18.4	1.3	60.1	0.3	6.3	32.0	1,379	1,193
Pennsylvania	47.4	39.4	0.1	5.2	8.0	4.1	42.2	0.0	4.7	49.1	5,990	7,309
Rhode Island	0.0	0.0	10.9	0.1	89.0	0.0	0.0	0.0	0.4	99.6	1,235	343

Appendix K. Medicaid Enrollment in Managed Care Plan Combinations Versus Fee-for-Service by Eligibility for All Enrollees, by State, 2008 (Continued)

State	Disabled Percentage of Total Enrollment					Aged (65+ Years) % of total enrollment					Total Medicaid FFS Payments ($ Millions)	Total Medicaid Premium Payments ($ Millions)
	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]	Comp + BH[a]	Other BH Combo with BH[b]	Comp (without BH)[c]	All Other Mgd Care Combos[d]	FFS Only[e]		
South Carolina	0.0	0.0	11.4	84.2	4.4	0.0	0.0	0.0	85.5	14.5	3,207	408
South Dakota	0.0	0.0	0.0	24.7	75.3	0.0	0.0	0.0	0.0	100.0	668	4
Tennessee	25.9	69.3	0.0	0.0	4.8	18.3	32.0	0.0	0.3	49.3	4,371	1,828
Texas	5.4	3.6	23.8	13.5	53.7	3.5	0.7	16.2	0.2	79.3	13,437	3,733
Utah	0.0	5.0	0.0	87.9	7.1	0.0	20.8	0.0	67.5	11.7	1,033	111
Vermont	0.0	0.0	0.0	36.3	63.7	0.0	0.0	0.0	1.2	98.8	910	5
Virginia	0.0	0.0	33.7	7.9	58.4	0.0	0.0	2.4	0.4	97.2	3,515	1,720
Washington	3.1	96.8	0.0	0.0	0.0	0.7	99.0	0.0	0.3	0.0	3,753	1,254
West Virginia	0.0	0.0	0.8	1.3	98.0	0.0	0.0	0.0	0.0	100.0	1,907	230
Wisconsin	0.0	0.2	1.9	21.2	76.7	0.0	0.0	1.4	7.5	91.1	3,091	1,578
Wyoming	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	517	0

Source: 2008 Medicaid Analytic eXtract (MAX) files

Notes: Percentages were calculated by counting months of enrollment for each Medicaid enrollee in a managed care plan combination or fee-for-service divided over total months of enrollment in Medicaid overall. BH = behavioral health; combo = combination; FFS = fee-for-service; Mgd = managed.

Plan Definitions:

[1] Comprehensive plan with behavioral plan

[2] Behavioral plan only, comprehensive plan with behavioral and dental plans, behavioral plan with Primary Care Case Management (PCCM), behavioral and dental plans with PCCM, behavioral and dental plans only

[3] Comprehensive plan only, comprehensive plan with dental plan only, comprehensive plan with other managed care plan

[4] Dental plan only, PCCM only, PCCM and dental plan, PCCM and other managed care plan, other managed care plan only, other combination

[5] FFS ONLY with no associated managed care plan

Appendix L. Medicaid Expenditures to Managed Care Plans by Eligibility for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008

	Children (0–18 Years) ($ Millions)				Adults (19–64 Years) ($ Millions)				Disabled (19–64 Years) ($ Millions)			
	MMEs		Non-MMEs		MMEs		Non-MMEs		MMEs		Non-MMEs	
State	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium
All United States	**22**	**4**	**32,763**	**26,024**	**315**	**4**	**21,185**	**18,243**	**42,096**	**3,116**	**70,500**	**16,044**
Alabama	0	0	602	342	2	0	226	19	526	7	852	102
Alaska	0	0	305	0	1	0	145	0	121	0	258	0
Arizona	0	0	298	1,468	2	50	401	2,183	71	509	308	1,518
Arkansas	0	0	865	17	1	0	167	1	498	1	968	4
California	1	0	2,968	2,990	41	16	3,250	1,049	4,647	676	9,288	1,010
Colorado	0	0	465	149	0	0	242	27	385	37	775	110
Connecticut	1	0	401	38	12	0	198	25	958	0	787	0
Delaware	0	0	105	110	1	0	101	243	130	3	178	98
Dist. of Columbia	0	0	110	120	10	1	44	119	318	3	588	72
Florida	2	0	1,509	999	8	1	1,171	364	1,787	89	2,820	979
Georgia	0	0	542	1,319	1	1	430	894	685	20	1,898	36
Hawaii	0	0	33	157	1	1	39	217	107	1	226	7
Idaho	0	0	248	27	0	0	122	4	190	1	452	1
Illinois	1	0	2,187	149	29	0	1,170	83	1,941	1	3,042	4
Indiana	0	0	417	674	1	2	126	478	879	2	1,269	85
Iowa	0	0	399	45	1	0	272	23	557	23	705	35
Kansas	0	0	184	260	1	1	51	141	382	23	585	76
Kentucky	0	0	878	278	3	1	508	119	498	27	1,495	270
Louisiana	0	0	1,100	20	3	0	535	2	684	0	1,798	2
Maine	1	0	38	0	6	0	69	0	823	0	89	0

Appendix L. Medicaid Expenditures to Managed Care Plans by Eligibility for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (continued)

	Children (0–18 Years) ($ Millions)				Adults (19–64 Years) ($ Millions)				Disabled (19–64 Years) ($ Millions)			
	MMEs		Non-MMEs		MMEs		Non-MMEs		MMEs		Non-MMEs	
State	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium
Maryland	0	0	754	478	3	1	307	360	8	18	1,571	430
Massachusetts	0	0	631	937	6	2	615	567	1,368	29	1,700	593
Michigan	0	0	523	991	11	134	334	759	309	252	936	1,347
Minnesota	0	0	355	796	8	5	176	466	1,365	53	1,611	68
Mississippi	0	0	638	0	1	0	334	0	416	0	936	0
Missouri	1	0	630	790	4	1	219	278	839	9	1,504	16
Montana	0	0	148	1	6	0	75	0	73	0	189	0
Nebraska	0	0	359	36	1	0	115	19	268	1	330	18
Nevada	0	0	198	108	1	0	63	48	112	0	399	1
New Hampshire	0	0	251	0	3	0	62	0	195	0	192	0
New Jersey	4	2	486	708	4	19	158	627	1,737	67	1,450	335
New Mexico	0	0	162	698	0	0	97	431	362	11	311	436
New York	1	0	2,495	2,014	66	15	3,845	3,326	8,344	207	10,305	1,319
North Carolina	0	0	2,006	65	13	0	1,128	11	1,151	33	2,868	57
North Dakota	0	0	85	0	0	0	49	0	130	0	108	0
Ohio	0	0	516	1,478	5	4	252	1,197	1,862	44	2,713	1,165
Oklahoma	0	0	916	79	2	0	345	9	486	6	880	21
Oregon	0	0	172	352	0	0	138	346	208	70	390	354
Pennsylvania	0	0	374	2,155	4	10	283	1,261	946	201	1,339	3,403
Rhode Island	0	0	121	156	3	1	18	143	347	0	391	42

Appendix L. Medicaid Expenditures to Managed Care Plans by Eligibility for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (continued)

	Children (0–18 Years) ($ Millions)				Adults (19–64 Years) ($ Millions)				Disabled (19–64 Years) ($ Millions)			
	MMEs		Non-MMEs		MMEs		Non-MMEs		MMEs		Non-MMEs	
State	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium	FFS	Premium
South Carolina	0	0	724	178	14	1	439	90	481	9	929	118
South Dakota	0	0	179	3	0	0	73	0	117	0	167	0
Tennessee	0	0	799	603	4	5	544	448	801	240	1,402	474
Texas	3	0	3,389	2,315	7	1	985	443	1,569	154	4,506	512
Utah	0	0	276	23	0	0	167	8	147	34	313	40
Vermont	0	0	192	3	3	0	182	2	147	0	208	0
Virginia	1	0	660	643	1	1	180	404	718	17	1,037	618
Washington	0	0	338	763	0	0	238	443	575	4	1,561	33
West Virginia	0	0	246	148	1	0	108	80	297	0	815	2
Wisconsin	0	0	350	339	14	3	349	484	430	231	895	233
Wyoming	0	0	136	0	0	0	52	0	104	0	122	0

Source: 2008 Medicaid Analytic eXtract (MAX) Files

Note: FFS, fee-for-service; MME = Medicare-Medicaid enrollee

Appendix L. Medicaid Expenditures to Managed Care Plans by Eligibility for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (continued)

State	Aged (65+ Years) ($ Millions)				Total Medicaid FFS ($ Millions)	Total Medicaid Premium ($ Millions)	Total Medicaid Payments ($ Millions)
	MMEs		Non-MMEs				
	FFS	Premium	FFS	Premium			
All United States	**54,523**	**4,566**	**2,800**	**676**	**224,204**	**68,677**	**292,881**
Alabama	688	3	4	0	2,900	474	3,375
Alaska	127	0	21	0	977	0	977
Arizona	34	673	42	77	1,156	6,478	7,634
Arkansas	745	1	34	0	3,278	23	3,301
California	5,213	903	617	54	26,024	6,698	32,723
Colorado	623	61	46	4	2,536	388	2,923
Connecticut	1,413	0	64	0	3,834	63	3,897
Delaware	183	1	6	3	703	459	1,163
Dist. of Columbia	270	1	24	0	1,363	317	1,680
Florida	2,404	265	87	93	9,788	2,790	12,579
Georgia	1,013	9	37	0	4,606	2,279	6,885
Hawaii	247	1	4	0	655	383	1,039
Idaho	206	1	12	0	1,229	34	1,264
Illinois	1,252	3	108	0	9,731	242	9,973
Indiana	1,112	0	34	0	3,838	1,242	5,079
Iowa	595	0	5	0	2,534	127	2,661
Kansas	466	12	21	1	1,690	514	2,204
Kentucky	972	18	13	3	4,368	716	5,084
Louisiana	886	2	34	0	5,041	26	5,067
Maine	933	0	1	0	1,960	0	1,960

Appendix L. Medicaid Expenditures to Managed Care Plans by Eligibility for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (continued)

	Aged (65+ Years) ($ Millions)				Total Medicaid FFS ($ Millions)	Total Medicaid Premium ($ Millions)	Total Medicaid Payments ($ Millions)
	MMEs		Non-MMEs				
State	FFS	Premium	FFS	Premium			
Maryland	2	3	82	0	2,728	1,291	4,019
Massachusetts	2,001	294	117	19	6,438	2,440	8,877
Michigan	1,334	71	10	1	3,457	3,555	7,012
Minnesota	940	466	19	45	4,474	1,899	6,373
Mississippi	729	0	10	0	3,064	0	3,064
Missouri	1,020	12	63	1	4,279	1,106	5,386
Montana	164	0	1	0	655	1	656
Nebraska	322	0	23	2	1,418	75	1,493
Nevada	188	1	11	0	973	158	1,131
New Hampshire	231	0	13	0	947	0	947
New Jersey	2,040	11	79	22	5,959	1,791	7,750
New Mexico	224	9	3	2	1,159	1,588	2,747
New York	8,798	818	493	126	34,347	7,825	42,172
North Carolina	1,705	5	9	0	8,881	171	9,052
North Dakota	178	0	1	0	552	1	552
Ohio	2,724	8	272	62	8,344	3,958	12,302
Oklahoma	616	7	24	0	3,270	123	3,393
Oregon	465	64	6	6	1,379	1,193	2,571
Pennsylvania	2,972	178	71	101	5,990	7,309	13,299
Rhode Island	348	0	7	0	1,235	343	1,578

Appendix L. Medicaid Expenditures to Managed Care Plans by Eligibility for Medicare-Medicaid Enrollees Versus Non-Medicare-Medicaid Enrollees, by State, 2008 (continued)

State	Aged (65+ Years) ($ Millions)				Total Medicaid FFS ($ Millions)	Total Medicaid Premium ($ Millions)	Total Medicaid Payments ($ Millions)
	MMEs		Non-MMEs				
	FFS	Premium	FFS	Premium			
South Carolina	619	13	0	0	3,207	408	3,615
South Dakota	131	0	1	0	668	4	672
Tennessee	807	55	13	3	4,371	1,828	6,199
Texas	2,885	295	95	11	13,437	3,733	17,170
Utah	125	5	4	0	1,033	111	1,144
Vermont	174	0	5	0	910	5	915
Virginia	878	2	42	34	3,515	1,720	5,235
Washington	944	9	96	2	3,753	1,254	5,007
West Virginia	435	0	4	0	1,907	230	2,137
Wisconsin	1,041	283	11	4	3,091	1,578	4,670
Wyoming	101	0	1	0	517	0	517

Source: 2008 Medicaid Analytic eXtract (MAX) Files

Note: FFS, fee-for-service; MME = Medicare-Medicaid enrollee

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