

Health Care / Medicaid

Caseloads are projected to have a net increase in the FY 2002-2003 biennium. The Healthy Families, Healthy Start, and CHIP-I populations will drive the primary growth, along with a small, anticipated increase in the Aged, Blind and Disabled (ABD) population. While caseload growth contributes to the amount of increased funds needed to maintain program services, medical inflation is also responsible for the increased funds required. In addition, the decline in cash assistance recipients in Ohio Works First (OWF) has caused a significant change in the Medicaid caseload composition. ABD eligibles comprised around 30 percent of the more than 1.2 million Medicaid eligibles in FY 1996, yet generated over 70 percent of all care-related Medicaid costs. By FY 2000, the ABD population had moved up to comprise about 34 percent of the 1.1 million Medicaid eligibles and generated about 80 percent of Medicaid spending. The cost of long-term care was the primary reason for the relative expense of the ABD population. In addition, the ABD population heavily utilizes some of the services with the fastest growing costs, such as prescription drugs.

Spending within the 525 line can generally be placed into one of eight major groupings: nursing homes (nursing facilities, or NFs, and Intermediate Care Facilities for the Mentally Retarded, or ICFs/MR), hospitals (inpatient and outpatient), physician services, prescription drugs, health maintenance organizations (HMOs), Medicare buy-in, waiver, and all other care. Prior to the implementation of the prospective payment system, most spending discussions focused on nursing homes; however, that emphasis has shifted somewhat in recent years to include financing the health care of certain eligibles through community-base service and the increasing cost of prescription drugs.

Another important point to note is the federal financial share of Ohio's Medicaid program changes every federal fiscal year. In accordance with federal law, the federal government shares in the state's cost of Medicaid at a matching rate known as the FMAP (Federal Medical Assistance Percentage).¹ The FMAP is calculated for each state based upon the state's per capita income in recent years relative to the entire nation. The general description of how this cost-sharing mechanism works has traditionally been as follows: for every \$1 dollar we (Ohio) spend on Medicaid, the federal government gives us 60 cents. However, from federal fiscal year (FFY) 1996 to FFY 1997, Ohio's FMAP rate dropped by 0.89 percentage points from 60.17 percent to 59.28 percent. An even larger drop occurred in FFY 1998, as Ohio's FMAP fell by 1.14 percentage points to 58.14 percent. In terms of Ohio's 525 line item, this resulted in a shift of approximately \$45.1 million from the Medicaid federal share to state GRF funding in FY 1998 and an additional shift of \$7.2 million in FY 1999. In total, across the biennium, approximately \$52.3 million of the financial burden in the 525 line item was shifted to the state share. However, Ohio's FMAP rate stopped declining in more recent years, improving by 0.12

¹ While the majority of the spending in the 525, Health Care/Medicaid, line item is matched at the FMAP, a few items, primarily contracts, within the All Other Care category are matched at 50 percent, and all family planning services receive a 90 percent match. In addition, about 15 percent of Medicare buy-in premiums receive no federal match. Lastly, the CHIP-II program is matched at about 70 percent.

and 0.41 percentage points to 58.26 percent and 58.67 percent in FFY 1999 and FFY 2000, respectively. In FFY 2001, the FMAP rate is 59.03 percent, a 0.36 percent increase over FFY 2000. However, in FFY 2002, the FMAP rate will fall to 58.78 percent, a decrease of 0.24 percent, shifting more of the responsibility of paying for the Medicaid program to the state.

HMO Assumption

While it is necessary to make multiple assumptions when forecasting Medicaid spending, one key assumption involves the use of managed care to finance the health care needs of Healthy Families/Healthy Start (HS) eligibles². Although Ohio has contracted with HMOs since the late 1970s to provide care for certain Medicaid eligibles, the use of capitated rates was not given major emphasis in Ohio's program until the state received an 1115 demonstration waiver in January 1995. As one initiative of the federally approved OhioCare proposal, the state was given the freedom to require mandatory HMO enrollment by Healthy Families/Healthy Start Medicaid eligibles. Ohio Medicaid's experience with mandatory enrollment on a large scale began in 1996, with the implementation of the waiver. However, despite a concerted effort to attract new plans, the program (as in the other areas of the country) has been plagued by limited interest and other obstacles. Counties with mandatory enrollment have dropped from a high of ten (Butler, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Montgomery, Stark, Summit and Wood) to four (Cuyahoga, Lorain, Lucas, and Summit).

LSC's baseline estimates assume that the "HMO penetration rate" will be about 29 percent for FY 2002 and FY 2003. In other words, about 29 percent of the Covered Family and Children consumers are expected to be enrolled in a Medicaid HMO during the next biennium.

Methodology

Due to the delayed submissions of claims by providers and delays in processing payments, claims are not always paid in the same quarter in which services are given to Medicaid eligibles. In fact, it is generally the case that providers are not completely reimbursed for all of the services they give to Medicaid eligibles until well over a year following the date of service. Thus, it is necessary to make the distinction between the date of service and the date of payment.

Because disbursements from the 525 line item reflect the payment of claims and not the provision of services, it is necessary to incorporate the appropriate payment lags when estimating spending from the 525 line item. In short, forecasting Medicaid spending involves the estimation of the number of Medicaid eligibles in each month. Then it is necessary to estimate the demand each eligibility group will have for each major category of service. The next step is to estimate the relevant cost-per-claim. Taken together these estimates can be used to predict the cost of services in a given period (in this case, quarterly). However, disbursement estimates reflect the payment of claims – so it is necessary to apply the appropriate payment lags before the estimates are complete.

² These eligible groups are also referred to as Covered Families and Children.

Eligibility

While individuals can become eligible for Medicaid programs that are funded out of the 525 line item by meeting any one of many sets of eligibility criteria, all of these various eligibility groups can be categorized into six major eligibility types: Aged, Blind and Disabled (ABD); Healthy Start (HS), Healthy Families, Qualified Medicare Beneficiaries (QMBs); and Specified Low-Income Medicare Beneficiaries (SLMBs); and a sixth group – Children in families with incomes at or below 150 percent of the federal poverty level (FPL) known as CHIP-I. Each of these groups will be discussed briefly in turn.

ABD. The ABD eligibility group is loosely based on the Supplemental Security Income (SSI) program. Although SSI eligibility generally leads to Medicaid eligibility in most states, Ohio and 11 other states exercise what is known as the “spend-down” option. In other words, Ohio has opted to use a more restrictive income test than that incorporated in the eligibility guidelines of the SSI program (100 percent of the FPL); however, once individuals who do not meet the initial ABD income test spend an amount on medical care such that their income after medical expenses is at or below the more restrictive ABD income level of about 63 percent of the FPL, they “spend-down” to Medicaid eligibility. This allows individuals who have expensive medical needs, but who may have incomes over the SSI level, to receive Medicaid coverage for the remainder of the month.

The ABD eligibility group is the most costly of the six groups. Not only do ABD eligibles generate more costly acute care services than the other groups, almost all of the Medicaid long-term-care recipients come from the ABD eligibility group.

The number of ABD eligibles increased rapidly in the early 1990s as the result of a dramatic increase in the number of children applying under the disability definition under the SSI program. This was followed by a decline in this population as the result of a change in federal law³. However, the Balanced Budget Act of 1997 reversed this more restrictive definition, making these children once again eligible for Medicaid. Growth over the next biennium is, however, expected to continue to be slow.

Healthy Start. Children up to age 19 and pregnant women, whose families’ incomes are below 150 percent of the FPL, are Medicaid eligible through the Healthy Start program.

Healthy Families. Apart from Healthy Start eligibles, Medicaid provides health care to other families and children. Prior to the enactment of the federal Personal Responsibility and Work Opportunity Act of 1996, which created the TANF block grant program for states (implemented in Ohio as Ohio Works First) to provide income maintenance services to low-income families, recipients of Aid to Dependent Children (ADC) were automatically eligible for Medicaid. Although TANF severs the link between cash assistance and Medicaid eligibility, a provision of the law requires states to

³ During 1996, federal legislation was passed which eliminated SSI eligibility for individuals whose alcohol and drug addiction is a material factor that contributes to their disabilities. Later that same year, the Personal Responsibility and Work Opportunity Act of 1996 tightened eligibility among children by making the disability definition more restrictive.

provide Medicaid coverage to families who meet guidelines for ADC eligibility as they were on July 16, 1996. In fact, federal law mandates that eligibility for a state's Medicaid program cannot be more restrictive than the ADC guidelines that existed in each state on July 16, 1996. "Ohio has designed OWF and made the allowable modifications to the July 1996 ADC plan in order to meet Ohio's goal that all OWF cash assistance recipients also automatically receive Medicaid. In addition, in some instances where OWF is more restrictive than the July 1996 ADC rules, individuals who will not be eligible to receive cash will be eligible for Medicaid under the Low-Income Families group which uses the July 1996 ADC policy."⁴

These Low-Income Families, who would have previously received cash assistance, continue to grow as a subset of an eligibility group referred to as "Healthy Families." Specifically, total Healthy Families, is comprised of OWF cash assistance, Transitional Medicaid, and Low-Income eligibles.

In addition to individuals who meet eligibility guidelines for 1996 ADC cash assistance, Medicaid eligibility is given to individuals who no longer meet "ADC" eligibility guidelines due to increased income, but previously received OWF cash assistance. Transitional Medicaid eligibles receive an additional 12 months of health care coverage, while families whose incomes exceed ADC guidelines due to the collection, or increased collection, of child or spousal support payments receive Medicaid coverage for four months and are referred to as Extended Medicaid. As a subset of Extended Medicaid, coverage is provided to individuals eligible for Title IV-E foster care and other miscellaneous groups.

QMBs and SLMBs. The following two eligibility groups, Qualified Medicare Beneficiaries (QMBs) and Specified Low-income Medicare Beneficiaries (SLMBs), are the result of a federal mandate that states Medicaid programs must "buy-in" to Medicare coverage for certain individuals. QMBs have incomes below 100 percent of the FPL, and Medicaid must pay for their Medicare premiums, copayments, and deductibles.⁵ For SLMBs, Medicaid covers the Medicare Part B premiums only for those with incomes between 100–120 percent of FPL. Premiums for both of these eligibility groups (and for Medicare-eligible ABD eligibles for whom the state chooses to buy-in to Medicare)⁶ are reflected in the Medicare buy-in service category. The copayments and deductibles of QMBs are reflected in the appropriate service categories, which Medicare covers. The growth in the number of QMB and SLMB eligibles in recent years has slowed as these relatively new programs reach more stable levels. In addition to these Medicare eligibles, the Balanced Budget Act of 1997 created two new eligibility groups under the name, Additional Low-Income Medicare Beneficiaries (ALMB) or Qualified Individuals (QIs). Effective January 1, 1998, the Department of Human Services was required to begin

⁴ Source: Ohio Medicaid Report, December 1998, Ohio Department of Human Services.

⁵ Because many individuals who are initially eligible for Medicaid through the QMB program "spend-down" to ABD eligibility during the month, the reported QMB population is understated. The QMB grouping in the eligibility table refers only to those QMB individuals who do not spend-down to ABD eligibility.

⁶ Under Medicare, eligibility is not limited to age alone. Eligibility is also based on work history (individual's payroll deductions while they were working, similar to Social Security qualifications). Ohio's Medicaid program buys-into Medicare for Medicaid eligibles who do not have the necessary work history for example, to qualify for Medicare, and purchases Medicare hospital coverage.

paying the full Medicare Part B premium for Medicare eligible individuals with incomes between 120–135 percent of FPL (known as the QI-1 group); and reimburse the Home Health Care portion of the Medicare Part B premium to individuals with incomes between 135–175 percent of FPL (known as the QI-2 group). All costs associated with the ALMB population are 100 percent federally funded.

CHIP-I. The Balanced Budget Act of 1997 added a sixth eligibility group to the Medicaid population that Ohio funds out of the 525 line item. The Act created the State Children’s Health Insurance Program (CHIP), Title XXI of the Social Security Act, giving states another option to initiate or expand health care to uninsured “low income” children. The program affords states increased flexibility in designing and implementing CHIP programs and provides states a higher federal matching payment than Medicaid. Prior to the passage of the Federal Balanced Budget Act of 1997, which included CHIP, Ohio included in its biennial budget a children’s health insurance expansion for children up to the age of 19 in families at or below 150 percent of the FPL. Combining the state’s initiative with the federal CHIP opportunity, Ohio submitted a CHIP State Plan to the Health Care Financing Administration (HCFA) to implement a Medicaid expansion under CHIP. HCFA approved Ohio’s CHIP State Plan on March 23, 1998 – making Ohio the fifth state approved to draw down CHIP funding. Ohio implemented its children’s health insurance expansion by expanding Healthy Start, to include Medicaid coverage for low-income children up to age 19, in families at or below 150 percent of the FPL. Children in families with incomes at or below 150 percent of the FPL receive Medicaid eligibility through the CHIP-I program.

CHIP-II. Am. Sub. H.B. 283 of the 123rd General Assembly, the main budget act, appropriated funds for the Children’s Health Insurance Plan CHIP-II under Title XXI, for uninsured children under age 19 in families with incomes between 150 percent and 200 percent of the FPL. CHIP-II had been scheduled to commence on January 1, 2000 to provide health care benefits to an estimated 4,400 average monthly eligible children in FY 2000, and 12,000 in FY 2001. The estimated costs were \$6.8 million in FY 2000 and \$23.8 million in FY 2001. The program, however, commenced six months later than expected, beginning on July 1, 2000. Because there is little data at this time for this new program, LSC chose to use the Executive’s forecast for CHIP-II. CHIP-II is appropriated in its own line item 600-426. The actual spending for the first half of FY 2001 was \$6.5 million. The Executive has estimated appropriations for CHIP-II at \$24,544,733 in FY 2002 and \$29,747,910 in FY 2003.

Cost Factors

Medical Costs

Medicaid spending on health care services that are market driven significantly outweighs program payments to providers that are tied to fee schedules. Consequently Medicaid, like any other third party payer, is very susceptible to market forces. In addition, payment rates for inpatient hospital care and prescription drugs are statutorily connected to market place trends. These increases of the medical prices are expected to

continue well into the future. Double-digit cost increases for health care are forecast for 2001, reflecting the biggest surge in medical inflation since the early 1990s.⁷

Medicaid Program Costs

Two factors have a major influence on the costs within each category of service: the number of claims and the cost-per-claim. In general, the cost of each claim in each service category (hospitals, prescription drugs, etc.) can be summed to equal the total cost for that category of service. Thus, to forecast the costs of services in each category, both the average number of claims and the average cost-per-claim must be estimated for each service category.

The estimated number of claims depends upon both the estimated number of eligibles and their expected demand for services. Historical relationships between the number of eligibles in each eligibility group and the number of claims they generate in each category of service allow for the calculation of utilization rates. By applying forecasts of utilization rates to forecasts of the number of eligibles, an estimated number of claims can be calculated.

Prescription Drugs. While most of the utilization rates are expected to remain relatively stable over the next biennium, one trend regarding the ABD group is worth noting. The number of prescription drug claims per ABD eligible has been steadily increasing in recent years. (LSC estimates that over 87 percent of all Medicaid prescription drug claims paid in FY 2002 will be generated by ABD eligibles.)

Expenditures for prescription drugs are also rising due to increases in: (1) market prices resulting from the introduction of a large number of new drugs; (2) mass market consumer advertising (in particular television); and (3) to a lesser extent, utilization rates by the ABD Medicaid population.

The prescription drug utilization rate for ABD eligibles is expected to increase by 6.76 percent in FY 2001, 6.08 percent in FY 2002, and 6.24 percent in FY 2003. On the surface, a 6.24 percent-plus utilization rate increase may not appear too alarming; however, the average cost per claim — the second major factor affecting total service category costs — is also increasing, but at a much greater rate. In FY 2001, LSC estimates that the prescription drug cost-per-claim for the ABD population will increase by 11.58 percent over FY 2000. Note that the increase in the prescription drug cost-per-claim is not entirely due to inflationary factors — it also may be due to an increased number of drugs per claim and a shift to higher cost drugs within each claim. The increases in cost-per-claim are expected to continue in FY 2002, increasing by 8.98 percent and by 8.79 percent in FY 2003.

The combined effect of the increased utilization rates and increased costs-per-claim for the ABD population, as well as other eligibility groups, are expected to result in an increase in prescription drug spending of 27.0 percent in FY 2001, 19.59 percent in FY 2002, and 17.16 percent in FY 2003.

Nursing Homes. Payments to nursing homes are based on cost reports. Nursing homes annually submit cost reports to the state's Department of Job and Family Services

⁷ Source: Health Inflation News, Vol. 9, No.12

(JFS), which are used to calculate facility-specific per diems for the following state fiscal year. In essence, each fiscal year's per diem rates are based on cost reports from the preceding calendar year. The per diem rates are then adjusted quarterly to account for differences in each resident's needs – known as the “case-mix adjustment.” LSC also offers the following more general observation on some of the important dynamics surrounding nursing homes and their costs of care. In this country, for various reasons related to demography, lifestyles, the physical environment, medical care, and so forth, people are living longer and the size of the aging population is growing. As a result, there is a larger pool of people that might require the more intensive level and more costly form of care associated with a nursing home stay and for longer periods of time as well. Aiding in constraining the acceleration of nursing home care costs associated with such a trend is the development of less-costly and more appropriate alternative forms of care, programs like PASSPORT, which target elements of the state's medically needy people with a nursing home level of care, and able to live in the community. From the perspective of nursing homes, this means that the medical conditions of those people occupying their beds these days are generally more acute than was previously the case. This rise in acuity level alone would increase the nursing home's cost of doing business and the state's per diem has grown to reflect that reality.

In summary, the rise in the state's per diem is fueled by heightened acuity levels, increased capital costs, and to a larger extent, elevated direct care costs. The average per diem in FY 2000 increased by 7.32 percent from FY 1999 levels of \$113.22 to \$121.51. The average per diem in FY 2001 is projected to grow by 9.18 percent to \$132.67. The average per diem in FY 2002 and FY 2003 is projected to grow by 7.69 percent to \$142.87 and 6.40 percent to \$152.01, respectively.

Inpatient and Outpatient Hospital Services. Estimated expenditures for Inpatient and Outpatient Hospital Service are \$1.5 billion and represent over 22 percent of line item 525 in FY 2001. The Ohio Administrative Code requires an annual inflationary update to inpatient rates; however, outpatient rates are based on a fee schedule that is not automatically inflated. Health economists are predicting increased health care inflation in the coming years. In addition, demand for more and expanded health care services continues to push up the costs. Moreover, the FY 2000-2001 biennial budget allowed JFS to increase payment rates for both Inpatient and Outpatient Hospital Service. The growth rate in spending for hospital care is projected to be 11.65 percent from FY 2001 to FY 2002, and 6.35 percent from FY 2002 to FY 2003.

Physician Services. The cost estimates for Physician Services reflect the historical costs of providing medical care plus these state-directed changes to fee schedules for certain participating providers. The FY 2000-2001 biennial budget allowed JFS to increase payment rates for certain community providers who do not get regular adjustments to their rates. The growth rate in spending is projected to be 22.83 percent from FY 2000 to FY 2001, 11.38 percent from FY 2001 to FY 2002, and 6.86 percent from FY 2002 to FY 2003.

All Other Care. Services such as dental care, home health care, other practitioners, and all other various health services are included in the All Other Care category. The double-digit predicted growth rate in spending in this category are due to

the following: 1) the increase in payment rates for certain community providers such as dentists, and ambulance services, and 2) expected higher health care inflation in the coming years.

Caseloads

The total number of persons eligible for Medicaid grew by 1.23 percent from 1,095,717 in FY 1999 to 1,109,203 in FY 2000. The total number of eligibles is estimated to reach 1,251,155 in FY 2001, a 12.8 percent increase over FY 2000. LSC forecasts that the number of persons eligible for Medicaid will continue to grow to 1,313,481 in FY 2002 and 1,332,997 in FY 2003, a 4.98 percent and a 1.49 percent increase, respectively.

The consistent increases in the number of children enrolled in Medicaid by way of CHIP-I, a trend that started in FY 1997, has been the primary driving force behind the growth in total caseload. The CHIP-I population is estimated to increase by 17.17 percent from FY 2000 to FY 2001. LSC forecasts an additional increase in the CHIP-I population of 10.55 percent in FY 2002 and 4.97 percent in FY 2003.

Increasing Medicaid caseloads can also be attributed to expansions in the program. During the FY 2000-2001 biennium, Medicaid eligibility was expanded in three areas. In January 2000, JFS expanded coverage to pregnant women from 133 percent to 150 percent of the FPL. In July 2000, JFS rolled out phase two of the Children's Health Insurance Program (CHIP), expanding Healthy Start eligibility to uninsured children from families with incomes between 150 percent and 200 percent of the FPL (phase one of CHIP was implemented in the FY 1998-1999 biennium through an expansion of Healthy Start to 150 percent of the FPL for all children). Also, in July 2000, JFS expanded coverage to parents with enrolled children for families with incomes at or below 100 percent of the FPL under the Healthy Families program.

The Healthy Families Medicaid caseload is expected to grow by 28.23 percent in FY 2001 due to the expansion stated above, as well as, the reinstatement of a number of eligibles to the program. Many families who left cash assistance under the OWF program mistakenly believed they were no longer eligible to receive Medicaid benefits. These families have been notified regarding their eligibility and are now returning to the Medicaid program in large numbers. Moreover, some of the children originally enrolled in the Medicaid through the Healthy Start program, now become eligible through the Healthy Family program with their parents. Hence, LSC expects that there will be a shift in the number of eligibles from the Healthy Start to the Healthy Families Medicaid caseloads. Healthy Families is the largest Medicaid eligibility group, representing 49.3 percent of all eligibles in FY 2001.

Lastly, the other major component of the Medicaid caseload — the ABD population — had an annual growth rate in the first half of the 1990s that averaged 7.6 percent. However, the numbers for fiscal years 1997, 1998 and 1999 suggested a stabilizing or decrease in the ABD caseload was afoot, as an almost imperceptible percentage increase of 0.32 percent was posted in FY 1997, followed by a 2.21 percent drop in FY 1998, and another 0.3 percent decline in FY 1999. However, in FY 2001, we are seeing another reversal as the downward trend in the ABD population has been interrupted by an estimated 2.36 percent increase in the caseload. LSC forecasts that this upward trend will continue with a 2.61 percent increase in FY 2002 and a 2.10 percent increase in FY 2003.

Medicaid Spending (GRF 600-525 only)								
Table 1								
LSC Baseline Estimates								
	FY 2000	% Change	FY 2001 Est.	% Change	FY 2002 Est.	% Change	FY 2003 Est.	% Change
Nursing Homes	\$2,463,014,260	6.55%	\$2,711,865,035	10.10%	\$2,943,707,563	8.55%	\$3,170,607,335	7.71%
Nursing Facilities	\$2,110,778,821	7.26%	\$2,327,661,802	10.28%	\$2,538,679,429	9.07%	\$2,741,096,010	7.97%
ICFs for the Mentally Retarded	\$352,235,439	2.53%	\$384,203,233	9.08%	\$405,028,133	5.42%	\$429,511,325	6.04%
Hospitals	\$1,268,037,776	5.29%	\$1,462,207,487	15.31%	\$1,632,485,521	11.65%	\$1,736,169,904	6.35%
Inpatient Hospitals	\$938,402,460	2.76%	\$1,051,345,006	12.04%	\$1,178,420,279	12.09%	\$1,270,553,140	7.82%
Outpatient Hospitals	\$329,635,316	13.24%	\$410,862,480	24.64%	\$454,065,242	10.52%	\$465,616,764	2.54%
Physicians	\$341,541,513	15.45%	\$419,526,519	22.83%	\$467,276,758	11.38%	\$499,342,003	6.86%
Prescription Drugs	\$674,264,621	11.72%	\$856,288,237	27.00%	\$1,023,993,935	19.59%	\$1,199,712,694	17.16%
Payments	\$845,232,399	13.99%	\$1,053,763,520	24.67%	\$1,260,145,133	19.59%	\$1,476,387,760	17.16%
Rebates	(\$170,967,778)	23.91%	(\$197,475,284)	15.50%	(\$236,151,198)	19.59%	(\$276,675,066)	17.16%
HMO	\$377,157,047	-6.12%	\$445,770,677	18.19%	\$497,886,819	11.69%	\$530,652,396	6.58%
Medicare Buy -In	\$121,083,904	-0.56%	\$122,002,156	0.76%	\$129,227,768	5.92%	\$139,321,001	7.81%
Waiver	\$121,812,177	69.48%	\$140,465,636	15.31%	\$153,189,447	9.06%	\$162,327,176	5.96%
All Other Care*	\$425,181,427	18.70%	\$532,688,264	25.28%	\$606,681,981	13.89%	\$674,173,432	11.12%
TOTAL	\$5,792,092,725	7.88%	\$6,690,814,009	15.52%	\$7,454,449,791	11.41%	\$8,112,305,940	8.83%
DSH Offsets	\$199,884,845		\$156,886,651		\$117,915,506		\$111,028,628	
Total net GRF Expenditures	<u>\$5,592,207,880</u>		<u>\$6,533,927,358</u>		<u>\$7,336,534,285</u>		<u>\$8,001,277,312</u>	
State Share	\$2,316,991,530		\$2,683,483,966		\$3,019,534,098		\$3,293,125,710	
Federal Share	\$3,275,216,350		\$3,850,443,392		\$4,317,000,187		\$4,708,151,602	
Effective FMAP	58.57%		58.93%		58.84%		58.84%	

This table only includes Medicaid spending through Job and Family Services' 600-525 line item.
 * Includes services such as dental care, home health care, and other practitioners, and includes various contracts.

Monthly Averages			
Table 2			
LSC Baseline Estimates			
Fiscal Year	Total HF/HS (CFC)*	Enrolled in HMO	Rate
1990	795,775	111,515	14.01%
1991	875,835	125,829	14.37%
1992	976,427	133,513	13.67%
1993	989,948	148,009	14.95%
1994	981,732	169,133	17.23%
1995	938,701	190,528	20.30%
1996	861,479	254,153	29.50%
1997	796,122	331,239	41.61%
1998	730,623	331,048	45.31%
1999	722,558	256,750	35.53%
2000	736,846	253,102	34.35%
2001 est.	870,882	253,268	29.08%
2002 est.	924,782	268,029	28.98%
2003 est.	935,395	271,057	28.98%

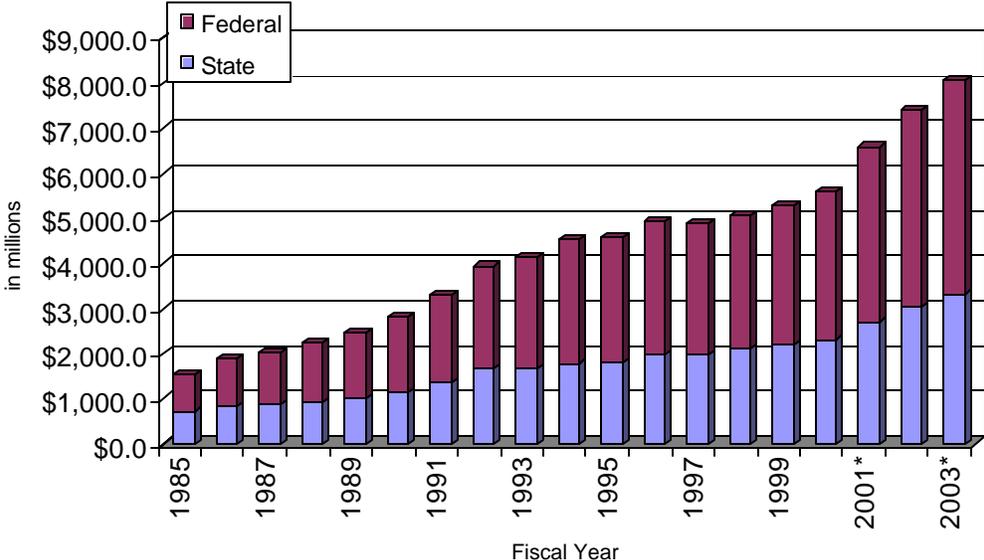
*CFC: Covered Families and Children

Medicaid (600-525) Spending History

FY 1985-2003

Chart 1

LSC Baseline Estimates*



**State and Federal Shares of GRF
600-525 Line Item**

Table 3

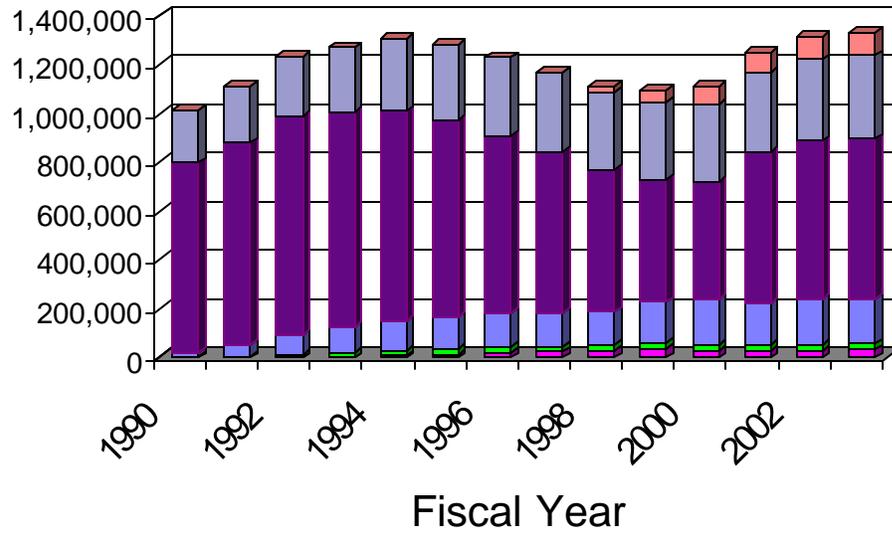
LSC Baseline Estimates

Fiscal Year	600-525		Financial Participation				Effective FMAP
	Total	% change	State	% change	Federal	% change	
1985	\$1,525,530,532		\$728,740,664		\$796,789,868		52.23%
1986	\$1,875,271,502	22.93%	\$818,556,010	12.32%	\$1,056,715,492	32.62%	56.35%
1987	\$2,037,330,381	8.64%	\$875,644,598	6.97%	\$1,161,685,783	9.93%	57.02%
1988	\$2,252,312,122	10.55%	\$937,412,305	7.05%	\$1,314,899,817	13.19%	58.38%
1989	\$2,444,781,342	8.55%	\$1,012,628,432	8.02%	\$1,432,152,910	8.92%	58.58%
1990	\$2,802,222,441	14.62%	\$1,147,790,312	13.35%	\$1,654,432,129	15.52%	59.04%
1991	\$3,304,346,333	17.92%	\$1,350,486,346	17.66%	\$1,953,859,987	18.10%	59.13%
1992	\$3,941,073,001	19.27%	\$1,661,556,377	23.03%	\$2,279,516,624	16.67%	57.84%
1993	\$4,149,379,774	5.29%	\$1,686,307,940	1.49%	\$2,463,071,834	8.05%	59.36%
1994	\$4,521,872,195	8.98%	\$1,779,356,709	5.52%	\$2,742,515,486	11.35%	60.65%
1995	\$4,585,549,544	1.41%	\$1,791,624,838	0.69%	\$2,793,924,706	1.87%	60.93%
1996	\$4,941,254,040	7.76%	\$1,961,677,854	9.49%	\$2,979,576,186	6.64%	60.30%
1997	\$4,897,184,802	-0.89%	\$1,983,237,415	1.10%	\$2,913,947,387	-2.20%	59.50%
1998	\$5,061,207,922	3.35%	\$2,104,197,194	6.10%	\$2,957,010,728	1.48%	58.43%
1999	\$5,276,846,835	4.26%	\$2,204,138,923	4.75%	\$3,072,707,912	3.91%	58.23%
2000	\$5,592,207,880	5.98%	\$2,316,991,530	5.12%	\$3,275,216,350	6.59%	58.57%
2001 est	\$5,592,207,880	5.98%	\$2,316,991,530	5.12%	\$3,275,216,350	6.59%	58.93%
2002 est	\$6,533,927,358	16.84%	\$2,683,483,966	15.82%	\$3,850,443,392	17.56%	58.84%
2003 est	\$7,336,534,285	12.28%	\$3,019,534,098	12.52%	\$4,317,000,187	12.12%	58.84%

Notes: Total Medicaid spending in 600-525 is lower than the amounts shown for FY 1998 – FY 2003 due to the offset of GRF funds with DSH monies.

Medicaid Eligibility - Monthly Averages

Chart 2



Medicaid Caseload by Eligibility Group

Table 4

LSC Baseline Estimates

Fiscal Year	ABD (no QMB)	QMB		SLMB		Healthy Start		Healthy Families		CHIP-I /HS		Total		
	% chg.	% chg.	% chg.	¹ %	% chg.	% chg.	% chg.	² %	% chg.	³ %	% chg.	% chg.	% chg.	
1990	214,247	1,646		0		15,837		779,937		0		1,011,667		
1991	228,955	6.87%	3,674	123.26%	0	47,007	196.81%	828,828	6.27%	0		1,108,464	9.57%	
1992	246,369	7.61%	9,602	161.38%	0	82,166	74.80%	894,261	7.89%	0		1,232,398	11.18%	
1993	263,676	7.02%	16,067	67.32%	420	109,162	32.86%	880,786	-1.51%	0		1,270,110	3.06%	
1994	296,654	12.51%	20,191	25.67%	6,395	1422.59%	123,663	13.28%	858,069	-2.58%	0	1,294,972	1.96%	
1995	309,576	4.36%	22,773	12.79%	12,955	102.58%	129,826	4.98%	808,875	-5.73%	0	1,284,005	-0.85%	
1996	321,978	4.01%	22,736	-0.16%	22,069	70.35%	139,529	7.47%	721,950	10.75%	0	1,228,262	-4.34%	
1997	323,023	0.32%	23,791	4.64%	23,233	5.28%	133,719	-4.16%	662,403	-8.25%	0	1,118,587	-8.93%	
1998	315,885	-2.21%	23,683	-0.45%	25,925	11.59%	137,912	3.14%	580,827	12.32%	23,767	1,107,999	-4.99%	
1999	314,855	-0.33%	23,538	-0.61%	34,764	34.10%	169,210	22.69%	500,840	13.77%	52,509	120.93%	1,095,717	-1.11%
2000	318,720	1.23%	23,635	0.41%	30,002	-13.70%	185,127	9.41%	481,064	-3.95%	70,655	34.56%	1,109,203	1.23%
2001*	326,239	2.36%	23,673	0.16%	30,060	0.19%	171,512	-7.35%	616,886	28.23%	82,785	17.17%	1,251,155	12.80%
2002*	334,755	2.61%	23,824	0.64%	30,120	0.20%	186,769	8.90%	646,495	4.805	91,518	10.55%	1,313,481	4.98%
2003*	341,795	2.10%	24,301	2.00%	31,506	4.60%	186,769	0.00%	652,558	0.94%	96,068	4.97%	1,332,997	1.49%

* LSC Baseline Estimates.

1. SLMB population growing due to a federal expansion for Medicare eligibles effective January 1, 1998.

All costs related to this new group, Additional Low-income Medicare Beneficiaries, are 100% federally reimbursable

2. Health Families includes OWF Cash Assistance, Transition & Low-income Medicaid eligibles. Now commonly grouped into Covered Families & Children, which also include Healthy Start and CHIP-I/HS.

3 CHIP-I/HS is a combined group of kids eligible for the state's 150% of FPL expansion implemented January 1, 1998.