

## ***Public Assistance Expenditures***

### ***Health Care/Medicaid***

#### **Overview**

The Office of Ohio Health Plans in the Department of Job and Family Services (JFS) operates several state and federally funded programs providing health care coverage to certain low-income and medically vulnerable people of all ages: Medicaid, the State Children's Health Insurance Program (SCHIP, created by the Social Security Act as Title XXI), the Hospital Care Assurance Program (HCAP, also created by the Social Security Act as Title XXI), and the state Disability Assistance Medical program (DA).

Medicaid, the largest health program in Ohio, was created by the Social Security Act as Title XIX, and became law in 1965. Medicaid is an entitlement program and is a state-federal partnership, which jointly funds the provision of adequate medical care to eligible needy persons. In this partnership, the federal government establishes broad national guidelines, and each state determines its own eligibility requirements, determines the scope of services, sets payment rates for services, and administers its program.

SCHIP allows Ohio to provide health care coverage to children who were not previously eligible for Medicaid and whose family income is below 200% of the federal poverty guideline (FPG). Through HCAP, hospitals are reimbursed for some of their costs of providing medical care to persons below 100% of FPG. The DA Medical program is state and county funded and provides limited medical coverage to persons who are not eligible for a federally funded program.

In Ohio, Medicaid and SCHIP provided health care coverage to about 1.4 million Ohioans every month in FY 2002. These programs apply to people in the following four distinct insurance markets: children in families with incomes at or below 200% of FPG; pregnant women with incomes at or below 150% of FPG; parents at or below 100% of the FPG; and low-income elderly and persons with disabilities of all ages, commonly referred to as Aged, Blind, and Disabled (ABD). Many consumers with disabilities have medical needs so extensive that commercial plans would deem them "uninsurable." Even though Medicare provides coverage for most of Ohio's elderly population, many of these individuals are "dually eligible," and Medicaid supplements their Medicare benefits by providing Medicaid coverage for services such as prescription medications and long-term care. Medicaid also provides assistance with Medicare premiums, co-payments, and deductibles to certain low-income seniors.

Although other state agencies provide Medicaid services, the vast majority of Medicaid spending occurs within the budget of JFS. Recognized by the federal government as Ohio's single Medicaid agency, JFS provides long-term care and basic medical services with state and federal moneys through GRF line item 600-525, Health Care/Medicaid. Beginning in FY 2003, the 600-525 line item is not only used to fund Medicaid, but also SCHIP, and DA Medical.<sup>11</sup> In addition to the funding from the GRF, several provider tax programs and other special revenues are used to pay for Medicaid services.<sup>12</sup>

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 states' cost of Medicaid at a matching rate known as the FMAP (Federal Medical Assistance Percentage). 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 one dollar Ohio spends on Medicaid, the federal government gives Ohio 60 cents. However, while the majority of the spending in line item 600-525, Health Care/Medicaid, is matched at the FMAP, a few items, primarily contracts, are matched at 50%, and all family planning services receive a 90% match. In addition, about 15% of Medicare buy-in premiums receive no federal match. Lastly, the State Children's Health Insurance Plan (SCHIP) is matched at an enhanced FMAP of about 70%.

### **Forecast Summary**

The total number of persons eligible for Medicaid grew by 11.19% from 1,276,967 in FY 2001 to 1,419,856 in FY 2002. LSC forecasts that the total number of eligibles will reach 1,559,487 in FY 2003, a 9.83% increase over FY 2002. Furthermore, LSC projects the number of persons eligible for Medicaid will grow to 1,637,550 in FY 2004 and 1,650,731 in FY 2005, a 5.01% and a 0.80% increase, respectively.

Spending within the 525 line item can generally be placed into one of nine major categories: long-term care (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, all other care, and DA Medical.

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<sup>11</sup> Prior to FY 2003, spending for part II of SCHIP is funded through line item 600-426, and spending for DA medical is funded through line item 600-511.

<sup>12</sup> Provider tax programs refer to assessments on hospitals, as well as bed taxes on nursing facilities and intermediate care facilities for the mentally retarded. The programs serve as a mechanism by which to draw additional federal matching funds.

Other special revenues include funds for the Disproportionate Share Hospital (DSH) offset, drug rebates, and the franchise fees.

LSC projects an increase in health care expenditures in FY 2004 of 16.64% or \$1,287 million in combined state and federal GRF dollars, with a state share increase of \$512 million. For FY 2005, LSC projects total health care expenditures will go up by another 7.42%, or \$669 million in combined state and federal GRF dollars, with a state share increase of \$278 million.

### **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 seven major types: Aged, Blind, and Disabled (ABD); Qualified Medicare Beneficiaries (QMBs); Specified Low-Income Medicare Beneficiaries (SLMBs); Healthy Families (HF); Healthy Start (HS); Children in families with incomes at or below 150% of the FPG known as CHIP-I; and Children in families with incomes between 150% and 200% of the FPG known as CHIP-II. Generally, Healthy Families, Healthy Start, CHIP-I, and CHIP-II are grouped as Covered Families and Children (CFC). 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% of the FPG); 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% of the FPG, they “spend-down” to Medicaid eligibility for the month. 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 seven 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 for the SSI program. This was followed by a decline in this population as the result of a change in federal law.<sup>13</sup> However, the Balanced Budget Act of 1997 reversed this more restrictive definition, making these children once again eligible for Medicaid. Despite these earlier changes, growth over the next biennium is expected to be slow.

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<sup>13</sup> During 1996, federal legislation was passed that 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.

**QMBs and SLMBs.** The following two eligibility groups, Qualified Medicare Beneficiaries (QMBs) and Specified Low-income Medicare Beneficiaries (SLMBs), are created by a federal mandate that states' Medicaid programs must "buy-in" to Medicare coverage for certain individuals. QMBs have incomes below 100% of the FPG, and Medicaid must pay for their Medicare premiums, copayments, and deductibles.<sup>14</sup> For SLMBs, Medicaid covers the Medicare Part B premiums only for those with incomes between 100% - 120% of FPG. Premiums for both of these eligibility groups (and for Medicare-eligible ABD eligibles for whom the state chooses to buy-in to Medicare)<sup>15</sup> 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.

**Healthy Start.** Children up to age 19 and pregnant women, whose families' incomes are below 150% of the FPG, 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 program (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 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."<sup>16</sup> 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.

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<sup>14</sup> 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.

<sup>15</sup> 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.

<sup>16</sup> Source: Ohio Medicaid Report, December 1998, Ohio Department of Human Services.

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 six months of health care coverage that can be extended for an additional six months if monthly income is less than or equal to 185% of the FPG. 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.

**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 under the regular Medicaid program. 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% of the FPG. Combining the state's initiative with the federal CHIP opportunity, Ohio submitted a CHIP State Plan to the Center for Medicare and Medicaid (CMS, formerly known as the Health Care Financing Administration, or HCFA) to implement a Medicaid expansion under CHIP. CMS 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 plan (CHIP-I) by expanding Healthy Start, to include Medicaid coverage for low-income children up to age 19, in families at or below 150% of the FPG.

**CHIP-II.** Am. Sub. H.B. 283 of the 123<sup>rd</sup> General Assembly, the main budget act, appropriated funds for the Children's Health Insurance Plan II (CHIP-II) under Title XXI, for uninsured children under age 19 in families with incomes between 150% and 200% of the FPG. CHIP-II commenced on July 1, 2000.

### **Caseloads Forecast**

**Total Caseload.** The total number of persons eligible for Medicaid grew by 11.19% from 1,276,967 in FY 2001 to 1,419,856 in FY 2002. The total number of eligibles is estimated to reach 1,559,487 in FY 2003, a 9.83% increase over FY 2002. LSC forecasts that the number of persons eligible for Medicaid will continue to grow to 1,637,550 in FY 2004 and 1,650,731 in FY 2005, a 5.01% and a 0.80% increase, respectively.

The last time the Medicaid program was expanded was in July 2000. At that time, JFS implemented two expansions. First, coverage was extended to parents with enrolled

children for families with incomes at or below 100% of the FPG under the Healthy Families program. Second, JFS rolled out CHIP-II, expanding Healthy Start eligibility to uninsured children from families with incomes between 150% and 200% of the FPG. No program expansions were implemented during the FYs 2002-2003 biennium. The forecast assumes that no program expansions will be implemented during the coming biennium.

Poor labor market conditions associated with the recession (which has not been declared to have ended as of this writing) have been the primary driving force behind the growth in total caseload. An additional factor behind the recent growth in caseload has been the CHIP-II program expansion. The eligible population for CHIP-II grew by slightly over 90% in FY 2002, and is forecast to grow by an additional 17.99% in FY 2003 as the process of enrolling those made newly eligible under the expansion reaches its conclusion.

**Covered Families and Children.** LSC forecasts that the overall CFC caseload will peak in the fourth quarter of FY 2004, and begin to drop in the second quarter of FY 2005 as the economy begins to recover. This forecast is based on a statistical model of the relationship between the Healthy Families caseload and the unemployment rate. Forecasts of future unemployment rates used for the caseload forecast are taken from the January 2003 economic forecast by Global Insight (formerly DRI-WEFA).

**Aged, Blind, and Disabled.** Growth in the ABD caseload accelerated in FY 2002, and this acceleration continued into the first half of FY 2003. This acceleration was driven by the disabled subcategory of the ABD category. The accelerated growth in the disabled subcategory is projected to continue through the end of FY 2003, after which the growth rate is projected to gradually return to a more typical historical rate. The Aged subcategory is projected to increase at average historical rates, with a slight adjustment for the growth in the overall Ohio population over the age of 65.

**HMO Penetration.** 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 CFC 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).

CFC eligibles access their health care benefits through either the traditional fee-for-service system or the Medicaid managed care program. The Medicaid managed care program has three different enrollment categories: mandatory, voluntary, and preferred option. In FY 2001, the state introduced the preferred option. Under preferred option, recipients are

automatically enrolled in managed care if they fail to select the traditional fee-for-service option. This policy has pushed up the HMO penetration rate<sup>17</sup> from 27.97% in FY 2001 to 32.44% in FY 2002.

LSC's baseline forecast assumes that the take up effect of the preferred option program will diminish in FY 2003, and the HMO penetration rate will be approximately 35% for FY 2004 and FY 2005. In other words, about 35% of all Covered Family and Children consumers are expected to be enrolled in a Medicaid HMO during the next biennium.

### **Medicaid Program Cost Forecast**

Medicaid program costs are estimated separately for each of the nine major expenditure categories described in the Forecast Summary section. After forecasting changes in the caseload, a cost per Medicaid recipient is projected. The cost per recipient is itself broken down into two components: the average number of claims per recipient, called the "utilization rate," and the average cost per claim submitted. The average cost per claim depends heavily on overall health care inflation -- Medicaid spending on health care services that are market driven significantly outweighs program payments to providers that are tied to fee schedules. In addition, payment rates for long-term care, inpatient hospital care, and prescription drugs are statutorily connected to market place trends. Consequently, Medicaid, like any other third party payer, is very susceptible to market forces.

Most measures of price inflation in the health care sector of the U.S. economy showed that inflation decelerated in 2002. Among the measures showing this are the Producer Price Index for Health Services, the price deflator for Personal Consumption Expenditures on Medical Care (PCE-MC), and the price deflator derived for the National Income and Product Accounts medical care component. Nevertheless, some components of the Consumer Price Index (CPI) indicate that some categories of care experienced an acceleration in inflation during 2002, and Global Insight is forecasting an acceleration in inflation in the overall health sector in 2003 and 2004.

Generally speaking, the forecast of average cost per claim in each category of care under Medicaid starts with historical data on costs per claim. To project whether increases in costs per claim would accelerate or decelerate, LSC used the Global Insight forecast of inflation, as measured by the price deflator for PCE-MC, as a baseline. This baseline was then adjusted separately for each category of care. For those categories for which there is a corresponding subcomponent of the CPI, that subcomponent is used to make the adjustment. Some of the subcategories of care that are lumped under the All Other Care component of Medicaid spending do not have a corresponding subcomponent of the CPI,

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<sup>17</sup> Penetration is the number of managed care eligible divided by total Covered Family and Children eligibles.

and in those cases the assumption regarding inflation was based on the PCE-MC with no adjustments. The prescription drug spending category received special treatment. The above method yielded a deceleration in health inflation in 2005. A separate Global Insight forecast of the price deflator for PCE on drugs indicated an acceleration of inflation in 2005. Due to the conflicting results from these two approaches, inflation for the prescription drug category was projected to continue at the same rate in FY 2005 as was projected for FY 2004.

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.

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.

***Nursing Facilities.*** Expenditures for nursing facilities' services were \$2.46 billion and represented approximately 35% of expenditures from line item 525 in FY 2002. Payments to nursing facilities are based on cost reports. Nursing facilities annually submit cost reports to JFS, which are used to calculate facility-specific per diems for the following state fiscal year. In other words, 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."

The FYs 2002-2003 biennial budget act established a maximum mean total per diem rate applicable to nursing facilities in FY 2002 and FY 2003. For FY 2002, the mean total per diem rate for all nursing facilities in the state, weighted by Medicaid days and calculated as of July 1, 2001, is not to exceed \$143.92. For FY 2003, the mean total per diem rate for all nursing facilities in the state, weighted by Medicaid days and calculated as of July 1,

2002, is not to exceed \$152.66, plus any difference between \$143.92 and the mean total per diem rate for all nursing facilities in the state for FY 2002, weighted by Medicaid days and calculated as of July 1, 2001, under the law governing the calculation of Medicaid reimbursement rates.

LSC also offers the following more general observation on some of the important dynamics surrounding nursing facilities 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 facility stay and for longer periods of time as well. To aid in constraining the acceleration of nursing facility care costs associated with such a trend is the development of less-costly alternative forms of care, programs like PASSPORT, which allow some people with a nursing home level of care to live in the community. From the perspective of nursing facilities, 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 facility'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 2002 increased by 8.37% from FY 2001 levels of \$132.31 to \$143.38. The average per diem in FY 2003 is projected to grow by 6.22% to \$152.29. The average per diem in FY 2004 and FY 2005 is projected to grow by 4.78% to \$159.56 and 5.25% to \$167.94, respectively. Estimated expenditures for Nursing Home Services are \$2.76 billion in FY 2004 and \$2.95 billion in FY 2005.

**Inpatient and Outpatient Hospital Services.** Expenditures for Inpatient and Outpatient Hospital Services were \$1.55 billion and represented approximately 22% of expenditures from the 525 line item in FY 2002.

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. The growth rate in spending for hospital care is projected to be 9.70% from FY 2003 to FY 2004, and 7.85% from FY 2004 to FY 2005. Estimated expenditures for Inpatient and Outpatient Hospital Services are \$1.97 billion in FY 2004 and \$2.12 billion in FY 2005.

**Physician Services.** The cost estimates for Physician Services reflect the historical costs of providing medical care. The growth rate in spending is projected to be 12.95% from FY 2002 to FY 2003, 9.74% from FY 2003 to FY 2004, and 6.88% from FY 2004 to

FY 2005. Estimated expenditures for Physician Services are \$582.6 million in FY 2004 and \$622.6 million in FY 2005.

**Prescription Drugs.** Expenditures for Prescription Drug Services were \$1.24 billion and represented approximately 17.5% of expenditures from the 525 line item in FY 2002. Offsetting the prescription drug services expenditures was the prescription drug rebate of \$258.5 million in FY 2002.

S.B. 261 of 124th General Assembly authorizes JFS to establish a supplemental drug rebate program under which drug manufacturers may be required to provide a supplemental rebate to the state as a condition of having their products covered by Medicaid without prior approval. The bill also allows the Director of JFS to apply for a federal Medicaid waiver, if necessary, to establish the program. It is expected that this program will be implemented in the coming biennium. LSC assumes that this policy will affect the growth of cost-per-claim, as well as drug utilization, and thus forecasts that the growth rates for cost-per-claim and utilization ratio will decelerate and hold constant for FY 2004 and FY 2005. Estimated expenditures for Prescription Drug Services are \$1.76 billion in FY 2004 and \$1.99 billion in FY 2005. Offsetting the prescription drug services expenditures is the prescription drug rebate estimated at \$371.8 million in FY 2004 and \$430.3 million in FY 2005.

The prescription drug utilization rate for ABD eligibles is expected to increase by 5.29% in FY 2003, 3.96% in FY 2004 and FY 2005. LSC estimates that the prescription drug cost-per-claim for the ABD population will increase by 6.37% over FY 2003. 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 2004 and FY 2005, increasing by 5.59% each year.

The combined effects 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 23.44% in FY 2003, 14.47% in FY 2004, and 12.98% in FY 2005.

**Disability Assistance**

The Disability Assistance (DA) program is a state- and county-funded effort to provide cash and/or medical assistance to persons not eligible for public assistance programs that are supported in whole or in part by federal funds, for example OWF or Supplemental Security Income. Eligibility criteria for DA are established by the state.

The DA program has two distinct components: DA cash assistance and DA medical assistance. There is no time limit for receipt of DA benefits; assistance is provided on an ongoing basis as long as all eligibility requirements are met.

Three recent pieces of legislation have had a direct effect on the DA program. These are Am. H.B. 249 and Sub. H.B. 167 of the 121<sup>st</sup> General Assembly and Am. Sub. H.B. 408 of the 122<sup>nd</sup> General Assembly. Am. H.B. 249 eliminated cash eligibility for people who had previously qualified solely because of a medication dependency. Emancipated minors also became eligible for DA benefits under H.B. 249. Sub. H.B. 167 and Am. Sub. H.B. 408 affected the DA program by easing certain qualifications for OWF. Under these two acts, the work history requirement and the 100-hour work rule for two-parent families have been eliminated, thus making it easier for DA recipients with children to meet qualifications for OWF.

In the wake of this legislation and the implementation of OWF, the DA cash and medical recipient caseloads both exhibited a steady decline until the Fall of 1999. Since then, however, the cash assistance caseload has been increasing steadily. In January 2001 the medical caseload also began to increase and, along with an increase in medical inflation, has added quickly to the cost of the program. LSC forecasts that these trends will continue at the same pace that has been exhibited since these upturns.

<b>Disability Assistance LSC Baseline Forecast</b>			
	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>
Average monthly cash recipients	15,393	17,442	19,247
Average monthly medical recipients	20,628	24,321	28,262
(millions \$)			
DA Cash	\$23.0	\$26.1	\$29.4
DA Medical	\$90.1	\$109.0	\$134.9
<b>DA Total -- LSC Forecast</b>	<b>\$113.1</b>	<b>\$135.1</b>	<b>\$164.3</b>
Recommended by Gov. -- DA Cash		\$22.8	\$22.8
Recommended by Gov. -- DA Medical		\$101.4	\$101.4
<b>DA Total--Recommended by Gov.</b>		<b>\$124.2</b>	<b>\$124.2</b>

If current eligibility criteria stay the same, LSC anticipates the FY 2004 average number of monthly recipients of DA cash benefits to be 17,442, which represents an increase of 13.3% from the level LBO estimates for FY 2003. If cash benefit levels stay the same, benefits for the year will total \$26.1 million, constituting an increase of 13.5% over the FY 2003 estimate for cash benefits. Total cash benefits for the DA program in FY 2005 are forecast to be \$29.4 million, representing a 12.6% increase from FY 2004. This reflects an expected increase in FY 2005 to about 19,250 average monthly recipients of DA cash.

If current eligibility criteria stay the same, the DA medical recipient caseload is expected to continue its recent increases. Overall expenditures to serve DA medical recipients are anticipated to increase in FY 2004 to \$109.0 million, representing a 21.0% increase over the FY 2003 estimate. If current eligibility criteria stay the same, DA medical expenditures will continue to increase. LSC anticipates total medical spending to increase to \$134.9 million in FY 2005, which represents a 23.8% increase. In addition to the effects of continued caseload growth, the calculation of DA expenditures includes the effects of inflation in medical costs. Historically, medical costs in the DA program constitute about 70% of total DA expenses.

Combined DA cash benefits and DA medical benefits are estimated to total \$113.1 million for FY 2003, \$135.1 million for FY 2004, and \$164.3 million for FY 2005. This assumes current eligibility and benefit levels. OBM estimates the combined total for

DA to be \$118.4 million in FY 2003, \$144.2 million in FY 2004, and \$180.4 million in FY 2005.

The Governor has recommended an increase of funding over the FY 2003 level to \$124.2 million for each year of the biennium. Since this level of funding is lower than what is required to fully fund the forecast growth in the DA caseload, it will be necessary, if funding is to stay within those levels, to introduce changes in the DA program and its eligibility criteria.

### **Methodology**

The forecast of DA cash recipients is based solely on a quantitative model that analyzes past trends in the DA cash recipient time series during the time period since implementation of October 1, 2000. This model takes the DA cash recipient time series and identifies patterns in the data. These patterns are assumed to continue into the future.

Total cash benefits payable are then determined by forecasting average benefits per month per recipient. Average benefits are forecast using a linear regression model. Multiplying the average cash benefits and the number of monthly recipients produces the total monthly benefit for DA cash. Summing the monthly benefits each fiscal year yields the yearly total DA cash benefit forecast.

The forecast of DA medical recipients is based solely on a quantitative model that analyzes past trends in the time series during the time period since October 2000. These trends are assumed to continue into the future.

To determine the baseline total spending, the DA cash benefit forecast and the DA medical forecast are simply added together.

*Legislative Service Commission*

**Health Care Spending (ALI 600-525 Only)**

**Table 1**

Service Category	FY 2002	FY 2003		FY 2004		FY 2005	
	Actual	Estimated	% Change	Estimated	% Change	Estimated	% Change
<b>Long Term Care</b>	\$2,878,316,825	\$3,023,192,682	5.03%	\$3,196,882,543	5.75%	\$3,403,753,579	6.47%
Nursing Facilities	\$2,461,762,040	\$2,594,029,881	5.37%	\$2,756,788,734	6.27%	\$2,950,871,715	7.04%
ICF/MRs	\$416,554,785	\$429,162,801	3.03%	\$440,093,809	2.55%	\$452,881,864	2.91%
<b>Hospitals</b>	\$1,554,044,390	\$1,795,104,002	15.51%	\$1,969,250,314	9.70%	\$2,123,763,924	7.85%
Inpatient	\$1,099,011,540	\$1,262,894,378	14.91%	\$1,380,190,293	9.29%	\$1,483,992,231	7.52%
Outpatient	\$455,032,850	\$532,209,624	16.96%	\$589,060,021	10.68%	\$639,771,693	8.61%
<b>Physicians</b>	\$469,970,680	\$530,853,727	12.95%	\$582,552,534	9.74%	\$622,620,895	6.88%
<b>Prescription Drugs</b>	\$1,244,229,690	\$1,535,835,042	23.44%	\$1,758,091,686	14.47%	\$1,986,332,347	12.98%
<b>HMO</b>	\$597,202,743	\$738,505,804	23.66%	\$847,102,898	14.70%	\$897,725,969	5.98%
<b>Medicare Buy-In</b>	\$133,386,397	\$151,071,008	13.26%	\$161,595,642	6.97%	\$172,718,896	6.88%
<b>Waiver</b>	\$162,482,168	\$183,394,398	12.87%	\$221,645,685	20.86%	\$248,613,924	12.17%
<b>All Other Care</b>	\$662,893,933	\$777,901,354	17.35%	\$879,958,142	13.12%	\$960,030,703	9.10%
<b>CHIP-II</b>	\$47,900,786						
<b>DA Medical</b>	\$67,868,259	\$90,100,000	32.76%	\$109,000,000	20.98%	\$134,900,000	23.76%
<b>Claims FY04 53rd Week</b>				\$92,000,000			
<b>Total</b>	<b>\$7,818,295,871</b>	<b>\$8,825,958,017</b>	<b>12.89%</b>	<b>\$9,818,079,444</b>	<b>11.24%</b>	<b>\$10,550,460,237</b>	<b>7.46%</b>
<b>Other Revenue Offset</b>	\$691,685,505	\$1,089,540,009		\$794,207,562		\$857,429,318	
<b>Total Net GRF Expenditures</b>	<b>\$7,126,610,366</b>	<b>\$7,736,418,008</b>	<b>8.56%</b>	<b>\$9,023,871,882</b>	<b>16.64%</b>	<b>\$9,693,030,919</b>	<b>7.42%</b>
<b>Federal Share</b>	\$4,200,424,150	\$4,515,241,231		\$5,290,034,376		\$5,680,676,907	
<b>State Share</b>	\$2,926,186,216	\$3,221,176,777		\$3,733,837,506		\$4,012,354,011	

Note:

1. This table only includes health care spending through Department of Job and Family Services' 600-525 line item. It includes spending for Medicaid, CHIP-I, CHIP-II, and DA Medical.
2. The forecast is the LSC baseline forecast, which assumes no change in the state health care policies and program for the upcoming biennium.
3. "Other Revenue Offset" includes revenue from drug rebates, franchise fees, DSH payments, and Budget Stabilization Fund. Expenditures of CHIP-II and DA Medical are included in the Other Revenue Offset for FY 2002 since CHIP-II was funded through line item 600-426 and DA Medical was funded through line item 600-511 prior to FY 2003.
4. The growth rate for FY 2003 for Hospitals, Physicians, Prescription Drugs, HMO, and All Other Care includes the growth of CHIP-II spending.
5. "All Other Care" includes services such as dental care, home health care, and other practitioners, and includes various contracts.
6. The FMAP rate used here is a blended FMAP.

**Health Care Spending  
Table 2**

Fiscal Year	ALI 600-525		Financial Participation			
	Total	% Change	State	% Change	Federal	% Change
1991	\$3,304,346,333	17.92%	\$1,350,486,346	17.66%	\$1,953,859,987	18.10%
1992	\$3,941,073,001	19.27%	\$1,661,556,377	23.03%	\$2,279,516,624	16.67%
1993	\$4,149,379,774	5.29%	\$1,686,307,940	1.49%	\$2,463,071,834	8.05%
1994	\$4,521,872,195	8.98%	\$1,779,356,709	5.52%	\$2,742,515,486	11.35%
1995	\$4,585,549,544	1.41%	\$1,791,624,838	0.69%	\$2,793,924,706	1.87%
1996	\$4,941,254,040	7.76%	\$1,971,066,236	10.02%	\$2,970,187,804	6.31%
1997	\$4,897,184,802	-0.89%	\$1,987,767,311	0.85%	\$2,909,417,491	-2.05%
1998	\$5,056,299,328	3.25%	\$2,107,465,560	6.02%	\$2,948,833,768	1.35%
1999	\$5,229,514,139	3.43%	\$2,214,699,238	5.09%	\$3,014,814,901	2.24%
2000	\$5,525,569,750	5.66%	\$2,294,216,560	3.59%	\$3,231,353,190	7.18%
2001	\$6,481,731,098	17.30%	\$2,657,509,750	15.84%	\$3,824,221,348	18.35%
2002	\$7,126,610,366	9.95%	\$2,926,186,216	10.11%	\$4,200,424,150	9.84%
2003*	\$7,736,418,008	8.56%	\$3,221,176,777	10.08%	\$4,515,241,231	7.49%
2004*	\$9,023,871,882	16.64%	\$3,733,837,506	15.92%	\$5,290,034,376	17.16%
2005*	\$9,693,030,918	7.42%	\$4,012,354,011	7.46%	\$5,680,676,907	7.38%

\* LSC baseline estimates

**Note:**

1. This table only includes health care spending through the Department of Job and Family Services' 600-525 line item. Beginning in FY 2003, it includes spending for CHIP-II, and DA Medical.
2. The LSC baseline forecast assumes no change in the state health care policies and program for the upcoming biennium.

**Medicaid Caseload by Eligibility Group  
Table 3**

Fiscal Year	ABD&CFC		ABD							
	Total		Total ABD		ABD (no QMB)		QMB		SLMB	
	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change
1991	1,108,464		232,629		228,955		3,674			
1992	1,232,398	11.18%	255,971	10.03%	246,369	7.61%	9,602	161.38%		
1993	1,270,110	3.06%	280,162	9.45%	263,676	7.02%	16,067	67.32%	420	
1994	1,294,972	1.96%	313,240	11.81%	286,655	8.71%	20,191	25.67%	6,395	
1995	1,284,005	-0.85%	345,304	10.24%	309,576	8.00%	22,773	12.79%	12,955	102.58%
1996	1,228,262	-4.34%	366,783	6.22%	321,978	4.01%	22,736	-0.16%	22,069	70.35%
1997	1,166,169	-5.06%	370,047	0.89%	323,023	0.32%	23,791	4.64%	23,233	5.27%
1998	1,107,999	-4.99%	365,493	-1.23%	315,884	-2.21%	23,683	-0.46%	25,925	11.59%
1999	1,095,716	-1.11%	373,158	2.10%	314,855	-0.33%	23,538	-0.61%	34,764	34.09%
2000	1,109,202	1.23%	372,357	-0.21%	318,720	1.23%	23,635	0.41%	30,002	-13.70%
2001	1,276,967	15.12%	376,886	1.22%	323,150	1.39%	22,451	-5.01%	31,284	4.28%
2002	1,419,856	11.19%	383,846	1.85%	327,427	1.32%	20,800	-7.35%	35,619	13.86%
2003*	1,559,487	9.83%	404,035	5.26%	342,955	4.74%	22,138	6.43%	38,942	9.33%
2004*	1,637,550	5.01%	421,222	4.25%	358,636	4.57%	22,775	2.88%	39,810	2.23%
2005*	1,650,731	0.80%	434,715	3.20%	370,959	3.44%	23,048	1.20%	40,708	2.25%

Fiscal Year	CFC									
	Total		Healthy Families		Healthy Start		CHIP-I / HS Exp		CHIPII	
	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change
1991	875,835		828,828		47,007					
1992	976,427	11.49%	894,261	7.89%	82,166	74.80%				
1993	989,948	1.38%	880,786	-1.51%	109,162	32.86%				
1994	981,732	-0.83%	858,069	-2.58%	123,663	13.28%				
1995	938,701	-4.38%	808,875	-5.73%	129,826	4.98%				
1996	861,479	-8.23%	721,950	-10.75%	139,529	7.47%				
1997	796,122	-7.59%	662,403	-8.25%	133,719	-4.16%				
1998	742,506	-6.73%	580,827	-12.32%	137,912	3.14%	23,767			
1999	722,558	-2.69%	500,840	-13.77%	169,210	22.69%	52,509	120.93%		
2000	736,846	1.98%	481,064	-3.95%	185,127	9.41%	70,655	34.56%		
2001	900,081	22.15%	657,175	36.61%	141,385	-23.63%	81,310	15.08%	20,210	
2002	1,036,010	15.10%	774,752	17.89%	130,898	-7.42%	91,897	13.02%	38,464	90.32%
2003*	1,155,452	11.53%	863,707	11.48%	143,126	9.34%	103,235	12.34%	45,385	17.99%
2004*	1,216,328	5.27%	906,511	4.96%	151,280	5.70%	109,721	6.28%	48,816	7.56%
2005*	1,216,016	-0.03%	906,935	0.05%	151,010	-0.18%	109,441	-0.25%	48,630	-0.38%

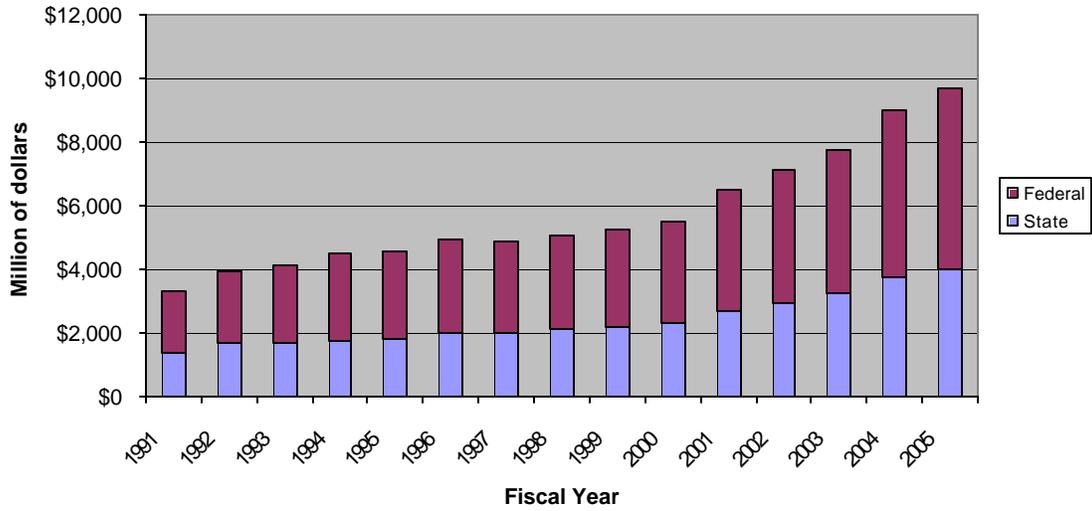
\* LSC baseline estimates

**Medicaid Caseload for Covered Families and Children (CFC):  
Fee-for-Service vs HMO  
Table 4**

Fiscal Year	Total CFC		FFS		HMO		Penetration Rate (=HMO/CFC)
	mo. avg.	% change	mo. avg.	% change	mo. avg.	% change	
1991	875,835		750,006		125,829		14.37%
1992	976,427	11.49%	842,914	12.39%	133,513	6.11%	13.67%
1993	989,948	1.38%	841,939	-0.12%	148,009	10.86%	14.95%
1994	981,732	-0.83%	812,600	-3.48%	169,133	14.27%	17.23%
1995	938,701	-4.38%	748,172	-7.93%	190,528	12.65%	20.30%
1996	861,479	-8.23%	607,327	-18.83%	254,153	33.39%	29.50%
1997	796,122	-7.59%	464,883	-23.45%	331,239	30.33%	41.61%
1998	742,506	-6.73%	411,458	-11.49%	331,048	-0.06%	44.59%
1999	722,558	-2.69%	465,809	13.21%	256,750	-22.44%	35.53%
2000	736,846	1.98%	483,743	3.85%	253,103	-1.42%	34.35%
2001	900,081	22.15%	648,350	34.03%	251,731	-0.54%	27.97%
2002	1,036,010	15.10%	699,979	7.96%	336,031	33.49%	32.44%
2003*	1,155,452	11.53%	757,613	8.23%	397,839	18.39%	34.43%
2004*	1,216,328	5.27%	790,213	4.30%	426,115	7.11%	35.03%
2005*	1,216,016	-0.03%	780,831	-1.19%	435,185	2.13%	35.79%

\* LSC baseline estimates

**Health Care (600-525 Only) Spending History**  
Chart 1



**Medicaid Eligibility - Monthly Averages**  
Chart 2

