

Public Assistance Expenditures *Health Care/Medicaid*

Overview

The Office of Ohio Health Plans in the Department of Job and Family Services (ODJFS) 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 Medical).

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 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 slightly over 1.6 million Ohioans every month in Fiscal Year (FY) 2004. 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, copayments, 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 ODJFS. Recognized by the federal government as Ohio's single Medicaid agency, ODJFS 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.¹⁴ In addition to the funding from the GRF, several provider tax programs and other special revenues are used to pay for Medicaid services.¹⁵

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 59 cents. However, while the majority of the spending in line item 600-525, Health Care/Medicaid, is reimbursed at the FMAP, a few items, primarily contracts, are reimbursed at 50%, and all family planning services are reimbursed at 90%. In addition, about 15% of Medicare buy-in premiums receive no federal reimbursement. Lastly, the State Children's Health Insurance Plan (SCHIP) is reimbursed at an enhanced FMAP of about 71%.

Forecast Summary

The total number of persons eligible for Medicaid grew by 5.74% from 1,551,530 in FY 2003 to 1,640,637 in FY 2004. The total number of eligibles is estimated to reach 1,720,848 in FY 2005, a 4.89% increase over FY 2004. LSC forecasts that the number of persons eligible for Medicaid will continue to grow to 1,771,015 in FY 2006, a 2.92% increase, before falling to 1,750,318 in FY 2007, a 1.17% decrease.

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

¹⁴ Prior to FY 2003, spending for part II of SCHIP was funded through line item 600-426, and spending for DA medical was funded through line item 600-511.

¹⁵ 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 reimbursement. Other special revenues include funds for the Disproportionate Share Hospital (DSH) offset and drug rebates.

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.

LSC projects an increase in health care expenditures in FY 2006 of 12.34% or \$1,303 million in combined state and federal GRF dollars, with a state share increase of \$526 million. For FY 2007, LSC projects total health care expenditures will go up by another 8.41%, or \$998 million in combined state and federal GRF dollars, with a state share increase of \$402 million.

These projections do not include the impacts of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which includes Medicare Part D. Those impacts will be discussed in LSC's Department of Job and Family Services - Medicaid redbook.

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. Growth over the next biennium is expected to be stable.

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.¹⁶ For SLMBs, Medicaid covers the Medicare Part B premiums only for those with incomes between 100% and 120% of the FPG. Premiums for both of these eligibility groups (and for Medicare-eligible ABD eligibles for whom the state chooses to buy-in to Medicare)¹⁷ 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 federal 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

¹⁶ The QMB grouping in the eligibility table refers only to those QMB individuals who do not "spend down" to ABD eligibility. 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.

¹⁷ 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.

July 1996 ADC policy."¹⁸ 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.

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 reimbursement rate 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 Services (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 123rd 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.

¹⁸ Source: Ohio Medicaid Report, December 1998, Ohio Department of Human Services.

Caseload Forecast

Total Caseload. The total number of persons eligible for Medicaid grew by 5.74% from 1,551,530 in FY 2003 to 1,640,637 in FY 2004. The total number of eligibles is estimated to reach 1,720,848 in FY 2005, a 4.89% increase over FY 2004. LSC forecasts that the number of persons eligible for Medicaid will continue to grow to 1,771,015 in FY 2006, a 2.92% increase, before falling to 1,750,318 in FY 2007, a 1.17% decrease.

The last time the Medicaid program had major expansions was in July 2000. At that time, ODJFS 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, ODJFS 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 current (FYs 2004-2005) biennium or the preceding biennium. The forecast assumes that no program expansions will be implemented during the coming biennium.

Poor labor market conditions associated with the recent recession (which officially ended for the nation as a whole in late 2001) 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 17.10% in FY 2003 before slowing to 7.67% in FY 2004, a rate more comparable to the other categories of eligibility.

Covered Families and Children. LSC forecasts that the overall CFC caseload will peak in the first half of FY 2006, and begin to drop in the third quarter of FY 2006 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 October 2004 economic forecast for Ohio by Global Insight.

Aged, Blind, and Disabled. Growth in the ABD caseload decelerated in FY 2004, but early signs for FY 2005 suggest that growth may accelerate again. Those eligible due to disability are the largest single subcategory within the ABD category of eligibility. The Social Security Administration forecast acceleration in the number of blind or disabled recipients of federally administered SSI benefits starting in CY 2003 in its *Annual Report of the Supplemental Security Income Program* released in May 2004. While this forecast is for a national figure, statistical analysis conducted by LSC staff indicates that growth in Ohio's disabled and blind caseload is highly correlated with this national data historically. LSC forecasts the number of ABD eligibles to grow by 4.33%

from FY 2004 to FY 2005, with growth decelerating to 4.19% in FY 2006 and 3.01% in FY 2007. The Aged subcategory is projected to increase at average historical rates.

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 of 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, Stark, 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 rate¹⁹ from 27.93% in FY 2001 to 39.44% in FY 2004.

LSC's baseline forecast assumes that the HMO penetration rate will continue to rise due to the Preferred Option. But it is expected to rise more slowly to approximately 41 or 42% for FY 2006 and FY 2007. In other words, about 41 or 42% of all Covered Family and Children consumers are expected to enroll in a Medicaid HMO during the next biennium, absent any new policy initiatives.

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,

¹⁹ Penetration is the number of managed care eligible divided by total Covered Family and Children eligibles.

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.

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 consumer expenditure — medical care (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, and in those cases the assumption regarding inflation was based on the PCE-MC with no adjustments.

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 \$2.71 billion and represented approximately 27.58% of expenditures from line item 525 in FY 2004.

Payments to nursing facilities are based on cost reports. Nursing facilities annually submit cost reports to ODJFS, 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 FY 2004-2005 biennial budget act temporarily suspended the statutory per diem rate formula and established a cap on growth in the per diem rates for FY 2004 and FY 2005. For FY 2004, the mean total per diem rate for all nursing facilities in the state, weighted by Medicaid days, after applying the cap was \$156.84. Department of Job and Family Services officials report that the mean would have been approximately \$164.11 if the statutory formula had been followed. For FY 2005, the equivalent figure after applying the cap is estimated to be \$159.31, while ODJFS officials indicate that the mean would have been approximately \$170.58 under the statutory formula.

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. Alternative forms of care like PASSPORT, which allow some people with a nursing home level of care to live in the community, aid in constraining the acceleration of nursing facility care costs. 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 forecast assumes that the statutory formula is resumed in FY 2006 and FY 2007. The per diem rates are forecast to average \$183.89 during FY 2006 and \$192.17 in FY 2007. The FY 2006 per diem rate forecast represents an increase of 7.6% over the ODJFS estimate of the statutory formula per diem for FY 2005, and the FY 2007 forecast represents an increase of 4.5% over the FY 2006 average. Estimated expenditures for Nursing Home Services are \$3.18 billion in FY 2006 and \$3.34 billion in FY 2007.

Inpatient and Outpatient Hospital Services. Expenditures for Inpatient and Outpatient Hospital Services were \$1.95 billion and represented approximately 19.84% of expenditures from the 525 line item in FY 2004.

ODJFS is amending rules to update and provide a more current weighting of the relative weights for Diagnostic Related Groups (DRG) used in the prospective payment system for hospital services, and to require annual recalibration updates thereafter. The Department estimates that the recalibration of the relative weights for DRGs will result in a decrease in reimbursement for hospital services.

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. LSC's projection is that hospital spending growth will slow to 7.87% in FY 2006 due to the impact of the hospital recalibration, and move to 9.95% in FY 2007, as both use and price are anticipated to grow.

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 5.99% from FY 2004 to FY 2005, 8.68% from FY 2005 to FY 2006, and 6.89% from FY 2006 to FY 2007. Estimated expenditures for Physician Services are \$688.1 million in FY 2006 and \$735.5 million in FY 2007.

Prescription Drugs. Expenditures for Prescription Drug Services were \$1.80 billion and represented approximately 18.28% of expenditures from the 525 line item in FY 2004. Offsetting the prescription drug services expenditures was the prescription drug rebate of \$455.4 million in FY 2004.

LSC expects prescription drug spending growth to decelerate but to still be one of the fastest growing health sectors. Growth in drug spending peaked in FY 2001 at 25.08%, slowed to 16.84% in FY 2004, and is projected to decelerate to 13.17% growth in FY 2005. Growth is projected to be 15.96% in FY 2006 and 13.93% in FY 2007. The high growth rate of FY 2001 was associated with increases in utilization, price, and the number of eligibles.

Medicare Buy-In. During September 2004, the U.S. Department of Health and Human Services (HHS) announced increases in Medicare premiums, coinsurance, and deductible costs that result in increases in Medicaid spending in calendar year 2005. The Medicare Part A premium increases 9.3% over the 2004 level and the Medicare Part B premiums increases 17.4%.

The cost estimates for Medicare Buy-In Services reflect the historical trend and the above policy changes. The growth rate in spending is projected to be 23.13% from FY 2004 to FY 2005, 14.00% from FY 2005 to FY 2006, and 6.55% from FY 2006 to FY 2007. Estimated expenditures for Medicare Buy-In Services are \$226.7 million in FY 2006 and \$241.6 million in FY 2007.

Health Care Spending (ALI 600-525 Only)
 Table 1

Service Category	FY 2004	FY 2005		FY 2006		FY 2007	
	Actual	Estimated	% Change	Estimated	% Change	Estimated	% Change
Long Term Care	\$3,151,206,177	\$3,209,023,721	1.83%	\$3,654,898,762	13.89%	\$3,834,587,403	4.92%
Nursing Facilities	\$2,709,358,490	\$2,763,155,804	1.99%	\$3,178,723,713	15.04%	\$3,342,871,469	5.16%
ICF/MRs	\$441,847,687	\$445,867,917	0.91%	\$476,175,049	6.80%	\$491,715,934	3.26%
Hospitals	\$1,948,373,488	\$2,133,104,386	9.48%	\$2,300,918,372	7.87%	\$2,529,847,825	9.95%
Inpatient	\$1,343,533,049	\$1,454,973,773	8.29%	\$1,534,604,584	5.47%	\$1,680,925,658	9.53%
Outpatient	\$604,840,439	\$678,130,613	12.12%	\$766,313,788	13.00%	\$848,922,167	10.78%
Physicians	\$597,405,355	\$633,175,859	5.99%	\$688,112,790	8.68%	\$735,501,705	6.89%
Prescription Drugs	\$1,795,101,223	\$2,031,575,195	13.17%	\$2,355,778,731	15.96%	\$2,683,937,819	13.93%
HMO	\$1,021,073,246	\$1,089,212,524	6.67%	\$1,208,792,969	10.98%	\$1,279,628,281	5.86%
Medicare Buy-In	\$161,514,543	\$198,871,376	23.13%	\$226,721,245	14.00%	\$241,571,334	6.55%
Waiver	\$198,082,600	\$222,013,634	12.08%	\$240,826,793	8.47%	\$261,536,360	8.60%
All Other Care	\$867,979,653	\$959,543,820	10.55%	\$1,110,159,784	15.70%	\$1,212,272,728	9.20%
DA Medical	\$81,661,526	\$84,506,719	3.48%	\$77,745,958	-8.00%	\$83,095,453	6.88%
Total	\$9,822,397,811	\$10,561,027,232	7.52%	\$11,863,955,405	12.34%	\$12,861,978,909	8.41%
Other Revenue Offset	\$909,500,595	\$974,995,942		\$1,234,010,311		\$1,267,931,829	
525 Total Payment	\$8,912,897,216	\$9,586,031,290	7.55%	\$10,629,945,094	10.89%	\$11,594,047,080	9.07%
Federal Share	\$5,206,914,554	\$5,695,423,079		\$6,337,278,360		\$6,919,638,241	
State Share	\$3,705,982,662	\$3,890,608,211		\$4,292,666,733		\$4,674,408,839	

- 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, CHIPI, CHIPII, 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, and DSH payments.
 4. "All Other Care" includes services such as dental care, home health care, and other practitioners, and includes various contracts.
 5. The FMAP rate used here is a blended FMAP.

Medicaid Caseload by Eligibility Group
 Table 2

Fiscal Year	ABD&CFC Total		ABD							
	mo. avg.	% change	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	1,096,115	-6.01%	365,493	-1.23%	315,884	-2.21%	23,683	-0.46%	25,925	11.59%
1999	1,095,716	-0.04%	373,158	2.10%	314,855	-0.33%	23,538	-0.61%	34,764	34.09%
2000	1,109,217	1.23%	372,357	-0.21%	318,720	1.23%	23,635	0.41%	30,002	-13.70%
2001	1,278,082	15.22%	376,885	1.22%	323,150	1.39%	22,451	-5.01%	31,284	4.28%
2002	1,419,856	11.09%	383,846	1.85%	327,427	1.32%	20,800	-7.35%	35,619	13.86%
2003	1,551,530	9.27%	401,254	4.53%	341,507	4.30%	22,146	6.47%	37,601	5.56%
2004	1,640,637	5.74%	411,815	2.63%	353,316	3.46%	22,728	2.63%	35,771	-4.87%
2005*	1,720,848	4.89%	429,637	4.33%	366,745	3.80%	24,080	5.95%	38,812	8.50%
2006*	1,771,015	2.92%	447,639	4.19%	383,218	4.49%	25,141	4.41%	39,280	1.21%
2007*	1,750,318	-1.17%	461,108	3.01%	396,274	3.41%	26,255	4.43%	38,580	-1.78%

Fiscal Year	CFC									
	Total CFC		Healthy Families		Healthy Start		CHIP I / HS Exp		CHIP II	
	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	730,623	-8.23%	580,827	-12.32%	137,912	3.14%	11,884			
1999	722,558	-1.10%	500,840	-13.77%	169,078	22.60%	52,640	342.96%		
2000	736,860	1.98%	481,064	-3.95%	185,127	9.49%	70,655	34.22%	14	
2001	901,197	22.30%	655,907	36.34%	140,865	-23.91%	81,822	15.81%	22,604	
2002	1,036,010	14.96%	774,752	18.12%	130,898	-7.08%	91,897	12.31%	38,464	70.16%
2003	1,150,276	11.03%	859,968	11.00%	142,946	9.20%	102,322	11.34%	45,041	17.10%
2004	1,228,822	6.83%	922,937	7.32%	148,710	4.03%	108,682	6.22%	48,494	7.67%
2005*	1,291,211	5.08%	983,542	6.57%	147,766	-0.63%	109,715	0.95%	50,188	3.49%
2006*	1,323,376	2.49%	1,008,858	2.57%	149,789	1.37%	113,118	3.10%	51,611	2.84%
2007*	1,289,209	-2.58%	981,935	-2.67%	146,734	-2.04%	110,306	-2.49%	50,234	-2.67%

* LSC baseline estimates

Covered Family and Children (CFC) Caseload: Fee-for-Service vs HMO
 Table 3

SFY	CFC							Healthy Families						
	Total		FFS		HMO		penetration	Total		FFS		HMO		penetration
	mth avg	% change	mth avg	% change	mth avg	% change	(=HMO/TOT)	mth avg	% change	mth avg	% change	mth avg	% change	(=HMO/TOT)
1990	795,775		684,260		111,515		14.01%	779,937		668,752		111,185		14.26%
1991	875,835	10.06%	750,006	9.61%	125,829	12.84%	14.37%	828,828	6.27%	703,423	5.18%	125,406	12.79%	15.13%
1992	976,427	11.49%	842,914	12.39%	133,513	6.11%	13.67%	894,261	7.89%	761,156	8.21%	133,106	6.14%	14.88%
1993	989,948	1.38%	841,939	-0.12%	148,009	10.86%	14.95%	880,786	-1.51%	734,891	-3.45%	145,895	9.61%	16.56%
1994	981,732	-0.83%	812,600	-3.48%	169,133	14.27%	17.23%	858,069	-2.58%	694,186	-5.54%	163,883	12.33%	19.10%
1995	938,701	-4.38%	748,172	-7.93%	190,528	12.65%	20.30%	808,875	-5.73%	629,009	-9.39%	179,866	9.75%	22.24%
1996	861,479	-8.23%	607,327	-18.83%	254,153	33.39%	29.50%	721,950	-10.75%	488,206	-22.38%	233,744	29.95%	32.38%
1997	796,122	-7.59%	464,883	-23.45%	331,239	30.33%	41.61%	662,403	-8.25%	361,072	-26.04%	301,331	28.91%	45.49%
1998	730,623	-8.23%	399,575	-14.05%	331,048	-0.06%	45.31%	580,827	-12.32%	285,781	-20.85%	295,046	-2.09%	50.80%
1999	722,558	-1.10%	465,809	16.58%	256,750	-22.44%	35.53%	500,840	-13.77%	291,929	2.15%	208,911	-29.19%	41.71%
2000	736,860	1.98%	483,757	3.85%	253,103	-1.42%	34.35%	481,064	-3.95%	292,497	0.19%	188,568	-9.74%	39.20%
2001	901,197	22.30%	649,466	34.25%	251,731	-0.54%	27.93%	655,907	36.34%	455,704	55.80%	200,203	6.17%	30.52%
2002	1,036,010	14.96%	699,979	7.78%	336,031	33.49%	32.44%	774,752	18.12%	505,707	10.97%	269,044	34.39%	34.73%
2003	1,150,276	11.03%	745,030	6.44%	405,246	20.60%	35.23%	859,968	11.00%	540,374	6.86%	319,594	18.79%	37.16%
2004	1,228,822	6.83%	744,139	-0.12%	484,683	19.60%	39.44%	922,937	7.32%	540,920	0.10%	382,017	19.53%	41.39%
2005*	1,291,211	5.08%	765,266	2.84%	525,945	8.51%	40.73%	983,542	6.57%	566,582	4.74%	416,960	9.15%	42.39%
2006*	1,323,376	2.49%	774,715	1.23%	548,660	4.32%	41.46%	1,008,858	2.57%	576,322	1.72%	432,536	3.74%	42.87%
2007*	1,289,209	-2.58%	742,525	-4.16%	546,685	-0.36%	42.40%	981,935	-2.67%	554,817	-3.73%	427,117	-1.25%	43.50%

SFY	Healthy Start					CHIP-I/HS								
	Total		FFS		HMO	penetration	Total		FFS		HMO	penetration		
	mth avg	% change	mth avg	% change	mth avg	% change	(=HMO/TOT)	mth avg	% change	mth avg	% change	mth avg	% change	(=HMO/TOT)
1990	15,837		15,508		330		2.08%							
1991	47,007		46,583	200.39%	423	28.39%	0.90%							
1992	82,166	74.80%	81,759	75.51%	407	-3.76%	0.50%							
1993	109,162	32.86%	107,048	30.93%	2,115	419.13%	1.94%							
1994	123,663	13.28%	118,414	10.62%	5,249	148.24%	4.24%							
1995	129,826	4.98%	119,164	0.63%	10,662	103.11%	8.21%							
1996	139,529	7.47%	119,121	-0.04%	20,408	91.41%	14.63%							
1997	133,719	-4.16%	103,811	-12.85%	29,908	46.55%	22.37%							
1998	137,912	3.14%	101,910	-1.83%	36,002	20.38%	26.11%	23,767		11,884				0.00%
1999	169,078	22.60%	130,114	27.68%	38,965	8.23%	23.05%	52,640	121.48%	43,766		8,874		16.86%
2000	185,127	9.49%	138,640	6.55%	46,486	19.30%	25.11%	70,655	34.22%	52,606	20.20%	18,049	103.39%	25.55%
2001	140,865	-23.91%	111,972	-19.24%	28,892	-37.85%	20.51%	81,822	15.81%	63,544	20.79%	18,279	1.27%	22.34%
2002	130,898	-7.08%	99,439	-11.19%	31,458	8.88%	24.03%	91,897	12.31%	67,297	5.91%	24,600	34.58%	26.77%
2003	142,946	9.20%	102,878	3.46%	40,068	27.37%	28.03%	102,322	11.34%	71,302	5.95%	31,019	26.09%	30.32%
2004	148,710	4.03%	100,908	-1.91%	47,802	19.30%	32.14%	108,682	6.22%	71,509	0.29%	37,173	19.84%	34.20%
2005*	147,766	-0.63%	98,361	-2.52%	49,405	3.35%	33.43%	109,715	0.95%	69,603	-2.67%	40,112	7.91%	36.56%
2006*	149,789	1.37%	97,596	-0.78%	52,193	5.64%	34.84%	113,118	3.10%	69,579	-0.03%	43,538	8.54%	38.49%
2007*	146,734	-2.04%	92,960	-4.75%	53,775	3.03%	36.65%	110,306	-2.49%	65,135	-6.39%	45,171	3.75%	40.95%

SFY	CHIP II						
	Total		FFS		HMO	penetration	
	mth avg	% change	mth avg	% change	mth avg	% change	(=HMO/TOT)
1990							
1991							
1992							
1993							
1994							
1995							
1996							
1997							
1998							
1999							
2000			14				
2001	22,604		18,246		4,358		19.28%
2002	38,464	70.16%	27,535	50.91%	10,929	150.80%	28.41%
2003	45,041	17.10%	30,476	10.68%	14,565	33.27%	32.34%
2004	48,494	7.67%	30,802	1.07%	17,692	21.47%	36.48%
2005*	50,188	3.49%	30,962	0.52%	19,226	8.68%	38.31%
2006*	51,611	2.84%	31,218	0.83%	20,394	6.07%	39.51%
2007*	50,234	-2.67%	29,613	-5.14%	20,621	1.12%	41.05%

* LSC baseline estimates

Medicaid Eligibility - Monthly Averages

