

## MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS & HEALTH REFORM

### Summary

#### 1. What is Medicaid and what does it do?

- Medicaid is the nation's primary health insurance program for Americans with low incomes and significant health care needs.
- Medicaid increases access to care and limits out-of-pocket burdens for low-income people.
- Medicaid is the largest source of funding for safety-net providers and the dominant payer for long-term care. Medicaid also helps to make Medicare work for low-income elderly and disabled beneficiaries.
- Medicaid provides an entitlement to coverage for individuals eligible for the program. Medicaid also guarantees federal matching payments to states with no cap in order to meet program needs.
- States administer Medicaid within broad federal rules.
- Although Medicaid is publicly financed, the program purchases health services primarily in the private sector.

#### 2. What does Medicaid cost and why?

- Medicaid accounts for about one sixth of total health care spending in the country.
- On a per enrollee basis, Medicaid spending is growing more slowly than premiums for employer-sponsored insurance or national health care spending. However it is subject to same market pressures as other payers.
- Enrollment is the dominant driver in Medicaid spending, especially during periods of economic downturn.
- The elderly and disabled account for the majority of Medicaid spending.
- Medicaid spending is concentrated among a small number of beneficiaries with complex health care needs.
- States have a strong incentive to manage Medicaid cost growth.

#### 3. What is Medicaid's role in state budgets?

- The Medicaid program is jointly funded by states and the federal government.
- Medicaid is a counter-cyclical program; during economic downturns, individuals lose jobs, incomes drop, state revenues decline, and more individuals qualify and enroll in Medicaid which increases spending.
- Medicaid is second largest item in state general fund budgets but also the single largest source of federal grant support to states, making it both a budget item and a revenue item in state budgets. Medicaid funds support health care providers, jobs and state economies overall.
- Due to budget pressures over the last decade, states have adopted an array of cost containment measures.

#### 4. What is Medicaid's role in the federal budget?

- Medicaid is the third-largest domestic program in the federal budget.
- Medicaid is exempt from automatic budget reductions; however Medicaid continues to be discussed as part of federal deficit reduction efforts.
- Leading budget proposals for FFY 2014 released by the Administration and House Republicans take fundamentally different approaches to Medicaid spending.
- The FMAP formula that determines the federal share of Medicaid spending has remained steady since the start of the program; Congress has only amended the formula to provide more federal funding, not less.

#### 5. What is Medicaid's role in health reform?

- Health reform builds on Medicaid as a base of coverage for low-income Americans.
- As they plan their FY 2014 budgets, states are debating whether to adopt the Medicaid expansion.
- The Federal Government will finance over 90% of the cost of the Medicaid expansion in new states; overall, many states are likely to see net savings from the Medicaid expansion.
- The Medicaid expansion would significantly reduce the uninsured and increase access to care.
- The ACA provides new options to expand community-based long-term care and to coordinate care for high cost populations.

## 1. What is Medicaid and what does it do?

**Medicaid is the nation's primary health insurance program for Americans with low incomes and significant health care needs.** Medicaid covers more than 62 million low-income Americans. The program provides health coverage for low-income families who lack access to other affordable coverage options and for individuals with disabilities for whom private coverage is often not available or inadequate. Today, Medicaid does not cover all individuals with low incomes. Millions of low-income adults (particularly adults without dependent children) are uninsured because they are not eligible for Medicaid and do not have access to other coverage. Given the wide array of health needs and limited incomes of enrollees, Medicaid provides a broad range of services, with limited cost-sharing.

**Medicaid increases access to care and limits out-of-pocket burdens for low-income people.** Children and adults enrolled in Medicaid have much better access to care than those without insurance. And compared with people who do have private health insurance, Medicaid enrollees fare just as well on most measures of access to care, despite often cited concerns about provider participation. There are issues related to access to some provider types like dentists and some specialists; however, these issues reflect more general provider shortages as well as problems with the geographic distribution of physicians that are not limited to Medicaid. Because the population covered is low-income, Medicaid has strict limitations on cost-sharing and premiums, so enrollees face far fewer financial barriers to care compared to the uninsured and many with private insurance. Medicaid's extensive use of managed care arrangements has helped to improve access to care for some of its enrollees.

**Medicaid is the largest source of funding for safety-net providers and the dominant payer for long-term care. Medicaid also helps to make Medicare work for low-income elderly and disabled beneficiaries.** Medicaid is the largest source of funding for safety-net providers (such as community health centers and public hospitals) that serve the poor and uninsured.<sup>i</sup> Many of these providers are located in low-income communities or rural areas with provider shortages. Medicaid is also the nation's largest payer for long-term care services in institutions and in the community. Medicaid helps to make Medicare work for over 9 million low-income elderly and disabled beneficiaries who rely on Medicaid to help pay for Medicare premiums, gaps in Medicare benefits, and long-term care needs.

**Medicaid provides an entitlement to coverage for individuals eligible for the program and a guarantee of federal matching payments to states with no cap to meet program needs.** Currently, Medicaid covers low-income individuals who meet categorical and income standards including children and parents, individuals with disabilities, and the elderly. Under the entitlement, states cannot cap or close enrollment for individuals who meet eligibility standards for the program. This helps to ensure that coverage is available during economic downturns. State expenditures for Medicaid are matched by the federal government, with states guaranteed at least \$1 in federal funds for every \$1 in state funds spent on the program. The federal matching rate (referred to as the FMAP) allows federal funds to flow to the states, making federal funding responsive to changing program needs like recessions, health care inflation, epidemics, or disasters.

**States have flexibility to administer Medicaid within broad federal rules.** State participation in Medicaid is optional. States that elect to participate, as all have done for the past 30 years, must meet core federal requirements related to coverage and benefits to receive federal matching funds. States have flexibility to cover populations and services beyond federal minimums and receive federal matching funds for these costs. States also have flexibility to determine how to deliver care and how much to pay providers. Flexibility to set eligibility levels has been limited over time by increases in federal minimum levels for children and pregnant women and more recently by eligibility protections put in place under the Patient Protection and Affordable Care Act (ACA). As a result of general flexibility there is large variation across state Medicaid programs. Four in ten dollars were spent on federally-required services provided to federal core enrollees in 2007 and the remaining 60% of spending was for state expansion enrollees and optional services.

**Although Medicaid is publicly financed, the program purchases health services primarily in the private sector.** Unlike the health system for veterans that is financed and operated by the government, Medicaid programs purchase services from private providers on a fee-for-service basis, by paying premiums to managed care plans under contracts, or through a combination of approaches. About two-thirds of Medicaid enrollees are enrolled in some type of managed care (fully capitated plans or primary care case management).<sup>ii</sup> These plans use networks of private providers to deliver covered services to their enrollees. Medicaid managed care enrollees are largely children and families, although many states are moving forward to enroll elderly and disabled beneficiaries in managed care plans as well.

## 2. What does Medicaid cost and why?

**Medicaid accounts for about one sixth of total health care spending in the country.** Medicaid, like other insurers, purchases health care services in the private market. In 2011, Medicaid represented 18% of all hospital spending and 31% of all nursing home spending in the U.S.<sup>iii</sup> In federal fiscal year (FFY) 2011, total federal and state Medicaid service spending (including disproportionate share hospital payments and payments to Medicare) was \$413.5 billion. About two-thirds was spent on hospital, physician, drugs, and other acute care services; about one-third was spent on nursing home and other long-term care services.<sup>iv</sup>

**On a per enrollee basis, Medicaid spending is growing more slowly than premiums for employer-sponsored insurance or national health care spending overall. However it is subject to same market pressures as other payers.** On a per enrollee basis, Medicaid spending growth is lower than the growth in both employer-sponsored insurance coverage and national health expenditures overall. From FFY 2007-2011, Medicaid spending per enrollee grew an average of 2.3% per year; the comparable rate of growth in the per capita costs of employer-sponsored insurance was 5.3% per year and 3.3% for national health expenditures per capita.<sup>v</sup> Even though Medicaid is growing more slowly than other health programs, Medicaid purchases services in the private market and is therefore subject to the same market pressures as other payers. It will take broader efforts that span all payers, both public and private, to bring overall health care costs under control.

**Enrollment is the dominant driver in Medicaid spending, especially during periods of economic downturn.** Medicaid costs are driven largely by increases in enrollment. Inflation in the price of the health care services that Medicaid buys, and the use of services by Medicaid enrollees, also affect Medicaid spending, but enrollment is the dominant driver. This is especially true during economic downturns, when unemployment rises and incomes fall, increasing the number of low-income people eligible for Medicaid. From FFY 2007 to FFY 2011, total Medicaid spending grew on average by 6.9% with enrollment growing on average by 5.6% and spending per enrollee only increasing by 2.3% on average.<sup>vi</sup>

**The elderly and disabled account for the majority of Medicaid spending.** While children and parents make up about 75% of Medicaid enrollees, they account for about a third of Medicaid spending. In contrast, the elderly and individuals with disabilities make up about 25% of enrollees but about two-thirds of spending. Medicaid spending per capita in FFY 2009 was \$2,305 for children and \$2,900 for non-disabled adults. Per capita spending for the elderly (\$13,149) and those with disabilities (\$15,840) was over 5 times the per capita spending for children and adults. The elderly and disabled have higher utilization and intensity of use for acute care services and the elderly and disabled are more likely to use long-term care services.<sup>vii</sup>

**Medicaid spending is concentrated among a small number of beneficiaries with significant health care needs.** Individuals dually-eligible for Medicare and Medicaid represent 15% of Medicaid enrollees and 38% of Medicaid spending. Medicaid helps these individuals pay for Medicare premiums and provides services and benefits that Medicare does not, including long-term care. Furthermore, only 5% of all Medicaid enrollees account for over half (54%) of Medicaid spending.<sup>viii</sup>

**States have a strong incentive to manage Medicaid cost growth.** Because states pay, on average, 43% of Medicaid costs, and because they must produce annual balanced budgets, states have a strong incentive to carefully manage program spending growth. Over the last decade, states have implemented an array of Medicaid cost containment measures as well as innovative service delivery models (including the use of managed care and medical home models) to manage the growth of Medicaid costs.<sup>ix</sup>

### 3. What is Medicaid's role in state budgets?

**The Medicaid program is jointly funded by states and the federal government.** The federal matching percentage (FMAP) varies by state (ranging from a statutory floor of 50% up to 73.4% for FFY 2013.)<sup>x</sup> The FMAP is based on a formula in the law that relates the FMAP to a state's average personal income; states with lower per capita incomes on average receive a higher matching rate. For every \$2 that states pay for a Medicaid-covered service, they receive at least \$1 back from the federal government. By the same token, to save just \$1 in state general fund spending on Medicaid, states need to cut at least \$2 in Medicaid spending.

**Medicaid is a counter-cyclical program; during economic downturns, individuals lose jobs, incomes drop, state revenues decline, and more individuals qualify and enroll in Medicaid which increases program spending.** During the recent recession, state revenues experienced record declines and Medicaid enrollment increased. While both contributed to state budget shortfalls, data show that declines in state revenues were a more significant factor in state budget gaps than increases in Medicaid spending.<sup>xi</sup> From October 1, 2008 through June 30, 2011, enhanced Medicaid matching funds from the American Recovery and Reinvestment Act (ARRA) were critical in helping to support state budgets and Medicaid. The ARRA temporarily increased the federal share of Medicaid payments and reduced the state share. Due to the ARRA, state spending on Medicaid declined for the first time on record in 2009 and 2010 even though total spending was growing. When these federal funds expired, states saw a large increase in state costs for Medicaid for SFY 2012 as states replaced these temporary federal funds. Looking ahead to state fiscal year (FY) 2014, states continue to experience some positive economic gains. States have experienced several quarters of positive tax revenue growth, though growth overall remains weak.<sup>xii</sup> While the national unemployment rate remains high, it has been trending downward, falling to 7.6 percent in March 2013.<sup>xiii</sup>

**Medicaid is second largest item in state general fund budgets but also the single largest source of federal grant support to states, making it both a budget item and a revenue item in state budgets. Medicaid funds support health care providers, jobs and state economies overall.** On average, states spend about 16% of their own funds on Medicaid, making it the second largest program in most states' general fund budgets (following elementary and secondary education, which represented 35% of state spending in FY 2011). These shares have remained relatively stable over the last decade. Medicaid matching funds are the single largest source of federal grant support to states (44% in FY 2011). Accounting for this federal revenue, Medicaid is a larger share of state overall budgets (24% in FY 2011).<sup>xiv</sup> By bringing revenues to hospitals, nursing homes, clinics, pharmacies, and other providers, Medicaid plays an important role in supporting jobs and economic activity in urban and rural communities alike.

**State budget pressure over much of the last decade has resulted in states adopting an array of cost containment measures.**<sup>xv</sup> During economic downturns, states have restricted provider payment rates and optional benefits for adults as primary responses to controlling Medicaid costs. Over the past decade, states have also made substantial changes to their pharmacy programs by employing a variety of sophisticated pharmacy management tools. In addition, there has been a steady movement toward efforts to better manage care in order to both improve care and control costs. States have been expanding managed care to more geographic areas within states and to new populations, including more complex populations. States are also working to better integrate care and financing for dual eligible beneficiaries given that they represent such a large share of Medicaid costs. Restrictions to eligibility and enrollment processes are prohibited under the maintenance of eligibility (MOE) requirements in the Affordable Care Act (ACA), resulting in eligibility levels and enrollment procedures remaining stable during the recent recessionary period.<sup>xvi</sup> The focus on cost containment as well as the improving economy resulted in historically low spending growth in FY 2012 and into FY 2013.

#### 4. What is Medicaid's role in the federal budget?

**Medicaid is the third-largest domestic program in the federal budget.** In FFY 2013, spending from Medicaid, Medicare, and Social Security accounted for about 47% of all federal spending (Medicaid accounting for 7% of federal spending, Medicare 17%, and Social Security 23%).<sup>xvii</sup> Compared to Medicare and Social Security, Medicaid has less impact on the federal budget because financing is shared by the federal government and the states with states paying 43% of the costs on average. States are given significant flexibility in the operation of their Medicaid programs within broad federal guidelines; this limits the ability of the federal government to control Medicaid spending. The Congressional Budget Office (CBO) projects federal Medicaid expenditures to grow by an average annual rate of 8% over the 2012-2023 budget window with enrollment increasing 2% per year. These estimates account for the effects of the Affordable Care Act and the June 2012 Supreme Court decision. CBO has also lowered its projections of future Federal Medicaid spending by 5.5% (\$239 billion) from its August 2012 baseline due in part to lower expected costs per person as current spending on the program has slowed.<sup>xviii</sup>

**Medicaid is exempt from automatic budget reductions; however Medicaid continues to be discussed as part of federal deficit reduction efforts.** The Budget Control Act of 2011 stipulated if Congress could not pass legislation to decrease federal deficits by \$1.5 trillion between FFY 2012 and FFY 2021 then a sequestration of \$1.2 trillion in federal funds should begin in January 2013. These cuts were delayed until March 1, 2013. Social Security, Medicaid, and other programs serving low-income individuals are exempt from the sequestration. However, Medicaid remains a part of ongoing deficit reduction discussions. Proposals to reduce federal Medicaid spending advanced by Congress and various deficit reduction commissions over the last few years have varied significantly in the scope and magnitude of the changes involved. Proposals advanced over the last few years include shifting duals to managed care, or program swaps (such giving the states and the federal government responsibility for financing and administration of certain parts of Medicaid such as acute care and long-term care, or certain populations). Some proposals would fundamentally change the structure and financing of Medicaid, such as the budget plan passed by the House of Representatives in 2011, 2012 and again in 2013 (discussed below).

**Leading budget proposals for FFY 2014 released by the Administration and House Republicans take fundamentally different approaches to Medicaid spending.** This House budget plan for FFY 2014, as in years past, would convert Medicaid into a block grant, capping federal Medicaid payments to each state at a specified dollar amount and limit program growth below expected levels based on enrollment and health care inflation to save federal money. A block grant would fundamentally change the entitlement and financing structure of the program and could shift costs to states, counties, providers, or low-income people. Accounting for the block grant and the repeal of the ACA, the House budget plan is estimated to reduce Medicaid spending by 38 percent by 2022.<sup>xix</sup> The Administration's FFY 2014 budget instead achieves savings through more targeted program reforms related to prescription drugs, durable medical equipment, and enhanced program integrity efforts.<sup>xx</sup> The Administration's budget emphasized working with states on efforts to expand Medicaid coverage; previous proposals to limit the use of provider taxes or blending matching rates were not included.<sup>xxi</sup>

**The FMAP formula that determines the federal share of Medicaid spending has remained steady since the start of the program; Congress has only amended the formula to provide more federal funding, not less.** The FMAP formula that governs the relative share of the cost of Medicaid services that the federal government pays has been basically unchanged since the enactment of the program in 1965. Congress has only amended the formula to provide additional funds targeted to particular services and populations (i.e. 90% match for family planning services and supplies or the higher matching rates for those newly eligible for Medicaid in 2014.) Congress has also enacted changes to temporarily increase the federal share of Medicaid payments during economic downturns. The current FMAP formula, which relies on lagged data, is inadequate to make timely adjustments for these sudden changes in economic conditions that increase Medicaid enrollment while reducing state revenues that finance the program. For this reason, in 2003-2004 and more recently through the American Recovery and Reinvestment Act (ARRA), Congress enacted legislation to provide federal program support and fiscal relief to states through Medicaid. The increase in the FMAP from the ARRA provided vital and timely fiscal relief to states in support of their Medicaid programs. Most states reported using the funds for multiple purposes such as addressing Medicaid or general fund budget shortfalls, helping to support increases in Medicaid enrollment, or to mitigate reductions in provider rates and benefits.<sup>xxii</sup>



## 5. What is Medicaid's role in health reform?

**Health reform builds on Medicaid as a base of coverage for low-income Americans.** The Patient Protection and Affordable Care Act (ACA) will extend health insurance coverage to millions of Americans through Medicaid and new health insurance exchanges. The ACA sets a national floor for Medicaid eligibility at 138% of poverty (FPL) (\$15,415 per year for an individual in 2012), bases eligibility on income, without regard to assets, and transitions to a uniform definition of income. These changes will primarily expand Medicaid coverage for adults (parents with limited Medicaid eligibility levels in many states and adults without dependent children who have been historically barred from Medicaid coverage.) Medicaid, along with tax credits for individuals with incomes between 100% and 400% of poverty to purchase coverage in new insurance exchanges, will help reduce the number of uninsured.

**As they plan their FY 2014 budgets, states are debating whether to adopt the Medicaid expansion.** In its June 2012 ruling on *National Federation of Independent Business v. Sebelius*, the Supreme Court declared the ACA, including the Medicaid expansion to adults up to 138% of poverty, constitutional. However, it limited the federal government's ability to enforce the expansion, effectively making implementation of the Medicaid expansion a state choice. States continue to analyze the fiscal, coverage and health effects of adopting the expansion. Other provisions in the ACA go into effect regardless of whether states implement the expansion such as requirements that most people must obtain insurance, the no-wrong-door interface for Exchange and Medicaid/CHIP coverage, new subsidies for the Exchange, and Medicaid eligibility simplification among others.

**The Federal Government will finance over 90% of the cost of the Medicaid expansion in new states; overall, many states are likely to see net savings from the Medicaid expansion.** The ACA provides 100% federal financing for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal share to 90% by 2020 and beyond. States will continue to receive their regular matching rates for individuals who qualify for Medicaid under eligibility rules in place when ACA was enacted. According to an analysis prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, the total cost of the Medicaid expansion, assuming all states participate, would be just over \$1 trillion over the 2013-2022 period with the federal government paying 93% of these costs.<sup>xxiii</sup> State costs could increase by an estimated 2.9%, small relative to increases in federal funding and other state spending on Medicaid. These costs are likely to be mitigated or offset due to reduced state spending for uncompensated care, reduced spending for programs that serve indigent populations (such as state funded mental health and substance abuse programs) among others. States could also see broader economic effects of the Medicaid expansion such as increased jobs, income and state tax revenues.<sup>xxiv</sup> Hospitals and other provider groups are also likely to benefit from the Medicaid expansion due to increased revenues tied to new coverage.

**The Medicaid expansion would significantly reduce the uninsured and increase access to care.** The Medicaid expansion would make millions of uninsured adults newly eligible for the program. If all states implement the Medicaid expansion, enrollment could increase by 21.3 million by 2022.<sup>xxv</sup> The Medicaid expansion, together with other provisions of the ACA, could cut the number of uninsured in half. If states do not implement the expansion, poor adults in these states will be left without affordable coverage options and will continue to face the health and financial consequences of being uninsured. A large body of research shows that Medicaid increases access to care.

**The ACA provides new options to expand community-based long-term care and to coordinate care for high cost populations.** The ACA also includes a number of other changes to Medicaid including new options to expand community-based long-term care, new funding for demonstration programs, and new opportunities for states to test innovative payment and delivery systems and to coordinate care for complex populations. A number of states are moving forward with new options like the new health home state plan option, the new balancing incentive program, and the new community first choice state plan option.<sup>xxvi</sup> The ACA also created the Center for Medicare & Medicaid Innovation and the CMS Medicare-Medicaid Coordination Office that are working together to implement demonstrations to test new payment and service delivery models that fully integrate care for dual eligible beneficiaries. A number of states are working with these offices on proposals to test capitated and/or managed fee-for-service models to integrate care and align financing for dual eligible beneficiaries.<sup>xxvii</sup>

See related Medicaid and its Role in State/Federal Budgets & Health Reform Chartpack at:  
<http://www.kff.org/medicaid/8162.cfm>

- <sup>i</sup> Shin, Peter et al. *Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth*. Kaiser Commission on Medicaid and the Uninsured, March 2013. <http://www.kff.org/uninsured/8098.cfm>.
- Zaman, Obaid S. et al. *America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristics Survey*. National Association of Public Hospitals and Health Systems, May 2010. <http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/2010-NAPH-Characteristics-Report.aspx?FT=.pdf>
- <sup>ii</sup> Based on data collected as of October 2010. Gifford, K. et al. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September 2011. <http://www.kff.org/medicaid/8220.cfm>. CMS has published more recent data (as of July 2011) that indicates nearly three-fourths of Medicaid enrollees are provided benefits through some sort of managed care arrangement, though this includes those that are provided more limited benefits as well as those that receive the majority or all of their care through a managed care arrangement.
- <sup>iii</sup> Includes neither spending on CHIP nor administrative spending. Definition of nursing facility care was revised from previous years and no longer includes residential care facilities for mental retardation, mental health or substance abuse. The nursing facility category includes continuing care retirement communities. CMS, Office of the Actuary, National Health Statistics Group, *National Health Expenditure Accounts*, 2013. Data for 2011.
- <sup>iv</sup> Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64).
- <sup>v</sup> Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64).
- <sup>vi</sup> Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64).
- <sup>vii</sup> KCMU/Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64, 2012. MSIS FFY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.
- <sup>viii</sup> KCMU/Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64, 2012. MSIS FFY 2008 data were used for PA, UT, and WI, but adjusted to 2009 CMS-64.
- <sup>ix</sup> Smith, V. et al. *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*. Kaiser Commission on Medicaid and the Uninsured, October 2012. <http://www.kff.org/medicaid/8380.cfm>.
- <sup>x</sup> Federal Register, November 30, 2011 (Vol 76, No. 230), pp 74061-74063, at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf>.
- <sup>xi</sup> Snyder, L, R Rudowitz, R Garfield, and T Gordon. *Why Does Medicaid Spending Vary Across States: A Chart Book of Factors Driving State Spending*. Kaiser Commission on Medicaid and the Uninsured, revised November 2012. <http://www.kff.org/medicaid/8378.cfm>.
- <sup>xii</sup> Dadayan, Lucy and Donald J. Boyd. "State Tax Revenues Continue Slow Rebound." *State Revenue Report, No. 90*. Rockefeller Institute, February 2013. [http://www.rockinst.org/pdf/government\\_finance/state\\_revenue\\_report/SSR-90.pdf](http://www.rockinst.org/pdf/government_finance/state_revenue_report/SSR-90.pdf).
- <sup>xiii</sup> *The Employment Situation – February 2013*. Bureau of Labor Statistics, March 8, 2013. [www.bls.gov](http://www.bls.gov).
- <sup>xiv</sup> Actual FY 2011 data reported in: *State Expenditure Report*. NASBO, December 2012. <http://www.nasbo.org>.
- <sup>xv</sup> Smith, V. et al. *Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*. Kaiser Commission on Medicaid and the Uninsured, October 2012. <http://www.kff.org/medicaid/8380.cfm>.
- <sup>xvi</sup> Heberlein, M et al. *Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012-2013*. Kaiser Commission on Medicaid and the Uninsured, January 2013. <http://www.kff.org/medicaid/8401.cfm>.
- <sup>xvii</sup> *The Budget and Economic Outlook: Fiscal Years 2013 to 2023*. Congressional Budget Office, February 2013. <http://www.cbo.gov/publication/43907>.
- <sup>xviii</sup> *How Much Will Medicaid Cost in the Future and Why: A Look at Federal Projections*. Kaiser Commission on Medicaid and the Uninsured, March 2013. <http://www.kff.org/medicaid/8430.cfm>. *The Budget and Economic Outlook: Fiscal Years 2013 to 2023*. Congressional Budget Office, February 2013. <http://www.cbo.gov/publication/43907>.
- <sup>xix</sup> Holahan, J. et al. *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*. Analysis completed by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2012. <https://www.kff.org/medicaid/8185.cfm>.
- <sup>xx</sup> *Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans*. U.S. Department of Health & Human Services, April 10, 2013. <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>.
- <sup>xxi</sup> Analytical Perspectives, Budget of the United States Government, Fiscal Year 2014. Office of Management and Budget, April 10, 2013. [http://www.whitehouse.gov/omb/budget/Analytical\\_Perspectives](http://www.whitehouse.gov/omb/budget/Analytical_Perspectives).
- <sup>xxii</sup> Miller, V. et al. *Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)*. Kaiser Commission on Medicaid and the Uninsured, October 2011. <http://www.kff.org/medicaid/8252.cfm>.

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<sup>xxiii</sup> Holahan, J. et al. *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*. Analysis completed by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

<https://www.kff.org/medicaid/8185.cfm>.

<sup>xxiv</sup> Holahan, J. et al. *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*. Analysis completed by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

<https://www.kff.org/medicaid/8185.cfm>.

<sup>xxv</sup> Holahan, J. et al. *National and State-by-State Impact of the 2012 House Republican Budget Plan for Medicaid*. Analysis completed by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

<https://www.kff.org/medicaid/8185.cfm>.

<sup>xxvi</sup> O'Malley Watts, M et al. *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options*. Kaiser Commission on Medicaid and the Uninsured, April 2013.

<http://www.kff.org/healthreform/8097.cfm>.

<sup>xxvii</sup> *State Demonstration Proposals to Integrate Care and Align Financing for Dual Eligible Beneficiaries*. Kaiser Commission on Medicaid and the Uninsured, March 2013. [http://www.kff.org/medicaid/dual\\_eligibles\\_map.cfm](http://www.kff.org/medicaid/dual_eligibles_map.cfm).

This publication (#8139-03) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.