



Office of External Affairs

CMS FACT SHEET

FOR IMMEDIATE RELEASE
July 11, 2006

CONTACT: CMS Media Affairs
(202) 690-6145

**Medicaid Spending Projections Down Again,
Reflecting Effective Federal and State Steps to Slow Spending Growth
While Providing Innovative Coverage**

Summary

Medicaid cost projections are once again declining, reflecting slower Medicaid spending growth in recent years. For the fiscal year (FY) 2006-2015 period, projected Federal Medicaid costs are \$224 billion lower than had been projected just a year ago – a reduction of 8 percent. This reflects a slowdown in Federal Medicaid spending growth from over 12 percent per year in fiscal year 2000-2002 to 7.2 percent from 2002-2005, down further to 4.6 percent projected for fiscal year 2006-2007. State Medicaid spending growth has simultaneously slowed significantly, with many states projecting lower costs in FY 2006 than FY 2005. States are also paying much less than had been predicted for drug coverage for “dual eligible” beneficiaries who are now getting coverage through Medicare.

The slowdown in Medicaid spending growth has resulted from many steps to deliver needed benefits more efficiently and effectively, implemented through innovative waivers and other collaborations between the States and the Federal government. Reform has resulted in greater use of private sector health plans rather than government-run “fee for service” that rewards providers for driving demand and creating incentives for over utilization. It has also resulted in more use of community-based long-term care services that beneficiaries with a disability prefer, and more alternatives to costly Medicaid-financed nursing home care.

The implementation of the Deficit Reduction Act provides new opportunities for states to work with the Federal government to build on the effective reforms to slow spending growth while providing needed coverage, and doing more to help people get the kind of care they prefer.

Trends in Medicaid Spending

The projections for federal Medicaid spending from FY 2007 through FY 2016 for Mid-Session Review 2006 are \$53.3 billion lower than the projections for the President's 2007 Budget. The projections for FY 2006 through 2015 in the Mid-Session Review 2006 are \$224.4 billion lower than the projections for Mid-Session Review 2005. This is a decline of 8 percent in projected federal Medicaid spending over the next ten years.

-- More --

The projections reflect a significant slowdown in Medicaid spending growth in recent years. With the recently enacted reforms in the Deficit Reduction Act to enable states to provide more flexible and effective benefits for the people they serve, we expect these savings to continue. Medicaid federal share spending grew 10.4 percent from FY 2000 to FY 2001 and 14.0 percent from FY 2001 to FY 2002. Since then, the rate of growth has been slowed. From FY 2002 to FY 2005, Medicaid federal share spending grew at an average rate of 7.2 percent per year. Medicaid federal share spending is projected to grow only 1.8 percent from FY 2005 to FY 2006, in part as a result of the additional Medicaid savings from Medicare-Medicaid “dual eligible” beneficiaries moving to Medicare drug coverage that is costing substantially less than had been projected. Even including the costs of drug coverage for Medicaid dual eligibles, Medicaid spending for FY 2005 to FY 2006 grew by less than 5.5 percent. From FY 2006 to FY 2007, Medicaid spending is projected to grow by 4.6 percent, continuing the trend in recent years toward lower rates of spending growth.

The reduction in spending growth is occurring even as more Americans get assistance with their health care costs through Medicaid and SCHIP. Enrollment in Medicaid is expected to continue to increase overall.

The slowdown in overall Medicaid spending growth has not resulted from shifts in Federal to state spending; it has been the result of Federal support for bipartisan state efforts to provide needed health care at a more sustainable cost. In FY 2006, 16 states are projecting to have lower Medicaid expenditures than in FY 2005, as reflected in their May estimates. These states are a mixture of large, medium, and small states, as diverse as GA, MD, MI, NH, NV, SC, SD, TX, and WI. Other large states are also experiencing slower growth. For example, between FY 2002 and FY 2003 California’s actual expenditures grew by 11.9 percent, and the state is currently projecting its expenditures to grow by 1.8 percent between FY 2006 and FY 2007. Florida’s actual expenditures between FY 2003 and FY 2004 grew by 17.1 percent, and the state is currently projecting its expenditures to grow half as quickly, by 8.6 percent, between FY 2006 and FY 2007.

Factors Related to Slowdown in Medicaid Spending Growth

The substantial slowdown in actual Medicaid spending growth in recent years, which in turn has resulted in significant reductions in projected Medicaid spending, is likely related to a combination of factors:

- State cost containment strategies, supported by efforts by CMS and expert groups to identify and promote best practices for delivering benefits effectively and at the lowest cost;
- Federal/state collaboration through waivers and innovative state plan amendments to deliver services more effectively—with much more widespread use of effective managed care coverage and home and community based services for long-term care;
- New tools provided by CMS to states to substantially reduce the growth in cost of prescription drugs, including steps to encourage greater use of generics, preferred drug lists, and multi-state drug purchasing pools.

- Shifting dual-eligibles' drug coverage from Medicaid to Medicare with the new Medicare drug benefit, with lower costs to states than had been expected (25 percent lower costs over 10 years than had been projected a year ago) and with states paying a progressively smaller share of drug costs;
- Increased federal oversight to prevent fraud, including increased funding of field investigators and enhanced joint analysis of potential Medicare and Medicaid fraud;
- Steps to assure accountability in financing needed Medicaid services by ending impermissible “recycling” which shifted costs to the federal government above allowed matching levels, which are expected to continue as a result of administrative and regulatory actions in the President’s budget. These initiatives have included improved efforts to oversee state claims for federal reimbursement and improved efforts to identify payment errors, and they are expected to continue through administrative and regulatory actions proposed in the President’s budget; and
- Improved economic conditions that have slowed the projected growth rate of enrollment.

Details: Changes In Medicaid Expenditures By Service Category

The slowdown in Medicaid spending growth has resulted from significant changes in how Medicaid pays for services, with substantial movement away from “fee for service” systems that pay more for more services, regardless of their quality or impact on patient health, and toward programs that focus on helping patients manage their illnesses and prevent complications, and that give beneficiaries more choice and control in how they receive services.

- In particular, the growth in use of institution-based care has slowed greatly.
 - Expenditures for inpatient hospital care grew by 13.2 percent between FY 2003 and FY 2004, 7.3 percent between FY 2004 and FY 2005, -0.1 percent between FY 2005 and FY 2006, and states are projecting just a 2.4 percent increase between FY 2006 and FY 2007.
 - Expenditures for nursing home payments grew by 9.6 percent between FY 2001 and FY 2002, -6.0 percent between FY 2002 and FY 2003, 4.2 percent between FY 2003 and FY 2004, -0.3 percent between FY 2004 and FY 2005, and states are projecting growth of 5.4 percent between FY 2005 and FY 2006 and 4.7 percent between FY 2006 and FY 2007.
- Expenditures for outpatient hospital care grew 0.9 percent between FY 2004 and 2005 and states are projecting a decrease in these expenditures of -4.1 percent between FY 2005 and 2006 and an increase of 1.6 percent between FY 2006 and FY 2007.
- Drug spending growth has declined from a growth rate of 18.1 percent between FY 2003 and FY 2004 to 7.5 percent between FY 2004 and FY 2005 and a projected decrease of -17.7 percent between FY 2005 and FY 2006 as a result of decreased spending on dual eligibles. The slowdown resulted from collaboration between the states and federal government to implement steps that slowed drug spending prior to the shift of duals to Medicare, and these steps are expected to continue to restrain spending growth. As noted

above, states are also paying less than had been expected toward the cost of drug coverage for dual eligibles in Medicare.

- In contrast, spending has increased more significantly in areas where services can be delivered more efficiently, including managed care and home and community based long-term care services. Spending on Home and Community Based Services is increasing at an average annual rate of 10.7 percent between FY 2002 to FY 2007 while the rate of growth for managed care services averages 9.5 percent per year for the same period..

Deficit Reduction Act Reforms Will Enable States to Deliver More Effective Medicaid Services

The recently-enacted Deficit Reduction Act is expected to help slow projected spending growth by providing more cost-effective access to needed health care services, through steps such as:

- Providing targeted packages to meet the specific needs of low-income families without the need for waivers—for example, disease management for children with asthma and intensive community services for individuals with mental illness. Meanwhile, individuals with disabilities and certain other vulnerable populations cannot be required to leave “regular Medicaid.”
- Enabling families to enroll in the same benefit package in order to preserve continuity of care. Today, one child may be in Medicaid, another in SCHIP and the parent in an employer plan.
- Providing premium assistance to help individuals and their employers pay for employment-related insurance, which keeps families connected to mainstream private insurance that they can keep and avoid the costs of replacing employer insurance with government Medicaid coverage.
- Promoting personal responsibility through programs such as “Get Healthy” initiatives and Health Opportunity Accounts. States may increase benefits or lower cost sharing for individuals participating in personal responsibility agreements.
 - For example, as a result of a reform plan approved in May, Kentucky's Medicaid coverage now includes special incentives, called “Get Healthy” Benefits, which are offered to further encourage healthy behaviors. These “Get Healthy” Benefits may include additional services such as, dental, vision, nutritional counseling and smoking cessation programs.
- Enabling individuals with a disability to return to their homes through the “Money Follows the Person” (MFP) Rebalancing Demonstration. States will receive an enhanced match rate for helping individuals who have been in institutions for at least six months return to their own homes. These reforms have not only been shown to increase beneficiary satisfaction and quality of life; they also lower costs per beneficiary, helping states keep Medicaid long-term care costs down.

- For example, Texas began their MFP demonstration program in September, 2001, and subsequently expanded it. As of March 31, 2006, 10,711 people have chosen to leave nursing facilities, have the institutional funds follow them, and move into the community. Savings are estimated at about 20 percent of what Texas previously spent on long-term services and supports when comparing the cost of a comparable package of nursing home services to the cost of the services in the community, and, at the same time, individuals in the MFP program report a higher quality of life.
- Promoting private long term care insurance as an alternative to Medicaid nursing home coverage, through adopting Long Term Care Partnership plans.

#