

medicaid and the uninsured

February 2012

A Mid-Year State Medicaid Budget Update for FY 2012 and A Look Forward to FY 2013

Executive Summary

As states prepared their budgets for FY 2012, almost all continued to experience the ongoing effects of the Great Recession including high unemployment and depressed state revenue collections. At the same time, states were forced to dramatically increase FY 2012 state spending for Medicaid by an average of 28.7% largely to replace temporary Medicaid federal stimulus funds that expired in June 2011. However, compared to 2011, adopted budgets for FY 2012 assumed total Medicaid spending growth of only 2.2% (a near record low) as well as slower enrollment growth. Even within tight FY 2012 budgets, states continue to plan and implement a number of high priority initiatives, including the integration of care for duals (those eligible for Medicaid and Medicare) and health care reform-related activities. This report, based on structured discussions in November 2011 with the Executive Board of the National Association of Medicaid Directors (NAMD) and survey questions e-mailed to all 50 states and DC in December 2011 and January 2012, provides a mid-fiscal year 2012 update on state Medicaid issues, augmenting the findings from the most recent comprehensive Medicaid budget survey report published in October 2011.¹ Key findings include:

For FY 2012, the majority of states are experiencing Medicaid spending and enrollment growth equal to or below original growth projections, and 10 states reported mid-year Medicaid cuts.

- Medicaid enrollment and spending pressure is moderating in many states in 2012 compared to 2011 with a number of states experiencing trends below original growth projections. While the recession is still driving overall enrollment and spending growth for Medicaid, putting overall pressure on state budgets and Medicaid, some lower than expected enrollment projections are easing pressure to implement additional cost containment measures.
- While more than half of the states reported a 50-50 chance of a FY 2012 budget shortfall at the beginning of the fiscal year, 10 states reported mid-year Medicaid budget cuts to close FY 2012 budget gaps. These mid-year cuts include additional benefit and provider rate restrictions. The Patient Protection and Affordable Care Act (ACA) "maintenance of eligibility" requirements generally prohibit states from restricting Medicaid eligibility or tightening enrollment procedures until 2014. While most of the states reported targeted changes, two states (Maine and Washington) are considering a range of significant cuts to help address state budget shortfalls.

Looking ahead, state interest in initiatives for duals remains high and states continue to move forward with the implementation of health reform.

- Medicaid Directors expressed support and enthusiasm for the new integration opportunities for duals made available to states by the Medicare-Medicaid Coordination Office and were hopeful that the integration initiatives will result in improved care for duals and budget savings for states. However some Directors suggested that a short timeline would make it difficult to ensure a smooth transition for enrollees.
- In the most recent annual budget survey, 38 states indicated plans to take advantage of new enhanced federal matching funds for eligibility systems. Nationally, 28 states have qualified for Exchange Establishment grants and 18 states have either passed legislation to establish an exchange or have plans to do so. In the discussion with the Medicaid Directors, most reported that progress on updating and modifying eligibility systems was underway; however, fewer states reported actions to adopt authorizing legislation or establish governing boards for exchanges. A few states reported completion of substantial planning activities and a few Directors said that their states were waiting for the resolution of pending litigation before moving forward with additional planning and implementation efforts.

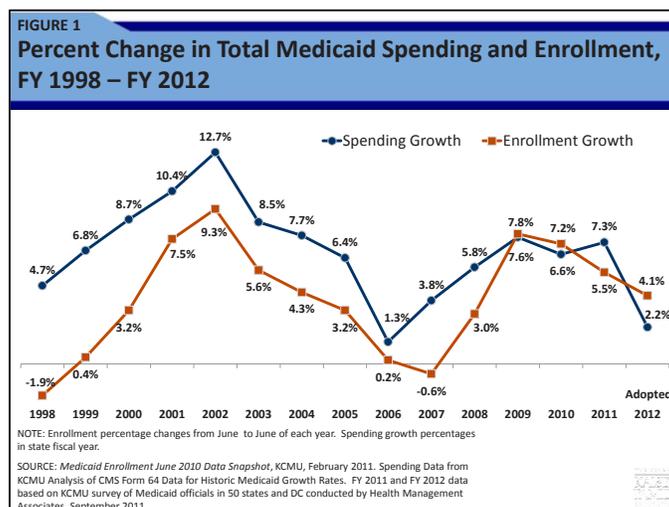
¹ Vernon Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder, "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured. October 2011. <http://www.kff.org/medicaid/8248.cfm>.

Introduction and Background

Medicaid is a federal entitlement program administered by the states providing health care and long-term services and supports to low-income Americans. Subject to federal rules, states have flexibility to structure their programs in terms of eligibility, benefits, delivery of services, and provider payments. In FFY 2011, the Congressional Budget Office (CBO) estimated total federal expenditures of \$274 billion for the Medicaid program, which covered 51.5 million individuals in December 2010.²

Medicaid is jointly financed by the states and federal government. The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage, or FMAP. A state's FMAP is calculated annually and varies inversely with average personal income in the state, but is subject to a 50 percent floor. From October 1, 2008 through June 30, 2011, the American Recovery and Reinvestment Act (ARRA) provided an estimated \$103 billion in fiscal relief to states in the form of enhanced FMAP.³

As states prepared FY 2012 budgets, most continued to experience the ongoing effects of the Great Recession including high unemployment and state revenue collections still below pre-recession levels. Nevertheless, states were forced to increase FY 2012 state funds for Medicaid budgets by 28.7 percent largely to replace federal funds from the expiring ARRA enhanced FMAP. Total Medicaid spending appropriation increases for FY 2012, however, averaged only 2.2 percent, one of the lowest rates on record. (Figure 1) These appropriations were also based on average enrollment growth of 4.1 percent. Except for North Dakota, every state and DC adopted at least one new Medicaid cost containment measure or policy for FY 2012.



Since the adoption of FY 2012 state budgets, state economic conditions, on the whole, have continued to slowly improve with the nation's unemployment rate dropping to a three year low of 8.3 percent in January 2012⁴ and overall state tax revenues have started to return to and increase above

² "The Budget Outlook: An Update," Congressional Budget Office. August 2011. <http://www.cbo.gov/ftpdocs/123xx/doc12316/08-24-BudgetEconUpdate.pdf>.

³ "Medicaid Enrollment: December 2010 Snapshot," The Kaiser Commission on Medicaid and the Uninsured. December 2011. <http://www.kff.org/medicaid/enrollmentreports.cfm>.

⁴ ARRA included an additional 6.2 percentage point increase in all states' FMAPs with additional targeted increases related to changes in the state's unemployment rate through December 2010. This was extended at a reduced rate through June 2011. For more information, see "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>.

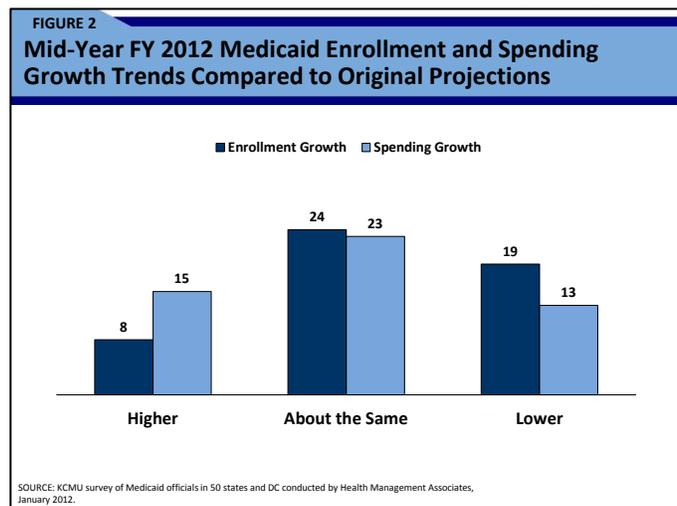
⁵ The Employment Situation – January 2012, Bureau of Labor Statistics, February 3, 2012.

pre-recession levels but are still well below their most recent peak.⁵ While managing within tight budgets, including reduced administrative budgets in many cases, state Medicaid programs continue to be engaged in the planning and implementation of a number of high priority initiatives including major health information technology initiatives (e.g., implementation of electronic health record incentive programs and claims payment system upgrades to implement the HIPAA 5010⁶ standards and ICD-10-CM⁷ diagnosis codes), integration of care for beneficiaries dually-eligible for Medicaid and Medicare (duals), managed care expansions and health care reform-related activities. It was within this context that discussions took place with Medicaid Directors in November 2011. Based on these structured discussions and a short survey of Medicaid Directors, this report provides a mid-fiscal year update on state Medicaid issues, augmenting the findings from a comprehensive Medicaid budget survey conducted in July and August 2011, the beginning of the fiscal year in most states.

Key Findings

For FY 2012, the majority of states are experiencing Medicaid spending and enrollment growth equal to or below original projections, and 10 states reported mid-year Medicaid cuts.

Medicaid enrollment and spending pressure is moderating in many states in 2012 compared to 2011 with a number of states experiencing trends below original growth projections. In the annual Medicaid budget survey, states projected Medicaid enrollment to increase on average by 4.1 percent in FY 2012, lower than the 5.5 percent rate of growth in FY 2011 and much lower than the 7.2 percent growth rate in FY 2010. According to the mid-FY 2012 survey results, 24 states reported that the most recent enrollment growth trend for FY 2012 was about the same as was projected at the beginning of FY 2012 and 19 states reported that the most recent trend was lower. (Figure 2) Only eight states indicated that 2012 enrollment trends were higher than originally projected. One state attributed higher than expected enrollment growth to eligibility simplifications adopted to address an application backlog and to qualify for federal CHIPRA bonus payments. Meanwhile, another state experiencing lower than expected enrollment reported that the state was actually forecasting an enrollment decline for the first time in four years alleviating the need for some previously considered cost containment measures.



On the spending side, original state appropriations for FY 2012 assumed total Medicaid spending growth of only 2.2 percent on average – one of the lowest rates on record – including 11 states adopting initial appropriations assuming negative growth and another five states assuming zero growth. Concerns about the adequacy of FY 2012 appropriations, however, led over half the states to indicate in the annual Medicaid budget survey that the likelihood of a Medicaid budget shortfall in FY 2012 was at least 50-50

⁵ Lucy Dadayan, "Tax Revenue Keeps Rising, But Growth Again Ticks Downward," The Nelson A. Rockefeller Institute of Government, January 26, 2012. http://www.rockinst.org/pdf/government_finance/state_revenue_report/2012-01-26-SRR_86.pdf.

⁶ The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all health insurance payers, including Medicaid, to comply with the electronic data interchange standards, established by the Secretary of Health and Human Services and the Accredited Standards Committee, for electronic health care transactions. The updated version of these standards, HIPAA 5010, will replace version 4010A1 on January 1, 2012.

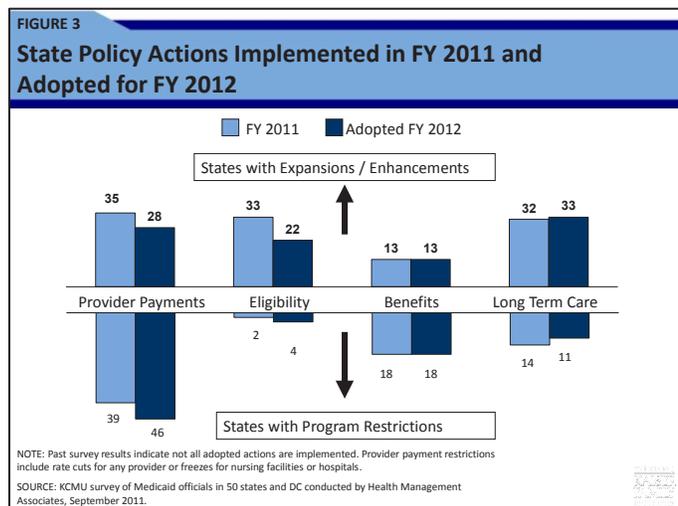
⁷ The ICD-10-CM is an updated and expanded diagnostic code set scheduled to replace the current set, on October 1, 2013.

while one-fourth of the states indicated a shortfall was virtually certain. At mid-year FY 2012, however, 23 states reported that their mid-year spending trend for FY 2012 was about the same as was projected at the beginning of FY 2012 and 13 states reported that the most recent trend was lower. Fifteen states said that the trend was higher suggesting that states, on average, may indeed experience in FY 2012 one of the lowest overall growth rates in total Medicaid spending since the 2006 implementation of the Part D drug benefit that transferred almost all drug spending for duals from Medicaid to Medicare.

As economic conditions have started to improve, Medicaid enrollment and spending trends in many states are starting to taper. According to the Bureau of Labor Statistics, the nation's unemployment rate, which peaked at 10 percent in October 2009, had dropped to 8.3 percent in January 2012, the lowest level in three years.⁸ However, significant state-to-state variations remain: four states and the District of Columbia had unemployment rates in December 2011 that remained at or above 10 percent while eight states had rates below 6 percent.⁹ Also, after seven quarters of growth (through September 2011), overall state tax revenues have started to return to and even increase above pre-recession levels in some states but are still well below their most recent peak.¹⁰

While more than half of the states reported a 50-50 chance of a FY 2012 Medicaid shortfall at the beginning of the fiscal year, 10 states reported mid-year Medicaid budget cuts. The most recent annual Medicaid budget survey reported that, for FY 2012, every state but North Dakota planned at least one cost containment policy action including 46 states that planned at least one provider rate cut or restriction, 18 states that planned to

reduce or restrict benefits, but only 4 states that planned eligibility reductions or restrictions.¹¹ (Figure 3) In this recent mid-year survey, 10 of 50 states responding reported plans to make additional FY 2012 Medicaid reductions beyond those planned at the beginning of this fiscal year. State cost containment options are limited by the ACA "maintenance of eligibility" requirement that prevents states from restricting Medicaid eligibility or tightening enrollment procedures until Health Benefit Exchanges become operational in 2014 (with certain exceptions). The actions reported by these ten states are therefore primarily focused on benefit and provider rate reductions. The ten states indicating mid-year reductions reported the following actions:



- **California.**¹² Mid-year cuts that were included in the original FY 2012 budget were triggered by lower revenue projections; the same copayment requirements and provider reductions that had been applied to managed care plans as part of the original FY 2012 budget will now be applied to

⁸ The Employment Situation – January 2012, Bureau of Labor Statistics, February 3, 2012.

⁹ Regional and State Employment and Unemployment Summary, Bureau of Labor Statistics, January 24, 2011.

¹⁰ Lucy Dadayan, "Tax Revenue Keeps Rising, But Growth Again Ticks Downward," The Nelson A. Rockefeller Institute of Government, January 26, 2012. http://www.rockinst.org/pdf/government_finance/state_revenue_report/2012-01-26-SRR_86.pdf.

¹¹ Two of these states – HI and IL – had planned eligibility and enrollment procedure changes that have since been denied by CMS.

¹² Some of the policy actions included in the state's FY 2012 budget, such as elimination of the adult day program, provider rate reductions, and institution of copayments have been enjoined by litigation or required waivers that have not yet been approved by CMS. For more info, see: <http://www.dhcs.ca.gov/Pages/BudgetActions.aspx>. Other states will likely also have actions that were included in their budgets but were not enacted; such changes will be captured in our next annual update of our Medicaid Budget Survey of fiscal years 2012 and 2013.

managed care plans that had originally been exempted including Program of All-Inclusive Care for the Elderly (PACE), Senior Care Aging Network (SCAN) and AIDS Healthcare Centers payments.¹³

- **Colorado.** The state is implementing a range of new Medicaid cost containment measures including: benefit restrictions such as age limits for developmental and adolescent depression screenings, caps on annual home health visits, and a pilot project to shift outpatient surgery from hospitals to less costly ambulatory surgical settings; increased incentives to use public transportation in the non-emergency medical transportation program; and a net reduction in pharmacy reimbursement (including a decrease in ingredient costs and increase in dispensing fees) along with other pharmacy changes such as competitive procurement of a sole source supplier for diabetic testing supplies.
- **Louisiana.** In March 2012, the fee-for-service mental health rehabilitation services program will be transitioned to the Louisiana Behavioral Health Partnership managed by a Statewide Management Organization (SMO). Until the SMO goes live, the state will employ an interim management tool to better control utilization of these services. The state will also achieve additional cost-savings as part of mid-year changes through administrative reductions and by no longer sending members hard copies of health plan provider directories (members can still request hard copies by mail, call for assistance, or view them online or in a local eligibility office).
- **Maine.** The governor has proposed additional cuts in his supplemental biennial budget, including: provider rate reductions, eligibility reductions for parents, elimination of coverage for childless adults, elimination of coverage of nearly all optional benefits (therapy, podiatry, dental among others), limitations on outpatient hospital visits and hospital admissions, pharmacy-related changes.
- **Maryland.** The state will reduce reimbursement rates for durable medical equipment and disposable medical supplies.
- **North Carolina.** The state is evaluating a number of cost containment options including additional rate reductions (targeted and across the board), modification to optional services and clinical policies to restrict usage of selected covered programs to address a projected \$139 million FY 2012 budget shortfall.
- **Pennsylvania.** The governor released proposed mid-year reductions January 19, 2012, which include a 10 percent reduction in state Medicaid funding for obstetrics and neonatal services, hospital-based burn centers, critical access hospitals, and trauma centers.¹⁴
- **Tennessee.** The FY 2012 budget contains a contingency appropriation to be funded with monies from the Special Disability Workload (SDW) settlement. If the SDW funding is not received, a 4.25 percent rate reduction is required for select providers. Because the state has determined that the SDW funds will not be available for FY 2012, the 4.25 percent rate reductions for selected providers will go into effect January 1, 2012; affecting nursing homes, the PACE program, home health providers, dentists, transportation providers, lab and x-ray providers, managed care administrative rates, and private ICF-MR providers.

¹³ "2012-2013 Governor's Budget Highlights – Department of Health Care Services," Department of Health Care Services, January 6, 2012. <http://www.dhcs.ca.gov/Documents/2012-13%20Budget%20Highlights.pdf>.

¹⁴ "2011-12 Budgetary Freeze Update," Pennsylvania Office of the Budget, January 19, 2012. http://www.budget.state.pa.us/portal/server.pt/community/current_and_proposed_commonwealth_budgets/4566

- **Washington.** Washington State legislators must close a \$1.4 billion budget gap in the FY 2011-2013 biennial state budget. Medicaid and related reductions under consideration include the following recommendations made by Governor Gregoire in her 2011-2013 supplemental budget proposal:¹⁵
 - Elimination of the Basic Health Plan that delivers health care to 35,000 low-income individuals.
 - Provider rate cuts affecting: critical access hospitals, school-based Medicaid services, developmental disability community residential providers, and home care agencies.
 - Benefit reductions, including: elimination of routine dental care for persons with developmental disabilities, long-term care clients and pregnant women; increasing the level-of-care requirements for personal care services; elimination of the Adult Day Health program; utilization management for mental health services; and elimination of medical interpreter services.
 - Imposition of nominal cost sharing for prescription services, non-emergent client transportation, non-emergent emergency room visits and physician services for Medicaid clients.
- **West Virginia.** The state will stop offering Aged and Disabled Waiver services to individuals whose application is received after December 5, 2011. Individuals who apply after December 5 will receive services when their eligibility is established and if funding for the program becomes available.¹⁶

Looking ahead, state interest in initiatives for duals remains high and states continue to move forward with the implementation of health reform.

State interest in integration initiatives for duals is high. Persons eligible for both Medicare and Medicaid (duals) are among the sickest and poorest individuals covered under either program. Recognizing the potential to improve care and reduce costs for this population, the ACA created a new Medicare-Medicaid Coordination Office charged with improving the integration of Medicare and Medicaid benefits for duals. In 2011, this office took two important steps toward this goal. First, it awarded \$1 million planning contracts to 15 states in April 2011 to design innovative approaches to integrate and coordinate care for duals. After the conclusion of an initial 12 month design phase, CMS will determine which of the states' proposals will move into the implementation phase targeted for 2012. Second, in July 2011 the Medicare-Medicaid Coordination Office announced new opportunities to align Medicare and Medicaid funding under either a capitated model or a managed fee for service model with the potential under both models for states to share in overall savings. States interested in entering into a demonstration agreement with CMS to test one or both models were invited to submit a letter of intent to CMS by October 2011. Thirty-eight states did so, including all 15 of the states that previously received a \$1 million planning contract.¹⁷

During the November 2011 structured discussion with Medicaid Directors on the NAMD Executive Board, there was widespread support and enthusiasm for the new integration opportunities for duals and their potential to improve care and reduce costs for the vulnerable duals population. However, the Directors also expressed a number of observations and concerns. First, there was tension between moving quickly to obtain budget savings and moving more slowly to ensure long-term success and a smooth transition for enrollees. Directors also discussed the issue that duals have varying needs that may require different integration and care coordination approaches. For example, duals under age 65 with severe disabilities or mental illness have different health care needs than frail elders. The Directors observed that states need to tailor different program design strategies to the different segments of the

¹⁵ Accessed at <http://www.ofm.wa.gov/budget12/highlights>.

¹⁶ "Medicaid curtails Aged Disabled Waiver enrollment," West Virginia Department of Health & Human Resources Announcement, November 2011. http://www.wvdhhr.org/communications/news_releases/MedicaidCurtailsAgedDisabledWaiverEnrollment.pdf.

¹⁷ MaryBeth Musumeci, "Financial Alignment Models for Dual Eligibles: An Update," Kaiser Commission on Medicaid and the Uninsured. November, 2011. <http://www.kff.org/medicaid/8260.cfm>

dual eligible population. Directors noted that cooperation between Medicare and Medicaid is key to success and there were concerns about how Medicare and Medicaid can work together to achieve integrated care. Finally, Medicaid Directors wanted to encourage CMS to consider all options for integration.

In preparation for health reform, there are many states in the process of updating and modifying eligibility systems and a number of states are moving forward with insurance exchanges. Many states currently operate very old Medicaid eligibility systems that in many cases are not able to meet the ACA requirements for 2014 to expand Medicaid eligibility, implement the new Medicaid income eligibility standard based on "Modified Adjusted Gross Income" (MAGI), and coordinate with new Health Benefit Exchanges. Responding to state concerns about the cost of upgrading these systems, CMS announced in November 2010 the availability of enhanced federal funding for new or upgraded systems including 90 percent federal match for development costs through December 2015 and 75 percent match for maintenance and operation. In the most recent annual Medicaid budget survey, 38 states indicated that they were planning to take advantage of the 90/10 enhanced match.

The ten Medicaid Directors participating in the November 2011 structured discussion were asked to comment on the status of efforts underway in their states to update and modify eligibility systems. Medicaid Directors thought the enhanced match and the ACA requirements would present an opportunity to address long-overdue needs to upgrade eligibility systems to make them more efficient. However, Directors also expressed continued concerns related to the feasibility of current deadlines, the need for further federal guidance, the challenges in working with other agencies that administer other impacted programs (such as Supplemental Nutrition Assistance Programs), uncertainties about where the eligibility system will reside (within which agencies and at what level of government), and whether the state has sufficient capacity to implement the changes. Other concerns expressed included whether private sector vendors had the "bandwidth" to support all of the states that are seeking to upgrade their systems at the same time and whether small states would have access to the same level of expertise as larger states.

With less than two years to go before the implementation of the state Health Benefit Exchanges called for by the ACA, 18 states have either passed legislation to establish an Exchange or have plans to do so; meanwhile, 28 states have qualified for Exchange Establishment grants.¹⁸ Among Medicaid Directors participating in the structured discussion, several states reported either adopting authorizing legislation and establishing governing boards or completion of substantial planning activities. Other states, however, are waiting for the resolution of pending litigation before moving forward.

In November 2011, the U.S. Supreme Court agreed to hear federal court appeals challenging the constitutionality of the ACA including the constitutionality of the individual mandate and the Medicaid expansion. The court scheduled five and a half hours of oral arguments to occur over three days in March 2012 and is expected to issue a decision by late June. Some Directors expressed concern, however, that the legislatures will have adjourned by the time pending litigation has been resolved, further delaying progress on the policy decisions needed for Exchange implementation.

¹⁸ "Establishing Health Insurance Exchanges: An Update on State Efforts," Kaiser Commission on Medicaid and the Uninsured. January 18, 2012. <http://www.kff.org/healthreform/8213.cfm>.

"2012 Progress Report: States Are Implementing Health Reform," The White House, January 18, 2012. http://www.whitehouse.gov/sites/default/files/01-18-12_exchange_report.pdf.

Outlook

States continue to grapple with the lingering effects of the Great Recession on state revenues and Medicaid spending, although many states are beginning to see signs of economic improvement. While most have avoided the need for additional mid-year budget cuts, a few states have yet to close budget gaps for FY 2012. The outlook for 2013 and beyond remains difficult with continued pressure to find Medicaid cuts, although few options for additional savings remain. At the time of the discussion Tennessee reported that the governor has already asked all state agencies to prepare to reduce FY 2013 budgets by 5 percent. California officials are hoping to achieve savings from dual eligible and managed long term care initiatives and Texas reported plans for a top down medical policy review of the amount, duration and scope of all benefits to identify savings for both mandatory and optional services. Medicaid remains front and center in state budget discussions as governors release proposed budgets for FY 2013. After successive years of budget cutting and cost-containment, many states are planning to take advantage of new integration opportunities for duals with the hope of health care improvements for this vulnerable population, but just as importantly, state budget savings.

Also, with less than two years to go before the ACA required Medicaid eligibility expansion and state Exchange implementation, many states are taking advantage of new federal financial support for eligible system modifications and upgrades that are now well underway. Progress on implementation of Exchanges is slower with some awaiting the resolution of litigation now pending before the U.S. Supreme Court. States continue to face the dual challenges of implementing health reform and coping with another year of budget shortfalls headed into FY 2013. However, Medicaid continues to provide critical health care services to low-income beneficiaries and the program is preparing to play a larger role with the implementation of health reform.

Methodology

The Kaiser Commission on Medicaid and the Uninsured convened a discussion with Medicaid directors who serve on the Executive Board of the National Association of Medicaid Directors (NAMd) focused on state economies, Medicaid enrollment and budget trends, policy directions, and state progress and concerns about implementing the ACA. The discussion took place in November 2011. Ten state Medicaid directors participated in the discussion from California, Illinois, Indiana, Kansas, North Carolina, Tennessee, Texas, Virginia, Washington, and West Virginia, along with NAMd staff.

This report also includes the findings from an e-mail survey of state officials in December 2011 and January 2012 to capture the most current information on state Medicaid enrollment, spending and cost control strategies. All 50 states and DC were surveyed about Medicaid changes that occurred since the beginning of FY 2012, which for most states was July 1, 2011.¹⁹ The e-mail survey update included three questions for each state:

1. Compared to enrollment growth projections reported in the annual Medicaid budget survey in July 2011, is the current enrollment trend for FY 2012 higher, lower or about the same?
2. Compared to total Medicaid spending projections reported in the annual Medicaid budget survey in July 2011, is the current spending trend for FY 2012 higher, lower or about the same?
3. In addition to any cost containment actions reported in the annual Medicaid budget survey in July 2011, are any mid-year reductions anticipated for FY 2012, to be implemented in the current fiscal year? (If a biennium budget, only include additional cuts that will be implemented in the current year.)

This report was prepared by Vernon Smith, Kathleen Gifford and Michael Nardone from Health Management Associates and Robin Rudowitz and Laura Snyder from the Kaiser Commission on Medicaid and the Uninsured

¹⁹ State fiscal years run from July 1 to June 30 for 46 states. The fiscal year begins on April 1 for New York, on September 1 in Texas and on October 1 for Alabama, Michigan and D.C.

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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 bi-partisan group of national leaders and experts in health care and public policy.