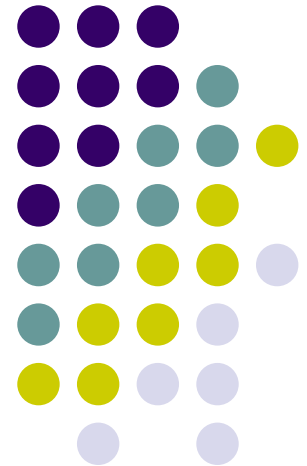
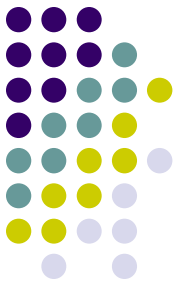


# Medicaid Reform: What Could a Federal Waiver Mean?

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Medicaid Reform Symposium  
Sarasota, FL  
November 22, 2004





# What role does Medicaid play in Florida?

- Important safety net especially in times of recession
  - Covers 2.2 million Floridians
  - US: 51 million people
- Major source of prenatal care
  - Covers 43% of all births
  - US: One-third of all births
- Provides long term care services to seniors and persons with disabilities
  - Pays for 66% of all nursing home days
- Pays Medicare cost-sharing for low-income seniors

Figure 3

# Percentage of Low-income Children in the US Without Health Insurance Has Fallen About One-Third Due to SCHIP and Medicaid

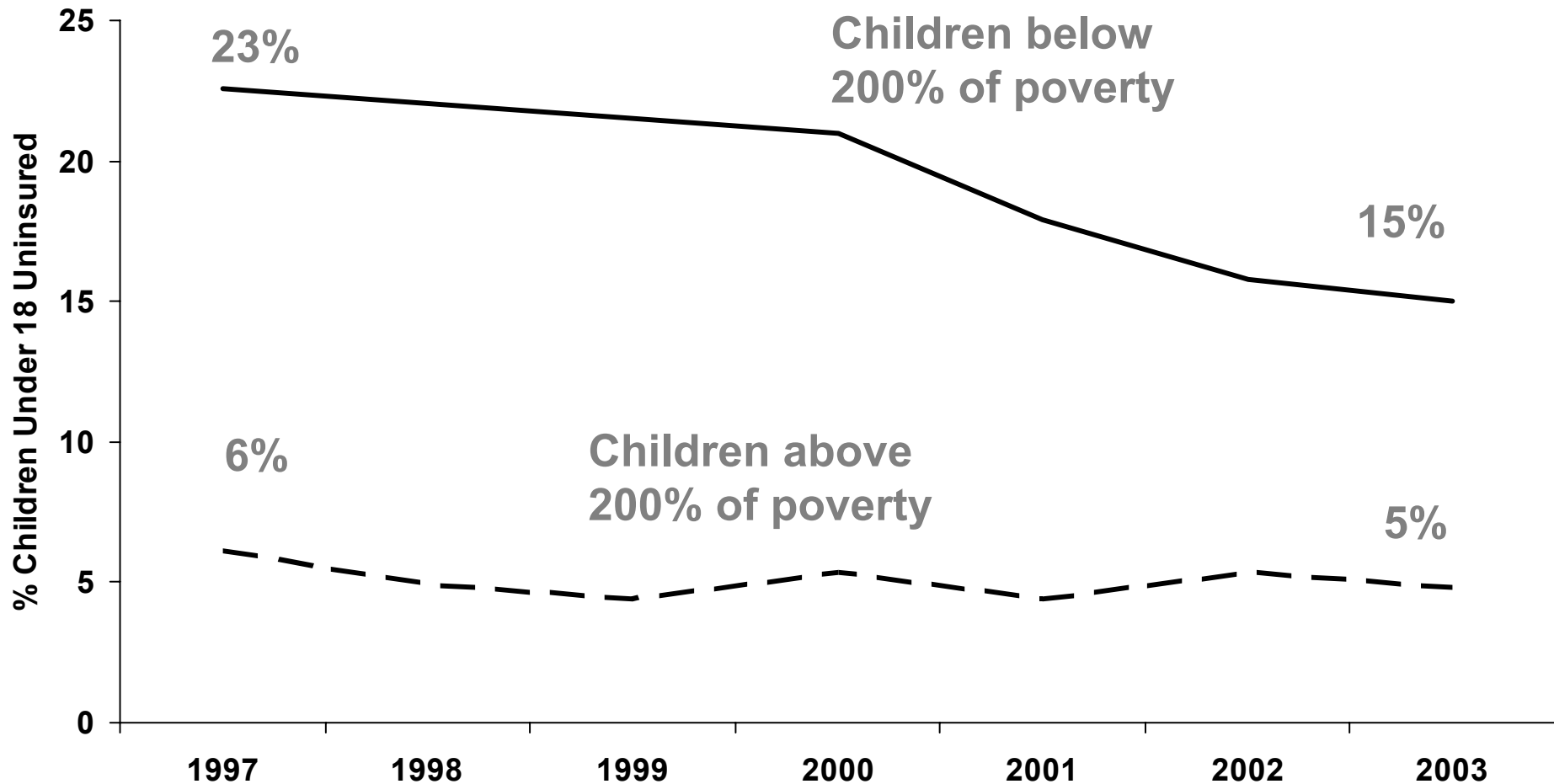
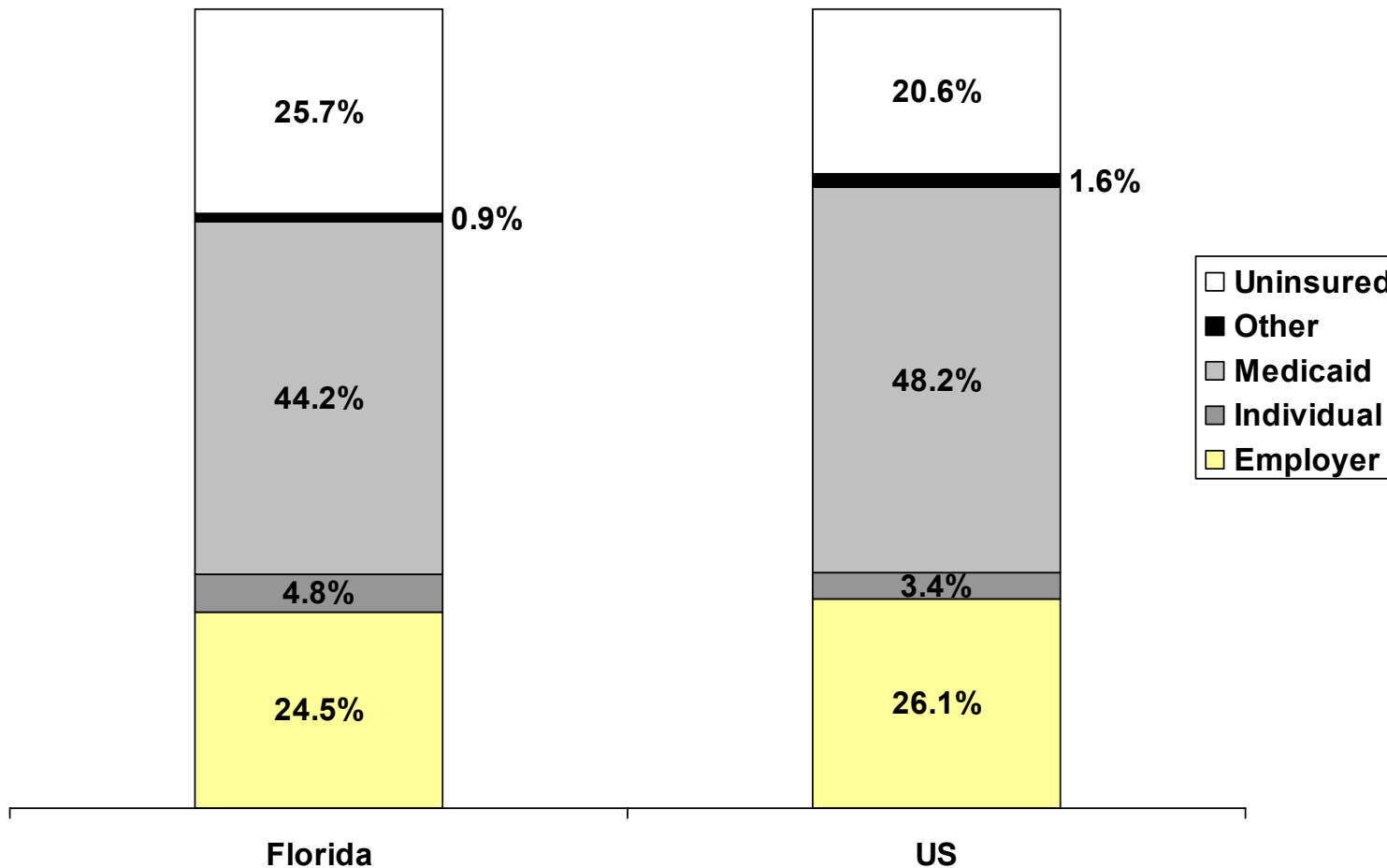
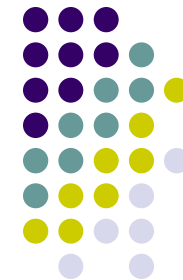


Figure 4

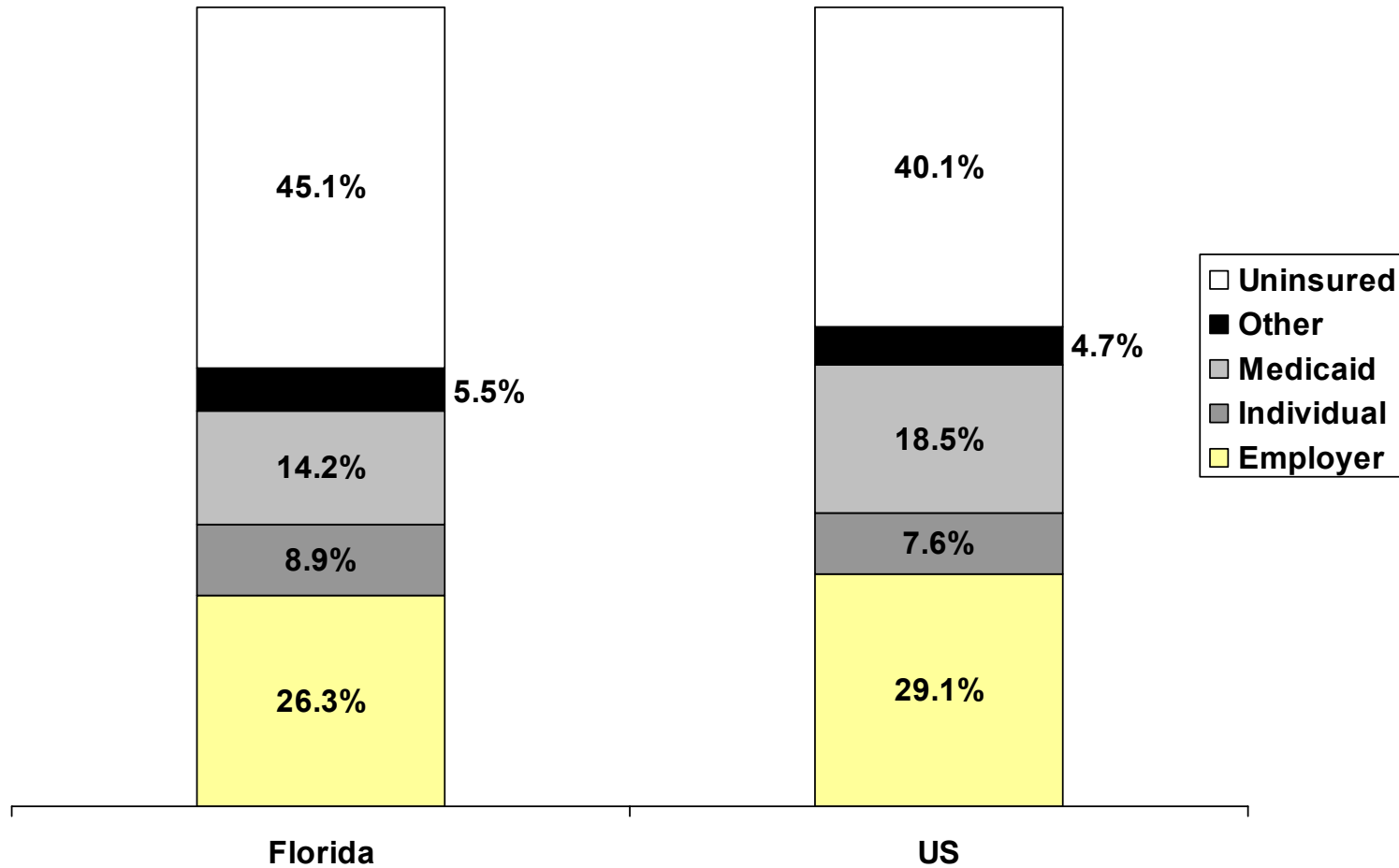
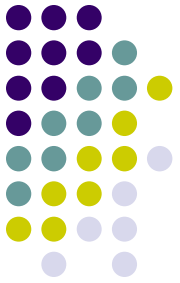
# Source of Health Care Coverage for Low-Income Children, 2002-2003



Low-income equates to family income below 200% of the federal poverty line. In 2003, the poverty line was \$15,260 for a family of three. Other includes private non-group and other public insurance (mostly Medicare and military-related). Medicaid includes SCHIP. Source: Urban Institute analysis of March 2003 and 2004 CPS data for the Kaiser Commission on Medicaid and the Uninsured *Health Insurance Coverage in America: 2003 Data Update*, forthcoming.

Figure 5

# Source of Health Care Coverage for Low-Income Nonelderly Adults, 2002-2003

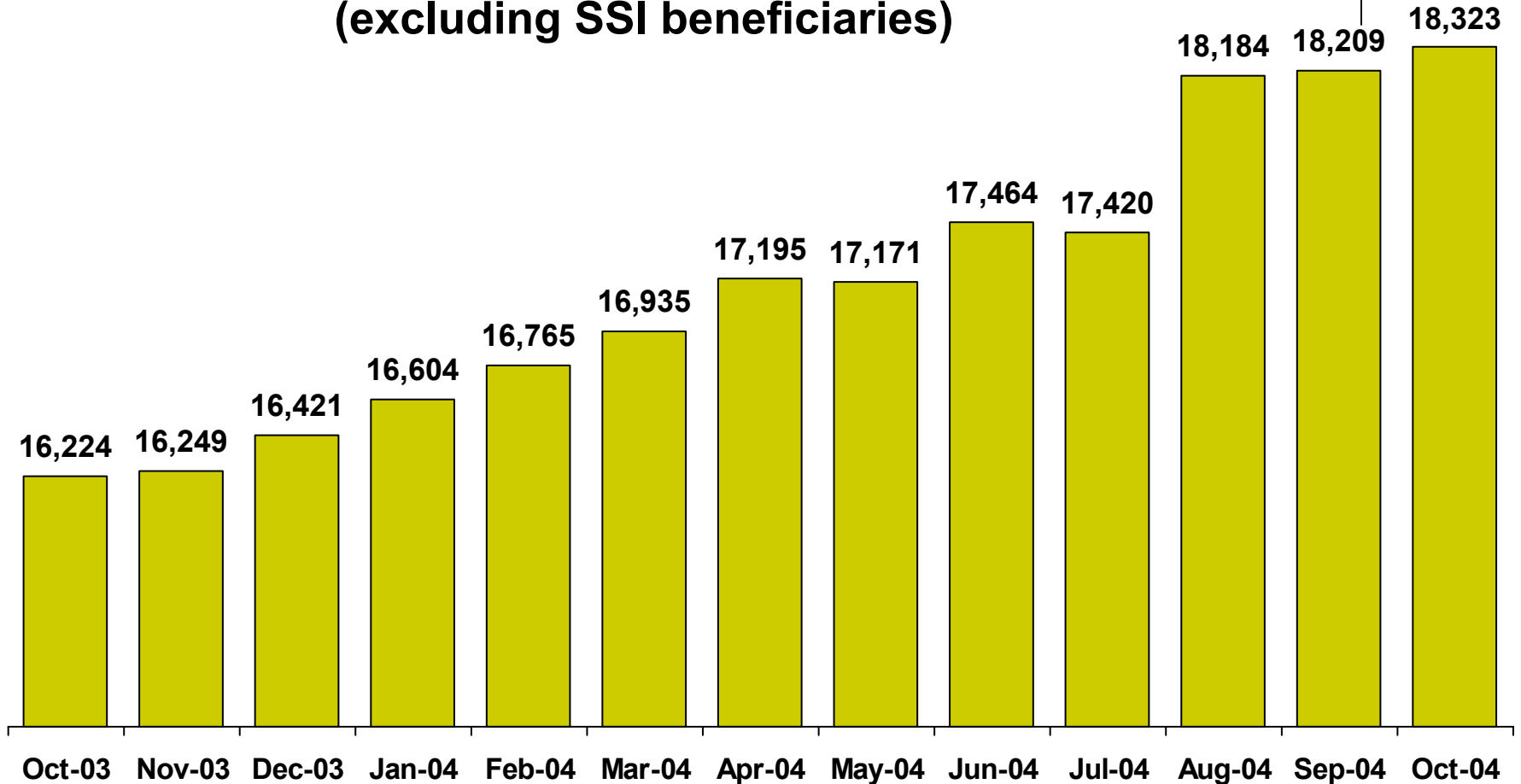
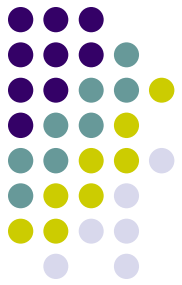


Low-income equates to family income below 200% of the federal poverty line. In 2003, the poverty line was \$15,260 for a family of three. Other includes private non-group and other public insurance (mostly Medicare and military-related). Medicaid includes SCHIP. Source: Urban Institute analysis of March 2003 and 2004 CPS data for the Kaiser Commission on Medicaid and the Uninsured *Health Insurance Coverage in America: 2003 Data Update*, forthcoming.

Figure 6

# Medicaid Enrollment in Sarasota County Over the Past Year

(excluding SSI beneficiaries)



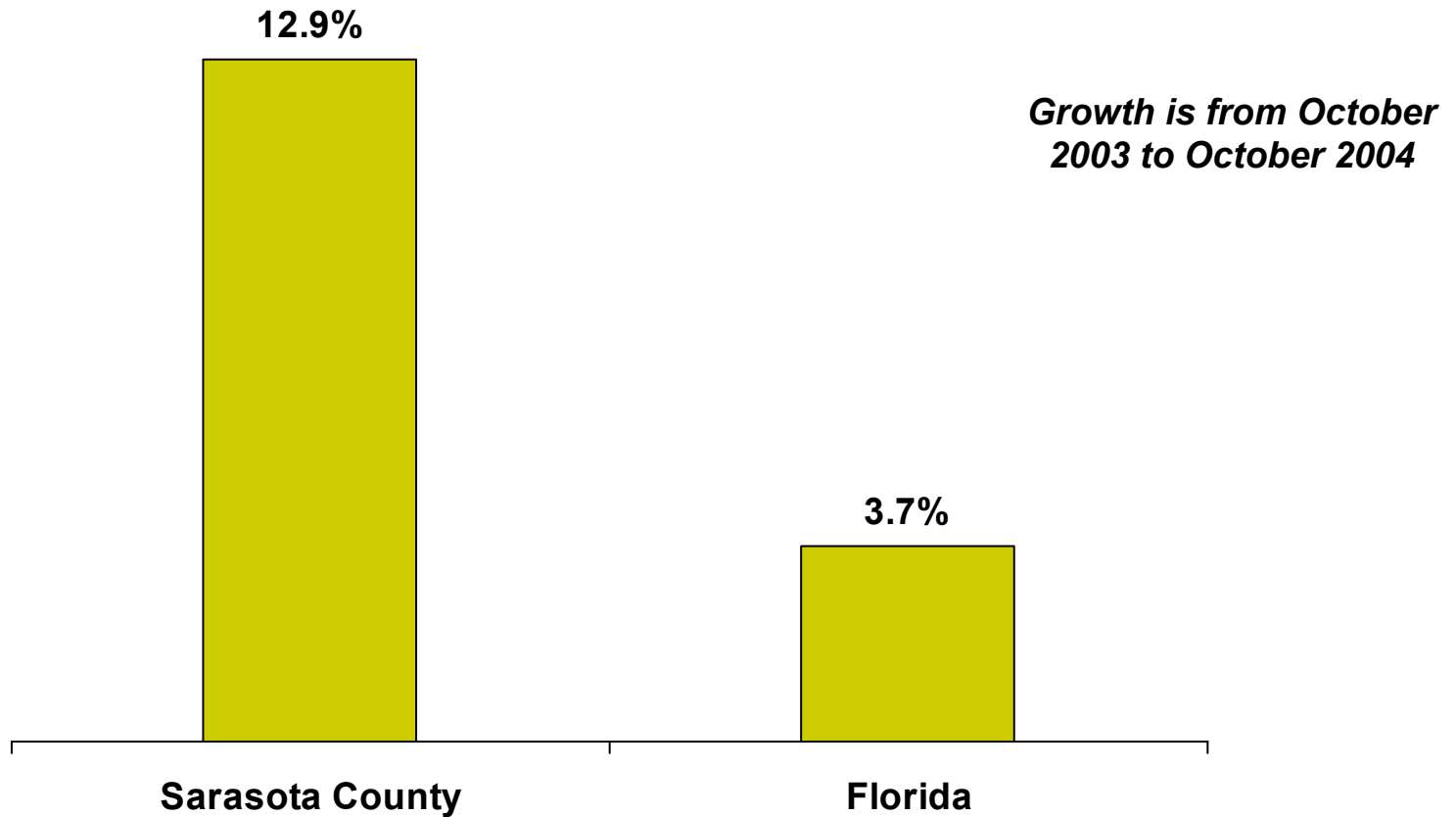
Note: Caseload data may vary from official federal caseload data due to federal reporting protocols, and does not include SSI beneficiaries who have eligibility for Medicaid determined by the Social Security Administration.

Source: Florida Dept. of Children and Families Economic Self Sufficiency Caseload Data. <http://www.dcf.state.fl.us/ess/reports/>

Figure 7

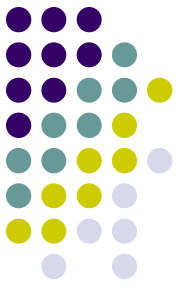


# Medicaid Enrollment in Sarasota County Has Increased at a Faster Rate than Florida Over the Past Year



Note: Caseload data may vary from official federal caseload data due to federal reporting protocols, and does not include SSI beneficiaries who have eligibility for Medicaid determined by the Social Security Administration.

Source: Florida Dept. of Children and Families Economic Self Sufficiency Caseload Data. <http://www.dcf.state.fl.us/ess/reports/>



# How does Medicaid Eligibility Work?

## “Mandatory” Groups

- Children under age 6  $\leq$  133% FPL
- Children age 6 and older  $\leq$  100% FPL
- Children in foster care
- Pregnant women  $\leq$  133% FPL
- Parents with incomes below state-established minimums (median = 60% FPL)
- Children, elderly and disabled SSI beneficiaries (incomes  $\leq$  74% FPL)
- Low-income Medicare beneficiaries

## “Optional” Groups

- Children and parents above minimum requirements
- Pregnant women  $>$ 133% FPL
- Disabled and elderly people  $>$  74% FPL, including those in nursing homes
- Disabled and elderly people served under Home and Community Based waivers
- Women with breast and cervical cancer
- Certain disabled people who are employed and buy into coverage
- Persons with high medical costs “Medically Needy”

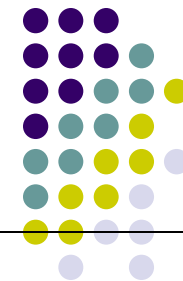
# Florida's Optional Medicaid Beneficiaries



- Infants 185-200% FPL
- Pregnant Women 151-185% FPL
- Medically Needy or “Spend Down” <24% FPL
- Seniors and People with Disabilities 74-88% FPL
- Silver Saver Program <200% FPL
- Breast and Cervical Cancer Treatment <200% FPL
- Family Planning Waiver Services

Figure 10

# What Does Medicaid Cover?



## Mandatory Services

## Optional Services

### *Acute Care*

- Physician, nurse practitioner and nurse midwife services
- Laboratory and x-ray services
- Inpatient and outpatient hospital services
- *Screening and treatment services for children (EPSDT)*
- Family planning services
- Federally-qualified health center (FQHC) and rural health clinic (RHC) services

- Prescribed drugs
- Medical care or remedial care furnished by licensed practitioners under state law
- Diagnostic, screening, preventive, and rehabilitative services
- Clinic services
- Dental services, dentures
- Physical therapy and related services
- Prosthetic devices
- Eyeglasses
- TB-related services
- Primary care case management services
- Other specified medical and remedial care

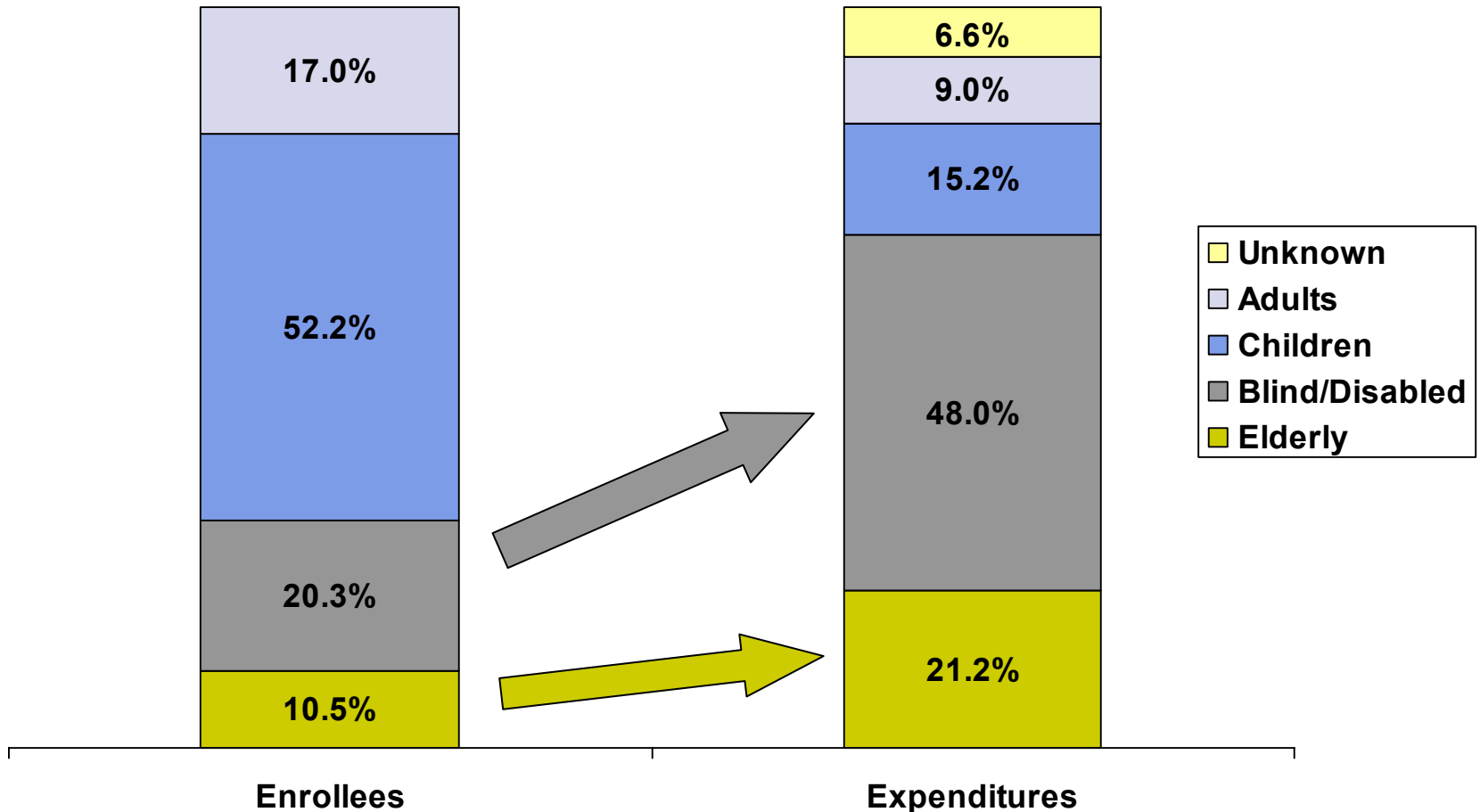
### *Long-term Care*

- Nursing facility services for people 21 years of age or older
- Home health care services (for people entitled to nursing facility care)

- Intermediate care facility for people with mental retardation (ICF/MR) services
- Inpatient and nursing facility services for people 65 or over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for children
- Home health care services
- Case Management services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Private duty nursing services
- Hospice care
- Services furnished under a “PACE” program
- Home and community-based (HCBS) services (under budget neutrality waiver)

Figure 11

# Elderly and People with Disabilities Account for More Than Two-Thirds of Florida's Medicaid Expenditures

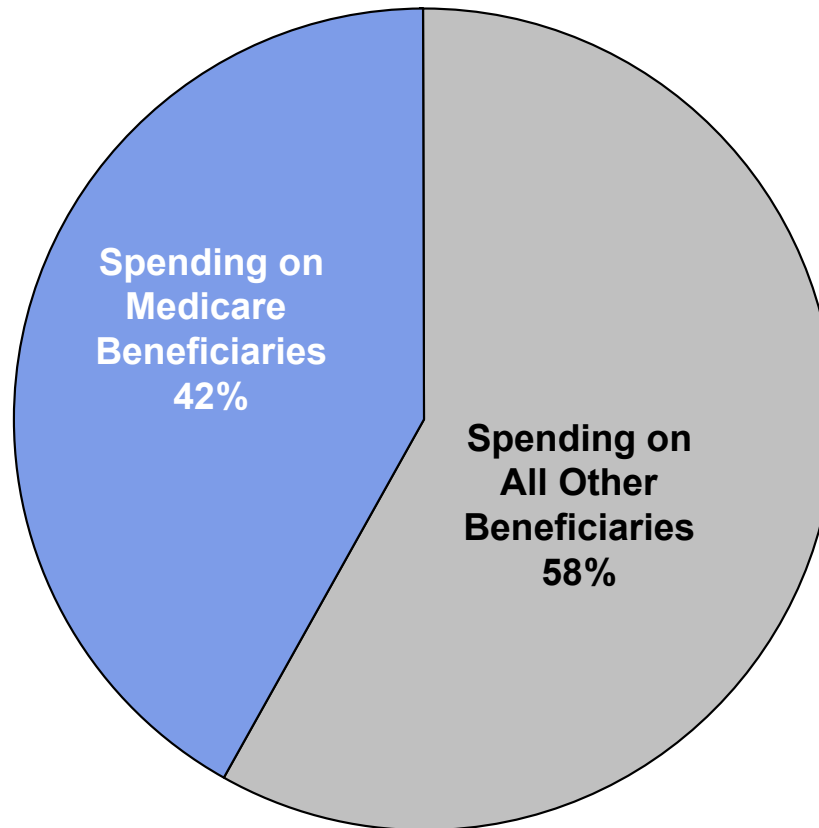
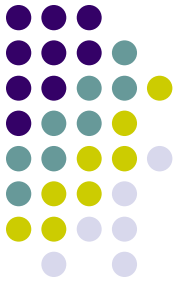


Source: Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data for 48 states plus the District of Columbia. Excludes Hawaii and Washington, which have not submitted data to CMS. Excludes spending on Medicaid Family Planning waivers.

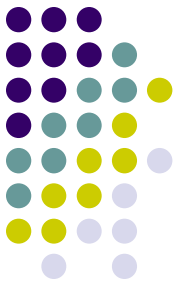
# Medicaid Fills Medicare's Gaps

Over Two-Fifths of Medicaid Benefit Spending is for Services for Medicare Beneficiaries

*This Grows Over Time with the Baby Boomers' Retirement*

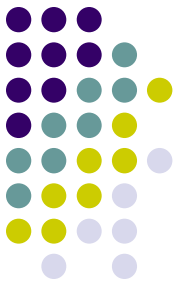


# Medicaid is a major component of a state's health care system



- Accounts for 16% of the nation's health care expenditures
- Single largest source of federal financing to states
  - FL estimates it will receive \$8.1 billion in federal Medicaid funds in FY 2005
- Provides key financial support to safety net health centers, hospitals and other providers
- Economic engine in many communities – for every dollar the state spends, it draws down \$1.44 in federal funds

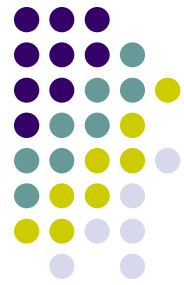
# Key Features of Medicaid Financing



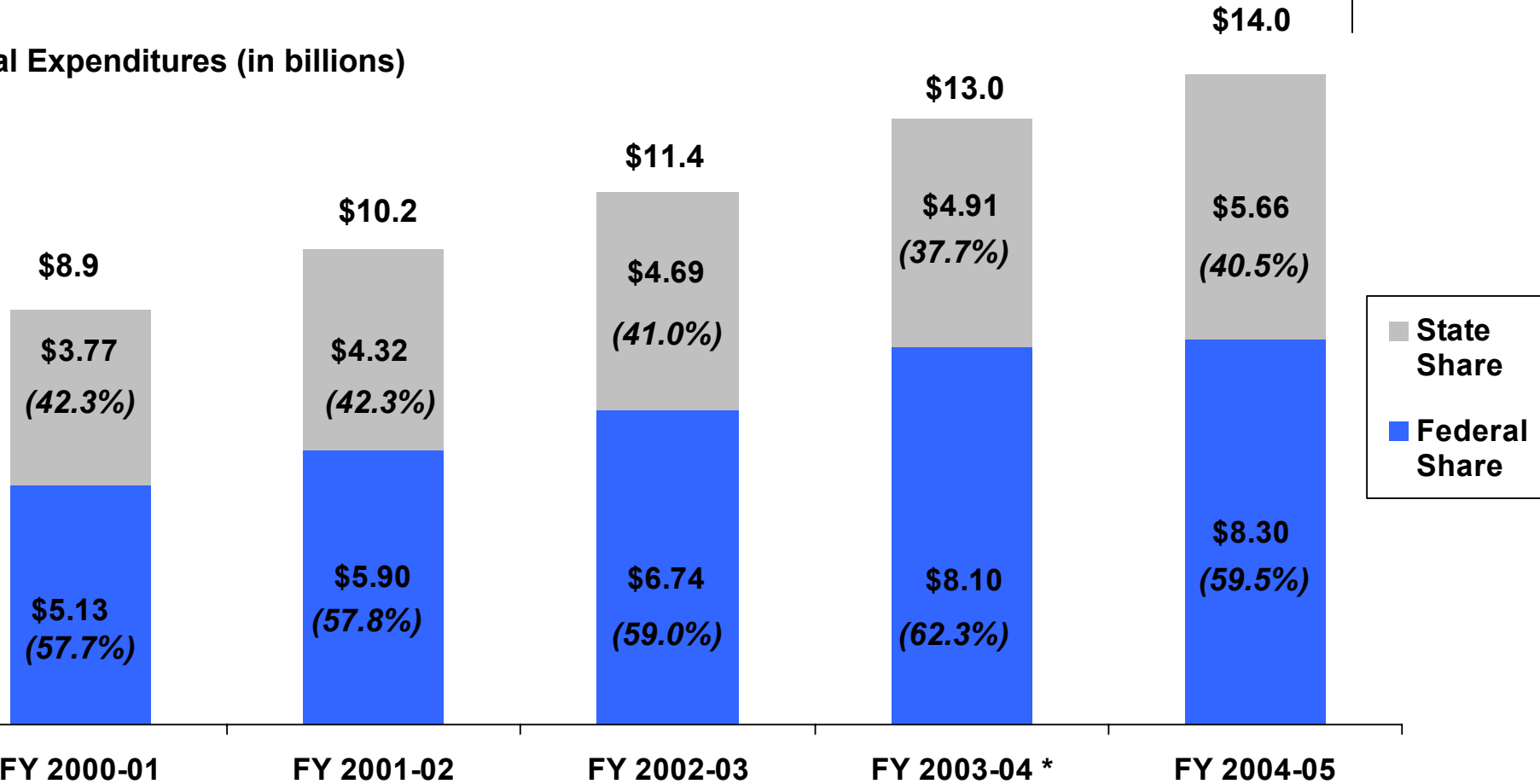
- Jointly financed by states and federal government
- Federal funds paid to states as a “match” on state spending
  - FL’s regular Medicaid match rate is 59%
- Federal funding for Medicaid available on an open-ended, as-needed basis
  - Federal funds for SCHIP (Healthy Kids/KidCare) are capped although state receives higher matching rate
    - FL’s SCHIP match rate is 71%

Figure 15

# Federal and State Share of Florida's Medicaid Expenditures



Total Expenditures (in billions)



■ State Share  
■ Federal Share

\* Note: For FY 2003-2004, Florida, like all states, received a temporary FMAP increase of 2.95% as part of the "Jobs and Growth Tax Relief Reconciliation Act of 2003." This enhanced matching rate expired on July 1, 2004.

Source: Medicaid expenditure data received from AHCA Bureau of Program Analysis, June 2004.



# Medicaid costs are growing, but the growth rate has slowed down

- Medicaid spending rose nationally by 8% in 2004; projected to fall to 4% in 2005
  - FL Medicaid expenditures rose on average 13.8% over last four years (FY99-00 to FY03-04) but state projects growth will decline to 7.3% from FY03-04 to FY04-05
- Growth in spending is attributable to increase in health care costs and rise in enrollment partially due to the recession
- States have been facing severe budget pressures. Medicaid costs were growing while revenues were shrinking. Revenues are starting to come back.

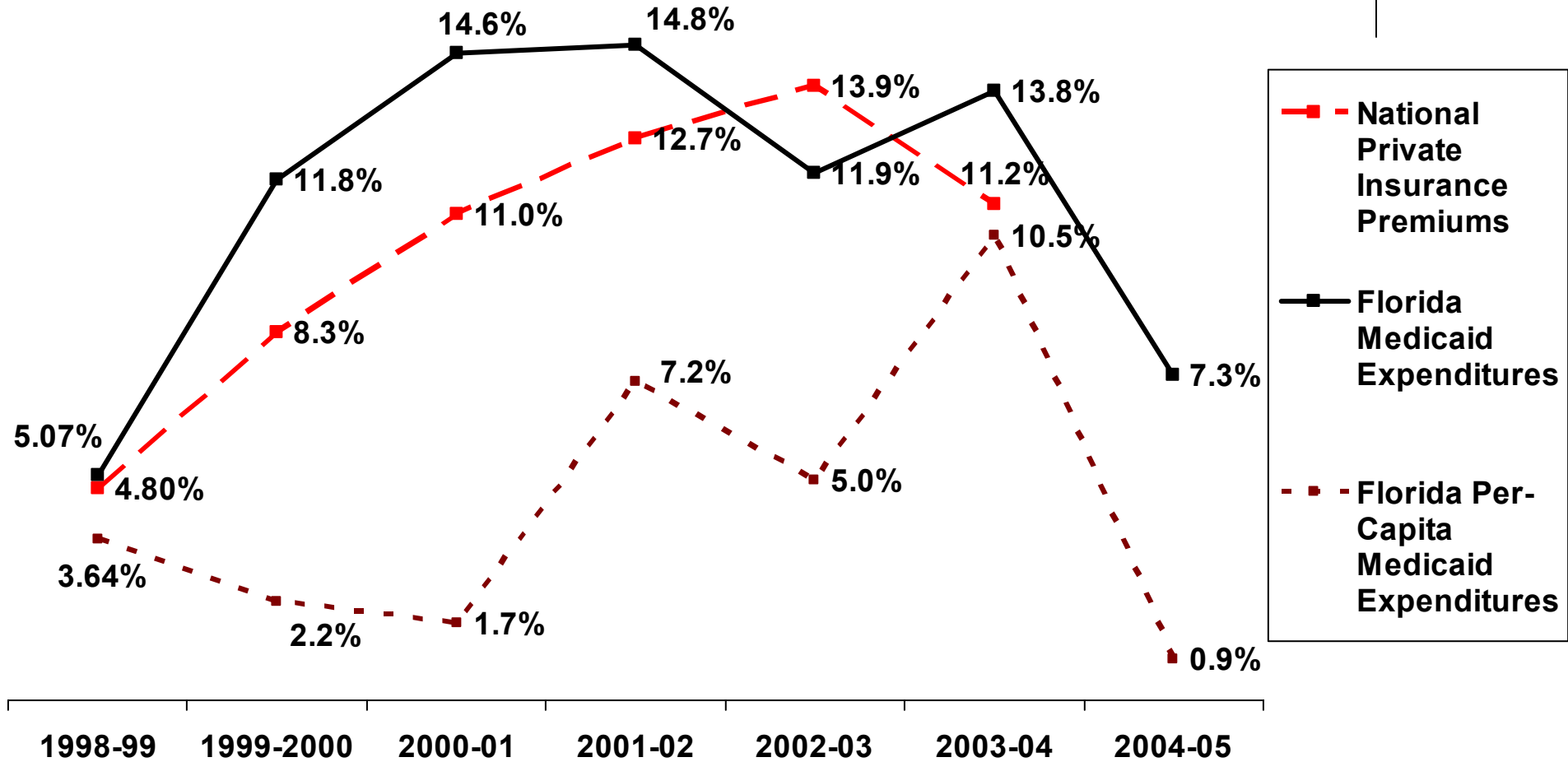
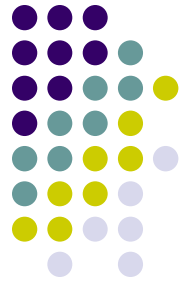


# Underlying Cost Pressures in Medicaid

- Long Term
  - Rising costs of “dual eligibles,” elderly and disabled enrolled in Medicare and Medicaid. Medicare effectively shifted costs to Medicaid
  - Rising medical costs that affect all health sectors, particularly rising prescription drug costs. (But there are signs that the health cost cycle may have peaked for now.)
  
- Short Term
  - Weak economy and falling private insurance leads to enrollment increases, particularly children and parents

Figure 18

# Private Insurance Premium Increases vs. Florida's Medicaid Expenditures

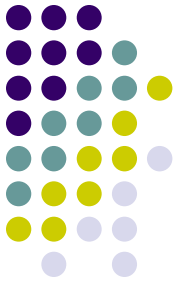


Note: Florida data represents Medicaid expenditures for July 1-June 30<sup>th</sup> of that fiscal year. 2004-05 data is based on General Appropriations.

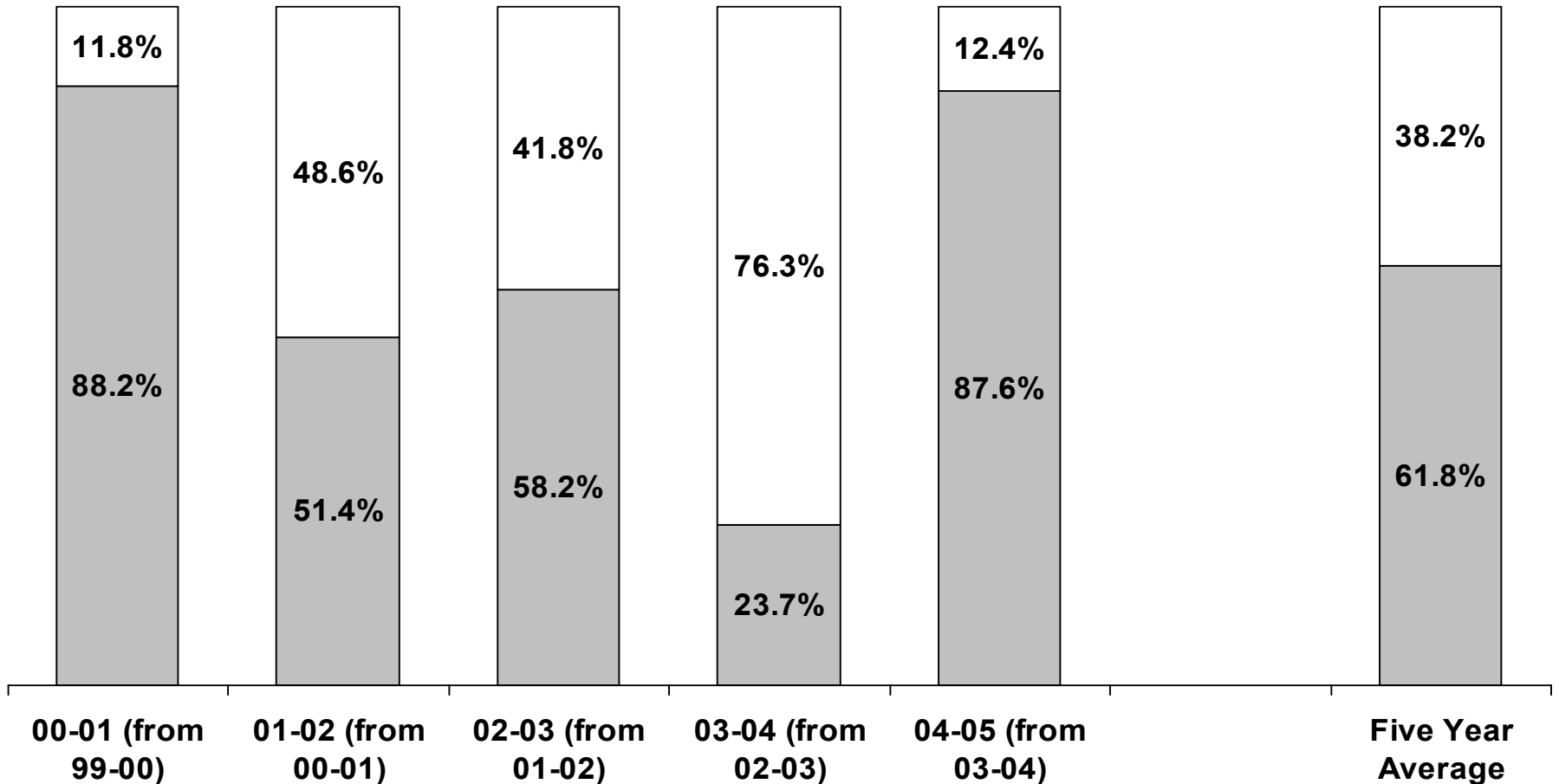
Source: Georgetown Health Policy Institute analysis based on Kaiser HRET 2004 Annual Survey, Florida Social Services Estimating Conference Medicaid Caseload data, 2/6/04; Medicaid expenditure data from AHCA Bureau of Program Analysis, June 2004.

Figure 19

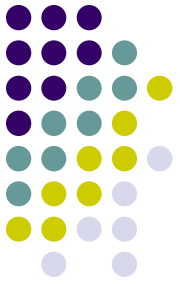
# Sources of Florida's Medicaid Expenditure Growth



- Expenditure Growth Due to Per-Capita Expenditures
- Expenditure Growth Due to Enrollment Increases



Source: Georgetown Health Policy Institute analysis based on Florida Social Services Estimating Conference Medicaid Caseload data, 2/6/04; Medicaid expenditure data from AHCA Bureau of Program Analysis, June 2004.



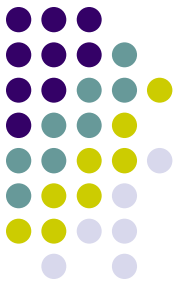
## Part 2

# Federal Medicaid Reform: What Could it Mean for Florida?



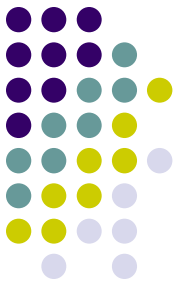
# What has been happening at the federal level?

- Federal FY04 Bush budget contained proposal to cap Medicaid funding in exchange for lots of flexibility to cut benefits, raise cost-sharing, restrict enrollment etc.
- Proposal was not endorsed by majority of NGA Task Force and Members of Congress had reservations
  - Gov Bush served on this Task Force and supported the proposal
- It appeared that the policy was being pursued through the waiver process – CT, NH, FL??, CA??



# Are other states considering global caps?

- **CT** – (Ex) Governor had proposed/Legislature passed 12-month prohibition
- **NH** – Governor was negotiating cap with Sec. Thompson. Legislature passed the following statutory language:  
*“The department of health and human services shall not amend nor seek to amend, nor gain nor seek to gain approval of waivers to, the state Medicaid plan in any way that results at any time in the consolidation of federal grants or allotments, caps on the federal portion of Medicaid spending, reductions in the federal share of Medicaid spending, or increases in the state share of Medicaid spending, without the prior approval of the fiscal committee of the general court.”*  
NH Governor lost election; future of waiver uncertain
- **CA** – Governor was developing a mega-waiver; state announced 8/2 that waiver would be delayed until January budget in response to concerns
- **FL** – ??



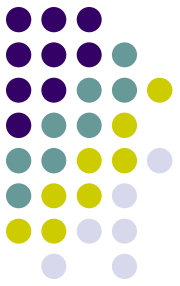
# TennCare Reform/Waiver Includes Some Troubling Concepts

- State is requesting “pre-approval” from the federal government to make any necessary changes to comply with budget pressures
- State budget cap of 26% of state general revenues
- Very restrictive definition of medical necessity
  - “Least costly alternative ... that is adequate for the medical condition of the enrollee... an alternative course may be no treatment at all..”



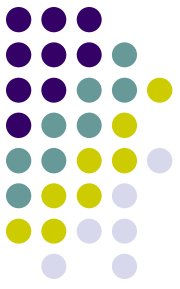
# What does the recent election mean for Medicaid?

- In light of the election results it appears the emphasis on significant change to Medicaid's financing system will shift from the waiver process to a debate in Congress about capping the program
- A proposal to cap federal Medicaid funding is likely to appear in the President's FY06 budget or arise during the Congressional budget process



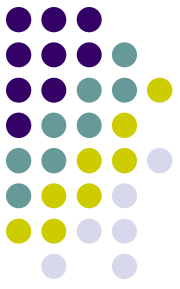
## Why do we think so?

- In an interview with Congress Daily prior to the election, CMS administrator Mark McClellan said the administration wants to reauthorize the SCHIP program next year rather than when it expires in 2007 *as part of an overall examination of Medicaid.*
- The Administration's FY04 budget proposal talked about making Medicaid more like SCHIP.
- SCHIP funding is capped.



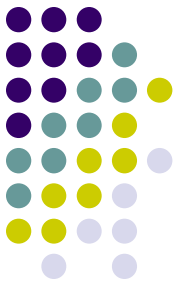
# Potential Changes to the Medicaid Program Through the Federal Budget Process

- **Entitlement caps** leading to automatic, deep cuts in virtually every program except Social Security.
  - Voted on by House earlier this year, expected to be revisited next year in both the House and Senate. Sounds benign – part of “reforming the budget process” – but actually very harmful.
  - House version would have reduced funding for entitlement programs by \$1.8 trillion over 10 years; federal Medicaid funding would have been cut almost \$400 billion
- **“Reconciliation” process**, in which Congress sets a multi-year deficit target and moves legislation on a fast track to make cuts in entitlement programs to meet that target
- **Tax policy changes** More tax cuts mean fewer resources available to fund health programs. Additional tax policy changes being made related to health care (health savings accounts)

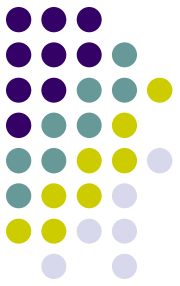


# What role will Florida play?

- “Buoyed by his brother’s performance in Florida on Election Day, Gov Jeb Bush is vowing to .. produce two politically potent years in the lame-duck phase of his final term His agenda includes ... with President Bush’s assistance, restructuring Medicaid in a way he hopes will become a model for the nation.”
- *Source: Tallahassee Democrat Monday, November 8, 2004*

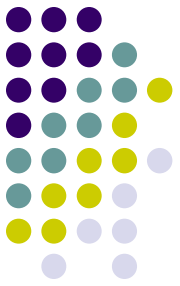


# What is the President's vision of Medicaid reform?



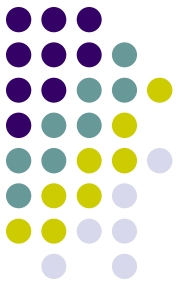
# Key Features of the President's Proposal

- Capped federal payments to states on at least “optional” federal funding
  - Payments front loaded to provide fiscal relief, but reductions in later years to make proposal “budget neutral” over 10 years
  - This time around unlikely to have any additional funds but will achieve budget savings
- No required state matching payments; “maintenance of effort” system instead
- Broad new flexibility over program rules



# Capped Federal Payments

- Based on 2002 spending, adjusted forward using 10-year growth projections
- Funding no longer based on actual changes in enrollment
- Funding no longer based on actual changes in health care costs, utilization, new technology

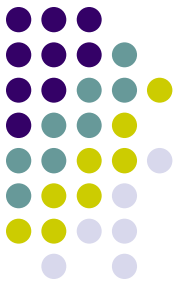


# President's plan would allow significant flexibility for "optional" beneficiaries and services

What could this mean?:

- Optional services could be provided for some people but not others
- Some services could be covered in some parts of the state but not others
- Closed formularies for drugs: high cost drugs could be excluded even if needed
- Higher cost sharing for beneficiaries; no limits for some groups
- Services, like inpatient hospital care, could be dropped
- Potential loss of federal nursing home quality standards, managed care protections, etc.

# How would Congress determine how much money a state gets?



- The mother of all formula fights!!
- SCHIP funding formula has not worked well
- Formula would likely include two components
  - Base amount
  - Inflator/Trend factor
    - Differences of a few percentage points can have dramatic impacts
- A Section 1115 waiver for Florida with a global cap would likely have a similar formula



**What would the President's proposal  
or a global cap waiver mean for  
Florida?**

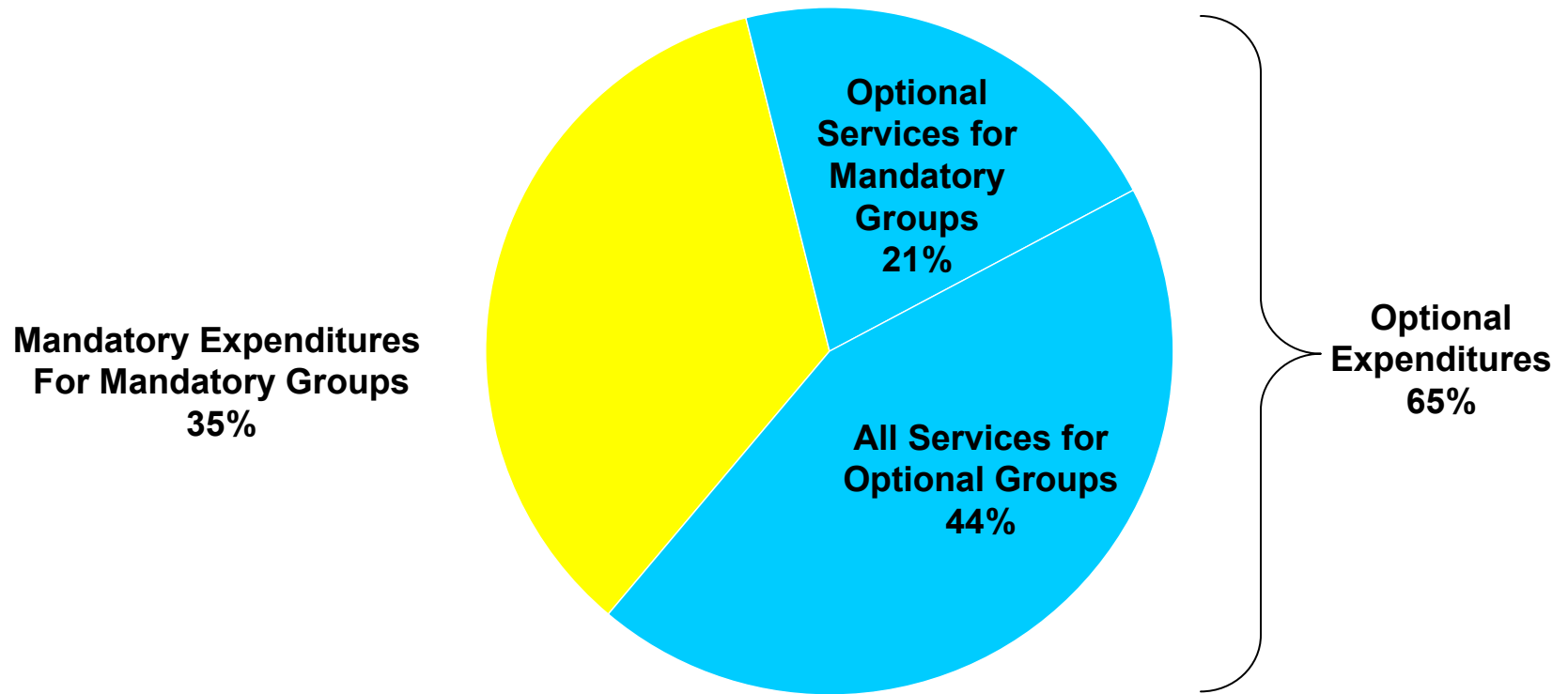
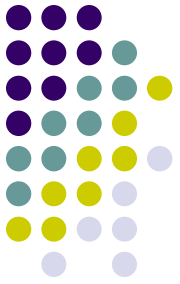


## **Risk #1**

**The Majority (and Possibly All) of Florida's Spending Would Fall Under the Cap**

Figure 35

# Most Spending in Medicaid is “Optional” (US, 1998)

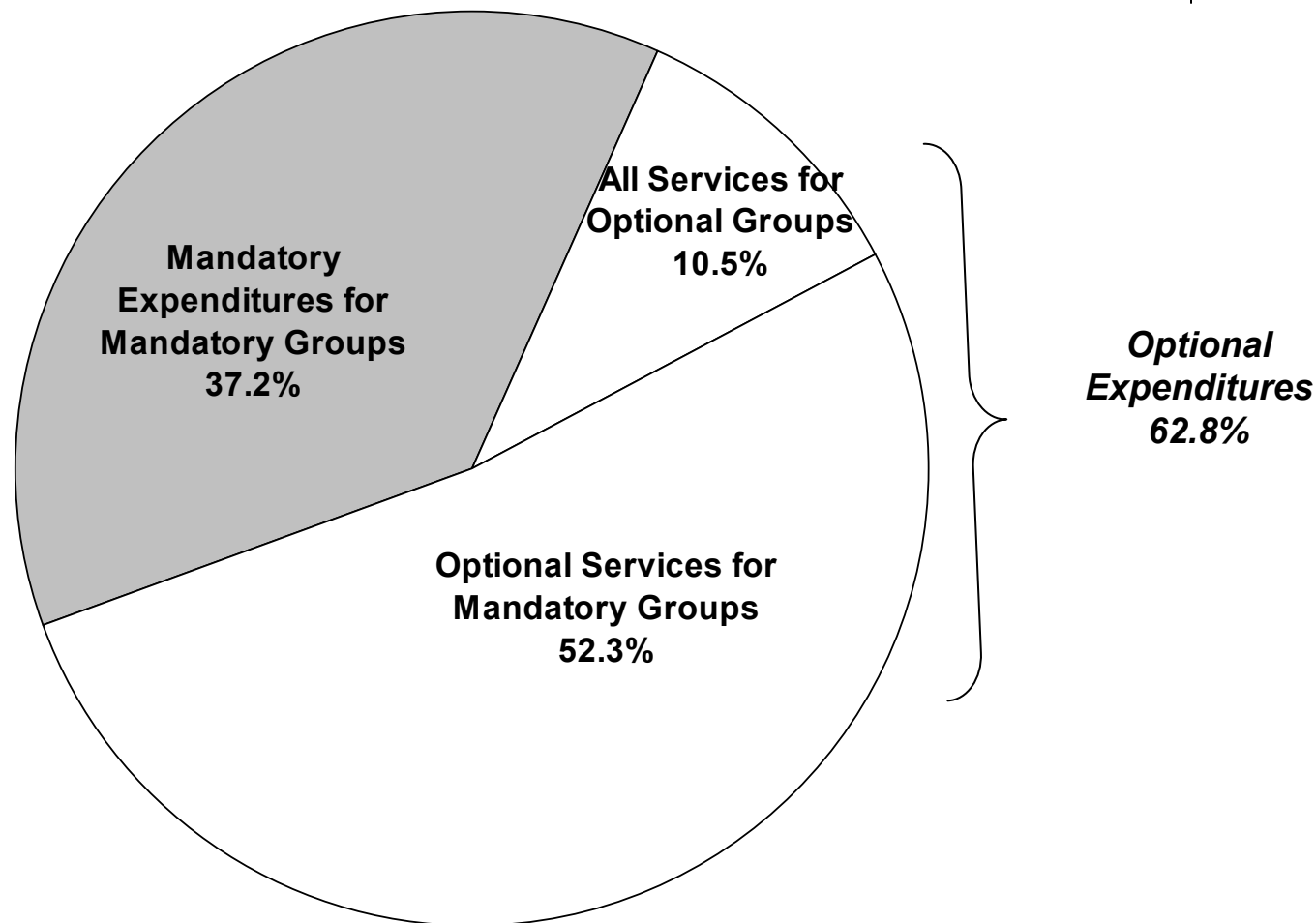


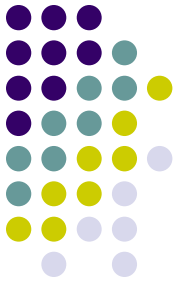
*Note: Expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.*

Figure 36



# Florida Medicaid Services for All Eligibles, FY 2003-3004





## **Risk #2**

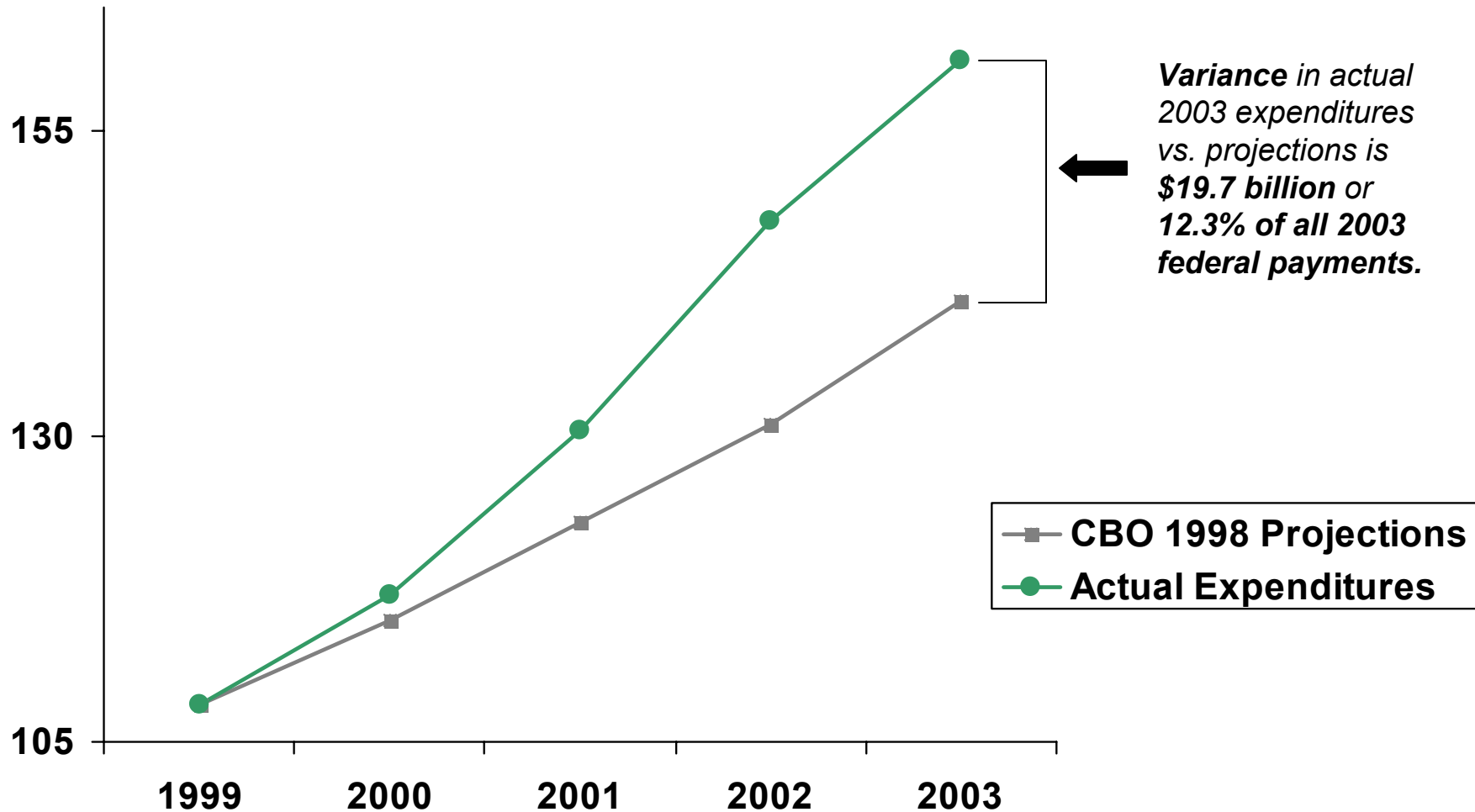
**It is very hard to predict the rate of growth in health care spending**

Figure 38

# Congressional Budget Office (CBO) Federal Medicaid Spending Projections for Fiscal Year 2003



(billions of dollars)





## **Risk #3**

**The block grant would change the fiscal incentives that encourage Florida to maintain investments in coverage or make other improvements such as increasing provider reimbursement**



# Matching System Creates Incentives to Maintain State Investment

## Current Law

Federal dollars lost if FL reduces Medicaid spending by \$125 million, at Medicaid and SCHIP match rates

Match Rate	State Funds Withdrawn (millions)	Federal Dollars Lost (millions)
59%	\$125	\$199
71%	\$125	\$214

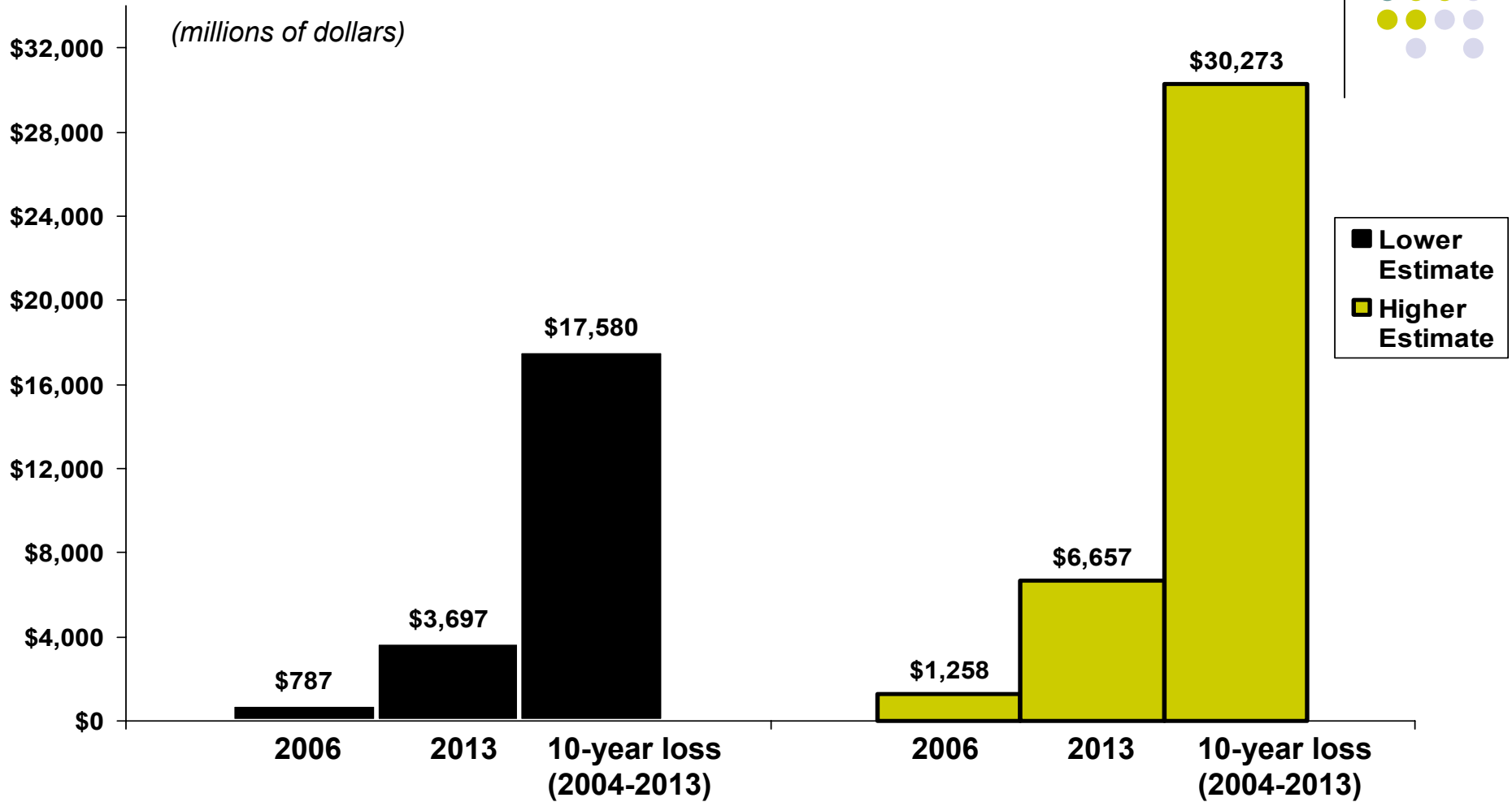
## Proposal

Federal dollars lost if FL reduces Medicaid spending by \$125 million (assuming state meets “MOE”)

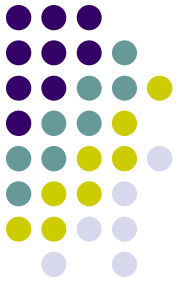
State Funds Withdrawn (millions)	Federal Dollars Lost (millions)
\$125	\$0

Figure 41

# Potential Loss of State Spending



*Note: Lower estimate shows the difference between MOE and state spending projections under current law assuming program expenditures grow at 8.15% (CBO 2004 Medicaid baseline growth for the years 2004-2013). Higher estimate shows the difference between MOE and state spending projections under current law assuming program expenditures grow at 10.81% (FL's Medicaid expenditure growth rate from 1998-2002). MOE growth is based on 2003-04 state expenditures as reported by AHCA, adjusted by the Medical CPI projected by HHS.*

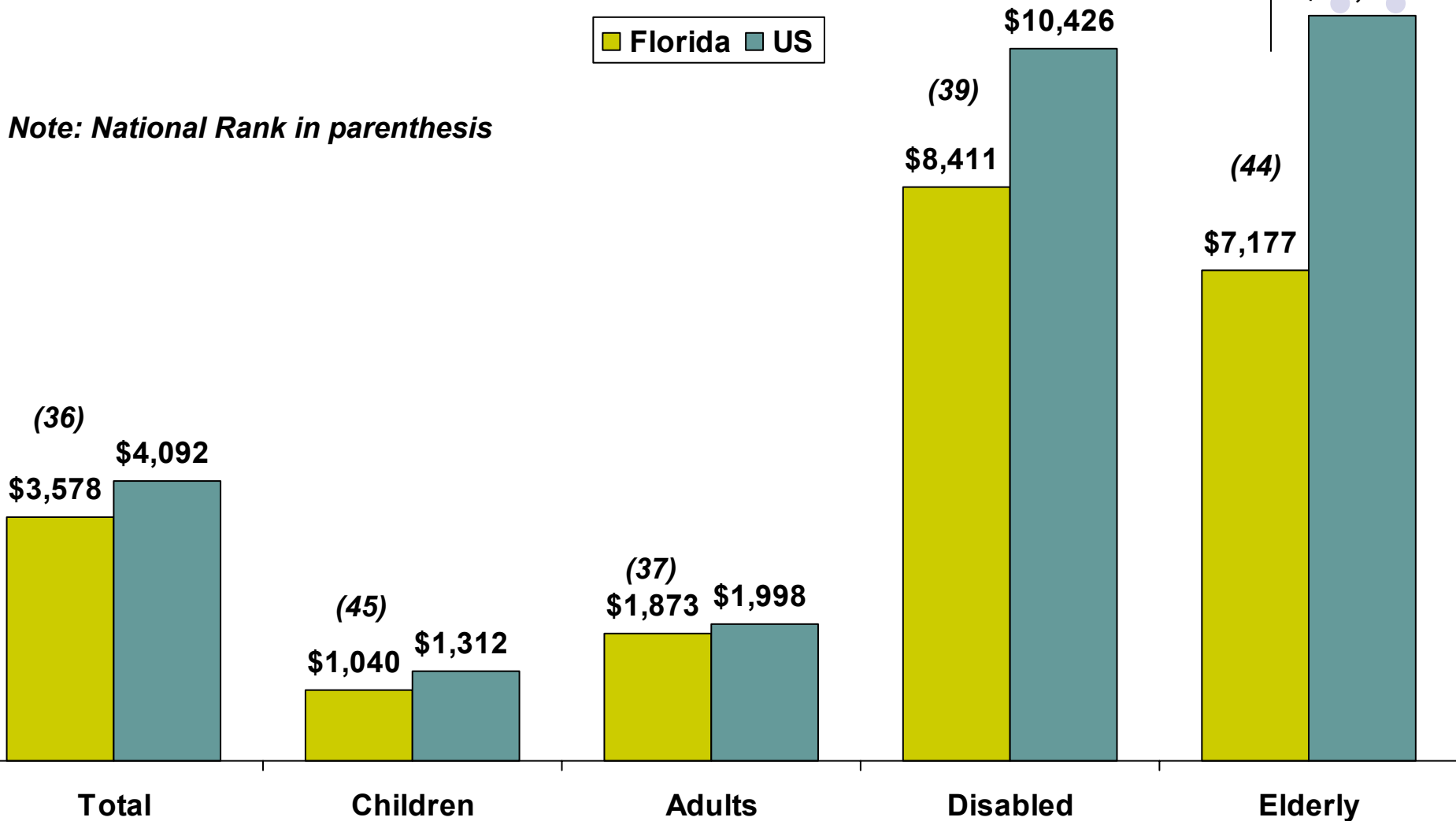


## **Risk #4**

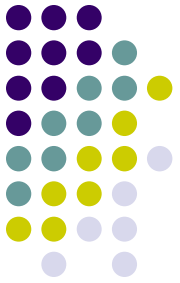
**Florida's historically low spending will be locked into its base**

Figure 43

# Florida's Medicaid Expenditures Per Beneficiary, By Category, 2001



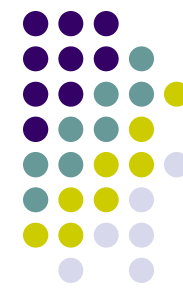
Source: Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data for 48 states plus the District of Columbia. Excludes Hawaii and Washington, which have not submitted data to CMS. Excludes spending on Medicaid Family Planning waivers.



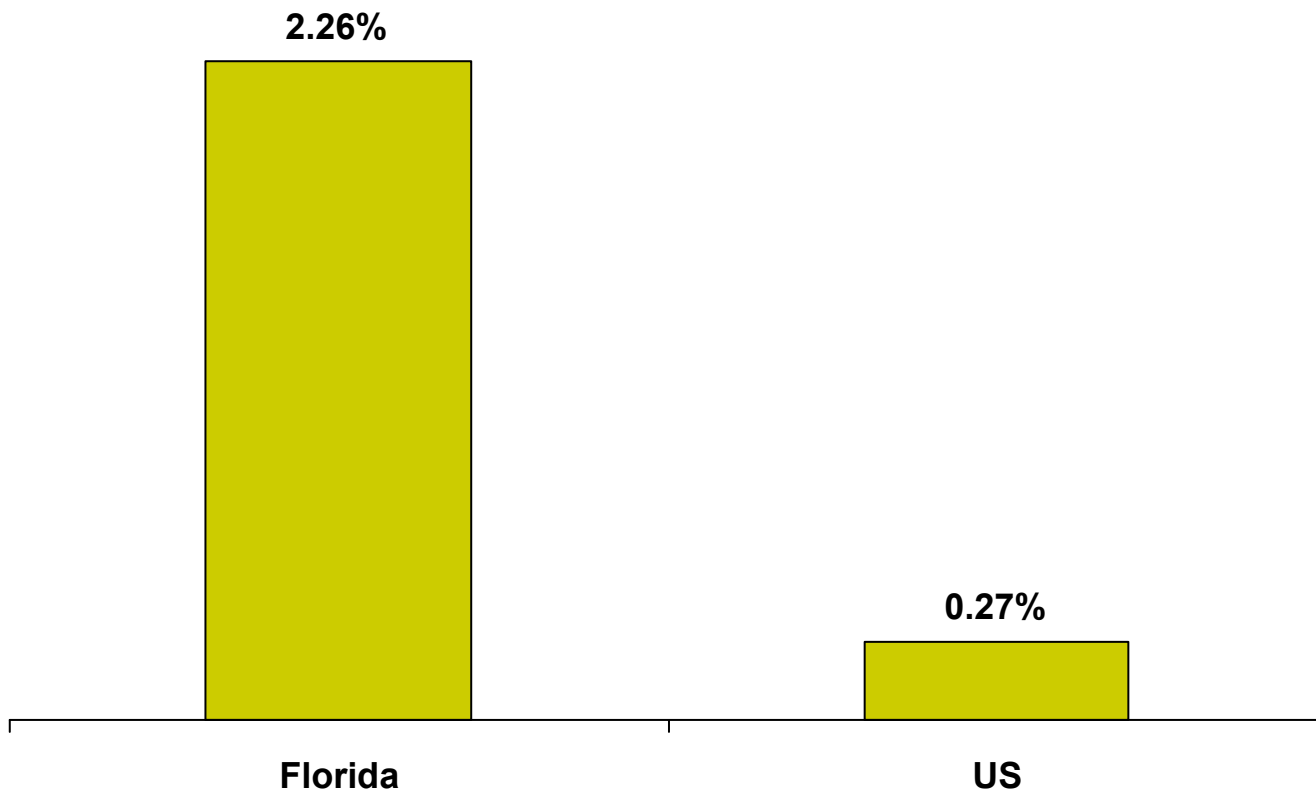
## **Risk #5**

**Will the growth rate under a block grant or a waiver be able to accommodate Florida's needs?**

Figure 45



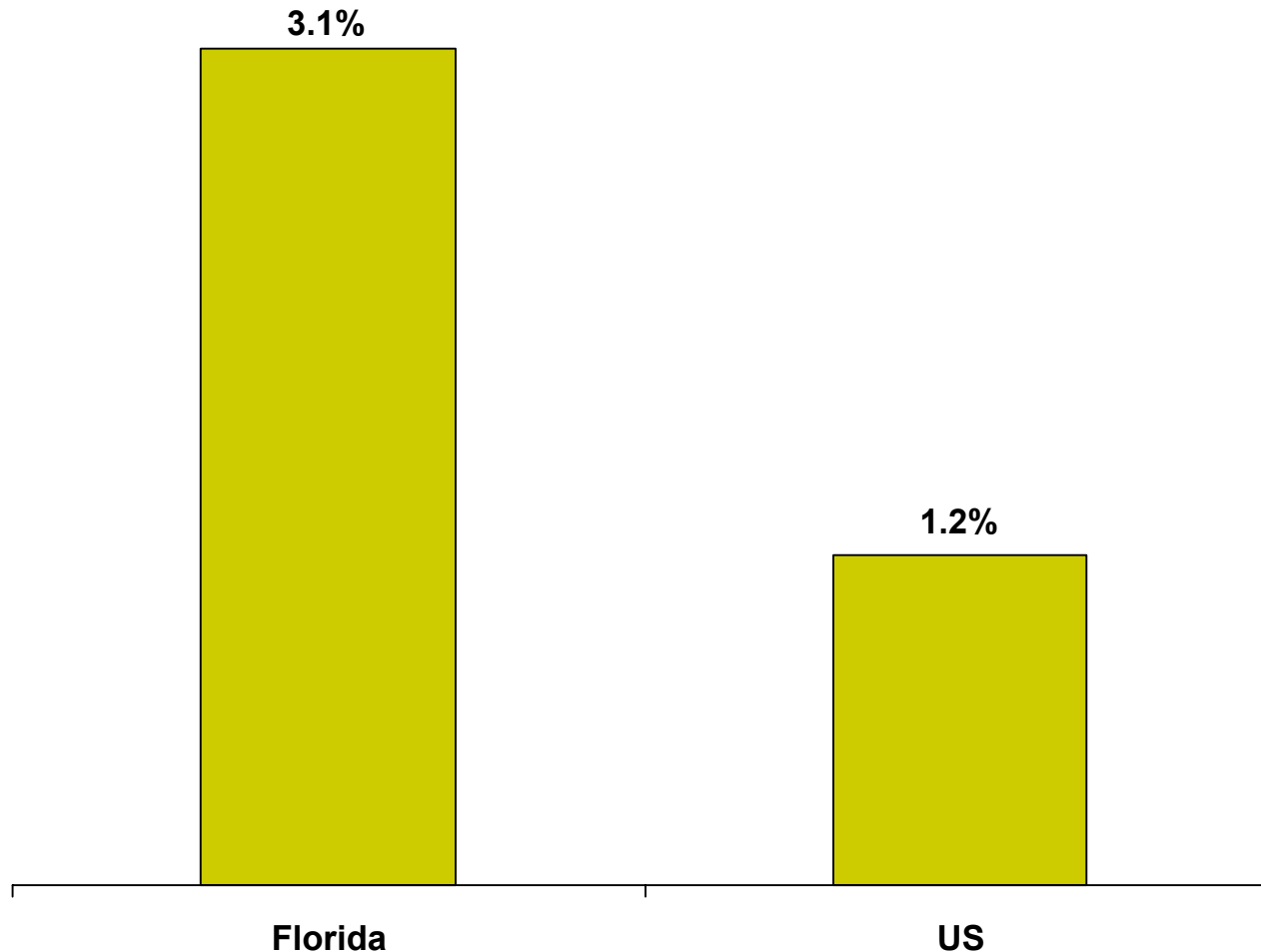
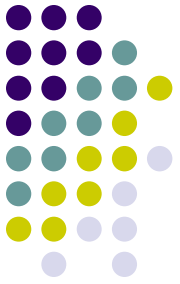
# Florida's Growth in Low-Income Elderly Exceeds that of the US (1992-2002)

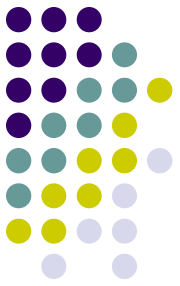


Note: Low-Income refers to income less than 200% of the federal poverty level (\$30,040/year for a family of three in 2002).  
Source: Georgetown University Health Policy Institute analysis based on March 1993-2003 Current Population Surveys.

Figure 46

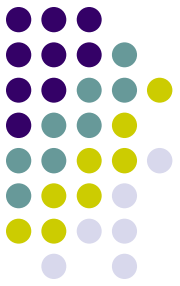
# Florida's Growth in Blind and Disabled SSI Beneficiaries Exceeds that of the US (1996-2003)





# Who will pay if federal funding is capped?

- Health care needs will still exist
- Costs get shifted to
  - Hospitals and other providers
  - Low-income families themselves
    - Additional premiums/cost-sharing leads to declines in enrollment/loss of access to needed services
  - Purchasers of private insurance
  - Other areas of state's budget

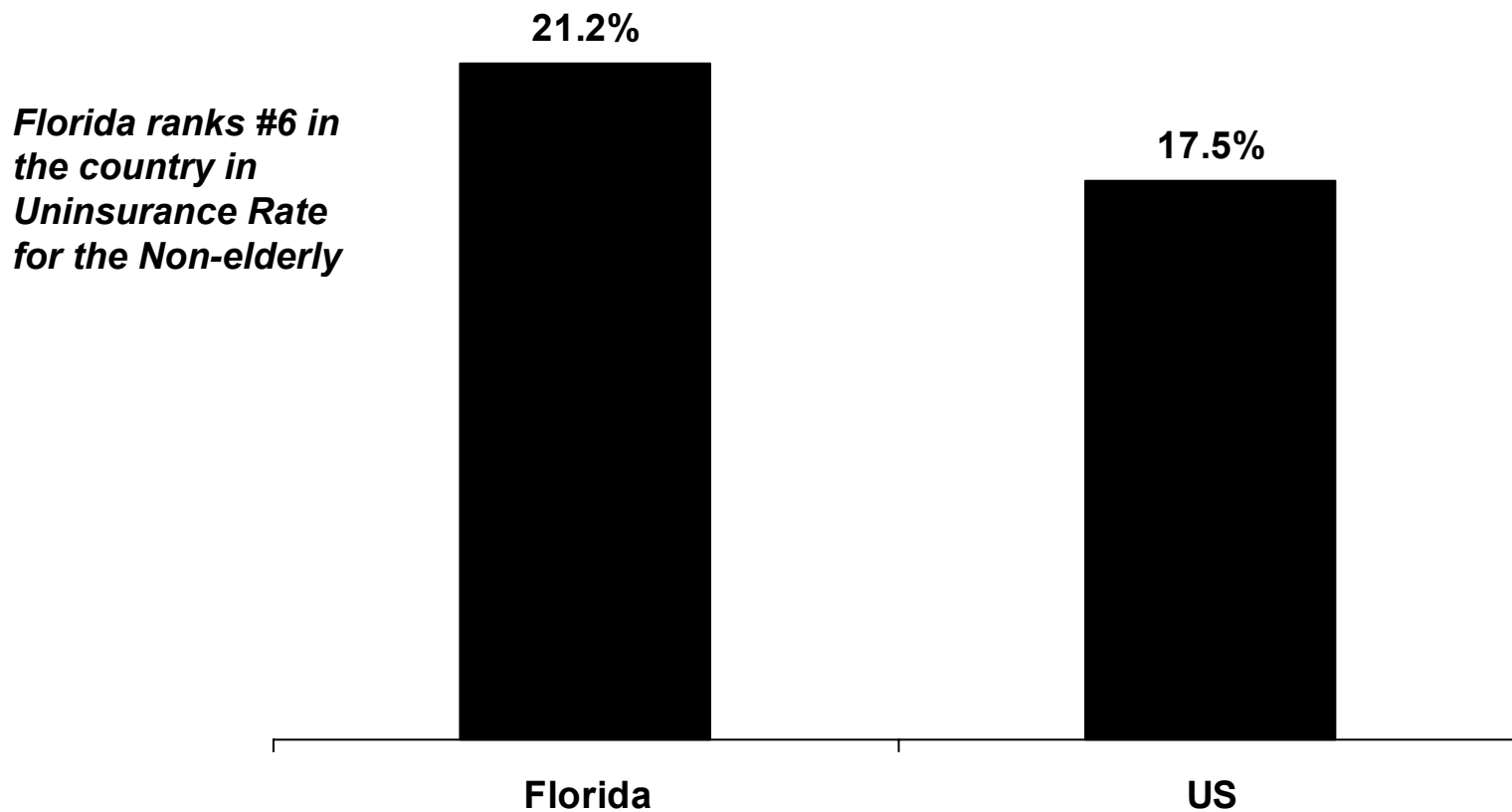


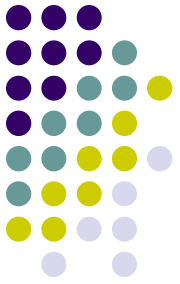
# Additional pressures on Florida's health care system

- High rate of uninsured persons already – no new federal funding would be available to address this
- Large number of immigrants who are ineligible for federal Medicaid funding
- Florida is currently one of two states in the country with closed enrollment for its Healthy Kids/KidCare program

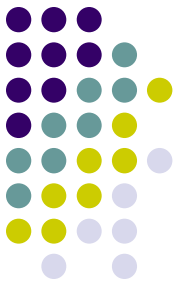


# Uninsurance Rate for Nonelderly Persons, 2002-2003





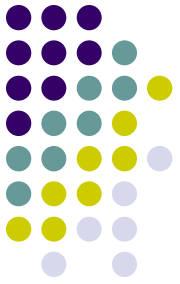
# Concluding thoughts on Medicaid reform



# Some questions to consider

- Federalizing costs for dual-eligibles
  - What will the impact of the Medicare prescription drug benefit be?
    - Will Florida see budget relief?
    - What kind of prescription drug coverage will be available?
    - Does the law need amending?
- Who should pay for long term care?
- What can we do about rising health care costs and the growing number of uninsured in our health care system generally?

# Some questions to consider, cont.



- Are there ways we can save money and improve efficiency in Medicaid without undermining the guarantee of coverage?
  - Increase prescription drug rebate
  - Improve coordination and disease management programs