## FLORIDA'S HEALTH AT RISK

*First in a series of educational briefs on issues impacting Florida's families*

# What Could a Waiver to Restructure Medicaid Mean for Florida?

## SUMMARY OF FINDINGS

- A Medicaid waiver which caps Florida's federal funding could hurt the state's neediest citizens and increase pressure to reduce provider reimbursement.
- Florida's demographics—in particular high levels of growth in the low-income elderly and disabled populations—and its low level of per person Medicaid spending could, under a cap, result in an artificially low level of federal Medicaid spending that doesn't meet the growing health needs of Floridians
- Under the cap, the state would likely receive more flexibility to, among other things, expand Medicaid coverage to children and adults who are otherwise ineligible
- Inadequate Medicaid funding for Florida's neediest could result in the shifting of costs to other parts of the state's health care system

## OVERVIEW

Florida's Medicaid program provides health care coverage and services to over two million state residents – approximately one in eight Floridians. In federal Fiscal Year 2004 the state of Florida is expected to receive $6.7 billion in federal Medicaid funding and spend $4.6 billion in state funding.[1] Medicaid is the single largest source of federal funds coming into the state. Any major changes to the way Medicaid is financed could have serious implications not only for Medicaid beneficiaries and providers, but the state's health care system as a whole.

Current Florida law requires that the Florida legislature must pass authorizing legislation for the state to apply for the waiver. The language does not need to be specific on how Medicaid would be changed. On March 30, 2004, Florida's Agency for Health Care Administration (AHCA) issued a letter seeking public comment on Gov. Jeb Bush's intention to seek "waiver authority from the federal Centers for Medicare and Medicaid Services to modernize the program and test a new model that leads to a sustainable and affordable program in the decades ahead." [2]

While few details have been released on what the changes proposed in a waiver application might look like, previous public pronouncements by state and federal officials suggest that *one of the central features of the waiver agreement is likely to be a significant change in the way the Medicaid program is financed – in particular the imposition of a cap on federal funding for the program.*[3] This brief seeks to examine the implications of such a cap. Future briefs in the series will examine programmatic changes that are being considered as they become available.

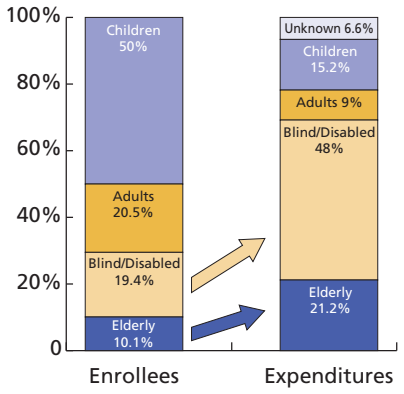
## BACKGROUND

*Who does Medicaid Cover?* Florida's Medicaid program currently serves over 2.1 million Floridians. Of these, over 1.2 million are children, 582,395 are persons with disabilities and 304,122 are seniors.[4] While children are the bulk of the beneficiaries, most of the costs arise from providing services to seniors and people with disabilities who have significant medical needs. (See Figure 1)

Under existing Medicaid law, states are required to cover certain groups of Medicaid beneficiaries ("mandatory" coverage groups) and may choose to cover additional groups ("optional" coverage groups).[5] In addition, Medicaid requires coverage of certain mandatory services, and states may elect to cover additional "optional" services. The terms "mandatory" and "optional" can be somewhat misleading however. Prescription drugs, for example, are considered an optional service under Medicaid. Nationally, approximately two-thirds of Medicaid spending is for "optional" services and/or "optional" beneficiaries.[6] In Florida, the state estimates that 62 percent of Medicaid spending is for optional services.[7] (See Figure 2)

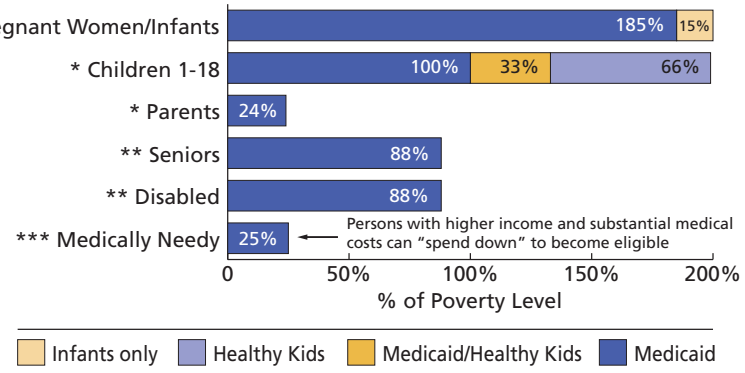
*How is Medicaid financed?* Medicaid is an open-ended federal-state matching program. This means that for any qualifying health services that Florida provides to an eligible person, Florida is assured that the federal government will share the cost. Florida's regular federal Medicaid matching rate is just under 59 percent.[8] In effect, the state draws down $1.44 in federal funding for every dollar it spends on Medicaid services.

**Figure 1: Elderly and People with Disabilities Account for More Than Two-Thirds of Florida's Medicaid Expenditures**




*Source: Centers for Medicare and Medicaid Services MSIS data, 2001.*

## Figure 2: Who is Eligible for Medicaid in Florida?




** Source: Cohen-Ross D, Cox L. " Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge." Kaiser Commission on Medicaid and the Uninsured, July 2003. Parents with earnings are eligible up to 63%.*

*** Source: "SSI-Related Programs Fact Sheet." Florida Department of Children and Families, April 2004.*

**** Source: Aged, Blind, and Disabled State Summaries, National Association of State Medicaid Directors, based on standards in effect on October, 2001.*

Medicaid is an entitlement for individuals meaning that anyone who meets the eligibility criteria established by the state must be enrolled. The current Medicaid financing structure recognizes this entitlement by ensuring that funding is open-ended i.e. states can be assured of receiving federal matching funds for any new enrollee. Thus, funding levels are directly tied to the number of enrollees and the actual cost of coverage. In exchange, eligible persons are guaranteed coverage and providers are guaranteed payment for services.

Because Medicaid funding is open-ended, increases in enrollment caused by economic downturns or state choices to expand coverage result in more federal funding. In contrast, the State Children's Health Insurance Program (SCHIP) -- in Florida this is known as the KidCare or Healthy Kids program -- is not an open-ended entitlement, and overall federal funding for Healthy Kids is capped. States receive matching funds for each child enrolled, but only up to a pre-determined capped allotment. While no state has reached its cap yet, many states are projected to do so in the next few years.

*How would a waiver change the way Medicaid is financed?* The kind of waiver that Florida is contemplating is known as a "Section 1115" Medicaid waiver.[9] There are many kinds of Section 1115 waivers; each needs to be considered on its own merits. The state is likely to seek approval for the Medicaid reform waiver under the Health Insurance Flexibility and Accountability (HIFA) initiative.[10]

The federal government (the Centers for Medicare and Medicaid Services - CMS) negotiates the waivers and has always required that no more federal funds be spent under the waiver than would have been spent without the waiver. This concept is known as *budget neutrality*. The way that this concept of budget neutrality has been enforced by the federal government in the past appears to be changing – moving in some recent waiver approvals from a per capita cap to a global cap.[11] (See "Defining Terms: Per Capita Caps V. Global Caps")

*What would moving to a global cap mean for Florida?* If a waiver agreement is reached which establishes a global cap on federal funding, the state of Florida will receive a pre-determined, set amount of federal funding for the period of the waiver. The state would be solely at risk for any additional costs not anticipated in the formula. In exchange for accepting the cap, the state is likely to be given additional flexibility to expand coverage to childless adults who are otherwise ineligible for Medicaid, reduce benefits, raise cost-sharing, cap enrollment for certain populations, and take other measures to reduce costs.[12] Would this be a good trade-off?

A global cap would likely be constructed using two basic components: a base amount and an inflation or growth factor. The base amount, in effect, is a snapshot of Florida's program at the time the waiver is negotiated. Florida's current Medicaid spending reflects state choices about covering optional populations and benefits as well as decisions about levels of provider reimbursement etc. As the chart below illustrates, Florida's current average spending per Medicaid beneficiary is quite low; the state ranks 39th out of 48 states.

### DEFINING TERMS: PER CAPITA CAPS V. GLOBAL CAPS

A *per capita cap* establishes a limit on the amount of federal funding per person that a state receives under a waiver program. Different groups of beneficiaries are likely to have different funding levels established to reflect higher and lower costs of serving them (for example children would be expected to have a lower per-person cap than the elderly). A per capita cap has a per-person limit in federal funding but no overall pre-set limit on federal funding that a state would receive. States are at risk for higher per person costs but not for higher enrollment.

A *global cap* establishes a pre-determined ceiling on the overall amount of federal funding that a state can receive for a specified period of time. For a Section 1115 waiver, this period is likely to be five years. A global cap would likely be determined by establishing a "base" level of funding, and applying an inflator or trend factor to increase the base amount over the specified period to account for inflation. Funding would no longer be tied to actual enrollment or linked to actual costs the state is incurring.

Low per capita spending generally reflects, among other things, low provider reimbursement. For the most costly population – the elderly – the state ranks 44 out of the 48 states for which data is available.[13] (See Figure 3)

Low per capita spending means that a global cap will lock Florida into a relatively low amount of funding per person that will make it difficult for the state to cover the cost of new drugs or other medical advances or make improvements such as increasing provider reimbursement or expanding coverage. Under Medicaid's current financing structure, the state would be assured that the federal government would incur 59% of the costs should the state need to cover a new cancer treatment or decide to raise provider reimbursement. Under a global cap the state would be responsible for 100% of the costs of such a change.

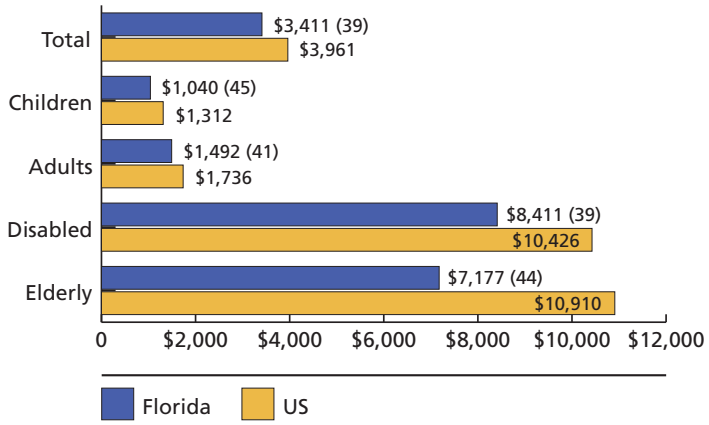
The second key component of a global cap formula is the growth rate or inflator. Growth factors attempt to account for increased health care costs and potentially unforeseen events such as natural disasters or epidemics, and changing demographics. Predicting future health care costs, however, is extremely difficult. In fact an examination of Florida's Medicaid expenditures recent growth illustrates how unpredictable growth rates can be. (See Table 1)

A state with a declining population may be more confident that a growth factor can be constructed to accommodate its needs. An examination of Florida's demographics, however, finds that *the state's population is growing particularly in those populations which are most likely to need intensive Medicaid services*. As Figure 4 illustrates, Florida's low-income elderly population is growing at a much faster rate than the U.S. average. From 1992-2002, Florida's annual average growth rate for elderly persons under 200% of the poverty level was 2.26% -- more than eight times higher than the U.S. average of .27%.[14] (See Figure 4)

Similarly Florida's growth rate for people with disabilities (including people who are blind) who are Medicaid-eligible was almost three times the national average over a recent five-year period. (See Figure 5)

In addition, the number of low-income children in Florida has been declining at a slower rate than the national average.[15]

## Figure 3: Florida's Medicaid Expenditures Per Beneficiary, By Category, 2001




*Source: Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data. US Total excludes Hawaii and Washington, neither of which have submitted their data to CMS yet.*

*Note: National Rank in parenthesis*

## CONCLUSION

A Section 1115 waiver which establishes a global cap on the level of federal Medicaid funding that Florida receives is likely to be problematic. Florida's demographics, in particular the rapid growth in low-income elderly and disabled persons, and historically low levels of Medicaid spending per beneficiary could combine to lock in an artificially low level of federal Medicaid spending relative to the health needs of Floridians. The state would likely be granted new options to reduce benefits, raise cost-sharing and establish waiting lists – options the state would likely use to avoid hitting the cap which would have troubling consequences for beneficiaries. In addition already low levels of provider reimbursement are likely to experience downwards pressure. Finally, if Medicaid funding can't meet the needs of these most vulnerable populations, someone else will have to step in. Major changes could result in shifting costs to other parts of the state's health care system.

*On July 1, 2003 Florida implemented an enrollment freeze in its KidCare program; state officials argued that they needed to stop enrolling children to avoid hitting the cap on their federal SCHIP funds.*[16]

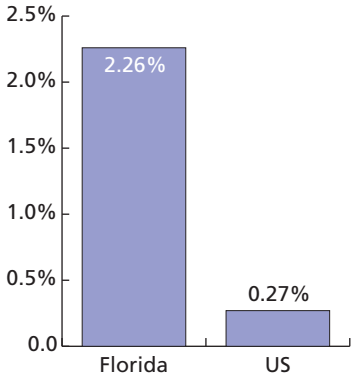
## Table 1: Florida's Medicaid Expenditure Growth for Recent Three Year Periods

| | |
|---|---|
| 1991-1993 | 22.7% |
| 1994-1996 | 5.39% |
| 1997-1999 | 3.01% |
| 2000-2002 | 14.6% |

*Source: Georgetown Health Policy Institute analysis*

## Figure 4: Florida's Growth in Low-Income Elderly Exceeds that of the US

*(1992-2002)*

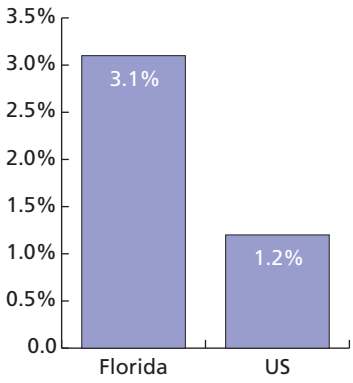



*Note: Low-Income refers to income less than 200% of the federal poverty level ($30,040/year for a family of three in 2002).*

*Source: Georgetown University Health Policy Institute analysis based on March 1993-2003 Current Population Surveys.*

## Figure 5: Florida's Growth in Blind and Disabled SSI Beneficiaries Exceeds that of the US

*(1996-2003)*




*Source: Georgetown University Health Policy Institute analysis based on Social Security Administration Annual Reports, 1996-2003.*

## FOOTNOTES

1 Data from the Centers for Medicare and Medicaid Services (CMS) forms CMS-37 and CMS-21B.

2 Letter from Mary Pat Moore, Interim Secretary, Florida Agency for Health Care Administration, March 30, 2004.

3 See most recently "Bush Strives to Rein in Medicaid" *St. Petersburg Times,* February 22, 2004.

4 Bureau of Program Analysis, Agency for Health Care Administration, April 2004.

5 Schneider A, et. al. *The Medicaid Resource Book.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), July 2002.

6 Urban Institute estimates, based on data from federal fiscal year 1998 HCFA 2082 and HCFA-64 reports, 2001.

7 Data from Tony Swanson, Management Analyst Supervisor, Fiscal Planning Section, Bureau of Medicaid Programming Analysis, AHCA, telephone conversation 4/21/04.

8 All states are currently receiving a temporary increase in the federal matching assistance percentage of 2.95 percent as a result of the "Jobs and Growth Tax Relief Reconciliation Act of 2003". This enhanced matching rate will expire on June 30, 2004 and Florida's FMAP will revert to 59 percent. Federal Register: December 3, 2003 (Volume 68, Number 232), pps. 67676-67678.

9 Section 1115 refers to the section of the Social Security Act which authorizes research and demonstration waivers. For more information on Section 1115 waivers generally, see Jeanne Lambrew, *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2001).

10 For more information on HIFA waivers see http://www.cms.hhs.gov/default.asp. Also see Mann, C., Artiga, S. and Guyer, J. *Assessing the Role of Recent Waivers in Providing New Coverage* (Washington, DC; Kaiser Commission on Medicaid and the Uninsured), December 2003.

11 See Guyer, J. *The Financing of Pharmacy Plus Waivers: Implications for Seniors on Medicaid of Global Funding Caps* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), May 2003.

12 For an examination of the kinds of policy choices states are pursuing through recent Section 1115 waivers to reduce costs, see S. Gill and C. Mann *Section 1115 Medicaid Waivers at a Glance: A Look at Recent State Activity.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), April 2003.

13 Georgetown Health Policy Institute analysis based on CMS MSIS 2001 data. The US total excludes Hawaii and Washington which have not yet submitted their data.

14 Georgetown Health Policy Institute analysis based on March 1993-2003 Current Population Surveys.

15 Florida's rate is -.22% as compared to a U.S. average of -.46%. Georgetown Health Policy Institute analysis based on March 1993-2003 Current Population Surveys.

16 Cohen Ross, D. and Cox L. *Out in The Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children* (Washington DC: Center on Budget and Policy Priorities) January 2004.

## WHAT COULD A WAIVER TO RESTRUCTURE MEDICAID MEAN FOR FLORIDA?

First in a series of educational briefs on issues impacting Florida's families – Florida's Health at Risk. Published by the Winter Park Health Foundation.

Winter Park
HEALTH FOUNDATION

CO-AUTHOR
Joan Alker
Health Policy Institute
Georgetown University
2233 Wisconsin Avenue NW, Suite 525
Washington, DC 20007
202-687-0880
jca25@georgetown.edu
www.ihcrp.georgetown.edu

CO-AUTHOR
Lisa Portelli
Winter Park Health Foundation
1870 Aloma Avenue, Suite 200
Winter Park, FL 32789
407/644-2300
lportelli@wphf.org
www.wphf.org