

Understanding Medicaid

Time:	Thursday, January 9, 2003 1:15 p.m. - 3:15 p.m.
Format:	Presentation and Discussion
Presenter:	Vernon K. Smith, Ph.D. Health Management Associates Lansing, MI
Florida Panelists:	Bob Sharpe, M.S.W. Deputy Secretary Florida Agency for Health Care Administration Tallahassee, FL Betsy Shenkman, Ph.D. University of Florida Gainesville, FL Mark H. Schlein, J.D. Senior Assistant Attorney General State of Florida Tallahassee, FL
Objectives:	<ul style="list-style-type: none">• Identify the structure and major functions of the Medicaid program and the options States have for tailoring Medicaid to meet local needs.• Describe the basic structure and goals of the State Children's Health Insurance Program (SCHIP).• Discuss factors contributing to rising program costs and explain what some States are doing to control costs.• Discuss the issue of fraud and abuse and Florida's efforts to curb these problems.



Materials:

- Smith presentation
- Smith V, Ellis E, Gifford K, Ramesh R, Wachino V. Medicaid Spending Growth: Results of a 2002 Survey. Kaiser Commission on Medicaid and the Uninsured. October, 2002. (Executive Summary and Introduction)
Available via: www.kff.org/content/2002/4064/4064.pdf
- Sharpe presentation
- Shenkman presentation
- Schlein presentation
- Ellis E, Smith V, Rousseau D. Medicaid Enrollment in 50 States: December 2001 Data Update. Kaiser Commission on Medicaid and the Uninsured. September, 2002.
Available Via: www.kff.org/content/2002/4067/4067.pdf

Bibliography: (Further suggested reading)



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Vernon K. Smith, Ph.D.



Understanding Medicaid: Challenges and Strategies in a Time of State Budget Shortfalls

*Vernon K. Smith, Ph.D.
Health Management Associates*

**2003 Florida Health Care Summit
Tallahassee, Florida
January 10, 2003**

What Medicaid Has Become: The Largest Health Program in America

- Health coverage for 47 million Americans in 2002
(Medicare covered 40 million in 2002)
 - Pays for over 1.3 million births annually
(37% of U.S. total in 1999)
 - Covered 24 million children in 2002
(U.S. Census counted 75.8 million children in 2001)
 - Pays for over half of HIV/AIDS care
 - Pays for 2/3 of nursing home patients-- half of all care
- Increasingly fills the gaps in Medicare
 - Covers 7 million low-income elderly and disabled
persons also on Medicare for Rx, nursing home care,
other services, premiums, coinsurance and deductibles

Sources: CBO Medicaid Baseline March 2002, NGA, SAMHSA, U.S. Census,
Kaiser Commission on Medicaid and the Uninsured.

Medicaid Has Become *The* Financing Vehicle for State and Local Health Care

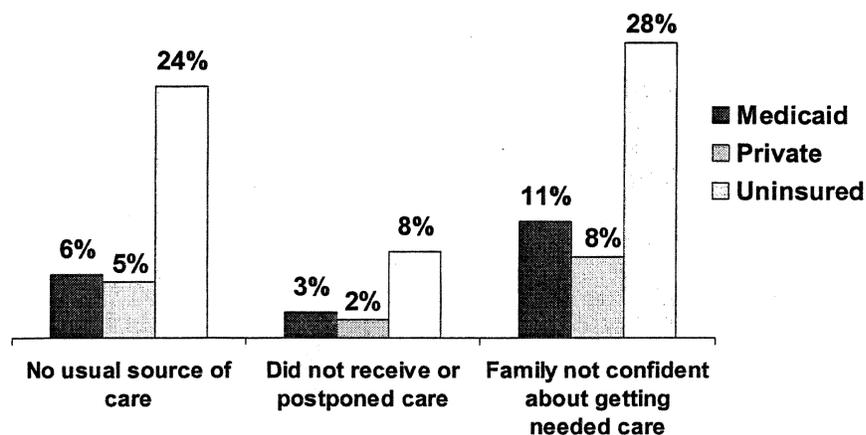
- Finances state and local health care provided through public health, mental health and other agencies
 - Over half of all publicly financed mental health care in U.S.¹
 - \$14 billion in disproportionate share payments to hospitals³
 - Unparalleled support for health care safety net
 - Has become the largest single source of federal grants to states— 44% of all federal funds to states in 2001²
- Spending exceeded \$250 billion in FY2002 (in federal, state and local funds)

Sources: ¹SAMHSA, ²NASBO, ³CBO March 2002 Medicaid Baseline.

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Medicaid Coverage for Low-Income Children Means Access to Care Similar to Private Insurance

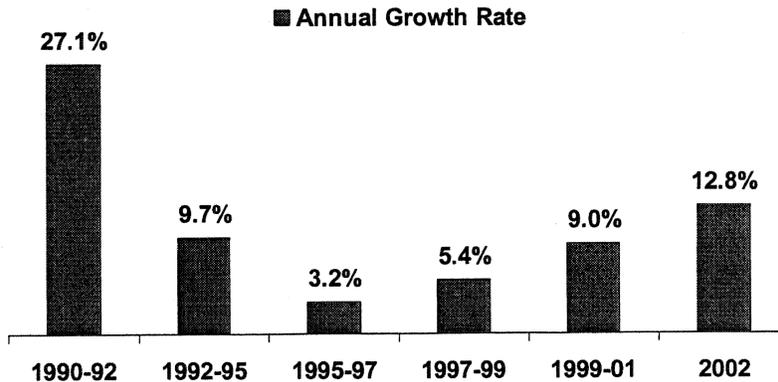


SOURCE: Dubay and Kenney, Health Affairs, 2001. Data are for 1997.

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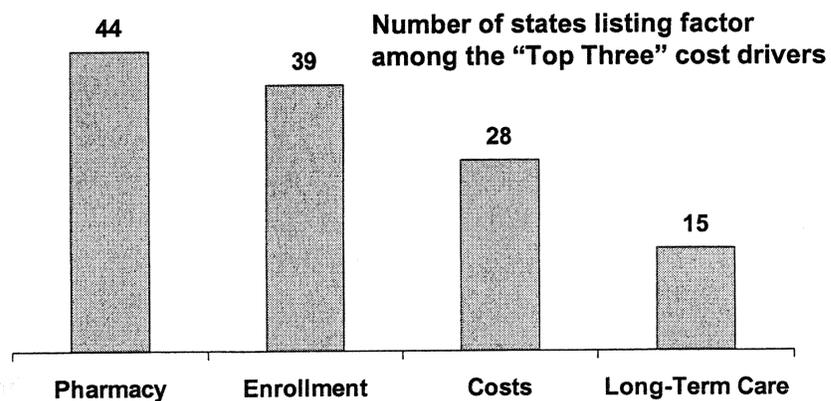
Average Annual Growth Rates of Total Medicaid Spending



SOURCE: 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, 2000. 2000-2002: Vernon Smith, Eileen Ellis, Kathleen Gifford, Rekha Ramesh and Victoria Wachino, *Medicaid Budget Trends: Results of a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication 4064. <http://www.kff.org/content/2002/4064/4064.pdf>
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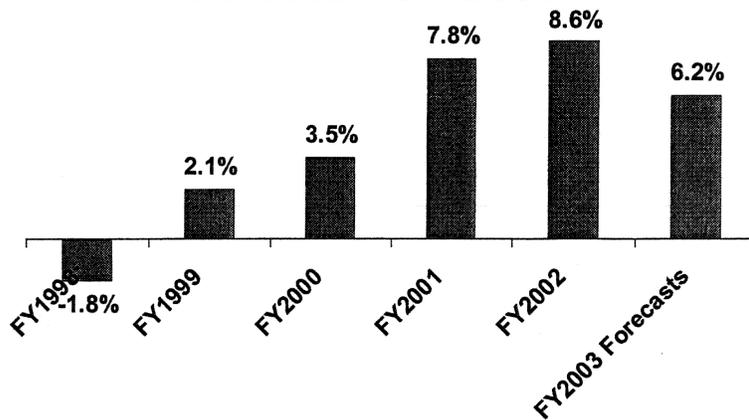
Key Factors Causing Medicaid Spending Growth in 2002



SOURCE: Vernon Smith, Eileen Ellis, Kathy Gifford, Rekha Ramesh and Victoria Wachino, *Medicaid Spending Growth: Results of a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication 4064. <http://www.kff.org/content/2002/4064/4064.pdf>
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U.S. Medicaid Enrollment Increases FY 1998 – FY 2003

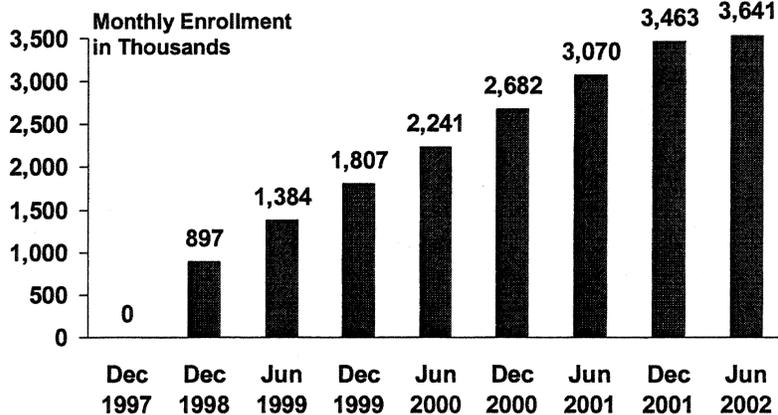


SOURCES: FY 1998-2001: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: December 2001 Data Update*, Kaiser Commission on Medicaid and the Uninsured, October 2002. Publication #4067. FY 2002-2003: Vernon Smith, Eileen Ellis, Kathleen Gifford, Rekha Ramesh and Victoria Wachino, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002. Publication #4064.

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Total SCHIP Enrollment in 50 States and the District of Columbia

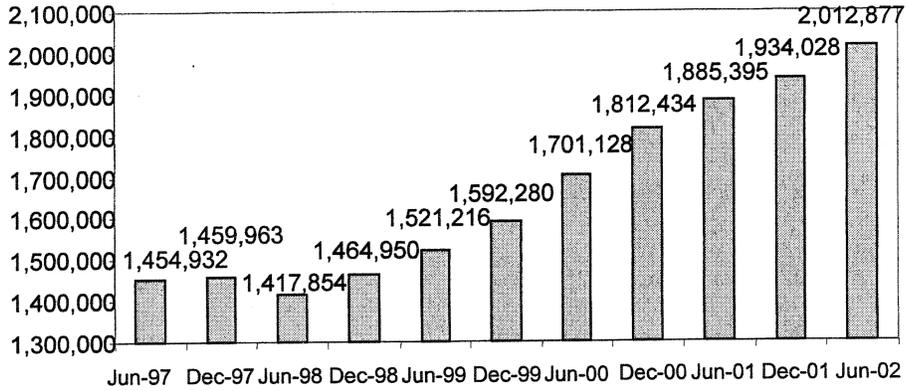


Note: SCHIP enrollment includes enrollment in separate CHIP programs and CHIP-funded Medicaid expansions. SOURCE: Vernon K. Smith and David M. Rousseau, *SCHIP Program Enrollment: June 2001 Update*, Kaiser Commission on Medicaid and the Uninsured, October 2002. Publication #4068.

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Total Florida Medicaid Enrolment

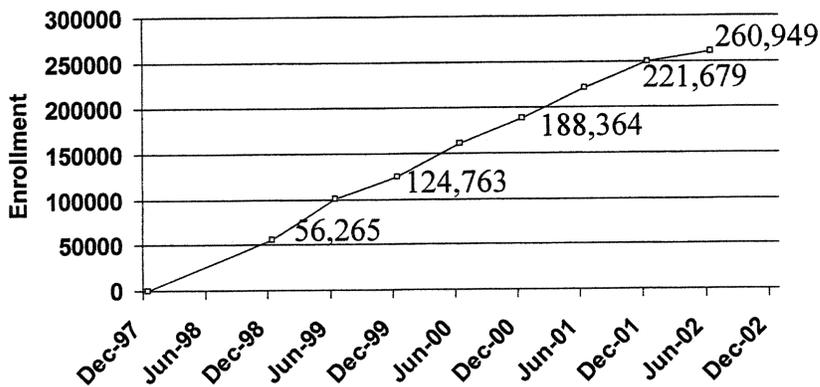


Source: HMA Survey of states for Kaiser Commission on Medicaid and the Uninsured, 2002.

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State Children's Health Insurance Program Florida SCHIP Enrollment



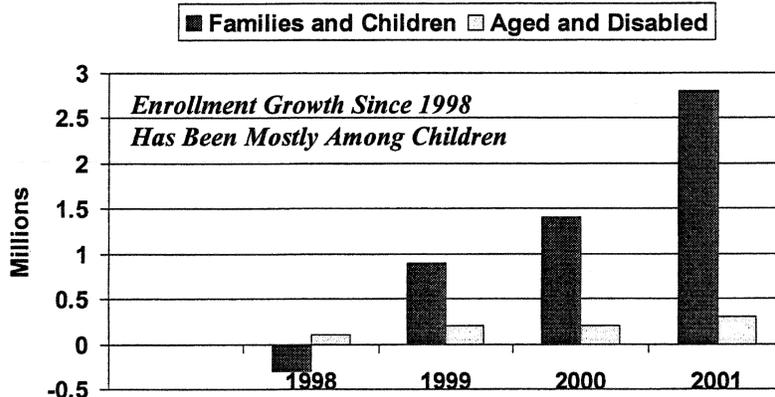
Source: Vernon Smith and David Rousseau, *SCHIP Program Enrollment: June 2002 Update*.

Kaiser Commission on Medicaid and the Uninsured, October 2002. Publication #4068.

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U.S. Medicaid Enrollment Growth: Children and Families Vs. Aged and Disabled 1998 - 2001



*Note: Based on data from 44 states.

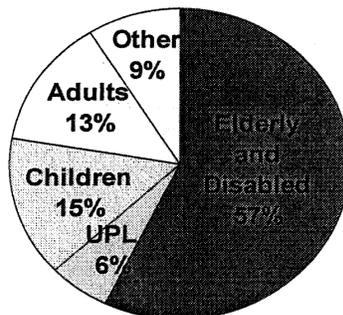
Source: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: December 2001 Data Update*, Kaiser Commission on Medicaid and the Uninsured, October 2002. Publication #4067. <http://www.kff.org/content/2002/4067/4067.pdf>

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Sources of Growth in U.S. Medicaid Expenditures, by Eligibility Group 2001-2002

2002 Spending Growth was Mostly Among Aged and Disabled



Total Increase = \$15.7 billion

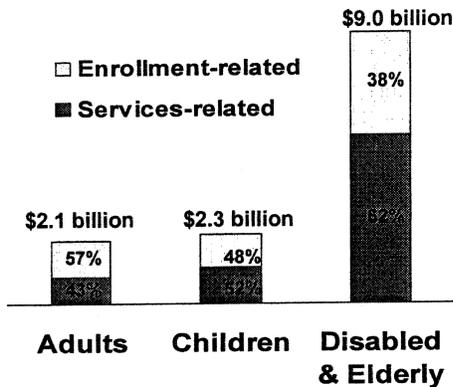
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Federal Medicaid baseline, March 2002.

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Sources of Growth in U.S. Medicaid Expenditures, Enrollment vs. Services 2001-2002

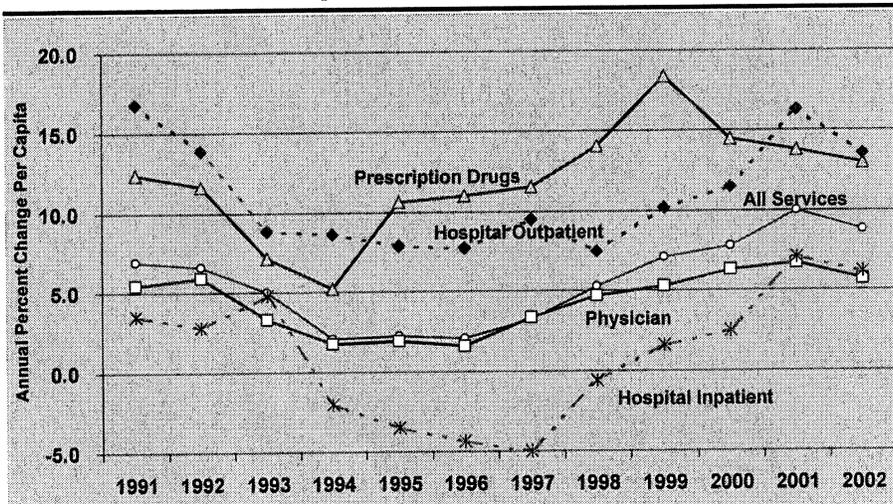
2002 Expenditure Growth for Was More Services-Related than Enrollment-Related



SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Federal Medicaid baseline, March 2002. Smith

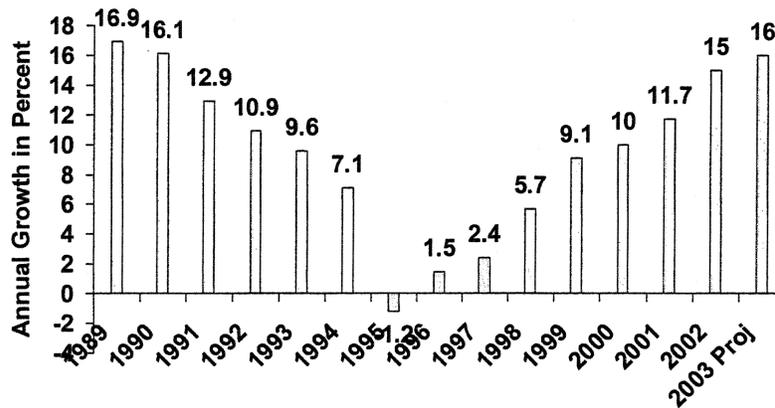
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Annual Percentage Change Health Care Spending, 1991-2002



Source: Milliman USA Health Cost Index, cited in Strunk, Ginsburg and Gabel, "Tracking Health Care Costs," Health Affairs Web Exclusive, 25 September 2002.

Average U.S. HMO Premium Increases 1988 – 2003

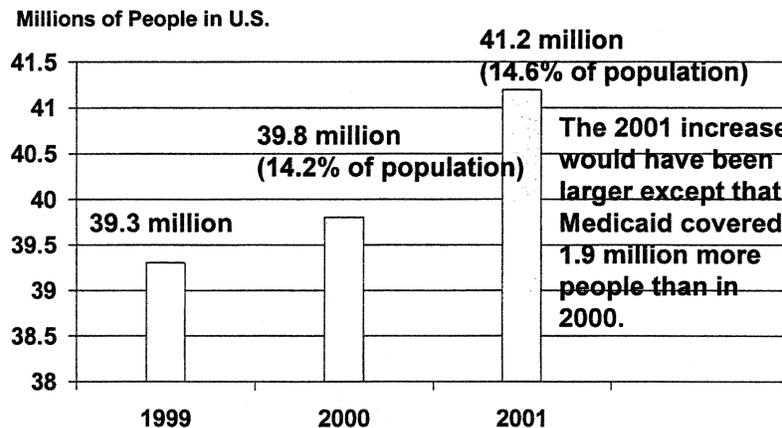


SOURCE: 1989-2002, AAHP, Mercer and Robert Hurley. 2003, Hewitt Associates

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As Health Insurance Premiums Rise, More Persons become Uninsured



U.S. Census Bureau, September 30, 2002.

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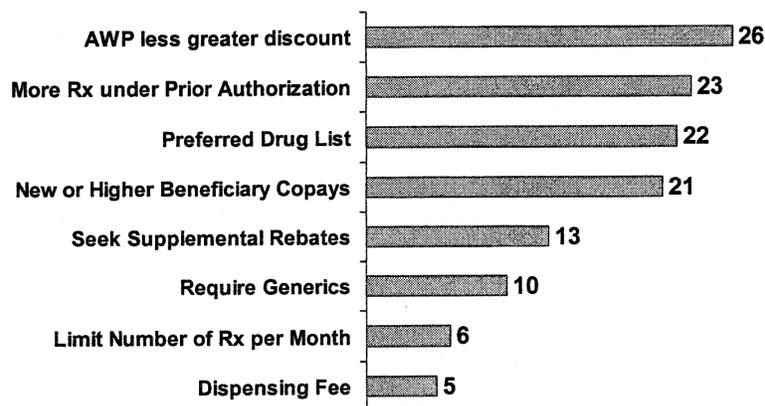
How are States Trying to Slow the Growth in Medicaid Spending?

- Rx controls
- Rate cuts or freezes
- Eligibility cuts
- Benefit cuts
- Beneficiary copays
- Administrative actions

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FY2003 Medicaid Pharmacy Policy and Payment Changes in 40 States

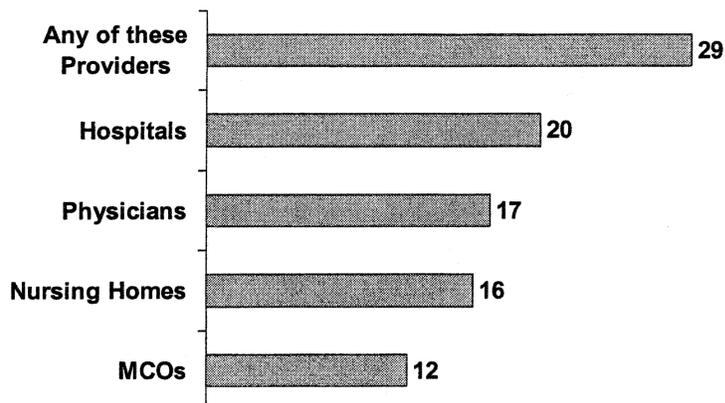


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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Medicaid Provider Payment Rates: 29 States Planned to Cut or Freeze Rates in FY2003



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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FY2003 Eligibility Cuts and Restrictions

- **Some states adopted plans to end eligibility for persons now on Medicaid:**
 - *Missouri* cut 32,000 adults effective July 1; TRO restored half
 - *Massachusetts* to eliminate coverage for 50,000 unemployed adults effective April 1, 2003
- **Mid-year cuts in FY2003 will result in further cuts in eligibility: For example**
 - *Nebraska* is cutting eligibility for 25,000 children and adults
 - *Oklahoma* proposed ending eligibility for 93,000 adults and children –now on hold
 - *Michigan* legislature on 12/5/03 approved cut of 40,000 beginning on March 1, 2003

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates

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Other FY 2003 Eligibility Restrictions

- ***New Jersey:*** stopped accepting Family Care applications on June 16, 2002, dropped (section 1931) income disregard for applicants, plans to increase reliance on charity care

- ***Missouri:*** reduced coverage for Transitional Medical Assistance and post-partum pregnancy-related care from two years to one year

- ***Tennessee:*** began redeterminations of eligibility for TennCare waiver enrollees – expected to cut 70,000+

-
- **Other states:**
 - restored asset tests and income reporting requirements for families and medically needy individuals
 - restricted spend-down (e.g., by limiting countable expenses)

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates

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FY2003 Benefit Cuts

- **15 states planned to reduce benefits**

- **Adult dental benefits were cut or restricted in eight states**

- **Other cuts included restrictions on home health, podiatry, chiropractic services, eyeglasses, psychological counseling**

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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Other Current Medicaid Strategies to Control Cost Growth FY 2003

- **New or higher copays – 15 states**
 - for vision, dental, podiatry, chiropractic, hearing
 - Partially to reduce direct costs and partially to make beneficiaries more cost conscious
- **Managed care expanded – 12 states**
 - Both HMO and primary care case management (PCCM) being expanded to additional counties.
 - Change from optional to mandatory enrollment.
 - Moving disabled and elderly into managed care.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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Other Current Medicaid Strategies

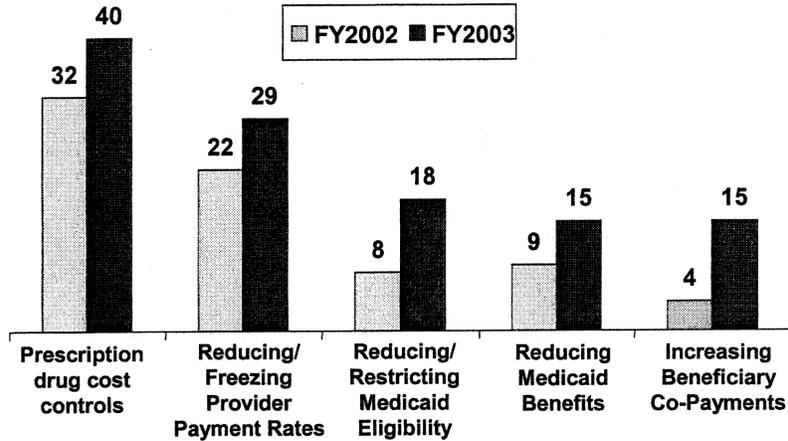
- **Strategies to organize health care --**
 - 21 states
 - Disease management and case management
- **Fraud and abuse controls, new or expanded**
 - 18 states
 - Focus on increased program integrity
- **Long Term Care**
 - 13 states
 - New payment methods, expanded community services
- **Maximizing Medicaid**
 - Use other funds (e.g., provider taxes) for non-federal share
 - “Medicaid-izing” state health programs

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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States' FY2002 and FY2003 Cost Containment Strategies to Control Spending Growth



SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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Half the States Expected to Submit a Waiver in FY 2003

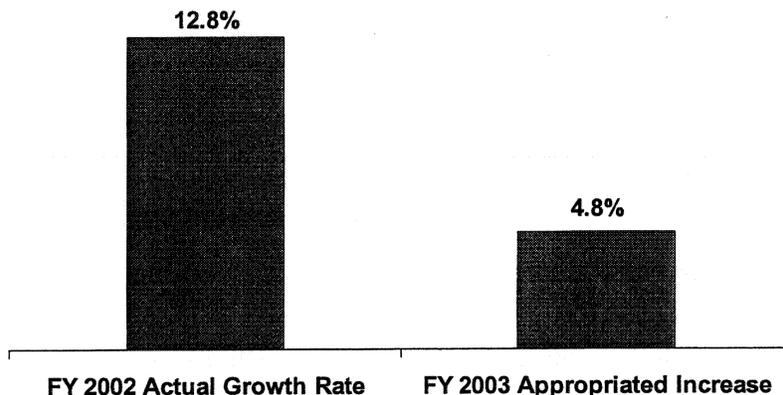
- Many states plan to use waivers to add, restructure or refinance Medicaid coverage
 - HIFA / Section 1115 waivers can add coverage for adults by restructuring benefits for other groups and using unspent SCHIP funds.
 - HIFA waivers can also be used to relieve fiscal pressures.
 - Pharmacy Plus waivers can provide a Medicaid-funded low-income senior prescription drug benefit and, in at least some states, refinance existing state drug assistance programs.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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Medicaid Expenditure Growth Rates FY 2002 Actual and FY 2003 Appropriated

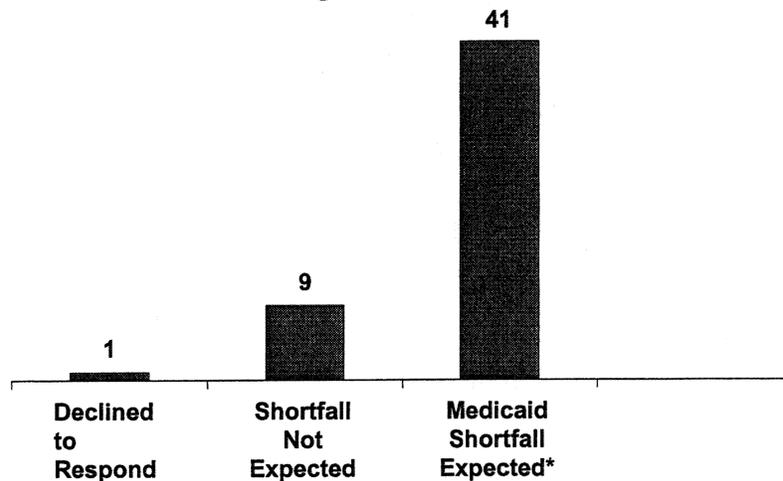


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.
Note: Percentages are unweighted averages of all 50 states and DC.

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Number of States Expecting a Medicaid Budget Shortfall in FY2003



NOTE: 41 states indicated the likelihood of a shortfall in FY2003 was 50% or greater.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

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2002 Was Toughest State Budget Year on Record

"A national recession ...pushed state budgets to their lowest point ever."

- Overall FY2002 budget shortfalls were estimated at 7.8% of revenues (previous high was 6.5% in 1992.)
- Mid-year budget cuts in 39 states (previous high was 35 states in 1992)

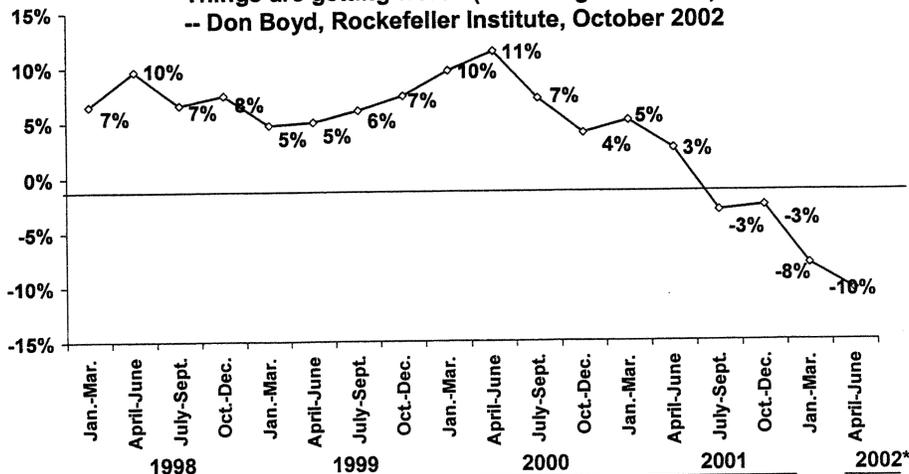
Source: National Association of State Budget Officers, *The Fiscal Survey of States*, May 2002.

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Change in Quarterly State Tax Revenue, FY 1999-2002

"Things are getting worse (and will get 'worsen')."
-- Don Boyd, Rockefeller Institute, October 2002



NOTE: Data for 2002 preliminary.

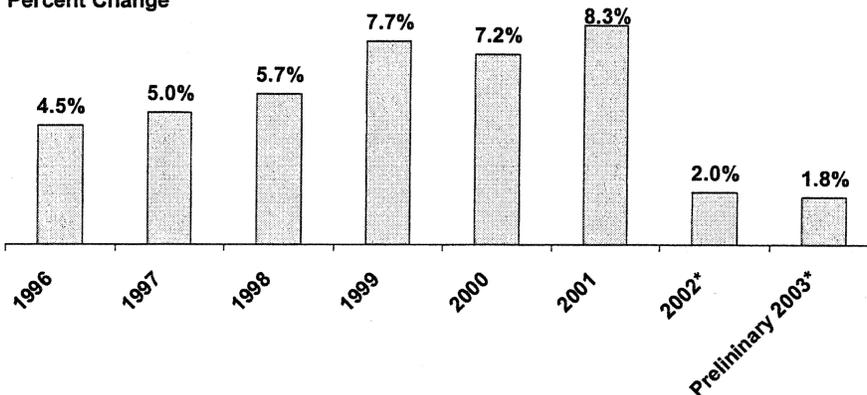
SOURCE: Rockefeller Institute of Government, *State Fiscal Brief*, 2001 and 2002 and *State Revenue Report*, September 2002

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Increases in State General Fund Spending FY 1996-2003

Percent Change



*NOTE: FY 2002 numbers are estimates and FY 2003 numbers are from NCSL Survey, July 2002.

SOURCE: National Association of State Budget Officers, May 2002.

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In State Budgets, Medicaid Spending Is the Biggest Issue

- **Spending growth: Medicaid vs. Total Budget**
 - FY2001 (actual)..... 10.6% vs. 8.3%
 - FY2002 (estimated)12.8% vs. 2.0%
 - FY2003 (appropriated)... 4.8% vs. 1.8%

Sources: NASBO, *The Fiscal Survey of States*, May 2002, and
Medicaid and Other State Healthcare Issues: The Current Situation.

A Supplement to the Fiscal Survey of the States, May 2002 .

FY2003 Medicaid from HMA survey for Kaiser Commission on Medicaid and the Uninsured
June 2002; Budget from NCSL survey, July 2002.

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Outlook for 2003: “Health-care costs are rising even faster than feared.”

- *Wall Street Journal*, October 2, 2002, reporting health benefit costs will rise by 15% in 2003, exceeding expected growth of 12%, according to Towers Perrin survey of large firms.
- Premiums “will rise 15.4% in 2003. [HMOs] will rise 16%”
 - *New York Times*, October 15, 2002, Hewitt Associates survey of 139 markets.
- Employer health costs to be up 14.6% in 2003.
 - *Wall Street Journal*, reporting Mercer Consulting survey of 2,900 public and private employers nationwide, December 9, 2002.
- Medical claim costs will increase 14% to 16% next year, the highest increases in a decade
 - The 2003 Segal Health Plan Cost Trend Survey

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Looking to the near future: “Oh my, the outlook for FY 2004 is unbelievably bad.” --State Official

- Expect Medicaid enrollment to increase, with increasing growth among the elderly and disabled
- Expect Medicaid cost growth to outpace growth in state revenues and other state programs
- Expect budget-driven pressure to examine all areas of Medicaid to slow spending growth
- Expect states to have to deal with Medicaid issues with little help from Washington

Source: Health Management Associates

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BACKGROUND MATERIALS

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Vernon K. Smith, Ph.D.



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commission on
medicaid
and the **uninsured**

**MEDICAID SPENDING GROWTH:
RESULTS FROM A 2002 SURVEY**

Prepared by

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Rekha Ramesh
Health Management Associates

Victoria Wachino
Kaiser Commission on Medicaid and the Uninsured



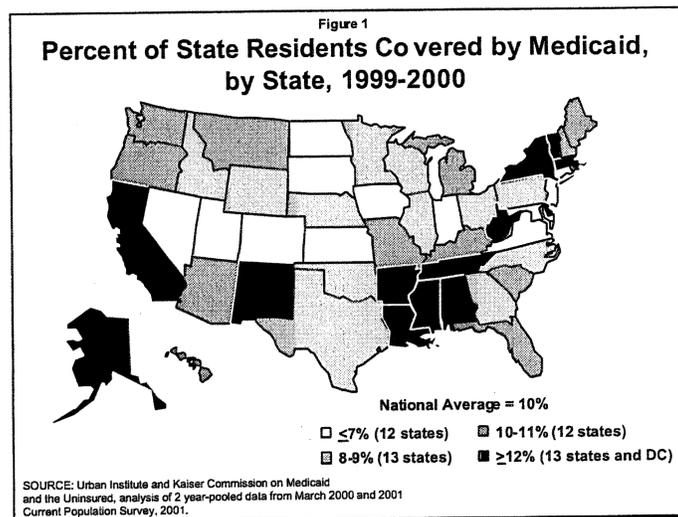
September 2002



Executive Summary

Medicaid, a joint federal-state program, plays a significant role in the lives of low-income people. It is expected to cover more than 47 million people this year, according to the Congressional Budget Office, including nearly 24 million children, 11 million adults, and more than 13 million elderly and disabled individuals. Federal Medicaid matching payments are projected to be \$147 billion in fiscal year 2002, while state spending is estimated at about \$100 billion.

Medicaid is often the only source of health coverage available for low-income children, a critical support for people with disabilities in the community and the sole source of financial assistance for most nursing home care. Medicaid covered about one in every 10 Americans, although this percentage varies by state (Figure 1).



To meet the diverse needs of the population it serves, Medicaid covers a broad range of health and long-term care services, including physician and hospital services, nursing home care and prescription drugs. Because the elderly and disabled tend to use more expensive services, they account for most of Medicaid's costs – although the elderly and disabled represent just over one-quarter of Medicaid enrollees, they account for two-thirds of Medicaid spending (Figure 2). Medicaid is the largest single purchaser of maternity care and pays for half of all nursing home care. Its significant support for hospitals and other health care providers means that Medicaid also plays a role in sustaining local economies. Medicaid is also the largest source of federal funds to the states, accounting for 43 percent of all federal grants-in-aid.

being depleted as states face what is for many their third consecutive year of budget shortfalls. At the same time, as the cost of health care services has grown, spending on Medicaid has been increasing significantly. During times of economic downturn, enrollment in Medicaid generally increases, adding to states' Medicaid costs.

Because Medicaid represents such a large part of their budgets and Medicaid costs are increasing faster than those of other state programs, many states have focused on Medicaid as a key part of their efforts to balance their state budgets. To identify state Medicaid spending trends and how states are responding to these trends and their overall fiscal conditions, the Kaiser Commission on Medicaid and the Uninsured contracted with Health Management Associates (HMA) to conduct a survey of Medicaid officials in all 50 states and the District of Columbia. The survey was purposefully conducted in May and June 2002, so states could describe specific actions taken in FY 2002 and their plans for FY 2003. This is the second year in which this survey has been conducted by HMA for the Kaiser Commission on Medicaid and the Uninsured. This report presents the findings from the 50- state survey.

The survey found that states are facing significantly increased Medicaid costs and that the overwhelming majority of states are implementing Medicaid cost control strategies. For the second year in a row, Medicaid spending has increased by more than 10 percent. States reported that in fiscal year 2002, total Medicaid spending increased 13 percent, while the state share of Medicaid spending increased 11 percent. These rates of growth are consistent with those of private health insurance, where premiums grew 12.7 percent in 2002, according to a recent Kaiser Family Foundation/Health Research and Educational Trusts survey.

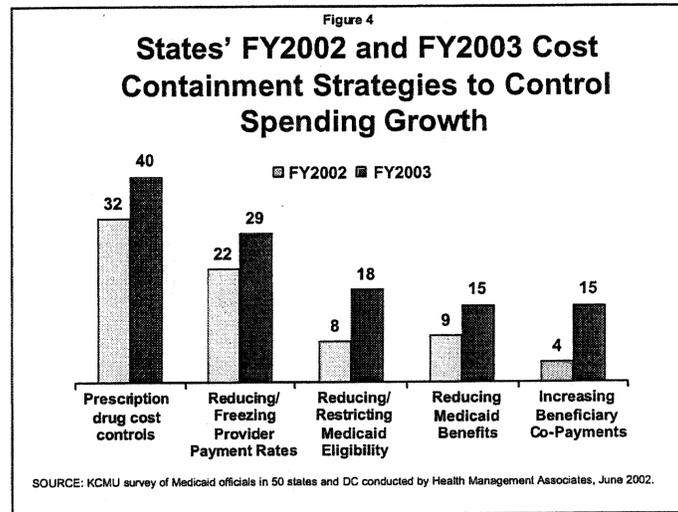
According to the states, increasing pharmacy costs and increased enrollment are the primary factors behind Medicaid spending growth:

- Forty-four states cited increased spending on prescription drugs as one of the three most significant factors increasing their Medicaid costs, and 25 of those states ranked prescription drugs as the single most significant factor behind increased Medicaid costs. States reported that increased use of drugs, the use of new drugs, and price increases for prescription drugs were factors behind their overall increased pharmacy spending.
- Thirty-nine states indicated that increased enrollment was one of the three greatest sources of Medicaid spending growth. Eighteen states cited increased enrollment as the most significant factor behind the state's Medicaid spending increase. States described two dynamics as underlying the growth in Medicaid enrollment: the economic downturn, which has caused more people to qualify to be eligible for Medicaid, and expansions in eligibility and outreach that states have undertaken in recent years.

Increased cost and use of medical care services as well as the cost of long-term care are also significant factors increasing Medicaid spending, according to the state officials surveyed. These factors, and the increasing cost of prescription drugs, are also significant factors driving the increase in private-sector health insurance.

In response to their overall fiscal situations and these Medicaid cost pressures, 45 states took action to reduce their Medicaid spending growth in Fiscal Year 2002. Forty-one states reported that they have plans underway to take additional actions for FY 2003, which started July 1 in

most states. As the fiscal year progresses, it is likely that more states will act to reduce their Medicaid spending. It is also notable that for each type of cost containment strategy, more states reported planning to undertake action in FY 2003 compared to FY 2002.



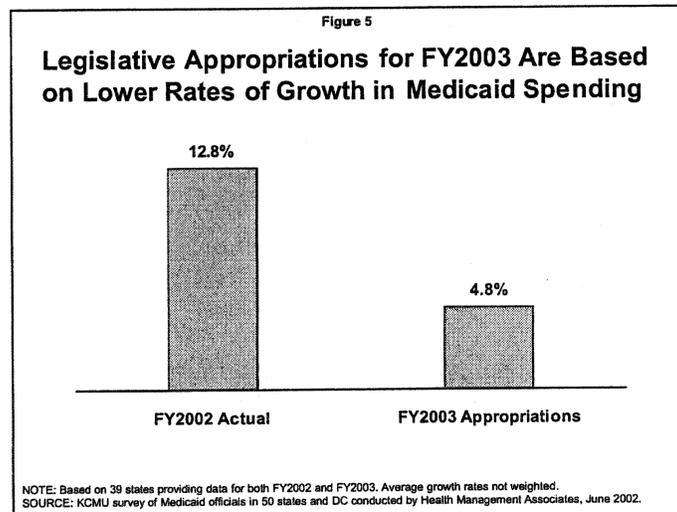
The most common cost containment action that states are undertaking are policies to control the cost and use of prescription drugs, but states are also limiting payments to providers, eliminating some benefits, and restricting eligibility (Figure 4):

- Forty states are planning to implement prescription drug cost controls in FY 2003, an increase over 32 states in FY 2002.
- A majority of states, 29, are either reducing or freezing some of their provider payment rates in FY 2003. Twenty-two states reported provider rate cuts or freezes for FY 2002.
- Fifteen states are reducing Medicaid benefits in FY 2003. Eight of these states reduced dental benefits; states reduced other benefits, such as home health, podiatry, and optical services as well. Nine states reduced benefits in FY 2002.
- Eighteen states are reducing or restricting Medicaid eligibility. Eight states implemented eligibility restrictions in FY 2002. Four states (Missouri, New Jersey, Nebraska, and Massachusetts) eliminated eligibility for thousands of people. States have also restricted eligibility by changing rules related to transitional medical assistance or changing rules related to their medically needy programs that will make fewer people eligible for Medicaid.
- Fifteen states are increasing beneficiary co-payments for services other than prescription drugs. Four states increased co-payments for non-prescription drug services in FY 2002.

In most cases, these cost reduction strategies slowed the rate of growth in Medicaid spending, but not enough to keep spending within the original legislative appropriation for the program. As a result, additional funding was required. Thirty-six states reported that their Medicaid programs received supplemental funding for Medicaid in FY 2002, an increase from the 31 states with supplemental funding in FY 2001. For FY 2003, 41 states reported that it is at least as likely as not that their Medicaid programs will require supplemental funding, with several states reporting that the need for supplemental Medicaid funding was already known to be certain.

Many states also indicated that they are seeking to make some longer-term, structural changes to their Medicaid programs through waivers. Seventeen states reported that they are developing or considering seeking waivers under the Center for Medicare and Medicaid Services' (CMS) Health Insurance Flexibility and Accountability initiative. Eighteen states also reported that they are developing pharmacy waivers, many of which would be submitted under CMS' "Pharmacy Plus" waiver guidelines.

The same pressures that increased Medicaid costs in FY 2002 will persist in FY 2003. State officials indicated that Medicaid enrollment is likely to continue to increase, particularly if the economy does not improve. State Medicaid enrollment forecasts are for increases that average 6.2 percent. Medical costs are expected to continue to increase as well, adding to the cost pressure, with prescription drug costs likely increasing again at double-digit rates. The factors that affect Medicaid are largely the same as those that increase costs for private insurance, where premiums increased by nearly 13 percent in 2002.

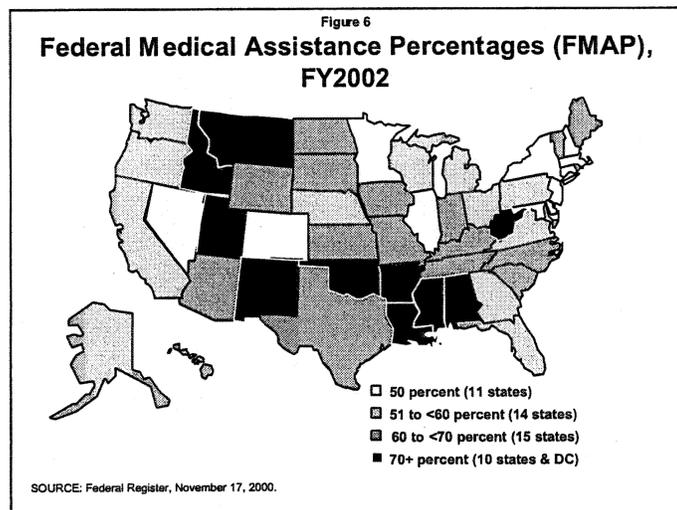


Despite these cost pressures, state legislatures appropriated increased funding for Medicaid for FY 2003 that averaged less than 5 percent (Figure 5). This suggests that in many states the original legislative appropriation will be insufficient to meet actual program expenditures. Medicaid officials indicated that further program cuts will likely be considered and additional funds will likely be needed in FY 2003. However, with state reserve and rainy day funds substantially depleted, it will be more difficult to find the funds needed to finance Medicaid this fiscal year and next.

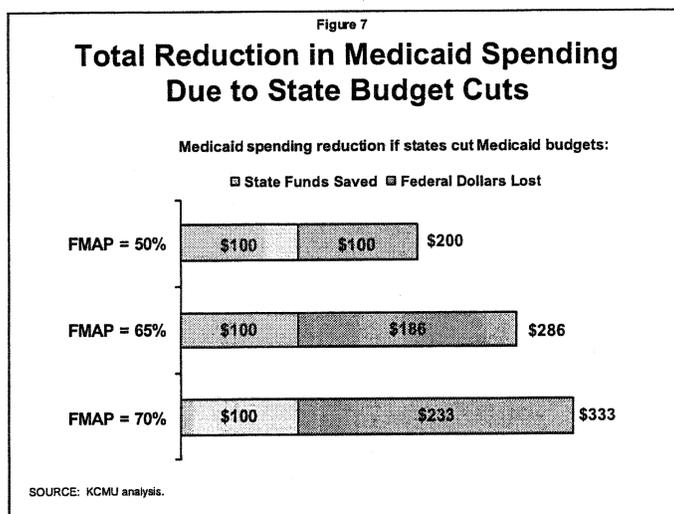
Introduction and Background

Medicaid is a joint federal and state program that is administered by the states within federal guidelines. Each state's Medicaid program is different, reflecting each state's priorities in coverage and benefits within the substantial flexibility states are afforded under federal law.

Within the federal structure, states enroll beneficiaries using their own eligibility criteria, decide which services are covered, and set payment rates for providers. States also decide other key policies, such as which eligibility groups receive care within a managed care system, how the state will use Medicaid to finance a range of other medical services such as those provided through the mental health or public health systems, and special payments to hospitals that serve a disproportionate share of indigent patients. While the federal government requires states that participate in Medicaid to provide a core set of benefits, it also permits states the flexibility to provide "optional" services at the states' discretion. Optional services include prescription drugs, which all states have elected to provide, as well as services like dental care, hospice care, and prosthetic devices.



The federal government and the states share responsibility for financing Medicaid. The federal government matches state spending for the services Medicaid covers on an open-ended basis. The federal matching rate, known as the federal medical assistance percentage (FMAP), varies by state and currently ranges from 50 percent to 77 percent and is based on state per capita income (Figure 6). On average, the federal government pays at least 57 percent of states' Medicaid expenditures. Because of the matching formula, state spending on Medicaid brings increased federal dollars to the state. For example, at a 50 percent matching rate, a state draws down one federal dollar for each state dollar it spends. At a 70 percent matching rate, a state draws down \$2.33 for every \$1 it spends (Figure 7). Medicaid's matching formula provides an important vehicle for states to leverage federal dollars to increase funding for health and long-term care services.



Medicaid finances almost three quarters of all state health spending. Federal Medicaid matching payments are designed to provide a fiscal incentive to states to extend health care coverage, because the federal government will pay at least half the cost of services that are allowable under Medicaid. Most states have used these open-ended matching payments to maximize the amount of federal Medicaid funds they obtain. States use Medicaid to fund many state public health services, mental health care, home health care, or school-based services, since many of the beneficiaries of these services are eligible for Medicaid. A few states also fund state health insurance programs or public health and hospital services through Medicaid, which can take significant fiscal pressure off of the state.¹ States have also employed a number of creative financing strategies to claim federal Medicaid matching funds up to upper payment limits, to the extent they are allowed under regulation. Using these strategies, sometimes in conjunction with intergovernmental transfers of funds, taxes on medical providers, or payments to disproportionate share hospitals, states can increase federal Medicaid payments with minimal or no increase in state funds. As a result of these state Medicaid maximization strategies, state spending on Medicaid frequently includes significant funding for a range of activities that go beyond a narrow definition of vendor payments for specific Medicaid services.

From a state fiscal perspective, Medicaid is a large program relative to the overall state budget. It is the second-largest item in most states' budgets, after elementary and secondary education. On average, states spend about 15 percent of their own funds on Medicaid, although that percentage varies from state to state based on the size of states' budgets and the decisions each state makes about how to carry out its program. Medicaid is the primary source of federal grant support to states, representing almost 43 percent of all federal grants to states.

Because of Medicaid's size, Medicaid expenditure growth can have an important impact on the overall fiscal condition of a State. As shown in Table 1, the share of state budgets allocated to Medicaid increased during the early 1990s, remained fairly stable in the late 1990s, and has recently started to increase somewhat.

¹ Teresa Coughlin and Stephen Zuckerman, "States' Use of Medicaid Maximization Strategies to Tap Federal Revenues," The Urban Institute, June 2002.



OVERHEADS

OVERHEADS

OVERHEADS

OVERHEADS

OVERHEADS

Bob Sharpe, M.S.W.



Florida Medicaid: A Status Report

The Health Summit

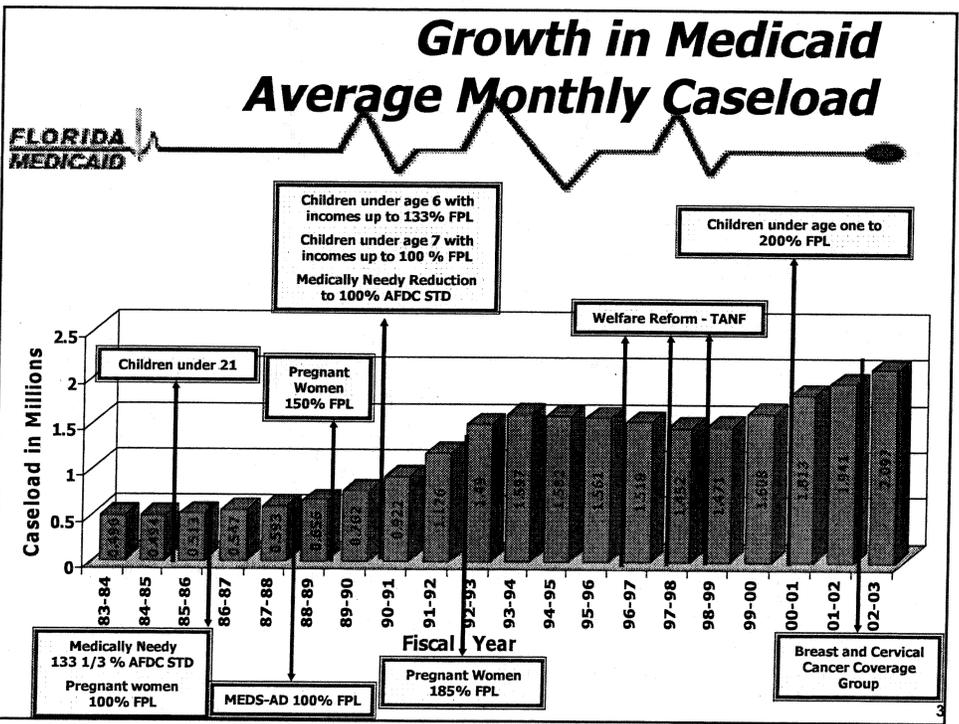
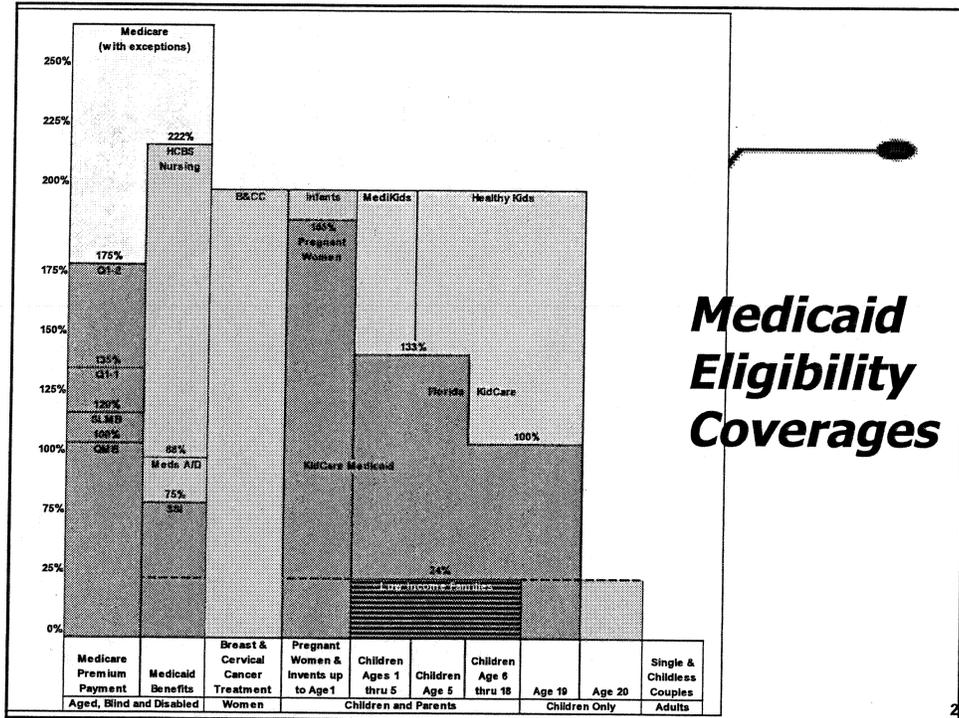
**FLORIDA
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*The Florida Legislature
January 9, 2003*

Medicaid Structure

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- ❖ *Federal Medicaid laws mandate certain benefits for certain populations*
- ❖ *But Medicaid programs vary considerably from state to state, and within states over time*
- ❖ *State Medicaid programs vary because of differences in:*
 - *optional service coverages*
 - *limits on mandatory and optional services*
 - *optional eligibility groups*
 - *income and asset limits to eligibility coverages*
 - *provider reimbursement levels*
- ❖ *Medicaid does not cover all low income individuals*
- ❖ *Individuals not covered are often working adults without children*
- ❖ *Medicaid serves the most vulnerable; in Florida:*
 - *27% of children*
 - *44% of pregnant women*
 - *66% of nursing home days*
 - *885,000 adults - parents, aged and disabled*
 - *52% of people with AIDS*



Florida Medicaid Eligibility Coverages

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FY 2002 - 03

TANF	24.4%	634,650
SSI²	73.75%	470,725
Unemployed Parent¹	24.2%	98,290
Medically Needy* ^{1 9}	24.2%	26,786
SOBRA Aged and Disabled (MEDS-AD)*	88.0%	96,552
Medicare Beneficiaries		
• Qualified Medicare Beneficiaries/ QMB	100%	22,426
• Specified Low Income Medicare Beneficiaries/SLMB	120%	35,607
• Qualified Individuals³	QI 1 135%	15,016
	QI 2 175%	

Mandatory * Optional Eligibility Categories Social Services Estimating Conference, October 16, 2002

¹ Family of 3; ²82.11% (Family of 2); ³100% Federally Funded; ⁹Effective May 1, 2003, the income standard is increased by \$270 for all beneficiaries except caretakers. The effective income limit will be about 46% FPL.

Florida Medicaid Eligibility Coverages

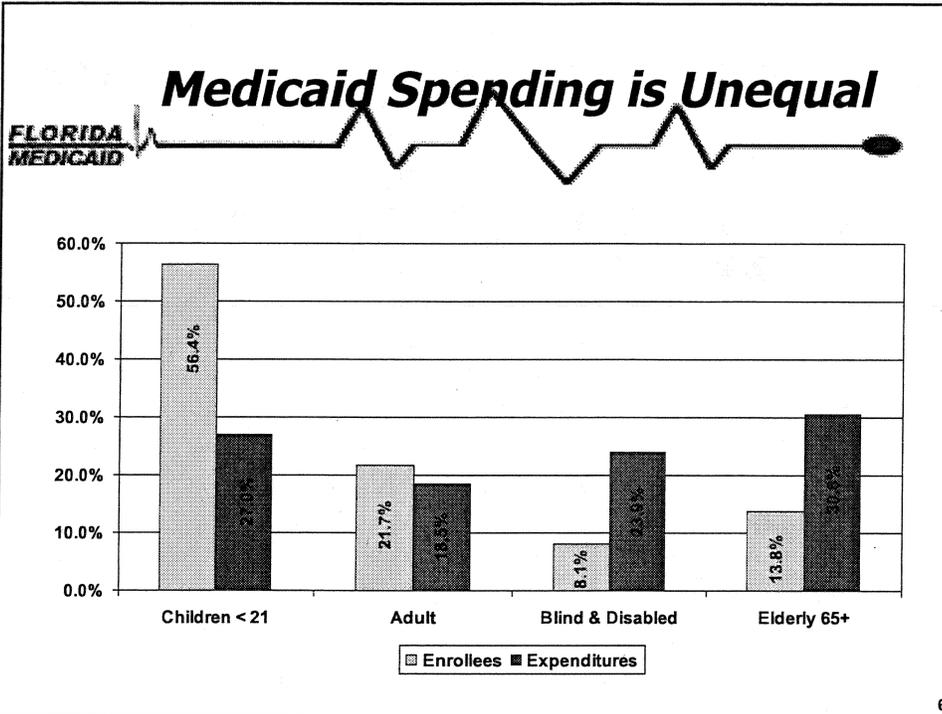
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FY 2002 - 03

Pregnant Women**	150%	46,839
Pregnant Women** ⁴	151% to 185%	5,759
Family Planning Waiver* ⁵	TANF/SSI Limits	109,979
Children		
• Birth to Age One-Above 185% to 200% of Poverty*⁶	200%	1,366
• Ages One*⁷	185%	50,001
• Ages One to Six	133%	195,155
• Born after 9/30/83 but not Age 19	100%	279,599
• Born before 10/1/83 but not Age 19*⁸	100%	598
• Refugee Assistance Program*³	TANF/SSI Limits	7,954
Total		2,097,302

Mandatory * Optional Eligibility Categories Social Services Estimating Conference, October 16, 2002

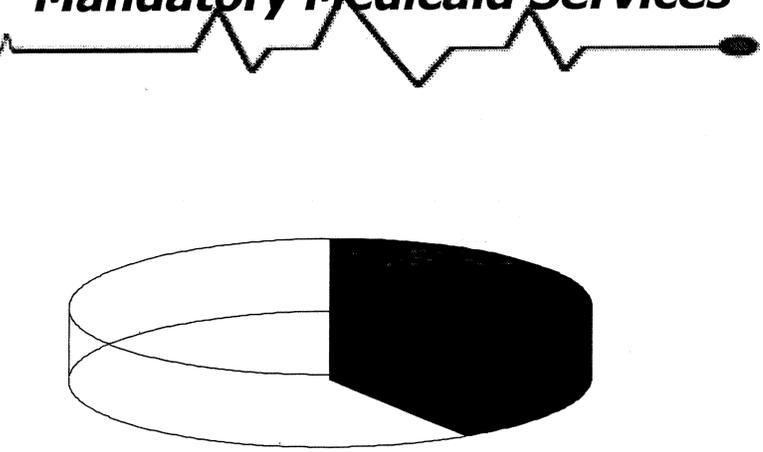
¹Family of 3; ²100% Federally Funded; ³Mandatory Coverage to 133%, Maintenance of Effort to 150% FPL; ⁴FFP is primarily at 90%; ⁵FFP is at the Title XXI Rate; ⁶Mandatory Coverage to 133%; Maintenance of effort to 185% due to Title XXI coverage of children; ⁷Enrollment will decline until 10/1/02; FFP at the Title XXI rate; ⁸Effective May 1, 2003, the income standard is increased by \$270 for all beneficiaries except caretakers. The effective income limit will be about 46% FPL.



- ## **Mandatory Medicaid Services**
- FLORIDA MEDICAID**
- ❖ *Physician Services*
 - ❖ *Rural Health*
 - ❖ *Inpatient Hospital*
 - ❖ *Outpatient Hospital*
 - ❖ *Skilled Nursing Home Services*
 - ❖ *Independent Lab and Portable X-ray Services*
 - ❖ *Home Health Care*
 - ❖ *Family Planning*
 - ❖ *Transportation*
 - ❖ *Nurse Midwife Services*
 - ❖ *Nurse Practitioner Services*
 - ❖ *Early & Periodic Screening of Children (EPSDT)/Child Health Check-Up*
- 7

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Mandatory Medicaid Services



8

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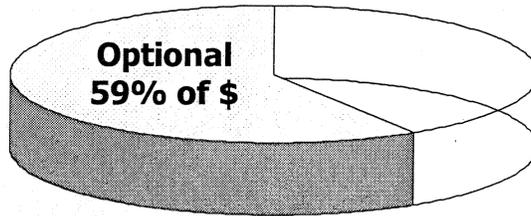
Florida Medicaid Optional Services

<ul style="list-style-type: none"> ❖ <i>Adult Health Screening</i> ❖ <i>Adult Dental, Visual and Hearing Services</i> ❖ <i>Ambulatory Surgical Centers</i> ❖ <i>Assistive Care</i> ❖ <i>Birth Center Services</i> ❖ <i>Children's Dental Services</i> ❖ <i>Chiropractic Services</i> ❖ <i>Community Mental Health</i> ❖ <i>County Health Department Clinic Services</i> ❖ <i>Dialysis Facility Services</i> ❖ <i>Durable Medical Equipment</i> ❖ <i>Early Intervention Services</i> ❖ <i>Home and Community-Based Services</i> ❖ <i>Healthy Start Services</i> ❖ <i>Hospice Care</i> ❖ <i>Intermediate Care Facilities/ Developmentally Disabled</i> ❖ <i>Intermediate Nursing Home Care</i> ❖ <i>Occupational Therapy</i> ❖ <i>Optometric Services</i> 	<ul style="list-style-type: none"> ❖ <i>Orthodontia</i> ❖ <i>Personal Care Services</i> ❖ <i>Registered Nurse First Assistant Services</i> ❖ <i>Physical Therapy</i> ❖ <i>Physician Assistant Services</i> ❖ <i>Podiatry Services</i> ❖ <i>Primary Care Case Management (MediPass)</i> ❖ <i>Prepaid Health Plans</i> ❖ <i>Prescribed Drugs</i> ❖ <i>Private Duty Nursing</i> ❖ <i>Respiratory Therapy</i> ❖ <i>Speech Therapy</i> ❖ <i>State Mental Hospital Services</i> ❖ <i>Subacute Inpatient Psychiatric Program for Children</i> ❖ <i>School-Based Services</i> ❖ <i>Targeted Case Management</i>
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9

Florida Medicaid Optional Services

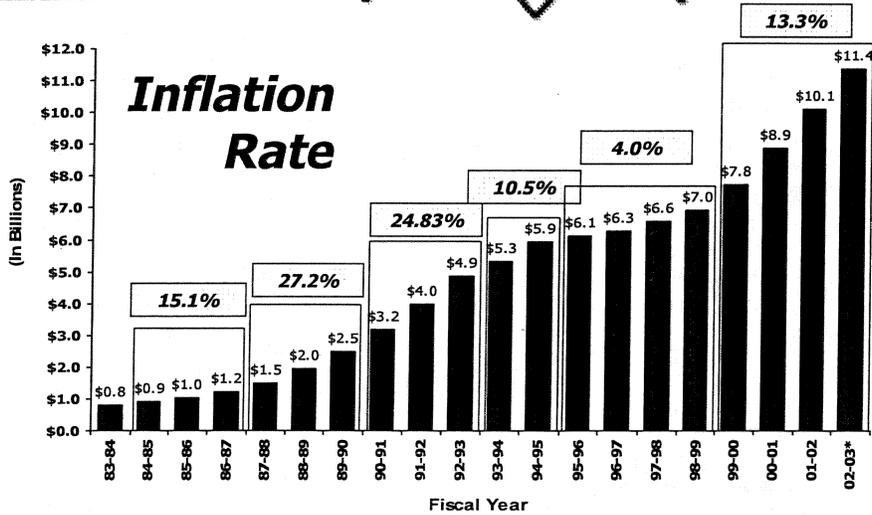
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10

Growth In Medicaid Service Expenditures

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*Social Services Estimating Conference, October 16, 2002. Adjusted for General Appropriations Act for FY 2002-03.

11

Growth in Medicaid Per Member Per Month Spending FY 1991-92 - FY 2002-03

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FY 1991-92	\$282.40	
FY 1992-93	\$271.33	-3.9%
FY 1993-94	\$278.26	2.6%
FY 1994-95	\$312.45	12.3%
FY 1995-96	\$327.82	4.9%
FY 1996-97	\$344.93	5.2%
FY 1997-98	\$379.56	10.0%
FY 1998-99	\$393.47	3.7%
FY 1999-00	\$401.78	2.1%
FY 2000-01	\$409.09	1.8%
FY 2001-02*	\$433.36	5.9%
FY 2002-03*	\$447.20	5.7%

* Estimated, Social Services Estimating Conference, October 16, 2002

12

The Florida Medicaid Managed Care System

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The Evolution of Florida's Medicaid Managed Care System

1970 - 1983

Fee-for-Service

1984 - 1997

Managed Acute Care

HMOs - Since 1984

MediPass (PCCM) - Since 1991

Provider Service Network - Since 2000

2000 - 2002

Disease Management

Population Management

Long Term Care Management

Other alternative Plans - Since 2001

2003

Disease Prevention/Self-Management

Integrated Care Management/Care Coordination

Provider Network Limits

New Risk Sharing Arrangements

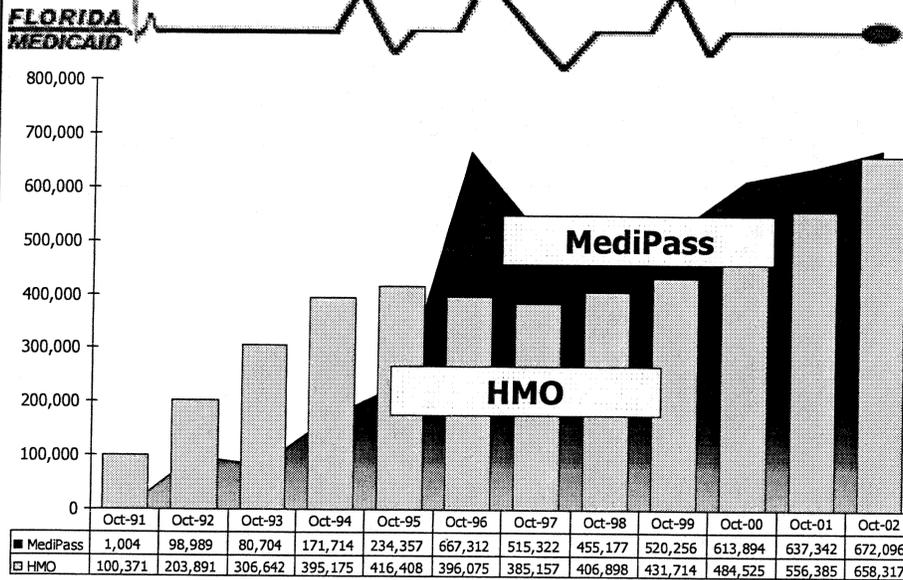
Outcomes Management/Improved Clinical Decision Making

Quality Assurance

Market Forces/Purchasing Strategies/ Performance-Based Contracting

13

Managed Care Enrollment Florida Medicaid



14

Florida Compared to the US

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Comparison	Florida	U.S.
Population Growth % (2003-04)	1.6%	.9%
% Population < 100% FPL (1999-00)	16%	15%
% Population Age 65+ (1999-00)	17%	12%
% of Population Uninsured (CPS - 2002)	17.5%	14.6%
Medicaid as % of Personal Health Care Expenditures (1998)	10.4%	15.7%
% of Population Medicaid Eligible (2000)	14.0%	11.2%
% Medicaid Non-Elderly Eligibles at < 100% FPL (1999-00)	55.0%	56.0%
% Medicaid Eligibles Aged and Disabled (FFY 1998)	30.0%	27.0%
% of Children Medicaid Eligible	29.3%	29.5%
% Medicaid Eligibles Receiving Cash Assistance (FFY 1998 - Florida Rank: 4th)	58%	45%
% of Births Financed by Medicaid (1999 - Florida Rank: 12 th)	43.0%	39.0%

15

Florida Compared to the US

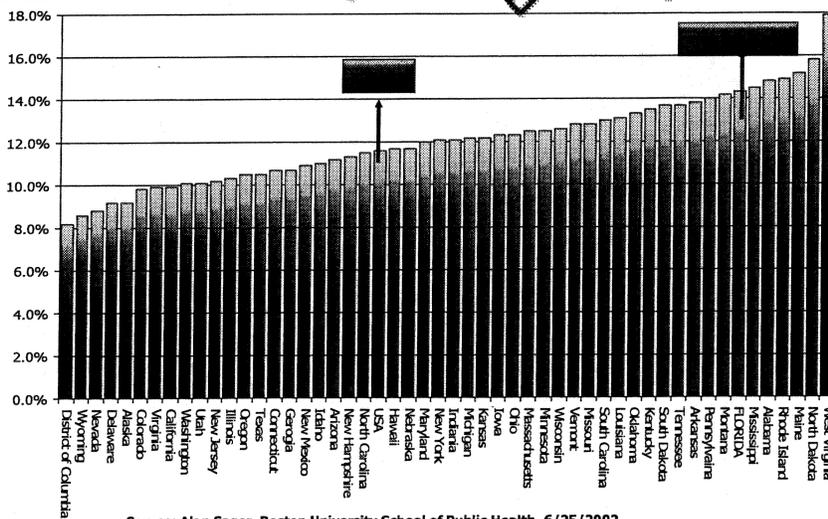
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Medicaid as % of State Budget (2001)	17.6%	19.6%
Average Annual Growth of Medicaid Eligibles (12/00-12/01)	7.9%	9.8%
% Medicaid Eligibles Enrolled in Managed Care (2001 – Florida Rank: 30 th)	61.0%	58.3%
% Annual Growth in Medicaid Spending (1990-98)	12.2%	10.5%
% Annual Growth in Medicaid Spending (1995-98)	2.5%	5.1%
% Annual Growth in Medicaid Spending (2002 - Estimated)	10.3%	13.3%
Per Eligible Per Year Medicaid Spending (FFY 1998 – Florida Rank: 42 nd)	\$3,061	\$3,822
Per Capita State Health Spending (SFY 1999 – Florida Rank: 42 nd)	\$656.14	\$872.62
AIDS Case Rate (2001 – Per 100,000 – Florida Rank: 4 th)	31.3	14.9
FMAP (FFY 2003)	58.83%	60.66%
FMAP - Highest		76.62%
FMAP – Lowest		50.00%
NH Beds Per 1,000 Age 65+ (1996)	25.6	49.1

16

Health's Share of Each State's Economy - 1998

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Source: Alan Sager, Boston University School of Public Health, 6/25/2002

17

Florida Medicaid – Recent Efforts to Control Costs

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- ❖ Eligibility Reductions
- ❖ Benefit Reductions
- ❖ Prescription Drug Cost Controls
- ❖ Fraud and Abuse Controls
- ❖ Service Authorization
- ❖ Disease Management
- ❖ Managed Care Expansion
- ❖ Competitive Bidding
- ❖ Provider Fee Reductions/Purchasing Reforms
- ❖ Nursing Home Diversion

**\$1 Billion
Total Medicaid
Savings
1999- 2003**

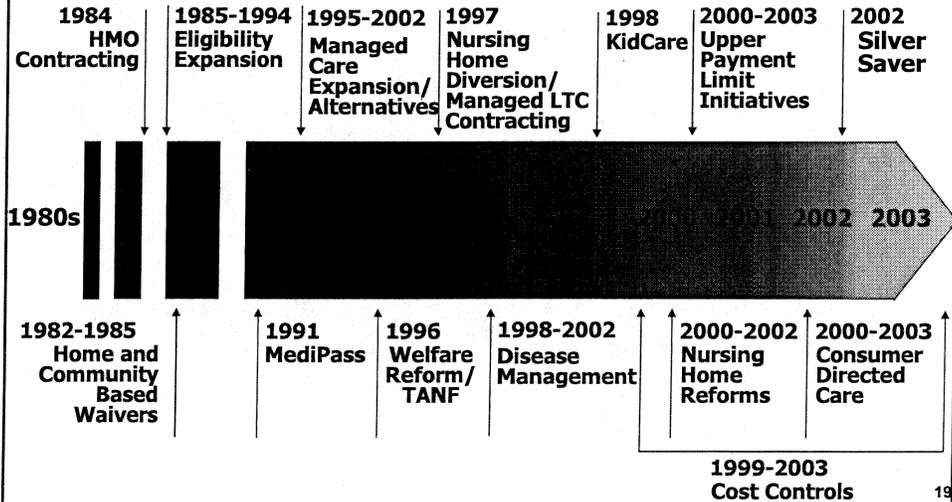
**\$500 Million
Drug Savings
2000-2002**

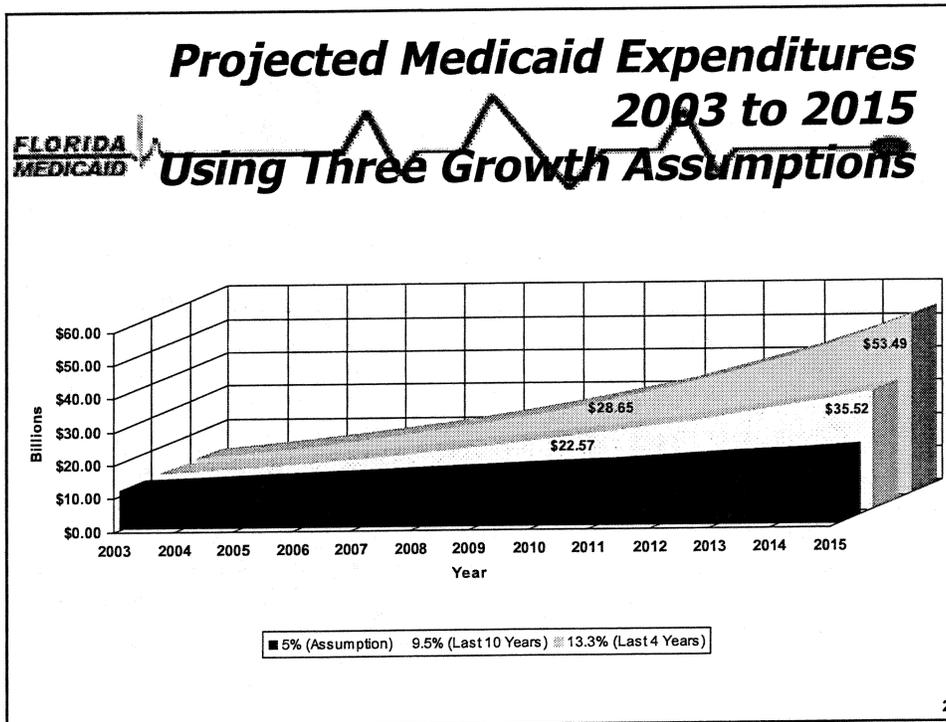
18

The Eras of Florida Medicaid

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▶ Innovative - Cost Conscious - Best Practices





- ### A Summary of Florida Medicaid Anti-Fraud and Abuse Measures – Medicaid Program Integrity The Nation's Model 1996–2002
- FLORIDA MEDICAID**
- Case Example

 - ❖ New Provider Application
 - ❖ New Provider Agreement
 - ❖ Periodic Provider Re-Enrollment
 - ❖ Financial/Criminal Background Screening
 - ❖ Fingerprinting
 - ❖ Provider Credentialing
 - ❖ New Provider Licensure Requirements
 - ❖ Surety Bonds
 - ❖ Provider Site Visits
 - ❖ Additional FMMIS Edits
 - ❖ New Sanction Tools
 - ❖ New Prior Authorization Requirements
 - ❖ New Utilization Review Programs
 - ❖ Provider Audits
 - ❖ Provider/Beneficiary Profiling
 - ❖ Payment Suspensions
 - ❖ Beneficiary Lock In
 - ❖ PRO/Peer Review Programs
 - ❖ Counterfeit-Proof Prescription Pads
 - ❖ Decision Support Systems/Data Warehouses
 - ❖ Fraud and Abuse Detection Contractor
 - ❖ Expanded Managed Care Contracting/Risk Contracting
 - ❖ Nursing Home Payment Edits – Eligibility/Level of Care
 - ❖ Additional Service Limits
 - ❖ Intraagency Medicaid Fraud and Abuse Committee (FACT)
 - ❖ Additional Investigators/Attorneys/Monitors
 - ❖ Performance Measurement System
 - ❖ Overpayment Recoupment Tracking System
 - ❖ Claims Payment Accuracy Rate Study
 - ❖ Eligibility Error Rate Study
- 21

Prescribed Drug Cost Control Program – 1999-2002

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Case Example

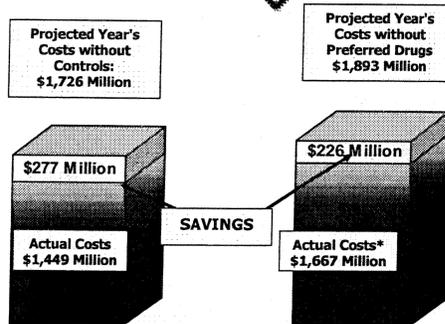
- ❖ Monthly Four Brand Prescription Drug Limit
- ❖ Preferred Drug List
- ❖ Supplemental Drug Manufacturer Rebates
- ❖ P&T Committee
- ❖ Drug Prior Authorization
- ❖ Therapeutic Consultation Program
- ❖ Intensified Benefit Management Program
- ❖ Therapeutic Academic Intervention Program (Detailing)
- ❖ Drug Therapy Limits
- ❖ Ingredient Cost Adjustments
- ❖ 34-Day Supply Limit
- ❖ No Early Refills
- ❖ HMO Capitation Rate Adjustments
- ❖ FDA Drug Use Guidelines
- ❖ Counterfeit-Proof Prescription Pads
- ❖ State MACs
- ❖ Diabetic Supply Contract – Competitive Bidding
- ❖ Diabetic Product/Mail Order Pharmacy – Competitive Bidding
- ❖ Beneficiary Pharmacy Lock-In
- ❖ Diverted Pharmaceutical Pilot Project (STAMP)
- ❖ HIV/AIDS and Mental Health Patient Drug Management Project (2002-03)
- ❖ Drug Data Management/Analysis Contractor – Data Warehouse (2002-03)
- ❖ Hemophilia Revenue Enhancement Program (2002-03)
- ❖ Wireless Handheld Clinical Pharmacology Drug Information Database (2002-03)
- ❖ Home Delivery Pharmaceutical Services Pilot Project (2002-03)

22

Florida Medicaid - Two Years of Major Drug Cost Control Initiatives

Two Years Total Savings: \$503 Million

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Introduction of the 4 Brand Drug Limit with Prior Authorization Policy

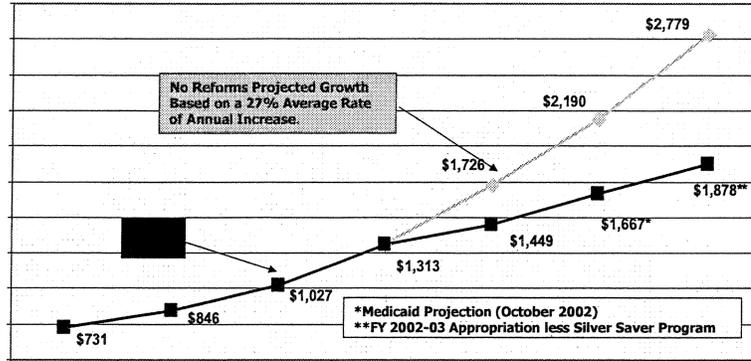
Continued 4 Brand Drug Limit and Introduced the Preferred Drug List Policy

*Actual Cost Projected (October 2002)

23

Medicaid Drug Cost Growth Comparison Spending with Reforms Versus Estimated Spending without Reform

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Note: The No-Reforms growth rate calculation is based on the actual average annual rate of growth for fiscal years 1998-99 through 2000-01. For FY 2000-01, the projected cost of \$1,726 million (derived from the February 2001 SSEC) was used since it did not include any cost reform impact.



OVERHEADS

OVERHEADS

OVERHEADS

OVERHEADS

OVERHEADS

Betsy A. Shenkman, Ph.D.





The Florida KidCare Program

Betsy Shenkman, PhD
Institute for Child Health Policy
University of Florida
January 2003



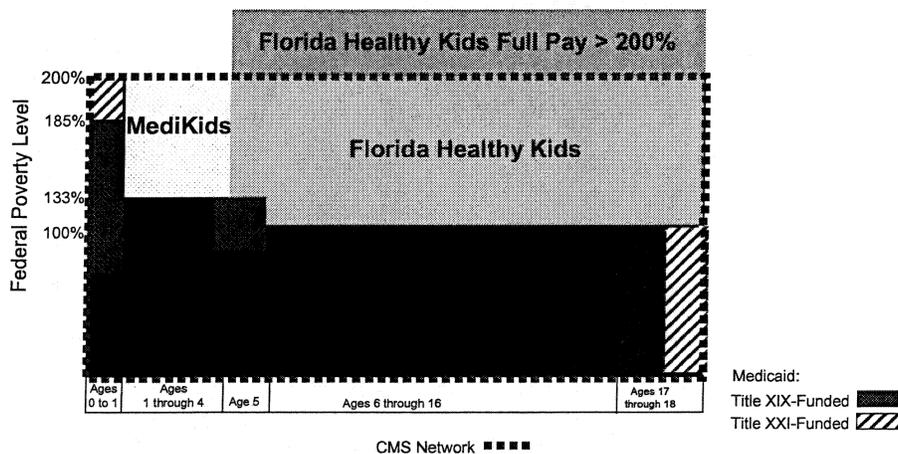
Purpose

- KidCare program structure
- Number and characteristics of those served
- Key evaluation findings
 - The passive renewal process and continuity of care
 - Disenrollment
 - Caring for children with special health care needs
 - Findings about quality of care

The KidCare Program Component Names and Participating Agencies

- Medicaid – Agency for Health Care Administration (AHCA)
- MediKids – AHCA
- Healthy Kids – Florida Healthy Kids Corporation
- Children’s Medical Services (CMS) – Department of Health (DOH)
 - DOH is also responsible for outreach

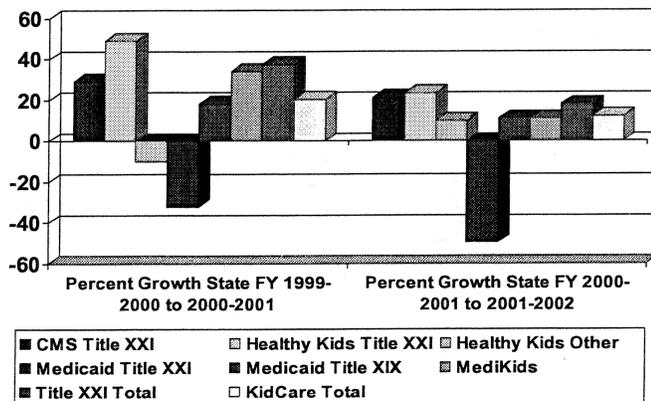
Florida KidCare Eligibility



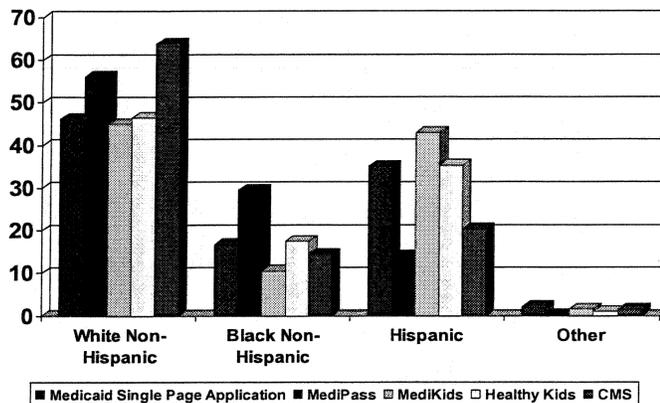
Enrollment as of June 30, 2002 (State Fiscal Year 2001-2002)

CMS Title XXI	7,546
Healthy Kids Title XXI	218,160
Healthy Kids Other	25,726
Healthy Kids Total	243,886
Medicaid Title XXI	6,062
Medicaid Title XIX	1,078,627
Medicaid Total	1,084,689
MediKids	29,611
Title XXI Total	261,379
KidCare Total	1,365,732

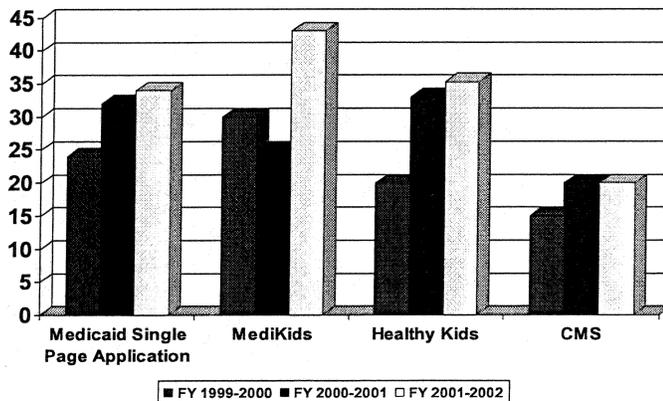
Change in Enrollment From State FY 2001 to State FY 2002



Race and Ethnicity of Program Enrollees



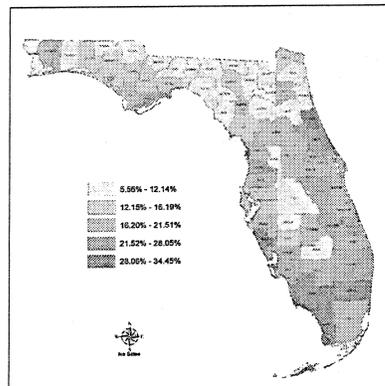
Percentage of Hispanic Enrollees From State FY 1999-2000 Through State FY 2001-2002



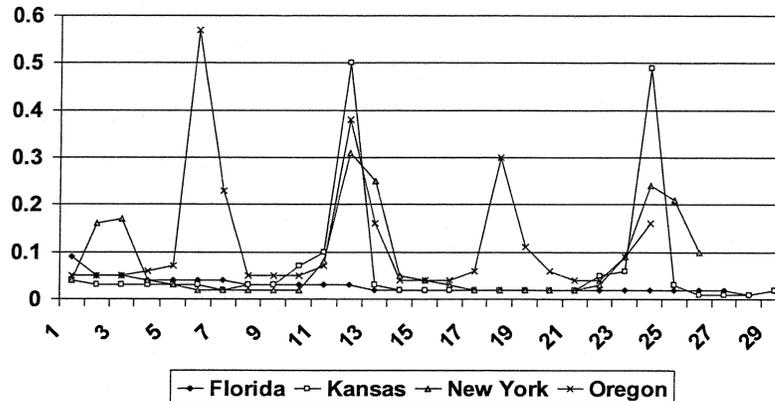
How Many Are Uninsured and Possibly Eligible?

- March 2002 estimate – about 15% of children age 0 to 19 in Florida are uninsured
- 388,902 are uninsured and potentially eligible for one of the KidCare Program components
- Estimates from Florida study conducted by Institute for Child Health Policy, similar estimates obtained from a different study conducted by Urban Institute.

Percentage of Children Covered by KidCare as a Function of Those Below 200% Federal Poverty Level



Children Disenrolling From Title XXI by Month – A Four State Comparison



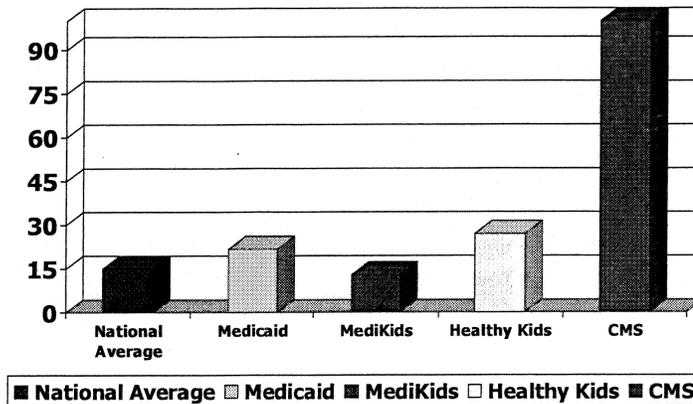
Study Funded by Agency for
Health Care Research and Quality

Disenrollment Analysis – Key Points

- Florida uses a passive renewal process; whereas other states in analysis did not
- Premium payment is a critical component of the passive renewal process
- Better continuity of care

Study funded by Agency for
Health Care Research and Quality

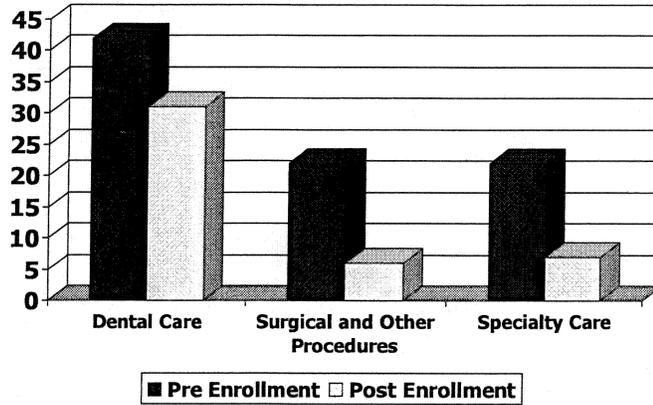
Children with Special Health Care Needs



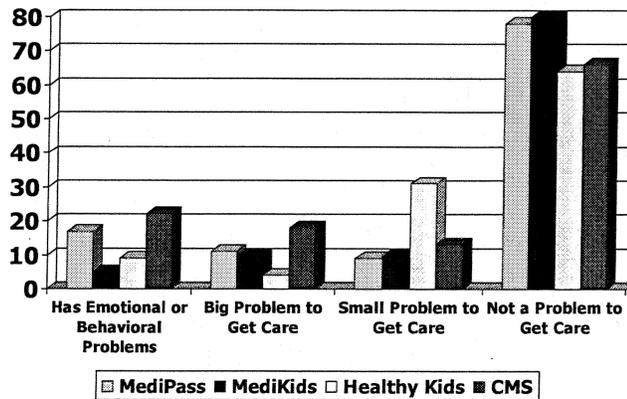
Key Points – Children with Special Health Care Needs

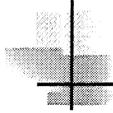
- Higher percentage of them in KidCare than might be expected based on national estimates
- More likely to remain enrolled in program than healthy children
- May see higher than expected health care costs
- Monitor provider network and quality carefully for these vulnerable children

Percentage with Unmet Needs or Problems Obtaining Care Pre and Post KidCare Enrollment



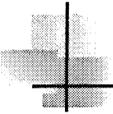
Getting Mental Health Care





General Health Care

- 84 percent of families encounter no problems in obtaining care
- 98 percent of children who needed specialty care received such care
- Over 90 percent of children have a usual source of care



Adolescent Health Care

- More adolescents receive preventive care counseling for safety issues, alcohol and drug use, tobacco use, and others from their providers post enrollment in Medicaid and Healthy Kids
- A significant decrease in percentage of adolescents in Healthy Kids Program reporting risk taking behaviors one year post-enrollment

Study funded by the Agency for
Health Care Research and Quality

Summary

- Multiple program components but the design works
- Greatly increases access to care and reduces unmet health care needs among enrollees
- Diverse population enrolled
- Great progress but still many uninsured children
- Special populations to consider
- Excellent quality of care

OVERHEADS

OVERHEADS

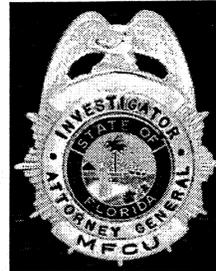
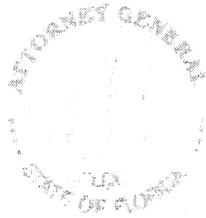
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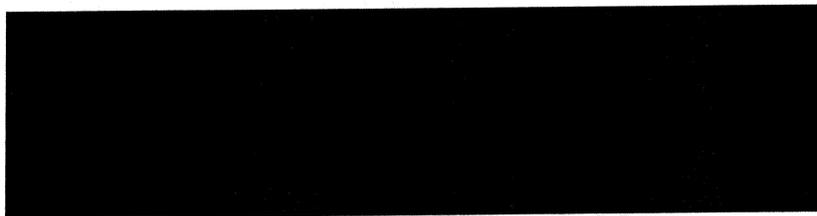
Mark H. Schlein, J.D.





**OFFICE OF THE
ATTORNEY GENERAL
Medicaid Fraud Control Unit**

MISSION



- 1. To conduct both criminal and civil investigations of provider fraud and abuse within the Medicaid Program;**
- 2. To conduct investigations of fraud in the administration of the Medicaid Program;**

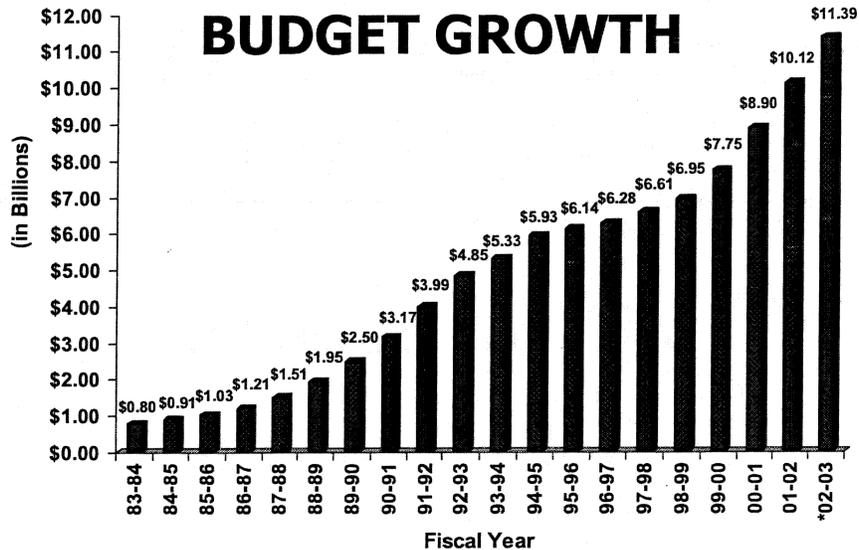
MISSION

(continued)

- 3. To conduct investigations of abuse, neglect and/or exploitation of vulnerable adults residing in facilities that receive Medicaid funds;**
- 4. To conduct investigations of abuse, neglect and/or exploitation in all assisted living facilities;**
- 5. To conduct investigations of the misuse of patient's private funds in facilities that receive Medicaid funds.**

**FLORIDA
MEDICAID BUDGET
\$11.3 BILLION
FY 2002–2003 (est.)**

FLORIDA MEDICAID BUDGET GROWTH



*Social Services Estimating Conference, February 2002, adjusted for General Appropriations Act for FY 2002-03.

FLORIDA MEDICAID PRESCRIPTION DRUG COSTS

\$1.97 BILLION
FY 2002–2003 (est.)

FLORIDA MEDICAID NURSING HOME EXPENDITURES

\$2.16 BILLION

FY 2002–2003 (est.)

ESTIMATED FLORIDA MEDICAID SPENDING FY 2002–2003

Source: Social Services
Estimating Conference,
February 2002, adjusted for
General Appropriations Act for
FY 2002-03.

Service	Estimated Annual Spending
Nursing Home Care	\$2,167,696,927
Prescribed Drugs	1,979,379,821
Hospital Inpatient Services	1,541,939,437
Prepared Health Plans	1,247,856,619
Home & Community Based Services	852,141,216
Physician	523,709,946
Supplemental Medical Insurance	456,853,132
Hospital Outpatient Services	428,207,255
Special Payments to Hospitals	400,650,266
Disproportionate Share Hospital Payments	242,493,344
Therapeutic Services for Children	174,823,639
Private Duty Nursing Services	147,188,309
ICFDD	140,541,224
Other	1,083,216,979
Total	\$11,386,698,114

