Moving Medicaid Forward in Florida

*Florida Health Care Affordability Summit*

Cindy Mann  
Partner, Manatt Health  

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Agenda

The New Medicaid

Medicaid in Florida: Current State Landscape

The Road Ahead

Impact of Expansion
The New Medicaid
Not Your Grandmother’s Medicaid Program

1965

Welfare Program

- Only available to “deserving poor”
  - Children and their parents
  - Elderly, blind, or disabled
- Linked to cash assistance programs
- Hard to get on and stay on

2016

Health Insurer

- Covers over 65 million – or nearly 1 in 4 – Americans
- Largest single insurer
- Streamlined eligibility and enrollment process
- Driver of payment and delivery reform

Medicaid Foundational to New Coverage Continuum

- Medicaid
- Children’s Health Insurance Program (CHIP)
- Premium Tax Credits and Cost-Sharing Reductions for QHPs
- Qualified Health Plans
- Employer-Based Coverage

Federal Poverty Level:
- 0%
- 100%
- 138%
- 200%
- 300%
- 400%
Coverage Foundational to Healthcare Transformation

Population Health

Delivery System Reform

Payment Reform

Coverage

Accessible
Affordable
Integrated
Medicaid in Florida: Current State Landscape
The Gap in the Florida’s Coverage Continuum

- **Premium Tax Credits and Cost-Sharing Reductions for QHPs**
- **Children’s Health Insurance Program (CHIP)**
- **Children’s Medicaid**
- **COVERAGE GAP (Parents)**
- **COVERAGE GAP (Childless Adults)**

Federal Poverty Level:
- 400%
- 300%
- 200%
- 138%
- 100%
- 0%
Over 900,000 Adults in Florida Are Expected to Gain Coverage Under Expansion

In the Coverage Gap: Too Much Earnings To Qualify for Medicaid and Too Little Earnings to Qualify for the Tax Credit through the Marketplace

**Maria:**
31-year-old single parent with two children who earns an annual salary of $20,000 as a daycare worker

**Sonia and John:**
62-year-old couple who annually earn $16,000 working part-time as grocery baggers at their local market

**Michael:**
45-year-old childless adult who annually earns $14,000 working as a landscaper and other seasonal jobs

Florida Spending Per Enrollee Below U.S. Average

Medicaid Spending per Enrollee (Full or Partial Benefit), 2011

http://kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee//
Medicaid Accounts for 32% of the Florida State Budget When State and Federal Funds are Considered

Florida State Budget (State & Federal Funds), FY 2013

- Medicaid: 32%
- All Other: 25%
- Transportation: 11%
- Higher Education: 9%
- Elementary & Secondary Education: 19%
- Corrections: 4%
- State General Funds: 23%
- Federal Funds: 58%
- Other State Funds*: 19%

*Includes intergovernmental transfers, provider taxes, fees, donations, assessments

Source: National Association of State Budget Officers, State Expenditure Report, Examining Fiscal 2012-2014 Spending
And 22% When Looking Only at Non-Federal Funds

Medicaid as a Share of Florida’s Total State Budget (Non-Federal Funds Only*)
FY 2013

- Medicaid: 22%
- Higher Education: 14%
- Elementary & Secondary Education: 26%
- Transportation: 12%
- Corrections: 6%
- All Other: 20%

* Includes intergovernmental transfers, provider taxes, fees, donations, assessments

Source: National Association of State Budget Officers, State Expenditure Report, Examining Fiscal 2012-2014 Spending
Florida Medicaid Program at a Crossroads
Florida’s “Section 1115” Waiver Expires June 2017

Managed Care

Low-Income Pool (LIP)

Delivery System Reform Incentive Payment (DSRIP)

Medicaid Expansion
Recent CMS Principles Regarding UC Pools

Nine states, including Florida, have Uncompensated Care (UC) pools as part of their Medicaid Section 1115 Waivers to help healthcare providers absorb costs of unpaid care.

• UC pools – called the Low Income Pool, or LIP, in Florida – have been used to defray the costs of:
  – Charity care to low-income and uninsured individuals
  – Bad debt
  – Differences in Medicaid payment rates to providers compared to other payers

• Recently, CMS has set out new principles affecting the size and use of UC pools:
  – *Permissible*: Charity care for low-income individuals that would not be covered in a Medicaid expansion
  – *Not Permissible*: Bad Debt
  – *Not Permissible*: Shortfalls due to low Medicaid provider payments

Source: CMS Letter to Justin Senior, May 21, 2015; Texas Transformation and Quality Improvement Waiver, Medicaid.gov
Florida’s total LIP funds reduced by 40% from $1 billion to $608 million beginning in FY 16

- Funding allowed for uncompensated care for low-income uninsured
- Funding *not* permitted for Medicaid shortfalls, uncompensated care that could be covered through a Medicaid expansion, or bad debt
- One year transition (FY 2015-2016) permitted

**Sources:**
Eight States have DSRIP 1115 Waivers

- **Washington**
  - Plans to implement in 2016, pending waiver approval
  
- **California**
  - Approved in 2010 for $6.67b; renewed in 2015 for $7.46b

- **Kansas**
  - Approved in 2013 for $100m, implemented in 2015

- **New York**
  - Approved in 2014 for $6.42b

- **New Hampshire**
  - Approved in 2016 for $150m

- **Massachusetts (DSTI)**
  - Approved in 2011 for $630m; extended for 2015-2017 for $690m; pending for renewal (est. $1.5B)

- **Illinois**
  - Waiver pending

- **Texas**
  - Approved 2011 for $11.4b

- **Virginina**
  - Waiver pending

- **Alabama**
  - Waiver approved in 2016 for $328m

Sources: Kaiser Family Foundation, 2015. *Key Themes from Delivery System Reform Incentive Payment Waivers in 4 States.*
; America’s Essential Hospitals, 2013. *Medicaid Payments to Incentive Delivery System Reform.*
; Department of Health and Human Services, 2015.
; New York:
For every $1 Florida were to invest in Medicaid expansion, $12.32 in federal funds would flow into the state.  

<table>
<thead>
<tr>
<th>Funding ($), (annual)</th>
<th>Federal dollars Florida would receive if the state expands Medicaid</th>
<th>$5.8 billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-Income Pool Total</td>
<td>$608 million</td>
<td></td>
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Medicaid expansion decisions as of January 2016. Arizona has submitted a waiver request to move to an alternative expansion approach. Coverage under Louisiana’s expansion is targeted to begin on July 1, 2016.
Medicaid Expansion Advances Coverage

Seven expansion states cut their uninsurance rates by > 50% from 2013 to 2015

- **Florida**
  - 2013: 22.1%
  - 2015: 15.7%

- **Arkansas**
  - 2013: 22.5%
  - 2015: 9.6%

- **Kentucky**
  - 2013: 20.4%
  - 2015: 7.5%

Note: “Expansion States” includes 29 US States whose expansion was in effect by the end of 2015. Louisiana and Montana are not included.

Manatt Analysis of Gallup-Healthways Well-Being Index (February 2016)
Early Results Across Expansion States

Sharp Drops in Hospital Uncompensated Care Costs

• In Arkansas, $1.1 billion reduction in hospital uncompensated care costs is expected between 2017-2021.
• In Connecticut, hospital uncompensated care was 1/3 lower than what it would have been without Medicaid expansion (2011 – 2013)
• The Iowa Hospital Association reported uncompensated care cases declined by 18.5%, saving hospitals approximately $32.5 million (January – June 2014)

Significant Reductions in Non-Medical Debt

• Medicaid expansions that began in 2014 have significantly reduced the number of unpaid non-medical bills and the amount of non-medical debt sent to third-party collection agencies
• Estimates indicate that Medicaid expansions are associated with a decrease in the amount of unpaid balances in collections of between $51 and $85

Economic Benefits to State Budgets

• Arkansas projects a net positive impact on the state budget of $637 million from 2017 – 2021.
• Kentucky has had a $300 million net positive impact on the State General Fund in two years and projects $820 million in savings from 2014-2021
• New Mexico’s expansion is expected to create a $300 million surplus for the State’s General Fund between 2014 and 2021

The Economics of Expansion: Impact on State Budgets

1. State Costs
   - Beginning in 2017, share of newly eligible adults
   - Some additional enrollment of already eligible children/adults
   - Increased administration costs

2. State Savings
   - Enhanced federal matching funds for some previously eligible Medicaid beneficiaries
   - Some services historically funded with State or local funds could be refinanced with Medicaid funds (such as spending on inpatient hospital costs of inmates)

3. Revenue Gains
   - Expansion could result in State revenue gains related to existing health plan and/or provider taxes as health plan and provider revenues increase

### ACA Newly Eligible FMAP

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>FMAP</th>
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<tbody>
<tr>
<td>2016</td>
<td>100%</td>
</tr>
<tr>
<td>2017</td>
<td>95%</td>
</tr>
<tr>
<td>2018</td>
<td>94%</td>
</tr>
<tr>
<td>2019</td>
<td>93%</td>
</tr>
<tr>
<td>2020 and thereafter</td>
<td>90%</td>
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</tbody>
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President Obama has proposed to provide all states at least three years of 100% FMAP
Improving Health and Controlling Costs: Medicaid Can Help Lead the Way

Medicaid’s New Role and Responsibilities Offer Important Opportunities to Improve Health and Lower Costs

FL Health Insurance Enrollment by Source, 2014

- Medicaid: 19%
- Medicare: 17%
- Uninsured: 15%
- Other Private: 8%
- Other Public: 2%
- ESI: 39%

Source: Kaiser Family Foundation, “Health Insurance Coverage of the Total Population”
http://kff.org/other/state-indicator/total-population/
Thank You!

*Cindy Mann*
Partner
CMann@manatt.com