



Presented by the Center for Health and Public Policy Studies, University of California, Berkeley,
and the Henry J. Kaiser Family Foundation



THE FUTURE OF MEDI-CAL: CHALLENGES AT THE FEDERAL, STATE, AND COUNTY LEVEL

CAN WE PRESERVE ACCESS IN AN ERA OF RISING HEALTH COSTS AND DECLINING REVENUES?

Tuesday, May 13, 2003, 3:00 - 5:00 p.m. ♦ State Capitol, Room 3191 ♦ Sacramento, California

Focus of This Roundtable

This roundtable will focus on the future direction of Medi-Cal, California's Medicaid program, in light of the state's current budget crisis. We will also discuss proposals at the national level to address state fiscal concerns, including the President's proposal to restructure Medicaid. Diminished resources at the federal, state, and county levels call for difficult trade-offs to balance California's budget. One of the key challenges is how to preserve a meaningful set of health benefits for the state's most vulnerable residents when services are most needed and state resources are most scarce. The briefing will examine the Davis Administration's proposed changes to Medi-Cal as well as initiatives under consideration by the Bush Administration, Congress, and the National Governors' Association. Approaches that have been adopted by other states to address rising program costs and budget shortfalls will also be discussed. Finally, the roundtable will consider the impact of proposed changes on the abilities of counties, plans, and providers to preserve access to coverage and services for Medicaid enrollees in a time of intense fiscal pressures.

Questions to be Addressed at This Roundtable

- ♦ What are Governor Davis's proposed changes to Medi-Cal coverage and benefits? How could these changes affect counties, the health plans and providers that serve Medi-Cal enrollees, and enrollees themselves?
- ♦ How has the California State Legislature responded to Davis's proposals?
- ♦ How are other states changing their Medicaid programs to address funding shortfalls? What could California's policymakers learn from other states in these efforts?
- ♦ What are national proposals to restructure Medicaid and how could these affect California's Medi-Cal program?

The Roundtable Panel

PRESENTERS

Daniel Carson, Director, Health Section, Legislative Analyst's Office

Victoria Wachino, Associate Director, Kaiser Commission on Medicaid and the Uninsured

RESPONDENTS

Maria Castañeda Calleros, Director, Healthy Families Program, CalOptima

Susan Fleischman, Medical Director, Venice Family Clinic

Anthony Wright, Executive Director, Health Access

Representative from the California State Association of Counties

Medi-Cal Today

The Medicaid program (Medi-Cal in California) plays a key role in providing access to health care for millions of low-income Americans. Under this jointly funded federal-state health care entitlement program for low-income individuals, the federal government sets the broad guidelines for Medicaid's mandatory eligibility categories and covered services, while states have authority to cover certain optional groups and services and set provider payment rates. In California, Medi-Cal covered acute and long-term care services for more than 6.5 million children, adults, seniors, and people with disabilities in 2002.

California, like other states, has used Medi-Cal and other public programs as a vehicle to improve coverage for vulnerable low-income populations who can't afford or who don't have access to private coverage. Some recent Medi-Cal eligibility improvements include:

- ♦ Expanding Medi-Cal eligibility for parents beyond federal minimum requirements by increasing the income limit up to 100% of the federal poverty level (FPL);
- ♦ Extending no-cost benefits to the aged, blind, and disabled for those earning up to 133% of FPL;
- ♦ Implementing a Medi-Cal buy-in for persons with disabilities earning up to 250% of FPL;
- ♦ Adopting 12 months of continuous eligibility for children in Medi-Cal.

Medi-Cal provides health coverage to a higher proportion of state residents than most other state Medicaid programs—approximately 14% of Californians, compared to a nationwide average of 11%. Largely as a result of expanded eligibility, enhanced outreach, and simplified enrollment in the late 1990s, followed by recent increases in California's unemployment rate and a decline in private coverage rates, Medi-Cal enrollment increased 23% between 1993-1994 and 2002-2003 (from 5.3 million to 6.5 million). Despite these increases, California still has one of the nation's highest rates of uninsured individuals among states (19%).

While California is one of four states that covers at least 30 of 34 optional services, its coverage of costly long-term care services under Medi-Cal has been lower than most states. California has historically had one of the lowest provider reimbursement rates in the nation, currently ranking 42 of 50 states. California also has the lowest spending per Medi-Cal beneficiary of all the states, in part due to its low spending on long-term care.

The total estimated Medi-Cal budget for fiscal year (FY) 2002-2003 is \$29.2 billion (about half of this comes from federal matching funds), an increase of 8.5% from the prior year. Medicaid spending is driven by a wide range of factors including the economy and enrollment, the increasing cost of health care services generally (especially prescription drugs), and increased utilization. At the same time costs have risen, state revenues have fallen as a result of the downturn in the economy and the resultant decrease in tax revenues. Furthermore, a recent change in the federal matching percentage (FMAP) paid to California in 2002-2003 from 51.4% to 50% means that the state has lost an estimated \$222 million in federal assistance alone. State spending on Medi-Cal accounts for approximately 16% of the state's total budget, and three-fourths of the state's General Fund spending for health services.

The Davis Administration's Budget Proposal

With a significant gap between California's revenues and expenses, the state's ability to continue to expand Medi-Cal coverage or simply to maintain existing eligibility and benefits levels will require difficult fiscal decisions. In an attempt to close a budget gap estimated by the Davis Administration to be \$35 billion, dramatic reductions have been proposed in Governor Davis's FY 2003-2004 budget. Through various program changes, the Governor has proposed to reduce Medi-Cal General Fund spending by 34%, to \$7.1 billion.

In his budget request for FY 2003-2004, Governor Davis proposed a number of changes to Medi-Cal, including:

- ◆ Shifting \$7.9 billion in health and human services program expenditures to counties under a realignment proposal;
- ◆ Reducing current Medi-Cal and non-Medi-Cal provider rates by a total of 15%, including physician and nursing home payments, but excluding hospital inpatient and outpatient services, federally-qualified health clinics, and rural health clinics;
- ◆ Rescinding the 1931(b) Medi-Cal eligibility expansion, currently at 100% of FPL, which would reduce income eligibility limits for working families to 61% of FPL;
- ◆ Reducing income eligibility limits for low-income aged, blind, and disabled individuals from 133% of FPL to the supplemental security income/state supplementary payment (SSI/SSP) benefit level (approximately 100% of FPL);
- ◆ Reinstating the Quarterly Status Report (eliminated in January 2000), which would require adults to verify their income and other application information every three months rather than annually;
- ◆ Eliminating a total of 18 optional benefits, including adult dental services and medical supplies.

With proposed cuts in eligibility, benefits, and provider rates, the Governor's budget would have repercussions for many Medi-Cal beneficiaries. Projections of the caseload reduction due to proposed eligibility restrictions or to eligible beneficiaries who do not reenroll range from 209,000 (the Administration's estimate) to upwards of one million. If enrollees who are no longer eligible for Medi-Cal or who do not retain their Medi-Cal coverage find no other source of coverage, they would join the ranks of the over 6 million uninsured Californians.

As of this writing, California's FY 2003-2004 budget remains a work in progress. Budget committees in both the Senate and the Assem-

bly voted against various midyear proposals to reduce the Medi-Cal budget, including reducing reimbursement rates, eliminating coverage for optional benefits, and reinstating quarterly verification of eligibility. In late March, the Senate voted against the Governor's "realignment" proposal to shift funding of 15% of the state's Medi-Cal costs to county government as well as the shift of long-term care costs. In recent budget negotiations, policymakers agreed to reduce Medi-Cal expenditures by requiring twice-yearly verification of Medi-Cal eligibility and controlling the cost of the dental benefit. In their upcoming budget discussions, state policymakers must weigh the trade-offs that will be required to maintain program integrity without jeopardizing access to services or quality of care for the state's neediest residents, while making responsible fiscal choices to ensure the long-run viability of the Medi-Cal program.

Medicaid and State Budgets

In the mid- to late-1990s when budget surpluses were common among states, many states lowered taxes and implemented public program expansions. Now, however, the majority of states face record budget shortfalls resulting in large part from reduced tax revenues and to a lesser degree, public program spending increases. Furthermore, per capita health care spending rose by 10% in 2001, the largest jump in a decade. In March 2003, the Congressional Budget Office (CBO) estimated that federal Medicaid costs would grow 13% during FY 2002 and 8% between 2003 and 2008. This growth has come at a time when states have the fewest resources to cover spending.

Medicaid is currently the second largest line item, after education, in most state budgets. Consequently, many states are implementing program changes designed to control Medicaid spending, including reducing eligibility, services, and provider reimbursement rates. These changes could have serious implications for enrollee coverage, access to health services and, ultimately, to state economies.

State Efforts to Control Medicaid Spending

Because Medicaid accounts for a significant share of annual state expenditures, finding ways to control Medicaid spending and to use existing resources more efficiently is a priority for states. A key challenge in the current fiscal climate is to meet increasing demands on public programs at a time of decreasing tax revenues. Historically, states have used managed care as a mechanism to control spending growth in Medicaid. Yet the majority of enrollees are already in managed care plans, so the cost-saving utility of this approach is limited.

In a recent survey of all 50 states commissioned by the Kaiser Commission on Medicaid and the Uninsured (KCMU), 49 states reported planning or taking action to reduce growth in Medicaid spending for FY 2003. States have attempted to reduce benefits and provider payments before making cuts to eligibility, but maintaining coverage for current eligibles is a growing challenge for many states. According to the KCMU study, specific changes being planned or implemented include: prescription drug cost controls (45 states); provider payment reductions (37 states); eligibility cuts and restrictions (27 states); reducing benefits (25 states); increasing beneficiary copayments (17 states); and spending reductions on long-term care (17 states). Many of these changes have been made without a waiver.

Restructuring Medicaid

In recent years, states have adopted many approaches to enhance their Medicaid programs to serve more individuals and to control program spending.

Expanding Medicaid and Cutting Costs

Many states have attempted to cover more individuals through their Medicaid programs, either by raising eligibility levels (usually done for pregnant women, parents, or children) or by extending eligibility to populations that have not traditionally qualified for assistance because they were not “categorically” eligible (such as adults without children). To make such changes, states can apply for special federal permission to “waive” certain portions of the federal Medicaid law so that they can implement five-year demonstration projects under Section 1115 of the Social Security Act.

Through the waiver process, states can receive federal dollars for coverage expansions, rather than using only state funds, although the changes must be “budget neutral” —that is, the new program cannot cost the Federal government any more than it would have spent for Medicaid absent the changes. More recently, states have sought to restructure their Medicaid programs to achieve cost savings by capping enrollment, reducing benefits, and increasing cost-sharing for enrollees.

In August 2002, the Bush administration announced the Health Insurance Flexibility and Accountability (HIFA) waiver initiative within Section 1115. Under the HIFA initiative, states have enhanced authority to expand coverage while reducing benefits, increasing cost sharing, and limiting enrollment in ways not otherwise permitted. These waivers must also be budget neutral. Declining revenues and increasing health care costs have led states to seek waivers to reduce Medicaid spending in ways not previously allowed. For instance, under the HIFA initiative, states can choose to expand coverage but must save money from reductions in benefits, higher copayments, and limits on eligibility for certain enrollees, or by using Medicaid or State Children’s Health Insurance Program (SCHIP) funds to re-finance existing coverage. In the current fiscal climate, many states are using the waivers to cut back coverage rather than expand to new populations. Finally, some have raised concerns that the use of waivers could increase existing cross-state variation in program design and create disparities in eligibility and coverage.

Another new federal waiver program is Pharmacy Plus, which offers states the opportunity to secure federal Medicaid matching funds for the cost of operating prescription drug programs for seniors, including existing programs they have funded with state-only dollars. To secure a Pharmacy Plus waiver, however, states are required to accept a cap on the amount of federal dollars they receive to provide services to all seniors on Medicaid, including nursing home care and other long-term care services. These waivers could pose a fiscal risk to states and may create new incentives to cut back on the coverage provided to seniors on Medicaid.

Given the absence of federal relief, flexibility to tailor the Medicaid program through the waiver process along with cost-containment strategies may be attractive to states experiencing fiscal strain. Yet such changes are not without their disadvantages. Cutting Medicaid eligibility or services could increase the burden on public health and

uncompensated care systems that have historically served the uninsured; and reducing Medicaid provider reimbursement rates may lead some providers to stop serving Medicaid enrollees altogether, further impeding access for enrollees. In addition, while coverage has been extended to some new populations, the coverage they receive can be limited to only outpatient care or only certain types of services, calling into question the adequacy of their coverage under Medicaid. Finally, broad state flexibility could significantly erode any national standards in place for the coverage of health and long-term care to low-income populations, as the states will likely adopt considerably different policies in response to this new flexibility.

Federal Changes to Medicaid: Implications for Medi-Cal

Whenever states face a fiscal crisis, Medicaid spending is always at the center of attention. The current fiscal crisis is no exception. Given the unpalatable options of cuts to services or benefits, states have looked to the federal government to assist them in both paying for Medicaid and providing them more flexibility to shape their programs. In response to state pleas for assistance, several proposals are under consideration. Proposals to increase the federal matching rate (FMAP) would increase the federal share of program costs and provide direct fiscal relief to states. Other options would shift more of the cost of care for the elderly and disabled entitled to both Medicare and Medicaid to the federal government, reducing state spending for Medicaid’s most costly beneficiaries. Still other proposals focus on general fiscal relief to states. In its budget for FY 2004, the Bush Administration introduced the framework of a Medicaid restructuring proposal that would consolidate and cap federal funding for both Medicaid and SCHIP building on the HIFA waiver program. The National Governor’s Association has formed a taskforce to consider the wide range of proposals that has been forwarded and make recommendations.

Under the Bush proposal, states could either opt to receive the block grant or they could retain the current administrative and funding structure for Medicaid and SCHIP. States opting for the block grant would gain broad flexibility over program coverage in return for a cap on federal funds based on the amount they received in 2002 (adjusted annually). The block grant would replace the current open ended matching funds. States that accept the block grants would be required to spend at least as much of their own funds on Medicaid and SCHIP as they spent in 2002, adjusted annually.

Although key details in the financing of this proposal are not available, the general concept is that by accepting the block grant, states would receive some additional federal funding for Medicaid in the near term and major flexibility to alter their Medicaid eligibility and coverage rules. Coverage for beneficiaries in mandatory coverage populations, which represent approximately two-thirds of beneficiaries nationally, would be required, but these mandatory populations could be subject to higher cost-sharing and limits on optional benefits. Mandatory populations include children under 5 years old and pregnant women under 133% FPL, and children ages 18 and younger up to 100% FPL. For optional populations, states would have broad authority to change Medicaid rules and regulations, modify eligibility requirements, and revise or eliminate benefits and services without having to apply for federal waivers as is now required. Optional groups include parents of low-income children and many aged and disabled Medicare beneficiaries. Two-thirds of

current Medicaid spending is for optional populations or benefits offered at state option.

The initial fiscal relief that states are offered under Bush's proposal is relatively modest — \$3.25 billion in 2004, totaling an estimated \$12.8 billion between 2004 and 2010. State budget shortfalls are expected to be upwards of \$70 billion in 2004. States would have to “repay” the federal government the initial amount in later years to achieve federal budget neutrality. For states with relatively high growth in Medicaid, the amount received under the block grant could be lower than the projected amount that would have been received under the existing federal match arrangement.

According to the Bush Administration, the intent of this proposal is to encourage flexibility within Medicaid so that states can have greater control of program costs as well as authority to implement program changes to accommodate local needs. Supporters of the Administration's proposal argue that it would increase states' incentive to deliver cost-effective services and would give states greater control over the design and administration of their own programs.

Opponents argue that the ultimate effect would be to end the entitlement and reduce the total amount of federal support for Medicaid and shift the shared financial risk of the program between federal and state resources over to the states. Opponents contend that states would likely be forced to scale back their Medicaid programs by reducing eligibility, providing fewer services, or raising beneficiary cost-sharing requirements. They believe that states already have considerable flexibility to shape eligibility and benefits for optional populations and have exercised it with their most recent round of cuts. Finally, some have raised concerns that there would be little accountability for how the estimated \$2.7 trillion in federal Medicaid dollars over the next 10 years will be used under the block grant.

Issues for California

Only the broad framework of the Bush Administration's proposal has been introduced and as such it is hard to estimate the impact of this proposal on California. However, if the Administration's proposal were implemented, California could opt to retain the current administrative and financing structure of its Medi-Cal and Healthy Families programs; however, the Bush proposal does not provide additional federal financial assistance to states that do not opt into the block grant. Combined with the state's already tight fiscal constraints, this option could exacerbate Medi-Cal budget pressures and could lead to eligibility restrictions and other program reductions in the short term. If California opted for the block grant funding, the state would absorb the risk that federal resources might not keep pace with increases in program costs due to growth in enrollment and health care costs. This option could increase the state's Medi-Cal funding burden and intensify pressure to make additional program reductions over the long term.

Furthermore, coverage for enrollees who are eligible for Medi-Cal as part of optional covered populations—such as parents with Medi-Cal eligible children, certain low-income children, and “medically

needy” individuals—could be reduced or eliminated. The optional benefits that California covers, such as prescription drugs, screening services, dental services, and eyeglasses, could be further limited or cut for both the mandatory and optional populations.

In attempting to sustain public programs while balancing the state's budget, California policymakers face difficult decisions involving both spending reductions and revenue increases. Accommodating competing demands for increasingly limited state dollars potentially jeopardizes coverage for the nearly one in five Californians who rely on Medi-Cal and other public insurance programs. Some beneficiaries could lose access to needed services, while others could lose coverage altogether. In addition, by spending fewer state dollars for Medi-Cal, California would lose valuable federal matching funds that would otherwise contribute to the state's economy. Tensions that have arisen in Medi-Cal— between expanding coverage and maintaining current levels of access, quality, and services, and between accommodating rising health care costs and addressing the state's budget shortfall—are likely to continue. These tensions will shape the debate about Medicaid reform at both the federal and state level.

For Further Reference

California Budget Project

<http://www.cbpp.org/>

California Department of Health Services Medical Care Services

<http://www.dhs.ca.gov/mcs/index.htm/>

Center on Budget and Policy Priorities

<http://www.cbpp.org/>

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.gov/>

Health Access

<http://www.health-access.org/>

Kaiser Commission on Medicaid and the Uninsured

<http://www.kff.org/sections.cgi?section=kcmu/>

Legislative Analyst's Office (LAO)

<http://www.lao.ca.gov/default.asp/>

Medi-Cal Policy Institute

<http://www.medi-cal.org/>

National Governor's Association

<http://www.nga.org/>

Official California Legislative Information

<http://www.leginfo.ca.gov/>

State Health Facts Online

<http://www.statehealthfacts.kff.org/>

This brief was prepared by Juliette Cubanski, MPP, MPH and Helen Ann Halpin, PhD, Center for Health and Public Policy Studies, and Alina Salganicoff, PhD and Barbara Wentworth, The Henry J. Kaiser Family Foundation.

The California Health Policy Roundtable is supported by the Henry J. Kaiser Family Foundation, Menlo Park, California, an independent philanthropy dedicated to providing information and analysis on health issues to policymakers, the media, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.