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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

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Continuing Certain Medicaid Options Will Increase Costs, But Benefit Recipients and the State

at a glance

Florida provides Medicaid services to several optional groups of recipients and several optional services that are not mandated by federal law. These include providing prenatal care to pregnant women with incomes above 150% and up to 185% of the federal poverty level, health care services in addition to prescription drugs to medically needy individuals, and dentures for Medicaid recipients over 21 years of age.

- Continuing prenatal care to pregnant women with incomes above 150% of the federal poverty level would cost approximately $51.1 million in Fiscal Year 2005-06, including $21 million in general revenue. These services benefit women and their babies and reduce the costs associated with poor birth outcomes.
- Providing medical care in addition to prescription drugs to the medically needy would cost approximately $292.8 million in Fiscal Year 2005-06, including $122.6 million in general revenue. These services help ensure access to and continuity of care and avoid cost-shifting the burden of uncompensated care.
- Restoring denture services for adult Medicaid recipients, which were discontinued in 2002, would cost approximately $19 million in Fiscal Year 2005-06, including $7.8 million in general revenue. These services benefit recipients by improving health and quality of life, and may reduce Medicaid expenses in other areas.

Scope

Chapter 2004-270, *Laws of Florida*, directs OPPAGA to identify the costs and benefits to the state of funding three Medicaid options—prenatal care to pregnant women with incomes above 150% and up to 185% of the federal poverty level, full health care services to medically needy individuals, and dentures for Medicaid recipients over 21 years of age. For each of these options, this report addresses Florida's history of providing the service, its expected continuation costs for Fiscal Year 2005-06, and the services' perceived benefits to the state and recipients.

Background

Florida's Medicaid program, authorized by Title XIX of the United States Social Security Act, as amended in 1965, is among the largest in the country. Its purpose is to improve the health of individuals who might otherwise go without medical care. Florida's Medicaid program provides health care services to approximately 2.1 million low-income persons each month who meet federal and state eligibility requirements. Medicaid mainly serves low-income families and children, elderly persons who need long-term care services, and persons with disabilities. In Florida, the Agency for Health Care Administration (AHCA) is the single state agency authorized to administer the Medicaid program.

For Fiscal Year 2004-05, the Legislature appropriated $14.7 billion, including $4.1 billion in general revenue, to operate the Medicaid program. [1] Most of these funds (98.6%) will pay for health care services for Medicaid recipients. The remaining 1.4% or $212 million will pay for administrative functions such as program planning, data processing, and contract management.

States receive funds from the federal government for providing health care services through Medicaid based on a formula that considers states' average per capita income. The minimum federal match is 50% and currently is as high as 77%. Florida's match for Fiscal Year 2005-06 is 58.9%. Thus, the state receives $1.43 from the federal government for each dollar it invests to pay for Medicaid health care services.

Although states can establish eligibility guidelines, Medicaid programs must offer a minimum set of mandatory services to certain low-income individuals in order to receive federal dollars. States cannot eliminate mandatory services or curtail services to mandatory groups of individuals. The federal government also gives states the flexibility to expand the Medicaid program. For example, states can expand coverage to include federally approved optional services or to serve optional groups of individuals. [2]

Over the years, Florida has expanded its Medicaid program to offer a number of optional services and to provide services for several optional populations. However, in an effort to control rising Medicaid costs, Ch. 2004-270, *Laws of Florida*, eliminated funding for two optional groups and one optional service starting in July 2005. Unless restored, Florida's Medicaid program will eliminate coverage for prenatal services to pregnant women with family incomes above 150% and up to 185% of the federal poverty level, limit the services provided to medically needy individuals to prescription drugs only, and no longer provide dentures for adult Medicaid recipients. For Fiscal Year 2005-06, AHCA has requested nearly $363 million, of which $149.2 million is state general revenue, to continue these three options. [3] These funds represent approximately 2.3% of the estimated costs to provide Medicaid health care services for Fiscal Year 2005-06.

Costs and Benefits

What are the costs and benefits to the state of providing prenatal care to pregnant women whose incomes are above 150% of the federal poverty level?

AHCA estimates that it will cost approximately $51.1 million in Fiscal Year 2005-06 to continue serving this optional group. Providing prenatal services has the benefit of improving women's chances of having healthy babies, which, in turn, reduces state costs associated with poor birth outcomes. If this option is eliminated, some savings would be offset because low-income women would likely seek care from county health departments or Medicaid's Medically Needy program, which would increase those programs's funding needs.

History. Florida has provided prenatal services to pregnant women above 150% and up to 185% of the federal poverty level since Fiscal Year 1992-93. Since 1990, the federal government has required state Medicaid programs to provide prenatal services to women who have incomes up to 133% of the federal poverty level. However, because Florida has served pregnant women with incomes up to 150% of the federal poverty level since 1986-87, the federal government requires Florida to continue providing prenatal services to this group. In Fiscal Year 1992-93, Florida expanded its Medicaid coverage to include prenatal care for pregnant women with incomes up to 185% of the federal poverty

[1] The remaining $10.6 billion comes from trust funds that include federal matching funds as well as other state funds derived from hospital taxes, drug rebates, and county contributions.

[2] Florida's mandatory and optional services and groups are described in statute. See ss. 409.903 and 409.904, *Florida Statutes*, for descriptions of mandatory and optional Medicaid recipient groups; ss. 409.905 and 409.906, *Florida Statutes,* for mandatory and optional Medicaid services; and Florida Medicaid Summary of Services FY 2004-05 for service descriptions.

[3] The $363 million is from AHCA's Fiscal Year 2004-05 legislative budget request.

level. [4] Services for this optional group will be sunset on June 30, 2005, unless reauthorized by the 2005 Legislature. Based on analyses of Medicaid eligibility data, we estimated that from October 2003 through September 2004, approximately 13,400 women with incomes above 150% of the federal poverty level were eligible for prenatal care services. [5]

Costs. AHCA estimates it will cost $51.1 million in Fiscal Year 2005-06 to continue providing prenatal care to women with incomes above 150% of the federal poverty level. AHCA estimates that if the state continues serving this optional group, it would cost the Medicaid program $51.1 million in Fiscal Year 2005-06. Based on Florida's current contribution level, this would require $21 million in general revenue funds.

Benefits. The program benefits women and their babies as well as helps the state avoid costs associated with poor birth outcomes. Pregnant women receive prenatal screenings and other services that improve their chances of having a healthy baby. Because these women are eligible for the full range of Medicaid services while they are pregnant, they can also receive regular medical care for conditions that may have been untreated due to lack of health insurance or ability to pay for health care.

Providing services to this optional group enables the state to leverage federal Medicaid dollars to provide prenatal care and other pregnancy-related services for more low-income women and women with high-risk pregnancies than it could otherwise. For example, the state's Healthy Start Program provides services to women with high-risk pregnancies regardless of income, insurance status, or citizenship. [6] Healthy Start receives Medicaid reimbursement for providing services to high-risk pregnant women who are Medicaid eligible, which in turn, increases the ability of Healthy Start to offer more services or to serve more women with high-risk pregnancies.

Services for low-income pregnant women have likely helped reduce Florida's infant mortality rate, which declined from 8.8 per 1,000 live births in 1992 to a low of 7 deaths per 1,000 live births in 2000. [7] Since 2000, the rate has increased to 7.5 deaths per 1,000 live births. The Department of Health is continuing to examine data to understand the causes of this increase.

Providing prenatal services helps the state avoid costs associated with poor birth outcomes. Mothers who do not receive prenatal care are more likely to give birth to babies who are premature or have low birth weights. [8] These babies are more likely to need costly medical services during their first year of life and are at greater risk of dying during the first year of life or of having conditions that require life-long social, educational, and long-term medical care. A recent National Governors Association report showed that, on average, hospital costs for a healthy newborn are $1,300 compared to $75,000 for low birth weight babies who have health problems. In 2003, Florida reported a total of 21,366 low birth weight infants. If the state no longer provides prenatal care to women in this optional group, the number of low birth weight infants and infant deaths may increase. While the number of infants who will need additional care cannot be reliably estimated, Medicaid will fund most of the care for these infants.

Providing this optional Medicaid program helps the state avoid some general revenue expenditures for other programs. If the program is eliminated, some pregnant women who currently receive services may seek care at county health departments. Department of Health officials estimate that this anticipated

[4] In 2004, for a family of three, 150% of the federal poverty level was $23,505 and 185% of the federal poverty level was $28,989.

[5] The Department of Children and Families (DCF) is responsible for determining Medicaid eligibility. Prior to October 2003, DCF did not maintain historical eligibility information; thus, this was the first 12-month period for which we could ascertain the number of women with incomes above 150% of the federal poverty level.

[6] Services include care coordination, home visits, nutritional counseling, breastfeeding support, parenting education, psychological counseling, and smoking cessation support.

[7] This decline coincides with the state's expansion of Medicaid prenatal care to include women with incomes between 150% and 185% of the federal poverty level and the creation of the Healthy Start program.

[8] These are babies weighing less than 5 lbs. 8 oz., including those weighing less than 3 lbs. 5 oz. (considered very low-weight babies).

increase in caseload would require an additional $4 million in general revenue funds for the county health departments.[9] In addition, some of these women would become eligible for services under Medicaid's Medically Needy program, assuming the state continues that optional program.[10] At the October 2004 Social Services Estimating Conference, AHCA officials estimated that eliminating prenatal services for this optional group would result in $32.2 million in increased costs for the Medically Needy program.[11] Thus, some state costs would be shifted rather than avoided if the state eliminates services to this group.

What are the costs and benefits to the state of providing full medical services to individuals who are medically needy?

AHCA estimates that for Fiscal Year 2005-06, it would cost an additional $292.8 million to continue providing full health care services to medically needy individuals. Continuing the program would enable individuals with catastrophic medical expenses to receive needed medical treatment as well as prescription drugs and would help avoid cost-shifting for uncompensated care and state Medicaid nursing home costs.

History. The Medicaid program has provided health care services to medically needy individuals since 1986. Medically needy persons are those who are aged or disabled, children and their caretakers, or pregnant women whose incomes are too high to qualify them as regular Medicaid recipients. States have the flexibility to define their medically needy populations and the services to be covered. In Fiscal Year 2003-04, 35 states and the District of Columbia provided Medicaid assistance to the medically needy. Historically, Florida has provided all Medicaid services to the medically needy except for long-term care services. Florida served 100,115 medically needy individuals in Fiscal Year 2003-04.

Florida's medically needy individuals typically fall into one of two categories. The first category includes persons who have short-term or unexpected accidents or illnesses. Individuals in this category tend to include families with children or non-citizens who are legal residents and need emergency medical treatment. The second category includes persons with chronic conditions that result in ongoing high medical costs. Individuals in this category generally are aged or disabled.

In Fiscal Year 2003-04, the aged and disabled (individuals more likely to have ongoing chronic conditions) accounted for only 38% of the medically needy group but were responsible for 62.4% of the costs to serve this group. In contrast, families with children and non-citizen legal residents (individuals more likely to experience short-term illnesses) represented 62% of the medically needy group but only 37.5% of the expenditures.

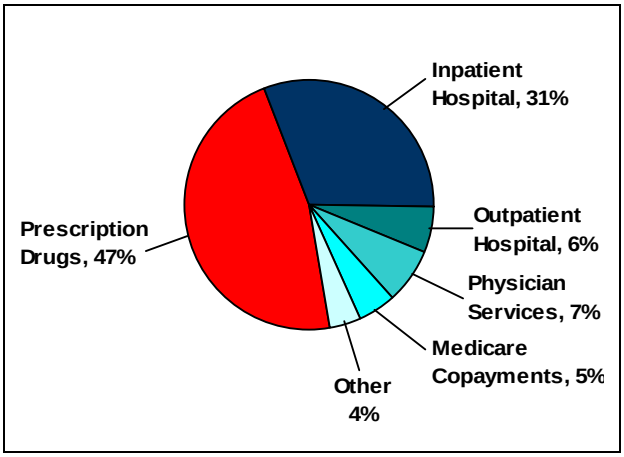
In that same year, it cost Florida's Medicaid program $469.7 million to provide health care services including prescription drugs to medically needy individuals. To reduce these costs, the 2004 Legislature provided that beginning in July 2005, Medicaid is to provide only prescription drugs to the medically needy. As shown in Exhibit 1, this will reduce program costs by over half.

[9] The $4 million represents the amount of general revenue the Department of Health estimates it would need to replace lost federal dollars for providing prenatal care for a portion of this optional group.

[10] According to federal law, as long as a state has a Medicaid Medically Needy program (even if services are restricted), pregnant women who quality as medically needy must be provided prenatal and delivery services.

[11] Most pregnant women in this optional group would likely incur costs that would qualify them for the Medically Needy program during a portion of their pregnancy. Hospitals incurring delivery charges for these women will likely encourage them to file for coverage under the Medically Needy Program so the hospital can receive Medicaid reimbursement for delivery services.

Exhibit 1
Prescription Drugs Accounted for 47% of Medicaid's Expenditures for Medically Needy Individuals in Fiscal Year 2003-04



Source: AHCA claims data for Fiscal Year 2003-04

Costs. AHCA anticipates it would cost $292.8 million to continue Medicaid services other than prescription drugs to the medically needy. AHCA has requested $292.8 million, which includes $120.3 million in general revenue, to restore health services other than prescription drugs for the medically needy. These additional dollars would pay for services such as physician, hospital, laboratory, and medical equipment for around 100,000 medically needy individuals.

If the Medically Needy program is continued but limited to providing prescription drugs, AHCA estimates that program costs will be approximately $279 million during Fiscal Year 2005-06. Some uncertainty exists in this estimate because the federal government will begin providing prescription services for dual eligible individuals through the Medicare Modernization Act (see Appendix A for more information on this act.) [12] In Fiscal Year 2003-04, dual eligible medically needy individuals accounted for two-thirds (68%) of the prescription drug costs for the medically needy. When the new federal drug benefit is implemented in January 2006, Florida will no longer receive federal funds for this group but will continue to have to pay a share of these costs. Also, as discussed on page 4, if prenatal services for women with incomes above 150% of the federal poverty level are eliminated, some women will likely turn to the Medicaid's Medically Needy program to cover their pregnancy and delivery costs.

Benefits. Full health care services benefit medically needy individuals by ensuring access to and continuity of care and helping avoid the burden of uncompensated care. Continuing the current program and providing full health services in addition to prescription drugs would benefit the medically needy by enabling them to receive continuous treatment for their conditions. If coverage is limited to prescription drugs, individuals who have long-term chronic conditions or severe progressive illnesses such as multiple sclerosis, diabetes, and congestive heart failure or those who need or have had organ transplants may avoid or delay needed or routine medical care and monitoring of their conditions. [13] This could compromise their current medical condition and their medications' effectiveness.

In addition, the program reduces the number of uninsured individuals in the state and supports state efforts to make health insurance available to all residents. [14] The only other state-supported program for very ill individuals who can not obtain health insurance is the high-risk-pool, which has been closed to new enrollees since 1991. [15]

Limiting the Medically Needy program to prescription drugs would result in higher costs to other state programs, which would partially offset the savings. In the absence of full health care services, some disabled medically needy individuals who currently live in their homes or communities with the assistance of support services such as personal care and durable medical equipment would face an increased risk of being placed in a nursing home or other institutional setting. Because some of these individuals would qualify for regular Medicaid benefits, a portion of the savings realized by

[12] Dual eligible persons are individuals who qualify for both Medicaid and Medicare.

[13] Routine monitoring includes tests to evaluate therapeutic levels of prescribed medicines as well as physician visits to prescribe and adjust dosages or brands.

[14] In 2004, Florida ranked 41st in the nation, with 18.2% of the population uninsured.

[15] As of September 2003, the state's high risk pool served 525 individuals.

reducing medically needy services would be offset by higher Medicaid nursing home costs. Although the number of individuals cannot be reliably estimated, the average annual cost to Medicaid for nursing home placement is currently $55,000.

Further, since some persons currently receiving program services would likely require some level of uncompensated care, limiting the program to prescription drugs would result in cost shifting that would affect health care costs paid through other public and private programs. For example, persons currently receiving program services would likely rely on the state's safety net system which includes certain hospitals, the county health departments, and federally qualified health care centers.[16] To support some of this uncompensated care, local governments may need to increase local taxes or shift funding from other services. In addition, costs to private health care plans may increase.

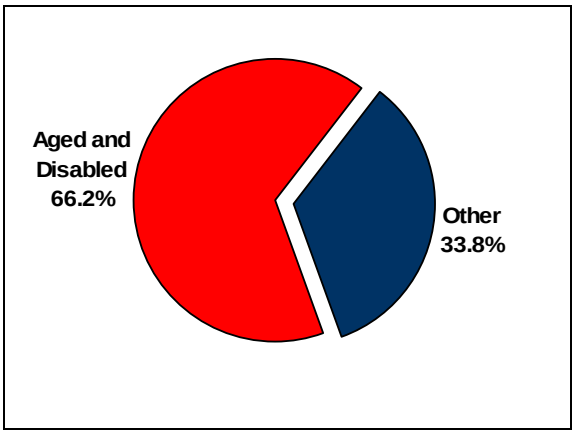
What are the costs and benefits to the state of providing dentures to Medicaid recipients over 21 years of age?

AHCA estimates that it would cost $19 million to provide dentures and related services to adult Medicaid recipients in Fiscal Year 2005-06. Restoring this Medicaid service would benefit recipients and could reduce Medicaid expenses in other health care areas.

History. Florida has paid for adult dentures for 24 of the last 26 years. Florida's Medicaid program has provided dental services since 1978. Until Fiscal Year 2002-03, these services included preventive care, emergency care, and dentures.[17] In Fiscal Year 2002-03, the Legislature limited dental coverage for Medicaid adult recipients to emergency dental care only. The 2004 Legislature restored funding to pay for adult dentures from January through June 2005. During this time, Medicaid recipients will be expected to contribute 5% of the cost of the dentures and related services.[18] As of September 2003, Medicaid programs in 28 states and the District of Columbia offered denture services.[19]

In Fiscal Year 2001-02, the last year of available funding, Medicaid provided dentures to 19,254 individuals. Two-thirds of these individuals were aged or disabled. (See Exhibit 2.)

Exhibit 2
In Fiscal Year 2001-02, 66% of Denture Recipients Were Considered Aged or Disabled



Source: OPPAGA analysis of AHCA claims data for FY 2001-02.

During that same year, $16.3 million or 70% of Medicaid's costs associated with providing dental services for adults were for dentures and related services. (See Exhibit 3.) These costs paid for extractions of remaining teeth, fitting, creating, and adjusting the denture, relining the denture foundation, and related services such as office visits.[20]

[16] The state's safety net health care system provides the majority of uncompensated care. These providers receive state funds and a fixed amount of federal matching funds which do not increase if uncompensated care increases. Other safety net system providers include county services supported by local taxes and charity care provided through donated professional services.

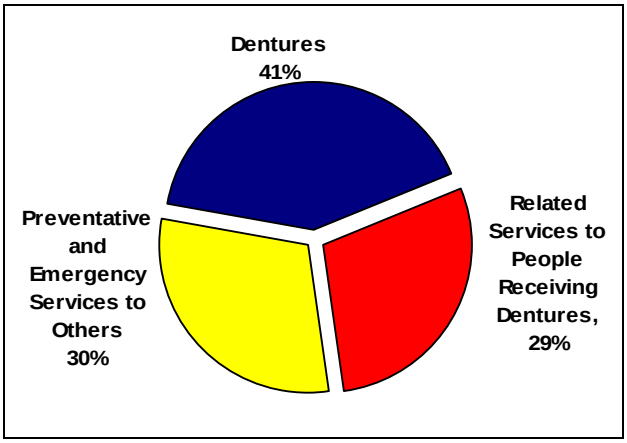
[17] Medicaid dental services have not included restorative treatments or partial dentures.

[18] Recipients that live in nursing homes or who receive health services from HMOs are exempt from paying 5% of the costs. Medicaid reduces provider payments by the co-payment amount, expecting individuals to pay their share of costs. Providers are prohibited from denying services to individuals who cannot meet this co-payment.

[19] Florida did not offer dentures in 2003.

[20] Individuals with extensive but incomplete tooth loss must have remaining teeth extracted to fit dentures.

Exhibit 3
Dentures and Related Services Accounted for 70% of the Total Expenditures for Adult Medicaid Recipients in Fiscal Year 2001-02



Source: OPPAGA analysis of AHCA claims data for FY 2001-02.

Costs. The Medicaid Program estimates that restoring denture services in Fiscal Year 2005-06 would cost $19 million in state and federal funds. AHCA has requested $19 million, of which $7.8 million is general revenue, to restore denture services for 24,000 Medicaid recipients in Fiscal Year 2005-06. The average cost per person for providing this service would be $793.

Benefits. Medicaid recipients and the state benefit when the state provides dentures through improved health and quality of life and avoiding additional costs for other Medicaid health care services. Dentures can improve an individual's self-esteem and quality of life, reduce the risk for some oral diseases, and improve absorption and digestion of essential vitamins and nutrients which can improve health. Individuals needing dentures are likely to have poorer nutrition and problems with digestion, which can exacerbate other health conditions. Thus, providing denture services could avoid Medicaid costs in other health care areas. However, neither AHCA nor other stakeholders are aware of any consequences to recipients nor have they assessed whether Medicaid costs increased since 2002 for recipients who needed but did not receive dentures.

Without Medicaid funding, some individuals may have difficulty obtaining dentures and may experience increased health problems. These persons must rely on a small network of charity and discounted care to receive dentures. Statewide, dental care for indigent populations is limited. The state's two dental schools, local charity networks, and some community health departments and federally qualified health centers offer dental services for individuals who cannot afford the full cost of these services. Payment is generally based on a sliding fee schedule. However, the availability of lower cost dental services varies by region. In addition, even if available, lower cost dental services may not include dentures.

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Appendix A

The Medicare Modernization Act Will Significantly Affect State Medicaid Programs

The federal government passed the Medicare Modernization Act (MMA) in 2003. This act established Medicare Part D which directs Medicare to provide prescription drug coverage to all enrollees starting in January 2006. Part D also will significantly affect the flow of funds between the federal and state governments for health care services.

Historically, Medicare has not provided prescription coverage to its beneficiaries. Most Medicare beneficiaries have paid for prescription drugs directly or by purchasing a supplemental insurance plan with prescription coverage. However, low income Medicare recipients, who are also eligible for Medicaid (dual eligibles), have relied on Medicaid to pay for their prescriptions. As with all Medicaid services, states receive federal matching funds to offset the costs of providing prescription drugs.

Once the Medicare program begins paying for prescription services, dual eligible enrollees will receive coverage for prescription drugs. As a result, the federal government will no longer provide states with Medicaid matching funds for these services.

Further, although states will no longer directly pay for prescription services for dual eligibles, they will be required to share the cost of this benefit. States will be required to pay the federal government 90% of what the state share would have been if Part D had not occurred. [21] The federal government will determine each state's payment using projections from calendar year 2003 expenditures and recipient enrollment data. AHCA estimates that Florida will pay $111.51 per dual eligible enrollee per month to the federal government as the state share of cost for the Part D program, although actual figures are not yet available. Thus, states are not likely to realize significant savings from this change but will merely shift expenditures from direct program support to a federal payment.

Because many of the details related to Medicare Part D have not been finalized, it is difficult for the state to accurately project the effect of these changes. For example, Medicare Part D will likely not include all of the medications currently available through Florida's Medicaid prescription drug benefit. At this time, the state has determined it will not provide these medications to beneficiaries in the absence of federal matching dollars, but these changes are not finalized.

[21] The state's responsibility to pay the federal government gradually decreases to 75% in calendar year 2015.