FLORIDA CENTER FOR FISCAL AND ECONOMIC POLICY

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Out of Options:
Medicaid Cuts in Areas Such As "Optional" Services Would Cost State More Than They Save

Given the persistence of Florida's budget shortfall and the inadequacy of Florida's finance and tax structure to meet the state's basic needs, the Medicaid program has already been targeted for deep cuts. Because of Medicaid's role as the safety net covering the lowest-income children, seniors, people with disabilities and pregnant women, any such cuts would have a significantly adverse affect on these most vulnerable Floridians.

Proposed Medicaid cuts will take one of at least three specific forms: 1) restrictions on the types of services available, 2) restrictions on who is eligible to receive services, and 3) restrictions (directly or indirectly) on the quantity[1] of services recipients can receive. This brief examines those three types of potential cuts and their relevance to the budget deliberations underway in preparation for the 2011 regular legislative session. Regardless of which form(s) the cuts take, they are unlikely to yield significant savings in state general revenue in the short term, as there is little to cut without reaching the bare federal minimum or causing significant harm to the Floridians who must rely on Medicaid. Beyond the short term, such cuts will cost the state much more than they save.

To conclude that a so-called optional benefit is somehow expendable or unnecessary would be a grave misinterpretation. The importance of these benefits is particularly clear given that Florida's Medicaid benefit package is less generous than those of many other states.

1. Proposals to Cut So-Called "Optional" Services

A. Optional Services Not Remotely Expendable

In addition to the set of "mandatory" benefits that state Medicaid programs must provide by federal law as part of a minimum package, they may elect to provide several dozen "optional" services. According to the Agency for Health Care Administration (AHCA), Florida Medicaid incorporates as many as 30 optional services.[2]

Optional services currently account for about 55 percent of Florida's total (federal and state) Medicaid spending.[3] Examples of optional benefits include dental care for adults, prescription drugs, and hospice care. However, it is not the service itself that is discretionary in almost half of Florida's optional services. Rather, what is optional is how the service is provided: either in a particular type of facility (for example, state mental hospital services) or by a particular type of provider (for example, physician assistant services that the state can choose to cover under Medicaid).

Most importantly, use of the "optional" label to describe such services is a complete misnomer. As explained further below, to conclude that a so-called optional benefit is somehow expendable or unnecessary would be a grave misinterpretation. The importance of these benefits is particularly clear given that Florida's Medicaid benefit package is less generous than that of many other states.[4,5]

The characteristics and health needs of Medicaid recipients and Floridians receiving employment-based coverage are not comparable. In particular, Medicaid serves only the poorest and most vulnerable Floridians, a group that on the whole has far more health problems and faces significantly more formidable barriers to care.

B. Medicaid Coverage vs. Private Coverage

In preparation for development of the 2011-12 state budget, legislative leaders have repeatedly insisted that the Medicaid benefit package must not be more robust than what is available in the private sector.[6] The key fallacy underlying this position is the assumption that the characteristics and health needs of Medicaid recipients and Floridians receiving employment-based coverage are comparable. In particular, Medicaid serves only the poorest and most vulnerable Floridians, a group that on the whole has far more health problems and faces significantly more formidable barriers to care.

In fact, recipients such as individuals with severe disabilities, seniors requiring nursing home care, children with complex health problems, and pregnant women are Medicaid-eligible as a result of their health condition or status (along with the fact that they have limited financial resources). The reality that such patients need access to much greater amounts and intensities of services than typical working-age adults renders comparisons between the two groups meaningless.

Another potentially confusing difference between Medicaid and private insurance coverage is that services sometimes considered supplemental under private coverage (e.g., dental, vision) are covered to a limited extent by Medicaid. As a result of the failure to distinguish the needs and characteristics of those with Medicaid vs. employment-based coverage, these services have become prominent targets.

First and foremost, the services available through Medicaid of this type are extremely limited in scope. Furthermore, recipients could never afford to pay for even such limited service out of pocket. For example, monthly income for seniors and people with disabilities receiving Supplemental Security Income (SSI) is $674. If dental services were eliminated, Medicaid could pay for extraction of a senior's teeth in a medical emergency but would not provide the dentures (s)he then would desperately need to

meet basic nutrition needs. All of the threatened optional Medicaid services are in fact key to the well-being of recipients with relevant health conditions, and low quality of life and jeopardized health and safety would certainly result from their elimination.

Also singled out for cuts are support services not considered medical care *per se,* but nevertheless promote successful health outcomes and save the system money. Case management, which provides coordination and linkage services for vulnerable recipients as they attempt to navigate a complex system of health and community services, is an example of such an essential service.

Finally, problems with the claim that private coverage would be cheaper than Medicaid become clearer upon examining the wide variation in average costs among diverse subgroups of Medicaid recipients. For example, although average Medicaid spending for SSI recipients is expected to be $1,482 per recipient per month in 2010-11[7], the average for the lowest-income children is only $140 per month. The average for all Medicaid clients is $570 per recipient per month; that amount compares favorably with total premiums for standard benefit packages available in private-sector coverage.

Individuals with severe disabilities, seniors requiring nursing home care, children with complex health problems, and pregnant women are Medicaid-eligible as a result of their health condition or status (and have limited financial resources). Therefore they differ from typical working-age adults.

In short, not only does Florida Medicaid coverage justifiably include some services generally not available in employment-based coverage, Medicaid also provides that coverage at or more cost-effectively than the private sector.

C. Limited Savings Potential from Optional Service Cuts

In light of Medicaid recipients' health needs and limited resources as well as the additional constraints explained below, not only is the list of optional services that can realistically be targeted for cuts relatively short, actually cutting those services would yield relatively inconsequential savings.

Table 1 below lists optional services most likely to be proposed for elimination. All have been proposed for elimination previously or were eliminated and subsequently restored.

Table 1 – Targeted "Optional" Services in Florida Medicaid

Medicaid "Optional" Benefit[8]	Description of Service Provided[9]	State General Revenue $ "Saved" (*in millions*)[10]	Matching Federal $ Lost (*in millions*)[11]	Number of Recipients Affected[12,13]
Dental services (for adults)	• Dentures and partial dentures	$13.2	$17.0	74,506
Podiatry services	• Treatment for corns, calluses, ingrown toenails, bunions, heel spurs, and arch problems • Treatment of ankle and foot injuries, deformities, and infections • Treatment of foot complaints associated with diabetes and other diseases	$2.1	$2.8	25,399 (including about 5,000 children)
Chiropractic services	• Treatment for neuro-musculoskeletal disorders and related clinical conditions including back pain, neck pain, and headaches	$0.7	$0.9	10,273 (including about 3,000 children)
Vision services (for adults) and Optometric services	• Eye exams and treatment of eye diseases • Fitting, dispensing and repair of eyeglasses (already limited to one pair every 2 years) • Contact lenses for more complex vision problems that are not corrected with regular eyeglasses or lenses • Prosthetic eye services when medically necessary	$6.5	$8.4	127,943
Hearing services (for adults)	• Hearing aid services	$1.2	$1.7	6,277
TOTAL		**$23.7**	**$30.8**	

Eliminating *all* of these services would save only $23.7 million in general revenue (i.e., less than 2 percent of the additional general revenue needed in the Medicaid program for 2011-12[14]). Further, the cost-shifting and cost-deferment associated with the loss of these services would be many times greater.

Another area in which the legislature seems likely to target reductions in optional services is within the Medically Needy program, which provides short-term coverage to individuals who are over the Medicaid income limit but have catastrophic medical expenses. Although recipients who qualify for Medicaid automatically (i.e., are "categorically needy") must have access to the full Medicaid benefit package described in the state plan for their eligibility group, medically needy recipients may be restricted to a more limited set of benefits.[15]

For example, during the 2008 legislative session, the original House budget proposed elimination of coverage of inpatient hospital care for all Medically Needy recipients except pregnant women and children. The measure was expected to achieve a "savings" of $75.5 million in general revenue.[16] Governor Scott's 2011-13 budget proposal went even further, calling for almost complete elimination of eligibility for the same group, effective July 1, 2012, preserving only access to physician services.[17] Most recently, the Senate's Medicaid managed care expansion proposal included a similar provision as well.[18]

Such cuts could be literally life-threatening. Examples of individuals who could face delayed or denied access include recipients with disability income only slightly above the SSI level ($674 per month) who need regular kidney dialysis, are awaiting an organ transplant, or who require specialized medications. The adverse economic impact of such action would also be significant: at least 3/4 of a billion dollars worth of economic activity and 7,000 primarily private-sector jobs in 2012-13.[19]

Federal Medicaid law limits the ways in which the legislature can cut services. For example, although prescription drugs – an optional benefit – absorbs a significant 8 percent of the Medicaid budget, the legislature cannot simply strip that benefit from specific groups whom they consider less deserving.

D. Permitted Variation vs. Required Variation

Federal Medicaid law includes an important protection requiring that services available to one category of Medicaid recipients "not be less in amount, duration, or scope than the medical assistance made available to" recipients in any other category.[20] This "comparability" requirement also applies to the services available to recipients within the same category. This appropriately limits the ways in which the legislature can cut services. For example, although prescription drugs – an optional benefit – absorbs a significant 8 percent of the Medicaid budget,[21] the legislature cannot simply strip that benefit from specific groups whom they consider less deserving.

There are exceptions to the comparability requirement, however. As one important example, children and youth are better insulated in federal law from efforts to erode benefits. In fact, states must cover all medically necessary mandatory and optional services for Medicaid-eligible children under the age of 21.[22] In particular, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a required benefit.[23]

Another exception, as implied above, involves the Medically Needy program. Although available benefits must be comparable among all groups of categorically needy (i.e., automatically Medicaid-eligible without meeting additional conditions) recipients, the requirement is not applicable to medically needy (i.e., must meet a "share of cost" requirement in order to become Medicaid-eligible) recipients. In particular, the legislature can make different sets of services available to different coverage groups within the Medically Needy program.[24]

On the other hand, examples of additional benefit flexibility given to the state include federal waivers that have authorized the creation of more than a dozen different initiatives providing home- and community-based services for recipients that would otherwise be at-risk for institutional placement.[25]

Finally, it is important to distinguish "optional" benefits from "limited" benefits. Some categories of recipients are defined either under federal law or via a federal waiver such that they are in fact ineligible to receive the full set of Medicaid "state plan" benefits.

These recipients receive limited services by design, as opposed to being denied access to services as a result of cuts imposed by the legislature. For example, low-income Floridians who have Medicare coverage but are not quite poor enough to qualify for full Medicaid[26] do not receive any health care services directly through the Medicaid program. Rather, Medicaid only helps pay their Medicare premiums and out-of-pocket costs.

2. Proposals to Restrict or Eliminate Coverage of So-Called "Optional" Groups

A. Optional Coverage Groups Not Remotely Expendable

One element of the federal-state Medicaid partnership has always been federal designation of "mandatory" coverage groups that include individuals who states must make eligible in order to draw down federal matching dollars. Mandatory coverage groups include extremely vulnerable Floridians, such as school-age children in households with incomes below the poverty level, as well as extremely low-income seniors and people with disabilities who receive Supplemental Security Income (SSI).[27]

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Beyond this, states may elect to extend or deny eligibility to so-called "optional" coverage groups. Despite the "optional" label, individuals in these groups are universally very low-income (or medically indigent) with no other means of securing essential coverage. Although states have considerable flexibility to cover a number of additional recipient groups, Florida has not used much of it. Optional groups covered by Florida Medicaid are listed in Table 2 below. As of December 2010, only about 180,000 (6 percent) of the more than 2.9 million Florida Medicaid recipients were members of these so-called optional groups.

Table 2 – "Optional" Coverage Groups in Florida Medicaid

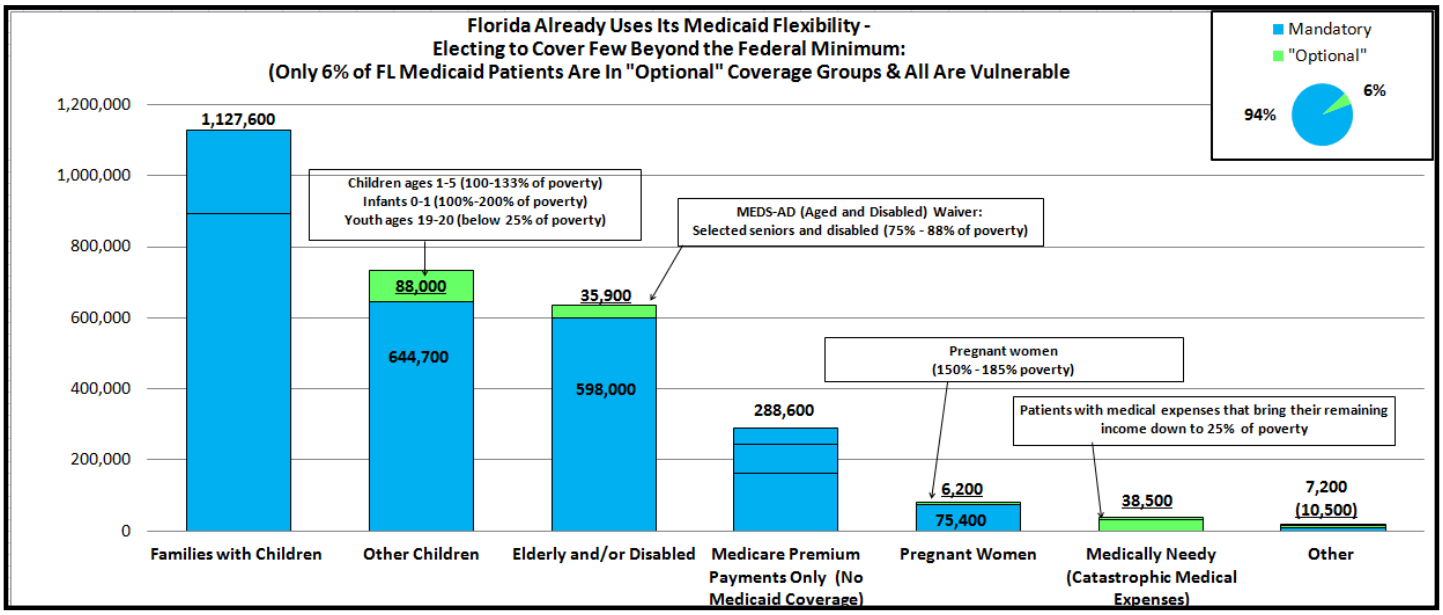
Optional Coverage Group[28]	Income Range[29] as a % of the Federal Poverty Level (FPL)	Annual Household Income Limit (for a family of 3, unless otherwise noted)[30]	Number of Recipients in Coverage Group - December 2010[31,32] *(rounded to nearest hundred)*
Infants under age 1	100% - 200% FPL	$18,531 - $37,060	7,200
Children ages 1-5	100% - 133% FPL	$18,531 - $24,645	70,600
Pregnant women	150% - 185% FPL	$27,796 - $34,281	6,200
Youth ages 19-20	Less than 25% FPL	Less than $4,716	10,300
Medically Needy (catastrophic medical expenses)	Eligibility is determined on a month to month basis. If after deducting eligible Medicaid	Less than $4,716	38,500

	expenses from a recipient's income, the remainder must be less than about 25% FPL		
MEDS-AD (Aged and Disabled) Waiver	74%[33] - 88% FPL Must also be in or at-risk for nursing home placement	$8,088 - $9,583 (single individual)	35,900
Others (refugees, family planning-only, Breast and Cervical Cancer program)	Varies[34]		11,000
TOTAL			**179,700**

The distribution of mandatory and optional groups across Florida Medicaid is shown below.

B. Limited Savings Potential from Optional Coverage Cuts

Since the purported aim of cuts is generation of cost savings, there is little to gain in that regard by eliminating coverage for these groups. Optional coverage groups accounted for a total of only 6.0 percent of total (federal and state) Medicaid spending in 2008.[35]



Furthermore, 5 out of every 6 dollars spent to cover optional groups go to the Medically Needy and MEDS-AD programs,[36] so eliminating all the other groups would trim less than 1 percent of the Medicaid budget. As a result, the legislature has frequently sought to reduce Medicaid costs by tightening or eliminating eligibility for these two programs. Both Medically Needy and MEDS-AD were assigned a sunset date in several of the last legislative sessions.[37] In 2002, the income eligibility limit for the MEDS-AD program was reduced from 90 percent to 88 percent of the poverty level.[38] The change was originally intended to be temporary, but the reduction remains in place today.

C. Maintenance of Effort Requirement Precludes Coverage Restrictions

A "maintenance of effort" (MOE) requirement included in the Patient Protection and Affordable Care Act (PPACA) provides that, until January 1, 2014 (the date by which new health insurance exchanges must become operational), the criteria used to determine Medicaid eligibility for adults cannot be any stricter than those in effect as of March 2010.[39] For children, the MOE requirement remains in effect until September 30, 2019.[40]

The most potentially impactful cost-cutting initiatives proposed for Florida Medicaid in recent years called for expanding the scope of Medicaid managed care. In particular, Medicaid HMOs are paid a capitated rate (i.e., a fixed amount per recipient per month). With capitation, for-profit HMOs have a financial incentive to reduce access to care.

Although Republican Governors have been pressing the Secretary of the federal Department of Health and Human Services (HHS) to grant exemptions from the requirement, she has indicated that she lacks the authority to do so. Consequently, measures that would tighten eligibility for these or other components of Medicaid would run afoul of the MOE requirement. If the legislature elected to ignore this requirement, it would put more than $100 billion in federal tax dollars earmarked for Florida, as well as at least 200,000 mostly private-sector jobs, at risk over the next several years.[41]

Arizona recently received confirmation from HHS that it did not need federal approval for its plan to end Medicaid eligibility for certain targeted recipients, but only because eligibility for those recipients was made possible via an *optional* federal waiver. Arizona can simply allow that waiver to expire.[42] That is wholly different from jettisoning a group already eligible under federal law from the rolls, as has been discussed by the Florida Legislature.

3. Proposals to (Directly or Indirectly) Restrict the Quantity of Services Provided

More subtle but potentially more problematic are proposals to limit the quantity of services available or accessible to Medicaid recipients. Again, federal law generally requires that the same "amount, duration and scope" of services be made available to most recipients. However, intentional strategies may be used to limit the true quantity of services to which recipients have access. These include requiring prior authorization for services, imposing or increasing cost-sharing requirements and reducing reimbursement rates for providers (which leads indirectly to service reductions). Such provisions are not new to Florida Medicaid, but the extent and scope of these proposed initiatives would be greater than ever.

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A full discussion of Medicaid managed care is beyond the scope of this brief. A forthcoming report will address specific Medicaid managed care expansion proposals under consideration for the 2011 session.

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Endnotes

[1] More precisely, quantity refers to amount, duration and scope

[2] AHCA, Presentation to the Budget Subcommittee on Senate Health and Human Services Appropriations, February 15, 2011, p.5

[3] See, e.g., Agency for Health Care Administration (AHCA), Presentation to the House Health and Human Services Committee, January 13, 2011, p.13

[4] Kaiser Family Foundation, Medicaid Benefits: Online Database

[5] Public Citizen Health Research Group, Unsettling Scores: A Ranking of State Medicaid Programs, April 2007, p.66

[6] See, e.g., Associated Press, "Florida Medicaid patients may lose dental, vision and mental health services", February 10, 2011

[7] All references to per recipient per month expenditures were taken from AHCA, Presentation to House HHS Committee, January 13, 2011, p.18

[8] Section 409.905, Florida Statutes

[9] AHCA, 2011-12 Legislative Budget Request (LBR), Schedule VIII-B, pp. 9-17

[10] Id.

[11] Id.

[12] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, "Florida's Medicaid Optional Benefits", February 10, 2011, p.2

[13] AHCA, 2011-12 LBR, Schedule VII-B, pp. 9-17

[14] Legislative Budget Commission, State of Florida, Long Term Financial Outlook, Fall 2010, p.67

[15] 42 CFR 440.240, 440.250

[16] See proviso language for Specific Appropriation 206, House Bill 5001, 1st Engrossed (2008)

[17] Governor Rick Scott, Governor's Proposed 2011-13Budget, Medicaid Conforming Bill

[18] Florida Senate, Draft 2011 Medicaid Reform Bill, p.46

[19] Estimates derived using the "Medicaid calculator" published by Families USA

[20] 42 USC § 1396a(a)(10)(B)

[21] Florida Legislature, Office of Economic and Demographic Research (EDR), Social Services Estimating Conference, Medicaid services Expenditures, December, 10 2010, p.2

[22] 42 USC §1396d(r)

[23] Id.

[24] 42 USC § 1396a(a)(10)(B)

[25] See http://ahca.myflorida.com/Medicaid/hcbs_waivers/index.shtml for a current list of home- and community-based waivers in Florida Medicaid

[26] For example, Qualified Medicare Beneficiaries and Special Low-Income Medicare Beneficiaries

[27] Section 409.903, Florida Statutes

[28] Section 409.904, Florida Statutes

[29] Department of Children and Families, e.g., Family-Related Medicaid Fact Sheet, March 2009

[30] Based on the 2011 federal poverty guidelines

[31] AHCA, Number of Medicaid Eligibles by Program-Group by Sex, December 2010

[32] AHCA, Presentation to Senate Health and Human Services Appropriations Committee, February 4, 2010, p.10

[33] The 2011 SSI payment level for an individual is equivalent to 74% FPL.

[34] For example, women ages 14-55 who lose their Medicaid coverage, have household income of less than 185% FPL and who meet other criteria are eligible for family planning services only for a period of up to 24months. See section 409.904(5), Florida Statutes.

[35] AHCA, Estimated Expenditures by Mandatory and Optional Service and Eligibility Group, June 2009

[36] Id.

[37] See e.g., sections 409.904(1) and 409.904(2), Florida Statutes (2010)

[38] Section 1, Chapter 2001-377, Laws of Florida

[39] Section 2001, Patient Protection and Affordable Care Act (PPACA)

[40] Id.

[41] FCFEP, Unhealthy Choices, p.1

[42] Arizona Republic**, "**Arizona Medicaid cuts OK, feds say," February 16, 2010