Issue Brief **January 2012**

Million Unwise, Billion Foolish:
How the Governor's Proposed Medicaid Cuts Will Hurt Florida's Economy

Summary:
The Governor's proposed 2012-13 budget calls for a $3 billion reduction in total appropriations. Key to achieving a reduction of this magnitude is a cut of more than $2 billion to the perennially targeted Medicaid program. However, the Governor's proposal ignores all of the following:

- Only about one-fifth of the funds "saved" would be state general revenue dollars. In fact, the majority of the reduction ($1.2 billion) would be in the form of lost federal matching dollars.
- The amount of general revenue needed to preserve Medicaid for next year is $3 billion (more than one-third) *less* than state projections issued prior to the start of the recession.
- The projected shortfall in Medicaid was specifically created by the legislature through the aggressive replacement of Florida's recurring investment of state funds with short-term federal stimulus dollars.
- The proposed cuts would be detrimental to both Florida and Floridians, undermining the already strained Medicaid system, imperiling access to care for the sickest, and siphoning Florida's share of federal tax dollars out of the economy.

About the Governor's Proposed HHS Budget:
Last month, Governor Rick Scott released his proposed budget for 2012-13. His proposal serves as the baseline from which the legislature will begin its budget deliberations. Central to his proposal calling for $66.4 billion in total spending, a $3 billion decrease from this year's total, are almost $1.9 billion in aggregate health and human services (HHS) cuts.[1]

More specifically, HHS programs and services would be reduced by 6.2 percent, from $29.9 billion to $28.1 billion, even as the needs of poor and vulnerable Floridians linger at or near record levels in the wake of the recession.

Given the Governor's opposition to exploring any options for increasing revenue, along his with insistence that spending be arbitrarily curtailed (though he has proposed a $1 billion increase in general

revenue K-12 education funding in response to very unpopular cuts made last year), it was inevitable that he would advance significant HHS cuts for consideration again this year.

Of the six state agencies responsible for the delivery of health and human services, only the Department of Children and Families' proposed budget includes a net increase in funding, and that would be through the restoration of previously cut funding as well as system and technology investments that would not provide direct service.

Medicaid: The Primary Target, Again

The bulk of the HHS reductions would be absorbed by the Agency for the Health Care Administration (AHCA), the state's Medicaid agency. Although proposed reductions would total $2.07 billion, only about one-fifth of that money would be state general revenue (GR).[2] That distinction is critical, because when the Governor defended his proposal, insisting that, "If we do nothing, [Medicaid] will bankrupt our state[3]", he could only have been referring to general revenue. GR is the portion of the Medicaid budget the state is directly responsible for raising.

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In particular, as detailed in this brief, in order to save $442 million in GR (less than 2 percent of the total projected to be available), the Governor proposes to turn away $1.2 billion in federal funds that will go to other states while leaving critical needs in Florida unaddressed.

The cuts are to be achieved through four measures[4] that not only adversely impact the hospitals that provide care to Medicaid recipients, but also the vulnerable Floridians that depend on Medicaid for health and well-being. Further, because the services that would become uncompensated care (or further under-compensated) as a result of these reductions are medically necessary, most or all of the services must still be provided regardless. A significant portion of those costs would be shifted to Floridians with private insurance coverage as a result.

1) Applying a new "rate banding" method for determining hospital reimbursement rates.[5]

Medicaid reimbursement rates paid to hospitals vary widely. In particular, hospitals that serve sicker and/or poorer patients generally receive higher reimbursement rates. This includes hospitals with trauma centers or neonatal intensive care units, as well as safety net hospitals that provide the bulk of charity care, graduate medical education, and organ transplants in the state. The hospitals that fill these critical but often unprofitable roles are partially subsidized through these higher Medicaid reimbursement rates.

Rate-banding would reduce the state's investment in Medicaid by arbitrarily restricting the factors that can be considered in determining the reimbursement rates paid to hospitals (as well as to HMOs for their hospital care contracts). Each hospital would be assigned to a category, and all hospitals in a given

category would be paid a uniform, lower rate that disregards many important considerations. The end result – and the intended aim – would be an almost 40 percent reduction in total Medicaid payment to Florida hospitals next year.

2) Reducing the maximum number of hospital inpatient days per year from 45 to 23 (for non-pregnant adults).[6]

Of the elderly and/or disabled recipients in Florida Medicaid, approximately 1.5 percent of them needed more than 23 days of inpatient hospital care (for either physical or behavioral health conditions) in 2009-10.[7] Although this is a small segment of the Medicaid population as a whole, it includes several thousand of the very sickest Floridians, and they accounted for more than 40 percent of total inpatient costs in Florida Medicaid.[8] And although Medicaid would continue to reimburse for additional days of inpatient care in the event of an emergency or trauma admission, hospitals would either need to absorb the cost of providing any other inpatient care (using means such as cost-shifting) or limit access.

3) Restricting the services provided to Medically Needy recipients to physician services, inpatient hospital care, outpatient hospital care, and prescription drugs only (for non-pregnant adults).[9]

Medically Needy recipients are patients whose household incomes exceed the Medicaid income eligibility limit but who have catastrophic medical needs. Such individuals become Medicaid-eligible in any month in which they meet their "share of cost" (i.e., their medical bills reduce their net income below the Medicaid eligibility limit).

Although direct hospital care is not a target for cuts in the Medically Needy program as in past years, other critical services such as home health care, x-ray and laboratory services, transportation and private duty nursing are proposed for elimination. Although the resulting GR "savings" would be small, the consequences of even these cuts could be dire. For example, a Medically Needy patient receiving a lifesaving organ transplant would be covered for the surgery, medications, and extensive hospital stay that followed, but might not be covered for or have access to all necessary follow-up care, potentially threatening the ultimate success of the procedure.

4) Limiting the number of hospital emergency room visits per year to 12 (for non-pregnant adults).[10]

Much like the policy change approved by the legislature last session (which is under federal review) which would impose a $100 co-payment requirement on recipients who seek care in a hospital emergency room for what is deemed non-emergency care, this cap would apparently take no other factors into consideration, including individual circumstances or access to providers.

Million Unwise AND Billion Foolish:

To assess the *actual* impact of these proposed actions on the state budget, we must examine changes in general revenue spending rather than total Medicaid spending as a whole. The vast majority of the Medicaid budget is funded from sources other than the state itself. Most importantly, federal funding will account for 57.7 percent of Florida's Medicaid spending in 2012-13.[11] Funds generated by local

governments and hospital taxing districts as well as direct assessments on providers are transferred to the state for the purpose of leveraging federal matching dollars. Consequently, the state GR invested in Medicaid for the current year constitutes only 20 percent of the total state Medicaid budget.[12] In the aggregate, every GR dollar spent on Medicaid this year will leverage $2.63 in federal funds.[13]

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Of the four targeted areas, $416 million (94 percent) of the proposed GR reductions would be realized through the two initiatives particularly harmful to hospitals and the Medicaid recipients they serve: payment "rate-banding" and limits on inpatient stays. As it is these uses that are most heavily supported by local government and hospital taxing district funds that also draw down Medicaid matching funds[14], the effective federal match rate[15] for these expenditures is almost 74 percent! The magnitude of the resulting loss to the Medicaid budget (and Florida's economy) in 2012-13 is therefore even more significant, as shown in Table 1 below. **In particular, $1.2 billion in federal matching dollars would be lost, along with an estimated 46,000 jobs.[16]**

Table 1: Summary of Proposed 2012-13 Medicaid Cuts

Proposed Payment or Benefit Reduction	Proposed State GR Funding Cut *(in millions)*	% of Total State GR "Saved"[17]	Non-Federal (local, provider, etc.) Funds Lost or Misused[18] *(in millions)*	Federal Funds Lost[19] *(in millions)*	Total Funds Lost or Wasted Due to GR Cut *(in millions)*
Hospital Payment "Rate-Banding"	$384.1	1.6%	339.2	$1,069.8	$1,853.1
Limiting Hospital Inpatient Stays	$32.2	0.1%	$34.0	$90.4	$156.6
Limiting Services to Medically Needy Recipients	$20.2	0.1%	$0.3	$28.0	$48.5
Limiting Hospital Emergency Room Visits	$5.2	0.0%	$0.0	$7.1	$12.2
TOTAL	**$441.6**	**1.8%**	**$433.6**	**$1,195.2**	**$2,070.4**

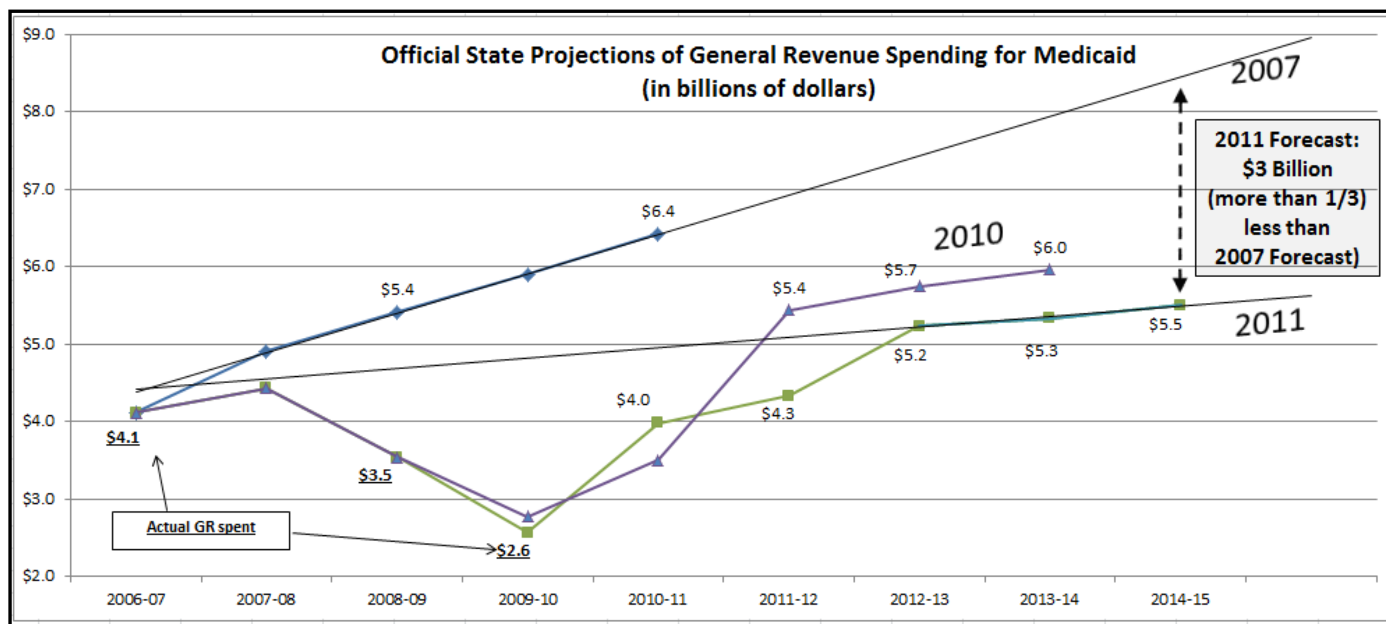
Breaking the Bank?

Table 2 and Figure A below compare three recent state economists' forecasts of GR spending on Medicaid. State forecasts include the current state fiscal year and the next three years. Trendlines are added to show projected GR spending levels if growth continued at forecasted rates.

Table 2: Summary of Medicaid GR Spending Forecasts

Year	State Forecast Re: Medicaid GR Spending
2007-08 Forecast[20]	The official projection was that spending would reach $6.43 billion by 2010-11, and at that rate, would reach $8.45 billion by 2014-15.
2010-11 Forecast[21]	The trendline showed GR spending reaching a much lower $6.22 billion by 2014-15.
2011-12 (Current Year) Forecast[22]	The 2014-15 GR spending projection was lowered to $5.50 billion.
	In addition, projected GR spending for this year (2011-12) was $4.3 billion, less than the *actual* $4.4 billion spending for 2007-08.
	Finally, projected GR spending for next year (2012-13) is $5.2 billion, less than the amount previously projected for 2008-09.

Figure A



In short, in just four years, the amount of general revenue the state projected would be needed to operate the Medicaid program in 2014-15 dropped by almost $3 billion, a 35 percent reduction. To the extent the state was ever at risk of Medicaid "breaking the bank", that risk is far lower now than it was in 2007.

Why the Medicaid GR Gap Isn't Nearly As Formidable As Advertised

The earlier state forecasts cited above were predicated on assumptions that have since been modified or become obsolete. Needless to say, there *have* been intervening factors in recent years that have

curbed the growth in GR spending on Medicaid. These include cost containment initiatives initiated by the legislature, particularly several budgets that included reductions in payment rates to providers. They also include factors not under the state's control such as the availability of federal Medicaid stimulus funds and recession-fueled increases in Medicaid enrollment levels.

Billions in federal stimulus funding was made available by Congress to boost the share of Medicaid costs borne by the federal government, softening the blow of the recession on state budgets. In Florida, the share of Medicaid spending paid by the federal government was 12.4 percent higher than the standard Federal Medical Assistance Percentage (FMAP) from October 2008 through December 2010. The FMAP increase was then phased out from January through June 2011. During that 33-month period, the legislature heavily decreased its investment of GR in Medicaid, removing far more from the program's budget than the amount necessary to preserve eligibility and services. As a result, an artificially inflated shortfall of GR funding for Medicaid was created once the stimulus funds stopped flowing. Refer to Figure A above.

During that 33-month period, the legislature heavily decreased its investment of GR, removing far more from the program's budget than the amount necessary to preserve eligibility and services. As a result, an artificially inflated shortfall of GR funding for Medicaid was created once the stimulus funds stopped flowing.

However, for the 2011-12 (current year) budget, the legislature filled the gap in part by tapping the balance of an indigent care trust fund that was not accessed the previous year when stimulus funding was still flowing. The Legislature also cut more than $300 million in General Revenue to hospitals, nursing homes, health departments, and other providers.

Putting this all together, from 2007-08 to 2012-13, the amount of general revenue invested in Medicaid increased by an average of $160 million (3.6 percent) per year. This is especially modest growth given that Medicaid enrollment will have increased by 1.2 million recipients (an average of 11 percent per year) during the same period, mainly due to recession-driven job and income losses. The relative size of the GR investment needed to sustain the Medicaid program will decrease further as the economic recovery continues, with total GR collections increasing even as enrollment decreases.

In conclusion, in light of the unprecedented leveraging that occurs when state general revenue is invested in Medicaid ($10.8 billion in federal tax dollars will come back into the state's economy in 2011-12 alone), as well as the extreme vulnerability of the Medicaid recipients who would be harmed by the proposed cuts, there simply is no rational basis for the Governor's insistence on yet another round of attacks undermining this critical safety net program.

This report was researched and written by Greg Mellowe. The report and its findings do not necessarily reflect the views of the FCFEP Board of Directors.

Endnotes

[1] Office of the Governor, Fiscal Year 2012-13 Recommended General Appropriations Act (GAA), p. 342

[2] Office of the Governor, Presentation of 2012-13 Policy and Budget Priorities, Senate Budget Committee on Health and Human Services Appropriations, December 2011, p.8

[3] Office of the Governor, "Education and Jobs Top Governor Scott's Budget Priorities" (*media release*), December 2011

[4] Additional Medicaid cuts are proposed for the Agency for Persons with Disabilities. Some services and rates are to be cut, although a portion of the funds are to be restored if the cuts are finalized. The net GR reduction would be $6.0M.

[5] See, e.g., Office of the Governor, 2012-13 Recommended GAA, p. 31

[6] Id., p., 32

[7] Agency for Health Care Administration (AHCA), Florida Medicaid Reform Data Book, Inpatient Days Tables, Nov 2011

[8] Id., Inpatient Annual Expenditures Tables

[9] Office of the Governor, 2012-13 Policy and Budget Recommendations, Budget Detail, December 2011

[10] Office of the Governor, Recommended GAA, p.33

[11] Florida Legislature, Office of Economic and Demographic Research (EDR), Social Services Estimating Conference (SSEC), Official FMAP Estimate, January 2012

[12] See EDR, SSEC, Medicaid Caseloads and Expenditures, July 2011, p.2 (i.e., based on 2011-12 appropriation)

[13] Id.

[14] See, e.g., EDR, SSEC, Medicaid Long Term Forecast, July 2011, pp.2-5

[15] In this situation, the effective federal match rate is the percentage of the total of only the federal and state GR funds. For example, suppose $2 of GR and $2 of other funds are used to draw down $6 of federal funding. The effective federal match rate would be $6 ÷ ($6 + $2), or 75%.

[16] Job loss estimate per the Florida Hospital Association

[17] Total GR available per EDR, Revenue Estimating Conference, Long-Term Revenue Analysis, November 2011, p.7

[18] For purposes of this table, local and provider-generated funds not used to leverage federal funding are described as "misused." The funding would still technically be available. However, transfer of these funds to the state is made solely for the purpose of leveraging federal funds, and that purpose would be thwarted.

[19] The total amount of federal funds lost as a result of a particular policy change was not directly available. Rather, the amount was derived using the assumption that 57.73% of the total funding reduction from all sources would be federal, and that there is a non-GR dollar reduction amount that, together with the GR reduction, create

[20] EDR, SSEC, Long-Term Medicaid Forecast, July 2007

[21] EDR, SSEC, Long-Term Medicaid Forecast, August 2010

[22] EDR, SSEC, Long-Term Medicaid Forecast, July 2011 (used in lieu of the more recent but similar October 2011 forecast for consistency.)