



GBPI

Georgia Budget and Policy Institute

Thoughtful Analysis...Responsible Policy

Overview and Summary of Governor's Provider Fee Proposals and Uses in Department of Community Health Budget in FY 2010

By Timothy Sweeney

The Governor's Budget avoids significant cuts to Medicaid and PeachCare by implementing new provider fees for hospitals and commercial HMOs. Without these fees the DCH budget would contain many holes. In total, the DCH budget directs \$317 million in provider fee revenue from commercial HMOs and hospitals as follows:

- \$174.6 million to base Medicaid funding (also generates federal funds);
- \$91.7 million to Medicaid provider rate increases (also generates federal funds);
- \$37 million to the Georgia Trauma Network Commission (GTNC);
- \$13.7 million to help offset uncompensated care costs for private hospitals (also generates federal funds).

In addition, the base DCH budget includes net CMO provider fee revenue of approximately \$32.8 million that would be eliminated without the Governor's proposal to also implement fees on commercial HMOs. Including this base funding in the DCH budget, **the provider fees included in the Governor's budget proposal add or protect approximately \$349.8 million of state funds in the DCH budget and nearly \$600 million in federal funds to Georgia.**

Background

In 2005, Department of Community Health (DCH) converted the state's Medicaid program from a fee-for-service (FFS) reimbursement model to a managed care model. In the prior FFS system, DCH was responsible for providing direct reimbursements to healthcare providers who serve Medicaid members. In the current Medicaid managed care system, DCH makes monthly "per-member / per-month" (pm/pm) payments to Care Management Organizations (CMOs), which then reimburse individual providers for services provided to the members. These pm/pm payments, also called capitation payments, are actuarially set to cover the average monthly cost of a Medicaid member, and these rates vary across eligibility categories and characteristics to account for utilization and other variances that drive actual costs.

When this conversion was initiated, DCH imposed a Quality Assessment Fee on the three CMOs serving the Medicaid population. This fee is built into the monthly capitation rates paid to the CMOs, and when the fee is paid to the CMOs the payment includes state funds as well as the corresponding federal funds. When the fee is collected, the state's revenue includes state and federal funds, meaning that the federal portion is "net" revenue to the state. The Governor's Amended FY 2009 budget estimates \$148.9 million in total CMO fee revenue, with approximately \$95.5 million being net revenue to the state. Because this fee is built into the rates paid to the CMOs, the fee does not financially affect these organizations.

Nationally, many states that operate managed care Medicaid programs include a similar fee for the contracting CMOs, which allows the states to generate additional federal funding. In response, the Federal Deficit Reduction Act (DRA), passed in 2005, makes changes to the federal rules that currently allow for this fee. Currently, states are allowed to charge a fee to “Medicaid Managed Care” providers without assessing the fee on commercial HMOs that do not contract with the state’s Medicaid program. The DRA eliminates the separate treatment of Medicaid CMOs. Therefore, beginning October 1, 2009, states wishing to assess this fee on the Medicaid managed care organizations will also have to assess an identical fee on all commercial managed care organizations operating in the state. As a result, Georgia must either eliminate the fee currently included in the Medicaid program (set at 5.5 percent), or broaden this fee to all managed care providers in the state. If the state broadens the fee, it could be set at any level between 0 and 5.5 percent, which is the maximum rate allowed under federal rules.

The Governor’s Proposal

The Governor’s FY 2010 budget proposal adheres with the new federal rules by extending the existing Medicaid CMO fee to all commercial HMOs in Georgia. At the same time, the Governor is proposing to reduce the existing 5.5 percent rate to 1.6 percent. Based on budget estimates, the net revenue generated by the 1.6 percent rate on the commercial HMOs will make up for the lost revenue as a result of the CMO rates dropping from 5.5 percent to 1.6 percent. In addition to implementing a 1.6 percent fee on commercial HMOs, the Governor’s budget also proposes a 1.6 percent provider fee on Georgia hospitals.

Overall, the provider fees proposed in the Governor’s FY 2010 budget total \$366.6 million, which is \$217.7 million above the FY 2009 amount. Table 1 shows estimated FY 2010 revenue by provider fee category.

Table 1	FY 2010 Provider Fee Revenue	
	<u>AFY 2009</u>	<u>FY 2010</u>
CMO Provider Fees	\$148,904,461	\$49,518,535
Commercial HMO Fees	\$0	\$57,333,746
Hospital Provider Fees	\$0	\$259,724,215
Total Provider Fee Revenue	\$148,904,461	\$366,576,496
Total HMO & Hospital Fees	\$0	\$317,057,961

In FY 2009, CMO provider fee revenue is built into the base Medicaid budget in DCH. While the reduced rate for the CMO fee in FY 2010 causes a loss in funding for Medicaid in FY 2010, the remaining \$49.5 million in revenue is built into the DCH base budget in FY 2010. Therefore, the additional revenue used in the Medicaid budget is the total raised by the new HMO fees and hospital fees (\$317.1 million). The following section provides an overview of the allocation of this new revenue in the Governor’s FY 2010 budget.

Use of Provider Fees

The Governor’s budget directs the new revenue generated by the HMO and hospital fees to fund base Medicaid costs, provider rate increases, trauma center funding, and Disproportionate Share Hospital (DSH) funding to offset uncompensated care costs for some private hospitals. Table 2

shows the amount of the new revenue directed to each of these categories, as well as expected federal funding that would accompany the increased state funding.

Table 2	Uses of FY 2010 Provider Fee Revenue	
	<u>New State Funds</u>	<u>Federal Funds</u>
Medicaid Base and Growth	\$166,602,239	\$308,691,218
PeachCare Base Funding	\$8,019,268	\$24,662,415
Provider Rate Increases	\$91,703,167	\$172,416,673
Trauma Center Funding	\$37,000,000	\$0
Pvt. Hospital DSH	\$13,713,384	\$25,409,030
Total Use of New Fees	\$317,038,058	\$531,179,336

Issues and Implications

The implementation of new provider fees in FY 2010 allows the Governor's budget proposal to avoid eligibility reductions and other significant Medicaid cuts in FY 2010. Furthermore, these new revenues provide for much needed provider rate increases, as well as significant funding to Georgia's trauma network and to offset uncompensated care costs for private hospitals. While the federal funds that accompany these fees enable total reimbursement back into the healthcare system to exceed the fees collected from HMOs and hospitals, many specific providers will not get back as much as they put in. In particular, many provider groups that will not be directly assessed fees will receive Medicaid reimbursement rate increases; and, many hospitals that do not generate significant Medicaid business will not benefit greatly from the reimbursement rate increases. DCH is currently performing an analysis of the winners and losers of the current proposal as it relates to the hospital fee portion of the Governor's proposal.

Until the winners and losers analysis from DCH is available, only basic analysis of the spending proposed in the Governor's proposal can be done. Furthermore, analysis of the winners and losers must take into account the losses to providers across Georgia that would occur as a result of the deep cuts required to balance the Medicaid budget in the absence of the new revenue proposed by the Governor. When taking these losses into account, it is clear that hospitals as a whole benefit from the implementation of the new fee, even though many individual hospitals will not see a positive return on their fees. Table 3 shows the estimated portion of the overall spending listed above that would likely flow to hospitals in Georgia.

Table 3	FY 2010 Provider Fees Directed to Hospitals¹	
	<u>State Funds</u>	<u>Federal Funds</u>
In/out patient rate increases	\$52,213,936	\$98,509,434
Est. hospital share of Medicaid Base	\$41,650,560	\$77,172,805
Est. hospital share of PeachCare Base	\$1,748,200	\$5,376,406
Trauma Center Funding	\$37,000,000	\$0
Pvt. Hospital DSH	\$13,713,384	\$25,409,030
Funding to Hospitals	\$146,326,080	\$206,467,675

In total, Table 3 indicates that hospitals would expect to see approximately \$352.8 million returned from the provider fee collections in FY 2010, while they would pay \$259.8 million in new fees.

While not all of the funds listed in Table 3 represent new funds above the FY 2009 base, these dollars do represent funds that would likely not remain in the Medicaid budget if not for the increased state revenues generated by these provider fees.

Furthermore, hospitals also benefit from the avoidance of further reductions not shown in Table 3 that could occur if the existing CMO fee (and its revenue included in the Medicaid base budget) is eliminated. As proposed, the FY 2010 budget includes \$32.8 million in net CMO fee revenue that is directed to the Medicaid base budget, generating \$60.7 million in attached federal funding. If the elimination of the CMO fee causes these funds to be cut, the estimated amount that could be passed on to hospitals is approximately \$8.2 million in state funds, with an additional \$15.2 million in federal funds leading to a total loss to Georgia hospitals of \$23.4 million.²

Conclusions

Going into FY 2010, DCH already has a \$200 million hole to fill to replace the use of one-time funds in FY 2009, and the state's overall revenue picture could force additional state fund cuts in Medicaid in FY 2010. The provider fee changes passed by Congress in the 2005 DRA present Georgia with additional difficult decisions, as these changes put more than \$90 million in net revenue in jeopardy unless the state is willing to consider broadening the existing CMO provider fees to include commercial HMOs.

In order to prevent dramatic cuts to Georgia's Medicaid program, the Governor proposes to broaden the existing CMO fee and to add a hospital provider fee as a new revenue stream. While these provider fees may not be the ideal funding mechanism for healthcare services in Georgia, the implementation of these fees appears vital to the DCH budget for FY 2010 and beyond.

Without these funds, the provider rate increases and the additional funding to private hospitals and trauma centers would certainly not be included in the DCH budget. In addition, approximately \$207.4 million in state funds would need to be cut from the base DCH budget without new revenues to offset the loss of new provider fees.³ Such cuts would also cost Georgia hundreds of millions in federal funds. In order to balance these cuts, DCH originally proposed in August that it would have to make the following cuts to services and eligibility, among others not listed:

- Eliminate the Katie Beckett program, which covers more than 3,000 children with special needs;
- Eliminate PeachCare coverage for more than 23,000 children in families with income above 200 percent of the federal poverty level;
- Eliminate coverage for more than 11,000 Medicaid members eligible due to catastrophic events;
- Eliminate dental coverage for pregnant women and children on PeachCare.

Even with these cuts, DCH savings would not approach the \$207.4 million needed to balance the DCH budget without new funding. Instead, these changes listed above would likely save only \$50 million in state funds in FY 2010, leaving a remaining budget gap of more than \$150 million.⁴ Furthermore, the budget gap would likely be even larger than described above, as the continued downturn in the economy is forecasted to produce greater enrollment growth than assumed in the Governor's budget proposal.⁵

The Georgia Budget and Policy Institute (GBPI) is an independent, nonprofit, non-partisan organization engaged in research and education on the fiscal and economic health of the state of Georgia. The GBPI provides reliable, accessible and timely analyses to promote greater state government fiscal accountability as a way to improve services to Georgians in need and to promote quality of life for all Georgians.

Endnotes

¹ Calculations based on FY 2006 DCH annual report data and authors estimates. In FY 2006, approximately 31.4% of all Medicaid spending went to hospitals, while 21.8% of PeachCare spending went for hospital services. The portion of Medicaid spending going to hospitals is likely lower among the CMO population than among the population remaining in fee-for-service Medicaid; however the rate among this population would be higher than the corresponding rate for PeachCare. Because CMO-population specific figures are not available for this analysis, we estimate that at least 25% of Medicaid spending in the CMO population flows to hospitals.

² Calculations for these figures mirrors calculations explained in note 1.

³ This represents the \$174.6 million in new fees directed to base Medicaid and PeachCare funding plus the net CMO fee revenue of \$32.8 million reflected in the base DCH appropriation that would be eliminated if the commercial HMO fee is not implemented.

⁴ Author's calculations based on cost estimates from DCH and historical PeachCare enrollment and cost data.

⁵ DCH stated in the Joint Appropriations Hearing January 23rd that the Governor's budget proposal was based on enrollment estimates from September 1, 2008 which assumed 1.3% enrollment growth in FY 2010. More recent DCH figures estimate enrollment growth in FY 2010 to be 6.2%. No funding estimate was attached to the revised enrollment growth figures.