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Overview of the Department of Community Health's FY 2010 Budget

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This brief summarizes the Department of Community Health's fiscal year 2010 budget enacted by the General Assembly and signed into law by Governor Perdue. It goes into effect July 1, 2009.

Georgia's Medicaid and PeachCare programs avoided significant cuts in large part due to a massive infusion of federal funds from the American Reinvestment and Recovery Act (ARRA) of 2009. The legislature redirected even more tobacco settlement funds to Medicaid in FY 2010, which also prevented deep cuts. Both decisions have offset the declining state general fund and prevented major cuts to Medicaid reimbursement rates, eligibility, and covered services.

The Department of Community Health did not escape budget cuts completely, as administrative reductions (much like in other agencies) and several programmatic changes were included.

The Department of Community Health's (DCH) FY 2010 budget also reflects the transfer of funding for the Division of Public Health as well as some regulatory functions from the Department of Human Resources (DHR) into DCH as part of DHR's reorganization.

Summary of the FY 2010 Department of Community Health Appropriation

In total, the FY 2010 general fund appropriation for DCH is \$1.97 billion. This represents a \$485.9 million decline from the original FY 2009 budget (before it was amended during this past year). The budget reflects the following major changes:

- An increase of \$203.2 million for Medicaid and PeachCare costs associated with expected enrollment growth and healthcare inflation;
- An increase of \$222.5 million to offset the loss of other funding sources used in FY 2009, including the loss of the Care Management Organization (CMO) quality assessment fee;
- A transfer of \$211.1 million in general funds to fund the Division of Public Health and the Office of Regulatory Services, which were moved from DHR to DCH;
- A cut of \$649.9 million in general funds, offset by increased federal funds from the American Recovery and Reinvestment Act;
- A cut of \$214.4 million in general funds, offset by allocating additional tobacco settlement funds;
- A cut of \$59.1 million in general funds as a result of delaying provider rate increases originally included in the FY 2009 budget.

Implications of the American Recovery and Reinvestment Act

Prior to the enactment of the ARRA, the federal government's contribution to Georgia's Medicaid program would have been 64.95 percent in FY 2010. The ARRA includes provisions that increase the Federal Medical Assistance Percentage, known as FMAP from October 1, 2008 through December 31, 2010.

The ARRA contains two FMAP provisions that benefit Georgia through December 31.

- First, the bill includes an across the board increase in FMAP by 6.2 percentage points for all states.
- In addition, the ARRA includes additional FMAP assistance to states suffering the most significant unemployment rate growth.

Together, these two provisions increase Georgia's FMAP for FY 2010 to approximately 74.82 percent, reducing Georgia's share of the costs of the Medicaid program to only 25.18 percent. This share represents a 28 percent reduction compared to the original FY 2010 FMAP.

Highlights of the Department of Community Health's Budget

Heading into the FY 2010 budget process, DCH faced significant challenges resulting from the governor's instructions to cut 5 percent from Medicaid in FY 2010, as well as the potential loss of Medicaid CMO quality assessment fee revenue as of October 1, 2009.

In order to fund Medicaid adequately and retain the existing CMO fee, Governor Perdue proposed implementing a hospital provider tax and extending the existing Medicaid CMO fee to all commercial HMOs throughout the state. Revenue generated by these fees would have been used to replace general fund appropriations in DCH as well as to implement modest increases to reimbursement rates paid to Medicaid providers.

The Georgia legislature enacted neither the hospital fee nor the commercial HMO fee proposed by the governor for FY 2010. Therefore, the state must discontinue charging the quality assessment fee to Medicaid CMOs as of October 1, 2009.¹

Medicaid and PeachCare programs in DCH avoided major programmatic cuts largely due to ARRA funds. In total, DCH and the state of Georgia has \$649.9 million as a result of the enhanced match rate that it does not have to take from the general fund. The agency is using \$142 million of this to cover expected Medicaid enrollment growth, however, the enhanced FMAP still replaces general fund allocation to DCH totaling \$507.9 million.

In addition, the state directed \$214.4 million in additional tobacco settlement funds to DCH in FY 2010 by redirecting some funds from other purposes and accelerating the use of 2010 settlement revenues. Including funds already directed to fund Medicaid, these additional funds bring the total tobacco settlement funds going to Medicaid in FY 2010 to \$265.3 million.² This represents approximately 85 percent of the state's spending of tobacco settlement funds.

Georgia Will Lose CMO Quality Assessment Fee Unless Law Passed

Currently, Georgia assesses a 5.5 percent quality assessment fee to three CMOs that participate in the state's Medicaid program. This fee is paid on the front end by the state, so the CMOs do not bare the cost of the fee. The fee generates revenue for the state, however, because the state funds are matched with federal dollars and then the combined total is collected by the state.

Federal changes passed in 2005 will disallow this arrangement effective October 1, 2009. However, states seeking to assess a fee to Medicaid CMOs may still do so if they require all commercial insurers to pay an identical fee.

Together, these two additional funding sources allow the state to fund fully the Medicaid and PeachCare programs without major cuts in the eligibility, services, or reimbursement rates, and without implementing new fees on hospitals and HMOs. However, because much of these funds are not expected to be available in FY 2011, DCH is expected to face a shortfall of approximately \$500 million next year, as detailed in the table below.

Use of One-Time ARRA and Tobacco Funds for Medicaid in DCH ^{3, 4}			
	(in millions)		
	FY 2010 Approp.	FY 2011 Est.	Potential Shortfall
ARRA Funds	\$649.9	\$355.3	\$294.6
Tobacco Funds	\$265.3	\$51.0	\$214.3
Total ARRA & Tobacco Funds to DCH for Medicaid	\$915.2	\$406.3	\$508.9

While DCH has avoided major programmatic cuts, the FY 2010 budget does include several smaller budget reductions as well as eliminating provider reimbursement rate increases originally funded in the FY 2009 budget. Eliminating the reimbursement rate reduces the state budget by approximately \$59.1 million relative to FY 2009. A collection of reductions combine to reduce the budget by an additional \$32.5 million, including:

- reducing reimbursement rates for physician-injectable drugs;
- reducing reimbursement rates to providers for durable medical equipment;
- policies designed to reduce expenditures for individuals who may not be eligible; and
- policies designed to reduce expenditures for people who may have other health coverage.

The DCH budget also includes a few notable, though small, funding increases:

- \$1.6 million to fund 100 new slots in the Independent Care Waiver Program;
- \$8.8 million for additional nursing home reimbursements;
- \$2 million to increase funding for Federally Qualified Health Centers;
- \$250,000 to allow DCH to pursue a federal Family Planning waiver which allows the state to serve women at similar eligibility levels to those it currently sets for pregnant women.

Finally, the enacted FY 2010 budget includes a variety of other substantive and technical changes that reduce the overall general fund appropriation to DCH for FY 2010. For instance, it delineates CMO fees and nursing home provider fee revenues as separate fund sources, whereas in FY 2009 these funds were counted as general fund appropriations. In addition, as is the case in many other agencies, several specific appropriations were eliminated or reduced, employees saw salary increases delayed or eliminated, vacant positions remain unfilled, and the agency is reducing or eliminating underutilized contracts.

Budget Implications of Transferring the Division of Public Health to DCH

Effective July 1, 2009, the Division of Public Health (DPH) moves from DHR into DCH. This move is part of the larger DHR restructuring effort outlined in House Bill 228. It also renames DHR to the Department of Human Services as well as moves several programs out of DHR to form a new agency – the Department of Behavioral Health and Developmental Disabilities. As a result, the FY 2010 budget appropriates funding for DPH directly to the DCH budget, increasing the FY 2010 DCH budget by approximately \$185.2 million relative to the unamended FY 2009 budget.

Compared to the unamended FY 2009 DPH budget, the FY 2010 DPH budget reflects a \$5 million increase driven by a \$23 million appropriation for trauma system funding that is funded by the governor’s “super speeder” fines. Aside from the sizable increase in funding because of the new fees, the remaining

portions of the DPH budget are cut by \$17.8 million (approximately 10 percent). Although the total reduction is comprised of dozens of separate reductions to the 12 programs that make up DPH, when combined the cuts are significant. For example, the budget eliminates funding for 20 filled positions throughout the division, and permanently eliminates an additional 34 vacant positions. The legislature cut state grant-in-aid funding to local health departments by \$1.5 million, and cut 18 other programs totaling \$3.9 million throughout the division. Examples include:

- closing the state health lab on Saturday;
- cutting funding for the State Heart Attack Prevention Program; and
- cutting funding for nutrition, cancer, and diabetes programs.

Budget Implications and Solutions Going Forward

In the absence of additional revenues, the significant infusion of federal Medicaid funds available in the ARRA and the acceleration of using tobacco settlement funds help the state avoid cutting Medicaid eligibility, services, or provider rates in a large-scale fashion in FY 2010.

The bulk of the savings achieved from ARRA funds and increased tobacco settlement funds is one-time in nature and will not be available in FY 2011 on the scale they are used in the FY 2010 budget. As a result, the Medicaid budget will have significant funding shortfalls going into FY 2011 that Georgia needs to resolve in order to maintain existing provider rates, eligibility levels, and covered services. Even more urgently, continued revenue declines are exhausting what little reserve funds the state had for FY 2009, and will likely force the state to revisit the FY 2010 budget that was enacted in April.

Overall Use of State Savings from ARRA

In addition to saving state funds in the DCH budget to reflect the enhanced FMAP provided by ARRA, the state budget also is realizing savings in Medicaid programs operated in the Department of Human Services (DHS) and the Department of Behavioral Health and Developmental Disabilities (DBH), both of which were formerly part of the Department of Human Resources. In DBH, the budget assumes the savings total \$65.1 million, while in DHS the savings total \$11.4 million.

The total DCH, DBH, and DHS state savings assumed in the budget for FY 2010 is \$726.4 million. After accounting for the \$142 million retained by DCH to cover estimated enrollment growth, the net savings to the general fund is \$584.4 million.

Because the ARRA's enhanced match rate expires in the middle of FY 2011, a significant portion of these savings will not be carried into FY 2011. Instead, Georgia would likely realize only about half the value of the FY 2010 savings in FY 2011. Therefore, additional funds will be needed in FY 2011 to maintain existing programs and account for additional enrollment growth.

By accepting the enhanced Medicaid matching funds under ARRA, Georgia is precluded from restricting eligibility standards or from implementing procedures that make it harder to enroll in Medicaid. As evidenced by the governor's proposed provider rate cuts in the 2009 legislative session, however, the state is allowed to cut provider reimbursement rates. Significant reimbursement rate cuts could be detrimental to the ability of Medicaid beneficiaries to obtain healthcare services, however, as lowering reimbursement rates could lead some providers to withdraw from Medicaid participation or to treat fewer beneficiaries.⁵

Furthermore, given nearly three-fourths of Medicaid spending represents federal funds, reducing provider rates significantly would cost Georgia \$3 in lost federal funding for every \$1 in state savings achieved. Even if providers continue to provide services for lower reimbursement rates, such reductions could force providers to increase charges to the privately insured, further eroding private coverage that is already declining in Georgia. In the end, such rate reductions that save state funds in the short term will greatly exacerbate the problems in the long term if they

lead to further increases in the number of uninsured Georgians and those who turn to Medicaid for health coverage. Although balancing the state budget without further cuts to Medicaid would prove difficult without new revenue sources, the legislature should thoroughly understand the serious financial impacts that could come with significant provider rate reductions.

As state revenues continue to fall, there are no easy solutions to maintain existing programs when the one-time funding used in FY 2010 is no longer available. Furthermore, the generous federal match the state realizes through the Medicaid program makes the state's investment in this program a significant economic driver in otherwise difficult times. Enacting cuts to DCH that take hundreds of millions of federal funds out of Georgia's economy could very well cost the state's economy much more than the state realizes in savings.

Although the recession has exacerbated Georgia's fiscal predicament, it highlights the state's structural deficit and illustrates the reasons ignoring the outdated tax code and ongoing preferential tax system jeopardizes Georgia's future. Significant cuts are already in progress and Georgia state government is among the most efficient in the country. Thus, revenue solutions must also be part of a deficit reduction plan. Revenue options the state can pursue related to healthcare are the following:

- Enact the proposal in HB 39 to increase Georgia's very low tobacco taxes, which would generate nearly \$450 million a year while also reducing medical costs and preventing children from smoking⁶;
- Enact the governor's original FY 2010 budget proposals to broaden the existing CMO fee to apply to commercial HMOs, thus preventing the phase out and bringing in additional revenue.

State leaders have decisively acted to provide Medicaid to its citizens. It must act now with foresight and deliberate cost-benefit analysis as one-time ARRA and tobacco settlement funds will run out beginning in January, 2011.

¹ For more information on the governor's original and revised budget proposals for the DCH budget see the following GBPI reports: [Overview and Summary of Governor's FY 2010 Budget Proposal for the Department of Community Health](#) and [UPDATE — Overview and Analysis of the Governor's Revised FY 2010 Budget Proposals for Georgia's Medicaid Program](#)

² Increased funding is available in FY 2010 because funding is not directed to the OneGeorgia Authority in FY 2010 and because the state is accelerating the expenditure of funds received in FY 2010 that under previously proposed spending strategies would have been spent the following year. This accelerated use of funds is not expected to affect the funding available in FY 2011.

³ The FY 2010 ARRA estimate is derived by the author from the data in the enacted FY 2010 budget. For FY 2011, the U.S. Government Accountability Office (GAO) estimates that total Medicaid savings to Georgia will be \$400 million. This amount includes savings that will be reflected in the Department of Human Services (formerly Department of Human Resources) budget. The table assumes that the share of FY 2011 savings realized in DCH will be equal to the portion of the FY 2010 savings reflected in DCH, which is 88.8%.

⁴ FY 2011 tobacco settlement funds estimate assumes all of the one-time funds used in FY 2010 will no longer be available in FY 2011, and that DCH instead will receive the same amount of Tobacco Funds it received in the original FY 2009 budget. Funding could again be redirected from the OneGeorgia Fund to DCH in FY 2011, resulting in a lower net loss, but this redirection would not maintain FY 2010 tobacco funding levels for Medicaid.

⁵ Karen L. Brodsky, M.H.S., "Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions," The Commonwealth Fund, August 2005, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2005/Aug/Best-Practices-in-Specialty-Provider-Recruitment-and-Retention--Challenges-and-Solutions.aspx#citation>, retrieved June, 22, 2009.

⁶ Tim Sweeney and Sarah Beth Gehl, "By Increasing Georgia's Low Cigarette Tax, HB 39 Would Yield Public Health Benefits," Georgia Budget and Policy Institute, revised February 2009, <http://www.gbpi.org/documents/20090221.pdf>.

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