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FY 2012 Budget Replaces Federal Recovery Funds, Inadequately Funds State Medicaid Program

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Summary

The enacted FY 2012 budget appropriates \$1.95 billion in General Fund support to the Department of Community Health (DCH), which represents an increase in General Fund support by \$572.7 million relative to the original FY 2011 appropriation. This funding increase comes as a result of the state restoring General Fund support originally removed when temporary enhanced federal funding was made available from the American Recovery and Reinvestment Act. The temporary enhanced federal funds expire at the end of FY 2011, and the new state funds offset the lost federal funds in FY 2012. Excluding the \$770.3 million added to replace the expiring federal assistance, the FY 2012 budget actually reduces General Fund support to the Department of Community Health (DCH) by \$197.6 million.

In addition to the DCH appropriation, the FY 2012 budget includes \$10 million in bond funding for DCH to implement a new Medicaid eligibility system. This bond will allow the state to generate \$90 million of federal funding at an enhanced match rate from the Affordable Care Act.

Although the FY 2012 budget does not make cuts to Medicaid or PeachCare eligibility, the enacted budget does not provide new funding for potential enrollment growth from FY 2011 to FY 2012 and redirects nearly \$80 million in base Medicaid funding to other areas of state government. The budget makes a variety of programmatic reductions to Medicaid and PeachCare, including increasing the scope of member co-payments and making slight reductions to reimbursement rates paid to doctors and other health care providers serving Medicaid and PeachCare patients. Finally, the FY 2012 budget relies on other measures that yield temporary savings that will not be available in future years.

The number of Georgians eligible for Medicaid has increased in recent years as a result of the economic downturn and an aging population. Even with the economy improving, Georgia's Medicaid program will likely continue to experience enrollment growth in FY 2012 and beyond. Furthermore, the continued aging of the state's population will mean that more Georgians will

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be eligible for nursing home and other long-term care services through the state's Medicaid program.

By failing to include funding for enrollment growth in FY 2012 and redirecting base Medicaid funding to other parts of state government, the FY 2012 budget does not adequately fund Georgia's Medicaid and PeachCare programs. Depending on enrollment growth in FY 2012, these programs face a potential state funding shortfall of \$110 million or more. Without new state funds to pay for new enrollees, DCH would likely need to examine substantial cuts to eligibility, covered services, or the reimbursement rates paid to doctors and other health care providers¹

In addition to a likely funding shortfall in the Medicaid and PeachCare programs, Georgia's State Health Benefit Plan (SHBP), which serves state employees, teachers, and other school system employees, also faces a funding shortfall in FY 2012. Even though the budget funds increased employer and employee contributions to SHBP in FY 2012, the most recent projections indicate that the plan will expend \$109.6 million more in benefits than it will collect in revenues, even after accounting for FY 2011 surplus funds carried forward to FY 2012. DCH is examining changes to address this discrepancy, but the changes will likely require additional employer and/or employee contributions in FY 2012 and beyond.

Between the funding shortfalls looming in FY 2012 and beyond for SHBP as well as the Medicaid and PeachCare programs, DCH will likely require significant new funding in the FY 2012 supplemental budget process. Furthermore, new funding will be needed in FY 2013 and FY 2014 to offset temporary savings and revenues that are embedded in the FY 2012 budget.

This report provides further examination of the enacted FY 2012 budget as well as the issues facing DCH in future fiscal years. (This report does not examine nor include funding for agencies attached to DCH for budget purposes, such as the State Medical Education Board and the Georgia Composite Medical Board. Furthermore, beginning in FY 2012, Georgia's public health functions have been moved to the new Department of Public Health. (Download GBPI's report on the FY 2012 Department of Public Health budget at www.gbpi.org for more information.)

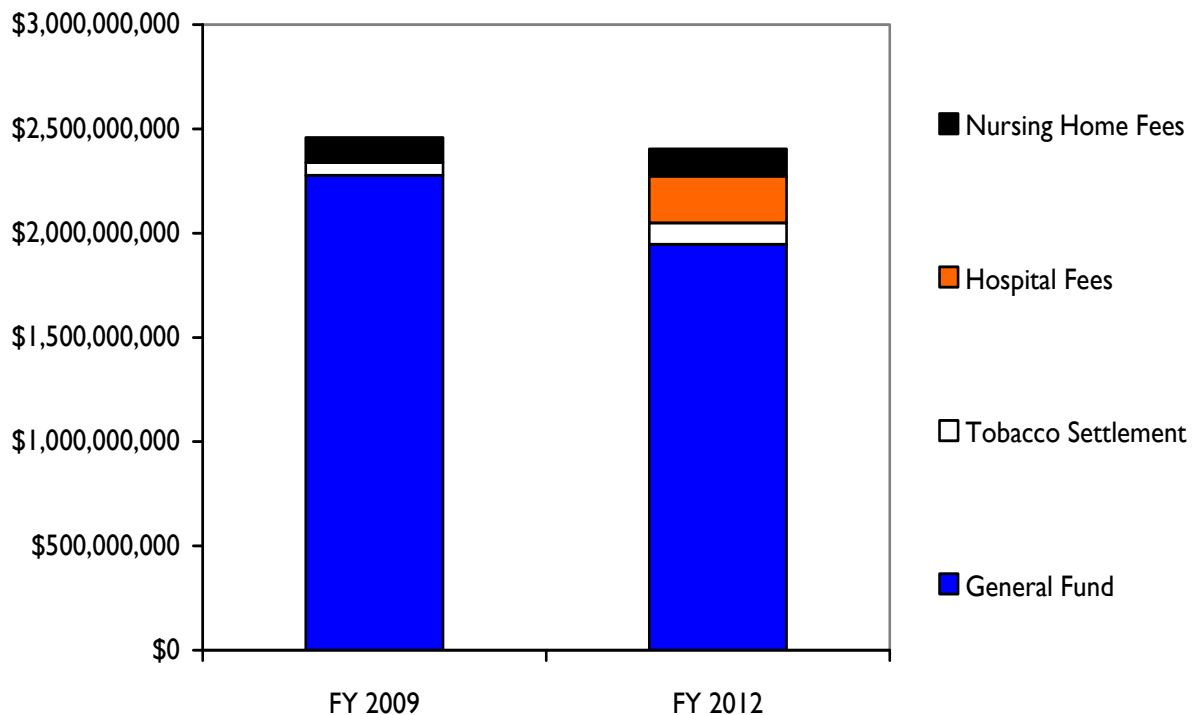
Department of Community Health

The Department of Community Health (DCH) houses a variety of health-related programs and functions. In particular, DCH operates the state's Medicaid and PeachCare programs that serve low-income, elderly, and/or people with disabilities, as well as the State Health Benefit Plan, which covers Georgia's state employees, teachers, and other school district employees. In addition, DCH houses several planning and regulatory functions related to health care, as well as Georgia's Indigent Care Trust Fund (ICTF), which helps offset uncompensated care costs for hospitals.

The enacted FY 2012 budget for DCH includes \$1.95 billion from the General Fund and \$457.7 million from other appropriated state funds (excluding intra-state governmental transfers to fund the State Health Benefit Plan). The combined state funds total represents a \$569.3 million increase from the originally enacted FY 2011 budget, yet represents a decline of \$201 million from FY 2011 when excluding funding added to replace expiring Recovery Act Funds.

Excluding funding for programs not part of DCH in FY 2009, the FY 2012 DCH General Fund appropriation is \$329.9 million, or 14.5 percent, below the amount originally appropriated to DCH in FY 2009. The FY 2012 budget includes increased tobacco settlement funding as well as new revenue from the temporary hospital provider fee that makes up a portion of the decline in General Fund support. Still, total state funds appropriated to DCH in FY 2012 fall \$54.6 million, or 2.2 percent, below the FY 2009 level.²³

Chart 1 State Funding Sources for DCH in FY 2009 and FY 2012



Medicaid and PeachCare

At \$1.88 billion, the Medicaid and PeachCare programs represent the vast majority (96 percent) of the General Funds appropriated to DCH in FY 2012. As of January 2011, these programs combine to serve nearly 1.7 million Georgians, and are forecasted to bring in more than \$4.6 billion in federal funds in FY 2012. The FY 2012 state funds appropriation represents an increase of \$592.5 million compared to the original FY 2011 budget as a result of state funds added to reflect the expiration of temporary federal assistance.

Table 1 FY 2012 State Funds for Medicaid & PeachCare (in millions)⁴

	Original. FY 2011 Budget	Enacted FY 2012 Budget
State Funds Adjustments for PeachCare and Medicaid		
Revised federal match rate		\$ 760.3
Reduced hospital fee revenue		-4.9
Redirect state funds to cover SHBP shortfall		-77.6
Provider reimbursement cuts, increased co-pays and other programmatic changes		-22.8
Other Medicaid and PeachCare changes		-62.6
Change from Original FY 2011 (cells may not add due to rounding)		592.5
	Original. FY 2011 Budget	Proposed FY 2012 Budget
State Funds for Medicaid and PeachCare		
State General Fund	\$ 1,280.6	\$ 1,876.4
Tobacco Settlement	100.6	102.2
Nursing Home Provider Fees	131.3	131.3
Hospital Provider Fee	229.0	224.1
Total State Funds	\$ 1,741.5	\$ 2,334.0

Though not reflected in the DCH appropriation, the FY 2012 budget also includes a \$10 million bond package for DCH to implement a new eligibility system for the Medicaid program. These funds will match \$90 million in enhanced federal funding available through the Affordable Care Act to assist states with technology upgrades to implement the national eligibility expansion in 2014. The debt service on the bond will be paid over a five year period, and is included in the section of the budget dealing with general obligation bonds.

FY 2012 Budget Leaves Significant Funding Shortfall for Medicaid Benefits

The FY 2012 enacted DCH budget includes significant new state funding to replace expiring one-time federal funding from the Recovery Act.⁵ Still, the enacted budget potentially leaves a \$110 million or more funding gap in FY 2012, based on GBPI analysis of the enacted budget and the original FY 2012 enrollment forecast. This shortfall is due to the fact that the enacted budget does not add new funding to cover projected enrollment growth in FY 2012 and because it diverts money from the Medicaid program to fund other state spending priorities, including the State Health Benefit Plan. Without new funding in the supplemental budget,

Georgia's Medicaid and PeachCare programs could be forced to reduce reimbursement rates paid to doctors and other providers, to reduce the number of Georgians served, or cut services available to enrolled individuals.

From FY 2009 to FY 2010, total Medicaid and PeachCare enrollment grew by 6.1 percent. Through the first six months of FY 2011, total enrollment grew by 3.4 percent. Initial DCH forecasts assumed that the rate of growth would continue to slow in FY 2012; however, these estimates still predicted overall enrollment increases from FY 2011 to FY 2012. Even with modest growth in FY 2012, initial DCH projections forecasted Medicaid costs to increase by approximately \$33.5 million in FY 2012, relative to FY 2011. The FY 2012 budget did not include new funding for these projected costs, and DCH has not yet released a revised forecast.

In addition, the FY 2012 budget removes \$77.5 million in General Fund support from the Medicaid budget and directs these funds to pay for other items in the state budget – namely increased state agency contributions to the State Health Benefit Plan and funding to the Governor's Emergency Fund to pay for projected interest payments for Georgia's Unemployment Insurance Trust Fund. The removal of these funds creates an additional funding shortfall, potentially bringing the total FY 2012 General Fund shortfall in Medicaid to approximately \$110 million or more, depending on actual enrollment growth.

Recent Enrollment Trends and Continuing High Uninsurance in Georgia

In FY 2010, total enrollment in the Medicaid and PeachCare programs grew by 6.1 percent compared to FY 2009. The final (amended) FY 2011 budget assumes total enrollment growth in the two programs will be approximately 2.3 percent; however, actual enrollment growth over the first six months of FY 2011 totaled 3.3 percent. Initial state forecasts predicted 1.4 percent enrollment growth in FY 2012.

Although DCH predicts slower FY 2012 enrollment growth than the state experienced in recent years, Georgia's uninsured rate has remained stubbornly high. Furthermore, many of Georgia's uninsured residents may already be eligible for coverage in either the Medicaid or PeachCare programs. In 2009, nearly 2 million non-elderly Georgians (22.5 percent of the non-elderly population) lacked health insurance. These figures represent the 5th highest raw number and the 5th highest uninsured rate in the U.S.

The fact that so many Georgians continue to lack health coverage is a possible indicator that demand for Medicaid and PeachCare could remain robust, even as the state slowly recovers from the Great Recession. Furthermore, recent Medicaid enrollment growth has been well below enrollment growth in other programs serving a similar population such as the Supplemental Nutrition Assistance Program (SNAP), commonly called Food Stamps. This could be another indicator that many Medicaid-eligible Georgians are not currently being covered.

Reflecting the Expiration of Enhanced Medicaid Funding in Recovery Act

The enacted budget adds \$760.3 million in new state General Fund support in FY 2012 to reflect changes in the Federal Medical Assistance Percentage (FMAP) for Georgia. This amount includes the following adjustments:

- \$684 million in new state funds to reflect the expiration of the enhanced FMAP originally made available through the federal Recovery Act;
- \$86.3 million in new state funds to restore a FY 2011 reduction due to the application of the enhanced FMAP to state “clawback” payments made to the federal government; and,
- \$10 million in state savings as a result of an increase in the base FMAP relative to the federal share in FY 2011.

The American Recovery and Reinvestment Act, originally passed in 2009, provided enhanced federal matching funds for Medicaid programs to help states balance their budgets without making major cuts to state health care safety nets in the midst of the recession. The enhanced federal match rate allowed Georgia to reduce state General Funds in the Medicaid budget and receive additional federal funds to replace them. In total, Georgia will receive approximately \$2 billion in additional federal Medicaid funds (from October 2008 through June 2011) as a result of the enhanced match rate.

In addition, a subsequent federal decision to apply the enhanced federal matching rate to state “clawback” payments required by the Medicare Part D prescription drug program resulted in additional state savings that are realized entirely in FY 2011.

The enhanced federal funds are slated to expire June 30, 2011. The state funding increases noted above simply offset lost federal funds and do not reflect new resources available to the Medicaid program (relative to the originally enacted FY 2011 budget).

Programmatic Reductions – Higher Member Cost Sharing and Reduced Reimbursement Rates

The enacted FY 2012 budget achieves General Fund savings by shifting costs to Medicaid and PeachCare enrollees as well as the doctors and other healthcare providers that participate in the program. Specifically, the budget cuts \$25.6 million to reflect the following changes:

- \$5.1 million in savings by reducing the reimbursement rates paid to Medicaid and PeachCare providers by one-half of a percent. Hospitals, nursing homes, and home- and community-based long-term care providers are exempt from this cut. In addition to the General Fund savings, this reduction reduces federal funding by \$10.3 million. The combined loss of funding for providers is \$15.4 million.
- \$5.1 million in savings to eliminate the outpatient hospital reimbursement floor for the Care Management Organizations (CMOs) that run the bulk of the Low Income Medicaid and PeachCare programs. This proposal effectively reduces payments from the CMOs for outpatient hospital services. In addition to the state savings, this change reduces federal funding by \$10.7 million, for a total funding loss to providers of \$15.8 million.

- \$5 million in savings by increasing existing co-payments for some Medicaid services provided to adults and by implementing new co-payments for children over six years of age in PeachCare. In addition to the General Fund savings, this reduction reduces federal funding by \$11.6 million, for a total funds reduction of \$16.6 million.
- \$10.4 million in savings by eliminating underperforming disease management contracts in the Aged, Blind, and Disabled program. This reduction is being taken as a result of contract performance not meeting agency standards.

In addition to the above reductions, the budget adds approximately \$2.8 million in new General Fund support for the following purposes:

- \$1.3 million to implement an “express lane eligibility” process that will share eligibility data between state programs serving the same population. In particular, this funding is to use existing eligibility data for Georgians receiving services under the Women, Infants, and Children (WIC) program to help enroll these same families in Medicaid if they are not already enrolled.
- \$1.0 million to move some medically fragile inmates into nursing homes or other long-term care facilities and utilize federal Medicaid matching funding to help pay for the medical care costs that would otherwise be fully paid by the state through the Department of Corrections’ budget.
- \$0.5 million to add 33 new slots for Independent Care Waiver Program, which provides community-based long-term care services to Georgians who would otherwise be served in nursing homes.

Overall, the programmatic changes included in the FY 2012 budget reduce General Fund spending by \$22.8 million. Though the provider rate cuts ultimately included in the budget are smaller than originally proposed, they still reduce total state and federal funding to Georgia’s health care system by \$31.2 million and could affect whether some providers stop participating in Medicaid and PeachCare.

Adding Co-payments to PeachCare Creates New Administrative Hassles

Federal rules governing the PeachCare for Kids program limit the amount of cost-sharing that can be charged to participating families to 5 percent of household income. Once families reach the 5 percent out-of-pocket cap, they must be exempted from further cost-sharing for the remainder of the month.

Currently, many families with children enrolled in PeachCare are responsible for monthly premiums that range from \$10 to \$70 per month, depending on family income and the number of children enrolled in the program.

The current premium levels do not bring families up to the 5 percent cap; however, the addition of co-payments could cause some families to approach and exceed the cap. Because co-payments are less predictable than monthly premiums, DCH will have to set up a system to monitor family out-of-pocket spending and alert families (and providers) if they exceed the cap and become exempt from future co-payments.

Furthermore, increasing cost-sharing to low-income families on Medicaid and PeachCare could affect enrollees and providers alike. First, higher out-of-pocket costs may incentivize some families to postpone needed health care services due to the financial cost, which could lead to worse health outcomes and even higher state costs down the road. Secondly, doctors and other providers are responsible for collecting the co-payments and receive lower state reimbursement rates under the assumption that member co-payments will make up the difference. Medicaid providers often still serve Medicaid patients even when they cannot pay their co-payments, which will mean that providers may not always be able to make up the difference from the lower reimbursement rates.

While the cuts discussed above may reduce access to services for some Medicaid and PeachCare enrollees, the additions will likely increase access to care for some Georgians. In particular, the addition of 33 new IWCP slots and efforts to streamline enrollment of eligible individuals receiving other state services will increase the number of Georgians receiving Medicaid services. Even after the addition of these new slots, approximately 130 Georgians would remain on the waiting list for ICWP services; many more Georgians likely desire ICWP slots but have not applied due to the lack of available funding.

Other Medicaid and PeachCare Changes

In addition to the changes detailed above, the proposed budget includes other adjustments that combine to decrease General Fund spending by \$64.2 million in FY 2012:

- \$11 million in savings in FY 2012 from drug company settlements;
- \$14.6 million in FY 2012 savings as a result of increased pharmacy rebates available due to the passage of the Affordable Care Act;
- \$6 million in savings in FY 2012 from anticipated federal bonus payments potentially available to Georgia if the state makes certain programmatic changes designed to increase enrollment and retention, and if the state meets certain enrollment targets for children;
- \$9.3 million in savings in FY 2012 as a result of the implementation of the Planning for Healthy Babies waiver program;
- \$15.1 million in savings in FY 2012 from federal reimbursements after the implementation of the Medicaid Management Information System conversion;
- \$1.6 million in General Fund savings by using additional Tobacco Settlement funding to replace General Fund appropriations; and,
- \$6.5 million in anticipated fraud settlements that will offset state spending.

In addition to the changes listed above, the FY 2012 budget reflects the delay of the June 2012 capitation payment to July 2012, which shifts costs from FY 2012 to FY 2013. This provision does not generate state savings relative to the original FY 2011 budget because the proposal was originally included in the FY 2011 budget. Funding was subsequently added in the Amended FY 2011 budget to fully fund the Medicaid budget for FY 2011, which allows the state to delay one capitation payment in FY 2012 instead of doing so in FY 2011. Delaying the 12th capitation payment from FY 2012 to FY 2013 creates a funding gap in FY 2013 (relative to FY 2012) that

will need to be replaced. Based on the amount originally reduced from the FY 2011 budget, the state will need to add \$82.2 million in FY 2013 to restore funding for 12 monthly capitation payments.

State Health Benefit Plan (SHBP)

The State Health Benefit Plan (SHBP) is the health insurance plan for state employees, teachers, and other “non-certified” school service personnel throughout the state. As of March 2011, the SHBP covered nearly 700,000 active and retired employees and their dependents. The FY 2012 budget appropriates \$3.1 billion to cover the projected benefit costs for the SHBP.

DCH currently projects FY 2012 SHBP expenses of approximately \$2.89 billion, however, the agency only forecasts revenue from employer and employee contributions totaling \$2.66 billion, a gap of approximately \$232 million. DCH forecasts FY 2011 surplus revenue of approximately \$122.7 million, which still leaves the SHBP approximately \$109.6 million short of projected funding needs in FY 2012.

The SHBP does not receive direct General Fund appropriations in the DCH budget. Instead, it receives funding from state agencies and school districts for employer and employee contributions on behalf of participating employees. These funds are appropriated as other funds in the DCH budget, but include General Fund contributions as well as contributions from other funding sources such as federal funds and local school district funds. Therefore, issues affecting the SHBP have an impact on the General Fund as well as on other appropriated funding sources and local school districts that make contributions on behalf of their employees.

In FY 2009 and FY 2010, the state used prior year surpluses in SHBP to help balance the overall state budget. In order to achieve state savings, agency contributions to the SHBP were lowered and the SHBP used prior year surplus funds to make up the gap from lower state and local contributions.

In FY 2009 and FY 2010, the SHBP used approximately \$863.5 million in prior year surplus funds and other one-time revenues.⁶ The depletion of these funds left the SHBP with only \$17 million in reserve funding at the end of FY 2010 – an amount sufficient to cover only two days worth of claims.⁷ Furthermore, increases to overall health care cost, increasing retirement rates among active SHBP members, and budget cuts that reduce payroll and thus the SHBP contributions from participating employers have put additional pressure on the financial status of the SHBP.

Because the SHBP plan year is the standard calendar year, structural plan changes that affect SHBP enrollees take effect in January of every year, and thus affect two state fiscal years. Changes to the contribution rates for employers (state agencies and school districts), however, are often made throughout the state fiscal year.

The Amended FY 2011 and FY 2012 budgets address the SHBP financial issues in a variety of ways. Key changes included in the Amended FY 2011 and/or the FY 2012 are highlighted below:

- Employee monthly premiums were increased by 10 percent in January 2011 and will increase by another 10 percent in January 2012;
- Special add-on fees for SHBP enrollees who smoke or who cover spouses who decline coverage through their own employer in favor of SHBP coverage were increased by \$20 and \$10 respectively. In 2011, SHBP enrollees who smoke (or cover a spouse or dependent who smokes) pay a monthly surcharge of \$80 while employees who enroll a spouse who is eligible for health coverage through their own employer will pay a \$50 monthly surcharge.
- Plan changes were implemented in January 2011 to eliminate the Open Access Plan health insurance option for SHBP members, and changes that increase co-payments, deductibles, and out-of-pocket maximums. These changes reduce plan expenses in FY 2011 and FY 2012.
- The percent of payroll contributions by state agencies varies throughout FY 2011 and FY 2012, but is increased above the contribution rates charged in FY 2010.
- Monthly per-member amounts charged to employers for “non-certified” school service personnel increased in FY 2011 and FY 2012 compared to the contributions in FY 2010.
- The FY 2012 budget directs DCH to generate savings in FY 2012 by maximizing the use of minimally invasive procedures in outpatient facilities. DCH has stated that the projected savings may not be possible based on the extent that SHBP already utilizes minimally invasive procedures.

In addition to changes to plan design and employee and employer contribution rates that affect the financial status of the SHBP in FY 2011 and FY 2012, several provisions of the national health care law, the Affordable Care Act, affect the SHBP.

First, new rules taking effect with the 2011 plan year require the SHBP to cover dependent children up to age 26 even if they are no longer enrolled in school. The SHBP forecasts new expenses as a result of this change, yet also projects new revenue from additional premiums paid by enrollees with dependent children.

Secondly, the Affordable Care Act requires health plans to provide a wider set of preventive care services to members without charging any co-payments or deductibles. This change is projected to increase costs as more individuals seek preventive care, and as enrollees no longer have to make out-of-pocket payments in order to receive the care.

Finally, a provision in the Affordable Care Act that provides financial assistance to employers who continue to provide health coverage to their retirees will generate significant savings for the SHBP. The Early Retiree Reinsurance Program is expected to generate approximately \$150 million in state savings in AFY 2011 and FY 2012 combined, as federal funding is made available to help offset plan spending for some high-cost retirees.

In total, many changes are made to the structure of the SHBP in 2011 and 2012, yet the plan is still projected to incur expenses in excess of revenues in FY 2012. DCH is planning to continue to examine the SHBP and will propose additional changes to reduce plan expenses and/or to increase employer and employee revenue to the plan. In addition, HR 810 created a study

committee to examine funding issues facing the SHBP. This committee is expected to meet in the summer of 2011.

Other DCH Programs and Departments

Although the vast majority of the DCH budget is directed to Medicaid, PeachCare, and the SHBP, the proposed budget also makes General Fund cuts to the remaining parts of the DCH budget, including its Administration program, the Health Care Access program, and the Healthcare Facility Regulation program.

In total, the FY 2012 budget cuts these remaining program by \$3.4 million, compared to the original FY 2011 budget, which represents a 4.3 percent cut to General Fund support for these programs.

Changes to the remaining DCH programs for FY 2012 include:

- Cutting \$2.7 million from DCH Administration. This cut includes savings generated as a result of the new Medicaid Management Information System (MMIS) vendor (\$5.8 million), savings from fraud control settlements (\$1 million), savings from an online eligibility system for nursing homes (\$200,000), as well as reduced salaries and savings from space consolidation. This amount also reflects the transfer of \$2.5 million from DHS due to the reorganization of the state's human services agencies referenced above, an increase in funding for SHBP contributions of \$1.2 million as well as several technical adjustments. (This amount does not reflect the transfer of \$19.2 million to fund administrative costs of the newly created Department of Public Health.)
- Increased funding to the Health Care Access Program totaling nearly \$400,000. This increase comes as a result of adding \$1 million to fund new health centers in four Georgia counties and nearly \$100,000 for increased SHBP contributions to the budget. These increases are offset by other cuts to the program that total approximately \$700,000. (The total amount does not include the transfer of more than \$500,000 to the Department of Public Health to move the administration of the Health Share Volunteer Unit to the new department.)
- Cutting \$1.1 million from the Healthcare Facility Regulation Program. This cut includes savings by eliminating funding for six inspector positions originally added in FY 2011, as well as reduced salaries for existing positions, reduced travel funding, elimination of funding for adult day care center licensure, and other technical adjustments.

Budget Implications in FY 2012 and Beyond

The lack of new state funding for potential Medicaid and PeachCare enrollment growth in FY 2012, along with the decision to redirect state funding from Medicaid to fund other parts of the state budget, has significant budget implications for FY 2012 and FY 2013. Depending on enrollment growth over the coming year, Georgia's Medicaid and PeachCare programs are potentially underfunded by \$110 million or more. This shortfall must be made up in the FY 2012 supplemental budget process, or else DCH will need to make significant cuts to services

and/or provider reimbursement rates.⁸ This funding shortfall must also be filled in the FY 2013 budget, along with funding for potential enrollment and inflationary growth in FY 2013.

Furthermore, the FY 2012 budget relies on other temporary savings and funding sources that will not be available in FY 2013 and beyond. In particular, the FY 2012 budget only funds 11 months of capitation payments instead of 12. Delaying the 12th payment into FY 2013 creates savings in FY 2012, however this savings must essentially be repaid in FY 2013. Adding the 12th capitation payment in the FY 2013 budget will require approximately \$82.2 million in new state funds. The FY 2012 budget also uses \$224.1 million in funding from the temporary hospital provider fee, which expires after FY 2013.

Without significant new funding in FY 2012 and in future years, DCH could be forced to consider dramatic cuts to the Medicaid and PeachCare programs. Georgia already operates a relatively low-cost program, as the state's Medicaid investment generally ranks towards the bottom in both per-capita and per-beneficiary spending. Significant cuts to the program would mean that more Georgians could find themselves uninsured and fewer Georgia doctors may accept Medicaid or PeachCare patients.

Programmatic cuts would be especially problematic in the face of the significant eligibility expansion the state must implement in January 2014. The Affordable Care Act increases Medicaid eligibility nationally to adults with incomes up to 133 percent of poverty (approximately \$14,400 for a single individual or \$24,400 for a family of three). While federal funding will pay for the vast majority of the costs associated with the expansion, changes in Georgia's programs that reduce provider participation will make it more difficult to successfully expand the program to the hundreds of thousands of uninsured Georgians who will be eligible.

In total, Georgia's Medicaid program faces significant funding needs in the next three fiscal years as a result of the decisions to redirect funding from the Medicaid program to elsewhere in the state budget and to use one-time savings strategies and temporary revenue streams to fund the program. As a result of the economic downturn and overall population growth coupled with the aging of the state's population, Georgia's Medicaid program plays an increasingly important role in the state's health care system. An inadequately funded Medicaid program will result in continued erosion of the provider network available to serve Georgians enrolled in the program as well as continued cost-shifting onto other parts of the health care system.

Finally, DCH must also address significant funding issues in the State Health Benefit Program. A funding shortfall in FY 2012 was closed in part by redirecting state funding otherwise needed to fund the Medicaid program; yet still the FY 2012 SHBP budget is not balanced. Previous state budgets have underfunded the SHBP to generate state budget savings while utilizing SHBP reserves built up in previous years to cover the costs of the program. These reserve funds are

no longer available, which means that state agencies, participating school districts, and the employees themselves will likely pay more for their health coverage in the coming years.

The fact that budget writers were forced to move money from the Medicaid program to pay for increased employer contributions to the SHBP is further evidence that the state needs more revenue to meet the health care needs of its citizens and its employees. Furthermore, the fact that neither the Medicaid program nor the SHBP is fully funded in the current fiscal year indicates that new revenues are needed immediately. Georgia's revenue system will continue to inadequately meet the needs of Georgians – including the 1.7 million Georgians on Medicaid or PeachCare, the nearly 700,000 enrolled in the SHBP, and the nearly 2 million Georgians who lack health coverage – unless policymakers enact responsible tax reform.

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¹ As initially passed, the Affordable Care Act prohibits states from making cuts to Medicaid or CHIP (PeachCare, in Georgia) programs; however, several proposals under consideration at the federal level would eliminate these protections and enable states to make cuts in eligibility.

² These figures exclude funding in the FY 2012 DCH budget for the Facility Regulation program, which was not part of DCH in FY 2009.

³ As originally passed, the Hospital Provider Fee will expire at the end of FY 2013.

⁴ GBPI analysis of Governor's proposed AFY 2011 and FY 2012 budgets.

⁵ The American Reinvestment and Recovery Act of 2009 included temporary enhance federal Medicaid funding to help states manage growing Medicaid populations without cutting eligibility levels or the services available to enrollees. These temporary funds will expire at the start of Georgia's FY 2012, and the budget adds state funds to replace the federal funds that are no longer available.

⁶ GBPI calculation based on DCH data presented to the DCH Board in August 2010. This amount includes \$472.9 million in prior year reserves, \$170.7 million in one-time revenue from long-term investment funds, and \$219.9 million in incurred but not reported reserve funds.

⁷ FY 2010 ending fund balance data from DCH Commissioner David Cook during a Joint Appropriations Budget Hearing, January 20, 2010.

⁸ Current federal Medicaid rules prohibit states from making cuts to eligibility in the years leading up to the 2014 eligibility expansion.