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Policy Report

FY 2013 Budget Analysis: Community Health

A Review of the Enacted Budget – FY 2013

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Summary

Georgia's Medicaid and PeachCare programs combine to serve more than 1.7 million Georgians and are vital parts of Georgia's health care system. From June 2008 to December 2011, enrollment in the two programs increased by more than 200,000 individuals or about 15 percent. Furthermore, this enrollment growth—concentrated among children—is the main reason why the uninsured rate for children in Georgia was lower from 2009 to 2010 than it was prior to the recession (2006 to 2007).

Despite enrollment growth and increases in health care costs in recent years, the FY 2013 budget appropriated fewer General Fund dollars to Medicaid and PeachCare than the enacted FY 2009 budget, which preceded the recession. Instead, the state relies on increased funding from other state fund sources, such as Tobacco Settlement funds, nursing home provider fees, and a temporary hospital provider fee to fund the two programs. Taking these other fund sources into account, Georgia's Medicaid and PeachCare programs receive $257 million, or 11 percent, more funding in FY 2013 than in FY 2009.

The hospital fee, enacted in 2010, has been crucial to maintaining state funding for these programs. When it expires after FY 2013,the state must either extend this fee or find an alternate funding source to avoid major programmatic cuts. One alternative that would also lead to long-term improvement in the health of Georgians is a $1 per pack increase in the state's cigarette tax, which is currently the 4th lowest rate in the country.

Georgia's Medicaid and PeachCare programs face additional challenges in the coming years to sustain recent coverage gains and improve the quality of care provided to Medicaid and PeachCare patients. First, state officials are planning to remake the portion of the program that serves elderly Georgians and individuals with disabilities. A finalized plan for the "redesign" is not yet available; however, significant programmatic changes could affect patients and providers alike. Further, a national Medicaid eligibility expansion coming in 2014 will bring billions in new federal funds to help Georgia's Medicaid program serve hundreds of thousands of low-income adults who lack coverage. This expansion could add more than 600,000 Georgians to the Medicaid program over the first six years with only modest new costs to the state and will dramatically reduce the number of Georgians who go without health coverage.

Budget Highlights

The FY 2013 budget directs $2.1 billion in state General Funds to Georgia's Medicaid and PeachCare programs in FY 2013, which represents an increase of $203.6 million, or 10.9 percent above FY 2012. The bulk of this increase (about 80 percent, or $165 million) is to restore funding eliminated in FY 2012. The FY 2013 budget:

- Adds $77.6 million to restore funding that was redirected in FY 2012 to fund the State Health Benefit Program (includes $145.9 million in federal funds);
- Adds $82.2 million to restore the 12th monthly CMO capitation payment that was unfunded in the FY 2012 budget (includes $162.7 million in federal funds);
- Adds $5.1 million to restore provider payment cuts originally enacted in the FY 2012 budget (includes $10.3 million in federal funds);
- Adds $8 million to reflect changes in PeachCare that allow state employees to enroll their children in the program (this change generates savings in the State Health Benefit Plan and generates $25.4 million in federal funds);
- Adds $4.7 million to increase provider payment rates for PeachCare so that providers do not experience reimbursement cuts when children move from SHBP to PeachCare (includes $14.8 million in federal funds);
- Adds $810,101 to fund 50 additional slots for the Independent Care Waiver Program (includes $1.6 million in federal funds); and
- Adds $5.5 million to increase payments to nursing homes ($26.1 million in nursing home fees are also used for this purpose -- the state funds combine to generate $57.6 million in new federal funds for nursing homes).

In addition to General Funds, Georgia's Medicaid and PeachCare programs receive $502.9 million in other state funds. The total state funds directed to Medicaid and PeachCare is shown in Table 1.

Table 1 Department of Community Health Fund Changes, FY 2009 - FY 2013

Fund Source	FY 2009 Enacted Budget	FY 2012 Enacted Budget	FY 2013 Enacted Budget	FY 2012-FY 2013 Change $	FY 2012-FY 2013 Change %	FY 2009-FY 2013 Change $	FY 2009-FY 2013 Change %
General Fund	$2,154,365,795	$1,876,356,808	$2,080,003,194	$203,646,386	10.9%	$(74,362,601)	-3.5%
Tobacco Settlement	$50,973,656	$102,193,257	$110,193,257	$8,000,000	7.8%	$59,219,601	116.2%
Hospital Fees	$0	$224,138,048	$235,302,027	$11,163,979	5.0%	$235,302,027	N/A
Nursing Home Fees	$120,805,958	$131,321,939	$157,444,961	$26,123,022	19.9%	$36,639,003	30.3%
Total State Funds	**$2,326,145,409**	**$2,334,010,052**	**$2,582,943,439**	**$248,933,387**	**10.7%**	**$256,798,030**	**11.0%**
General Funds, Hospial Funds, and Nursing Home Fees	**$2,275,171,753**	**$2,231,816,795**	**$2,472,750,182**	**$240,933,387**	**10.8%**	**$197,578,429**	**8.7%**

Recent Trends

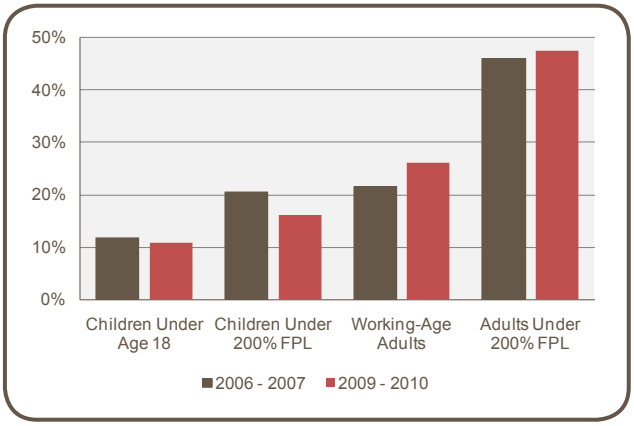
Enrollment Growth

Together, Georgia's Medicaid and PeachCare programs experienced significant enrollment growth over the past three-plus years as Georgia's economy soured and the state's unemployment rate steadily rose. In fact, this counter-cyclical nature of the programs is intentional, as the programs are predictably more important when times are tough. In total, 220,000 more Georgians were enrolled in either Medicaid or PeachCare in December 2011 than in June 2008 (before the recession hit). Because these programs are overwhelmingly targeted to children, the majority (more than 7 out of 10) of the new enrollees have been children.

Georgia's Medicaid and PeachCare programs have helped low-income Georgians (especially children) replace private coverage lost during the recession. Increased enrollment in these programs has been the main reason why the uninsured

rate for children in Georgia—and most notably, the uninsured rate for low-income children —has declined in recent years. In fact, fewer children in Georgia were uninsured in 2009 to 2010 than in 2006 to 2007, despite the recession and an increase in Georgia's overall population.[1] As shown in Figure 1, the uninsured rate for children and for low-income children declined over this time frame, while the rate increased for adults.[2] Growth in Medicaid and PeachCare fueled these gains, which were most prominent for children from low-income families, while less generous eligibility standards for adults limit Medicaid coverage of low-income adults in Georgia.

Figure 1 Medicaid and PeachCare Fueled Increased Children's Health Coverage Amid Recession



Federal Funds and Other State Sources Replace General Fund Spending

Because of the enrollment growth in Medicaid and PeachCare since 2008, total funding (including state and federal fund sources) also increased. In particular, the 2009 American Reinvestment and Recovery Act provided enhanced Medicaid matching funds to help states cope with growing Medicaid enrollment at the same time that state revenues were declining.[3] From FY 2009 through FY 2011, Georgia received more than $1.7 billion in enhanced federal Medicaid funding that allowed the state to reduce state appropriations for Medicaid by an equal amount. These enhanced funds allowed Georgia to serve a growing Medicaid population with significantly fewer state funds, while avoiding major cuts to eligibility, services, or provider reimbursement rates.

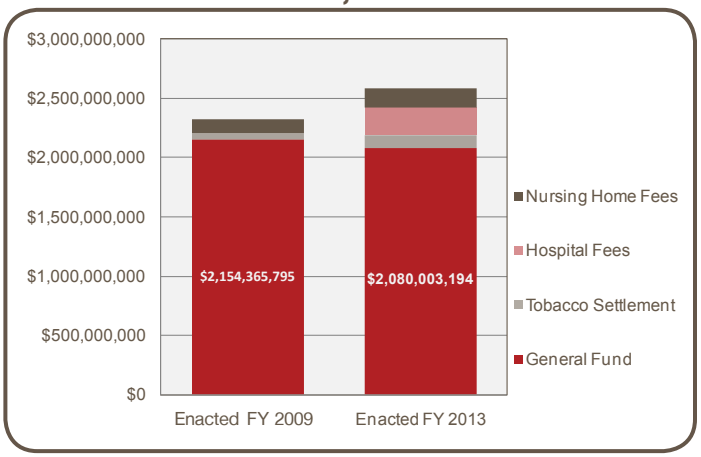
Even though the enhanced federal funds were temporary and expired in FY 2011, the current budget still appropriates fewer General Fund dollars to Medicaid and PeachCare compared to the enacted FY 2009 budget, which preceded the recession. Instead, the Medicaid and PeachCare programs rely on other (state) funding sources to cover its growing population.

In 2010, the state enacted a temporary three-year hospital provider fee, beginning in FY 2011, to fund Medicaid and PeachCare instead of increasing General Fund support. This fee is expected to generate $235.3 million in FY 2013, though a portion of this revenue is used to increase reimbursement rates to hospitals so as to mitigate the impact of the fee.[4]

The Medicaid budget also relies more heavily on Tobacco Settlement funds than in the enacted FY 2009 budget. Over the last five years, the share of Georgia's Tobacco Settlement Funds directed to Medicaid has increased from roughly one-third of the annual total in the enacted FY 2009 budget to more than three-fourths of total Tobacco Funds in FY 2013.[5] As a result, Georgia will spend nearly $60 million more from Tobacco Settlement funds on Medicaid in FY 2013 than in the enacted FY 2009 budget. Finally, the FY 2013 budget also utilizes $36.6 million in increased nursing home provider fees in FY 2013, as compared to FY 2009, which is an increase of 30 percent.

As shown in Figure 2, Georgia's Medicaid and PeachCare programs receive greater state funds in FY 2013 than in the enacted FY 2009 budget, even though the programs operate with nearly $75 million less in General Fund support.

Figure 2 State Funds for Medicaid and PeachCare, FY 2009 - FY 2013



Policy Outlook

Medicaid and PeachCare have been crucial resources to Georgia families over the last several years. While employer-sponsored health coverage has been declining for more than a decade, Medicaid and PeachCare are the primary reasons why health coverage rates for Georgia's children have improved since before the recession, while adult coverage rates have declined.[6] Still, Medicaid and PeachCare face challenges in the coming years, due to declining and/or temporary state funding sources and potential policy changes affecting the programs.

State Funding Issues

First, Georgia's Medicaid and PeachCare programs will face a significant funding shortfall in FY 2014 as a result of the expiration of the temporary hospital provider fee and cash flow issues created by state budgeting decisions. The hospital fee is expected to generate approximately $235 million in FY 2013. Approximately one-third of the revenue ($80.7 million) is used to increase Medicaid/PeachCare reimbursement rates paid to participating hospitals, while the remaining $154.6 million is used to fund the Medicaid base budget. If the fee expires at the end of FY 2013, as scheduled, state officials must either find a replacement revenue source or cut the programs.

One option the state should consider to fill-in the lost funding from the hospital fee is an increase to the state's tax on tobacco products. Currently, Georgia's cigarette tax of 37 cents per pack is the 4th lowest in the U.S. and is about 75 percent below the national average of $1.46 per pack. A $1 increase in the per-pack tax rate would generate at least $350 million in new state revenue annually, which is more than enough to offset the lost hospital fee revenue.[7]

Furthermore, increasing the cigarette tax has the added benefit of discouraging smoking, especially for younger Georgians.

In addition, state budgetary decisions in recent years have forced DCH to use Medicaid reserves designated to pay claims that have been "incurred-but-not-reported" (IBNR) to instead pay for ongoing costs of the program. Continually using these IBNR reserves in this fashion could create cash-flow issues, and eventually limit the program's ability to make timely payments to doctors, hospitals and other providers. In addition, the Amended FY 2012 budget included funding for only 11 of the 12 monthly "capitation" payments to the three CMOs that operate a portion of the Medicaid and PeachCare programs. This lost payment will eventually need to be made up in a future budget year, as the current CMO contracts will expire in 2013 or 2014.[8]

Policy Changes: State Medicaid "Redesign"

In addition to state funding issues looming in FY 2014, DCH is currently in the middle of a Medicaid "redesign" effort that could dramatically alter the way Georgia serves Medicaid and PeachCare members. While details of the redesign are sparse, the state is considering alternatives to the current system that could enroll more Medicaid members in managed care plans.

Currently, most Medicaid and PeachCare members (including most children, pregnant women, and non-disabled individuals) are enrolled in managed care plans, which are also called Care Management Organizations (CMOs). The state pays a set monthly amount to the CMO for each person enrolled with that plan, and the CMO is responsible for managing the individual's care and directly paying the doctors, hospitals, and other providers who serve them.

On the other hand, Georgians who are eligible for Medicaid due to being elderly, blind, or by having a qualifying disability are not served by the CMOs. Instead, the state pays for their care directly to the doctors, hospitals, nursing homes, pharmacies, and others who provide services. The state also operates several "waivers," which allow the state to waive certain federal rules to provide a specialized set of services to individuals with special needs (such as a developmental or physical disability).

Although the most substantial changes could come in the form of moving populations into managed care programs that are not served by CMOs, changes to the existing CMO programs could also impact enrollees. For example, initial state documents indicated that the state would consider increasing out-of-pocket costs for members covered by the CMOs, which could limit access to care for some individuals.

Medicaid Eligibility Expansion in 2014

Beginning in January 2014, Medicaid eligibility will expand nationally to cover more low-income adults, who are largely ineligible for Medicaid. In particular, the income-eligibility threshold will increase to 138 percent of the federal poverty level (approximately $15,400 per year for an individual, or $26,300 for a family of three) for all (citizen) adults. Currently, Georgia's Medicaid program does not cover childless-adults and covers adults with dependent children (parents) only up to about half the federal poverty level (about $10,000 for a family of three).

The national Medicaid expansion is a key component to the 2010 national health care law, the Affordable Care Act (ACA), and is almost entirely paid for with new federal funds. In fact, from 2014 to 2016, federal funds will pay for 100 percent of the costs for newly eligible adults who enroll in Medicaid. Beginning in 2017, the federal share will fall slightly to 95 percent and will phase down to 90 percent in 2020 and beyond. During this time period, the state will still be responsible for its existing match rate (approximately 34 percent in FY 2013) for Georgians who are already eligible for Medicaid.

According to national estimates, the Medicaid expansion will expand health insurance coverage to 650,000 to 900,000 low-income Georgians, the vast majority of whom would otherwise go without coverage. At the same time, because the expansion is largely paid for with new federal funds, Georgia would incur cost increases of less than three percent over the first six years, compared to what the state would spend in absence of the expansion. Furthermore, from 2014 through 2019, Georgia's health care sector will benefit from more than $14 billion in federal Medicaid funds to cover the newly insured members.[9]

While the ACA includes other provisions that significantly expand health coverage in Georgia, the Medicaid expansion alone could cover 25 to 40 percent of the uninsured population in Georgia. Instead of going without health care or relying on charity and/or uncompensated care at a hospital Emergency Department, these Georgians will be eligible for primary care services and will be more able to properly utilize the health care system when they are sick.

Although the coverage expansion is largely funded with federal funds, the newly eligible Georgians will still present a logistical challenge to Georgia's Medicaid program. To prepare for the expansion, DCH is taking advantage of a 9-to-1 federal funding rate to invest $100 million ($10 million in state funds) to overhaul the state's eligibility systems. Still, the state will likely require other administrative funding increases to adequately prepare for the influx of new enrollees and to ensure that individuals who have long been left out of the health care system have the necessary assistance to help them access needed services in an efficient manner.

Currently, the constitutionality of the ACA in general and the Medicaid expansion in particular are under review by the Supreme Court; a ruling is expected in June 2012. If the Medicaid expansion is stuck down along with the rest of the ACA, Georgia will lose out on billions of federal funds. Without the enhanced federal funding included in the ACA, Georgia would face significant financial obstacles in establishing programs to cover more of Georgia's nearly two million uninsured residents.[10]

The national Medicaid expansion will require new state resources over the coming years. However, the return on this investment will be exceptionally high, as hundreds of thousands of Georgians will have better access to needed health care services. In the long run, covering these Georgians will reduce cost shifting in the health care system and will help Georgia's health care providers better serve the state's population.

Endnotes

[1] Data from the Current Population Survey of the U.S. Census, accessed through the table creator feature, http://www.census.gov/cps/data/cpstablecreator.html

[2] Ibid.

[3] The Recovery Act temporarily increased the matching rates state received for Medicaid, meaning that fewer state funds were needed to generate more federal Medicaid contributions. One condition of the funding increase was that states were not allowed to reduce eligibility or covered services.

[4] Including new federal funds generated by the rate increase, Medicaid payments across all hospitals are increased by an amount equal to the total revenue raised by the hospital fee. Individual hospitals experience rate increases that may be greater or lower than their fee payments.

[5] The Enacted FY 2009 budget directed $51 million of the $159.1 million Tobacco Settlement total to Medicaid (32%). The FY 2013 budget directs $110.2 million to Medicaid, which is 76% of the $145.6 million Tobacco Settlement total.

[6] According to U.S. Census data, 69% of Georgians under 65 were covered with employer-sponsored health insurance in 1999-2000. In 2009-2010, the percent of Georgians under 65 with employer-coverage was 55.7%.

[7] A state fiscal note in 2009 estimated that a $1 per pack increase (along with tax increases for other tobacco products) would generate $449.2 million. Additional estimates have projected lower amounts.

[8] In order to generate budgetary savings in FY 2012, the June 2012 capitation payments to the three CMOs will be delayed until July 2012. The FY 2013 budget contains only 12 monthly payments, which means that the June 2013 payment will also be deferred to July 2013 – which is in FY 2014. Prior to the end of the existing contracts with the three CMOs, the state must make up the missed payment, which means a 13th payment will likely be needed in either FY 2013 or FY 2014.

[9] Enrollment and cost estimates from a national analysis released by the Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Spending in Health Reform: National and state-by-state results for adults at or below 133% FPL," Prepared by John Holahan and Irene Headen, Urban Institute. May 2010.

[10] The case before the Supreme Court includes a specific challenge to the Medicaid Expansion in addition to the challenge to the individual mandate. If the majority of the law remains and only the Medicaid expansion is ruled unconstitutional, Georgia would likely be able to utilize other aspects of the ACA (such as the affordability tax credits that are available to purchasers through the health insurance exchanges) to cover low-income individuals who are currently not eligible for Medicaid.

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