Government Payers

Most Georgia hospitals depend heavily on payments for services provided to patients insured by governmental programs. For example, the Medicare and Medicaid programs account for more than half of the typical hospital's net patient revenue.[27]

1. Medicare

Established in 1965, Medicare is available to most people beginning at age 65 and to those with end stage renal (kidney) disease or total disability. The Medicare program is funded by a combination of contributions made by employers and their employees while the employee is actively working; premiums paid by Medicare participants; and federal funds. More than 1.2 million Georgians were enrolled in Medicare coverage in 2018.[28]

Medicare is overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS) and is administered through contractors known as Medicare Administrative Contractors (MACs). The MAC for Georgia, as of early 2018, is Palmetto GBA and is located in Columbia, South Carolina.

Medicare pays predetermined, non-negotiable fixed amounts for hospital services based on the patient's diagnosis and treatment. For inpatient services, this is known as a DRG, or diagnosis-related group. For outpatient services, Medicare uses Ambulatory Payment Classifications (APCs). Services in each DRG or APC are similar clinically and require the use of similar resources. A payment rate is established for each DRG and APC.[29] This Medicare payment methodology for inpatient and outpatient services is considered by Medicare as a Prospective Payment System (PPS).

Medicare payments vary among geographic regions to reflect local wage rates. For example, PPS hospitals in Georgia's rural areas receive lower payment rates from Medicare than urban facilities. Likewise, southern states like Georgia receive lower payment rates from Medicare as compared to their northern peers, generally due to higher wages in that region of the country. ***Medicare payments have been less than Medicare costs since 2002 and continue to remain below break-even, as shown in Figure 5 on page 20.***

Inside the H

More than 1.2 million Georgians were enrolled in Medicare coverage in 2018.[28]

Medicare is made up of:

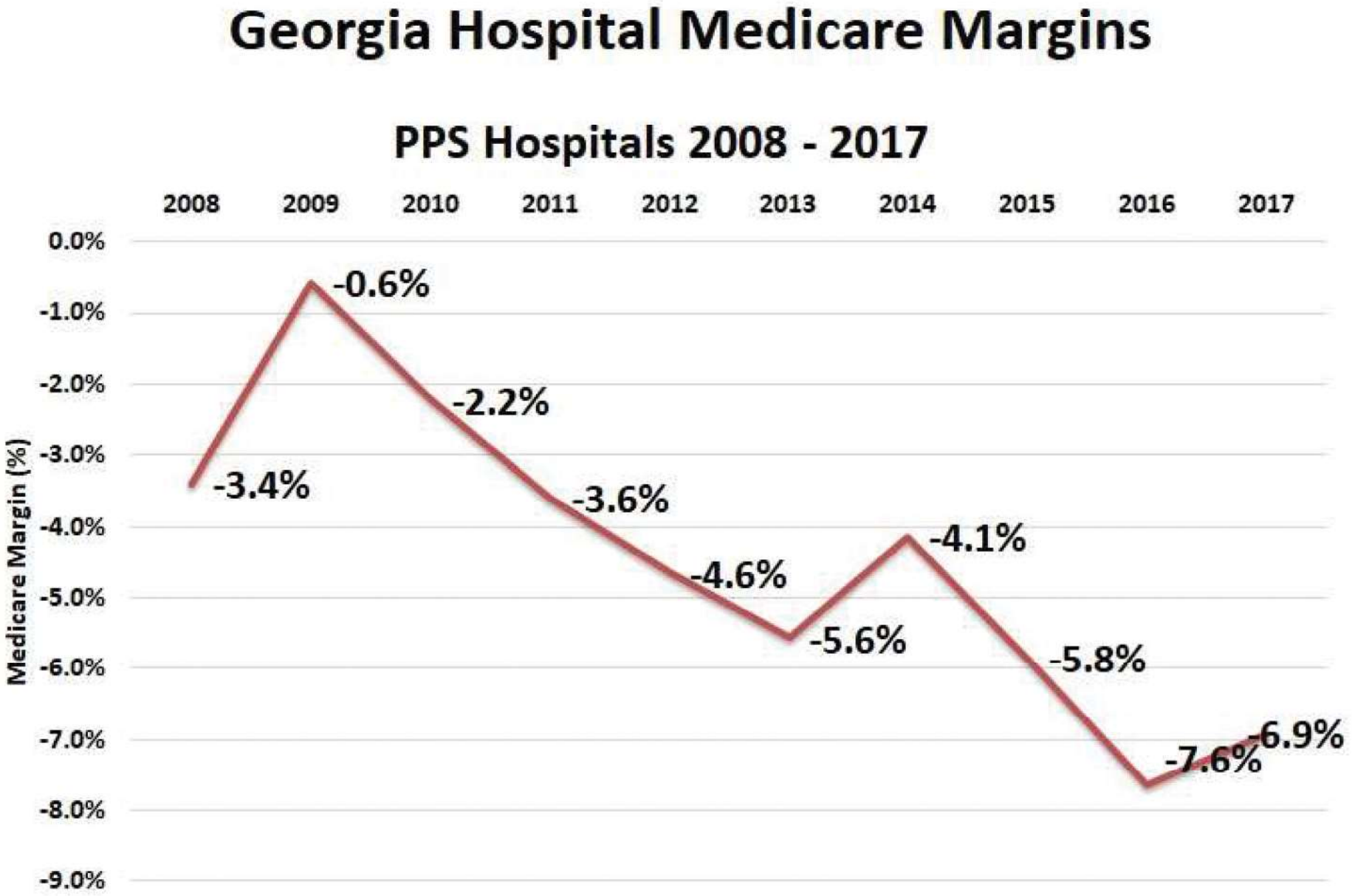
- **Part A, which covers hospital benefits;**
- **Part B, which covers outpatient and physician services;**
- **Part C, an option to receive benefits through private insurance plans known as "Medicare Advantage" plans; and**
- **Part D, Medicare's prescription drug plan.**

<u>Medicare</u>
Serves most people age 65 or older regardless of income.

<u>Medicaid</u>
Serves the low income and disabled.

Overall, Medicare pays less than cost to most hospitals. In FY 2017, Medicare paid 93 percent of cost to PPS hospitals for inpatient and outpatient services.[30]

Figure 5



Through aggressive cost cutting and efficiency improvements, hospitals were able to slowly reverse the downward negative Medicare margin trend beginning in 2007. Margins were on track to return to a positive status by 2010; however, additional federal budget-cutting measures that year eroded that improvement. The 2010 Patient Protection and Affordable Care Act (ACA), the Budget Control Act of 2011, the American Taxpayer Relief Act of 2012, the Bipartisan Budget Act of 2013, the Medicare Access and CHIP Reauthorization Act of 2015, the Bipartisan Budget Act of 2015 and the Bipartisan Budget Act of 2018 are expected to reduce future Medicare reimbursement to Georgia's hospitals by up to 17.3 percent, accounting for $17.3 billion in revenue reductions between 2010 and 2028.[31] *Figure 6 on page 22 reflects the reduction of Medicare revenue due to federal budget-cutting measures.*

2. Medicaid

Established in 1965, Medicaid is available to low-income individuals, pregnant women, and the aged, blind or disabled. Jointly funded by the federal and state governments, the program is operated by the states and overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS). Georgia's Medicaid program is administered by the Georgia Department of Community Health.

Inside the H

Who is Eligible for Medicaid?

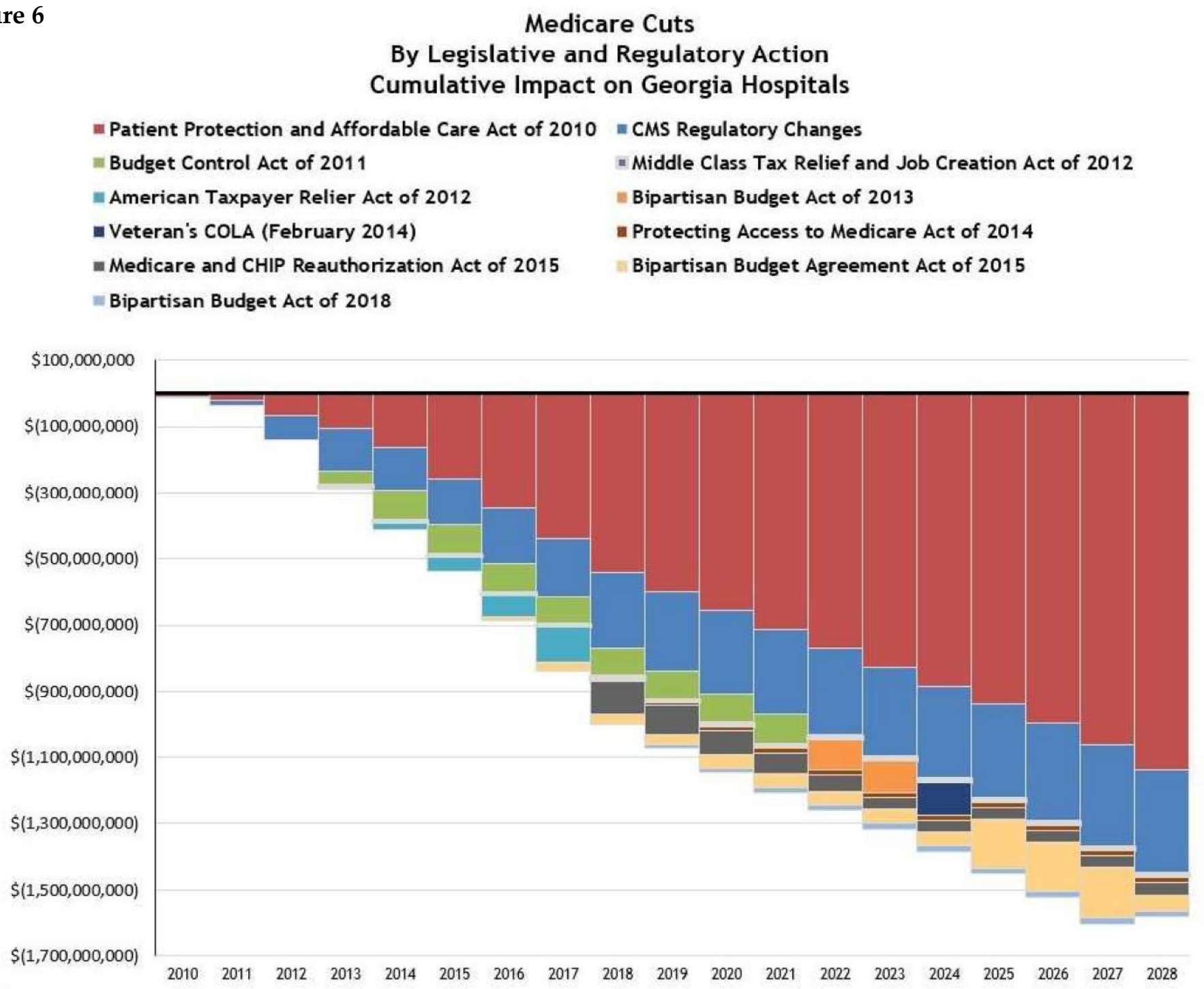
Contrary to popular belief, Medicaid does not provide coverage to all low-income people.

To qualify for Medicaid coverage, persons must meet:

- **Income eligibility criteria;**
- **Certain clinical or categorical criteria such as being under age 19, pregnant, aged, blind or disabled;**
- **Resource eligibility limits;**
- **Immigration criteria;[32] and**
- **State residency requirements.**

Georgia Medicaid covered an average of 2 million beneficiaries each month during FY 2019.[33]

Figure 6



The federal government sets minimum standards, but states can choose to cover people at higher income levels and define additional eligible populations. ***See Figure 7 on page 23 for an overview of the populations to whom Medicaid is available in Georgia.***

As of January 2014, the federal *Patient Protection and Affordable Care Act (ACA)* provided enhanced federal funding to states that elected to expand Medicaid coverage to 138 percent of the Federal Poverty Level for all legal U.S. residents.[34] The state originally estimated that almost 570,000 uninsured children and adults would have been eligible for new Medicaid coverage in 2014 had the state decided to expand.[35]

In early 2019, Gov. Brian Kemp signed the *Patients First Act* into law. In late 2019, Gov. Kemp unveiled the Section 1115 and Section 1332 waivers aimed at alleviating Georgia's uninsured crisis. The Georgia Pathways (115 Waiver) provides coverage to those who meet certain work requirements. The Georgia Access (1332 Waiver) proposes to eliminate a provision of the ACA that prohibits employers from helping employees offset the cost of insurance plans purchased through healthcare.gov.[36]

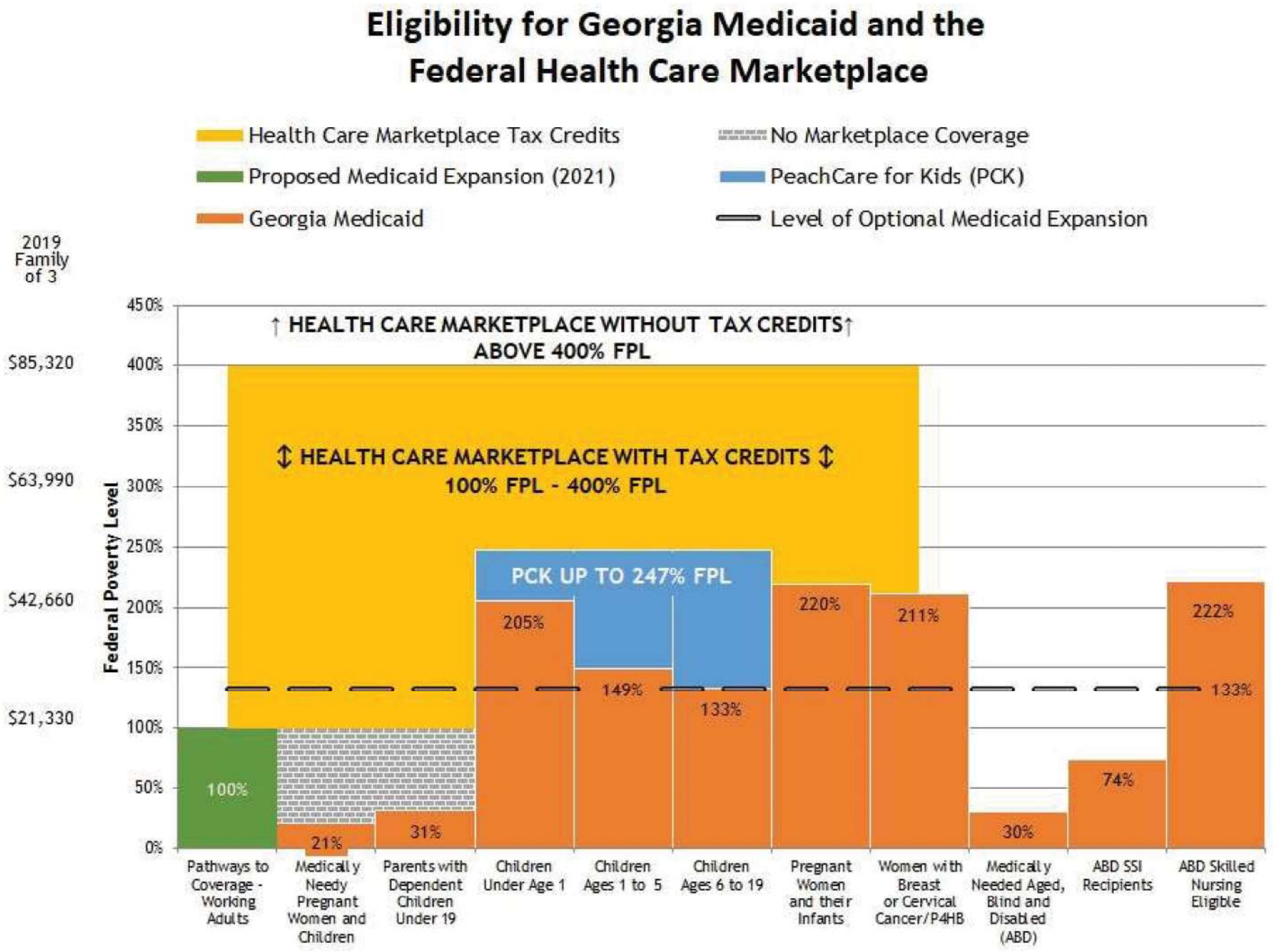
Inside the H

The *Patients First Act* authorizes the Georgia Department of Community Health to submit a Section 1115 Medicaid Waiver request to the Centers for Medicare and Medicaid Services. It also authorizes Gov. Kemp to submit a Section 1332 State Innovation Waiver to pursue health insurance coverage solutions for the commercial health insurance marketplace.

The first, Georgia Pathways (1115 Waiver), would provide health coverage to Georgians who meet certain work requirements, either by enrolling them in Medicaid or covering a portion of an employer-based health plan. At the time of this publication, this waiver is subject to the approval of the federal government.

The second, Georgia Access (1332 Waiver), would provide the consumers the ability to purchase insurance plans directly from insurance providers and would create a state reinsurance program in which Georgia would use the money to help insurance companies cover the cost of their sickest patients.

Figure 7



How Does Medicaid Pay?

Georgia Medicaid covers both inpatient and outpatient hospital services under two different payment arrangements: fee-for-service (FFS) and through Care Management Organizations (CMOs).

Under the FFS arrangement, a hospital bills the state directly for each covered service provided to a Medicaid patient and is paid based on uniform and predetermined Medicaid payment policies.

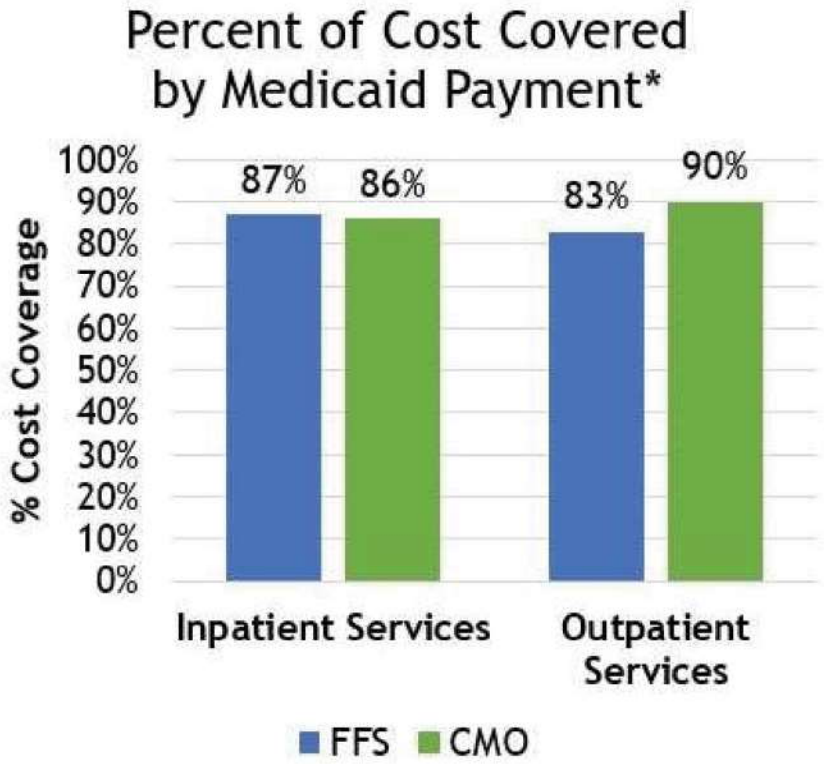
- **Inpatient Services -** Georgia Medicaid pays predetermined fixed amounts for services based on the patient's diagnosis and treatment (i.e., DRGs). Hospitals are assigned to peer groups. Each peer group has a unique base payment that is multiplied by the applicable DRG to determine a claim-specific payment. Hospitals with graduate medical education programs may receive additional payments to cover Medicaid's share of cost for these programs. Base payments are calculated using past operating and capital costs; however, payments are not guaranteed to cover current costs. DRG base payments were last updated in January 2019 and based on hospital costs from 2016.[37]

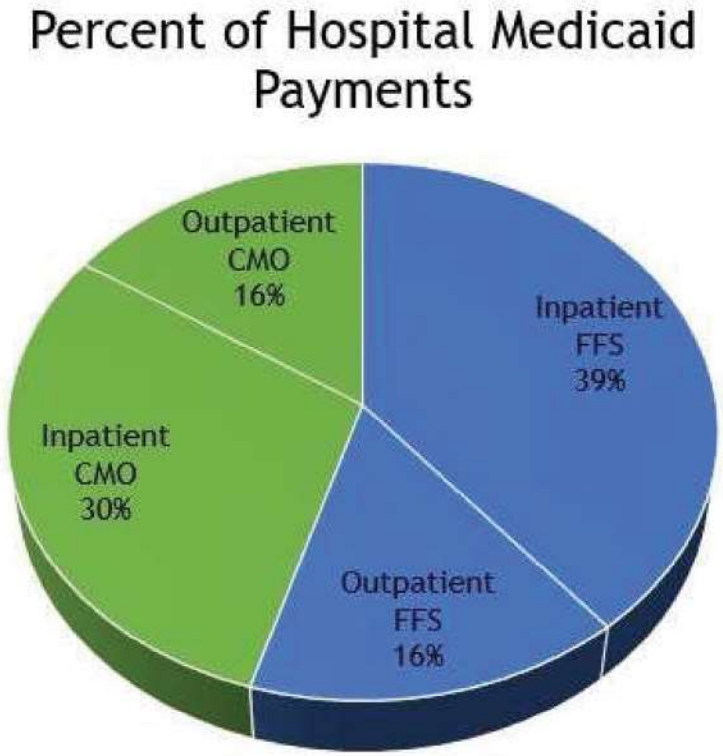
- **Outpatient Services -** Georgia Medicaid makes interim payments to hospitals based on the hospital's charge for an outpatient service and later uses actual cost to settle the difference between the interim payment and the final payment. Final payments for cost-based services to critical access hospitals and state hospitals are paid at 100 percent of cost, while all other hospitals are currently paid at 85.6 percent of cost. This means that hospitals paid at 85.6 percent of cost are guaranteed by policy to lose 14.4 percent of their costs on Medicaid patients served in outpatient settings. There are some services that are not subject to cost-based payment. Examples include non-emergent use of the emergency room, injectable drugs and certain laboratory procedures. Hospitals are paid using a fee schedule for these kinds of services.

Under the CMOs, Georgia Medicaid pays a fixed monthly payment to a CMO based on the number of Medicaid members enrolled in the CMO's plan. The CMO is then responsible for paying providers, including hospitals, for covered services provided to the CMO's enrolled members. The hospital bills the CMO for services based on contractual payment terms that have been negotiated between the hospital and the CMOs in order for the hospital to participate in the CMO's provider network. The CMOs are required by state law to pay hospitals that do not participate in the CMO's provider network 100 percent of the fee-for-service Medicaid rate for emergency services. However, non-emergency services may be covered at 90 percent of the fee-for-service Medicaid rate if there have been three failed attempts by the CMO to negotiate a contract with the hospital. The CMOs may require authorization for non-emergent services and if it is not obtained may deny the claim entirely.

Figure 8

FY 2017 Georgia Medicaid Cost Coverage





*Considers that hospitals financed a rate adjustment through the use of the Hospital Provider Payment Program. Medicaid payments were reduced by the amount of the Provider Payment cost not reimbursement by Medicaid. Does not include supplemental payments.

Because CMOs negotiate with each hospital, payment methodologies for inpatient and outpatient services vary by hospital. The percentage of cost paid by the CMOs has been historically lower than FFS. Most CMOs are for-profit entities that are paid fixed payments by the state. Therefore, in addition to covering payments to providers for medical services, they must also:

- Cover their own administrative costs; and
- Earn a profit for their shareholders.

In FY 2017, Georgia Medicaid, under both payment arrangements, paid 13 percent less than cost for Medicaid inpatient and outpatient hospital services.[38] ***See Figure 8 on page 26 for more details.***

How is Medicaid Funded?

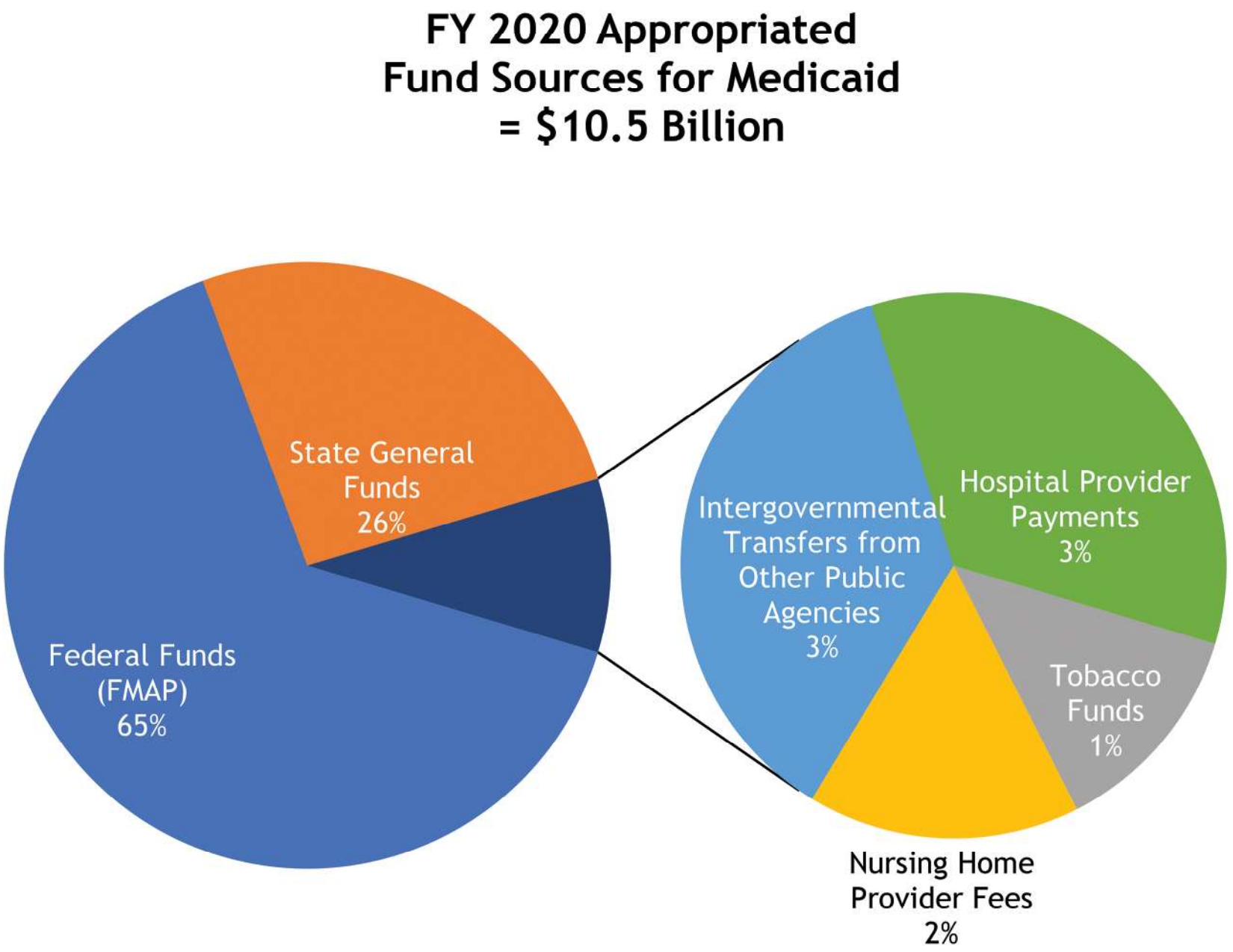
Medicaid is jointly funded by the federal and state governments. Generally, for each dollar paid to providers serving Medicaid patients, the federal government provides funding for about two-thirds of the payment while the State of Georgia pays the remaining one-third.

- **FEDERAL SHARE:** The federal share is called the Federal Medical Assistance Percentage (FMAP) and the exact amount is determined annually by CMS based on each state's per-capita income. The lower the per-capita income, the higher the FMAP. For FFY 2021, Georgia's FMAP for Medicaid is 67.03 percent. Other states' FMAPs range from 50.0 percent (multiple states) to 77.76 percent (Mississippi).[39] As of January 2014, states that elected to expand Medicaid coverage up to 138 percent of the federal poverty level received 100 percent FMAP for the expansion population's expenditures through 2016. As of 2017, FMAP is reduced for this population each year, reaching 90 percent by 2020 and remaining at that level.

- **STATE SHARE:** The state share is made available through the General Assembly's annual appropriation to the Department of Community Health and other state agencies that pay for health care services for Medicaid members. Most state appropriations for Medicaid come from general state funds; however, a portion of the state share is paid for by fees or payments made to the state from (a) hospitals and nursing homes; (b) proceeds from the Tobacco Master Settlement Agreement; and (c) local Intergovernmental Transfers (IGTS).[40] See Figure 9 for more details on the sources of Medicaid funding.

See Figure 9 on page 28 for more details on the sources of Medicaid funding.[41]

Figure 9



3. Special Supplemental Payments

Because hospitals do not receive sufficient payment to cover the costs of serving Medicaid and uninsured patients, some hospitals are eligible for special supplemental payments. In 2018, almost one-third of Georgians were either uninsured (14 percent) or enrolled in Medicaid (17 percent).[42]

Medicaid Disproportionate Share Hospital Program

The Disproportionate Share Hospital (DSH) program is a federal program that provides hospitals payment toward the cost of care for the uninsured and any remaining uncompensated Medicaid costs (after Upper Payment Limit (UPL) payments are considered). (See page 31 for more information on UPL payments.) In FY 2017, uninsured patients paid only about 6 percent toward their cost of care.[43]

Generally, to qualify for a DSH payment in Georgia, a hospital must meet the federal criteria of having at least a 1 percent Medicaid utilization rate and have an ongoing capability to do non-emergent delivery of newborns. Once eligible for DSH, the amount of DSH funds paid to a hospital depends on the burden of uncompensated Medicaid and uninsured care relative to other eligible hospitals. It is also dependent on the amount of federal funding made available to the state in the annual DSH allotment.

The state must provide state matching funds to draw down the annual federal allotment. The state's share is based on the state's FMAP rate. In Georgia, public hospitals provide the state matching funds via intergovernmental transfers. Private hospitals must depend on an annual state fund appropriation for their state matching funds.

Inside the H

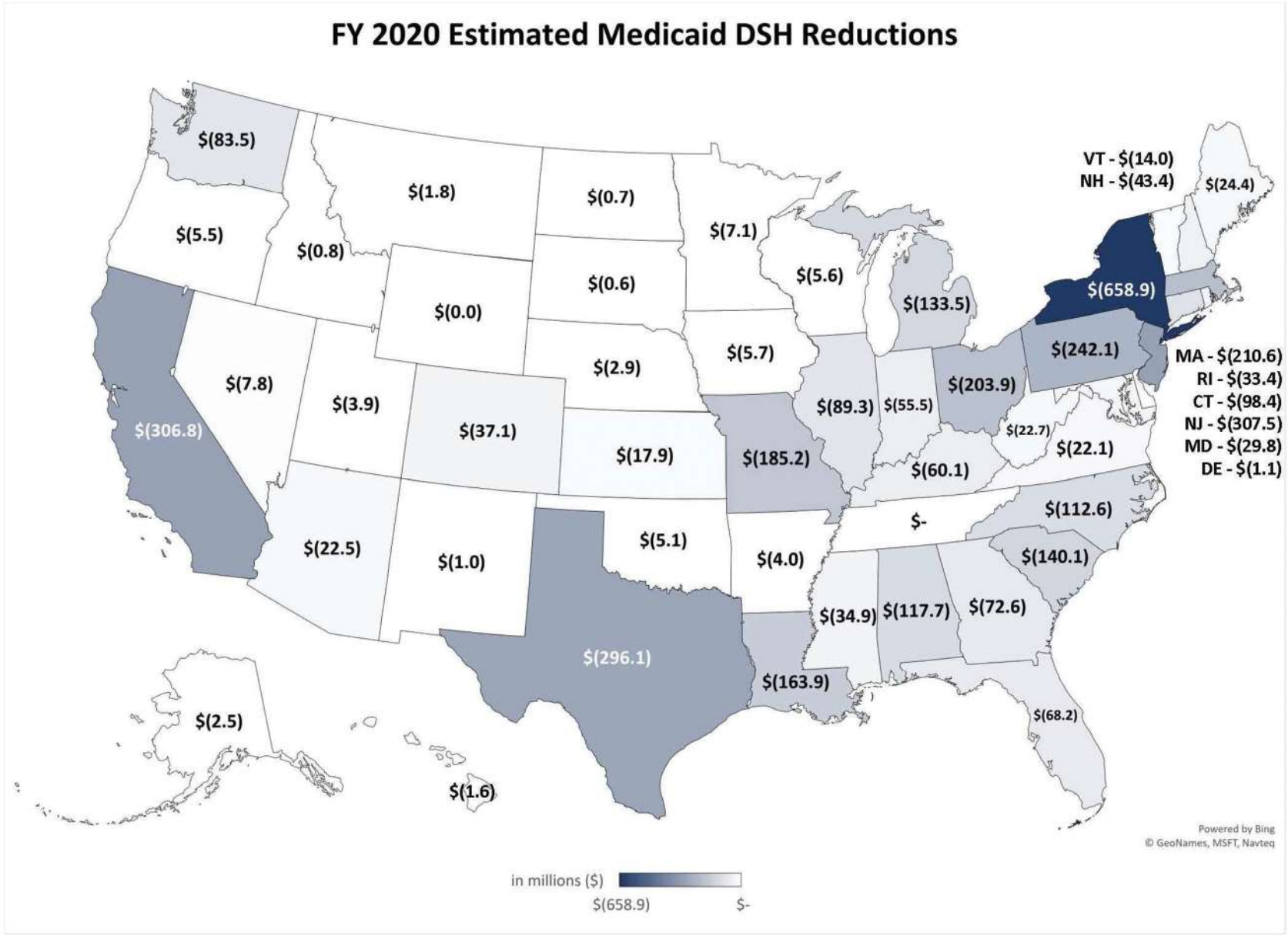
The Uninsured in Georgia

- **1 in 8 Georgians, or 12 percent (1,266,000), is uninsured.**
- **Georgia ranks third-highest in the nation for the percentage of its citizens uninsured.**
- **1 in 15 children in Georgia, or 6 percent (166,100) is uninsured.**

SOURCE: Kaiser Commission on Medicaid and the Uninsured, 2016

After considering all payment sources for Medicaid and the uninsured, hospitals were paid 91 percent of cost for Medicaid and 21 percent of costs for the uninsured in FY 2017.[44] To offset these remaining cost deficits, hospitals need to receive payments from other payers in excess of cost to break even.

Figure 10



The 2010 *Patient Protection and Affordable Care Act* (ACA) included significant cuts to the Medicaid DSH program beginning in 2014 through 2020, based on the premise that more patients will be insured due to the provisions of the ACA (e.g., participation in the Health Insurance Marketplace and Medicaid expansion) and, therefore, hospitals will not incur as much uncompensated care.

Subsequent federal legislation delayed these cuts until May 2020 but extended them through 2025.[45] These cuts will occur regardless of a state's decision to expand Medicaid. Nationally, available DSH funds will decrease by 24 percent beginning in FY 2020 and escalate to a 48 percent reduction by 2021. G***eorgia's reductions are estimated to start at $73 million in FY 2020 (See Figure 10 on page 30 for the estimated FY 2020 reductions by state) and increase to $145 million by 2021.*** In FFY 2019, Georgia's federal DSH allotment was $309 million.[46]

Medicaid Upper Payment Limit Payments

Certain hospitals qualify for supplemental payments to help subsidize regular Medicaid payments that are less than cost. These payments are paid in addition to regular Medicaid payments and are often referred to as Upper Payment Limit (UPL) payments, where the maximum that Medicaid can pay (i.e., the UPL) is either cost or what Medicare would have paid for a service provided to a Medicaid patient. Supplemental payment levels are determined by calculating the difference between the UPL and what Medicaid actually paid hospitals for inpatient and outpatient services under fee-for-service.

Since UPL payments are capped and, therefore, limited, the state categorizes hospitals into two groups, with priority given to the following types of hospitals based on their specific roles in the state or community: regional perinatal centers, hospitals with poison control centers, teaching hospitals, critical access hospitals and hospitals with sickle cell treatment centers. After these targeted payments have been made, the state pays any residual funds to public and certain private hospitals. For UPL payment purposes, public hospitals are defined as hospitals owned or operated by state or local governmental entities.

Inside the H

In FY 2019, supplemental payments to all hospitals totaled $172 million, with $62 million made for targeted payments and $110 million made in residual payments to public and certain private hospitals.[47] In the future, supplemental payments under the current UPL program are expected to decline due to ongoing reductions in Medicare payments (resulting in reductions in the maximum amount of Medicaid funds that can be paid).

UPL payments are funded with a combination of federal and state matching funds based on the FMAP for each state. In Georgia, the source of the state matching funds for residual UPL payments to public hospitals is intergovernmental transfers (IGTs) made by the local governmental entity affiliated with the public hospital. For targeted UPL payments and residual payments to critical access hospitals, the state matching funds have been made available through state appropriations. State matching funds for the residual payments to other private hospitals come from provider payments made by hospitals participating in the Hospital Medicaid Financing Program.

4. PeachCare for Kids

The State Children's Health Insurance Program (SCHIP) was a 1997 expansion of the federal Medicaid program. If authorized by an act of a state legislature, SCHIP allowed states to cover additional children in families with incomes that were modest but too high to qualify for Medicaid. SCHIP funding used a federal funding formula that assigned a higher share of the program's cost to the federal government than the Medicaid program; however, each state was capped at an annual allotment. Like Medicaid, states were required to match federal funds with state funds but at a lower rate as compared to Medicaid.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 extended and expanded the State Children's Health Insurance Program (now referred to as CHIP) through 2013. Under the Act, CHIP continued as a capped program with enhanced matching rates. Each state received an annual allotment and states could receive federal funds for CHIP up to the allotted amount. A state match was still required. In 2010, the Patient Protection and Affordable Care Act (ACA) extended CHIP funding through 2015. Though funding was only appropriated through 2015, the ACA contains a Maintenance of Effort (MOE) clause that required states to continue offering Medicaid and CHIP at 2010 levels until 2019. In 2015, the Medicare Access and CHIP Reauthorization Act once again extended CHIP funding through 2017. More recently, Congress passed a six-year extension of CHIP funding as part of a broader continuing resolution to fund the federal government. MOE provisions require states to continue offering CHIP at levels up to 300 percent of the federal poverty level if they were doing so before 2010.[48]

In Georgia, the CHIP program is referred to as the PeachCare for Kids (PCK) program and covers children not eligible for Medicaid in families with annual incomes up to 247 percent of the federal poverty level (about $52,685 for a family of three.[49]) In FY 2019, Georgia covered an average of almost 141,000 children each month.[50] This is down considerably from the FY 2014 average monthly level of 218,000 children. Effective Jan. 1, 2014, PCK members ages six through 19 with incomes between 100 percent and 133 percent of the federal poverty level were transitioned to Medicaid as required by the ACA. Premiums are required for children ages 6 and over and are based on a sliding scale dependent on a family's income as a percentage of the federal poverty level. For FY 2020, premiums range from a maximum of $36 for one child up to a maximum of $72 per family.[51]

Historically, Georgia's enhanced FMAP for CHIP has been around 75 percent; however, as of Oct. 1, 2015 through Sept. 30, 2019, the CHIP FMAP increased by 23 points (up to a maximum of 100 percent) as a result of the ACA. Georgia's enhanced FMAP was at 100 percent for most program expenditures. A provision of the HEALTHY KIDS Act phased out the enhanced FMAP rate beginning in FY 2020. For FY 2021, Georgia's FMAP is now at 76.92 percent.[52]

Hospitals providing care to PCK members are subject to the same payment methodologies used for Georgia Medicaid.

5. State Health Benefit Plan

The State Health Benefit Plan (SHBP) is self-insured and provides health care insurance coverage for Georgia's active and retired state employees, teachers and school personnel. It is considered a government payer since the plan is self-insured by the state, but it offers one fully insured HMO plan and uses private plans for administrative services.

In FY 2019, the State Health Benefit Plan provided coverage for a monthly average of 666,000 members statewide at a cost of nearly $4.8 billion.[53] The Plan is financed by premiums paid by members as well as employer contributions, which come from state agencies (for state employees) as well as local boards of education (for teachers and non-certificated school service personnel). The amount of premiums and employer contributions are set annually by the Board of Community Health.

The State Health Benefit Plan offers the following:

- Health Reimbursement Arrangement
- Health Maintenance Organization
- High Deductible Health Plan

The Plan offers the following options:[54]

- **Health Reimbursement Arrangement (HRA) -** To align with plan options offered by the federal Health Insurance Marketplace, SHBP members can select from Bronze, Silver or Gold options. Members selecting one of these "metal" options are required to pay deductibles and coinsurance. Members get a starting balance in an HRA account funded by the plan. HRA funding ranges from $100 (Bronze Individual) to $800 (Gold Family) depending on the plan and coverage level. Members can earn additional HRA funds by participating in well-being activities (up to $480 for individuals and $960 for families). HRA plans are offered exclusively by Anthem Blue Cross and Blue Shield.

- **Health Maintenance Organization (HMO) -** HMO members pay copayments but must use providers within the HMO network to receive coverage. Statewide, members can select from two vendors (Anthem Blue Cross and Blue Shield or United HealthCare), while members in the Atlanta region have a third option with Kaiser Permanente.[55]

- **High Deductible Health Plan (HDHP) -** Members selecting the HDHP option are required to pay coinsurance and have higher deductibles in exchange for lower premiums. Enrollment in an HDHP also allows a member to utilize a Health Savings Account. The HDHP option is offered exclusively by United HealthCare.

The Plan uses separate vendors for pharmacy benefit management (CVS Caremark) and wellness programs (Sharecare).

Premiums and member cost-sharing differ by option, with the HDHP option having the lowest premiums but highest member cost-sharing. The HMO and Gold HRA plans have the most expensive premiums but have the lowest member cost-sharing. All plans have a maximum out-of-pocket that varies depending on the plan. Members can pay additional premiums to cover a spouse and any dependents. Tobacco users are assessed a surcharge to promote tobacco cessation and use of the Tobacco Cessation Telephonic Coaching Program. Members can have the tobacco surcharge removed by completing certain wellness requirements.

Providers serving SHBP members must collect deductibles, copayments and coinsurance amounts from members to subsidize insurance benefit payments received from the SHBP. Members who can afford to pay but fail to may be subject to the provider's collection efforts. Unpaid cost-sharing by members may be written off by the provider as either indigent/charity care or bad debt. As discussed previously, these losses must be made up by the provider by making a profit on payments received from other payers.

When available, the SHBP encourages members to utilize other insurance options:

- To receive a premium subsidy, members ages 65 and older are required to participate in one of two SHBP Medicare Advantage Plans (MAP). The MAP options are offered by United HealthCare and Anthem Blue Cross and Blue Shield.

- Members of SHBP can elect to enroll their dependent children in the PeachCare for Kids (PCK) program if their family income is less than 247 percent of the Federal Poverty Level (FPL). Parents of such children are likely to find this option financially attractive due to much lower premiums and cost sharing in the PCK program as compared to the SHBP. Additionally, the PCK program offers some benefits not provided in the SHBP, like dental services. From a provider's perspective, payments for services from the PCK program are much lower than those available from the State Health Benefit Plan and typically do not cover the cost of care provided.

- The SHBP offers a TRICARE Supplement Plan to employees and dependents who are eligible for SHBP coverage and enrolled in TRICARE.[56] The TRICARE Supplement Plan works with TRICARE, the health care program serving Uniformed Service members, retirees and their families worldwide, to pay the balance of covered medical expenses after TRICARE pays.