

Medicaid Managed Care Fee Summary

States have the option of funding some of their share of Medicaid expenditures by using revenue from provider fees on hospitals, nursing homes, managed care organizations, and other health care providers.

Directive	Notes	Key Points
Federal Laws:	<ul style="list-style-type: none"> • Federal Law change requiring all state managed care plans to be treated equally: DRA 2005 • Date of federal law and rule changes: <ol style="list-style-type: none"> 1. Deficit Reduction Act of 2005, 2. Tax Relief and Health Care Act of 2006 (Reduced it to 5.5%) and 3. CMS Final Rule passage 2/2008 	<ul style="list-style-type: none"> • <u>Effective date of the federal law: October 1, 2009</u>
State Law :	<ul style="list-style-type: none"> • State Law that requires compliance with the federal law: • House Bill 392 May 2005 (31-8-170) • Sponsored by Representatives Brown of the 69th, Harbin of the 118th, Keen of the 179th, and Cooper of the 41st • Federal Law reference made in the Georgia Law: "31-8-173. (a) Each care management organization shall be assessed a quality assessment fee, in an amount to be determined by the department based on anticipated revenue estimates included in the state budget report, with respect to its gross direct premiums for the preceding quarter. • The quality assessment fee shall be assessed uniformly upon all care management organizations. • The aggregate quality assessment fees imposed under this article shall not exceed the maximum amount that may be assessed pursuant to the 6 percent indirect guarantee threshold set forth in 42 C.F.R. Section 433.68(f)(3)(i)." 	<p><u>State Law passed in 2005 requires compliance with the federal law:</u></p>
State of Georgia/CMO Contract:	<ul style="list-style-type: none"> • Language in the contract about the Managed Care fee: • Date of original CMO-State Contracts Execution: 2005 • Section 9.2 "The Contractor shall remit the Quality Assessment fee, as provided for in O.C.G.A. §31-8-170 et seq., in the manner prescribed by DCH." • CMS reviews the Managed Care fees as a part of the approval of the capitation rate 	<ul style="list-style-type: none"> • Amount of revenue generated for the state each fiscal year by the Managed Care fee= <p style="text-align: center; color: red; font-weight: bold;"> FY2007 = \$81.7 Million FY2008 = \$89.9 Million </p>
Managed Care Managed Care Fee	<p><u>Choice A Recommended.</u></p> <p><u>Approved by Governor & DCH Board of Directors</u></p> <p>Next Steps:</p> <ul style="list-style-type: none"> • Medicaid State Plan amendment • As a normal course of rate setting for the Medicaid CMO's, CMS will have to approve FY 2010 capitation rates, which would reflect the percentage of revenue that is assessed the QA fee. • The Governor may also need to be specific about the % collected in his budget, as part of setting the state revenue estimate. Currently, it is assumed that we assess the maximum amount. 	<p style="text-align: center;">CHOICES</p> <p><u>Choice A:</u></p> <ul style="list-style-type: none"> • Continue managed care fee • Comply with the federal law by expanding it to include commercial managed care plans • Use a 3% Managed Care Fee rate to cover the current revenue provided by the CMO's (\$90M) <u>and</u> the state budget reduction <p><u>Choice B:</u></p> <ul style="list-style-type: none"> • Discontinue the use to the managed care fee • Reduce Medicaid budget to meet 5% target reduction (\$113.8M) • AND Replace the \$90 M in lost Managed Care fee revenue

Medicaid Managed Care Fee Summary – Federal Laws

Background

- In 1991, the first Bush Administration sought, and Congress enacted, reform legislation that amended the federal Medicaid statute. The reform legislation set detailed criteria for when a state could use revenues from provider fees on hospitals, nursing facilities, managed care organizations (MCOs), and other providers. That Administration implemented these statutory criteria through regulations issued in November 1992.
- The criteria included that the provider fees must be “broad-based,” and prohibited “hold harmless” provisions — ie states may not “hold harmless” providers who are supposed to be paying the fee for any portion of the costs.
- Over two thirds of the states have established such Managed Care fees and rely on revenues from them to help pay their share of the cost of their Medicaid programs.

FEDERAL LAWS & CMS RULE REGARDING MANAGED CARE FEE

Deficit Reduction Act of 2005 - S.1932

CHAPTER 5--STATE FINANCING UNDER MEDICAID

SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) **In General-** Section 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).’.

(b) **Effective Date-**

(1) **IN GENERAL-** Subject to paragraph (2), the amendment made by subsection (a) shall be effective as of the date of the enactment of this Act.

(2) **DELAY IN EFFECTIVE DATE-**

(A) **IN GENERAL-** Subject to subparagraph (B), in the case of a State specified in subparagraph (B), the amendment made by subsection (a) **shall be effective as of October 1, 2009.**

(B) **SPECIFIED STATES-** For purposes of subparagraph (A), the States specified in this subparagraph are States that have enacted a law providing for a tax on the services of a Medicaid managed care organization with a contract under section 1903(m) of the Social Security Act as of December 8, 2005.

Tax Relief and Health Care Act of 2006 - H.R.6111

SEC. 403. CHANGE IN THRESHOLD FOR MEDICAID INDIRECT HOLD HARMLESS PROVISION OF BROAD-BASED HEALTH CARE TAXES.

Section 1903(w)(4)(C) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)) is amended--

(1) by inserting ‘(i)’ after ‘(C)’; and

(2) by adding at the end the following:

‘(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and before October 1, 2011, **‘5.5 percent’ shall be substituted for ‘6 percent’ each place it appears.**’.

*Health Care-Related Provider Tax:

Final rule issued Feb. 22, 2008. Effective April 22, 2008.

Regulation required under the Tax Relief and Health Care of 2006 and temporary reduction in provider tax rate from 6% to 5.5% instead of the 3% the Administration proposed.

The regulation imposes more stringent language in applying the hold harmless test and affords CMS broad flexibility in identifying relationships between provider taxes and Medicaid payments.

It extends the class of permissible health care taxes to managed care organizations, but does not extend the ICF/MR class to broader home and community based services. ANCOR provided comments.