DEPARTMENT OF AUDITS AND ACCOUNTS

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Honorable Jack Hill
Chairman, Senate Appropriations
234 State Capitol
Atlanta, Georgia 30334

SUBJECT: Fiscal Note
Senate Bill (LC 33 8084)

Dear Chairman Hill,

The bill would transfer all medical assistance coverage for foster children from care management organization (CMO) to the fee-for-service Medicaid program. The change from CMO to the fee-for-service Medicaid program would occur upon expiration or renewal of the CMO contract or earlier if authorized under terms of the contact. This bill would apply to medical assistance coverage for all foster children less than 18 years of age in a foster home or the foster care system and individuals who are less than 26 years of age and were in a foster home or the foster care system until their 18th birthday.

The bill is expected to have a fiscal impact related to Medicaid healthcare spending, administration, and foster care youth placements. Additional state costs associated with higher healthcare spending and administrative costs is estimated at $19.2 million. However, it is likely that DFCS would have an undetermined level of savings related to its placements.

Additional Healthcare Spending

The bill is estimated to increase costs of healthcare services approximately $27.3 million annually, with the state share of the increase approximately $9.0 million (**Exhibit 1**). The increase is based on a Department of Community Health (DCH) analysis of the utilization of health services by the foster care population prior to the population's transition to managed care, adjusted for the current cost of Medicaid services and the approximate foster care population (17,300). The analysis assumes that the population will utilize more high cost services under the fee-for-service model.

Exhibit 1: Projected FY 2021 Healthcare Service Costs under FFS and Managed Care

	Under Fee-for-Service – LC 33 8084	Under Managed Care – Current Law	Additional Cost
Total Funds	$155,024,839	$127,730,471	**$27,294,368**
State Funds	$51,003,172	$42,023,325	**$8,979,847**

The fee-for-service model would shift responsibility for certain services from DCH to the Departments of Behavioral Health and Developmental Disabilities (DBHDD) and Public Health (DPH). It should be noted that DBHDD expects significantly higher behavioral health claim costs than those projected by DCH and included in Exhibit 1. For example, DCH's analysis assumes approximately $2,660 in total behavioral spending per individual in FY 2021, though DBHDD indicated spending was approximately $6,000 per individual in FY 2012.

Administrative Costs

Under managed care, a portion of the costs paid to the care management organization is used for administration such as care coordination and prior authorizations, as well as items such as premium taxes and corporate profit. These costs would not occur under the bill. However, new administrative costs are assumed to be incurred by DBHDD for the population receiving behavioral health services. As shown in Exhibit 2, the net additional cost to the state is estimated at $10.3 million. *(DBHDD indicated the need for additional discussions about rebuilding its services for this population, including the level of services, which would impact the estimated costs.)*

Exhibit 2: Administrative Increase Under Fee-for-Service Medicaid

	Under Fee-for-Service – LC 33 8084	Under Managed Care – Current Law	Additional Cost
Total Funds	$45,668,937	$17,582,920	**$28,086,017**
State Funds	$16,053,776	$5,784,781	**$10,268,995**

DBHDD administrative costs include the following:

- Administrative service organization ($900,000 state funds) – The administrative service organization provider certification, prior authorization, annual quality reviews, and utilization review and management. DBHDD currently contracts with agencies to provide services, while the CMO has contracted with individual providers. DBHDD anticipates the need to add 200-300 of the current providers for the foster care population.

- Staff ($515,000 state funds) – DBHDD estimated the need for additional staff for clinical oversight and coordination within the interdepartmental system of care network (DBHDD/DCH/DFCS/DJJ), provider enrollment, policy, information technology, and ASO liaison.

- Care coordination ($13.1 million state funds) – Care coordination would likely entail numerous activities, such as referrals to various providers, coordinating relationships between child-serving systems/agencies, creation of individual health plans, and planning/securing/reviewing the delivery of health care. Without clinical information on the population, DBHDD estimated that 20% of the foster care population would require intensive care coordination and 60% would require some level of care coordination. DBHDD indicated that its estimate does not assume a particular delivery model (state employee vs. contractor) but is based on the cost for the intellectual and development disability population. It should be noted that this type of care coordination did not occur prior to the foster care population's move to managed care.

- Community Service Board capacity ($1.5 million state funds) – DBHDD noted that community service boards (CSBs) reduced their child-serving workforce to match the reduction in the population served. It estimated funding for technical assistance, training, and personnel development targeted to CSBs that serve as the safety net.

Potential Cost Savings Related to DFCS Placements

DFCS noted that a significant portion of the foster care population requires behavioral health services. In the first six months of FY 2020, DFCS reported spending $3.1 million for psychiatric residential treatment facility (PRTF) placements not approved by the CMO. In these instances, DFCS determined that a youth needed psychiatric treatment and resulting costs were borne entirely by the state (i.e., no federal Medicaid funds). DCH's analysis of the foster care population prior to managed care noted that utilization of health services would likely increase with a transition to FFS. In addition, DFCS officials indicated that these services were more frequently authorized for Medicaid coverage under the FFS model. To the extent that Medicaid authorizations increase for services already acquired by DFCS, state costs will be reduced by the use of federal Medicaid funds. The federal government pays approximately 67% of healthcare service costs.

DFCS also attributed a portion of its "hoteling/emergency supervision" to the lack of authorized behavioral health services. It noted that foster care placements fail at a higher rate for youth who do not have sufficient services, resulting in higher hoteling costs. DFCS stated that it spent $6.3 million on these services in the first six months of FY 2020.

Sincerely,

Greg S. Griffin
State Auditor

Kelly Farr, Director
Office of Planning and Budget

GSG/KF/lr